REPORT TO:	**NHS SOMERSET INTEGRATED CARE BOARD** **ICB Board Part A**	**ENCLOSURE:** **E**
DATE OF MEETING:	**26 September 2024**	
REPORT TITLE:	**Somerset ICS Infrastructure Strategy**	
REPORT AUTHOR:	**Richard Baum (Head of Strategic Planning – SFT) and Christine Young (Sustainability and Estates Manager – NHS Somerset)**	
EXECUTIVE SPONSOR:	**Alison Henly – Chief Finance Officer and Director of Performance and Contracting**	
PRESENTED BY:	**Richard Baum and Christine Young**	

PURPOSE	DESCRIPTION	SELECT
Approve	To formally receive a report and approve its recommendations, (authorising body/committee for the final decision)	☐
Endorse	To support the recommendation (not the authorising body/committee for the final decision)	☒
Discuss	To discuss, in depth, a report noting its implications	☒
Note	To note, without the need for discussion	☐
Assurance	To assure the Board/Committee that systems and processes are in place, or to advise of a gap along with mitigations	☐

LINKS TO STRATEGIC OBJECTIVES
(Please select any which are impacted on / relevant to this paper)

- ☒ Objective 1: Improve the health and wellbeing of the population
- ☒ Objective 2: Reduce inequalities
- ☒ Objective 3: Provide the best care and support to children and adults
- ☒ Objective 4: Strengthen care and support in local communities
- ☒ Objective 5: Respond well to complex needs
- ☒ Objective 6: Enable broader social and economic development
- ☒ Objective 7: Enhance productivity and value for money

PREVIOUS CONSIDERATION / ENGAGEMENT

The Infrastructure Strategy was presented to the ICB Finance Committee in July 2024 and has been developed in collaboration with the ICS-wide Estates Group, with advice from NHS England.

REPORT TO COMMITTEE / BOARD

Board is asked to note the enclosed Somerset ICS Infrastructure Strategy, to discuss its contents as appropriate, and to endorse the decision of the Finance Committee to submit the Strategy to NHS England on behalf of the ICS.

Board is asked to note that the Strategy is a working document which will be revised over time, to reflect changing circumstances and priorities. It may also change as a result of feedback received from NHS England.

IMPACT ASSESSMENTS – KEY ISSUES IDENTIFIED (please enter 'N/A' where not applicable)	
Reducing Inequalities/Equality & Diversity	No EIA has been completed because this strategy does not contain detailed plans for specific service changes. Where there are changes to infrastructure flowing from the Strategy, the appropriate EIA process(es) will be followed.
Quality	There are aspects of the Strategy focusing on service quality and workforce. The Strategy notes that changes to infrastructure are designed to improve service quality, and that these will not be achieved without an appropriately resourced and skilled level of Estates workforce. In addition, the general health and care workforce will be better recruited and retailed as a result of improved infrastructure.
Safeguarding	N/A
Financial/Resource/ Value for Money	The schemes set out in the Strategy have significant financial costs. NHS England requested a complete picture of all desired infrastructure improvements over the next ten years. We completed this but are clear that the vast majority will be unaffordable given current financial constraints. All ICB Infrastructure Strategies are similarly restricted.
Sustainability	The ICS Infrastructure strategy is one of several inter-linked supporting strategies that set out how the ICS's overall objectives will be delivered, including the Green Plan. The ICS Green Plan sets out nine core aims to drive us to our net zero carbon target. Some of these relate directly to our estate, whereas others are more peripheral. The aims are aligned to the Estates Net Zero Carbon Delivery Plan and underpinned by the ICS Strategic Aims.
Governance/Legal/ Privacy	N/A
Confidentiality	N/A
Risk Description	There is a risk element in the body of the document

Somerset Integrated Care System

Health and Care Infrastructure Strategy

2024 - 2034

Contents

1. Foreword

The development of our ICS has been the result of a partnership between local organisations that have come together to plan and deliver joined-up health and care services to improve the lives of people living across Somerset.

Colleagues from across the Health and Care system, including NHS, Council and voluntary sector partners, have already worked together to help Somerset recover from the Covid-19 pandemic. We now want to build on this with this Infrastructure strategy, which sets out the current and future demands on health and care buildings across the county and looks to deliver an estate which meets the health needs of our population in an efficient and effective way for all of Somerset.

Instrumental in the development of this strategy have been the Estates teams across our partner organisations, which play a key role in planning how we will improve and adapt our estate to support and enable our health and care services meet the needs of our population.

The estate will play its part in the transformation and integration of our health and care services, and through collaborative working we will capitalise on this opportunity to redesign and create an estate suited to the needs of our ICS.

2. Purpose and aim of the strategy

This Infrastructure Strategy for the Somerset Integrated Care System aims to describe our current estates infrastructure, and how this might change in the coming years.

We aim to give readers a full understanding of the size, scope and condition of the current estates' infrastructure. This ranges from NHS acute hospitals to community and mental health facilities, GP practices and dental surgeries. Outside of primary and secondary care NHS services, it also includes residential care homes and Council facilities, infrastructure related to the Ambulance Service, and infrastructure used by other organisations in the ICS involved in delivering care to local people.

A key aim of the Strategy is to set out our plans for the future, and how we intend to realise them. This includes both strategic and financial plans, but also the risks and issues which might prevent us from achieving our goals. These challenges, whether they be to do with our population or our finances, are important to understand to place our plans in context.

The overall purpose of the Strategy is to allow readers and members of the ICS to fully understand our infrastructure, how we want it to change, and how we might achieve those changes.

3. Executive Summary

The public health and care estate in Somerset is large and varies considerably in its condition and age. Some of our buildings are modern and flexible, fit for modern healthcare delivery. Others are over 150 years old and no longer easy to keep safe. The organisations within the ICS also manage their estate in different ways. Some of it is directly owned and managed, some is leased, and the Council acts as a Corporate Landlord for some of its estate.

This ICS Infrastructure strategy describes the current estate, sets out a vision for the future, and explains how the organisations making up the ICS will realise this vision collaboratively. It also lays out the significant challenges faced in doing this, particularly given funding restrictions and the increasing difficulties of managing greater demand in facilities which are not fit for purpose.

Somerset faces key challenges which impact its infrastructure now and/or in the future. These include:

- Demographics: Our population in is on average older than the rest of England, meaning that our infrastructure must reflect this, and needs to change quicker than elsewhere.
- Housing Developments. The population across Somerset will grow by over 10% by 2045. More housing is required, but this means more pressure on health infrastructure, especially given the higher proportion of older people living in (and moving to) Somerset.
- Estate Condition and Functional Suitability. The condition of our estate is mixed and often poor.
- Lack of living accommodation for colleagues. Somerset has a chronic shortage of keyworker housing.
- Backlog Maintenance & Asset Management. There is significant backlog maintenance identified across key sites. Significant old estate means higher maintenance costs.
- Future constraints on capital availability. Capital expenditure limits are not high enough to allow us to make the investments required, and this situation may worsen over time.

3. Executive Summary

Somerset ICS's priorities are to:

- Put the health and wellbeing of the people of Somerset at the heart of our approach.
- Work as anchor institutions within our local economy and commit to 'buy local, employ local and invest local' wherever possible.
- Ensure that the views of the people of Somerset are central within our decision-making.
- Develop an ICS collaborative working approach, underpinned by a systems mindset.
- Establish the ICP and its ownership of the integrated care strategy for Somerset, in the context of the Health and Wellbeing Board's Improving Lives Strategy and the needs of the population.
- Develop and implement a system-wide strategy to sustain and develop primary care.
- Develop and begin to implement our 5-year joint forward plan and 2-year operational plan.

The ICS is made up of several organisations. Major sites at which health and care services are delivered or managed include County Hall in Taunton, Musgrove Park Hospital and Yeovil District Hospital. We also have over a dozen community hospitals, and hundreds of smaller facilities for outpatient services, community care, primary care, and council care services and office colleagues.

We have undertaken an exercise to identify those parts of our estate which could be classed as "Core", "Flex", and "Tail". Core estate is good quality and fit for purpose. Flex estate is of an acceptable quality but does not allow us to fully realise our ambitions. Tail estate is poor quality estate that is not fit for purpose. Overall, the ICS estate has a mixture of Core, Flex and Tail facilities. Buildings of different categories can often be found on the same site, particularly the larger sites such as Musgrove Park Hospital and Yeovil District Hospital.

We want to take forward the following five principles:

1. Ensuring that the health estate meets the objectives of the clinical strategy through promoting safe, effective, high-quality care delivered in the most appropriate setting and through enhancing health and wellbeing.
2. Ensuring that the health estate promotes colleague wellbeing and productivity.
3. Ensuring the current health estate is fully and effectively utilised and reducing estate where it is not required or not cost effective to maintain.
4. Ensuring that current health estate is fit for purpose.
5. Reducing the running costs of the health estate to enable better use of resources.

3. Executive Summary

Over the next few years, we will transform in- and out-of-hospital care. The healthcare estates will need to adapt, and this will particularly be pertinent to ambulatory and community-based care. However, a large part of the healthcare estate will continue to provide services that will not be affected by the changes in the model of care, and this will apply to acute and mental health inpatient facilities.

New models of care should reduce the dependence on bed-based care by helping provide alternative settings of care to offset the growth in demand. This may not however reduce the number of overall beds and avoid the need to invest in expanding the estate across the trust, and particularly at the acute sites.

We will work as a system to move to new approaches to asset management. These will include the Council becoming a Corporate Landlord with one dedicated property department.

We will look to develop services which reflects the ICS's desire to work at a neighbourhood level and to deliver services which reflect the stated needs of local communities. This will involve continuing to gather data and feedback from local people, and to develop services which can be delivered at the most appropriate scale from facilities of high quality within local communities.

4. Introduction

Who are the partner organisations that make up our ICS?

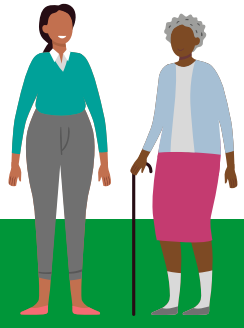
The Somerset Integrated Care System (ICS) is made up of organisations including Somerset NHS Foundation Trust and Somerset Council, which own, lease and work from a large and varied estate, including landmark buildings such as County Hall in Taunton, and two major district general hospitals. It also includes Primary Care health services, Council services and other partners working out of many buildings of various ages and sizes. Overall, the ICS delivers care from hundreds of facilities ranging from community centres and libraries to state-of-the-art modern diagnostic health centres.

Across Somerset, the organisations making up the ICS provide primary care, community health services, social care, mental health and acute hospital services, as well as other public services which contribute to the health and wellbeing of our population. Services are provided from buildings which contribute to our shared community, acting as social and community hubs, and helping with population wellbeing which goes far beyond the direct provision of health and care services.

The public health and care estate varies considerably in its condition and age. There is a mix of modern fit for purpose buildings, and older buildings and infrastructure, some of which are over 150 years old. This variety provides challenges in the delivery of high-quality healthcare services. The organisations within the ICS also manage their estate in different ways. Some of it is directly owned and managed, some is leased, and the Council acts as a Corporate Landlord for some of its estate.

The Somerset ICS exists to help people live healthy lives, supported by thriving communities with timely and easy access to high quality and efficient public services. Ensuring that we have good quality, accessible, local buildings and facilities to deliver public services is key to helping the ICS achieve its aims. The ICS ten-year vision is to create:

- A thriving and productive Somerset that is ambitious, confident and focused on improving people's lives.
- A county of resilient, well-connected, safe and strong communities working to reduce inequalities.
- A county infrastructure that supports affordable housing, economic prosperity and sustainable public services
- A county and environment where all partners, private and voluntary sectors, focus on improving the health and well-being of all our communities.
- The aim of this Infrastructure strategy is to outline our current position, explain what we want to do to help the ICS achieve its aims, and set out how we will do it.



The ICS Infrastructure strategy

The ICS Infrastructure strategy is one of several inter-linked supporting strategies that set out how the ICS's overall objectives will be delivered. It sits alongside the ICS Clinical Strategy, and similar strategies for areas such as digital development, sustainability, workforce and finance.

This ICS Infrastructure strategy aims to provide:

- A description of the current estate, including its strengths and weaknesses.
- A vision for the future of the estate owned, leased and operated by ICS member organisations, together with a robust framework for the planning, management and investment to achieve that vision.
- Evidence of the alignment of the estate plans across different organisations, to ensure that all the constituent organisations within the ICS work in a coherent way to develop an estate of the right size, location, type, condition, cost and quality.
- Assurance that there are articulated plans in place across all relevant ICS organisations to ensure that estate is managed, used and resourced in an efficient secure and safe way and complies with all necessary policies and standards.
- The context in which new proposals and business cases for capital investment can be assessed.

This strategy is structured to respond to three fundamental questions. This is the standard approach to developing an Infrastructure strategy as laid down by the Department of Health. The three questions are:

Where are we now?

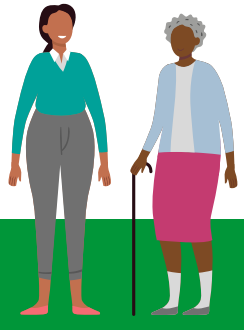
This section describes the current ICS estate. It provides an analysis of the status and performance of the current estate and provides a baseline against which to develop and measure future action.

Where do we want to be?

This section provides the basis and context for identifying the strategic direction for the ICS estate, and its consequent requirements.

How do we get there?

The final section of the document sets out how it is proposed to manage and develop the estate across the ICS, to achieve the plans and targets established. This includes the consideration of collaboration between organisations.



How we developed our Infrastructure strategy

Our Infrastructure strategy was developed using a strong and well-established partnership approach with colleagues working across Somerset, providing a solid basis for collaboration to ensure the enabling function of the healthcare estate can flourish as the ICS develops.

The infrastructure strategy was coordinated by an ICS-wide Estates Group which met monthly. This comprised representatives from all the major organisations in the ICS. It was complemented by regular bi-lateral and multi-organisational discussions and workshops.

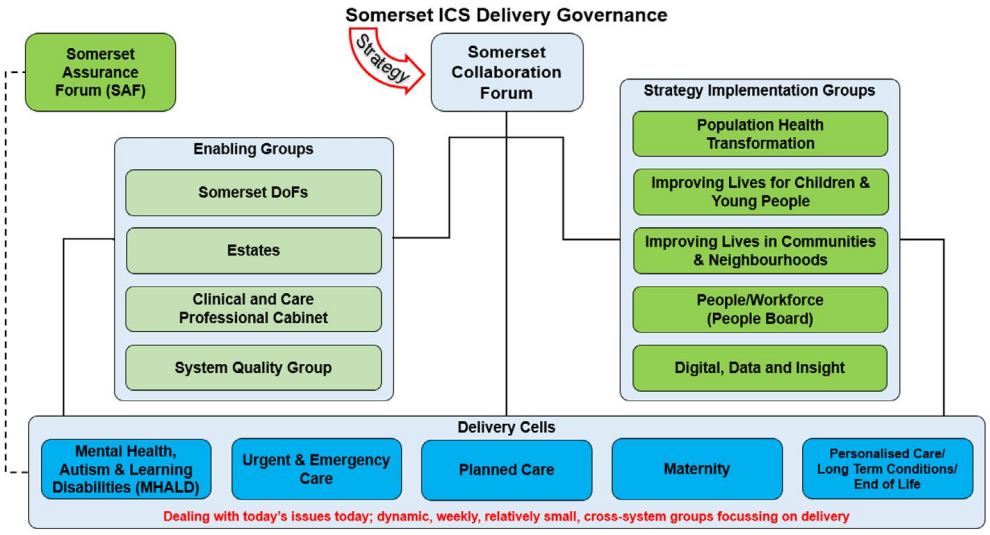
This system-wide Estate Strategy seeks to show how the NHS estate across Somerset can change to support new models of care, deliver better outcomes to patients, and provide best value for money. While this is our plan for our estate, it will complement, inform, and be integral to wider integration developments between the NHS, local government, and the voluntary sector.

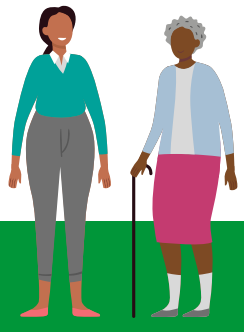
ICS and Infrastructure strategy governance

The ICS is led by an NHS Integrated Care Board (ICB), an organisation with responsibility for NHS functions and budgets, and an Integrated Care Partnership (ICP), a statutory committee bringing together all system partners to produce a health and care strategy.

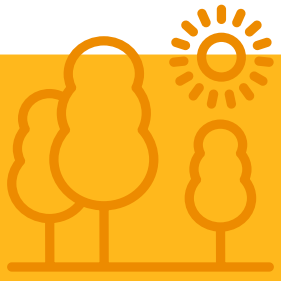
We have established a robust governance process to ensure that the infrastructure strategy develops because of collaborative working at a system level, making decisions for the benefit of the system and our population as a whole.

The infrastructure strategy workstream links operationally to the ICS Executive for its direction through its Senior Responsible Officer. It is one of several operational groups within the ICS. Its main role is to bring key system partners together to develop and deliver the strategic estates vision and objectives that support the Integrated Care System to realise its vision, purpose, goals, and deliver upon its priorities. Our Infrastructure strategy workstream is comprised of members leading the estate function across system partners, including links to local authorities and One Public Estate (OPE) partners. Our NHSE/I Estates Delivery Lead has also been very involved in the development of this Strategy from the outset.





5. National context



The environment within which the NHS operates is changing. The population is increasingly ageing, and this national issue is of particular prominence in Somerset. Significant advances in medicine and surgery mean that the way that healthcare is delivered is also changing, and the facilities needed to deliver it well will need to change as a result. Patient expectations are becoming different, and there is a need to harness research, innovation, and technology in how we improve services and the facilities in which they are delivered.

These developments and the national policies which relate to them sit alongside the local drivers in being the foundations of our Infrastructure strategy. They guide, set, and inform 'where we want to be' and 'how we get there'.

This ICS Infrastructure strategy captures how our estate and infrastructure will utilise, enable, support, and empower collaborative delivery, ensuring that all parts of the Somerset ICS are improving lives together.

The NHS Long Term Plan (LTP) (2019)

The NHS Long Term Plan sets out how the NHS will tackle the pressure its staff are facing while making extra funding go as far as possible. As it does so, it must accelerate the redesign of patient care to future-proof the NHS for the decade ahead.

It also sets out four major, practical changes to the NHS service model, to be delivered over the following five years:

- Boosting 'out-of-hospital' care, and joining up primary and community health services
- Reducing pressure on emergency hospital services
- Digitally enabled primary and outpatient care
- Increasing focus by local NHS organisations on population health and local partnerships

There are some key opportunities for estates outlined in the LTP including "the NHS will improve the way it uses its land, buildings and equipment." This includes the following key highlights:

- Improving quality and productivity, energy efficiency and dispose of unnecessary land to enable reinvestment while supporting the Government's target to build new homes for staff.
- System providers working together to reduce the amount of non-clinical space, freeing up space for clinical or other activity.
- In line with Lord Carter's recommendations, the NHS needs to exploit opportunities for consolidation of the non-clinical estate to improve efficiency with a 30% cost reduction target, less than 2.5% unoccupied space and less than 35% non-clinical space.
- Increase the provision of diagnostic equipment and services including digitisation of the service to meet the growing demand.

5. National context

The LTP suggests that the NHS will continue to maximise the productivity benefits generated from estate, through improving utilisation of clinical space, ensuring build and maintenance is done sustainably, improving energy efficiency, and releasing properties that are no longer needed.

This ICS Infrastructure strategy has been developed taking account of the guidance put forward in the LTP and responding to the challenges of the Carter, Naylor and Fuller review. These include some of the challenges detailed elsewhere in this document, including Primary Care, hospital bed capacity, community services, social services and digital maturity.

The Naylor Review (2017)

In March 2017, Sir Robert Naylor produced his report for the then Secretary of State titled **'NHS Property and Estates: Why the estate matters for Patients'**. The review identified the opportunity to release £2bn of NHS assets for reinvestment and deliver land for 26,000 new homes. The report outlined 17 separate recommendations relevant to national or local structures, the four following recommendations are of note:

- Systems should develop affordable estates and infrastructure plans, with an associated capital strategy, to deliver the 5 Year Forward View (5YFV) and address backlog maintenance. These plans should be supported by robust business cases. The new NHS Property Board should support the development of these plans.
- System estates plans, and their delivery should be assessed against targets informed by the benchmarks developed for this review. Land vacated by the NHS should be prioritised for the development of residential homes for NHS staff, where there is a need.
- Substantial capital investment is needed to deliver service transformation in well evidenced STP (now ICS) plans. This could be met by contributions from three sources: property disposals, private capital (for primary care) and from HM Treasury.

The focus of capital investment in the past has been weighted towards secondary care, but it may now be the case that this needs to be changed. However, the current GP owner-occupier model includes perverse incentives which can make cross-system collaboration more difficult. As with the NHS workforce, we need to recognise that the current mindset and approach to estates may need to change to enable better system-wide working. This will help to build estates models that better align with delivery of clinical, digital and workforce strategies.

The Fuller Review

In November 2021 Amanda Pritchard, NHS Chief Executive, asked Dr Claire Fuller, Chief Executive-designate Surrey Heartlands Integrated Care System (ICS) and GP, to undertake a stocktake on integrated primary care, looking at what is working well, why it's working well and how we can accelerate the implementation of integrated primary care (incorporating the current 4 pillars of general practice, community pharmacy, dentistry and optometry) across systems. The Fuller Stocktake sets out a new vision for integrated primary care based on developing streamlined access to urgent care for those that need it, more personalised care from a team of professionals for those with complex care needs, and a proactive approach to prevention at greater scale. This resulted in a shared, system-wide approach to estates, including NHS trust participation in system estates reviews, with organisations co-locating teams in neighbourhoods and places.

5. National context

The New Hospitals Programme (2020)

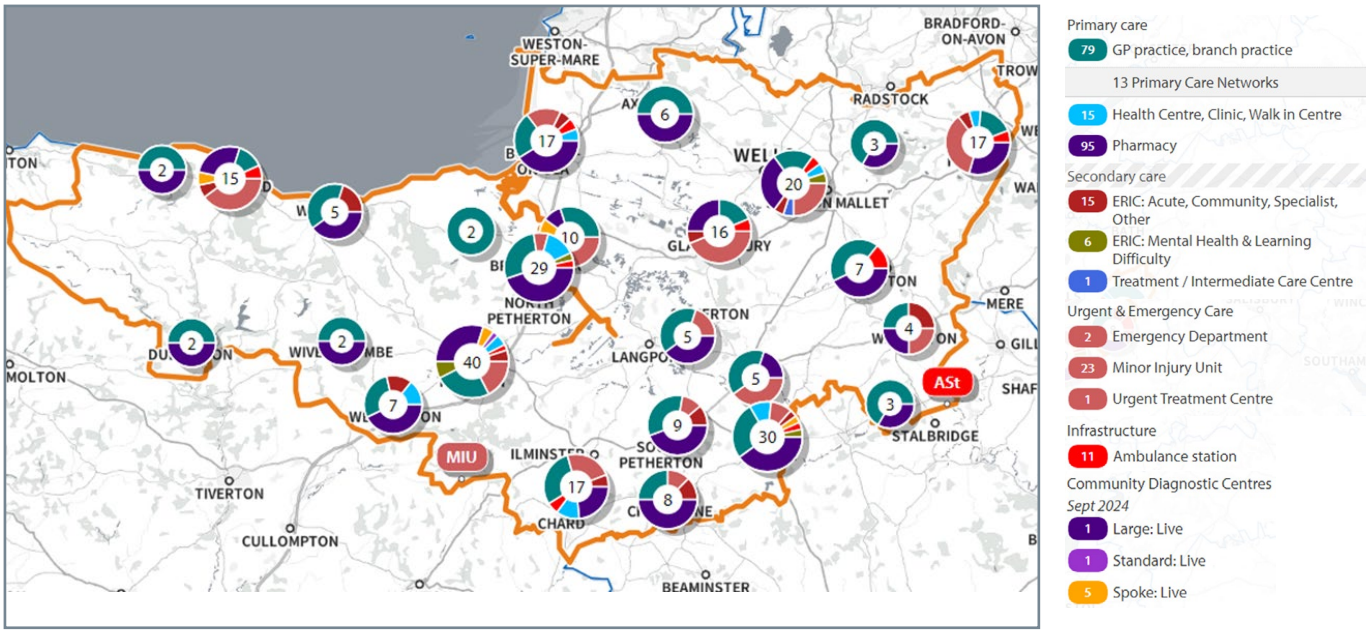
The New Hospitals Programme aims to deliver 40 new hospitals by 2030. Somerset NHS Foundation Trust has developed plans for significant investment in its two District General Hospital sites as part of this programme. If delivered, these plans will lead to historic investment on the hospital sites, radically altering the facilities which we provide care from, and completely transforming our two biggest hospitals. The plans have yet to be formally signed off, but this Infrastructure strategy sets out what we want to achieve with our new facilities, and how we will use them to deliver our priorities.

Our infrastructure is maintained and improved through capital investment, which is a key part of meeting current and future patient demand through ensuring patient safety, better health outcomes, reducing key cost drivers in the system and supporting the NHS workforce to do their jobs effectively, in well-designed and safe settings. Investment in well-designed buildings can also help improve productivity and reduce costs across the NHS estate, for example reducing maintenance costs, or reducing walking times for staff.

Somerset in context: Key Estates Challenges

Demographics: Our population in is on average older than the rest of England, increasing the need for health and social care support, as multi-morbidity, frailty, and risk of emergency admissions increase with age. This impacts the way we need to plan our services and infrastructure, most notably accessibility to our primary and community provision. There has also been a recent increase in demand from children and young people accessing our services due to emotional wellbeing and mental health needs, and gaps in learning following the pandemic.

Fig 1. Somerset Healthcare Estate



5. National context

Estate Condition and Functional Suitability

The condition of our estate influences the experience of those working or being treated there. Some of our estate is modern and well equipped, however, other parts of it are ageing and carry significant backlog maintenance, which results in high running costs and requires considerable ongoing maintenance. We also have properties that are no longer fit for purpose, unable to support new ways of working and provide the most appropriate care in the most appropriate place. Some estate remains underutilised as it does not provide the suitable, flexible, infrastructure required to align with new operational delivery models of care. There are challenges within primary care premises to offer community and secondary care services, thereby impacting the provision of integrated care. Much of the primary care premises in many places are not fit for purpose for current delivery or for implementing future plans.

Backlog Maintenance & Asset Management

There is significant backlog maintenance identified across key sites, including 1940s facilities at Musgrove Park Hospital, and some primary care facilities built in the 1800s. The condition of our estate is mixed, with significant tracts of aged estate carrying the higher risk backlog maintenance requirement.

Leasehold properties and IFRS16

Our approach to estates planning must consider the International Financial Reporting Standard (IFRS) 16, which relates to leasehold property. This requires organisations to consider the right-of-use of assets, and the correct financial treatment of leases in this context. This has significant impact on organisational balance sheets, and sometimes disincentivises lease renewals.

Future constraints on capital availability

We are working in an environment with increasingly challenging finances, and a lack of available capital. Capital expenditure limits are not high enough to allow us to make the investments required, and this situation may worsen over time. Without appropriate amounts of capital available, the system will struggle to make improvements to the fabric of buildings. New accounting standards requiring the capitalisation of leases makes this situation more challenging still.

Lack of living accommodation for colleagues

Somerset has a chronic shortage of keyworker housing, and the existing staff accommodation on acute hospital sites is nowhere near enough to meet demand. Without managing the accommodation estate, either through building, buying or leasing more, we will not be able to attract and retain the colleagues necessary to deliver services into the future. We are working across the ICS to use our size and scope to enter the property market on behalf of colleagues, and to use existing accommodation in the most flexible and effective way possible.

5. National context

Housing Developments

The population across our system is around 575,000 and growing (it is projected to grow by over 10% in the next 20 years), with migration into Somerset exceeding those moving out of the area. Population numbers and characteristics lie as fundamental determinants of the total demand for health and care services. Somerset is characterised by a population that is growing in numbers, and with a higher proportion of older people than the national average. Growth is largely from migration, with people moving in for work – particularly in and around urban areas, and at retirement, particularly on the coast and rural areas. The proportion of older people is growing whilst that of working-age is declining. This means that fewer working age people are potentially available to provide care for the older people, who tend to have greater and more complex health needs. This is the greatest strategic challenge to provision of health and care services in the county.

To cope with this increasing population more housing is required, however, new development places additional demand upon existing infrastructure and services such as health and social care. We must also consider how we best develop new infrastructure to reflect changing need.

The population is divided approximately equally between rural and urban. Housing estates in the major towns are the areas of Somerset that score highest on the Index of Multiple Deprivation, and although they tend to have younger populations than the countryside, the conditions associated with poor housing and low income mean that there are areas of considerable health need, as covered in the JSNA report on vulnerable children and young people. Rural areas are generally fairly prosperous, especially within commuting distance of the towns, but the mix of housing types can mean that individuals and households in need are 'lost in the averages', and providing services to a widely dispersed population is a particular challenge.

Index of Multiple Deprivation

The 2021 Census showed that **Somerset has a population of 571,600, an increase of around 41,600 people since 2011**. About half of the population live in rural areas, and the rest in small to medium sized towns and villages. Taunton is the largest urban area with a population of approximately 70,000 people.

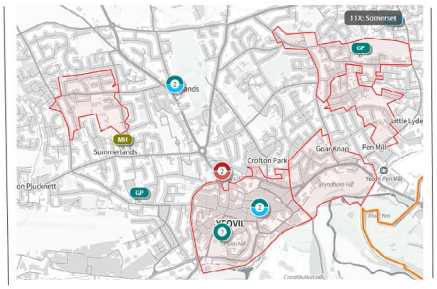
The most deprived 20% of the national population is identified by the national Index of Multiple Deprivation (IMD). The IMD has seven domains with indicators accounting for a wide range of social determinants of health.

Somerset has less deprivation than the England average. Approximately 10% of the Somerset population fall into the England Core 20 most deprived group, which are mainly centred in urban areas, see map. There is a lot of rural deprivation which is not as extreme but exacerbated by poor transport and access to services, and digital exclusion, especially in West Somerset and coastal areas. (SJNA).

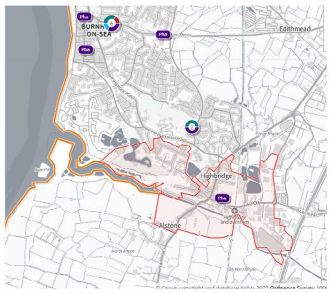
5. National context

Fig.2 Somerset Areas of Deprivation (source: Shape Atlas)

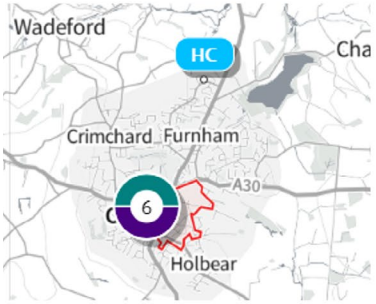
Wellington



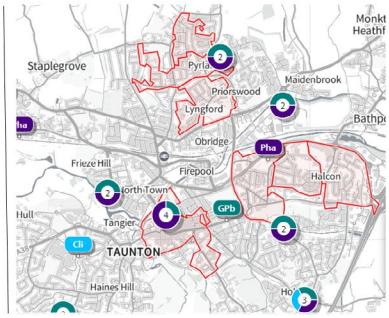
Yeovil



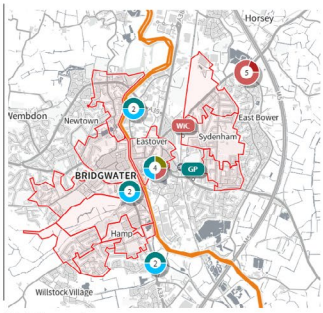
Burnham & Highbridge



Chard



Taunton



Bridgwater

Housing Developments

Life expectancy in Somerset is above the national average and premature mortality rates are lower, although on average the last 17 years are spent in ill health. Whilst this presents a positive picture of population health, indicators at different stages of the life course are mixed, whilst the ageing demographics, particularly in West Somerset, mean that longer life expectancy and healthy life expectancy nevertheless generate increasing pressures on the health and care system over time.

Health indicators for children and young people in Somerset present a mixed picture, with infant mortality similar to the England average, fewer low birth weight babies than the national average, good oral health in five-year olds (Somerset 17.5% decay v 23.4% England), and a lower-than-average proportion of children overweight than average in year 6. There are more concerning indicators among older children and adolescents, with hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14 years) and young people (15-24) significantly above the England average and emergency admissions for intentional self-harm (Somerset 289.2 per 100k) significantly worse than nationally (England 181.2).

Mental health is a further concern among adults, deaths from suicide are much higher than the national average (Somerset 14.3 per 100k, England 10), and admissions due to alcohol are significantly worse that the England average. It's estimated that whilst about three out of four people with physical illness receive treatment but only one in four people with mental health problems do.

Adult health is particularly affected by the ageing population. The number of people with dementia is likely to double by 2035 to around 18,000. Only about 54% of the estimated cases are diagnosed compared to 62% nationally. Further to this, emergency hospital admissions due to falls in people aged 65-79 are lower than the England average but higher among those aged over 80. (SJNA).

6. Delivering a Net Zero National Health Service (2020)

Climate change poses a major threat to our health as well as our planet. The environment is changing, that change is accelerating, and this has direct and immediate consequences for our patients, the public and the NHS.

The NHS was founded to provide high-quality care for all, now, and for future generations. Understanding that climate change and human health are inextricably linked, in October 2020, it became the first in the world to commit to delivering a net zero national health system. This means improving healthcare while reducing harmful carbon emissions, and investing in efforts that remove greenhouse gases from the atmosphere.

With around 4% of the country's carbon emissions, and over 7% of the economy, the NHS has an essential role to play in meeting the net zero targets set under the Climate Change Act (Delivering a 'Net Zero' National Health Service).

Since the NHS published the 'Delivering a Net-Zero National Health Service 'in October 2020, there have been further developments in this area with the publication of the Net Zero Carbon Building Standards in February 2023.

In response to the health emergency that climate change carries two clear and feasible targets emerge for the NHS net zero commitment, based on the scale of the challenge posed by climate change:

- For the emissions we control directly (the NHS Carbon Footprint), net-zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032.
- For the emissions we can influence (our NHS Carbon Footprint Plus), net-zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.

Success in reducing the emissions of the NHS estate will lay the foundation for carbon reductions across the NHS. We can lead the way on net zero through decarbonising the estate – helping to give other functions the confidence and direction needed to define their own actions to support our joint progress.

Early action – between 2021 and 2031 – will focus on our areas of greatest opportunity, achieving operational reductions in emissions from building energy, water, waste and our estates and facilities fleet.

Progress will also be made on longer term goals in our New Hospital Programme, through engaging our suppliers and improving access to low-carbon transport for staff.

This early action will help to mitigate against rising costs for carbon offsetting. Offsetting is not an accepted mitigation factor within the NHS for the NHS Carbon Footprint, due to the urgent need to focus on reducing emissions that we are responsible for. (Estates Net Zero Carbon Delivery Plan).

6. Delivering a Net Zero National Health Service (2020)

Many of our facilities across our public estate in Somerset, are old and inefficient. Our ICS Green Plan, and the organisational sustainability plans which feed into it, address Net Zero as a whole. A large part of that is making sure that our estate is as energy efficient, sustainably developed and environmentally friendly as possible. As we develop new buildings and renovate old ones, we will also be able to contribute to the Net Zero agenda more broadly by recognising the importance of an estate which promotes joined up and sustainable travel for patients. This emphasises the importance of working in partnership across our region to ensure our Estate Strategies are robust and enable system wide resilience.

In February 2023 the **NHS Net Zero Building Standard** was published. Whilst the approach to managing whole life carbon in the https://www.england.nhs.uk/estates/nhs-net-zero-building-standard The Standard is relevant to all healthcare buildings; it also applies to all investments in new buildings and upgrades to existing facilities.

To meet its targets for estates and facilities, organisations will need to ensure that all operational and capital expenditure between now and 2032 not only addresses the purpose that it is to be used for but also enables the implementation of measures that support emissions reduction. Importantly, this does not need to be spent exclusively on decarbonisation projects but can and should form a central part of NHS capital planning and decision making.

Safer, greener buildings and Net Zero

Our ICS Green Plan is underpinned by the UN's 17 Sustainable Development Goals. The climate crisis is worsening as greenhouse gas emissions continue to rise. The latest Intergovernmental Panel on Climate Change report finds that global temperature is already 1.1 °C above pre-industrial levels and is likely to reach or surpass the critical 1.5 °C tipping point by 2035. There have been numerous catastrophic heat waves, droughts, flooding and wildfires. Rising sea levels are threatening hundreds of millions of people in coastal communities. In addition, the world is currently facing the largest species extinction event since the dinosaur age and the oceans were burdened with over 17 million metric tons of plastic pollution in 2021, with projections showing a potential significant increase.

6. Delivering a Net Zero National Health Service (2020)

Extract from the UN Development Goals Report 2023

Fig. 3 (The-Sustainable-Development-Goals-Report-2023.pdf (un.org))

Our ICS Green Plans will provide buildings that utilise zero carbon energy. Our services will minimise the use of resources and we will improve ecology and biodiversity across our public estate to provide a haven of well-being for our patients, colleagues and visitors.

Biodiversity Net Gain (BNG) is a way of creating and improving natural habitats. BNG makes sure development has a measurably positive impact ('net gain') on biodiversity, compared to what was there before development.

The Green Plans set out high level objectives to reach the net zero carbon target. However, the sustainable interventions that will achieve these objectives, and the ultimate goal, have much wider potential benefits such as enabling improved wellbeing for colleagues and patients, improved diets and reduced costs of delivering our services and for those people accessing our services.

Nine core aims have been set across the ICS to drive us to our net zero carbon target. Some of these relate directly to our estate, whereas others are more peripheral. The aims are aligned to the Estates Net Zero Carbon Delivery Plan and underpinned by the ICS Strategic Aims (see Section 6 Clinical strategy and clinical operational plans).

A green whole organisation approach

Working with our supply chain

Net zero carbon buildings

Reducing waste generated by our services

Reducing emissions from travel

Green anaesthesia and other medicine

Food and Nutrition

Transformation to digital healthcare

Adaptation to the impacts of climate change

As our Infrastructure strategy is delivered, we will embed the following principles into our work, and work closely with ICS partners to ensure that Net Zero, increased environmental sustainability, and wider green delivery are at the heart of our developments.

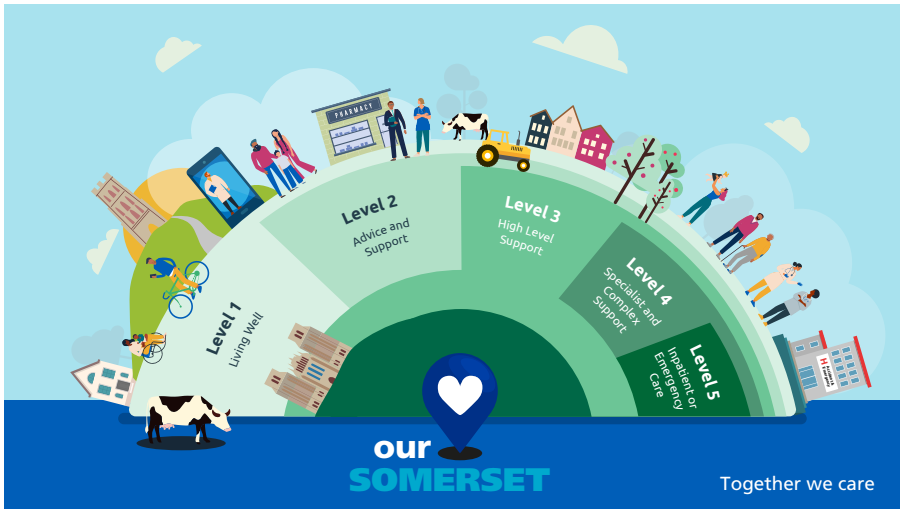
6. Delivering a Net Zero National Health Service (2020)

Core Aim	
A green whole organisation approach	Raising the profile and understanding of sustainability across the ICS workforce and leadership teams.
Working with our supply chain	Work with our supply chain and Quality Improvement to reduce single use plastics and identify suitable items for re-use or re-manufacturing. In compliance with PPN 06/20;06/21 providing appropriate support within our supply chains around Carbon Reduction Plans, Net Zero Commitments, and Evergreen Supplier Assessments. Embed social value in all procurements and contracts.
Net zero carbon buildings	Achieve net zero carbon for all energy use in buildings across our ICS estate. In compliance with mandated guidance around Biodiversity Net Gain (BNG) from 12 February 2024 under Schedule 7A of the Town and Country Planning Act 1990 (as inserted by Schedule 14 of the Environment Act 2021) developers must deliver a BNG of 10%. This means as an ICS we are committed to ensuring any developments across our estate will result in more or better-quality natural habitat than there was before development.
Reducing waste generated by our services.	Reduce waste and implement the principles of the circular economy across our ICS estate and supply chain. ICS Members will strive to achieve zero waste to landfill for non-clinical waste by 2030.
Reducing emissions from travel	Reduce our impact on local air quality through travel and transport. The carbon emissions from ICS-controlled transport will be net zero by 2040 with a minimum 80% reduction in carbon emissions by 2030.
Green anaesthesia and other medicine	Reduce CO2 emissions associated with anaesthetic gases, inhalers and other medicines. Tackling overprescribing as set out in the Somerset Medicines Green Carbon Footprint Strategy. Improve access and patient outcomes by moving more towards social prescribing and nature-based interventions and activities.
Food and Nutrition	Reduce overall food waste and ensure the provision of healthier, locally sourced, minimally processed foods and seasonal menus. Clear focus on obesity, diabetes and weight related operations.
Transformation to digital healthcare	The NHS Delivering a Net Zero report highlights the importance of digital interventions to reduce carbon. Embed net zero principles across all clinical services especially through digital transformation. Review care pathways and opportunities to increase digitisation of services and minimise patient travel.
Adaptation to the impacts of climate change	Mitigate the effects of climate change and severe weather conditions. All ICS members to have a climate change adaptation plan by 2024. Acting on adaptation will improve the resilience of our services and the communities they serve, lessen the burden of illness and disease, and reduce health inequalities. Climate change adaptation means responding to both the projected and current impacts of climate change and adverse weather events.

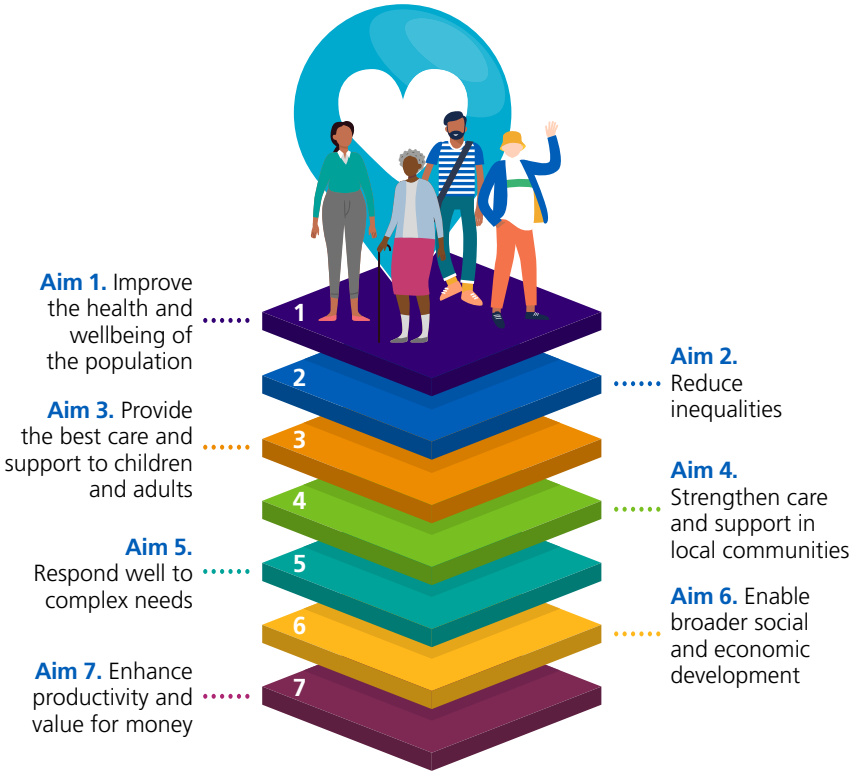
7. Clinical strategy and clinical operational plans

ICS Strategy

The Somerset ICS has set out its strategy in the document "Our ambition for a healthier future in Somerset 2023-28". Having described the current challenges and opportunities for the county, the strategy sets out a vision and a new model of care.



The Somerset 'Model of Care' shows how we intend to support people through their health and care needs, with a focus on prevention as the basic building block. The model of care will be delivered with a focus on our ICS seven strategic aims. The first five of these aims make up the first five strategic aims of Somerset NHS Foundation Trust as well, showing a common thread articulated in organisational strategies. The sixth and seventh are particularly pertinent to estates, as we need to deliver new uses for our estate, and new estate, in a way which maximises the potential of the county and does so whilst delivering excellent value for money.



7. Clinical strategy and clinical operational plans

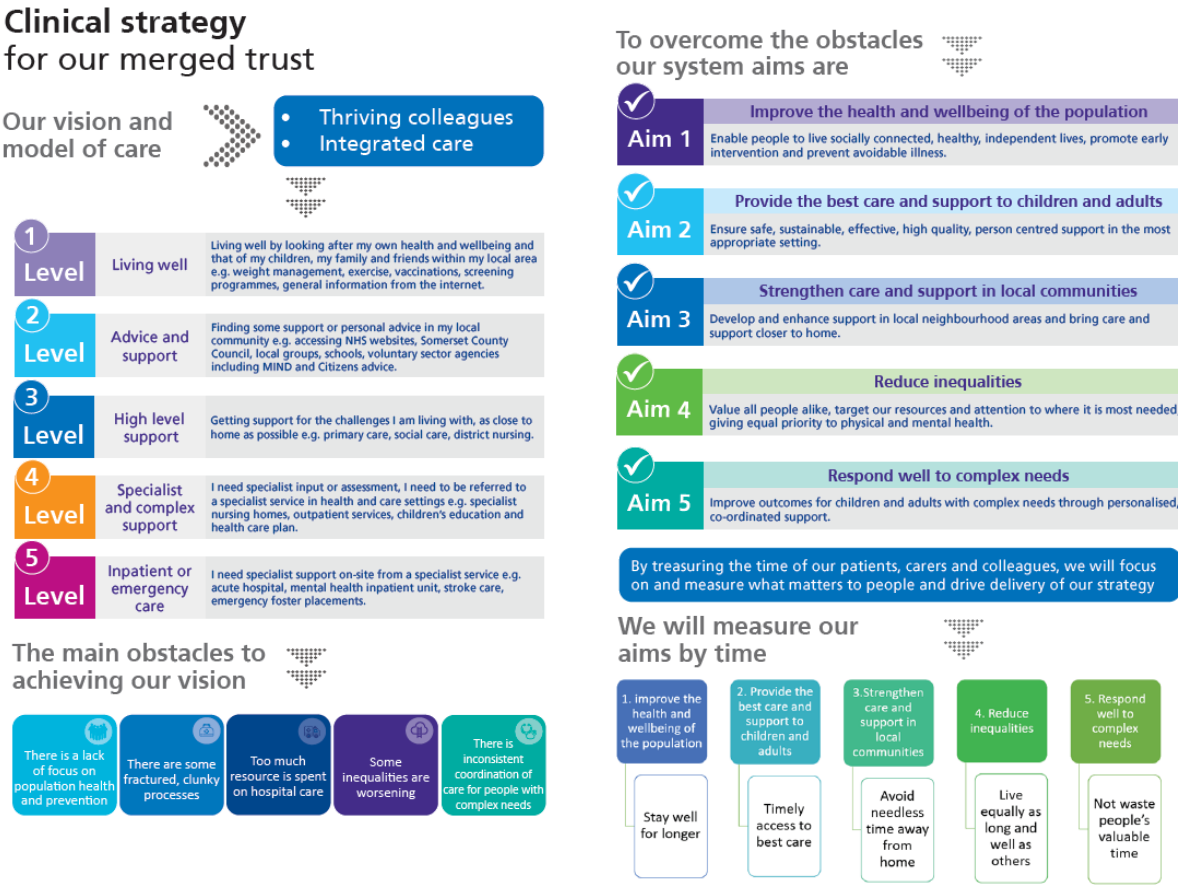
Somerset NHS Foundation Trust clinical strategy

Somerset NHS Foundation Trust delivers acute, community and mental health services for Somerset as part of the ICS, as well as delivering around a quarter of GP services for the county. Its clinical strategy seeks to improve the quality of the services that it provides.

The trust's model of care covers the entire pathway from living well through to inpatient care and describes how the trust will deliver better services at every level to keep people well for longer, out of hospital where possible, and making the most of their time.

The trust has identified a series of obstacles that impede effective service delivery, such as poor coordination between services, too much resource delivered through hospitals, and a lack of focus on illness prevention. Having identified these obstacles, there are now plans to overcome them through the programmes that the trust is delivering to achieve its strategic objectives. Many of the obstacles would be partially relieved with better buildings, and better use of existing buildings. As a result, the clinical and estates strategies are closely connected. We are clear that we won't be able to achieve excellent clinical services without an estate fit to deliver them from. Similarly, as we look to develop our estate, we are clear that it needs to change to meet the goals of the clinical strategy.

Somerset NHS Foundation Trust's clinical strategy can be summarised as follows:



7. Clinical strategy and clinical operational plans

Aligning workstreams with Estates, and wider community involvement

The Clinical Strategy above is one of several supporting strategies that will help the trust achieve its objectives. The trust's objectives are aligned with those of the ICS. Another of the supporting strategies is this Infrastructure strategy.

Management of the alignment is achieved through the governance processes outlined elsewhere in this document. But in brief, estates issues are coordinated via the multi-partner ICS Estates Group, the chair of which is a member of the ICB Board and the Board of Somerset NHS Foundation Trust. The ICS Estates Group is one of several ICS- level groups charged with the coordination of individual organisational work, to make sure that the whole ICS is pulling in the same direction.

The ICS Estates Group also involves representatives from the Police, voluntary sector and the wider public sector. Part of the work of the group is to bring together all the strands of related work being taken forward elsewhere. This includes projects such as One Public Estate, where public sector organisations consider what efficiencies and sharing initiatives could be taken forward across the entire public sector estate, breaking down organisational boundaries to ensure that money is efficiently spent and kept within the public sector where possible. We are conscious of our role as public sector organisations, and the wider responsibilities that that entails. The Council has a specific remit for economic regeneration, but all ICS partners realise their responsibilities to the county as a whole, and their economic and social heft as large employers. The work of the ICS Estates Group, and of this strategy, moves beyond simply improving buildings and looks to the social good that we can engender from a more strategic approach to Estates planning.

8. Our ICS Priorities

Somerset ICS was created in July 2022 and is still maturing. Under our initial priorities for the ICS we will:

- **Put the health and wellbeing of the people of Somerset at the heart of our approach and work together to address inequality by targeting our focus and resources towards prevention and early intervention, while ensuring the sustainability of our statutory services. We will underpin this with an ICS-wide approach to population health improvement.**
- **Work as anchor institutions within our local economy and commit to 'buy local, employ local and invest local' wherever possible, playing our part in workforce development and economic regeneration.**
- **Ensure that the views of the people of Somerset are central within our decision-making.**
- **Develop an ICS collaborative working approach, underpinned by a systems mindset.**
- **Establish the ICP and its ownership of the integrated care strategy for Somerset, in the context of the Health and Wellbeing Board's Improving Lives Strategy and the needs of the population.**
- **Develop and implement a system-wide strategy to sustain and develop primary care.**
- **Develop and begin to implement our 5-year joint forward plan and 2-year operational plan.**

The Somerset ICS has agreed five health and care aims which will enable us, collectively, to deliver the trust's clinical strategy and the wider county's health and care strategy. As a system, we developed these aims based on the challenges Somerset faces in delivering consistently high quality and efficient care (the obstacles set out above), as well as the current and future needs of the Somerset population.

Our five clinical health and care aims are:

Aim 1: Improve the health and wellbeing of the population. Enable people to live socially connected, healthy, independent lives, promote early intervention and prevent avoidable illness.

Aim 2: Provide the best care and support to children and adults. Ensure safe, sustainable, effective, high quality, person-centred support in the most appropriate setting.

Aim 3: Strengthen care and support in local communities. Develop and enhance support in local neighbourhood areas and bring care and support closer to home.

Aim 4: Reduce inequalities. Value all people alike, target our resources and attention to where it is most needed, giving equal priority to physical and mental health.

Aim 5: Respond well to complex needs. Improve outcomes for children and adults with complex needs through personalised, co-ordinated support.

8. Our ICS Priorities

These aims have an impact on our estate, and/or will be achieved as a result of work that we can undertake to improve our estate.

For example, we know that the best way to promote early intervention and help people live independent lives (Aim 1) is to make sure that care is accessible locally from high quality, easy-to-reach and easy-to-use facilities in local communities. Aim 2 specifically mentions the most appropriate setting for the delivery of care, and we want to improve and develop our estates and facilities to achieve this. Neighbourhoods (Aim 3) need good quality buildings, and part of our work across partners in the One Public Estate project is to make sure that this is the case and that we efficiently use the large and varied estate that we have. A reduction in inequalities (Aim 4) cannot be achieved quickly or well without recognising the need for public facilities of the right quality and in the right locations. And we recognise that for Aim 5 and the care of our most complex and vulnerable patients, we need specialist facilities and buildings fit to house the most modern equipment. We also need to maximise our buildings' abilities to use technology for both routine and complex care.

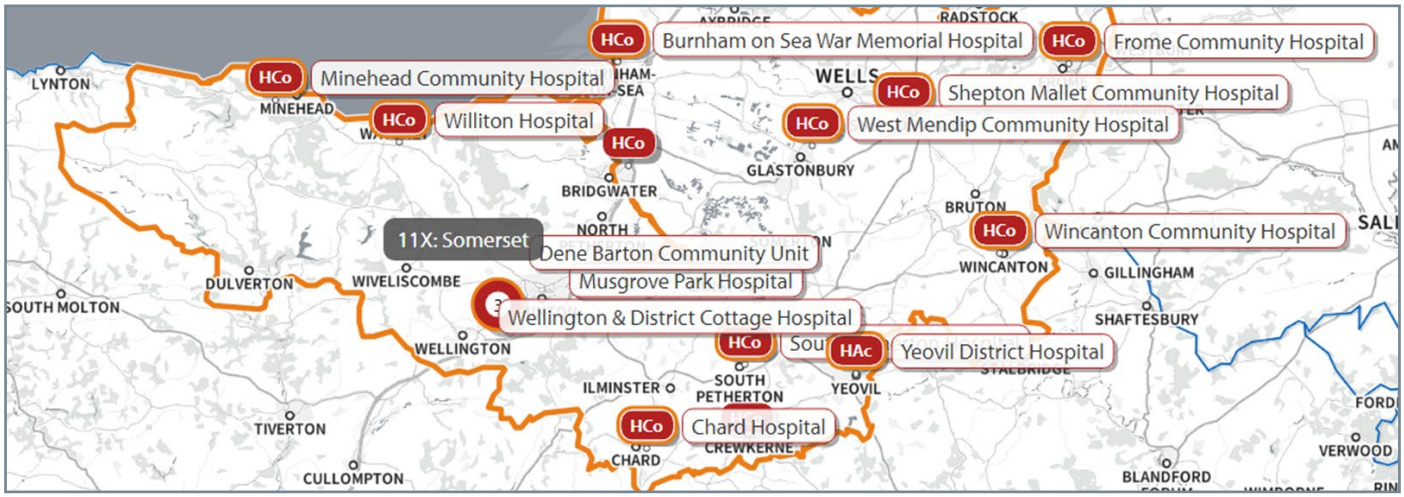
We operate in the context of an infrastructure which is not without risk. There are several facilities where we are delivering services from sub-optimal buildings, and these poor starting points will have a big impact on our ability to achieve our aims. For example, maternity services at Musgrove Park Hospital in Taunton are delivered from 1940s buildings far beyond the end of their useful lives and presenting significant safety and service continuity challenges. Lack of capital funding has made replacing these buildings impossible so far. These and other risks are considered in more detail below.

9. Where are we now?

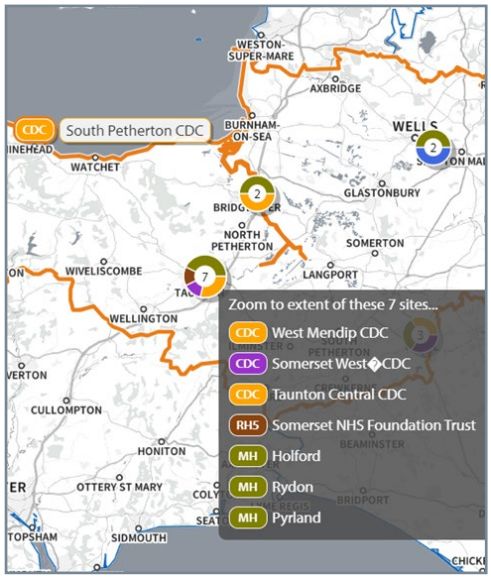
The ICS is made up of several constituent organisations which lease, own and operate a variety of buildings.

These include major sites such as County Hall in Taunton, Musgrove Park Hospital and Yeovil District Hospital, as well as over a dozen community hospitals, and many smaller buildings and facilities for the delivery of outpatient services, community care, primary care, and council care services. We also have numerous office buildings of various sizes across the county. Some of our buildings are multi-use, and they represent a wide range of ages, sizes and conditions.

The maps below show the location and geographic spread of the major health estate, including acute hospitals, MIUs and community hospitals across the county.



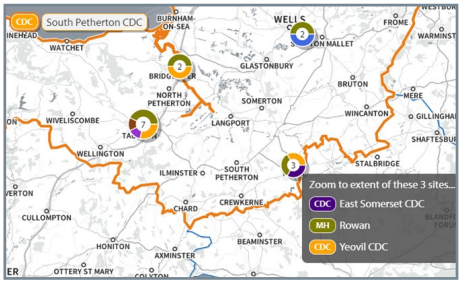
Acute and Community Hospital Sites



Community diagnostic centres

Community hospital sites

Community diagnostic centres - SPOKE



Community diagnostic centres - Large and standard

9. Where are we now?

The partners that make up our ICS have the following estate:

Somerset Foundation Trust (SFT) Musgrove Park Hospital

SFT delivers its services from a wide variety of locations and buildings. Its largest site is Musgrove Park Hospital (MPH), a District General Hospital covering an area of over 32 acres, with over 700 beds. MPH began life as a United States military hospital during World War II. After the war, it continued in use as a Ministry of Pensions Hospital and only became a General Hospital within the National Health Service in 1951.

Until the 1980s, most clinical services on site were delivered from World War II-era buildings including Nissen huts, one of which still stands today. The accommodation today known as the "Old Building" was constructed in 1942 and is still used as the accommodation for paediatrics, general theatres, critical care and various other, smaller services. The Maternity service is also delivered from accommodation of a similar age, and there are significant risks in our maternity buildings including fire risks and the availability of emergency theatres. We mitigate these risks as far as possible but it is clear that buildings are far from optimal. A range of newer buildings have been developed on the site from the Queens Building opened in 1987 the Duchess Building, which opened in 1995, the Beacon Centre (a PFI development), opened in 2009, and the Jubilee Building, which opened in 2014. There is currently a development of new surgical centre which will address the provision of operating theatres, critical care and endoscopy facilities.

The hospital site is tightly constrained, with no spare land, and significant space pressures on site. Significant accommodation and space problems remain to continue to deliver services and develop on what is a very tightly packed site. Old buildings offer a poor patient experience and are very expensive to maintain. The Trust's long-term aim for its estate is to improve patient experience by replacing old, inefficient buildings with new ones. The Site was announced as one of the New Hospital Programme 40 new hospitals in 2019/2020 and as a result has developed a strategic plan for the development of the site as part of the national New Hospitals Programme. Hospital improvement plans will be delivered according to the principles of the national Hospital 2.0 standards

As part of the strategy to transfer services to the community where possible and to focus on essential services on the Musgrove Site the Trust developed two diagnostic centres including a community diagnostic centre in partnership with the independent sector and an ophthalmology hub.

The Trust delivers facilities from 70,000m2 of Community estates including 13 community hospitals (37,000m2), four dental access centres, sixteen community health buildings (14,000m2) and four principal mental health sites (17,000m2), with a further 14 smaller sites (2,000m2). The buildings comprise of a mix of inpatient provision, day units, residential provision and community team bases. In addition, community services are delivered from a wide range of other venues, including GP surgeries, under licence agreements. The current community and mental health estate is generally in good condition, operationally sound and safe after significant investment in the improvement of facilities for the people who access the sites. Investment has generally been used to enhance the environments and meet modern day standards.

9. Where are we now?

Yeovil District Hospital

SFT's second district general hospital site is Yeovil District Hospital (YDH), located close to Yeovil town centre. The 1970s site was designed to 1960s standards and suffered from under-investment for many years However, there has been investment in the estate over the last five years, which has been targeted to the areas of greatest need. In addition, there has been ongoing programmes of works to address backlog maintenance issues which have contributed to upgrading the general environment as well as other projects to improve space configuration, sustainability and safety issues. The overall site needs continued investment to ensure it meets current standards of estate and delivery of care.

There remains limited capacity to develop services on the site, due to constrained space. Routine maintenance is challenging due to the lack of capacity to close areas for refurbishment, the capacity within theatres, endoscopy and outpatients has become constrained with limited ability to expand within the building.

Over the past 2 years there have been significant planned developments within the site which will expand the capacity quality and resilience of the site which are currently in progress

- Additional day case theatre to support elective recovery and resilience of theatre capacity.
- Development of a Breast Care Centre funded by fundraising from our local community.
- Investment in energy efficiency, infrastructure, and carbon reduction plans
- Additional outpatient capacity
- Development of an additional inpatient theatre and bed capacity
- Development of a standalone diagnostic centre on site providing a range of diagnostic services
- The site will require significant and continued investment over the coming years to ensure the provision of facilities, particularly due to the constrained nature of the site and the difficulty in coordinating multiple projects on such a site at the same time.

Community buildings

The trust operates 13-community hospital facilities, which range in age and current functional suitability. The oldest Crewkerne Hospital is over 150 years old with Bridgwater Hospital the most recent which was opening in 2014. The hospitals provide varied range of services which vary across sites and include Minor Injury units, imaging, community investigation units, rehabilitation beds, outpatient services in addition to community services. The estates are currently mixed with a range of functionally suitable facilities in the newest hospitals whilst several of the older hospitals' present challenges in meeting current building standards.

The Trust provides community-based services from a range of other settings including owned and leased buildings, over recent years there have been pressures on the accommodation on community buildings, these have been alleviated by the development of additional capacity within the Taunton areas focusing on families' services and community services.

The lease for office accommodation at Mallard Court, Bridgwater has a break clause in March 2024. Alternative options for office accommodation in Bridgwater are being explored with Somerset County Council as part of the One Public Estate opportunities with a view of issuing notice to the landlord for Mallard Court. Similar One Public Estates office accommodation opportunities are being explored with other healthcare partners in Yeovil.

Mental Health

The current configuration of adult mental health inpatient facilities across the county is unsuitable for the provision of high-quality patient care. There are significant quality and safety issues for patients with provision of inpatient services in the existing two "standalone" wards in the East of the county, one of which is a substantial distance from an emergency department and cannot offer 24/7 medical cover.

The Board of the former Somerset Partnership NHS Foundation Trust decided in July 2016 to move away from providing stand-alone mental health wards based on patient safety and quality of care. Following public consultation that concluded in late 2019, SFT Trust Board agreed to relocate the St Andrew's ward on the Wells Priory Health Park to the Summerland Hospital site in Yeovil adjacent to the existing Rowan ward. The proposal to provide 2 inter-linked wards enables a more sustainable provision of service that offers a greater level of confidence in managing crisis and emergency situations, preventing harm to other patients and colleagues. The new ward is currently under construction and due to complete Mid 2023. The newly built and refurbished Rowan wards will both benefit from ensuites to all bedrooms and include a review of all the safety and anti-ligature features. The design provides a flexibility to bed management, enabling single sex accommodation to be provided if required and the addition of a shared Extra Care Area.

Plans are underway to consolidate services on the residual estate at Wells Priory Health Park, providing an opportunity to relocate services currently provided in some of the more poorer quality estate into new refurbished accommodation. This will require further investment in the coming years and has been identified as a future funding requirement.

Over the past five years there has been considerable investment in both the inpatient and community based mental health estate including facilities in Bridgwater and Taunton. During 2021 the Trust took the opportunity to purchase and develop several 'high street' and community-based facilities which will operated in conjunction with the voluntary sector.

9. Where are we now?

Working in partnership

Our work on developing the estate is not something that we are pursuing alone. We have investigated the opportunities available to us using subsidiary organisations and private sector partnerships to open up new ways of managing property and enabling finance for refurbishment and new build.

The trust entered into a Private Finance Initiative (PFI) contract in 2008 for the construction of the Beacon Cancer centre. This enabled the delivery of a brand-new building for radiotherapy and chemotherapy delivery amongst other cancer-related services, and this building will revert to the trust after 25 years. The arrangement also includes replacement of radiotherapy linear accelerators, as well as other equipment and the maintenance of the building.

Our partnership work has extended to other parts of the estate as well. We delivered a 9-storey car park on the Musgrove Park Hospital site as part of a partnership with a private sector partner which also manages wider parking provision on site. We have also delivered other smaller buildings and facilities in partnership with the private sector which has easier and more flexible access to capital funds.

In Yeovil, we wholly own Simply Serve Ltd (SSL), which is a subsidiary company of the Foundation Trust and delivers maintenance of our estate. Again, this innovative arrangement has come about as a way of becoming more flexible with our financing arrangements, opening up new funding streams which wouldn't be open to use under traditional NHS finance regimes.

9. Where are we now?

Primary Care

Symphony Healthcare Services (SHS) manage GP practice estate across the county on behalf of the trust. SHS currently manage 16 GP practice buildings, all but two of which are leased.

The Fuller Report reported that there are 8,911 premises in England, 22% of which are pre-1948 and 49% of which are owned by GPs, 35% owned by a third party, and 14% owned by NHS Property Services. Around 2,000 premises have been identified by GPs as not being fit for purpose. There has been no significant investment in GP, pharmacy, optometry or dental estate since old Primary Care Trusts ceased to exist in 2013. Since that time, the Somerset population has grown, as has the number of people seeking Primary Care support. The number of appointments has increased and is increasing, as is the number of appointments per patient. Primary care itself has expanded, with significantly more roles now than a decade ago.

We have undertaken a broad and deep assessment of the condition of the Primary Care GP Estate as part of our work on the PCN Estates Toolkit Phase 2. Overall, the outputs of working on the toolkit have shown that quality of the estate varies. In terms of its size, the overall space for GP practices across the county is appropriate for the level of population that we have today. However, this masks significant variance across different PCNs and practices. Many of the practices pose no challenges, but there is a need for change across some of the estate. For example, North Petherton surgery is too small, and alternative locations are being sought for when the current lease expires. Similar issues exist at Crewkerne and at Bruton surgery, and a planning application for a larger surgery is currently being progressed. At Ryalls Park Medical Centre in Yeovil, there are plans for a two-storey extension, funded by the landlord in exchange for a renewed lease. This will provide additional capacity when Yeovil Medical Centre closes. Two practices are working out of 18th century buildings, but even more modern buildings pose challenges. For example, some 1980s buildings are now reaching the end of their useful life.

Where issues exist, there is no single cause or solution. In some areas the problems relate to the condition of the buildings, whereas in other areas the issue is size. Even some more modern buildings are now considered too small to cope with the demands of an increased and increasingly needy population.

The third phase of the PCN toolkit will allow us to better understand the condition of the wider Primacy Care estate, moving beyond GP practices. We intend to undertake this work in early 2024.

https://www.england.nhs.uk/wp-content/uploads/2022/05/next-steps-for-integrating-primary-care-fuller-stocktake-report.pdf

9. Where are we now?

Somerset Council

Somerset Council is a new organisation, created in 2023 by combining the functions of 5 predecessor councils (Mendip, Sedgemoor, South Somerset, and Somerset West and Taunton District Councils and Somerset County Council).

The Council inherited a large property asset base, with a wide variety of lease / tenancy arrangements, occupants and building types – managing this large and complex estate will bring challenges. However, the combination of resources, skills and assets inherited from each of the predecessor councils will also bring opportunities, and strategic advantages.

There is a significant maintenance backlog. Estimating the level of backlog maintenance across the Somerset Council estate is very uncertain, due to the age and quality of existing condition survey data; however, a recent high-level estimate has valued the property maintenance backlog at £10-£15m for the non-schools operational properties that the new Council has maintenance responsibility for. Across the estate, there are properties that are approaching the end of their lifespan, where repair and maintenance is not economically viable – whilst there are no immediate concerns, in the longer term this issue will need to be addressed. Funding from government to address the condition of buildings currently falls far, far short of what is needed, both locally in Somerset and at a national level.

On top of the financial challenge of this significant maintenance backlog, Somerset Council will also face a challenge in the cost and difficulty of decarbonising its estate in order to meet its Climate Emergency Strategy commitments.

The predecessor County and District Councils have made a positive start to estate decarbonisation, and Somerset Council will inherit a non-schools estate where heat decarbonisation has been achieved in a number of properties, together with a technical / professional property workforce that has developed skills and learning in new, low-carbon technology.

Key worker Accommodation

We know that an important part of our infrastructure is the provision of accommodation for our staff, some of whom move here from other parts of the country, and an increasing number of whom move here from abroad e.g. doctors and nurses. Somerset is not the obvious destination for overseas colleagues, but a good way of enticing them is to provide them with high quality accommodation.

Somerset NHS Foundation Trust has a limited number of properties which it owns and leases, principally on or near to its hospital sites. The accommodation is a mixture of Houses of Multiple Occupation (HMOs) and a small number of family dwellings. There is also a large population of medical students who live in halls-of-residence style accommodation whilst training with the trust.

We are working with public and private sector partners to explore the potential for more key worker accommodation, as we recognise that a lack of accommodation is a barrier to the achievement of our aims. A number of options are being explored, and they are at various stages of development. Some, such as linking with estate agents and offering landlords rent guarantees, are short term and likely to yield results quickly. Longer term plans include the provision of keyworker accommodation as part of regeneration activity in the centre of Taunton and Yeovil.

9. Where are we now?

Estates and Facilities workforce challenges

Our Estates and Facilities workforce faces challenges that mean it will be more difficult for us to achieve our aims. A major workforce challenge is age. 35.8% of Somerset FT's Estates workforce is over 55, and 20% is over 60. Only 3.6% are under 25. Recruitment of skilled colleagues with trade backgrounds such as electricians, fitters/plumbers, estates professionals and project managers is very challenging. The Trust is supporting the recruitment of these posts with the implementation of recruitment and retention premium, but even with this additional incentive our salary rates are below the regional and national market rate.

The situation is exacerbated by the Hinkley Point C project, which is the largest civil engineering project in Europe, and which has had a major impact on the availability of skilled staff in the region. Salaries paid by the trust for an electrician are around £28,000 (inclusive of premium) which is less than half the pay offered by Hinkley. The colleagues we need to clean and cater our estate are also difficult to find, as similarly skilled roles in retail offer more sociable hours and better pay. Fewer staff and increasing vacancies has led to an increase in pressure on existing staff. This in turn has had an impact on sickness rates, and now colleagues working on and in our infrastructure report up to 10% sickness against a target of 4%. We are working with Bridgwater and Taunton College to see how we might develop and upskill our existing staff and also to develop apprenticeships and training courses, but these will take some years to make a difference and would come at financial cost which the trust cannot currently afford. There are also growing demands as programmes like the New Hospital Programme and increased digitalisation change the patterns of demand that our workforce must meet.

Commercial Opportunities

Our estate and wider infrastructure present us with a number of commercial opportunities, which we will explore. For example, there are value-add campaigns which are aimed at patients, visitors and NHS colleagues. Somerset NHS FT has established a contractual relationship with a third-party provider who has a trusted reputation through working with 43 NHS providers. Campaigns funded by third-party charities and commercial organisations such as Macmillan Cancer Care and the British Heart Foundation are hosted at our sites across acute and community facilities, enabling digital and wall advertising, from which the trust receives an income share.

The trust has also begun to pilot direct advertising with consumer-facing providers of services within Somerset, using external lift doors and car park barrier sleeves. Any income received will support internal projects within SFT. This has the potential to expand over time. Other opportunities include naming rights, which are being explored on a case-by-case basis.

9. Where are we now?

Estates Data

We have significant data regarding the ICS estate, including its size and condition, its age and its current usage. This is used to inform decision making, for example the current work being undertaken as part of the Primary Care Network toolkit. This piece of work analyses the Primary Care estate (GP practices and the wider estate e.g. dental and pharmacy) and considers its current size and condition relative to population need. This allows us to plan more carefully for future estates expenditure, and to inform debates about more transformative change.

We have undertaken an exercise to identify those parts of our estate which could be classed as "Core", "Flex", and "Tail", using those terms as described by NHS England as follows:

- **Core: Good quality, fit-for purpose and future proof estate that aligns with the ltp and the ICS's clinical strategy.**
- **Flex: Estate that is of an acceptable quality, or provides unique access to services, but does not fully enable the ambitions of the LTP.**
- **Tail: Poor quality estate that is not fit-for purpose or for patient-facing services and should be phased out when alternative estate is available.**

Overall, the ICS estate has a mixture of Core, Flex and Tail facilities. Buildings of different categories can often be found on the same site, particularly the larger sites such as Musgrove Park Hospital and Yeovil District Hospital. For example, at Musgrove Park, Core estate includes the Jubilee Building, which was opened in 2013 and contains over 100 en-suite rooms used for medical and surgical patients. These modern facilities allow us to deliver high quality care, which is aligned to the ICS clinical strategy, from a building which is flexible and fit for its purpose. However, it is immediately adjacent to the older Queen's and Princess buildings, which have reached the end of their intended lifespan, and would now be classed as "Flex" because of the limitations of existing space and the costs associated with refurbishment and expansion.

On the very same site, our Maternity services and general operating theatres are over 70 years old and would be classed as "Tail". These buildings are no longer fit for purpose, are expensive to maintain and keep safe, and will be demolished as soon as alternative facilities are available. For theatres, this will be within the next two years, as construction is already underway for replacements as part of the hospital's surgical centre new build. For Maternity however, no solution has yet been found, and funding from the national New Hospitals Programme has not yet been fully agreed. As a result, we continue to deliver services from unsuitable buildings.

This pattern of mixed quality facilities is continued across the ICS. A consistent and severe lack of capital funding from government means that there are few options for improving the condition of Flex and Tail facilities. In addition, the costs of maintaining them divert money from maintaining Core facilities, meaning that these will decline in quality quicker.

9. Where are we now?

Partners making up our ICS have identified and categorised the following facilities:

Somerset FT

Building Name	Complex / Site	Core Flex Tail
14A Taunton Road	14A Taunton Road	Flex
Angel Place Shopping Centre	Angel Place	Tail
Unit 8	Bartech 4 Unit	Tail
Unit 10a	Bartech 4 Unit	Tail
Unit 12	Bartech 4 Unit	Tail
Bracken House	Bracken House	Flex
Bridgwater hospital	Bridgwater Hospital	Core
Wessex House	Broadway Health Park	Flex
Bridgwater House	Bridgwater House	Flex
Ash Ward	Broadway Health Park	Flex
Willow Ward	Broadway Health Park	Flex
Burnham on Sea Hospital	Burnham-On-Sea Hospital	Tail
Peter Holmes Annex	Burnham-On-Sea Hospital	Tail
Chard Hospital	Chard Community Hospital	Tail
Frome Dental Access Centre	Colliers Court	Flex
Chantry Day Hospital	Colliers Court	Flex
Courtlands Industrial Warehouse	Courtlands Industrial Warehouse	Flex
Crewkerne Hospital	Crewkerne Hospital	Tail
Dene Barton Hospital	Dene Barton Hospital	Flex
East Reach House	East Reach House	Flex
2 Fore Street	Fore Street	Flex
Frome Hospital	Frome Hospital	Core
Store Block	Frome Hospital	Core
22-23a Market Place	Frome Market Place	Tail
Glanville House	Glanville House	Flex
Harrison House	Harrison House	Flex
Millstream House	Millstream House	Flex
Minehead Hospital	Minehead Hospital	Core
Mulberry Centre	Mulberry Centre	Flex
Parkgate House	Parkgate House	Tail
PMVA Centre	PMVA Centre	Flex

9. Where are we now?

Building Name	Complex / Site	Core Flex Tail
Priorswood	Priorswood	Flex
Priory House	Priory Health Park	Flex
The Bridge	Priory Health Park	Flex
Rosebank	Priory Health Park	Flex
Outpatient medical centre	Priory Health Park	Flex
Phoenix House	Priory Health Park	Flex
St Andrews	Priory Health Park	Flex
Robert Blake Clinic	Robert Blake Clinic	Flex
Shepton Admin	Shepton Mallet Hospital	Tail
Shepton Maternity	Shepton Mallet Hospital	Tail
Shepton Mallet Hospital	Shepton Mallet Hospital	Tail
South Petherton Community Hospital	South Petherton Hospital	Core
Southwood House	Southwood House	Flex
Yeovil Dental Access Centre	Summerlands	Tail
Magnolia House	Summerlands	Flex
The Baildon Centre	Summerlands	Flex
Rowan Ward	Summerlands	Core
Swing bridge Centre	Swingbridge Centre	Flex
The Exchange	The Exchange	Tail
The Horizon Centre	The Horizon Centre	Flex
Tower Vaccination Centre	Tower Vaccination Centre	tail
Victoria Park Medical Centre	Victoria Park	Flex
Wellington Dental Access Centre	Wellington Dental Access Centre	Tail
Wellington Hospital	Wellington Hospital	Tail
Stratfield Day Centre	Wellington Hospital	Tail
Holford House	Wellsprings Hospital Site	flex
Rydon House	Wellsprings Hospital Site	flex
Pyrland House	Wellsprings Hospital Site	flex
1 Cheddon Mews	Wellsprings Hospital Site	flex
Cheddon Lodge	Wellsprings Hospital Site	flex
Foundation House	Wellsprings Hospital Site	flex
Doctors Bungalow	Wellsprings Hospital Site	flex
30 Cheddon Mews	Wellsprings Hospital Site	flex

9. Where are we now?

Building Name	Complex / Site	Core Flex Tail
West Mendip Community Hospital	West Mendip Community Hospital	Core
Williton Hospital	Williton Hospital	Flex
Wincanton Community Hospital	Wincanton Hospital	Flex
Duchess Building	Musgrove Park Hospital	Flex
Queens Building	Musgrove Park Hospital	Flex
Old Building	Musgrove Park Hospital	Flex
SSD	Musgrove Park Hospital	Core
Jubilee Building	Musgrove Park Hospital	Core
Cedars Multi Storey Car Park	Musgrove Park Hospital	Core
Parkside	Musgrove Park Hospital	Flex
Maternity	Musgrove Park Hospital	tail
Staff accommodation houses	Musgrove Park Hospital	Flex
Staff accommodation	Musgrove Park Hospital	Flex
EFM building	Musgrove Park Hospital	Flex
Barton house	Musgrove Park Hospital	Flex
Lydeard house	Musgrove Park Hospital	Flex
Bastable Lodge	Musgrove Park Hospital	Flex
Beacon Centre	Musgrove Park Hospital	core
Day surgery	Musgrove Park Hospital	Flex
OTS theatre	Musgrove Park Hospital	core
Pathology	Musgrove Park Hospital	Flex
Maintenance/boiler house	Musgrove Park Hospital	Flex
The Breeze	Musgrove Park Hospital	Flex
Main Kitchen	Musgrove Park Hospital	Flex
Yeovil Hospital - Tower and Podium	Yeovil District Hospital	Flex
Women's Hospital	Yeovil District Hospital	Flex
Modular theatre	Yeovil District Hospital	Core
YDH MSCP	Yeovil District Hospital	Core
Convamore	Yeovil District Hospital	Flex
Boilerhouse	Yeovil District Hospital	Flex
Maintenance workshop	Yeovil District Hospital	Flex
Artillery rd	Yeovil District Hospital	Flex
Nautilus house	Yeovil District Hospital	Flex

9. Where are we now?

Partners making up our ICS have identified and categorised the following facilities:

Primary Care

Practice Name	Core Flex Tail
North Petherton Surgery	Tail
St James Medical Centre – Taunton	Flex
St James Medical Centre - Orchard MC, Norton Fitzwarren	Flex
Bruton Surgery	Tail
Ariel Healthcare - Fore Street, Chard	Tail
Ariel Healthcare - St Mary's, Chard	Core
Cheddar Medical Centre	Flex
Crown Medical Centre, Taunton	Flex
Luson Surgery, Wellington	Tail
Axbridge & Wedmore Medical Practice - Axbridge Surgery	Core
Axbridge & Wedmore Medical Practice - Wedmore Surgery	Tail
Langport Surgery	Flex
College Way Surgery, Taunton	Flex
Oaklands Surgery, Yeovil	Flex
Oaklands Surgery - Yeovil HC	Tail
Penn Hill Surgery, Yeovil	Tail
Taunton Vale Healthcare - Blackbrook Surgery, Taunton	Core
Taunton Vale Healthcare - Victoria Gate Surgery, Taunton	Core
Cranleigh Gardens Medical Centre, Bridgwater	Core
Cranleigh Gardens Medical Centre - Westonzoyland Surgery	Flex
Quantock Vale Surgery, Bishops Lydeard	Flex
Preston Grove Medical Centre, Yeovil	Flex
Redgate Medical Centre, Bridgwater	Flex
Minehead Medical Centre	Core
Glastonbury Surgery	Core

9. Where are we now?

Practice Name	Core Flex or Tail Estate
Warwick House Medical Practice, Taunton	Flex
West Coker Surgery	Flex
Quantock Medical Centre, Nether Stowey	Core
Park Medical Practice, Shepton Mallet	Core
Park Medical Practice: Evercreech Surgery	Core
French Weir Health Centre, Taunton	Flex
Brent Area Medical Centre, East Brent	Core
Grove House Surgery, Shepton Mallet	Tail
Beckington Family Practice	Flex
Beckington Family Practice - Fromefield Surgery	Core
Hamdon MC - Stoke-sub-Hamdon	Core
Crewkerne Health Centre - Health Centre	Flex
Crewkerne Health Centre - West One Surgery	Core
Vine Surgery Partnership, Street	Core
Vine Surgery Partnership - Health Suites, Street	Flex
Wells City Practice	Core
Highbridge Medical Centre	Core
Burnham & Berrow Medical Centre - Burnham Surgery	Core
Burnham & Berrow Medical Centre - Berrow MC	Flex
Wells Health Centre	Core
Dunster & Porlock Surgeries - Dunster Surgery	Core
Dunster & Porlock Surgeries - Porlock MC	Core
West Somerset Healthcare - Wiliton Surgery	Core
West Somerset Healthcare - Watchet Surgery	Flex
Polden Medical Practice - Woolavingdon Surgery	Core
Polden Medical Practice - Edington Surgery	Flex
Queen Camel Medical Centre	Core
Oakhill Surgery	Core

9. Where are we now?

Practice Name	Core Flex Tail
Millbrook Surgery, Castle Cary	Core
Mendip Country Practice, Coleford	Core
Milborne Port Surgery	Core
Milborne Port Surgery - Templecombe Surgery	Tail
Cannington Health Centre	Flex
Lister House Surgery, Wiveliscombe	Core
Taunton Road Medical Centre, Bridgwater	Flex
East Quay Medical Centre, Bridgwater	Flex
Martock Surgery & South Petherton PC - Martock Surgery	Core
Martock Surgery & South Petherton Medical Centre - South Petherton MC	Core
Ryalls Park Medical Centre, Yeovil	Flex
Lyngford Park Surgery, Taunton	Core
North Curry Health Centre	Core
Wincanton Health Centre	Core
Church View Medical Centre, Broadway	Core
Wellington Medical Centre	Core
Somerset Bridge Medical Centre, Bridgwater	Core
Diamond Health Group - Henford Lodge, Yeovil	Core
Diamond Health Group - Abbey Manor MP, Yeovil	Core
Buttercross Health Centre - Somerton Surgery	Core
Buttercross Health Centre - Ilchester Surgery	Flex
Glastonbury Health Centre	Core
Creech Medical Centre	Core
Frome Medical Practice	Flex
Summervale Surgery, Ilminster	Core
Meadows Surgery, Ilminster	Core
Exmoor Medical Centre	Core

9. Where are we now?

Partners making up our ICS have identified and categorised the following facilities:

Primary Care

Practice Name	Core Flex or Tail Estate
County Hall A Block, Taunton	Flex
County Hall B Block, Taunton	Core
County Hall C Block, Taunton	Tail
Deane House, Taunton	Flex
Bridgwater House, Bridgwater	Flex
Brympton Way, Yeovil	Tail
Petters House, Yeovil	Tail
Yeovil Library	Core
Shape Mendip – Asham building (Shepton Mallet)	Core
Shape Mendip – Sharpham building (Shepton Mallet)	Tail
West Somerset House - Williton	Core

10. Where do we want to be?

Responding to national drivers

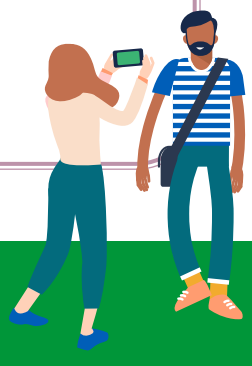
The combined estate of the NHS and local authorities make up one of the largest landowners in England. The organisations that make up the Somerset ICS are anchor institutions in our county, with the opportunity to intentionally manage land and buildings in a way that has a positive social, economic and environmental impact. The effects of good management can improve the health and wellbeing of communities and reduce health inequalities.

NHS England has developed practical information for ICSs to use their estates to deliver improvements in health inequalities. In Somerset, we want to deliver our Infrastructure strategy using the 10 building blocks set out by NHS England, using our organisations' individual Strategic Estates Aims to collaboratively bring about improvements based on a nationally recognised framework. We will achieve the building blocks by moving forward with the following principles:

Building Block	Principles
Supporting Community Development	• Use of premises by the community and voluntary, community and social enterprise (VCSE) organisations • Co-location of community facilities and public services • Supporting integrated care and partnership working • Using and supporting community assets.
Improving Location and Access	• Estate located in areas of high deprivation or improving access from those areas (for healthcare and employment) • Catalysing improvements to transport infrastructure particularly affordable public transport. • Encouraging active travel such as walking or cycling • Exemplar inclusive physical and cultural design.
Supporting healthier communities	• Providing healthy and affordable food options for patients, visitors and NHS staff • Improving connectivity to wider public services in areas of greatest need • Enabling social interactions and reducing isolation through volunteering • Inclusive indoor and outdoor exercise facilities, supporting prevention programmes.
Facilitating economic development	• Catalysing regeneration of communities in urban or rural areas • Improving footfall of high streets • Enhancing civic pride • Supporting town and spatial planning and improving public realm – attracting investment.

10. Where do we want to be?

Building Block	Principles
Enabling access to green space	• Use of estates and land for social prescribing and community projects • Creating new or improving quality of natural environment and green space for people and wildlife • Use of green space for physical activity, play spaces, socialising and food growing.
Access to good, inclusive employment and training in Estates	• Enhancing access to employment, skills and training programmes for communities that experience inequalities (across planning, construction and facilities management) • Fair terms and conditions and supporting health and wellbeing of employees and career progression including supply chains. • Provision of space for training, education and upskilling.
Improved design	• Developing safe, healthy, physically and culturally inclusive spaces • Embedding community engagement • Supporting digital inclusion • Quality public realm.
Access to quality and affordable housing	• Re-using and developing estate for affordable and inclusive key worker accommodation. • Re-using and developing estate into housing to support vulnerable communities.
Reducing negative environmental impact	• Supporting Net Zero carbon targets and sustainable consumption and production • Reducing air pollution through fleet innovation (eg low emission vehicles) • Raising awareness of environmental actions staff, patients and visitors can implement at work and home.
Social value in procurement	• Supporting local business or VCSE • Consideration of social, environmental and economic impacts of supply chain • Embedding at least 10% social value and optimising social, economic and environmental investment • Sharing investment.



10. Where do we want to be?

ICS Vision

Somerset ICS is a partnership of organisations, including Somerset Council, the NHS, and the voluntary, community, faith and social enterprise sector (VCFSE). Its purpose is to remove barriers to providing joined up care for local people and communities. It will build collaborative leadership; a focus on quality improvement; innovations in the workforce; in the use of digital solutions and information sharing; and work with communities where the impact of decisions is best understood.

Building on the themes above, the Somerset ICS ten-year vision is to create:

- **A thriving and productive Somerset that is ambitious, confident and focused on improving people's lives.**
- **A county of resilient, well-connected, safe and strong communities working to reduce inequalities.**
- **A county infrastructure that supports affordable housing, economic prosperity and sustainable public services**
- **A county and environment where all partners, private and voluntary sectors, focus on improving the health and well-being of all our communities.**

Vision statement

The Somerset ICS Estate Vision is to ensure the delivery of high-quality healthcare facilities which meets the requirements of the clinical Strategy. The ICS will provide healthcare facilities as close to our communities as possible and deliver our design vision for our new and existing facilities. We want to retain existing centres of excellence as a priority, rather than spreading resources more thinly but more widely. The estate will support the delivery of commitments in regard to net-zero carbon and the Green Plan.

The key objectives include the delivery of better care in communities. We recognise that this will mean a transfer of care from acute hospitals into the community, with attendant impact on the Estate and facilities that the trust requires.

The estate will:

- Work for the people that use it.
- Help to deliver the trust clinical strategy.
- Be safe, well maintained, effective and welcoming.
- Support the trust's aim to value all people alike.
- Reflect the trust's design aspirations.

Achievement of the Infrastructure strategy will come from adopting the following five principles:

- Ensuring that the health estate meets the objectives of the clinical strategy through promoting safe, effective, high-quality care delivered in the most appropriate setting and through enhancing health and wellbeing.
- Ensuring that the health estate promotes colleague wellbeing and productivity.
- Ensuring the current health estate is fully and effectively utilised and reducing estate where it is not required or not cost effective to maintain.
- Ensuring that current health estate is fit for purpose.
- Reducing the running costs of the health estate to enable better use of resources.

10. Where do we want to be?

These principles have been built upon to give more detail to those charged with improving our estate:

Principle	Description
Ensuring that the health estate meets the objectives of the clinical strategy through promoting safe, effective, high-quality care delivered in the most appropriate setting and through enhancing health and wellbeing.	• All healthcare environments are designed to ensure patient and colleague safety, with safety taking precedence over all other design considerations. • Everyone is supported by a high quality, therapeutic environment that delivers confidence, dignity, physical and mental well-being. • Trust estates will promote equity and inclusivity, making everyone feel welcome and valued. • The patient environment is designed to ensure that patients and their families/others have access to well desi Services need be located near to patient homes in appropriate community settings whenever this is the right thing to do, meaning that only those services that need to be based in hospital settings are based in hospital settings. • The future development of the healthcare estates should ensure that the views and aspirations of patients and the wider community are reflected in all trust healthcare environments, and wherever possible estates are co-designed and conceived. • Trust estates will facilitate the treatment and support of people with complex needs including those with dementia, learning difficulties and other forms of disability. • The estates should support the carers' charter, making it easy for carers to provide care. • The trust's-built environment will pursue high standards of effectiveness in order to drive efficiency and to reduce the time that patients need to spend in health care settings. • Planning of services and health care environments will include the benefits of digital technology. • Trust estates will facilitate colleagues and patients to make the right choices by making these choices the easiest options to take. • Opportunities will be identified to ensure that the development of trust healthcare estates benefit from learning about current best practice and cutting edge, innovative design solutions.
Ensuring that the health estate promotes colleague well-being and productivity.	• All healthcare environments are designed to ensure safety for everyone. • Facilities for promoting colleague well-being will be high quality and evidence based, ensuring colleagues feel valued. • The environment is designed to ensure that everyone has access to outside space which will include areas to enhance resilience and reduce stress for colleagues. • A high priority will be placed on training and education facilities. • Dedicated social spaces will be provided that do not compromise patient confidentiality. • The built environment will pursue high standards of effectiveness in order to support the delivery of patient care and improve colleague productivity and reduce stress.

10. Where do we want to be?

These principles have been built upon to give more detail to those charged with improving our estate:

Principle	Description
Ensuring the current health estate is fully and effectively utilised and reducing estate where it is not required or not cost effective to maintain.	• The use of the Trust's estates is prioritised for those services that cannot be provided or delivered through agile working arrangements. • Where appropriate modern working practices that improve workplace productivity should be adopted that maximise the utilisation of the estate, this might involve open planning work with workstations suitable for flexible working. • As part of the development of new models of care, where surplus estate is identified then disposal opportunities should be explored. • Opportunities for working with other public and voluntary sector organisations to optimise the use of the public estates should be actively pursued. • The use of fixed assets is maximised, with the intention of moving towards 7-day utilisation.
Ensuring that current health estate is fit for purpose.	• Improvements to the estate should be designed to ensure flexibility and resilience to adapt to a range of functions and enable separation of flows. • Healthcare is undergoing continuous change. Healthcare environments should be designed to be as flexible and adaptable as possible to respond to the changing requirements of healthcare provision. • Sufficient investment should be made in the estate to reduce the risk of infrastructure failure. • Capital investment plans should aim to eliminate backlog maintenance where national capital funding allocations allow.
Reducing the running costs of the health estate to enable better use of resources	• The future development of estates should optimise low carbon technologies that assist with achieving a net zero carbon future targets for the NHS by 2030. • The future development of the estate should take account of the whole life cycle cost are part of any investment decisions. • The built environment will promote effective people centred pathways, should enhance effectiveness to drive efficiency. • To actively benchmark performance against national standards for cost effectiveness and efficiencies and to constantly seek new innovative work practices in order to increase the effectiveness and reduce costs.

10. Where do we want to be?

BUILDING FOR HEALTH

NHS England

There are many ways NHS estates can intentionally and strategically add social value, enhance the wider determinants of health, and help to reduce health inequalities. They can be grouped into 10 key building blocks for health:

1 SUPPORTING COMMUNITY DEVELOPMENT

- Use of premises by the community and VCSE organisations
- Co-location of community facilities and public services
- Supporting integrated care and partnership working
- Utilising and supporting community assets.

2 IMPROVING LOCATION AND ACCESS

- Estate located in areas of high deprivation or improving access from those areas (for healthcare and employment)
- Catalysing improvements to transport infrastructure particularly affordable public transport
- Encouraging active travel such as walking or cycling
- Exemplar inclusive physical and cultural design.

3 SUPPORTING HEALTHIER COMMUNITIES

- Providing healthy and affordable food options for patients, visitors and NHS staff
- Improving connectivity to wider public services in areas of greatest need
- Enabling social interactions and reducing isolation through volunteering
- Inclusive indoor and outdoor exercise facilities, supporting prevention programmes.

4 FACILITATING ECONOMIC DEVELOPMENT

- Catalysing regeneration of communities in urban or rural areas
- Improving footfall of high streets
- Enhancing civic pride
- Supporting town and spatial planning and improving public realm - attracting investment.

5 ENABLING ACCESS TO GREENSPACE

- Use of estates and land for social prescribing and community projects
- Creating new or improving quality of natural environment and green space for people and wildlife
- Use of green space for physical activity, play spaces, socialising and food growing.

6 ACCESS TO GOOD INCLUSIVE EMPLOYMENT AND TRAINING IN ESTATES

- Enhancing access to employment, skills and training programmes for communities that experience inequalities (across planning, construction and facilities management)
- Fair terms and conditions and supporting health and wellbeing of employees and career progreesion including supply chains
- Provision of space for training, education and upskilling.

7 IMPROVED DESIGN

- Developing safe, healthy, physically and culturally inclusive spaces
- Embedding community engagement
- Supporting digital inclusion
- Quality public realm.

8 ACCESS TO QUALITY AND AFFORDABLE HOUSING

- Re-using and developing estate for affordable and inclusive key worker accommodation
- Re-using and developing estate into housing to support vulnerable communities.

9 REDUCING NEGATIVE ENVIRONMENTAL IMPACT

- Supporting Net Zero carbon targets and sustainable consumption and production
- Reducing air polution through fleet innovation (eg low emission vehicles)
- Raising awareness of environmental actions staff, patients and visitors can implement at work and home.

10 SOCIAL VALUE IN PROCUREMENT

- Supporting local business or VCSE
- Consideration of social, environmental and economic impacts of supply chain
- Embedding at least 10% social value and optimising social, economic and environmental investment
- Sharing investment.

10. Where do we want to be?

Primary Care

Perhaps the most complicated sector for estates in Somerset is Primary Care, which is delivered from a huge range of properties of different sizes and conditions, in every community in the county. We have engaged with Community Health Partnerships to undertake an assessment of need using the Primary Care Network (PCN) Estates Toolkit. This informs our future plans.

The assessment has two parts – clinical strategy and estates assessment, including assessment of need. At the moment we have undertaken work on GP practices only, the outputs of which are touched upon in the "Where are we now?" section of this report above. Our work will broaden to include other parts of the Primary Care sector in 2024 including dentistry and pharmacy.

The Primary Care Toolkit work focuses predominantly on the size of the estate, allowing us to see which practices are too small, or risk becoming too small as the population grows. Working at a PCN level, it allows us to consider the sustainability of the current model, and to think about the ramifications of changing it. We have given each practice a prioritisation score based on the variance between assessed need and current practice size. However, the work has not taken into account other important variables such as the condition of buildings, and the context in which they sit. For example, GP practices in a more urban area might be considered more flexible in terms of future configuration or location than rural practices.

Our work has also confirmed that there is a pressing need to address specific problems in individual premises e.g. Crewkerne and Bruton, and we intend to prioritise these locations and facilities.

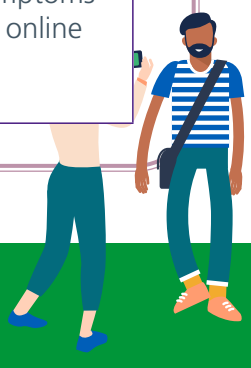
Our Primary Care Networks operate in neighbourhoods across the county. Our engagement with them as part of the Primary Care Network Toolkit national exercise has helped us identify some of our neighbourhood estates and infrastructure priorities. Each PCN has identified a clinical vision, and the impacts on physical infrastructure for this vision have also been identified. For each of our PCNs, the vision and estates implications are as follows:

Primary Care

As detailed above, we have engaged with Community Health Partnerships to undertake an assessment of need using the Primary Care Network (PCN) Estates Toolkit. This informs our future plans. Each PCN has used the information on its clinical priorities to identify infrastructure needs, and to consider what will need to happen to enable them. These enabling actions are detailed below:

10. Where do we want to be?

What will change? Population health issue	How will we make it happen?	Physical implications	Enablers
CENTRAL MENDIP			
• Improving care for frail and vulnerable patients: • Increase early diagnosis rate for Dementia. • Improve outcomes for LD clients. • Improving post-acute care for all discharges	• Care co-ordination hub (Highfield House) including MDT including community geriatrician and OPMH, working with pharmacy leads and frailty specialist nursing team. • Rapid Dementia diagnosis? • Follow up on acute discharges. • Social prescribers and Health connectors • Paramedics • Access to rapid diagnostics	• Space in each member practice to host the MDT. • Diagnostics available - rapid blood tests/ x-ray	• Digital joined up records from practices including consent. • Funding • Brave AI • Discharge summaries. • Remote working
• Improving long term condition management • Diabetes; cardiac	• Highfield House Hub as a base • Increasing prevention and early intervention and anticipatory care planning • Diabetes and pre-diabetes work • Targeting populations in deprivation and patients whose chronic illness has deteriorated. • Work with cohort of patients whose conditions fluctuate in terms of need.	• Consulting space • Admin space • Community space • Diagnostics – bloods and pathology	• IT to support online interactions. • Remote working • Brave AI and other data analytics
• Reducing health inequalities: hard to reach groups.	• PCN staff working with Health Inequalities lead GP. • Social prescribers • Targeting populations in deprivation	• Admin space incl for MDTs • Community space	• VSCE input • IT to support online interactions. • Remote working
• Menopause Management	• Group clinics.	• Admin space • Community space	• Increased education of clinicians and patients on cancer symptoms • IT to support online interactions



10. Where do we want to be?

What will change? Population health issue	How will we make it happen?	Physical implications	Enablers
• Reduce incidence of Cancer	• Earlier detection and intervention model • Link to LTC work. • Targeting populations in deprivation	• Consulting space • Admin space incl for MDTs	• Increased education of clinicians and patients on cancer symptoms • IT to support online interactions. • Improved cancer screening reporting
WEST MENDIP			
• Long term condition management – including cancer and STIA.	• The PCN currently run frailty, palliative care and complex care clinics through individual practices. • The PCN would like to create PCN hubs for rapid assessments and regular monitoring for long term condition patients. • Ongoing research in stroke and hypertension finding. • Work with Macmillan and cancer care coordinators around cancer reviews, screening, social media and community drop ins.	• A hub where patients can attend and can be seen by an MDT of clinicians in one venue. • Diagnostics available - rapid blood tests/ x-ray • Use of home working and hot desking when appropriate.	• Estate from local authority • Digital joined up records from practices including consent. • Workforce including AARS roles. • PCN service - practices working together in a hub. • Funding • Community providers in several locations so care is provided close to people's homes in the 3 areas of west Mendip.
• Hard to reach patients - Targeting central Glastonbury patients – travelling community, van dwellers and the homeless.	• Links with SFT outreach teams and GP for inclusion and homeless help. • Ongoing training for primary care staff.		• Digital joined up records from practices. • Community providers in several locations • Funding • PCN service – practices working together in a hub.

10. Where do we want to be?

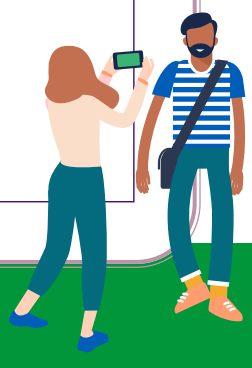
What will change? Population health issue	How will we make it happen?	Physical implications	Enablers
• Mental health services available for our population – high rates of depression within this PCN.	• The PCN currently have a social prescribing team in place. • Old persons mental health is included within the complex care team. • In the future the PCN want to employ mental health practitioners who specialise in adult and children mental health.	• Requirement for consulting space • Requirement for MDT meetings and huddles	• Workforce including ARRS roles. • PCN services – practices working together.
• Increased urgent care services.	• Same day urgent care centre is desirable.	• Requirement for consulting space • A PCN hub for all practices to use for same day urgent care services.	• Estate from local authority if space is not available in GP practice. • Funding • Workforce – including ARRS roles.
• Reduce contact in primary care and hospital admissions.	• The social care team review discharges from hospital to prevent re admission. • Searches with BRAVE AI	• Social team currently working from home or hot desking.	• Workforce including ARRS roles. • PCN services- practices, working together.
BRIDGEWATER			
• Mental health services available for children	• Health and wellbeing hub provides MH walk in and booked appointments for children and adults. • Child mental health practitioner present within PCN. • Practitioner is working with schools and outreach team to support children with their MH. • MH care coordinator to work with practitioner – based in Victoria hub. • MH team working with social workers to tackle safeguarding concerns within the PCN.	• Space for MDT meetings either at hub or one of the practices.	• Digital joined up records from practices including consent. • Workforce including ARRS roles. • PCN service - practices working together in a hub. • Funding

10. Where do we want to be?

What will change? Population health issue	How will we make it happen?	Physical implications	Enablers
• Mental health services available for adults	• Adult mental health practitioner presents in the PCN. • MH care coordinator works with practitioner to arrange consultations/services. • Health and wellbeing hub providing MH walk in and booked appointments.	• Space for MDT meetings either at hub or one of the practices	• Digital joined up records from practices including consent. • Workforce including ARRS roles. • PCN service - practices working together in a hub. • Funding
• Long term condition management – diabetes, COPD/ respiratory conditions, cancer etc.	• Expanding the Health and wellbeing hub into a community investigation hub where phlebotomy and diagnostics can take place. • Providing improved access to diagnostic tests and other services through a one stop shop approach. • PCN Specialist respiratory team nurse can be based at the HUB.	• Additional space to expand the hub. Adding additional rooms for consultations and diagnostic services.	• Estate from local authority • Community provider • Digital joined up records from practices including consent. • Workforce including ARRS roles. • CN service - practices working together in a hub. • Funding
• Tackling adult and child obesity	• Working with SASP (Somerset Activity & Sports Partnership) to encourage service users to take care of their physical and mental wellbeing.		• Community provider/ voluntary sector • Digital joined up records from practices including consent. • Practices working together.

10. Where do we want to be?

What will change? Population health issue	How will we make it happen?	Physical implications	Enablers
NORTH SEDGEMOOR			
• Heart Failure in the housebound (Clinical Intervention): • Locally delivered service for monitoring/ managing our heart failure patients who cannot engage with out-patient secondary care provision.	• Home based monitoring and assessment/care. • Patient education • Possibility of a virtual ward • exclude care home patients re access to secondary care not housebound.	• Mobile care/ support team with workload guided by daily monitoring.	• Digital technology to enable home monitoring. • Funding for equipment and maintenance of equipment/IT/technical support (on- boarding) • What happens if equipment fails - back up response - service level agreement? • Workforce including AARS roles.
• Fibromyalgia/ possibly non-clinical intervention • Limited current service apart from GP consultations • Design set of interventions to support current diverse health needs of this unique population.	• Upskill clinician but also aim for group/educational consultations, support material available. • Role for health coaching • Peer support group • Evidence based approach to pain management in this patient group.	• Admin coordination of group consultations • Work closely with surgeries.	• Venue for peer support • Non-clinical PCN staff with skills in group consultation and group facilitation • Clinical staff with skills in group consultations • Clinical support for non-clinical staff
• Improve Frailty and Complex Care	• Complex care team operating as an MDT. • Input from secondary care as needed. • Initial focus on patients who reside in their own homes. • Use of Brave AI to stratify and anticipate needs. • Supports EHCH too. • Dementia care - currently CH staff liaise and have had consultant to support but future shaped by SFT model which may push back to Primary Care.	• Consulting space • Admin space	• Funding • Joint working with hospice



10. Where do we want to be?

What will change? Population health issue	How will we make it happen?	Physical implications	Enablers
• Menopause	• Work with practice and patients to raise awareness of issues arising from the menopause and increase the number of resources available.	• Group consultations	• Proactively working with Health Coaches to give them the information and resources to support this group.
• Reduce health inequalities within the community and target hard to reach groups (including Romany and Gypsy population in area West of A38, and agriculture workers) • Highbridge a Priority – large homeless population	• Using the CORE20Plus 5 principles to focus on: • Improving early diagnosis of cancer (stage 1 or 2) • Hypertension • SMI • Respiratory	• Consulting space • Admin space • Community space	• IT to support online interactions. • Remote working
• Improving access to urgent primary care.	• PCN services configured to manage the more routine same day urgent primary care to release GP time to focus on complex care. • CLEAR Project	• TBC	• TBC
TAUNTON DEANE WEST			
• Anticipatory care planning – moderately frail patients	• Searches with BRAVE AI • PCN OT will visit patients in their home	• TBC	• Reduce contact in primary care and hospital admissions
• Personalised care planning – care homes	• PCN complex care nurse will review patients in their homes. • Weekly virtual ward rounds • MDT's • Staff training for Care Homes	• Training site venue required to allow Care Home staff to come together	• Reduce contact in primary care and hospital admissions. • To look at joint digital records and proxy access to EMIS for Care Homes

10. Where do we want to be?

What will change? Population health issue	How will we make it happen?	Physical implications	Enablers
• Personalised care planning – diabetics with obesity and depression age 35-55	• Refer for social prescribing by a care coordinator to improve health outcomes.	• Need a health and wellbeing hub to support these patients. • MDT discussions	• Library for a large group meeting. • Care Coordinators and health and wellbeing coaches.
• Care of newly diagnosed cancer patients • Setting up a support group	• Cancer Care Coordinator to facilitate the setting up of this.	• Venue required to hold support groups.	• Estates required. • Cancer care coordinator to support.
• Transgender health screening	• Cancer Care Coordinator to review patients and support attendance at screening programmes.	• Appropriate screening sessions	• Correct medical coding – cancer care coordinator to support attendance.
• Learning disability patients and health screening	• Support offered by care coordinator for patients to attend	• Skill development of care home staff	• Good siting of screening venues e.g. mobile breast screening van
• Patients with hypertension	• Pharmacists review and sign posting to community pharmacy, library	• More clinical space to hold clinic sessions.	• Estates required. • Digital communication with community pharmacies
• Patients on high-risk medications	• Pharmacists review and sign posting to other organisations	• More clinical space to hold clinic sessions.	• Estates required.
• Children and young people with mental health problems	• CYP mental health worker to engage with local schools to support	• More clinical space for 1-1 sessions with families or group work	• Estates required. • Digital communication with the mental health team

10. Where do we want to be?

What will change? Population health issue	How will we make it happen?	Physical implications	Enablers
TONE VALLEY			
• Management of long-term health conditions	• Building on core work within practices with practice nurse and LTC reviews. • Improve quality and education for team. • Improve identification of new patients. • Facilitate secondary care reaching patients within the community.		• Community provider. • Digital joined up records from practices with patient identification. • Release of clinical space by moving admin teams • Extra Workforce including ARRS. • PCN service – practices working together in a hub. • Funding
• Anticipatory care – population health approach	• An Occupational therapist has been recruited to review this issue. We would like to employ another OT and care coordinator to support this project. • Link with SFT ACP for frailty and anticipatory care.	• Consultation/ admin Space for OT and care coordinator	• Digital joined up records from practices with patient identification. • Extra Workforce including ARRS. • Funding • Research
• Mental health and wellbeing support	• Health and wellbeing service in Taunton – SFT lead but covers all PCNs. • Health coach provision as part of the H&W service. All practices referring to the health coaches. This would allow a single point of access for village and neighbourhood teams. • Increase support for PCN workforce and improve MDT working	• Consultation/ admin Space for new ARRS roles	• Community provider • Digital joined up records from practices with patient identification. • Release of clinical space by moving admin teams • Extra workforce including ARRS

10. Where do we want to be?

What will change? Population health issue	How will we make it happen?	Physical implications	Enablers
• Care provision for frail and vulnerable patients.	• We would like to have Care coordinators deliver enhanced care in care homes alongside complex care nurses and GPs.	• Consultation/ admin Space for new ARRS roles	• Care homes. • Digital joined up records from practices with patient identification. • Extra Workforce including ARRS. • MDT working • PCN service – practices working together in a hub. • Funding
• Health inclusion for hard-to-reach groups	• We would like to recruit a care coordinator to support health inclusion in hard-to-reach patients – LD, Homeless, Refugee	• Consultation/ admin space for new ARRS roles	• Digital joined up records from practices with patient identification. • Extra Workforce including ARRS. • MDT working • PCN service – practices working together in a hub. • Funding • Research
WEST SOMERSET			
• Improving care for complex and vulnerable patients: • Support for these patients at home	• Utilisation and further development of our Complex Care Nurses	• A central hub for workforce and neighbourhood partners	• Funding to allow continuation and expansion of the neighbourhood hub
• Support for Primary Care	• Use of ARRS working as an MDT alongside GP practices to deliver person centred care.	• Requirement for consulting space	• Support for practices to further develop space or utilise existing space patient note digitalisation. • Progression of SWAST rotational paramedic model

10. Where do we want to be?

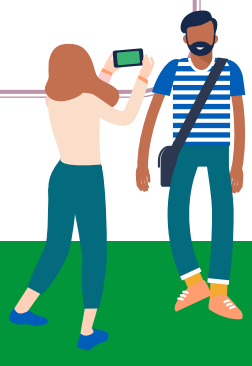
What will change? Population health issue	How will we make it happen?	Physical implications	Enablers
• Mental health and wellbeing support	• Health Coaches and close working with neighbourhood partners providing mental health services and social prescribing support	• Requirement for consulting space • Requirement for MDT meetings and huddles	• IT funding for ARRS/ health coaches • Funding for community space
• Support for Deprivation and Cost of Living Crisis	• Expansion of our close working relationship with our Village Agents (SPLW)	• Requirement for consulting space • Requirement for MDT meetings and huddles	• Additional funding for SPLWs given that West Somerset is the most deprived area in the country. • Continuation of neighbourhood hub to enable joint working
• Long term condition Support and Anticipatory Care	• Engagement in population health projects such as Optum for preventative care • Use of BRAVE AI digital tool for proactive care	• Requirement for consulting space/ community space and admin space for this work to be done.	• Population Health Lead nurse role- continuation of funding long term • SASP joint working • Higher level patient comms and education regarding PCNs and their work.
• Urgent Care Need	• Work closely with SFT to address this need in West Somerset.	• Better utilisation of the local MIU both in terms of space and OOH provision.	• Successful recruitment of clinical workforce across primary and secondary care

10. Where do we want to be?

What will change? Population health issue	How will we make it happen?	Physical implications	Enablers
CLICK			
• Management of long-term health conditions – including cancer, STIA and CHD	• Setting up Community Investigation Hub using Ward at Chard Hospital to run from Jan 23. This will increase access to rapid diagnostics and tests, creating a one stop shop approach. • The PCN would like to expand the hub locations – one hub in each town (Ilminster, Chard and Langport). • The hub would provide space for paramedics, pharmacists and physician associates to be able to assess and consult patients. • Occupational Therapists working on pain management so patients can return to work. • Plans to create a Complex Care Team in 2023.	• Estate for each hub within the towns. • Space for MDT hub	• Estate from local authority • Community provider • Digital joined up records from practices including consent. • Workforce including ARRS roles. • PCN service - practices working together in a hub. • Funding
• Mental health services available for adults	• Adult Mental Health Practitioner due to start in 2023. • Health coaches working with low level MH.	• Extra consultation space for new MH roles	• Digital joined up records from practices including consent. • Workforce including ARRS roles. • PCN service - practices working together in a hub. • Funding
• Mental health services available for children	• A Children and Young Persons' Mental Health Practitioner has just started. • Health coaches working with low level MH.	• Extra consultation space for new MH roles	• Digital joined up records from practices including consent. • Workforce including ARRS roles. • PCN service - practices working together in a hub. • Funding

10. Where do we want to be?

What will change? Population health issue	How will we make it happen?	Physical implications	Enablers
WEST SOMERSET			
• Prevalence of diabetes & Tackling adult and child obesity	• Working with SASP (Somerset Activity & Sports Partnership) to encourage service users to take care of their physical and mental wellbeing. • Health Coaches. Mainly working with obesity and Weight loss programmes. • HCs workload is going to include getting people off sick notes. • High prevalence of Diabetes is a concern within the PCN. Regular diabetic clinics run within the PCN however there is a lack of engagement from patients.	• Extra consultation space for Diabetic Clinic	• Digital joined up records from practices including consent. • Community provider • Workforce including ARRS roles. • PCN service - practices working together in a hub. • Funding • Moving admin staff for clinic space
• Improving care for frail and vulnerable patients	• Physician Associates go into Care Homes on weekly basis with Emergency care practitioners to assess frail and vulnerable patients.	• Space for a potential Frailty MDT	• Care homes. • Digital joined up records from practices including consent. • Workforce including ARRS roles. • PCN service - practices working together in a hub. • Funding
• Reducing deprivation within the PCN population	• Initial focus on Chard. • Embedding joint working with SASP and local authority	• TBC	• Digital joined up records from practices including consent. • PCN service • Research • Funding

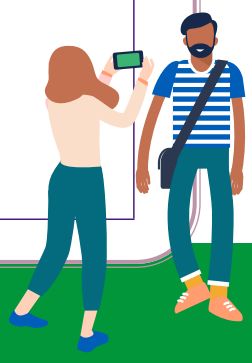


10. Where do we want to be?

What will change? Population health issue	How will we make it happen?	Physical implications	Enablers
RURAL PRACTICE NETWORK (RPN)			
• Improving care for frail and vulnerable patients	• Carrying out structured medication reviews and medicines optimisation on patients identified as frail and vulnerable. • Extra training for staff across the PCN to improve on awareness of frail and vulnerable patients. • Improved coding and data collection for frailty across the area. • Frailty MDT team for the PCN.	• Consultation rooms/space for extra training and MDT meetings.	• Care homes. • Digital joined up records from practices including consent. • Release of clinical space by moving admin teams • Workforce including ARRS roles. • PCN service - practices working together in a hub. • Funding
• Improving support available for patients suffering with dementia	• Dementia care pathway – patients who are newly diagnosed with dementia will be linked to a dementia support worker to work through what support is in place for them or what support is needed.		• Digital joined up records from practice. • PCN service – practices working together. • Extra workforce ARRS roles (Support Worker)
• Management of long-term health conditions – cancer, STIA etc.	• Further development of neighbourhood team through the complex care team. • A clinical investigation hub (one stop shop approach) to be based at Wincanton Community Hospital. Temporarily moved to Milborne Port due to technical issues at the hospital. • 'Show me your Meds' project – regular review of long-term medications.	• Consultation rooms for investigation hub at Wincanton community hospital. Improved IT facilities. • Diagnostics equipment for investigation hub (MRI, CT, phlebotomy etc.)	• Estate from local authority. • Community provider. • Digital joined up records from practices. • Release of clinical space by moving admin teams • Extra Workforce including ARRS. • PCN service – practices working together in a hub. • Funding

10. Where do we want to be?

What will change? Population health issue	How will we make it happen?	Physical implications	Enablers
	• Polypharmacy – taking early intervention to prevent medications from being over prescribed.	• Activation' Hub to enable prevention and early intervention for additional LTCs and diabetes and obesity management	
• Services available for Mental health – Opioid abuse.	• Carrying out regular reviews and follow ups with patients who are opioid users. • Working with 'Ten Footsteps' to improve pain management and opioid use for chronic pain patients. • Improving counselling and support services for patients that are addicted to opioids. • MDT team that focusses on patients who suffer from opioid addiction. • Social prescribers are available within the PCN to help with pain management and other mental health issues.	• Space to hold regular meetings with social prescribers (village halls etc.) • Extra room for MDT team meetings.	• Digital joined up records from practices including consent. • Release of clinical space by moving admin teams • Workforce including ARRS roles. • PCN service - practices working together in a hub. • Funding • Estate from local authority (village halls etc.)
SOUTH SOMERSET WEST (SSW)			
• Management of long-term health conditions including cancer and STIA	• Improve personalised care referral – We need to improve the way in which we refer into personalised care within the PCN. We have selected 'Joy' as the platform of choice which interacts directly with EMIS. • PCN personalised care formation – create personalised care group of health coaches, care coordinators and SPLW for high intensity patients.	• Estate to run Community investigation hub in various places through the PCN to improve access for patients. • Equipment for community investigation hub – MRI, CT etc. • Consultation space for new ARRS roles to see patients face to face.	• Estate from local authority • Digital joined up records from practices including consent. • Release of clinical space by moving admin teams • Workforce including ARRS roles. • PCN service - practices working together in a hub. • Funding



10. Where do we want to be?

What will change? Population health issue	How will we make it happen?	Physical implications	Enablers
	• Create a cancer coordinator within the PCN as part of the PCN's personalised care group formation. One of the current health coaches would like to lead on cancer. Training requirements need to be identified. • Remote monitoring to prevent people with multiple long-term conditions that have had 2 or more unplanned hospital admissions in the past 12 months from further admissions during winter 2022/23. • Establish a community investigation hub at South Petherton hospital – access to rapid diagnostics and tests.	• Improved IT system.	
• Improving care for frail and vulnerable patients	• PCN Frailty service – MDT team focusing on vulnerable and frail patients – covering care homes. This service is run by the ageing well programme. • Establish a community investigation hub at South Petherton hospital – access to rapid diagnostics and tests.	• Estate to run Community investigation hub in various places through the PCN to improve access for patients. • Equipment for community investigation hub – MRI, CT etc. • Group space for MDT meetings.	• Estate from local authority, • Care homes. • Community provider – ageing well programme. • Digital joined up records from practices including consent. • Release of clinical space by moving admin teams • Workforce including ARRS roles. • PCN service - practices working together in a hub. • Funding

10. Where do we want to be?

What will change? Population health issue	How will we make it happen?	Physical implications	Enablers
• Increased urgent care or 'same day' services. • Improving access to primary care and allowing GPs to focus on complex patients. • Preventing unnecessary admissions to A&E.	• Community acute response service within the PCN. Patients that would normally be sent to A&E can be seen in South Petherton Hospital. • Community Pharmacist Community service – increase same day appointments.	• Space within South Petherton hospital. • Consultation rooms for pharmacist team.	• Digital joined up records from practices including consent. • Workforce including ARRS roles. • PCN service - practices working together in a hub. • Funding
• Tackling adult and child obesity	• SASP partnership – create a partnership with SASP to share learning, improve mentorship and access training and advice.	• Space for activities – learning to cook healthy meals, exercise etc.	• Community provider • Funding • Estate/space from local authority (village hall, community space etc.) • PCN service – practices working together in a hub. • Digital joined up records from practices including consent
• Identifying patients that are more 'at risk' of deterioration.	• Using population health data to inform specific approach to cohorts – for example BMI 40+, smoker with mental health challenges. Encouraging these patients to live a healthier lifestyle to prevent deterioration.		• Funding • Digital • Digital joined up records from practices including consent

10. Where do we want to be?

What will change? Population health issue	How will we make it happen?	Physical implications	Enablers
YEOVIL			
• Improving care for frail and vulnerable patients	• The PCN would like to establish a community investigation hub to increase patient access to rapid diagnostics and tests. • The PCN would like to focus on improving care provision for vulnerable patients in care homes (for example a frailty MDT).	• Estate for community investigation hub • Space for potential MDT	• Care homes. • Digital joined up records from practices including consent. • Workforce including AARS roles. • PCN service - practices working together in a hub. • Funding
• Mental health services available	• A prevalence of low-level MH issues across the population (includes anxiety, depression, low mood). PCN wish to use their services to support early diagnosis thereby enabling GPs to focus more on chronic illness. • GPs need improved guidance when signposting MH patients.		• Digital joined up records from practices including consent. • Workforce including AARS roles. • PCN service - practices working together in a hub. • Funding • Training and development

10. Where do we want to be?

What will change? Population health issue	How will we make it happen?	Physical implications	Enablers
• Management of diabetes & • Tackling adult and child obesity.	• There is a high prevalence of diabetes within the younger population of the PCN (linked to obesity). The PCN plan to recruit a diabetes nurse to set up a diabetic clinic and support practice GPs. • Working with 'My Way Diabetes Somerset' to encourage patients to manage their diabetes and improve their quality of life. • Working with SASP (Somerset Activity & Sports Partnership) to encourage service users to take care of their physical and mental wellbeing.	• Extra consultation space for diabetic clinic	• Digital joined up records from practices including consent. • Community provider • Workforce including AARS roles. • PCN service - practices working together in a hub. • Funding • Moving admin staff for clinic space
• Support available for hospital discharges	• MDT (Care coordinators; community services; social care; families) working together to ensure high quality transition between hospital and home to ensure that people are not readmitted unnecessarily.		• Digital joined up records from practices including consent. • Community provider • Workforce including AARS roles. • PCN service - practices working together in a hub. • Comprehensive discharge summaries that support smooth transition for patients • Funding

For pharmacy, there is support for one "super pharmacy" per PCN area, with spokes in practices. But at present there is no money for this.

For primary care dental services, activity has been commissioned for 50% of the population. About 80% of people would like access to a dentist, but this would need much more commissioned activity but perhaps not more NHS facilities due to the existence of private facilities.

Developing Integrated Neighbourhood Teams

We know that local people appreciate being able to access a wide range of services from a single building. We are exploring the development of Integrated Community Teams including community nurses and primary care working in the same building.

Neighbourhood working is vital to meeting the needs of local people. Now, our approach to developing neighbourhood working is still developing. We are bringing together the right teams in local areas to meet health needs, and part of our plans for the future are to develop these to make them more sophisticated and responsive.

A key first step will be defining the relevant geographies that will best meet population need. At the moment there are different numbers of community teams (8) and PCNs (13), and it may be that these need to be aligned or managed in a different way to deliver services at the appropriate degree of scale.

We have begun to work with specific localities and sub-divisions across the county to try to do this, for example in Frome, in Mendip (Shepton Mallet and Wells), and in the Crewkerne / South Petherton / Chard area. These will continue and will shape our discussions as we look to develop teams and services which meet specific local need. We already have some good neighbourhood-level data from Phase 2 of the PCN Toolkit, which has told us about the needs of local GP practices. We will build on this as more data emerges, to make sure that service developments reflect local need at a neighbourhood level.

Somerset FT - Working in partnership.

We already work in innovative ways with public and private sector partners and have delivered new and improved facilities as a result, such as the Beacon Centre and multi-storey car park at Musgrove Park Hospital. Looking forward, we have entered into a 15-year collaborative and strategic partnership with Prime PLC. Prime work with private sector investors, planning experts and others to find solutions for NHS organisations to deliver new and improved estate. Our 15-year agreement with Prime is helping the trust to plan for the future of our estate and deliver transformational change at pace. We have developed a masterplan for our estate across the county and are working with Prime to identify and assess opportunities for new developments, funding options and wider estates solutions.

The trust has specific Estates objectives for the medium and long term, across acute, community and Mental Health.

Acute Estate

The two main hospital sites will be redeveloped in the medium-long term, and business cases are being developed for both general hospital sites, which aim to win government funding via the New Hospitals Programme.

- At YDH there is a Development Control Plan that encompasses the longer-term view of site redevelopment and expansion to accommodate the increased activity and to reduce back log costs and achieve compliance with the new standards of care. Current key investments include a new Breast Care Unit, Modular Theatre, 5th general theatre, and a new modular ward. It also provides for expansion of the outpatient's department, and in the longer term aims to provide more bed capacity, an elective care centre and emergency care centre.
- The key components of the plans to redevelop Musgrove Park Hospital are a new Surgical Centre (construction of which is already underway), and wholesale replacement of older buildings with new-build facilities including a new Women's and Children's building.

Community Services

Community services include service expansions for community services at Harrison House, and investment in community dental services in Dorset and Yeovil, and family services Victoria Park medical centre.

The Somerset NHS FT estate has 13 community hospitals which accommodate a range of community services and a significant number of community inpatient beds. Evidence indicates that the current number of beds is no longer appropriate or sustainable for modern healthcare or in a health system that aspires to care for people at home or as close to home as possible.

One the most significant consequences of any decision to reduce community hospital inpatient beds will be the issue of the use and viability of some of the community hospital sites and this will be considered as part of FFMF. Any significant service change would be subject to public consultation. During this period, we will maintain the existing community hospital estate and seek to utilise the available space to deliver key community services in line with our clinical strategy. The trust will also continue the development of services in communities including diagnostic facilities.

Mental Health

The trust's mental health estate objectives are focused on adult mental health inpatient wards, consolidating at Summerlands for East Somerset and then the reconfiguration of services at Wells Health Priory Park. We also plan investment in mental health accommodation for adults and younger people in domestic or high street settings across Somerset.

Digital Transformation

We know that digital service delivery gives us the opportunity to deliver services in new ways, and to use our estate differently. Our vision for digital services is to provide digital services that are effective and highly interconnected, and which drive excellent support and care, communication, information, and improved efficiency.

We will support both patients and colleagues to become more digitally enabled, promoting self-management and breaking down barriers between digital systems to make better use of our facilities. We want to deliver care without boundaries - seamless working across health and care settings and sites, with care supported in neighbourhoods, closer to home, with a resilient, secure infrastructure that delivers innovation.

Digital inclusion is vital to this, particularly in a rural county such as Somerset. We will work with system partners to support the people of Somerset to access care without barriers arising from a gap in skills, knowledge or access to technology.

Telemedicine has the potential to decrease travel mileage for patients needing to attend primary care appointments. The continued uptake of Brave AI across our PCNs will provide more positive outcomes for patients and deliver significant carbon savings.

Our ICS Digital Strategy has nine aims. We want to:

- **Increase** our capacity to generate population health management data to support informed interventions across the Somerset system.
- **Develop** our automation capability to support operational and clinical processes and improve productivity and quality.
- **Invest** in the development of digital skills across the merged trust.
- **Ensure** the interoperability of our systems using national open standards to enable a single view of the patient.
- **Invest** in artificial intelligence to support quicker, more reliable clinical diagnosis.
- **Continue** the drive to paperless solutions to realise efficiencies.
- **Roll out** processes which enable patients to share personally collected data.
- **Jointly procure** digital system replacements which support the creation of a unified electronic patient record and common use of SIDER.85
- **Support** transformation and clinical teams to understand their services' data and improve our trust's performance on Model Hospital benchmarking.

Some of these aims are more pertinent to the infrastructure strategy than others, but overall, the achievement of our Digital Strategy will help our buildings and facilities become more sustainable, fit for the future and supportive of our wider aims.

Capital pipeline – live and unfunded projects.

We have worked across the Somerset system to identify capital projects for development. Somerset FT has the largest care estate in the county, and the largest programme for investment. The trust has many live projects, and plans for many others over the next five years. There are also projects which we would like to progress with, but which are currently unfunded. We hope that funding becomes available for these but will work with partners to drive efficiencies in our financial planning to drive cost down and make them more affordable within existing budgets and capital expenditure limits. Much of our capital expenditure is spent on backlog maintenance, ongoing maintenance, and equipment replacement. Despite this, we continue to work from an estate requiring many millions of pounds of critical backlog maintenance. The amount left over for other things including new developments is significantly smaller. A large proportion of capital monies are spent outside direct estates as well, including on digital projects and infrastructure upgrades. These will mean that our existing estate is improved but will not deliver transformational change to the locations in which services are delivered or the types of services delivered from existing facilities.

Other ICS partners have also identified projects which we wish to take forward over the next 10 years.

The constraints affecting our capital programme mean that there are many projects that we would like to deliver which currently do not have a funding source identified. These include:

Family hub facilities

Investment in "family hub" facilities in Taunton and potentially other locations in the county. These would bring together a range of primary and community health care facilities and council services in a single location. There are no current facilities suitable for the range of services that we would like to deliver from hubs, and so instead we are continuing with existing partnership arrangements such as using libraries and community centres for low-level health care. However, were funding to be made available, we would develop facilities such as these.

YDH Medical Education

Our estate does not only deliver services for patients. We also train current staff and students. The current facilities available at Yeovil District Hospital to do this are too small and in the wrong location. We would like to work with partners in the town to develop larger, better facilities for training, and free up hospital accommodation for clinical services.

Yeatman Ophthalmology Theatre Replacement

Our ophthalmology theatre at the Yeatman Centre near to Yeovil is small and outdated. We want to replace and expand the facility, potentially in a different location, should funds allow.

10. Where do we want to be?

MPH Maternity Second Theatre

We currently have insufficient theatre space in Maternity services at Musgrove Park Hospital, which is particularly challenging in periods of peak emergency demand. This has been identified as a risk, and we wish to proceed with the expansion of theatre space as soon as capital funding allows.

West Mendip Campus Solution

Services in Wells and Shepton Mallet are delivered from old buildings that are not fit for purpose. The situation has arisen in a patchwork way over time, and requires bringing together in buildings that are bigger, more modern and easier to access. No funding source has been identified to achieve this.

In addition, we have identified many other schemes and developments that we would like to take forward, but which are currently partially or wholly unfunded. These include:

- Extensions and modifications to various GP practices across the county
- Investment in community assets in neighbourhoods across Somerset
- Scheme at our acute hospitals including the replacement and expansion of the Radiotherapy service (including new Linear Accelerators), the replacement of Ward 9 at Musgrove Park Hospital, and new buildings for various clinical services.

Details on costs and financial phasing for these schemes is included in the capital template return accompanying this document.

The above schemes are for the future. We currently have several live projects which are helping to transform our estate. In headline terms, these include the following:

Musgrove Park Hospital

- A reconfiguration of our Stroke facilities, making improvements to how care and the administration of the service are delivered.
- The creation of a new model box room for our Maxillofacial surgery service.

Yeovil District Hospital

- Improvements to air conditioning to make our estate more energy efficient, and better for patients and colleagues.
- Improvements to car parking, to promote easier access to services.

Community and Mental Health services

- Investment in dental services that the trust provides in Yeovil and in Dorset, including new and improved facilities there.
- Mental health ward reconfigurations to allow for better care delivery across several wards.
- Investment in a town centre macular injection facility, at the rear of an existing community-based ophthalmic facility which is modern and easily accessible in Yeovil.

10. Where do we want to be?

Somerset Council

Somerset Council has developed a set of strategic objectives for its estate, using the Council Priorities. These objectives guide policy making and decisions on how the Council's property and land portfolio will be used. The Strategic Objectives are as follows:

- **The Council's estate is financially sustainable, efficient, and effective.**
- **Assets that are fit for purpose, safe & compliant.**
- **Assets that address the Climate Emergency.**
- **The Council's estate supports prosperity and economic growth.**
- **Address the growing challenges in the Council's school buildings estate.**

The meaning of each objective is explained in the table below:

Objective	Meaning
The Council's estate is financially sustainable, efficient, and effective.	This strategy objective will ensure that the Council is able to deliver effectively in a very challenging financial environment, and that the property estate does not create an unsustainable burden for future generations of Somerset council taxpayers.
Assets that are fit for purpose, safe & compliant.	This strategy objective will ensure that the Council meets all legal requirements in the management of its estate, and that assets support effective, modern service delivery for customers and effective, modern workspaces for staff. This includes proactive compliance with the Equalities Act 2010, relevant Health and Safety regulations, and other relevant legislation.
Assets that address the Climate Emergency.	This strategy objective will directly support the Council Plan priority to deliver a greener, more sustainable Somerset, as well as delivering against the Climate Emergency Strategy goal of decarbonising the local authority estate and operations.
The Council's estate supports prosperity and economic growth.	This strategy objective will directly support the Council Plan priority to deliver a flourishing and resilient Somerset.
Address the growing challenges in the Council's school buildings estate.	This strategy objective will also directly support the Council Plan priority to deliver a flourishing and resilient Somerset, as well as addressing one of the most significant challenges created by a long period of austerity.

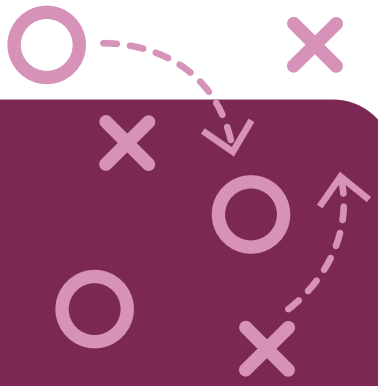
10. Where do we want to be?

Using the estate to reduce health inequalities.

Our ICS Infrastructure strategy looks to build on the individual organisations' Estates Strategies to deliver an overarching improvement for Somerset. We want to use the estate to reduce health inequalities, and we have the scale, resources and commitment to do so. We will seek to follow the direction given by NHS England, which has identified the ten ways in which an improved NHS Estate can deliver improved social value and improvements to the wider determinants of health.

We know that the NHS and the Council are two of the largest employers in the county. We have the scope, reach and influence to make a big difference to how buildings are used to make people's lives better in all the ways identified above. Not only that, but our buildings are unique in that they are more accessible to, and more accessed by, members of the public than perhaps any other buildings. They are also used predominantly by sections of the public who may have particular vulnerabilities. As a result, we will take our responsibilities seriously when designing new buildings and altering new ones, to create a built environment which makes the county a better place to live and access public services.

11. How do we get there?



The previous sections have identified the ICS's current estate, and the organisational objectives in place to improve it. It set out the 10 building blocks that we want to use as foundations for improving the estate and reducing health inequalities. This section explains the how the organisations within the ICS plan to evolve the estate and secure the necessary investment to fund it.

Over the coming years the population served by the ICS will change, and the estate needed to meet population need will also have to change. Any plan must identify those changes that are already planned and where there is a degree of certainty about the future of services, but the plan must also begin to anticipate future model of service delivery and how the estate might need to adapt to meet changing requirements.

Somerset FT

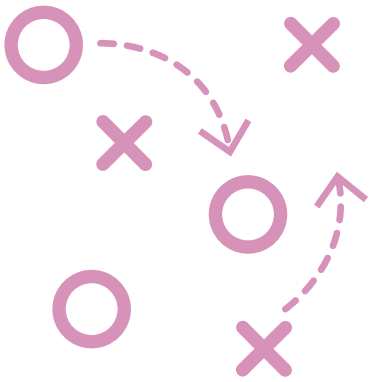
The trust's eight strategic objectives are as follows:

- Improve the health and wellbeing of the population.
- Provide the best care and support to people.
- Strengthen care and support in local communities.
- Reduce inequalities.
- Respond well to complex needs.
- Support our colleagues to deliver the best care and support through a compassionate, inclusive, and learning culture.
- Live within our means and use our resources wisely.
- Develop a high performing organisation delivering the vision of the trust.

Five are the system clinical aims that have been developed through widespread engagement as part of the ICS development plan. The other three describe the type of organisation that the trust wants to be, and its statutory requirements.

It is anticipated that there will be a transformation in and out of hospital care and that some of the existing healthcare estate will either need to adapt to models of care or in some cases be surplus to healthcare provision. These changes are most likely to impact on the current settings that provide ambulatory and community-based care. However, a large part of the healthcare estate will continue to provide services that will not be affected by the changes in the model of care, and this will apply to acute and mental health inpatient facilities. New models of care should reduce the dependence on bed-based care by helping provide alternative settings of care to offset the growth in demand. This may not however reduce the number of overall beds and avoid the need to invest in expanding the estate across the trust, and particularly at the acute sites.

11. How do we get there?



Acute Hospital Care priorities and workstreams

There are some services delivered from the acute hospital site which could be delivered from elsewhere, were it possible to transfer some services away from the hospital, this would allow for more flexibility around those which remain and create more flexibility within the sites.

The transfer of services away from the acute hospital site goes beyond those which are traditionally delivered elsewhere. There are some services, delivered from many hospitals, which do not require the infrastructure of a hospital, and which could be provided elsewhere. For example, many imaging services such as MRI and CT scanning can (and often are) provided in locations without other healthcare services nearby. Potential local solutions include using industrial land close to transport links, and potentially offering improvements such as free parking, rather than providing these services from the hospital site. Moving services off the acute hospital site would create capacity to manage the additional demand outlined in the overall infrastructure strategy. Continuing to ensure that new technologies such as virtual appointments, hospital at home and remote monitoring is used to minimise the need to patients to attend or stay in a hospital site.

The trust has already developed a new community imaging facility and has moved some clinics and minor procedures from their traditional hospital base into community settings. This has freed up space within hospitals for expanded and new services. But the core estates issues remain – old, hard-to-maintain facilities that are not suitable for modern healthcare.

Community and Mental Health facilities

The trust has a significant number of community inpatient beds. Evidence indicates that this number of beds is no longer appropriate or sustainable for modern healthcare or in a health system that aspires to care for people at home or as close to home as possible. The Community Settings of Care (CSOC) work stream of Fit for My Future has been reviewing the model of community bed-based care. There could currently be as many as 313 beds across Somerset's 13 community hospitals if all temporarily closed beds were reopened and additional beds were opened in other available areas. The currently commissioned bed-base is 214 beds. It is possible that the system may only require 124 – 134 beds under the new models of care, so there is potentially a significant surplus in potential capacity compared to demand. This means we have the opportunity to reconfigure beds between community hospital sites. These considerations will represent the most significant potential change to the healthcare estate for Somerset as we look to better manage the overall estate to reduce costs. The community estate will continue to be developed to maximise the use of community facilities, maximise the use of intermediate care facilities and other opportunities.

The trust will continue to maintain and enhance the estate for mental health services, reflecting the changing need for these services, both ensuring that inpatient facilities are suitable for modern standards and the community estate meets the need for the expanding and changing services and the ability to work closely with partners across the county.

11. How do we get there?

Somerset Council

The Council as Corporate Landlord

In the past, public-sector assets have often been managed by services rather than a centralised department. For example, the libraries service would be responsible for all or almost all facets of property asset management for the buildings from which they operate – for example, arranging repairs, statutory compliance, and the financial management of premises costs.

Local authorities are moving towards an asset management approach known as the Corporate Landlord model, which manages assets owned by the Council centrally by one dedicated property department. This allows for improved corporate oversight by the Council of important issues such as compliance and financial management. The approach also drives improvement in the utilisation and long-term value of the property estate, by enabling flexibility to adapt to changing requirements, driving the optimisation of properties through co-location, and improving the quality of decision making on asset management issues by bringing a professional, longer-term focus. Somerset Council will adopt this approach.

Somerset Council will operate the Corporate Landlord model of property management for the majority of its non-Housing Revenue Account (HRA) land and buildings assets.

An important principle of the Corporate Landlord model in Somerset is ensuring that the property estate meets the needs of the Council, and the communities and customers it serves. For the Corporate Landlord model to work effectively, it is important that the property function engages thoroughly with its internal customers – the services occupying buildings and service commissioners who deliver outcomes through the council's estate - to fully understand their property requirements. This requires strong relationships to be built and maintained and for communication to be open in both directions. At Somerset Council, a collaborative approach with open communication will be fostered through formal, regular communication and feedback, and informally through a strong collaborative culture and positive working relationships.

Equally important is engagement work with communities and customers, using the insights of community representatives and customer intelligence data to understand how Council assets can be used to meet the needs of the population of Somerset most effectively. This engagement will drive discussions about how asset devolution, or a greater community involvement in local assets, might drive better value and outcomes for communities and customers.

The five predecessor councils have all been active in working with local partners, in particular through a long-running One Public Estate programme in Somerset. Somerset Council will build on this approach, using the opportunity of a stronger, single voice for local government in Somerset to drive collaboration with local partners and stronger engagement with central government departments. This is particularly relevant for local Health and Police partner organisations, who are already integrated into the Somerset Council estate: the council will continue to collaborate closely with these partners, where appropriate taking joint decisions through the One Public Estate and Integrated Care System partner governance.

11. How do we get there?

How the Council will deliver the Council's strategic objectives in relation to Estates

In the "Where do we want to be?" section above, we outlined the Council's strategic objectives. The table below shows how we will use those to achieve our Infrastructure strategy aims and get to where we want to be:

Strategic Objective	What we will do to achieve it
The Council's estate is financially sustainable, efficient, and effective.	• Rationalise and reduce the number of buildings and areas of land wherever possible and appropriate, considering potential long- and medium-term needs, and ensuring assets are held for a clear purpose and provide best value. • Improve the effectiveness and financial sustainability of assets, devolving assets where appropriate and working with partners and services to maximise use and value. • Adopt and implement a Corporate Landlord model for the non-schools estate, which treats all properties as a corporate resource and manages them centrally. • Protect heritage assets where and when affordable, bring them into a financially sustainable use, devolving or disposing of them to deliver long term sustainable protection. • Develop an acquisitions policy to ensure new assets are financially sustainable and reduce costs. • Develop proactive maintenance strategies, or dispose of assets, to ensure long term affordability.
Assets that are fit for purpose, safe & compliant.	• Work in partnership with building users and service departments to ensure assets are safe, effective and optimised to support service delivery. • Consider the location of buildings to support accessibility for people who do not have access to a car. Proactively assess the accessibility of buildings and where reasonable, make adjustments to ensure that buildings are accessible and support customers and staff with protected characteristics. • Modernise asset records and systems and monitor the condition and safe use of buildings to provide comprehensive assurance of compliance and health and safety.
The Council's estate is used to meet housing and care needs, with an emphasis on social housing.	• Rationalise and reduce the council's estate in urban areas, to release sites for housing. • Work with partners, central government and the council's housing services to facilitate the use of surplus land for social housing (including community led and self-build schemes). • Work with social care commissioners to use the council's asset base to improve the sufficiency of care placements in the county.

11. How do we get there?

Strategic Objective	What we will do to achieve it
The Council's estate supports prosperity and economic growth.	• Maintain a strategic, targeted network of economic development sites to support business growth. • Retain a rural estate to develop opportunities to support new entrants to farming. • Where appropriate and affordable, work with partners and develop opportunities to utilise surplus assets to support regeneration and economic growth. • Ensure that Asset Rationalisation strategies support the sustainability of Town Centre economies.
Address the growing challenges in the Council's school buildings estate.	• Lobby and influence central government to provide funds to address the critical condition of Somerset schools. • Develop strategies for the replacement of end-of-life school buildings. • Work in partnership with school leaders to improve proactive maintenance practices in schools. • Work in partnership with school leaders to ensure school buildings are safe.

What this will mean in practice

The Council's strategic priorities will be made real as buildings change and new ones are built. Perhaps the largest front-line Council estates class is the residential care estate. There are residential care sites that are being built now, and also legacy estate that is becoming out dated, meaning that over the next few years the nature of that estate will change significantly. The Council is currently building its fifth children's residential home, with plans to build seven. These are small (1-3 bed) units for children with high needs related to mental health and behaviour, with a clear relationship with NHS CAMHS services. The development of these smaller, more bespoke facilities for particular needs will be a hallmark of the changing residential care estate. There will also be investment is specific facilities for Children with disabilities, and young people leaving care.

For adults, the residential care estate is primarily legacy stock, leased to providers. It is either becoming outdated or is being handed back by providers because they don't want it anymore. As a result, it is likely that there will be a shortage in residential care beds in the future, and a re-design of services towards home care and nursing care. The Council is exploring the potential for strategic partnering arrangements for residential care, using brownfield sites with a guaranteed number of places. The ICS will seek to understand the potential for further partnership arrangements and multi-organisational facilities and services in the future.

For example, we will increase the focus on independent living in future, through the development of hubs for advice and low-level assistance. This will involve the greater use of libraries and community centres for low level health and wellbeing services. There will be a move away from new facilities, and towards existing things like high street facilities, which will avoid construction costs and remove any potential stigma about attending facilities and utilising services.

There are currently nine Family Hubs, which are bases for public health nursing teams, providing a range of family support and health and care services. These are in deprived areas, replacing Sure Start centres. There are also numerous pop-up clinics in place, and we intend to further develop these services in the coming years.

We will not abandon new facilities entirely. For example, the New Somerset Academy is emerging, to be delivered from the site of the old Bridgwater community hospital, and with a satellite centre in Minehead.

However, a lack of funding makes it difficult to move from ideas to delivery. Across the ICS we are exploring funding models, and the ability of partner organisations to borrow for capital investment, marry plans to revenue budgets, and develop business cases for new buildings.

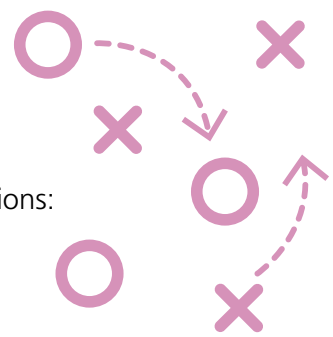
A focus on the wider determinants of health

We are conscious of the Council's role in enhancing the broader health of local communities. This goes beyond simply sharing Council or High Street buildings with health services. It also involves things like active travel – public transport, walking and cycling. Situating office hubs and customer locations will be key to this. The NHS Travel & Transport Strategy[2] also details this partnership working approach and to include strategic direction in the next iteration of the Green Plans (current plans expire 2025). There is also a commitment in the strategy to reduce staff travel emissions by 50% through shifts to more sustainable forms of travel and the electrification of personal vehicles. This will also need to be considered when thinking of where staff work.

We are also continuing conversations between public sector partners and the private sector regarding the development of Keyworker and affordable housing for the county, to attract and retain colleagues and to make sure that they and their families have good quality places to live, with affordable rents and purchase prices.

https://www.england.nhs.uk/long-read/net-zero-travel-and-transport-strategy/

11. How do we get there?



Programme Delivery

There are a range of options available to provide funding to achieve estates aspirations:

Generation of surpluses through regular activities

This option is the traditional method of funding capital developments. However, the financial position of public service providers has significantly deteriorated rendering this method of funding as practically unviable.

Bidding for capital investment from central government

This approach is becoming more commonplace and has been used successfully to secure investment in new community hospitals, maternity services, winter pressures, urgent and emergency care. Recently, SFT applied for STP capital funding and has been successful in the Wave 3 £79.4m bid to fund "Surgical Centre" rebuilding programme (theatres, critical care and associated facilities) and the Wave 4 bid to fund the £11.524m Acute Assessment Hub. The strategy allows the ICS to take a tactical approach to bidding for capital as and when it becomes available.

Utilisation of alternative financing methods and partnership arrangements

Given the likely constraints on capital investment the use of other funding routes will be explored. These have been used successfully across the county in the provision of car parking, residences, and diagnostic facilities. The expansion of these may be limited due to the impact on the national capital resource limit and overall revenue affordability but will continue to be explored and developed where appropriate.

Capital Programme

The capital programme for the next five years will mainly be financed through the ICS capital resource allocation, the majority of this will be allocated to Somerset FT as the single NHS provider within the county, as a small ICS this is relatively constrained and will be utilised for equipment replacement, backlog maintenance and small service developments, it will also be required to support the aspirations set out in the digital strategy. It will not be sufficient to make significant strategic estate change as described within the New Hospitals Programme, and therefore plans will need to be augmented with the additional funding streams noted above, aligning developments with the national Hospital 2.0 programme. The capital programme will aim to deliver several key projects together with other ongoing maintenance and renewal schemes.

- The detailed ICS capital programme for the next two years (2024/25 and 2025/26) is included in the appendices to this document. It shows that the allocated capital funding element for Somerset is £29.7m pa, and that calls on capital for infrastructure investment are significantly higher than this resulting in a £10m shortfall in the second year. There are substantial externally funded capital works planned, including the new surgical centre at Musgrove Park Hospital and large investments in digital infrastructure.

11. How do we get there?

One Public Estate – Working together to use our estate better.

One Public Estate is an established national programme delivered in partnership by the Office of Government Property (OGP) 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. Managing population growth in collaboration with local planning authorities. A collaborative and innovative relationship must continue to underpin the relationships between the ICB, Trust and local authority to ensuring the delivery of services to residents. The partnership we have with them will play a key role in making shared decisions on how to use resources, design services and improve population health at 'Place' level.

The ICS comprises at least two of the largest employers in the county, with more buildings for clinical, service delivery and office use than any other organisation. We are part of the wider Somerset public sector which also includes Avon and Somerset Police, another organisation with a large and varied estate.

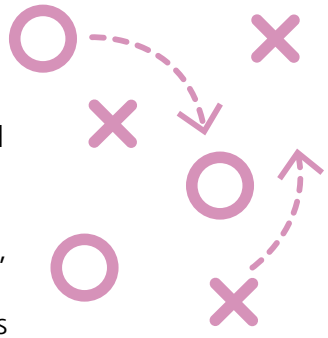
Our ICS is taking a lead role in the Somerset One Public Estate project. The national One Public Estate (OPE) programme supports locally led partnerships of public sector bodies to collaborate around their public service delivery strategies and estate needs. It will help partners to repurpose surplus public estate for housing, regeneration, and other locally determined uses.

We are working with Montagu Evans, the property consultants, to assess how best to use our whole public estate for the good of local communities, taking advantage of estate which might be surplus to one organisation's needs, but valuable to another. We want to break down organisational boundaries and recognise our common goals of improving services for local people, using and improving existing public sector estate as a different way of broadening and bettering our offer.

The core partners in the Somerset OPE project are the Council, the NHS (Somerset NHS FT and Primary Care) and the Police. Other important partners are:

- Third Sector and Ambulance
- Fire
- Colleges
- Central Government departments (especially Probation, Defra and DWP/Job Centre+)

We have identified 'Core Estate' including buildings from the former District Councils, Wynford House in Yeovil, Mallard Court in Bridgwater (staff relocations point), Wells Priory, Yeovil Police HQ, and the Police site at Express Park in Bridgwater. These buildings have the potential for wider public sector usage beyond their current use, and we will continue to investigate how best to utilise our existing space. There is also significant scope for better usage of other estate. Such estate includes community-based working and field-working in the context of the Primary / Community Care estate, locality-based Police



estate, Council Children's and Adults services, Council surveyors and engineers, and other property such as libraries. We know that bringing a wider range of services to buildings in local communities has the potential for positive results for those communities. These could include influencing behaviours to deliver crime reduction, health improvements, and improved recruitment/retention of colleagues. We also know that if, after an analysis of community estate, it is agreed that alternative uses would be better, we have the opportunity to proceed in a way that is beneficial to local communities e.g. through job creation or the creation of keyworker accommodation.

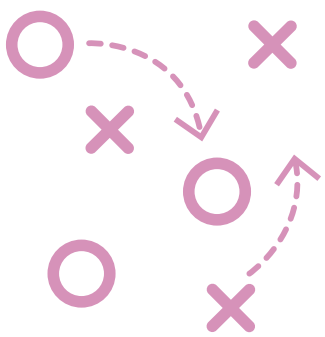
We want to work with partners holistically, looking at the public estate as a whole and doing what is best for the people of Somerset, not individual organisations. We are also conscious of our wider social responsibilities, and the need to deliver decarbonisation as we develop our estate.

Impact of new housing, and s.106 funding

The population of Somerset is estimated to grow in the coming years (it is projected to grow by over 10% in the next 20 years). This will increase health need, but this increase will be exacerbated as the population ages and there are not only increased numbers of local people, but increased numbers of older people living with ill health. Whilst our clinical strategy aims to help people live well and mitigate the impact of a growing population, we know that demand for services will grow. As a result, we are using Planning legislation to help mitigate these impacts, by claiming levies from the property developers building homes which attract more people to the local area.

The Town and Country Planning Act 1990 contains provisions for organisations to claim monies from developers if they are impacted by developments. S.106 of the Act allows this, and we have applied / plan to apply for s.106 monies for a variety of projects which are needed as a result of developments taking place or planned. Developer contributions will be sought for major developments of more than 20 dwellings to mitigate any unfunded impacts of population growth linked to those developments. For example, many new developments will increase pressure on primary care services, either by taking the local population above the level suitable for local GP provision or adding further to an already-existing deficit in provision. In such cases, we use a standardised formula to calculate the cost to the local health economy and claim this back as part of the s106 process for things such as buildings improvement.

In Secondary Care (acute, community and mental health), the methodology for claiming s.106 funding varies across England. We are currently working on an approach which will allow us to put contribution requests in, which will be in the region of approx. £800-900 per dwelling, on top of the primary care levy. However, current capital expenditure limits on NHS bodies mean that any s.106 funding received for the NHS outside of Primary Care cannot be spent as additional capital. The principal rationale for our s106 claims is the need to increase capacity and healthcare infrastructure considering an increasing population. The increases in capacity align with published local development plans for the county and the towns within it. Although these local plans consider Office for National Statistics (ONS) projections, often new developments lead to population growth over and above these projected population numbers.



Community Infrastructure Levy

In addition to s.106, we will also seek to maximise our income for estates improvement secured via the Community Infrastructure Levy. This is separate from s106, automatically applicable to all developments with new dwellings. The levy in other areas is approximately £3,000 per dwelling, although in Somerset there is currently no levy imposed. The levy would be collected by the local authority, but unlike s.106 there is no guarantee that the funding will be received by the organisations directly affected by the development. Spend is controlled by the local authority, both in terms of rate per dwelling and totality.

Projects to be funded via s.106 and Community Infrastructure Levy

The legal entity affected by the developments apply to the Council for s106 funding i.e. ICB for Primary Care funding, and SFT for Secondary Care (acute, community and mental health) funding. This is done at the planning application stage. The application is open to challenge, but if it's agreed then the money is ringfenced to the organisation affected. Despite the good process being in place for CIL and s.106, the timeliness of receiving funding is not helpful. The ICS has claimed for over £5m, of s.106 funding to date and has had several hundred thousand pounds agreed. But at present, only £13,000 has been delivered.

We plan to continue engaging with all stakeholders, from the development planning stage onwards, to consider the strategic health needs of the population as a whole in accessing s.106 funding. This will mark a change by being a more pro-active approach based on population health, rather than our historic approach which reacted to developments at the approval stage. We are learning from other local areas such as Dorset and Surrey Heartlands, where there have been different approaches taken to working with Councils, Councillors, developers and other stakeholders.

Risks

- We have identified the following key risks as those most pertinent to our Infrastructure Strategy. Mitigating actions gave been identified, but for some of the risks there remain significant challenges, particularly those where the ICS maintains limited control.

11. How do we get there?

Risk	Mitigations
If there is insufficient capital funding available to maintain and improve infrastructure **Then we will be unable to maintain our current buildings or deliver new and improved facilities for local people**	The financial challenges facing both the NHS and Council in Somerset remain significant. There appears to be little prospect of short-term funding increases. The capital pipeline has identified need which significantly outstrips the supply of capital funding. As a result, we will attempt to mitigate the most critical risks through ongoing maintenance of facilities, whilst exploring options with private providers and other potential partners for further investment.
If Somerset Council's financial position remains highly challenged **Then the ability of the Council to realise its infrastructure plans will be compromised**	Somerset Council has a plan in place to return to financial sustainability. This will mean short-term reductions in expenditure, and the potential sale of assets. However, work with One Public Estate partners means that asset sales may allow for innovative solutions across the ICS which help address infrastructure needs of other partners.
If there continues to be a lack of centrally coordinated estates /infrastructure leadership at ICS level **Then we will continue to rely on individual organisations and colleagues within them, delivering insufficiently coordinated planning.**	The ICS Estates and Infrastructure group is a system-wide forum which meets regularly. The effectiveness of this body is under review, and where it is found that additional resource would be helpful in delivering system-wide infrastructure improvements, we will consider making investment in this area.
If individual organisational priorities are of a higher priority than system-wide priorities **Then we risk prioritising short-term and narrowly focused objectives over system-wide strategic priorities.**	We will continue to work as a system wherever possible, coordinating our efforts through the ICS Estates and Infrastructure group. Where priorities conflict between individual organisations and the systems as a whole, the ICB will act as a coordinating function to establish solutions which meet the neds of all parties.
If there is increasing demand for services **Then our infrastructure plans may be insufficient.**	The plans for future infrastructure investment do take into account likely demand increases. However, these are necessarily estimates, and infrastructure investments are necessarily long term. If there is a divergence between planned and actual demand which has a negative impact on our ability to meet the needs of the population, we will re-visit our plans and re-target resources accordingly.

11. How do we get there?

Review Arrangements

- This strategy is intended to be a live document and part of an iterative process requiring regular review and updating as necessary to ensure that it remains relevant. It is expected that this strategy will be reviewed on an annual basis with timing dictated by policy changes, local strategy, and events which will have a significant impact on our ICS estate. This will ensure that the detail contained within the document remains accurate and up to date, and that the strategy will be best placed to satisfy the demands of the changing political landscape.

- We want to involve all our ICS partners across Somerset in the ongoing review of our infrastructure strategy. As the ICS itself matures and further service strategies are published, this strategy will further develop to ensure alignment.

- The strategy will be complemented by organisational operating plans which will set out the practical steps necessary to deliver our objectives. These will be used to monitor progress and to inform any changes necessary for the strategy itself.

Appendix x – Somerset ICS Capital Programme 2024/5 and 2025/6

Somerset ICS Provider Capital Plan Summary	2024/25 £'000	2025/26 £'000
Allocated Somerset Capital Envelope Funding	**29,726**	**29,728**
Additional Expected Allocation	**1,538**	
Less Ringfenced ICB Capital Allocation	**(1,007)**	**(1,007)**
Additional Envelope Transfer to ICB	**0**	**0**
Total Envelope Available to Trust	**30,257**	**28,721**
Somerset ICS Provider Capital Plan Summary **INTERNAL ENVELOPE**	**2024/25** **£'000**	**2025/26** **£'000**
COUNTY WIDE BUDGETS		
Feasibility/HEAG/Environment	825	825
Backlog Maintenance	6,500	6,500
Major Medical & Surgical Equipment	3,250	3,250
Information Technology	2,300	4,300
Infrastructure Upgrade & Carbon Neutral	250	250
Internal EHR Programme - Trust Wide	0	9,022
Other Digital Programmes	4,500	2,500
IMIP phase 2 onwards	345	400
Other Schemes yet to be identified	0	0
Total Combined Budgets	**17,970**	**27,047**
Total MPH Site Risks / Plant & Equipment	**550**	**550**
MPH - Site and Service Development		
Surgical Internal	1,375	2,160
HV Works MPH	1,300	1,000
Radiotherapy CT Replacement	0	815
Maternity Fire Doors and Compartmentalisation/fire suppression & 2nd theatre	2,600	1,500
Total MPH Site and Service Development	**5,275**	**5,475**
Total YDH Main Site Budgets	**2,815**	**2,400**
Total - YDH Site Risks / Plant and equipment Replacement	**430**	**430**
YDH - Site and Service Development		
Minor Schemes	225	425
5th theatre slippage commitment	1,186	395
Image Sharing Project	469	0
Stroke Services Reconfiguration Planning	1,000	1,000
SHS	180	180
Total - YDH Site and Service Development	**3,060**	**2,000**
Total Community / Mental Health - Site Risks / Plant & Equipment	**300**	**300**
Community Site and Service Development		
Other Projects	700	650
Yeovil Dental	650	0
Macular Injections - Yeovil Town Centre	500	0
Total Community / Mental Health Site and Service Development	**1,850**	**650**
TOTAL TRUST EXPENDITURE FROM CAPITAL ALLOCATION	**32,250**	**38,852**
Balance/(Shortfall) for Site Risks & Site Developments	**(1,993)**	**(10,131)**

our SOMERSET
Together we care

Somerset Council

NHS
Somerset
NHS Foundation Trust

NHS
Somerset

HEALTH AND CARE INFRASTRUCTURE STRATEGY

DISPOSALS

This is intended as a live document as a template and check on the Strategy for recording disposals.

NB: It is necessary to refer to HBN0-08 in regard to Surplus Land and Disposals. It is a Requirement of HBN0-08 Part B that:
4.2 Only land and property
that is required to enable FTs
and Trusts to fulfil their
function of healthcare provider
should be retained.
4.3 The estate should be
reviewed regularly to identify
surplus property

4.4 A surplus property should
be sold as soon as possible and
not be retained.

1. Site Details											2. Receipt Forecasting											3. Receipt Recording							4. Top 3 barriers to Disposal			5. Comments
Registered on e-PIMS (e-PIMS Holding reference)	Departmental ID	Land/ property/building name	Address	Postcode 1st half	Postcode 2nd half	Region	Asset Tenure: Freehold - FH; Leasehold - LH; Mixed Tenure	Site Area (ha)	If a building on site also record floor area (sq m)	Programme or Portfolio Type (eg NHP)	Pipeline Site Type (planned or potential)	Site Surplus (Date when identified as Surplus)	Surplus but identified for reuse/repurpose within ICS Strategy - state new use proposed	Town Planning Consent No/Oline/Full	Town Planning Application Reference	Level and type of de-risking activity required - further information can be provided in comments Section	Unconditional contract forecast date (Quarter)	Unconditional contract forecast date (Year)	Forecast receipt value/Valuation £	Estate Agent Appointed	Forecast receipt value - confidence rating (low/ med/ high)	Sold receipt value £	Method of disposal (i.e. private treaty, informal/formal tender, etc.)	Type of sale Conditional or Unconditional	Sharing in future development value Yes/ No	Date contract went unconditional	Name of purchaser	End Use for Residential or Other Use - State	Barrier 1	Barrier 2	Barrier 3	Free text comments
Nil Return																																

Somerset Capital Prioritisation Methodology

Version 0 : 10/6/24

Assessment criterion	Key questions	Raw score	Question weighting	Weighted score	Criteria weighting	Total weighted score
Patient risk, outcomes, accessibility and health inequalities	1. To what extent does the project reduce patient risk / harm?	10	30%	3	25%	0.75
	2. To what extent does the project improve patient outcomes and address population health needs?	10	30%	3		0.75
	3. To what extent does the project improve patient accessibility?	10	20%	2		0.5
	4. To what extent does the project reduce health inequalities especially in high deprivation areas?	10	20%	2		0.5
Clinical model and strategic service alignment	1. To what extent does the projects clinical and service outcomes align with the ICB & Trusts clinical models, priorities, digital strategy, service plans, operational challenges and service resilience?	10	50%	5	20%	1
	2. To what extent does the project address service performance targets e.g. 4 hour wait?	10	50%	5		1
	3. Alert - does project address a fragile service / risk of service failure?	**Y/N**				
Financial sustainability	1. To what extent is the project affordable in terms of recurrent revenue and CDEL? Does the project demonstrate good VFM?	10	60%	6	20%	1.2
	2. To what extent does the project improve productivity i.e. patient throughput?	10	20%	2		0.4
	3. To what extent does the project improve service specific financial benchmarks?	10	20%	2		0.4
Capacity and demand management	1. To what extent does the project reduce the current demand - capacity gap and or address future demand?	10	50%	5	15%	0.75
	2. To what extent does the project reduce the demand for services by e.g. reducing intensity gradient, early intervention, prevention?	10	50%	5		0.75
Workforce benefits	1. To what extent does the project improve workforce outcomes in terms of recruitment, retention, staff contentment?	10	100%	10	10%	1
Strategic estates alignment	1. To what extent does the project improve statutory compliance / condition of the building?	10	30%	3	10%	0.3
	2. To what extent is the project deliverable in terms of cost/time/risk factors?	10	25%	2.5		0.25
	3. To what extent does the project align with strategic drivers e.g. ICS Infrastructure Strategy/Naylor/Carter/NZC/Fuller?	10	20%	2		0.2
	4. To what extent does the project optimise the asset in terms of function / utilisation / quality / environmental management?	10	25%	2.5		0.25
	5. Alert - does this project address a critical business continuity risk and is therefore a "must do" project?	**Y/N**				
			SCORE	**60**	100%	**10**
			MAX	**60**	**100%**	**10**