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The healthcare infrastructure specialist

Future Approach to Planning Primary Care Premises in Wales

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Section 6. Recommendations

Appendices

Document control

Report for	NHSWSSP
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Executive Summary

This report is intended to inform the development of future primary care estate in Wales. The advisory notes herein have been compiled as a result of extensive engagement with the wider public and those who provide public services. It provides guidance on core design principles for modern estates; it does not set out a prescriptive or narrow model of care.

In this report we have assessed the needs of the primary care estate and what is needed to deliver the right health care service in the right place for patients in Wales, that is both inclusive of and accessible to all and meets the standards as set out to meet the 10 commitments agreed in 'A Healthier Wales'.

The project is fully aligned to the principles of the Primary Care Model for Wales, in seeking to provide a whole system approach that demonstrates integration of health, local authority and voluntary sector services, and has facilitated collaboration and consultation to reach a consensus on the type of primary care provision that patients and staff would like to see that gives the best support to people, gives easy access to local services for care when needed and technological solutions to improve access to support self-care. Three important key principles for consideration of future developments include:

- Clusters of services should have a significant focus on how they will allow enhanced community-based services, through flexible facilities for multi-professional teams in accommodation that can house a broad range of local services and a widening of access for people to visible self-care. A significant focus for wellbeing services should be demonstrated to support key areas of need, such as for mental health.
- Analysis of the nationally agreed direction of travel for health care in Wales has demonstrated that there is an overall view that the Health Boards should take a population approach to developing clinical care services where there is evidence that local contexts and population health has been a fundamental consideration of how investment in services will meet residents' respective needs.
- In order for this to take place there should be a nationally led system for regular review of the condition of the primary care estate to ensure that agreements for local primary care estates planning meets the motivations to deliver care differently and ensure the principles of sustainable estates provision are aligned with ambitions to be long term and in support of integration. A national collection of a common core estates data set would provide the essential data required to inform future investment prioritisation and decision making. The digital infrastructure is central to this and critical for a more efficient model of pandemic resilient estates capacity.

The proposed model of estate and facilities outlined in section 2 should be adjusted and viewed through the lens of:

- Identified local need.
- Sustainable capital investment ambitions.
- The national context – current capacity and condition of general practice estate in Wales.

The model can be used to form the basis of a framework for future investment decisions; however, there are five core recommendations to enable successful implementation and delivery of core facilities providing the right services and infrastructure in the right place.

Recommendation 1 – Address existing gaps in Primary Care data and investment in a suitable platform for data analysis

Having access to the right primary and community care estate data is an essential element of developing robust investment plans and evaluating business cases. Investment is required into a suitable platform to hold the suggested Wales National Data set to enable informed decision making at a national and local level.

Recommendation 2 – Individual next steps Health Board Primary Care Estates plan

It is recommended that a geographical area is identified and piloted prior to roll out of a full-scale primary care estates and service planning project being commenced per Health Board.

Recommendation 3 - Construction of a prioritisation framework for investment

A suggested prioritisation framework has been provided as an appendix to this report. It is recommended that this framework, along with the outputs of the data collection and facet surveys, is used to enable informed future investment decisions and facility planning that will respond to these identified needs – as well as allowing assessment against existing health property options across Wales.

Recommendation 4 – Create a Wales wide ownership strategy

This report outlines options for future ownership of premises and the support services required. The appraisal of these options will lead to a Wales wide strategy and provide a trajectory for future ownership models.

Recommendation 5 – Create a Wales wide funding and accounting review

To tie in with the Ownership Strategy, this funding and accounting review would investigate the provision of grant funding to GPs and how this aligns with Premises Cost Directions.

Introduction

Health and care service providers are working together across Wales to deliver on recommendations of new ways of working across Primary and Secondary care that supports all health and care organisations working together in a joined-up way.

In 2019[1], it was identified that there was a need to assess the potential primary care estate requirements to ensure that built facilities will continue to meet primary care needs across the Health Boards and provide the facilities required to meet the challenges of the differing health needs of the population and localised growth.

This report is aimed at informing the development of the future primary care estate in Wales and is based on a review of the population changes and potential impact on the needs within primary care, an assessment of the current estate and recommendations of future developments. The key aims of the project have been to:

- Evaluate how primary care premises in Wales meet the needs and desires of the citizens of Wales and suggest the optimum means for utilising premises to deliver that service.
- Review of policies and guidance for the design of premises and tested against external examples, to give assurance that they meet the strategic and policy targets.
- Evaluate the Primary Care estate, in terms of how it meets strategic policy aims and conforms to agreed future approach to premises.
- Assess the mechanism for owning and operating the premises, both currently and against the future approach, to ensure effective estate transformation.

The main priority of NHS Wales is to achieve the best possible health outcomes for the population by assessing local needs, determining priorities and strategies for service delivery and investing in services that meet new and emerging ways of working, on behalf of the population. Any primary care estate development proposals must therefore embody the following principles:

- The primary care estate meets the demands of the clinical strategy and is delivered in the right place with the right facilities;
- The existing and retained estate is fully utilised;
- The estate is fit for future purposes;
- Investment in the estate allows for a reduction in backlog maintenance and a reduction in running costs;
- Where possible, co-location with other public sector bodies should be considered to allow care to be provided more efficiently and closer to people's homes, although not always possible/viable;
- 'Healthy' locality models are used to inform infrastructure developments across Wales.

[1] A Healthier Wales: Our Plan for Health and Social Care: https://gov.wales/sites/default/files/publications/2019-10/a-healthier-wales-action-plan.pdf

The report provides guidance on core design principles for modern estates, but it does not seek to be prescriptive, thereby allowing for local interpretation based on each Health Board's community requirements. The model suggested does form the basis of a framework for future investment decisions however, the proposed model of estate and facilities outlined in section 2.4 should therefore be viewed through the lens of:

- Individualised Health Board identified local need;
- Sustainable capital investment ambitions based on the identified local need and current capacity and condition of general practice estate;
- The national context and priorities for development and investment.

To ensure that the outcome of this report is representative to staff, patients, and the public, it has been compiled following extensive engagement with service providers and service users and has identified six recurrent themes from stakeholder engagement that should be considered first and foremost. These are detailed in Section 2.3.

This document has also been produced with consideration for how Covid-19 has impacted on the delivery of healthcare across Wales. Whilst changes in the delivery of primary and community care occurred during 2020-2021, it has been important to not only assess the future impact of digitalisation for access to healthcare consultations but also the impact of the severe strains placed on the provision of some services such as for people with mental health needs and the backlog within elective care for patients which has added extra strain on primary care.

A standalone summary document has been produced.

Section 1. Background and methodology

1.1 Background

This report, commissioned by the Welsh Government in December 2020, evaluates the current estate of Primary Care General Practice premises across Wales. It proposes how to transform it to be capable of delivering a modern, optimised, and accessible service that meets all patients' needs in line with the Primary Care Model for Wales (2019)[2]. It aligns with the principles of that model, which seeks to provide:

- A whole-system approach that integrates health, Local Authority and voluntary sector services, and is facilitated by collaboration and consultation;
- Support to help people remain healthy, with easy access to local services for care when it is needed;
- Technological solutions to improve access to information, advice and care, and to support self-care; and
- Strong and professional leadership across sectors and agencies to drive improvement.

1.2 Project methodology – four key themes

The project approach was to gather and analyse data then make recommendations broadly aligned to four key themes:

Figure 1: Four Key Themes

THEME 1: Align with national policies and strategies

The methodology employed for this theme was to:

- Review the current approach to investment and/or development of primary care premises in Wales and conduct a gap analysis comparing the findings against best practice.
- Map the current provision of primary care estates in Wales in relation to:
  - physical capacity to allow for future growth and development
  - environmental conditions and sustainable estate

[2] Primary Care Model for Wales (2019) https://primarycareone.nhs.wales/files/sharing-practice/primary-care-model-for-wales-april-2019-pdf/

THEME 2: Focused stakeholder engagement

The methodology employed for this theme was to:

- Seek input from clinical and non-clinical stakeholders regarding the service provision for their patients - engagement with: Welsh Government; Health Boards.
- Focused engagement sessions:
  - define optimal provision of services, building on the understanding of how the existing service(s) are performing
  - highlight changes required to provide better integrated care and to shift care closer to home.
- A holistic approach – surveys were issued to all GP practices and the general public.
- 1:1 engagement with leads for:
  - Local Authorities:
  - Health Board leads.
  - Wider stakeholders;

THEME 3: Review existing premises

Available estate data was gathered and analysed (see sections 2 and 3 for details); it was noted that the provided data was often incomplete or out of date; as the data proved to be an unreliable source it affected this report's ability to conduct assessments and provide accurate recommendations on the current position in order to inform the future estates. This finding emerged during the research and analysis stages as a significant issue and due to this the following methodology was used to determine the assumptions needed:

- Analysis of the current estates' strategies of each Health Board;
- Review the core minimum data set;
- Complete a gap analysis of the existing information available;
- Enable consideration of future opportunities and constraints and proposed strategic direction; and propose a solution that is sustainable and fit for the future needs;
- Develop an overall 'Future Model Design Principle' that is based on:
  - care provision required;
  - minimum access requirements for local people;
  - exemplar block plans and functional content.

THEME 4: Consider property ownership

Across Wales there is a range of ownership models for primary care premises. The report reviews these and makes recommendations on future models for ownership that can be used as enablers for transformative improvements in service quality. See section 4 for details.

The methodology employed for this theme was to:

- Confirm existing ownership models within the primary care portfolio;
- Conduct risk benefit analysis of potential ownership models;
- Align proposed ownership models with Welsh policies and long-term objectives.

Section 2. Review of policy, best practice and proposed design principles

2.1 National policy and strategies

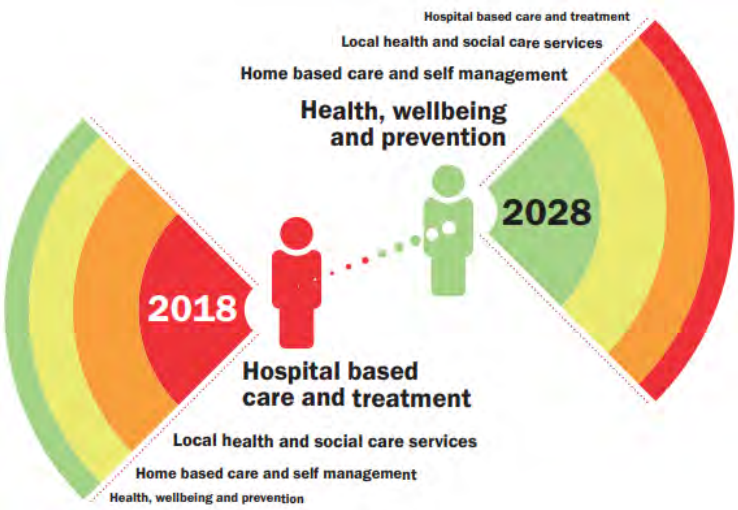
An understanding of national policies and strategies was gained through stakeholder engagement, alongside a review of the following literature:

A Healthier Wales: Long Term Plan for Health and Social Care (2019)

This long-term plan is a national whole-system transformation programme for health and social care, focused on health, well-being and preventing illness.

It encompasses a shift towards providing seamless care closer to home with nationally consistent quality, safety and access levels.

Figure 2: A Healthier Wales 2018 to 2028



Strategic delivery plans will transform the health and care system via digitalisation, integration, shifting of some secondary care services into primary care settings and personalising services to each patient holistically through a number of programmes that are at different stages of implementation:

- Encouraging well-being:
  - Healthy Schools Programme (education on health);
  - Caerphilly Cohort Study (impacts of lifestyle factors);
  - Healthy Working Wales.
- Addressing inequality:
  - Whole system approach to tackling social gradients (reaching more patients through communities),
  - Equal and holistic approach (regardless of age, mental or physical illness, etc.);
- Access to seamless care services:
  - Local GP provision of different professional and specialist services;
  - Modern technologies, digital and face to face services;
  - Post-hospital community care.
- Shifting some secondary care services to primary care:

- Objectives to reduce unnecessary admission, support people with more complex conditions to receive treatment nearer to home, reducing length of stay in hospitals (community care, improved diagnosis and options for specialised treatments in hospitals).

- Increasing use of technologies: better access for patients, links to unplanned / emergency care, population assessment and locally supported services that are closer to home where possible and enable confidentiality to be preserved through better care pathways

Figure 3: National Transformation Programme

Long term plan core delivery is focused on:

- improved population health and well-being;
- improved health and social care workforce;
- better health and social care services;
- higher value health and social care.

A Healthier Wales – the ten national design principles

This will be achieved by embracing the following design principles:

Prevention and early intervention – acting to enable and encourage good health and wellbeing throughout life; anticipating and predicting poor health and wellbeing.

Safety – not only healthcare that does no harm but enabling people to live safely within families and communities, safeguarding people from becoming at risk of abuse, neglect or other kinds of harm.

Independence – supporting people to manage their own health and wellbeing, be resilient and independent for longer, in their own homes and localities, including speeding up recovery after treatment and care, and supporting self-management of long-term conditions.

Voice – empowering people with the information and support they need to understand and to manage their health and wellbeing, to make decisions about care and treatment based on 'what matters' to them, and to contribute to improving our whole system approach to health and care; simple clear timely communication and co-ordinated engagement appropriate to age and level of understanding.

Personalised – health and care services which are tailored to individual needs and preferences including in the language of their choice; precision medicine; involving people in decisions about their care and treatment; supporting people to manage their own care and outcomes.

Seamless – services and information which are less complex and better co-ordinated for the individual; close professional integration, joint working, and information sharing between services and providers to avoid transitions between services which create uncertainty for the individual.

Higher value – achieving better outcomes and a better experience for people at reduced cost; care and treatment which is designed to achieve 'what matters' and which is delivered by the right person at the right time; less variation and no harm.

Evidence driven – using research, knowledge and information to understand what works; learning from and working with others; using innovation and improvement to develop and evaluate better tools and ways of working.

Scalable – ensuring that good practice scales up from local to regional and national level, and out to other teams and organisations.

Transformative – ensuring that new ways of working are affordable and sustainable, that they change and replace existing approaches, rather than add an extra permanent service layer to what we do now.

National Clinical Framework: A learning health and care system (2021)

The National Clinical Framework has established the model needed for the planning and delivery of clinical services. It outlines that Health Boards should take a population approach to developing clinical services, assessing each local context and population health to meet residents' respective needs.

In the wider partnership agenda, health services and Public Services Boards can also work together to tackle the socioeconomic determinants of health, such as local housing, environment, social health needs, mental health and education.

The framework's vision of shifting healthcare from secondary to primary and community settings requires clear service planning to ensure that where the value of delivery is higher in some areas, the local need is clearly understood, and resources balanced across the healthcare system, to allow the greatest impact of service provision in the community setting.

Primary care estates observations

- There is a significant focus on diverting the public to community-based services. This will mean more flexible use of facilities and require additional estates capacity to accommodate a broadening range of local services.
- The prevention agenda relies on increased physical screening capacity to support early identification of lifestyle risk factors, and a widening of access to visible self-care and risk identification resources. All new facilities should include different options for wellbeing services that brings health and care services together through diverse engagement resources in welcoming environments.
- The increase in need for mental health services, particularly post-pandemic requires an additional 400 counselling spaces nationally. By providing ease of access for patients within the community mental health, audiology, musculoskeletal, podiatry, ophthalmic and diagnostic services can be offered more locally.

Well-being of Future Generations (Wales) Act 2015

The Act aims to improve the social, economic, environmental and cultural well-being of Wales:

Figure 4: Well-being of Future Generations Goals

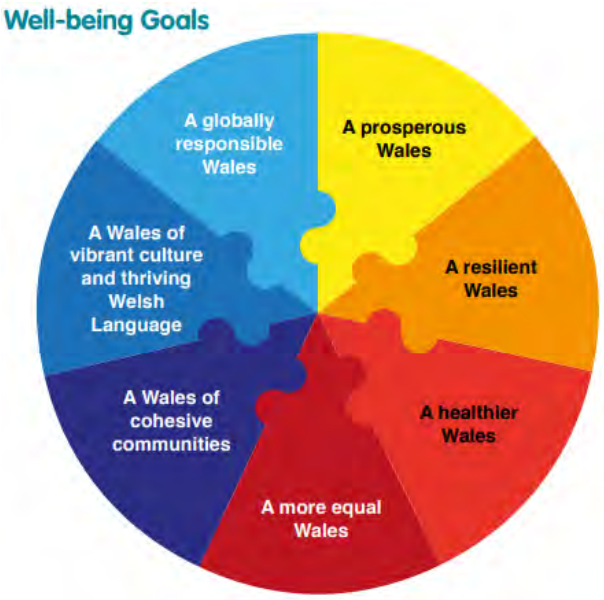
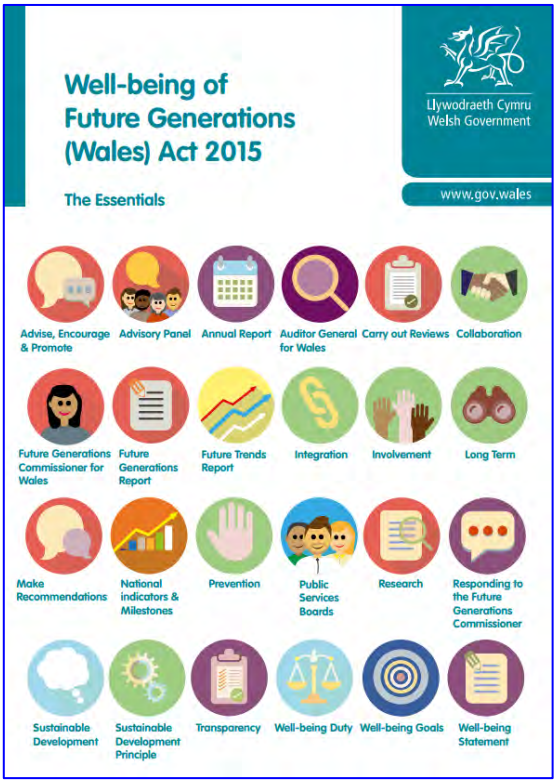


Figure 5: Well-being of Future Generations Act Essentials



It establishes a 'Sustainable Development Principle' to ensure that public bodies provide the needs of the current population without compromising the ability of future generations to meet their needs.

It sets five 'ways of working' to ensure implementation of the principle when delivery services for people: long term, prevention, integration, collaboration and involvement.

It will make the public bodies listed in the Act think more about the long-term, work better with people and communities and each other, look to prevent problems and take a more joined-up approach.

Primary care estates observations

- All prospective investment should be considered through the lens of forecast health needs analysis; this should not be excessively localised but considering wider Health Board area needs.
- Public Services Boards should be the recipients and ultimate approvers of primary care estates strategies to ensure the wider assets are explored in advance of significant new build infrastructure projects.
- The Public Services Boards should be provided with funds to distribute as annual condition and capacity improvement grants; up to a value of £20k these should be issued with a focus on holistic local wellbeing facilities

Taking Wales Forward 2016-2021

This document sets out how the Welsh Government will deliver more and better jobs through a stronger, fairer economy, improve and reform public services, and build a united, connected, and sustainable Wales. The 'Health and Active' section states:

> "*Good health underpins all of our ambitions for Wales. We are committed to helping improve health and well-being for all. Living healthy lives allows us to fulfil our potential, meet our educational aspirations and play a full part in the economy and society of Wales. Our ambition is to embed healthy living throughout our programmes and to place a focus on health at the heart of everything that we do. An ageing, growing and changing population is increasing demand and costs of healthcare. There is still too big a gap between the health of the richest and poorest in our communities. These challenges require a range of responses from birth through to old age maximising health and well-being throughout life. We remain committed to the founding principles of the NHS, healthcare free and accessible to all at the point of need. We will protect and improve the Welsh NHS over the next five years and ensure it develops effectively to meet future needs. However, the NHS needs to reflect the needs of our modern society, with closer links between health and social services, strengthened community provision and better organisation of general hospital and specialised services. We will move more care and services from hospitals into communities, supported by integrated and sustainable Health and Care Services capable of meeting current demand and future need. We will deliver timely care and treatment to patients when they need it.*"

It identifies key improvements to healthcare services:

- Introduce a New Treatment Fund to give people in Wales fast access to new and innovative treatments and work to end the postcode lottery for drugs and treatments not routinely available on the NHS.
- Continue to improve access to GP practices, making it easier to get an appointment.
- Invest in community pharmacies to allow access to health in different ways and take pressure off General Practice.
- Seek to establish a Parliamentary Review into the long-term future of Health and Social Care in Wales.
- Increase investment in facilities to reduce waiting times and exploit digital technologies to help speed up the diagnosis of illness.
- Invest in a new generation of integrated health and social services centres alongside the transformation of our hospital estate.

Future Wales – The National Plan 2040

Policy 6 of this document calls for a "Town Centre First" approach suggesting that health facilities should be located in town and city centres where possible. This policy applies to developments of significant scale, to be determined by planning authorities. However, it is important that clinical need, determined by population demand, is at the forefront of decision-making for future health facility locations.

Primary care estates observations

- The location of primary care estate should be integrated with wider community services that have been developed to build on supporting community cohesion such as offering group gathering spaces.
- Prosperity is built on opportunity and access to learning and new health and wellbeing facilities should include areas for the public and health workforce to access group education sessions and digital training resources.
- Facilities at all levels should include a range of new employment opportunities, particularly in remote areas of high reported unemployment

Prosperity for All: Economic Action Plan (2019)

The four key themes identified in 'Taking Wales Forward 2016-2021)' inform this strategy:

- Prosperous and Secure;
- Healthy and Active;
- Ambitious and Learning;
- United and Connected.

Five priority areas are identified, which by improving how services are delivered can have the greatest impact for further action over the long term.

Figure 6: Prosperity for All

The Economic Action Plan pays close attention to the obligations under the Well-being of Future Generations (Wales) Act. Embedding the principles of the Act within its strategic thinking and policy development has informed, influenced and shaped the Plan. In particular, the Plan reflects, aligns with and contributes to the well-being goals, objectives and ways of working of the Act.

The Primary Care Model for Wales

The primary care model for Wales takes a whole-system approach to transforming the health and well-being system, where patients can access a wide range of services, closer to home. This approach supports 'A Healthier Wales', encouraging individuals to self-manage their health, efficiently access correct services and focus on prevention, early action and wider well-being as a treatment for illness.

Key implementation strategies include integration of primary/community care and shifting services from secondary to primary care settings. Focus has included delivering a national system for general practices to deliver stable services – analysing demand, population data and pressures on the services etc.

Local actions concentrate on improving efficiency via digitalisation / integration of primary and wider care services / secondary services in primary settings / collaboration of wider professionals.

The Primary Care Model [3] provides seamless working between partners at community level through the primary care clusters. The model was endorsed by stakeholders through the National Primary Care Board in March 2018. Stakeholders include Health Boards, Public Health Wales, the Wales Ambulance Trust, Social Services, and representatives from the third sector and the General Practitioner Wales Committee. There are formal delivery milestones to drive action locally to adopt and adapt the model at pace and scale in all parts of Wales.

Allied Health Professions Framework for Wales: Looking Forward Together (2020)

This framework follows the quadruple aims of A Healthier Wales, following the Happier, Healthier, Longer Lives objectives.

It specifies working in partnership with citizens to:

- Improve population health outcomes;
- Improve quality and access to Allied Health Professionals;
- Provide higher value Allied Health Professionals;
- Ensure a vibrant workforce.

Key actions outlined by the framework include:

- Greater digitalisation of services;
- Evidence-based best practice;
- Collaboration with citizens/national strategic programmes;
- Integrated/collaborative working with other professions.

Primary care estates observations

- National and local networks could adopt overall responsibility for local primary care estates planning; with a quality assurance role to regularly review the condition of the estate.
- Digital infrastructure investment will be critical to achieving a more efficient model of pandemic resilient, estates capacity in the future.
- Flexible accommodation for virtual and in-person multi-disciplinary teams case management should be provided for in all scales of primary care estates provision.

NHS Wales Decarbonisation Strategic Delivery Plan (2020)

This strategy document sets out Welsh Government plans for decarbonisation in Wales with goals of having a Net zero public sector and 70 percent of Wales electricity consumption to be renewable, by 2030.

The plan breaks down emissions within Wales in 2018/19 into three scopes and four categories, identifying 46 initiatives for decarbonising Wales. It sets a commitment to provide £16m in capital finance for the first year of delivery (2021-2022).

[3] Wales Primary Care Model: https://gov.wales/primary-health-care-html

It provides full support to the Climate Emergency for Wales, giving high priority to business cases with low carbon options, producing and implementing a delivery plan and accrediting new builds/refurbishments to a net zero carbon framework.

The delivery plan implementation approach splits activities between Mobilisation and Investment and Revision approach, describing governance and support for decarbonisation specific resource objectives.

NHS Wales will undertake decarbonisation initiatives, which are structured into six activity streams: carbon management, buildings, transport, procurement, estate planning/land use and approach to healthcare.

Case study 1 – Understanding Carbon Footprint

The Carbon Positive Project evaluated Natural Resources Wales's net carbon status, accounting for both GHG emissions and carbon sequestration across the whole of NRW's owned and managed estate. NRW calculated emissions across the full range of their activities and operation, including buildings, transport, land, assets and the procurement of goods and services.

The findings of the project suggest that whilst buildings are important, other areas are far more so.

For example, NRW estimated nearly 60 percent of their emissions resulted from the procurement of goods and services.

Latterly, the NHS Wales Shared Services Partnership commissioned an assessment of the NHS Wales overall carbon footprint on behalf of Welsh Government. The report found the NHS Wales emissions amounted to:

- Building use – 30%
- Transport – 21%
- Procurement – 49%

Primary care estates observations

- Community owned and managed facilities in line with good practice standards of operation to ensure collaboration and involvement between the public and public sector service providers.
- Consider options for access to training accommodation and virtual learning resources.
- Ensure the principles of sustainable estates provision are aligned with ambitions to be long term, prevention focused, and in support of integration.

2.2 Learning from national and international examples

Introduction

The intention of this section is to provide an overview of the examples, from a national and international perspective, that are driving the changes in future service provision and set the context for this report. Each example promotes integrated working between health, social care and public health and has developed a mandate describing the key elements to deliver including services actions that:

- Give people access to primary care through the provision of extended services ensuring patients get the right care at the right time and of the right quality. It is recognised that delay in providing care can lead to poorer clinical and social outcomes whereas early intervention of care services in the community provided by dedicated teams are highly effective in improving outcomes and simultaneously reducing costs.
- Provision of an integrated approach to health and social care enabling people with more complex conditions to be offered screening and secondary prevention reflecting their higher risk of poor physical health.
- Consideration of increased access to services for children and young people as a priority group for health promotion and prevention, together with early intervention where required.
- Digitalised services that support linkage in relation to ease of access, delivering care in different ways, improving patient experience, and supporting best outcomes.
- Developments in primary care that meet the needs of the local populations with a focus on inequalities to ensure all needs are met across all ages – addressing the entire spectrum of people's physical, mental and social needs.

Examples of good practice in Wales

There are numerous reported exemplars of good practice regarding integrated health and social care across Wales. Described below are some highlights of the models that have been indicated and reviewed over the course of the stakeholder engagement work undertaken, and all have the following common themes:

- Integrated facilities at the heart of Welsh communities.
- Encouraging the public to engage with a wide range of support and services.
- Building clinical and support service relationships across sectors and diverse population groups.

Healthy Prestatyn

The Healthy Prestatyn model developed as a result of three practices coming to the end of their contracts simultaneously and finding a constrictive impact resulting in the establishment of an integrated primary care model. The aim of their network is operating as a broad and forward-looking range of professionals who are grouped together into Key Teams. There are five of these multi-disciplinary Key Teams, each one caring for a specific group of patients.

Each Key Team contains of GPs, Nurse Practitioners, Occupational Therapists, Pharmacists and a dedicated coordinator. Supporting the teams are a range of other highly skilled professionals (for example, physiotherapists).

This arrangement means that the individual members of the public with differing needs can be seen directly by the person most appropriate for their care needs and ensures that the GPs can devote their time to those patients who still need to see a doctor.

@Loudoun Square, Loudoun Square in Cardiff

This development involved the construction of a new multi-purpose building '@Loudoun' that houses a new health centre, a culture and media centre, social enterprise units and a community hub, 13 new retail units and 61 affordable homes. These changes within a particularly small 0.8-hectare area required careful planning and effective partnership working together to ensure that as little disruption as possible was caused to the community. The development was, therefore, approached in three phases over a 140-week period. The phasing of the development and an innovative approach ensured that none of the facility was closed during the build and services could be continued through using the ground floor of the new houses as temporary shops to allow the retailers to keep trading.

@Loudoun is located at the cornerstone of the development and provides:

- Modern health centre;
- Pharmacy;
- Culture and Media centre;
- Community and training rooms and a commercial kitchen;
- Council information service;
- Social enterprise units;
- Butetown Employment Support and Training Service (BEST).

The new facilities included in @Loudoun mirror the project objectives to tackle long-standing community issues, including unemployment, safety, and health. The Butetown Employment Support and Training Service (BEST) provides a wide range of advice to residents from completing job applications, contacting employers and advising on interview techniques. The facilities provided by the Culture and Media Centre and social enterprise units also provide the support to grow talent and ambition in the local community. The new health centre with its increased patient capacity and modern facilities contributes towards improving access and the standards of health within the area. In addition, the adjacent shops along Bute Street have benefitted from new contemporary units which have been designed to complement the look and feel of the community and are supported with plenty of lighting and CCTV to improve the safety of the area.

Ceredigion Integrated Care Hubs

In Cardigan, a suite of services is provided to reflect the needs of the local population, including community dental and pharmacy services; a GP / nurse led minor injuries walk-in service with telemedicine links to the emergency department provides quick and easy access for patients; radiology and diagnostics for care away from the acute service; a phlebotomy service; and an outpatient suite with consulting rooms and clinical treatment facilities for pre-assessment and outpatient consultations by visiting clinicians and social workers.

The services also provide a range of disease-specific assessments for heart failure, motor neurone disease clinics, and Chronic Obstructive Pulmonary Disease services; enhanced telemedicine equipment in clinical areas providing remote access to specialists from across the professions; rehabilitation services, providing opportunities for intensive and slow stream rehabilitation to restore function and improve independence, supported by therapists, nurses and social care staff within the Community Resource Team; mental health and learning disabilities services; a base for the local Community Resource Team in south Ceredigion; and third sector services.

Healthy Blaenavon

As an Integrated Wellbeing Network 'Healthy Blaenavon' provides a framework for the well-being collaborative in this community. It is a social movement with a set of principles and a brand with which local organisations and the community can associate activities that improve their health and well-being. With a pan-public sector governance model, the Integrated Wellbeing Network is currently focusing on key project that include:

- *Blaenavon Resource Centre – more than health care*. Developing the Resource Centre as somewhere that the community can access information, advice and support for a range of situations.
- *Family Engagement Programme – in partnership with Street Games*. An opportunity to bend resources to encourage families to improve their health and well-being, but on their terms.
- *Intergenerational activity – improving perceptions of young people*. Led by the Hwb Youth Centre, supported by the Healthy Blaenavon Officer and in partnership with the Police and Community Safety.
- *Living with Diabetes*. This project led by Blaenavon Primary School developed independently of Healthy Blaenavon but the film that has been produced could be used as part of a wider campaign. Children from the school will also be involved in community engagement to identify what can be done to make Blaenavon healthy.

The Butetown Community Centre

This service is run by a voluntary management committee of dedicated people who take legal responsibility for the running of the Centre and ensure that it is well-run and operates within the rules and regulations set out in the governing documents and legislation. This is a registered charity, self-funding, and all revenue generated is put back into the Centre to help to improve and expand the services and activities. The centre offers a range of non-health community services including access to Citizens Advice Bureau, Adult Education, Community groups, cooking classes and community enterprises.

Health Living Hub, Kingsway Practice, Swansea

GPs at a Swansea Practice have opened the wellbeing centre for local patients to encourage self-care and ease the increasing pressures on doctors' time. The Healthy Living Hub aims to provide a friendly welcoming space in the heart of the city. The Hub is run by the Kingsway Wellbeing Project which is a charity which was established in December 2018. The charity was set up with the aim to bring low-cost health and wellbeing services to Swansea city centre.

The service aims are many: to develop a range of classes to suit everyone that help to promote fitness and wellbeing at a low price; to provide local residents with the opportunity to access classes such as yoga, tai chi and Pilates to help with strength, fitness and mental well-being. They also have a small gym that is used daily throughout the week by patients of the Kingsway Practice, and they hope to be able to open gym facilities during evenings and weekends soon.

Sunnyside Wellness Village

This proposed development involves 59 homes and a healthcare centre. It is a collaboration between housing association Linc Cymru and what is now Cwm Taf University Health Board.

The three-storey health centre will house a GP practice, formed by the transfer of services from Ashfield Practice and Newcastle Practice, a pharmacy, and a specialist community dentist unit for specialist patients with obesity, with phobias or who have additional needs.

It will also incorporate the existing Quarella Road Clinic which provides sexual health services and the Bryntirion Clinic which provides podiatry and orthotic service.

Tredegar

Tredegar Health and Well-being Centre is being built on the site of the former Tredegar General Hospital. The existing facility had become outdated and was not fit-for-purpose, resulting in services temporarily moving off-site and leaving space with zero utilisation. The facility had reached physical constraints for both service expansion and development, with no scope for multi-service delivery.

The new Tredegar Health and Wellbeing Centre aims to target patient access, by co-locating a range of services, providing a 'one-stop-shop' of holistic care. It will facilitate continuous care, 'closer to home' via smoother referrals and link with community services to promote social and digital inclusion.

Maelfa

The development of a well-being hub at Maelfa has been approved to provide primary and community services for Cardiff and Vale UHB. Services from Llanedeyrn Health Centre and GP practice are relocating to the hub. This is alongside a range of integration-focused specialised health clinics, including district nursing, counselling and podiatry. The Health Centre and Community Hub will offer a 'one stop' for health services, education and advice. It will build on the existing education services provided by Cardiff council and the voluntary sector at the 'Powerhouse Hub' incorporating a range of services for local people in one location. The wellbeing hub will provide:

- Community rooms and an advice area bringing together health, local authority and third sector groups.
- A range of specialist health clinics including those for children and young people, people with mental health needs and links to the acute service for the provision of audiology and heart services.
- Replacement of the multi-use games area and relocation of a community café.

Bro Ddyfi Community Hospital, Machynlleth

A community hospital in Powys will be upgraded to a wellbeing hub including access to health and social care, well-being, prevention and health promotion facilities. A base for health, local authority and third sector teams, encouraging integrated and efficient care.

The upgrade includes providing General Medical Services, bookable spaces/hot desks for visiting organisations, multi-disciplinary accommodation, separation of the adult mental health centre, improvement of staff facilities, dedicated palliative care ward, redeveloped front entrance, enhanced pathways, cafe, compliance, disposal/redirected use of external buildings and improved car parking. The estate is a refurbishment of the existing building with a number of planned extensions.

Welsh exemplar conclusions and recommendations

- The wide range of exemplar programmes in Wales gives many benefits for the public and is an excellent baseline to be built upon. Their alignment with national policy should be shared widely as part of this report to support future developments.
- Delivering developments at the scale of those featured in every locality is not sustainable, so it is recommended that through the use of technology, hub and spoke approaches should be explored to ensure small local community versions of these developments can be achieved on a pan-Wales basis.
- The importance of ensuring equitable access across a range of protected characteristic groups has been a priority within these developments and this should continue in future developments.
- The life cycle costs of these larger developments need to be carefully considered as part of wider estate planning approach.

Examples of International good practice

UK 'Intelligent healthcare design'[4]

Intelligent design relates to the development of repeatable and scalable healthcare facilities – building floor plates that:

- Meet optimal configuration in line with best practice guidance.
- Optimise flow and space utilisation.
- Reduce development costs for new facilities across a designated healthcare economy.

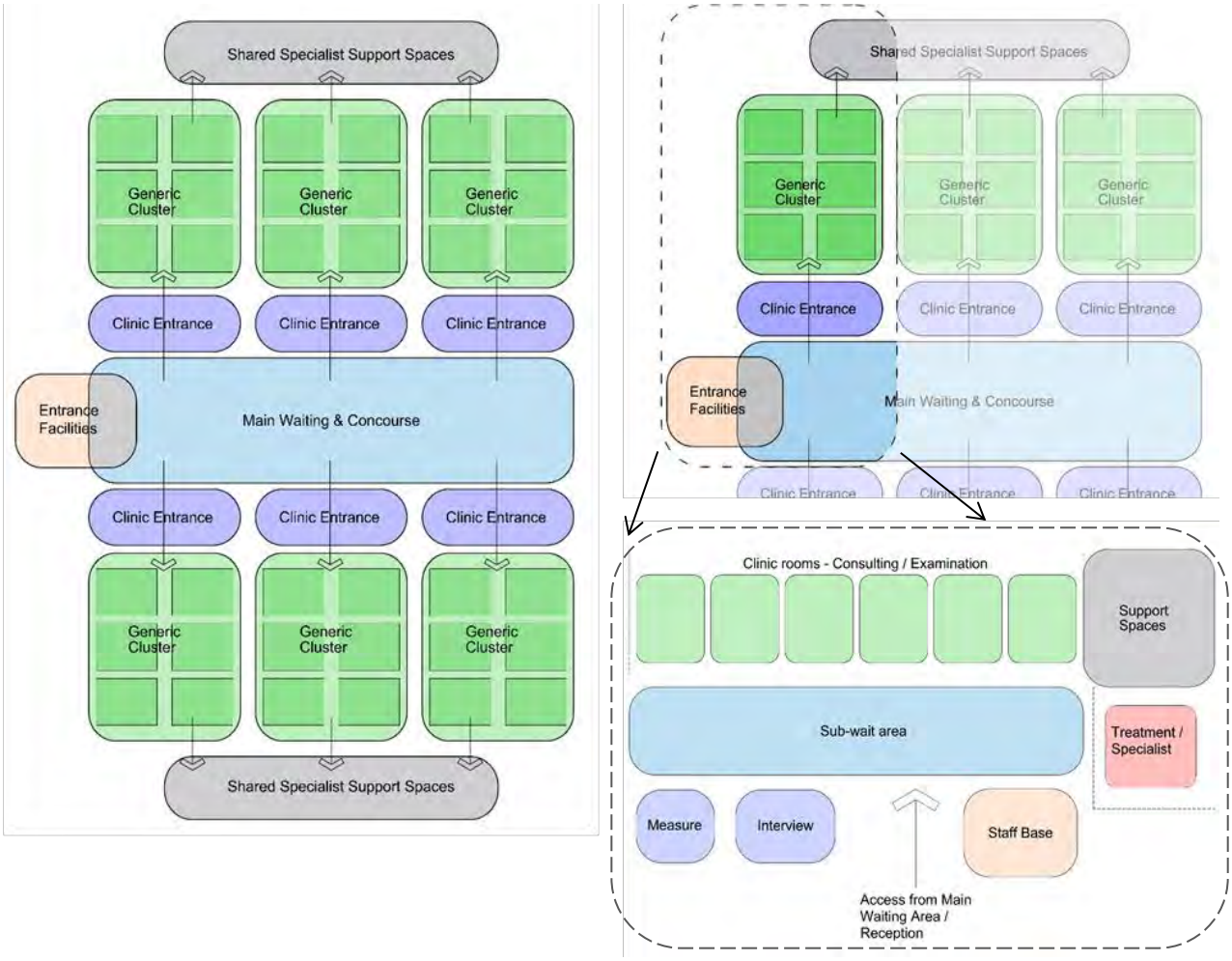
Considerations for repeatability in each facility or department includes:

- **Operational policies:** providing guidance notes where appropriate in support of estates design and optimal configurations.
- **'Rules':** A set of 'rules' has been set out on which the next stage of the Intelligent Hospital programme can be based.

[4] Intelligent Hospitals October 2020, Archus, New Hospital Programme.

- **Repeatable rooms** have been identified but this should not be restrictive or excessively prescriptive.
- **Issues** have been identified that need to be resolved in greater detail before proceeding.
- **Unit sizes are estimated** where appropriate.
- **Typologies can be illustrated** where appropriate.
- **Clusters:** the size of the suites of rooms which can be standardised.

Figure 7: Intelligent design clusters



Applied predominantly within the acute sector, the learning regarding clustered consultation spaces is particularly relevant in the context of scale of building design.

Consultation and procedure rooms are configured in a cluster of six or eight rooms with flexible purpose to supported shared use of capacity that can be scaled up.

UK Health Building Note 11-01 Technical Guidance

Health Building Note (HBN) 11-01 is currently being refreshed and will include some post-Covid 19 pandemic learning. The core focus is efficient, flexible use of primary care estate that is appropriate for more digital services in future and modern ways of team working.

For digital consultations and more flexible working arrangements for staff the guidance will provide exemplars of potential alternative space requirements/schedules of accommodation. However, it is noted that data is not yet available on:

- Current and likely future use of the various modalities of virtual delivery (telephone, telecon, text, email).
- How it will be spread across appointments (first/second/etc).
- Usage demographics.

The ambition will be to recharacterize the majority of out-of-hours provision as 'digital first' with the NHS Long Term Plan commitment for all patients to be offered digital-first primary care by 2023-2024.

Recruitment and retention are a key determinant of wider capacity design and practices will need to have good facilities to train students of all types and to be able to build their recruitment drives around this.

All healthcare facilities will need to support NHS targets for Net Zero Carbon. The HBN addresses this with various recommendations, including that the locations are accessible by sustainable transport; premises have charging points in car parks for electric vehicles and utility points for mobile clinical services; facilities should be energy efficient in all respects.

UK Diagnostics recovery and renewal study

Constraint on diagnostic capacity in the UK has been highlighted, after five years of growing demand, which has been intensified by the COVID-19 pandemic due to an increasing backlog, resulting in increased waiting times for diagnostic services.

New models of diagnostic service to look to shift some diagnostics into community settings, via community diagnostic hubs and at-home diagnostic tests. These approaches reduce pressure on acute hospitals sites by to re-locating services and reduced hospital visits.

Care closer to home provides:

- Increased patient convenience.
- Improved equity of access to services.
- Progress towards Net Zero Carbon targets due to reduced travel.
- Virtual at-home services preserve patient safety by reducing risk of infection.

The long-term strategic plan in "A Healthier Wales" defines the target where 'People will only go to a general hospital when it is essential'. It describes the process for achieving this as moving services into community centres and focusing acute facilities on providing specialist services. An example of this is demonstrated at the Royal Glamorgan Hospital in Llantrisant, Cwm Taf, where £6 million of capital funding[5] was invested in construction of a diagnostic hub, seeking to provide more quantity and higher quality of diagnostic services to South Wales.

[5] £6 million for new diagnostic hub at the Royal Glamorgan Hospital, November 2016: https://cwmtafmorgannwg.wales/6-million-new-diagnostic-hub-royal-glamorgan-hospital/

Primary care models in New Zealand

Three types of care models have been piloted across New Zealand to address equity, access and capacity challenges faced in primary and secondary care. Although further analysis and evaluation is required, the following approaches strongly align with the models of Wales and the UK:

- **Health Care Homes** originating from the US Group health Cooperative Medical Home model transforms general practices via; telephone clinical triage pre-appointment; virtual consultations; electronic clinical work pre-appointment; increase in professional roles (clinical pharmacists and medical centre assistants); management shift to facilitate analysis of practice care and business management. Although this did not show a reduction in utilisation of hospitals, demonstrated improvements in primary care capacity, reduction in pressures on GPs/nursing staff and financial performance.
- **The Acute Demand model** piloted in Canterbury encouraged services to shift from secondary care to community via an acute Demand Management System with the local primary and community care providers to reduce the number of admissions to acute care via emergency or referrals. As a result, they found activity shifted to planned care instead of emergency or same day services.
- The **Nirvana approach** is an open-access model which offers walk-in visits and accessible hours, tackling equity and accessibility issues. Although wait times were relatively higher due to increased visit rates, costs were minimised due to savings from avoiding cancellations or "no shows" and health indicators suggested positive performance against national health targets. Although the COVID-19 pandemic may hinder this model due to the need to control infection, it offers a model which could be adapted on a virtual level, to increase engagement rates and accessibility issues.

The core learning from these models is that any effective configuration of primary care should include a blended range of facilities aligned with local needs, access consideration and that accommodation should be able to accommodate out of hours, unplanned primary care, and surges in demand.

Primary and community healthcare in Sweden

Healthcare in Sweden is a combination of public and private provision, with services decentralised to a regional level. Primary care is provided at Primary Healthcare Centres (PHCs) with between one and 20 GPs per PHC. Services are provided by multidisciplinary teams, consisting of at least one GP, a nurse and often social workers, psychologists, physiotherapists.

Specialist nurses cover child clinics, for immunisation and check-ups, and care for patients with chronic conditions. Patients register at PHCs to receive care but are not allocated to a single GP. Average visits to the GP are 15-30 minutes with 10-18 visits per day. Legislation within Sweden requires same day contact from a nurse and GP within one week. GPs are a gateway to the system but do not act as gate keepers.

The healthcare system has been shifting secondary tasks into primary care settings. IT Infrastructure (national website) is being constructed to improve collaboration between secondary and primary care, allocating tasks and responsibilities.

The system has reported clear empirical evidence, of good medical outcomes (management of chronic conditions, high patient satisfaction, reduced acute admissions) and holistic care is achieved through high patient enrolment, multidisciplinary care and sufficient time allocated for visits.

There are isolated challenges associated with the shortage of GPs and high rate of rental doctors at PHCs can cause poor continuity and inequity. Any large-scale development in Wales should seek to cap the scale of consolidated primary care at a level where continuity of care can be maintained; particularly to support those with complex multi-factorial needs.

The Norrtaelje Model transforms health and social care, to integrate the funding and management of services provided. It caters for all ages but has a focus on 65 + years. It aims to vertically and horizontally integrate and restructure pathways to ensure greater patient satisfaction and improved management of complex conditions - easier and effective transitions between levels/types of care through coordinated services & a care coordinator role.

This model has resulted in reduced costs, effective redistribution of resources and improved geriatric care. Care competence and continuity improved, reducing costs and improving quality of elderly care pathways. The Implementation of the model faced cultural challenges and difficulty when shifting IT infrastructure but proved successful by reducing systems from 14 to three.

Primary care facilities in Germany

The German Primary Care System has a clear separation between outpatient/inpatient and generalist/specialist. Patients have direct access to physicians without the need for referral and have a choice of where to source their care, although all doctors treat patients on an outpatient basis. There is no gatekeeping system, so all professions can be accessed directly.

General practice physicians self-employed in a contract to health insurance companies. General practices are not legally bound to opening hours and usual provide virtual services. Out of hours services are directed to the emergency services of the panel-doctor union or Emergency Department. Communication, collaboration and integration between primary, acute and wider care is minimal and communication between GPs is rare and problematic.

Primary care provides basic diagnostics but requires specialists for further tests, although most of the contact with GPs results in no referral.

Current and future Primary care has not been considered in national policy documents and there has been a reported lack of specific budget for facilities development, with capital planning being centralised to regional level. Statutory health-insured patients are organised and cared for by physicians in regional associations, who have the obligation to provide all services in all specialties.

Quality of care varies due to the financial incentives but has been improved due to the disease management programme, which cares for patients with chronic illness. However, hospital admission rates of primary care sensitive conditions show an indication of the lack of primary care quality and challenges with access in an increasingly fragmented primary care system.

Primary care facilities in Scotland

Published in 2017, the Scottish government released its Long-Term strategy for Primary Care Ownership, where, over a 15-year period, Health Boards will gradually take on the responsibility of entering into contracts with private landlords and maintenance of premises.

To support the GP-owned estate and facilitate a smooth transition into the new model, the Scottish government has introduced GP sustainability loans. These interest-free loans are available to GP contractors for up to 20 percent of the existing-use value of premises.

The loan is prioritised based on need and seeks to create stability and incentive for being a partner in a GP Practice.

In exchange for the loan, the Health Board will be given the right to buy the GP premises in the future, with the aim of shifting ownership of all GP premises from GP contractors to the Health Boards by 2043; but Health Boards are not expected to start buying premises before 2038.

World Health Organisation (WHO) 'Vision for Primary Care'

In 2018, the WHO published a global perspective on the vision for primary care and described an approach to best practice. This approach is built on the foundations of 40 years of data gathering and learning since the *Alma-Alta Declaration on Primary Healthcare* in 1978. The WHO vision describes the principle aims of and recommended approach to delivering primary care, identifying integrated care as an integral component to successful delivery.

Addressing the core components of primary care, the WHO emphasises the critical role of 'First Contact' with the health service. Primary care services facilitate access to wider services, improving outcomes over time due to increased likelihood of continuity of care. 'Continuity' emphasises the importance of 'seamless' transitions across healthcare services via relational, management and informational continuity over time.

'Coordination' illustrates integrated services and the importance of collaboration between the health, non-health, voluntary and third sector, providing a seamless and holistic approach to care. Similarly, 'Comprehensiveness' describes the scope of Primary Care, where Primary Services can address a range of complex healthcare needs, via care provision or referral.

Primary care facilities in Canada

In 2000, a fund of $800 million was established to support a transition of Primary Care across Canada. A model of 'Four Essential Building Blocks' were established, in order of priority, identifying four core conditions for potential models of care.

Continuity and co-ordination of care

Seamless transition between care levels and specialities is enabled by service integration, care management and care networks, providing access, guidance and information to patients. Care managers direct patients on a pathway through the healthcare system, ensuring seamless transitions between levels and types of care.

Care networks provide ongoing support to patients with chronic health conditions to develop care plans and ensure the appropriate care is provided.

Early detection and action

Public health and front-line medical care prove a higher success rate when integrated, with European models demonstrating success rates with primary care taking responsibility for immunisation. A holistic approach to health promotion and prevention is critical to improving long term health.

Better information on needs and outcomes

Improved provision of information to healthcare providers develops the knowledge base available of best-practice care, as well as the ability to accurately assess the needs of the population for policy evaluation.

Patients' access to information enables continuity and coordination of care, for patients to make informed decisions and the healthcare professionals to monitor and assess their patients.

New and stronger incentives:

Implementing efficient Primary Care requires sufficient incentives. Wider healthcare services must have sufficient funds made available to them to encourage a shift into Primary care settings. Confirmation of a stable model will ensure certainty of long-term funding and strategy, allowing professionals to develop in their environment.

Piloted across Canada, the model was implemented with flexibility according to the needs of each province, allowing evaluation of success of various applications. The following examples were aligned with the four building blocks:

- Increase in community-based primary care organisations (providing comprehensive services to a certain population);
- More interdisciplinary teams (enhanced roles for nurses, pharmacists and other providers);
- Better transitions to hospitals, specialists and community services;
- Emphasis on Health promotion, disease/injury prevention and chronic illness management;
- Expanded access to essential services 24 hours, 7 days per week.

Analysis of the success of the Primary Care reform shows positive but uneven progress across Canada due to differing approaches to implementation. The main facilitators for a successful Primary Care reform to improve the performance primary care are identified below.

- **Strong financial commitment to reform** - Facilitating change and creating incentives to care providers to support change, as well as attracting and retaining medical and non-medical professionals in the primary care system.
- **Collaboration between government officials and professional associations** - Reduce resistance from professional by engaging with them on initiatives and proposed models of care, as well as integrating them into leadership to encourage change.
- **Legislative support, giving an official role to non-medical professionals in primary care** - Encouraging the development of interdisciplinary teams and collaborative practice among professions.

The case for change

Each of the exemplar models are shown to have been developed through an assessment of the changing health needs of the local populations, to provide access to effective care that is in line with nationally driven recommendations for improved workflows, adaptability, and to meet the locally assessed diverse needs and challenges.

Whole system clinical pathways are the drivers for change, whilst joined up working within cluster arrangements will provide more specific efficiency and effectiveness. Each of the exemplars demonstrates, at different levels, a consideration of the multiple working opportunities of the newly designed facilities across a range of types and how flexible working across multiple specialities, for longer hours across a seven-day week, allows multidisciplinary teams in health and social care to work alongside each other to communicate effectively, facilitating improved patient flow in operational cross-service pathways.

The agreed infrastructure that supports the model of working is shown to help patients better manage their health supported by the right resources when these are required. This is particularly important for patients with multiple complex conditions and the more vulnerable. Providing a range of facilities depending on local need but allows for other services to use will support local need at the most relevant times and days of the week. Providing health education services outside of core hours in locations assessed as accessible may also help to reach patient groups access services which they currently cannot e.g., services for those with mental ill health. Providing sessional space to host allied NHS health services including counselling, physiotherapy, out of hospital care provision, substance misuse, sexual health and other services will make them locally accessible, reduce non-attendance at appointments and engage patients in accessing services and delivering overall value for money.

Having the shared space to employ different types of staff can be demonstrated and will meet the NHS Wales ambitions of integrated care. Examples of new roles can be seen to transform local services such as; a practice-based pharmacist supporting patients and undertaking audits to manage the prescribing budget as well as strengthening communication between the practice and local community pharmacies and widening the clinical knowledge base and expertise. A sessional general practice physiotherapist can often save significant clinical time as well as improve communication with musculoskeletal teams. These are just two examples of the benefits for patients and the efficiencies for the healthcare system of operating multi-professional and multidisciplinary services that have been delivered based on identified local need.

2.3 Emerging themes from stakeholder engagement

Introduction

The stakeholder engagement process identified and engaged with key groups of people and organisations who are affected by or have the capacity to influence the way that health and care services are delivered. This process formed a critical part of the report findings and involved a wide range of stakeholders through active and inclusive engagement. The Public and GPs were engaged via online surveys, exceeding the expected response rates, receiving 842 responses in total. The engagement was conducted between January and March 2021, via interviews and workshops, including Health Boards, Local Authorities, Wider health professionals and more.

Health Board and Local Authority meetings

All Health Boards and a number of Local Authorities participated in individual preliminary interviews, seeking to understand the status of each area's population need, challenges and estate strategies. The Health Boards also had the opportunity to engage in a workshop, contributing towards the model of care design and service level provision in the following section, 2.4.

These workshops were used to develop an exemplar model of care and service provision, and jointly consider where prospects exist for future co-location of premises and service collaboration.

GP Surveys

The Survey was distributed to General Practices via Welsh Government and NHS Property Services to General Practice Managers. It comprised questions seeking to understand key current estates and care delivery challenges, as well as questions on key priorities for future care provision. The survey successfully received a total of 170 responses from GP medical and admin/managerial staff, distributed across Health Boards with the following responses: 38 Cardiff and Vale, 35 Aneurin Bevan, 35 Betsi Cadwaladr, 18 Hywel Dda, 17 Cwm Taf, 17 Swansea Bay, and 7 Powys.

Survey findings

When asked "Which of the following are your priorities for development, either in your practice or in your wider community, over the next 10 years?" there were **three top themes** identified as key priorities for primary care services over the next ten years.

Each of these themes have implications for future delivery of health care and correlate with the exemplar models described in Section 2.2.

Table 1: Summary of key findings themes and implications for health delivery

Themes	Improved access to services	Better multi-disciplinary working	Integrated care pathways
Implications for Future Delivery	**This is intrinsically linked to different ways of working** and does not necessarily mean the same level of services need to be provided in all areas. By working within a cluster arrangement of numbers and types of facilities more people will have access to a full range of services; either digitally, within their own home, close to their home or in specialist centres.	**Workforce considerations, including better multi-disciplinary working.** In line with exemplar model practice, new roles and different ways of working across teams will provide a more flexible way of working and better access to health and care for patients.	**Development of new care pathways and more integrated services.** Integrated services within a cluster of practices and facilities will enable care to be provided more efficiently, resulting in less unnecessary hospital attendances.

Responses from this survey also highlighted several themes of current significant challenges. When asked "What are the current obstacles to delivering high-quality care services?", across all Health Boards, proportions of respondents gave free-hand answers which mentioned the following themes as significant challenges.

Of those free-hand responses:

30% mentioned: COVID-19 pandemic issues (vaccination service pressures/restrictions):

- Due to the COVID-19 pandemic, pressures on GPs to provide high quality services has been heightened. As the majority of practices have taken a dramatic shift into providing digital services, demand has increased for consultations, as well as the pressure to provide vaccination programmes and maintain pre-COVID access standards.

40% mentioned: A lack of space, Not fit-for-purpose premises or poor quality due to age, capacity and facilities.

- Practices are seeking to widely expand their services but are restricted by their facilities and require an expansion of space in premises to accommodate them. Single practices often expand their services, spread over several facilities, and face efficiency challenges as a result. As practices currently hold physical medical records, there is a desire to digitalise in order to create space and increase utilisation rates, however funding is required to achieve these targets.

30% mentioned: High demand for, but lack of secondary care services, such as mental health support.

- Communication and transfer of care between primary and secondary care services are highlighted as key challenges. Due to long waiting times for diagnostic and specialist secondary care, patients are often facing long referral times and worsened conditions, result in repeat consultations with GPs.

- To improve referral periods and waiting times, investment should be made in providing diagnostic/community hubs and in IT infrastructure. These will reduce pressures on acute services and improve continuity of care, providing efficient communication systems and single, digital medical records for patients.

30% mentioned: Recruitment challenges, particularly in key areas for: GPs, Nurses and Administration Staff.

- A number of reasons were identified for recruitment issues, however key themes included lack of access to training, uncertainty around partner liability 'Last man standing' (covered section 4) and poor contracting mechanisms for wider employment.
- Consequentially, this proves a requirement for training facilities within practices, to attract health professionals, as well as a shift in the ownership model, to remove risk of employment.

20% mentioned: Lack of available funding, particularly to enable expansion of buildings (and therefore services)

- A lack of funding exists across primary care to support an increasing population, ageing/not fit for purpose facilities and a backlog of workload due to COVID-19. It is also highlighted through several responses that the strategic shift of services from secondary into primary care requires support via re-allocation of resources, staff, funding and space, to avoid a shift of workload onto GPs.
- GPs' responses highlight their willingness to work across practices to support service expansion but require further support. Interdisciplinary team working requires funding for space and integration within the primary care community. Engagement of GPs/clusters on local projects will receive positive response to integrated working and expansion of services.

Public surveys

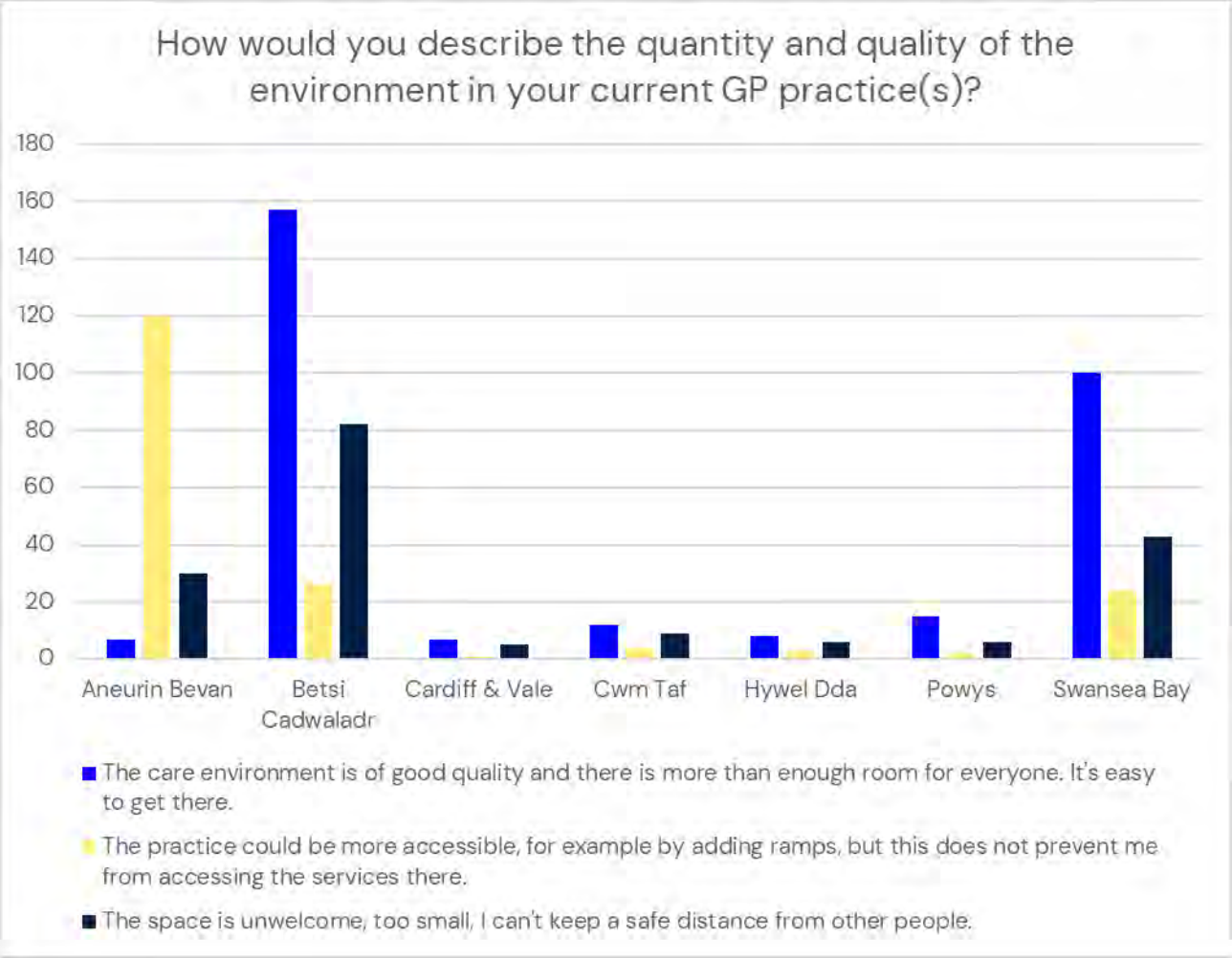
The Public Survey comprised questions seeking to understand the public's perspective on the quality of health provision, expected travel times, additional services required and community health facilities. The survey successfully received a total of 672 responses.

Survey findings

The public survey results provided findings on the how the public perceive the quantity and quality of their current GP health facilities. Respondents had the following options when responding to the question "How would you describe the quantity and quality of the environment in your current GP practice(s)?":

- The care environment is of good quality and there is more than enough room for everyone. It's easy to get there.
- The practice could be more accessible, for example by adding ramps, but this does not prevent me from accessing the services there.

Figure 8: Public Survey - How would you describe the quantity and quality of the environment in your current GP practice(s)?



As demonstrated in the table below, each Health board received a variety of responses conveying a range of poor, moderate and good quality and quantity of primary care estates. A considerable proportion of respondents gave encouraging feedback on the estate, for example in Betsi Cadwaladr and Swansea Bay. However, the moderate and negative responses account for a large portion of feedback and should not be discounted. Next steps should be taken on an individual Health Board level to identify specific premises with poor quality and quantity, and prioritised (see section 6).

(Individual survey charts and findings can be found in Appendix A – Health Board Summaries.)

Areas that were important to the public for improvements to services included:

Reduced waiting	Digital services	Car parking
Reduced time waiting for appointments	Improved digital access: more options for appointments by phone, PC or other device	Having ease of access to car parking

The findings from these survey responses fed into several workshops with the Health Boards and wider stakeholders, to develop the proposed design principles set out below.

2.4 Proposed design principles for primary care estate

Approach and reference activities

The illustrative guidance within this section seeks to translate how the direction of travel for primary and community care services in Wales should be provided at a range of primary care facilities. The outputs have been designed following feedback from multiple clinical, professional and public services stakeholders in order to understand and review the actual need in the context of best practice design principles.

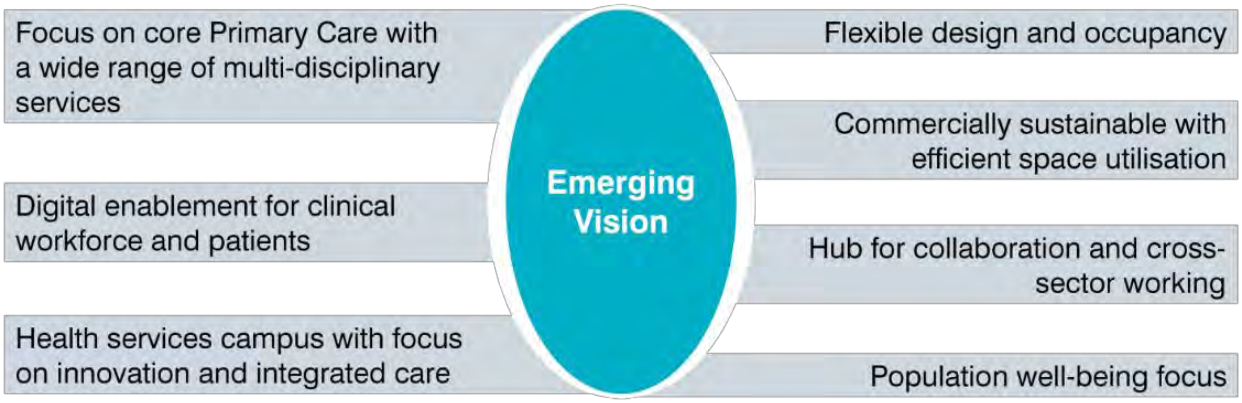
A series of workshops were undertaken to define the levels of provision most applicable in a Welsh context and to meet the different challenges of both towns and rural areas. This was then utilised to determine the key services and facilities that should typically be provided for each population by scale and by premises level.

The outcome of this development work is not intended to be prescriptive, but rather it should be interpreted in a local context as examples of the upper and lower limits of estimated space and service provision needed and able to be utilised as a benchmark by which development costs can be evaluated.

Vision and design principles

The emerging vision for the model is very much focused on flexible functions and adaptable design that supports changing service provision; with the pace of healthcare model evolution there is an acknowledgment that the primary care estate needs today may not be recognisable in the context of models in as little as 10 years' time.

Figure 9: Key features of the vision



The feedback from engagement activities and known service developments needed undertaken as part of this study has persistently highlighted the following **key principles** that are important elements of the future development of the primary care estate in Wales:

Figure 10: Key principles

Consideration for models of care

The Health Board engagement has highlighted the following factors that are important to consider for design of primary care:

- No 'one size fits all' model exists; demographics and local population needs should be assessed and reflected in areas of focus.
  - As an example, the focus could be on issues of substance abuse and unemployment, as well as on services for diagnostic services and chronic conditions management.
- Value exists in exploring non-medical satellite practices, to act as an additional level of care but linked to the wider cluster of care delivery.

- Wider well-being need is heightened, with a focus on non-medical community facilities (e.g. gyms, gardens etc).
- Improvements to signposting and wayfinding services to encourage patients to access early help.
- Additional capacity is required, where new services are provided – for example:
  - Ear wax treatments,
  - Physiotherapy gyms,
  - Optometry diagnostic capacity.
- Voluntary sector and wider community support organisations should be considered for accommodation within health and wellbeing facilities, particularly in areas of higher need - including Age UK, Princes Trust.

Figure 11: Considerations for models of care

- Further work is required to increase operational hours to 7-day / 12-hour services, as this has a concomitant impact on unscheduled out-of-hours care services.
- Consideration is needed for appropriate types out of hours services, as it is critical to ensure efficient space utilisation and service provision that reflects the needs of all age groups.

Key emerging themes

The following should be considered in the development of the wider primary and community care estate:

Training, multi-disciplinary working and workforce development

- Whilst traditional training methods are evolving to include a significant remote learning approach, observational learning/senior clinical supervision is still critical and can be shared across sites to make more effective use of facilities.
- Focus on new roles including advanced paramedic practitioners (APP), GP with Specialist Interest (GPwSI), primary care practitioners and clinical associate roles all key to new facilities.
- Need facilities and the environment to be attractive to newly trained clinical staff to develop new skills and support retention of staff.
- Development of single point contact models with GPs and multi-disciplinary teams.
- Care coordinators in Local Authority areas have the local knowledge in the neighbourhood, help to educate people not going into hospitals especially acute sites and organise wellbeing hobbies Community Agents also work closely with Social Prescribers key aims to help to divert limit "social" visits to the GPs.
- The Community Agents and Social prescribers work with the GP Cluster lead in the South Pilot to offer whole person care. The aim of the multi-disciplinary working is to work with people with known high risk or complex needs to ensure care is wrapped around the

individual to act quickly to avoid or prevent unnecessary hospital admission and to educate to prevent hospitals access, particularly acute sites via emergency department.

- Community Agents also help to spot opportunities to meet unmet need and coordinators to organise wellbeing activities encouraging the local community to support local citizens.
- Medical Assessment Units have been piloted in acute settings to offer diagnostic testing which offer short term admission up to 72hrs to establish the root cause of a health need or offer IV antibiotics. The care package is kept open on a retainer to enable swift discharge.

Digital innovation, diagnostics and mobile working

- Digital enablement training required for staff and public. Also, reliable Wi-Fi is required to ensure new technology functions as intended.
- Systems integration and single sign-on important facility to support multi-disciplinary team community mode.
- Facilities for digital consultation and digital enablement training made available to the public.
- New site development should include point of care testing and imaging wherever feasible.
- Digital familiarisation support required but tools such as Echo in homes has helped to reduce DNAs and loneliness.
- The growth in digital delivery of care creates a need for an increase in data requirements. Because of this there is a need for practices to have the capability and resource to effectively analyse and use the data well. This has been recognised in the WHBN36 guidance for primary care facilities to have flexibility for future use – specifically to accommodate new advances in technology, new treatment regimens/techniques or demographic changes[6].

Environment of care

- The presence of windows in the workplace and access to natural light have been linked to an increase satisfaction at work and better performance of complex visible tasks[7]
- Whilst light is known to impact outcomes in in health settings by reducing feelings of depression and decreasing length of stay in hospitals, light is also known to give higher patient satisfaction and perceptions of less medicalised, comfortable, welcoming and high-quality environments and is generally thought to be important to be incorporated into the lighting design both inside and out. Energy and environmental performance is also a key challenge and maximising the use of natural light can contribute to reducing the use of electrical lighting and the buildings carbon footprint.

[6] Welsh Health Building Note 36General medical practices in Wales Revision 1 2017

[7] The affects of exposure to natural light in the workplace on health and activity of workers; A systematic review JBI Library, Volume 8 Issue 16.

Co-location and collaboration

- A virtual multi-disciplinary model requires the facility to enable meetings to take place in person to build culture of collaboration.
- Facilities being able to support a social care interface are key. With wider investment in cultural integration being of relevance to the way that areas are shared or segregated in larger facilities.
- Consideration that it is important to collocate young people's facilities in a non-threatening environment. Skills, social, sexual health and digital facilities will all encourage young people to attend a health and wellbeing centre, but the environment needs to be inter-generational.
- A recognition that it is not always optimum to completely collocate e.g. pharmacy leads would be more in favour of sessional support for smoking cessation, sexual health etc.
- Hub and spoke deployment points will be needed for the wider mobile clinical workforce to link. Equipment storage, multi-professional advice, rest/change areas and training should all be available in a range of locations.
- Hosted services should be non-negotiable as part of general medical services/cluster requirements. These services should not be subject to eviction at limited notice either. Services such as musculoskeletal and Improving Access to Psychological Therapies (IAPT) provide significant community benefit as diversionary pathways and so should not face instability or expensive rent tariffs to be able to provide.
- Practice mergers take considerable time to embed. Benefits only generated through sound day to day management and ensuring shared facilities in new buildings are optimised.

Flexible design to support sessional models

As outlined, by having the ambition to move towards a fully integrated care system. Primary care developments will be key to enable this change for more flexible ways of working with a focus on:

- Introducing new ways of working so that health and care organisations across Wales are working together in a joined-up way.
- Getting the best outcomes for the local population; enabling people to live better lives and manage their health and wellbeing effectively.
- Assessing local needs and adapting service provision to meet the needs of individual communities and population groups within the local and regional footprint, in line with the recommendations seen in WHBH36 that flexibility within newly designed premises need to take account of the changing population and management of an aging population and make provision for an environment that is older person friendly to ensure sustainability of the future estate.
- Ensuring equity of provision with standardised care models and reducing any variation in outcomes.
- Constantly responding and adapting to support people effectively with the aim of addressing their more complex needs in the right place, first time.

In recent years, the use of digital/phone contact for primary care consultations has taken hold and grown year on year. If this pattern continues as expected, there will be fewer attendances at surgeries and less emphasis on the need for paper-based notes to be stored in practices.[8] However, this direction of travel is matched by a sustained increase in multi-morbidity / complexity of work in primary care so that those patients who do need to attend their practice in person have increasingly intensive needs, involving longer appointments and accessible buildings meaning that the impact of these trends should be quantified and factored into service planning.

The surge in patient's uptake of remote health services since Covid-19 supports this change[9] and over coming years there will be opportunities and expectations for using technology to work differently with service users and offer the potential to improve efficiency including:

- Video, text or email-based communication with service users.
- Better links between service providers working within wider clusters and allowing ease of access to specialist services.
- Electronic shared room booking systems that allow different service providers to utilise space as well as appointments in and out of hours.

These will reduce overall demand on estate and change and modernise staffing skill mix and profiles. Successful and thriving clusters of GPs tend to teach/train medical, nursing and other students. If the ambition is for more practices to be involved in teaching and training in some way and to this aim is developing links with the university medical schools, universities and Health Education Wales integrated services will support the success through flexible and shared accommodation.

Standardised rooms

The development of standardised rooms and spaces should be a "loose fit" based on ergonomics, standard equipment requirements and flexibility for future adaption as service models change. Architects will design new facilities using most efficient planning grids and standardised rooms/modules. Learning from the new Cavell Centres in England[10], there should be an inclusion of activity spaces for a wide range of services (including inpatients and diagnostics)

Public needs focus

- Confidentiality within the environment is important for consideration within the reception design as some patients do not want to divulge details of their needs as a part of case triage which takes place within hearing range of other patients.
- Patients have indicated the value of locally provided services over size, facility availability and condition of premises.
- It is important to recognise the variable car ownership across Welsh localities, as well as how different people choose to access services in areas of significant deprivation.

[8] Digital Health and Care Wales 2021 - https://digitalhealth.wales/national-data-resource

[9] The impact of Covid-19 and the use of digital technology in the NHS – Nuffield Trust 2020

[10] Cavell Centres

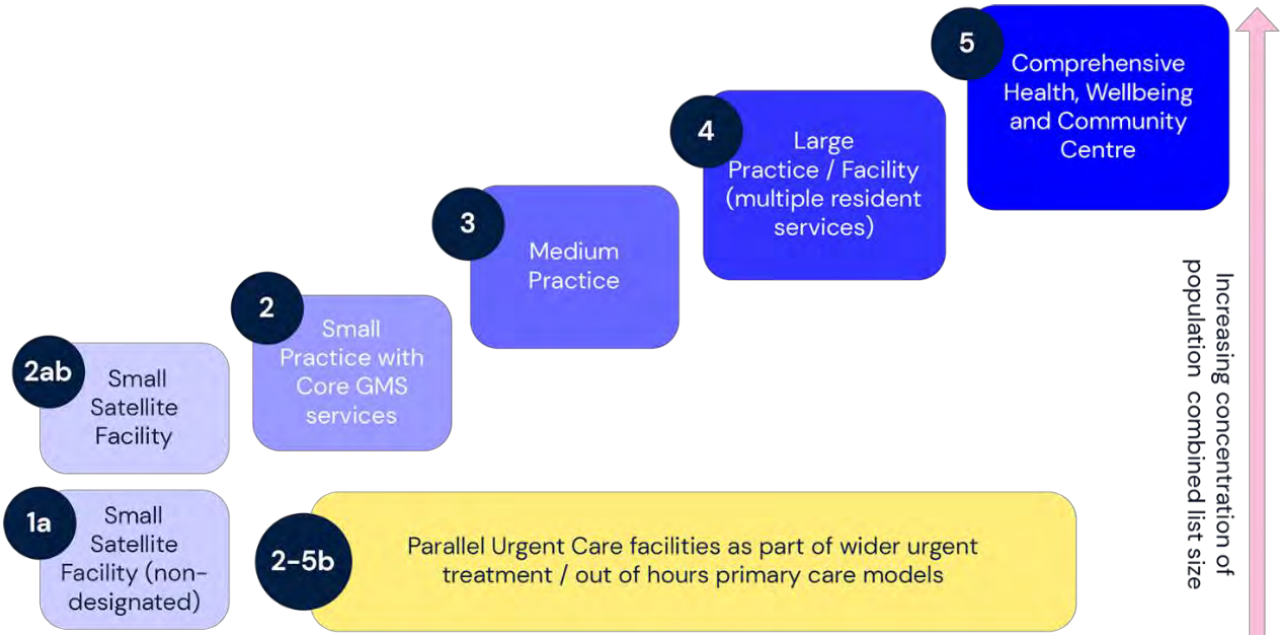
- Transport access and parking is a critical priority for the public and adequate access to parking either at the health centre or nearby should be a key consideration of site selection and design development and weighed up against required planning requirements.
- Working in different ways across specialities will allow for flexible appointment systems for patients. Ranges of health professionals working in primary care delivering care closer to home or out of usual hours will specifically support certain groups of patients who require support/privacy to arrange consultations.
- Social prescribing and care navigation functions have shown significant outcome benefits and facilities should include sessional and fixed spaces for these teams.
- There is a need for personal care support for patients with complex needs in larger community facilities to allow those with wider needs to feel comfortable attending.
- Pandemic resilience through single direction of flow and sub-wait areas (appropriately spaced) is recommended in new building design to ensure separate entrance and exit points if required.
- Options to explore car park consultation/check-in facilities in future.

Model of care provision illustration

The model is based on a series of scaled levels of standardised facilities/services that are dependent on the local overall population concentration. Specific health and wellbeing needs within clusters and localities and the availability of other local complimentary services within the locality.

Most current facilities in Wales are in Level 2 and 3 facilities but there is an emerging trend for developing larger Level 4 and 5 premises.

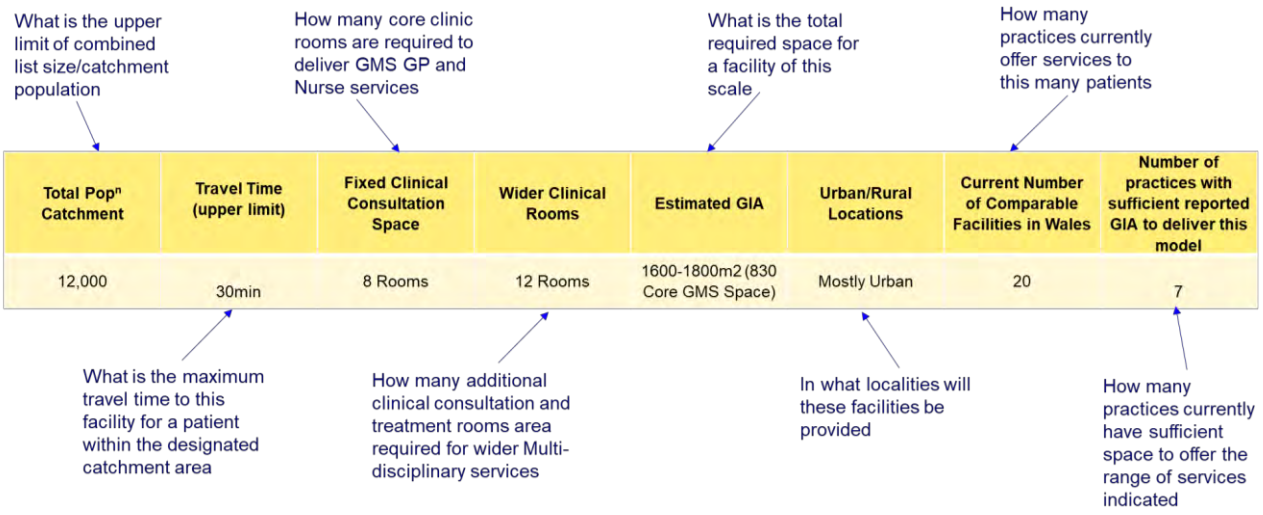
Figure 12: Illustration of Facility levels



There is also recognition that the direction of travel around designated urgent primary care services will require adaptation in the capacity available. Where possible this service should be delivered as a part of an integrated infrastructure as there may be benefits for both clinical workforce and facilities. It is likely however that the hours of operation of each Level and the degree of future collocation with acute sites may shift over time and so this principle will need to be reviewed over subsequent phases of work.

The assumptions relating to each level of service are captured within a key facts table, the features include:

Figure 13: Key facts features



Assumptions and services under consideration

For the purpose calculating the indicative space requirement for facilities at each Level of the model, some standard occupancy and activity assumptions have been applied in line with expected operational models. It is important to note that these are variable nationally, with some areas demonstrating significantly higher attendance rates and some practices embracing significant increases in operational hours for General Medical Services.

At this stage it is assumed:

- The average annual attendance rate of 6 appointment per registered patient per year – this is used as a baseline but can be adapted based on local demographic. For instance areas with a higher number of elderly patients the attendance may be higher
- Core operating hours of 8.00-18.00 Monday to Friday (some practices operating shorter hours with an evening weekend session).
- Clinical space utilisation at the recommended rate of 85 percent to account for future proofing and growth
- 20 percent of service consultations being delivered in a treatment room with practice or specialist nurses or another allied health professional.

The list of services is not exhaustive and should be viewed as a foundation for local population and clinical consultation and planning. An n outline menu of services that may be offered depending on the level of facility and the type of facility needed Are demonstrated below.

Figure 14: Health and care services to be considered in future developments

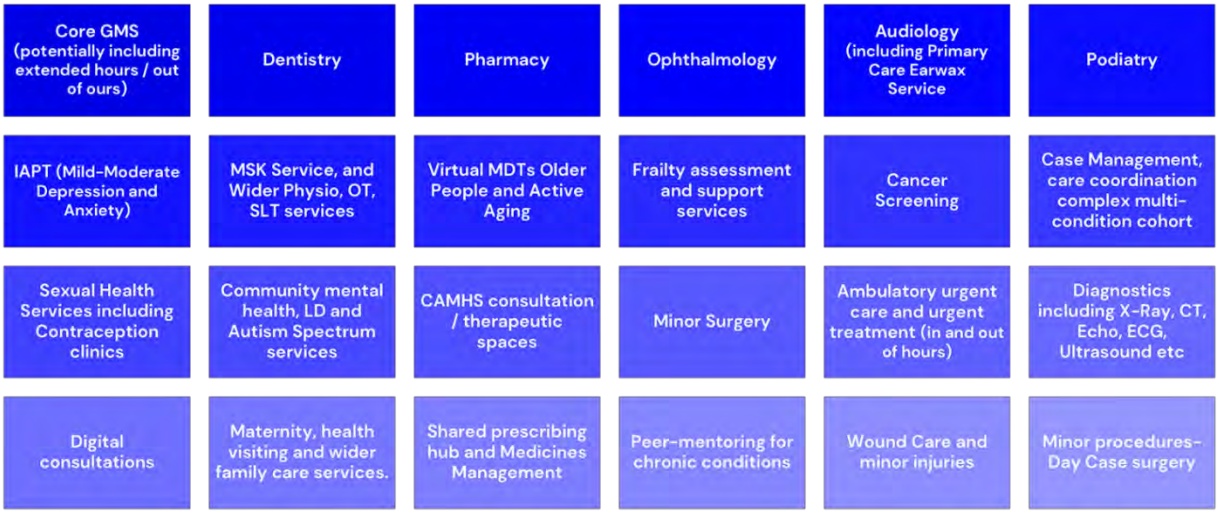


Figure 15: Wider community and well-being services to be considered in future developments

Descriptions of facilities: Levels 1-5

This section includes a detailed illustration of the different facilities and service levels. The overall space required for each facility are described in line with the following access definitions:

- **Core:** Services and facilities that need to be a permanent offer at the facility; requiring full time, ring fenced clinical or non-clinical spaces.
- **Sessional:** Services that are offered on a regular basis (over agreed sessions per week) either by satellite services, mobile clinical service sessions or part time practice staff; a proportion of clinical space will be allocated within each facility for each service. These sessional services may also be able to be provided in non-practice type facilities (for example local shops, care facilities, schools) for remote communities to access services locally.

- **Periodic:** Occasional visiting services at fixed points or on an ad hoc basis throughout the year, e.g. flu vaccinations or monthly public health screening sessions; access on a flexible basis to shared bookable spaces. These periodic services may also be able to be provided in non-practice type facilities (for example local shops, care facilities, schools) for remote communities to access services locally.
- **Virtually/via remote multi-disciplinary team**: essential services are provided for patients and the public to engage remotely either via online resources or digital consultation and counselling functionality; digital consultation facilities also allocated on both bookable and drop-in basis.

Level 1a summary description

Total Population catchment	1500
Travel time (upper limit)	15min
Fixed clinical consultation spaces	0 - flexible
Wider clinical rooms	0 – flexible
Estimated Gross Internal Area	250-300m^2

Urban / rural location	Predominantly Rural
Current no. comparable facilities in Wales	None currently
No. practices with sufficient reported GIA to deliver this model	

Level 1a facilities are a departure from the established norms around health owned and operated premises. These facilities are focused on enabling access and enhancing community facilities in small and/or rural populations. The agreed service provision may be offered from a range of premises, which may not be a traditional General Practice, but delivered in a shared accommodation and accessible on a flexible basis over an agreed number of days per week.

Depending on the numbers of patients the service is supporting will inform the service needs, but local management and security of the premises will determine the safe hours of access as the facility. These facilities should be linked to the wider integrated health and care system so that all patients have access to a wider range of services as and when they need it, but the facility will have the opportunity to be maintained by the local community under a cooperative model with some light touch support within the cluster from the larger facilities.

Members of the public, particularly with transport or mobility limitations, should be able to access a range of digital resources and occasional visiting services at the facility. The facility should operate a range of local community groups activities but not necessarily designated clinical consultation spaces.

This facility will also provide enabling facilities to support the public in undertaking remote consultations if they do not have access to appropriate devices at home. The indicative services and facilities for provision at this level include:

Core Services (Resident)

- Digital consultations within a private space;
- Community social, Performance and Art spaces;
- Outside Space/Community gardens and kitchens;
- Charities meeting spaces to support fundraising/community engagement;
- Signposting and wellbeing library to support selfcare.

Wider Clinical and Non- Clinical Services (Dedicated sessional basis)

- Wellbeing services and social prescribing.

Periodic Services (Shared Space)

- Improving Access to Psychological Therapies (IATP) (mild-moderate depression and anxiety);
- Peer-mentoring for chronic conditions;
- Citizen's Advice Bureau;
- Third sector advisors (Age UK, Arts, National Autistic Society, cancer charities and young people's charities);

Occasional or virtual service access (no dedicated Space) but shared space to be utilised by a range of people

- Core General Medical Services (potentially include extended / out of hours) – delivered on agreed sessional basis depending on local population size and need;
- Child and Adolescent Mental Health Services (CAMHS) consultations;
- Employment services;
- Care Navigators;
- Libraries (virtual/actual);
- Support for victims of crime/domestic abuse;
- Prevention, Immunisation and wider health improvement (smoking cessation, weight loss, substance misuse support).

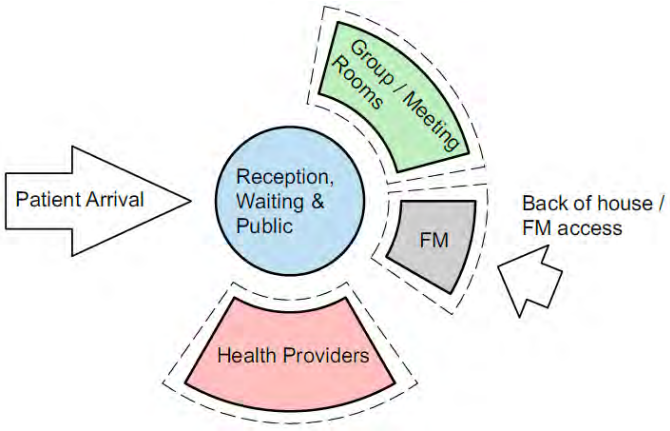
To support the activities and services outlined above, the illustrative functional content, or rooms/functions, is demonstrated by a Schedule of Accommodation in Appendix D.

Level 1 Exemplar Layout Illustration – with zoning for different health provisions

The Level 1 facility example is a single storey concept, based on patients and visitors arriving at a central public core, providing reception, waiting and public facilities. Accommodation is then split into discreet 'zones' that are accessed from the central core, including clinical and support zones.

The clinical zones include group rooms and other health and social care providers. Separate access is provided to the FM area for deliveries etc.

Figure 16: Level 1a Illustration



Level 1b summary description

Total Population catchment	1500
Travel time (upper limit)	20min
Fixed clinical consultation spaces	2 rooms
Wider clinical rooms	1 Room
Estimated Gross Internal Area	300-370m^2

Urban / rural location	Mixed but mostly rural
Current no. comparable facilities in Wales	TBC
No. practices with sufficient reported GIA to deliver this model	TBC

Similar to Level 1a, this level of provision includes some limited designated clinical capacity to provide a facility both for scheduled/sessional services and a space where community teams can safely access/treat patients without asking them to travel to larger designated health facilities for all appointments. The case of the latter this will provide an alternative to patients' homes which may not always present an optimal environment for aseptic technique wound care, clinical observations or confidential counselling away from family members.

The service planned within a Level 1b facility could include the following:

Core Services (Resident)

- Community social, performance and art spaces;
- Outside space / community gardens and kitchens;
- Charities meeting spaces to support fundraising / community engagement;
- Signposting and wellbeing library to support selfcare.

Wider Clinical and Non- Clinical Services (Dedicated sessional basis)

- Core General Medical Services (potentially include extended/out of hours);
- Chronic Conditions Clinics;
- IATP (Mild-Moderate Depression and Anxiety);
- musculoskeletal Service and Wider Physio, Occupational Therapy (OT), Speech & Language Therapy (SLT) services;
- Employment services;
- Care Navigators;
- Case Management, Care coordination complex multi-condition cohort.
- Community mental health, Learning Difficulties and Autism Spectrum Services;
- Peer-mentoring for chronic conditions;
- Wound care and Minor injuries;
- Sexual Health Services including contraception clinics;
- Wellbeing services and social prescribing.

Periodic Services (Shared Space)

- Audiology (incl. Primary Care Earwax service).
- Podiatry.
- Virtual multi-disciplinary teams older people and Active ageing.
- CAMHS consultation/therapeutic spaces.
- Citizen's advice bureau
- Maternity, health visiting and wider family care services.
- Health screening, immunisation and fit testing.
- Prevention, Immunisation and wider health improvement (smoking cessation, weight loss, substance misuse support)

Occasional or virtual service access (no dedicated space)

- Ambulatory urgent care and urgent treatment (in and out of hours)
- Libraries (virtual/actual)
- Support for victims of crime/domestic abuse

To support the activities and services outlined above, the illustrative functional content, or rooms/functions, is demonstrated by a Schedule of Accommodation in Appendix D.

For exemplar layout illustration, see Level 1 above.

Level 2 summary description

Total Population catchment	6,000
Travel time (upper limit)	20min
Fixed clinical consultation spaces	4-6 (inc. Training)
Wider clinical rooms	10
Estimated Gross Internal Area	650-750m^2

Urban / rural location	Equally distributed - all settings (unless there is a level 4/5 Facility)
Current no. comparable facilities in Wales	TBC
No. practices with sufficient reported GIA to deliver this model	TBC

The Level 2 facilities are most similar to current General Medical Services aligned, small practices. Operating either five or six days a week with smaller catchment population these facilities are likely to host two to three fixed clinical staff (GP and/or practice nurse) and periodic additional multidisciplinary services. Services will be accessed through established pre-bookable mechanisms with self-check-in stations. The enhancements planned to standard footprints should include at least 1 training rooms, public wellbeing resource access digital consultation rooms.

Out of hours local populations are likely to have to travel to a larger regional centre but in some cases, practices may elect to operate seven days and/or night-time unplanned services by arrangement following a virtual consultation / triage. The exemplar models show that this out of hours service provision may be offered by different members of a multi-professional team depending on local health care need.

The planned service provision in a facility at this level could include:

Core Services (Resident)

- Core General Medical Services (potentially include extended / out of hours);
- Chronic Conditions Clinics;
- Case Management, Care coordination complex multi-condition cohort;
- Sexual Health Services including contraception clinics;
- Digital consultations;
- Outside Space / Community gardens and kitchens;
- Health screening, immunisation and fit testing;
- Signposting and wellbeing library to support selfcare.

Wider Clinical and Non- Clinical Services (Dedicated sessional basis)

- Podiatry;
- IATP (Mild-Moderate Depression and Anxiety);
- musculoskeletal Service and Wider Physio, OT, SLT services;
- Virtual multi-disciplinary teams older people and Active ageing;
- Frailty Assessment and Support Services;
- Minor Surgery;
- Maternity, health visiting and wider family care services;
- Shared prescribing hub and medicine management;
- Wound care and Minor injuries;
- Wellbeing services and social prescribing.

Periodic Services (Shared Space)

- Audiology (including Primary Care Earwax service);
- CAMHS consultation/therapeutic spaces;
- Peer-mentoring for chronic conditions;
- Care Navigators;
- Citizen's advice bureau;
- Prevention, Immunisation and wider health improvement (smoking cessation, weight loss, substance misuse support);
- Third sector advisors (Age UK, Arts, Cancer Charities, National Autistic Society and Young Peoples charities).

Occasional or virtual service access (no dedicated Space)

- Libraries (virtual/actual);
- Support for victims of crime/domestic abuse;
- Charities meeting spaces to support fundraising/community engagement.

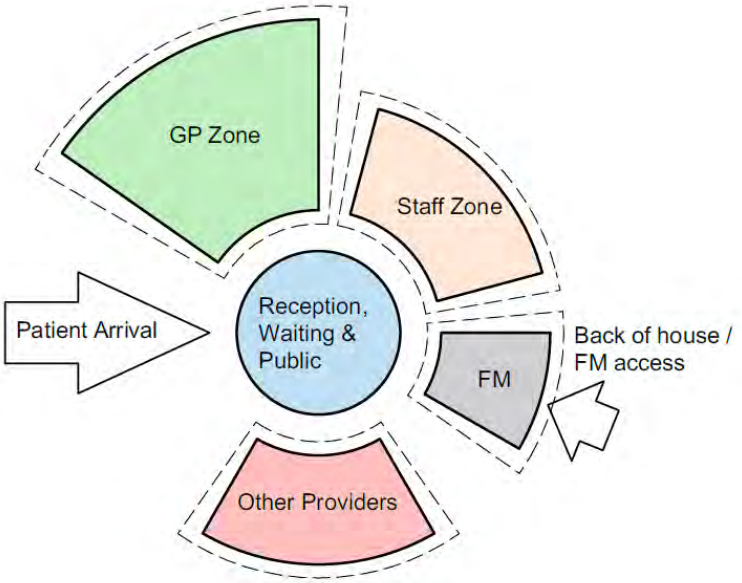
To support the activities and services outlined above, the illustrative functional content, or rooms/functions, is demonstrated by a Schedule of Accommodation in Appendix D.

Level 2 Exemplar Layout Illustration

The Level 2 facility example is a single storey concept, based on patients and visitors arriving at a central public core, providing reception, waiting and commercial facilities. Accommodation is then split into discreet 'zones' that are accessed from the central core, including clinical, staff and support zones.

The clinical zones include GPs and other health and social care providers. Separate access is provided to the FM area for deliveries etc.

Figure 17: Level 2 Illustration



Level 3 summary description

Total Population catchment	12,000
Travel time (upper limit)	30min
Fixed clinical consultation spaces	8 rooms
Wider clinical rooms	12 rooms
Estimated Gross Internal Area	1900m2 (830 Core GMS Space)

Urban / rural location	Mostly Urban
Current no. comparable facilities in Wales	TBC
No. practices with sufficient reported GIA to deliver this model	TBC

The most common current provision within Wales aligns with the Level 3 premises description. With between four and six fixed GPs, core nurse capacity and training status this facility should offer all substantive General Medical Services with a wider provision for visiting complimentary services and community-initiated activities. The core operating hours are likely to be focused on Monday to Friday 8-6pm but improvements in utilisation of available space could be secured by scheduling sessional services in the evenings and at weekends.

There will be a tension within the current estate as to whether the wider services planned for a level three facility can be accommodated within existing footprints. In the event the opportunity to expand is limited priority should be given to training capacity and sessional clinical services; with wider public services signposted either through a new level 1 facility or existing complimentary public service.

The planned service provision in a facility at this level could include:

Core Services (Resident)

- Core General Medical Services (potentially include extended/out of hours);
- Chronic Conditions Clinics;
- Pharmacy;
- IATP (Mild-Moderate Depression and Anxiety);
- musculoskeletal service and Wider Physio, OT, SLT services;
- Case Management, Care coordination complex multi-condition cohort;
- Digital consultations;
- Sexual Health services including contraception clinics;
- Wound care and Minor injuries;
- Community social, Performance and Art spaces;
- Libraries (virtual/actual);
- Wellbeing services and social prescribing;
- Health screening, immunisation and fit testing;
- Signposting and wellbeing library to support selfcare.

Wider Clinical and Non- Clinical Services (Dedicated sessional basis)

- Audiology (incl. Primary Care Earwax service);
- Podiatry;
- Virtual multi-disciplinary teams older people and Active ageing;
- Frailty Assessment and Support Services;
- Community mental health, Learning Difficulties and Autism Spectrum Services;
- Peer-mentoring for chronic conditions;
- Minor procedures - Day case surgery;
- Care Navigators;
- Citizens Advice bureau;
- Support for victims of crime/domestic abuse;
- Wrap around childcare for low-income working households;

- CAMHS consultation/therapeutic spaces;
- Minor Surgery;
- Maternity, health visiting and wider family care services;
- Shared prescribing hub and medicine management;
- Prevention, Immunisation and wider health improvement (smoking cessation, weight loss, substance misuse support);
- Charities meeting spaces to support fundraising/community engagement.

Periodic Services (Shared Space)

- Dentistry;
- Employment services;
- Third sector advisors (Age UK, Arts, National Autistic Society and Young Peoples charities).

Occasional or virtual service access (no dedicated Space)

- None

To support the activities and services outlined above, the illustrative functional content, or rooms/functions, is demonstrated by a Schedule of Accommodation in Appendix D.

Level 3 Exemplar Layout Illustration

The Level 3 facility example is a single storey concept, based on patients and visitors arriving at a central public core, providing reception, waiting and commercial facilities. Accommodation is then split into discreet 'zones' that are accessed from the central core, including clinical, staff and support zones.

The clinical zones include GPs and other health and social care providers. The clinical zones can be further split into clusters of clinical rooms. Separate access is provided to the FM area for deliveries etc.

Figure 18: Level 3 Illustration

Level 4 summary description

Total Population catchment	24,000
Travel time (upper limit)	30
Fixed clinical consultation spaces	20 rooms
Wider clinical rooms	15-20 rooms
Estimated Gross Internal Area	1200-1500m^2

Urban / rural location	Predominantly suburban with tactical rural hubs
Current no. comparable facilities in Wales	TBC
No. practices with sufficient reported GIA to deliver this model	TBC

A Level 4 facility offers an opportunity to provide a hub for primary and community services across a wider locality and catchment population. In addition to core and enhanced community services these facilities should provide wide range of fixed community and health resources on substantive and/or sessional basis. This is a significant step change in capacity with a diverse range of both clinical and commercial capacity with the introduction of fixed Pharmacy, care navigation and wider advisory services.

The facility should be accessible through a range of self-presenting and booked routes (service determinant) and should include a range of community resources to encourage the populations to engage with health improvement services.

The level 4 facility should be accessible seven days per week, but some services would only be available on a booked basis during core office hours.

The planned service provision in a facility at this Level could include:

Core Services (Resident)

- Core General Medical Services (potentially extended/out of hours);
- Chronic Conditions Clinics;
- Pharmacy;
- Podiatry;
- IATP (Mild-Moderate Depression and Anxiety);
- musculoskeletal Service and Wider Physio, OT, SLT services;
- Virtual multi-disciplinary teams older people and Active ageing;
- Frailty Assessment and Support Services;
- Case Management, Care coordination complex multi-condition cohort;
- Sexual Health Services including contraception clinics;
- Minor Surgery;
- Digital consultations;
- Maternity, health visiting and wider family care services;
- Wound care and Minor injuries;
- Learning through Play areas for young people;
- Community social, Performance and Art spaces;
- Outside Space/Community gardens and kitchens;

- Care Navigators;
- Nutrition and Physical Fitness education and facilities (Gym/Pool);
- Libraries (virtual/actual);
- Support for victims of crime/domestic abuse;
- Wellbeing services and social prescribing;
- Health screening, immunisation and fit testing;
- Social Hub for young people with community sport teams and activities;
- Signposting and wellbeing library to support selfcare.

Wider Clinical and Non- Clinical Services (Dedicated sessional basis)

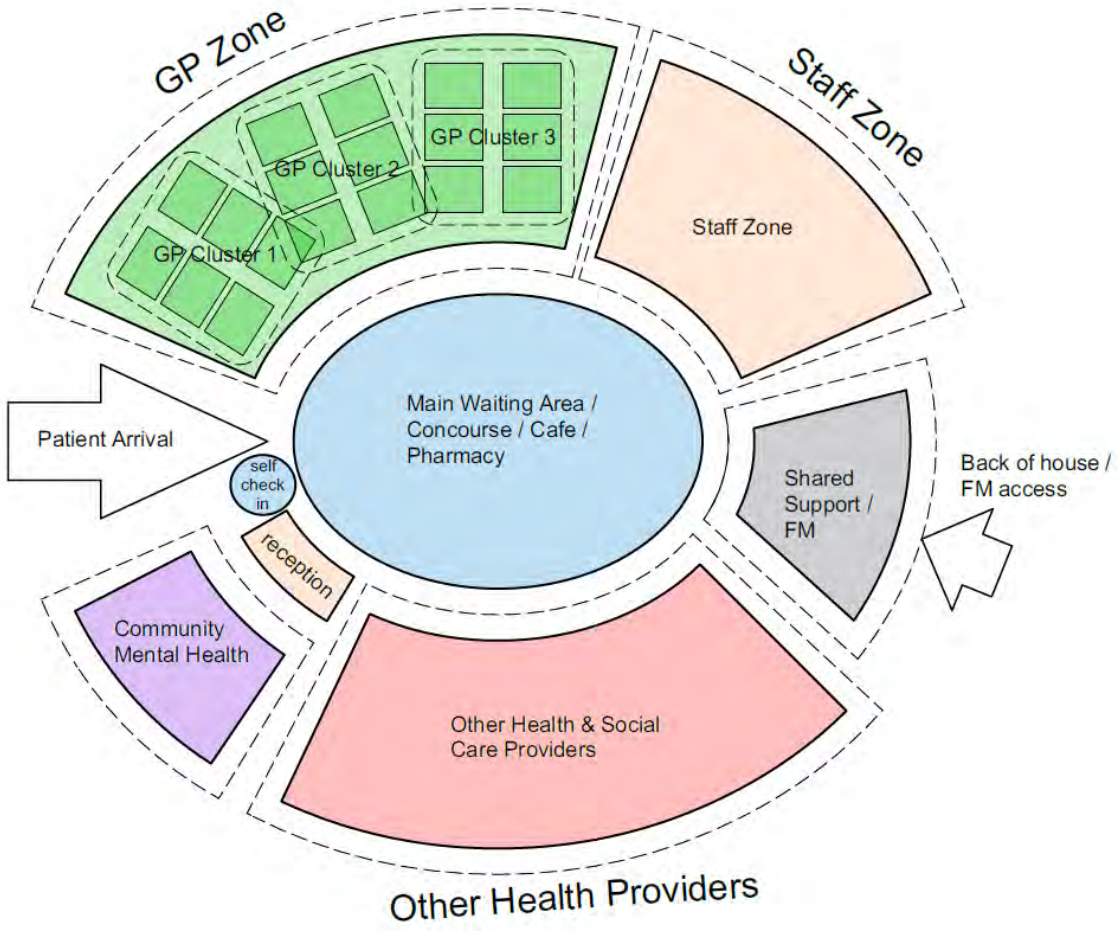
- Dentistry;
- Ophthalmology;
- Audiology (including Primary Care Earwax service);
- Cancer screening;
- Community mental health, Learning Difficulties and Autism Spectrum Services;
- CAMHS consultation/therapeutic spaces;
- Shared prescribing hub and medicine management;
- Peer-mentoring for chronic conditions;
- Minor procedures - Day case surgery; Employment services;
- Community Kitchen/Café;
- Citizen's advice bureau;
- Wrap around childcare for low-income working households;
- Prevention, Immunisation and wider health improvement (smoking cessation, weight loss, substance misuse support);
- Third sector advisors (Age UK, Arts, National Autistic Society and Young Peoples charities);
- Charities meeting spaces to support fundraising/community engagement.

To support the activities and services outlined above, the illustrative functional content, or rooms/functions, is demonstrated by a Schedule of Accommodation in Appendix D.

Level 4 Exemplar Layout Illustration

The Level 4 facility example is a single storey concept, based on patients and visitors arriving at a central public core, providing reception, waiting and commercial facilities. Accommodation is then split into discreet 'zones' that are accessed from the central core, including clinical, staff and support zones. The clinical zones include GPs and other health and social care providers. The clinical zones can be further split into clusters of clinical rooms. Separate access is provided to the FM area for deliveries etc.

Figure 19: Level 4 Illustration



Level 5 summary description

Total Population catchment	35-50000
Travel time (upper limit)	45 mins
Fixed clinical consultation spaces	40 cons. / procedure rooms
Wider clinical rooms	30 rooms/ diagnostic zones
Estimated Gross Internal Area	6500-7000m^2

Urban / rural location	Urban only *
Current no. comparable facilities in Wales	None at present
No. practices with sufficient reported GIA to deliver this model	1-2 Health & Wellbeing Centres planned

(unless planned as mitigation for rural acute/ diagnostic service access challenges*

This facility should seek to provide services for 35-50,000 population and able to combine a number of practices. The model aligns with the Swedish integrated care Primary Healthcare Centres; where patients may not register with a specific GP or practice but would be able to access a wider range of integrated services as directed by a core team of advisory clinical navigators.

The scale, cost and workforce commitment for effective delivery of this level of facility indicates that there are unlikely to be more than eight of these facilities Wales-wide. The

location of the facility should be planned to maximise access and generate significant consolidation benefits as a replacement for public estate with prohibitive renovation/replacement costs.

The level five construct can be considered through the lens of a virtual network of smaller facilities, and there should be number of complimentary public facilities of appropriate condition within the catchment area.

The planned service provision in a facility at this Level could include:

Core Services (Resident)

- Core General Medical Services (potentially include extended/out of hours);
- Chronic Conditions Clinics;
- Dentistry;
- Pharmacy;
- Ophthalmology;
- Audiology (including Primary Care Earwax service);
- Podiatry;
- IATP (Mild-Moderate Depression and Anxiety);
- musculoskeletal Service and Wider Physio, OT, SLT services;
- Virtual multi-disciplinary teams older people and Active ageing;
- Frailty Assessment and Support Services;
- Case Management, Care coordination complex multi-condition cohort;
- Sexual Health Services including contraception clinics;
- Minor Surgery;
- Ambulatory urgent care and urgent treatment (in and out of hours);
- Diagnostics including X-Ray, CT Echo, ECG, Ultrasound etc;
- Digital consultations;
- Wellbeing services and social prescribing; Maternity, health visiting and wider family care services;
- Wound care and Minor injuries;
- Learning through Play areas for young people;
- Community social, Performance and Art spaces;
- Outside Space/Community gardens and kitchens;
- Community Kitchen/Café;
- Care Navigators;
- Nutrition and Physical Fitness education and facilities (Gym/Pool);
- Libraries (virtual/actual);
- Support for victims of crime/domestic abuse;
- Health screening, immunisation and fit testing;
- Social Hub for young people with community sport teams and activities;
- Wrap around childcare for low-income working households;
- Prevention, Immunisation and wider health improvement (smoking cessation, weight loss, substance misuse support);
- Charities meeting spaces to support fundraising/community engagement;
- Signposting and wellbeing library to support selfcare.

Wider Clinical and Non- Clinical Services (Dedicated sessional basis)

- Community mental health, Learning Difficulties and Autism Spectrum Services;
- CAMHS consultation/therapeutic spaces;
- Minor procedures - Day case surgery;
- Shared prescribing hub and medicine management;
- Employment services;
- Citizen's advice bureau.

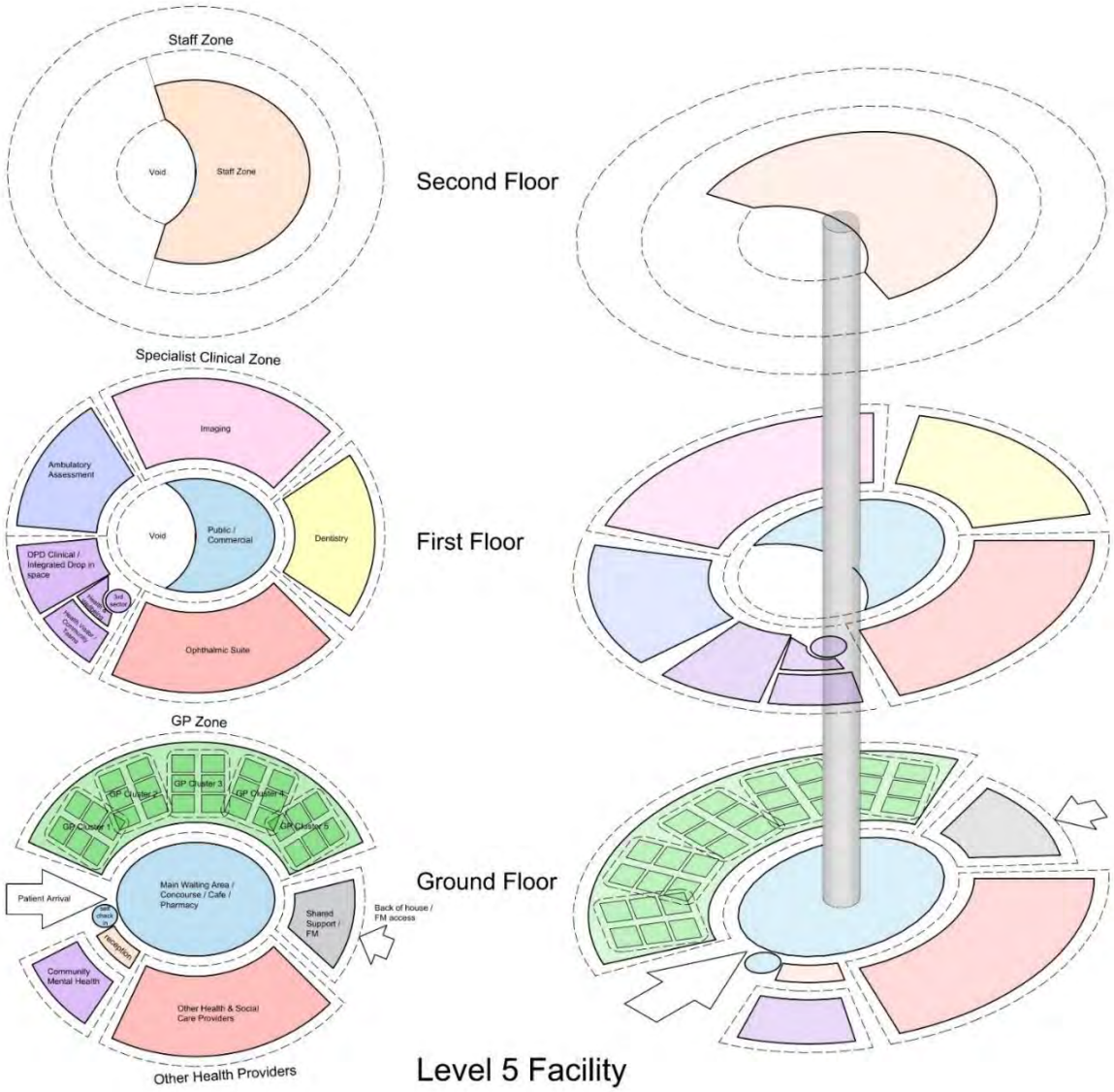
Periodic Services (Shared Space)

- Cancer screening;
- Peer-mentoring for chronic conditions;
- Third sector advisors (Age UK, Arts, National Autistic Society, cancer charities and Young Peoples charities).

To support the activities and services outlined above, the illustrative functional content, or rooms/functions, is demonstrated by a Schedule of Accommodation in Appendix D.

Level 5 Exemplar Layout Illustration

Figure 20: Level 5 Illustration



The Level 5 facility example is split into 3 storeys with clinical accommodation on the ground floor and first floor, and Staff spaces on the second floor. The concept is based on patients and visitors arriving at a central public core, providing reception, waiting and commercial facilities. Clinical accommodation is then split into discreet ‘zones’ that are accessed from the central core and can be further split into clusters of clinical rooms.

The ground floor includes GP accommodation, other health and social care providers, community mental health, and associated FM support. Specialist clinical areas are contained on the first floor and are split into specialities. Separate access is provided to the FM area for deliveries etc.

Section 3. Analysis

3.1 Introduction

This section gives an outline on the importance of assessing local health needs and linking this to current service provision, in order to identify gaps of need. This section is carried out at a national level for illustrative purposes and should be followed on an individual Health Board level to extract meaningful conclusions. (A more detailed analysis by individual Health Board can be found in Appendix A).

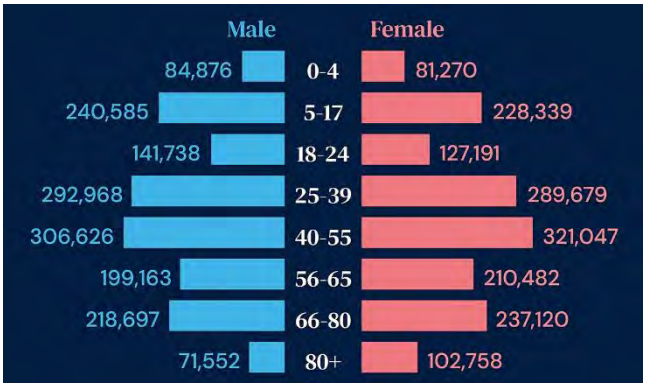
A key element of strategic planning for the primary care estate is understanding the current and future demographic. This includes not only understanding the local and regional population, but also assessing the predicted size of the population, through growth of regeneration and housing. When coupled with analysis of patient access and travel time, this enables planning for service provision in a locality area.

3.2 Analysis and understanding of current and predicted population need

The population of Wales is diverse and changing and there are noticeable inequalities in life expectancy in some areas. The changing demographics mean that demand for primary health services will continue to grow. It is in this context that there is a key requirement to provide sustainable, improved, accessible and integrated services that are resilient and fit for future health provision. People living in more deprived areas experience comparatively poor health, with a lower life expectancy than those living in the least deprived areas. As well as life expectancy, deprivation itself is a predictor for high levels of urgent and emergency care need and is associated with higher levels of morbidity and frailty, which themselves are also predictive of higher care demand for both health and social care.

Current age profile

Figure 21: Age vs Gender profile[11]



By firstly analysing the numbers of people living in Wales and then in more granular detail by Health Board, concentrations of people with specific health needs can be identified, enabling targeted service provision based on need.

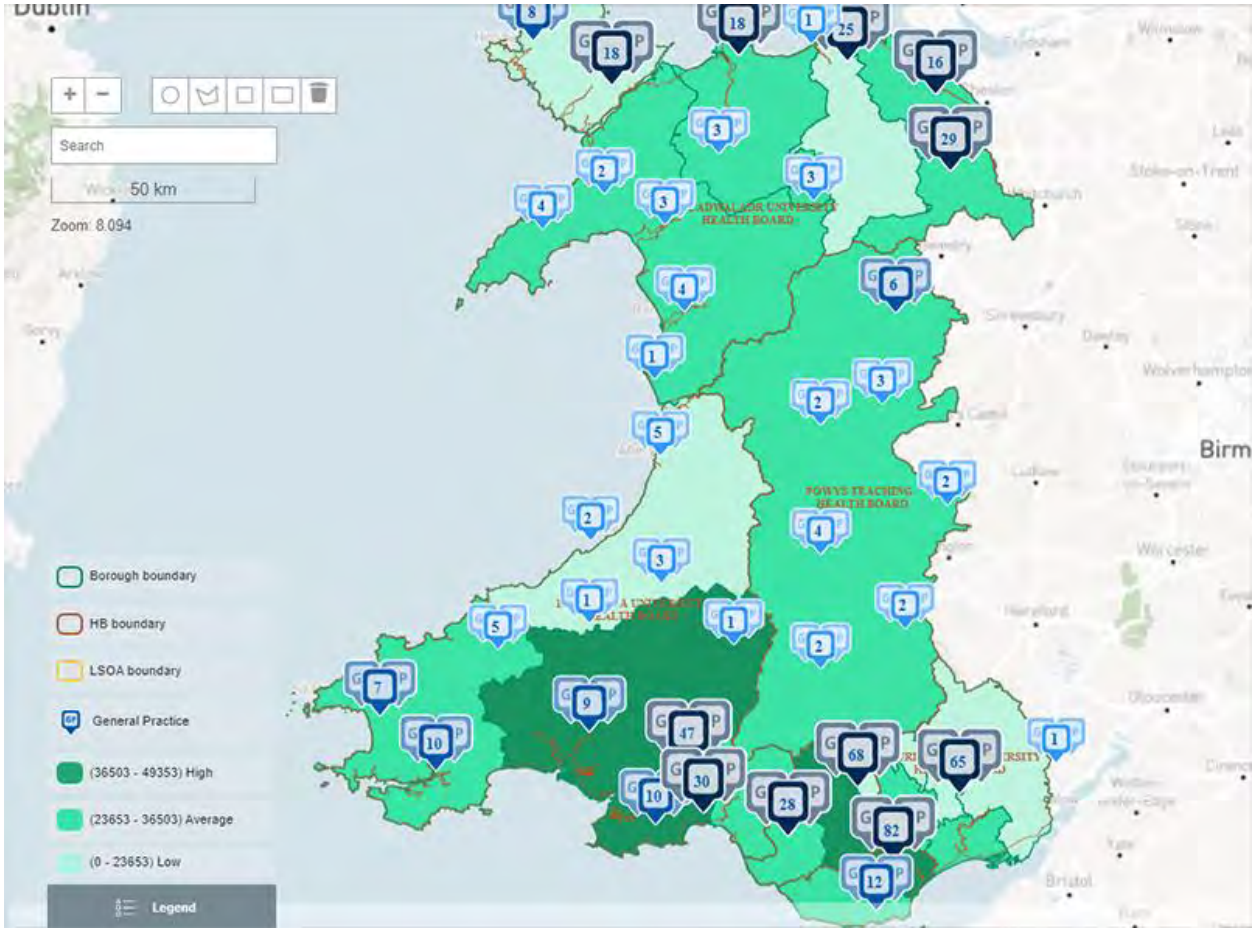
[11] Stats Wales, Age distribution of population by gender and local authority, Accessed March 2021.

This is not to say that services should be concentrated in those areas only but gives an indication of the level of service or facility needed. This also enables planning for cluster-based working with satellite facilities remaining part of the wider network regionally and possibly delivered, particularly if a specialist service such as COPD management, by the same team of clinical staff.

The detailed heat maps by individual Health Board can be seen to demonstrate where, in key areas of Wales, the population is predicted to continue to get older, with the greatest projected increase being in the over 70 years age group.

This change in demographics will alter the requirements of the population in these areas and also allows likely disease profiling to be completed. Health issues that more typically affect older people being more prevalent; these include more complex illnesses with two or more health conditions and other health issues such as Musculo-Skeletal problems and Diabetes. The higher numbers of older people living in identified areas will have very different needs and services designed to be delivered in different ways, more targeted types of service provision and more locally delivered where possible. Alternative care pathway arrangements, such as community therapy sessions, care in the patient's home for some assessments and treatments and more innovative communication services and working arrangements between the acute services and primary and community care will be a key consideration of cluster-based planning.

Figure 22: Mapping to show high-level concentrations of people in the higher age profiles



The age profiling by area has also shown a greater number of females than males who are above 65 years of age and significantly higher numbers of females over 80 years[12].

The assessment of future growth also shows the overall aging population is predicted to increase further with projected increases of around -45 thousand over the next five years including those aged 90 or older and services where health, social care and community services can work together to provide public services and facilities in different ways and more cost effectively[13].

Figure 23: Age 66+ growth projection

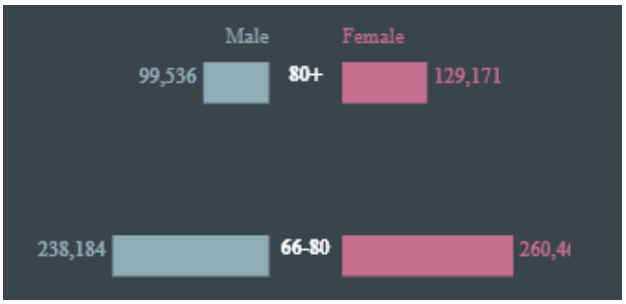
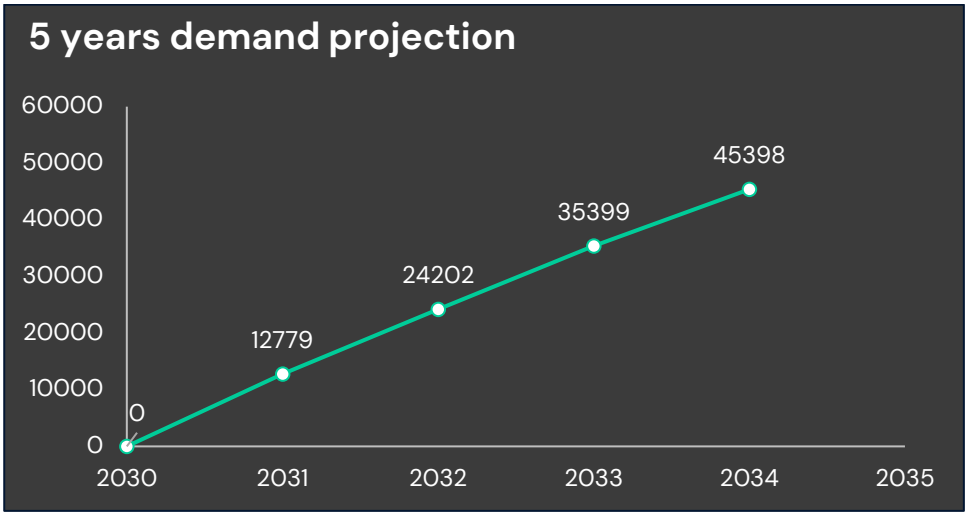


Figure 24: Demand Projection



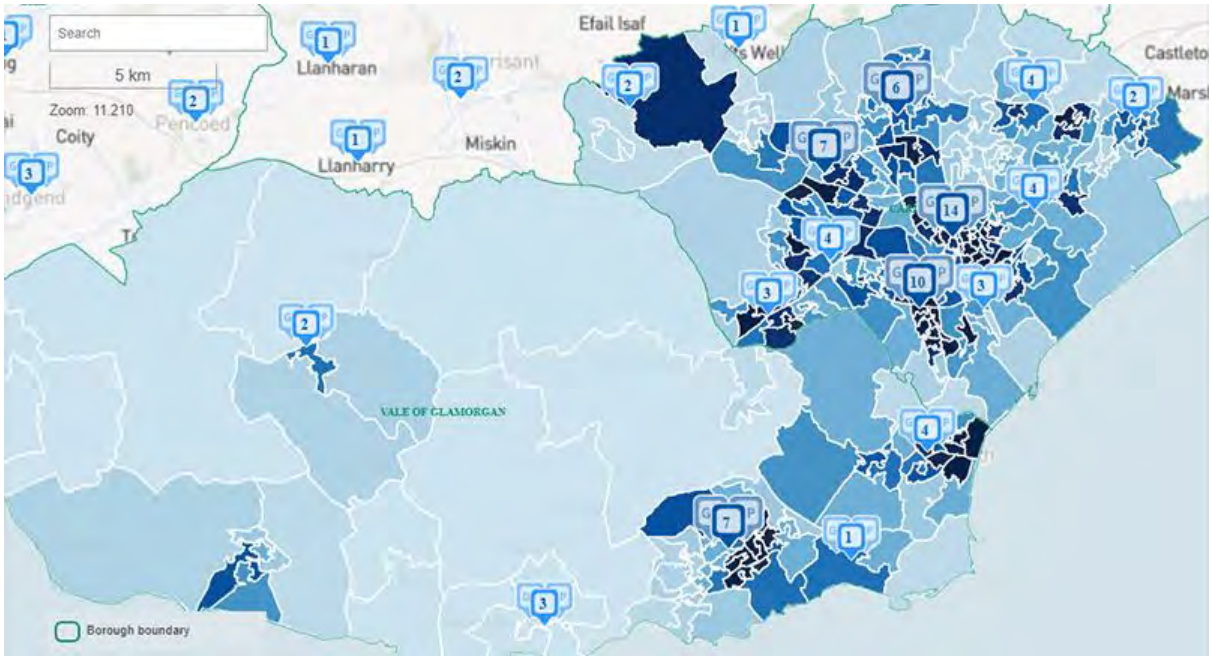
By looking at each Health Board it is possible to review where service provision is currently sited and population densities by age profile. This can identify, at a more detailed level, gaps in current service provision are and enable an integrated review of the types of services, access to them and the best way to deliver them based on the local population need.

As an example, looking at Cardiff and Vale Health Board, an overview of the numbers of GP practices and/or health centres, or facilities linked to health (such as pharmacies) can be seen. The diagram below typically shows a higher concentration within the city of Cardiff and surrounding towns which would be expected but also demonstrates how ranges of services are limited for people in less dense areas, yet health needs may be the same or higher.

[12] Health mapping and statistics CO-Plug 2021

[13] Mapping and Statistics - StatsWales: Population projection by local authority by year Coplug

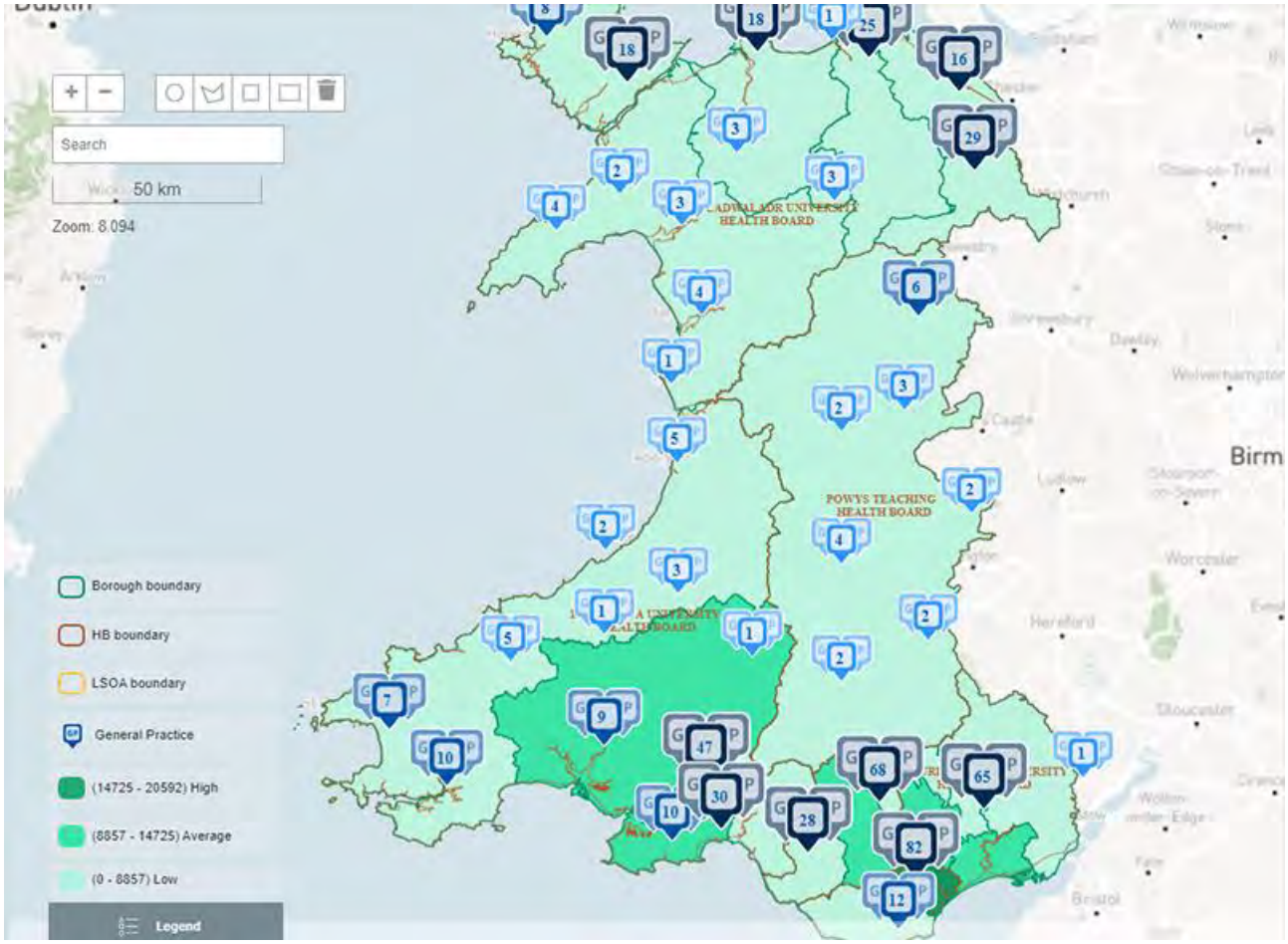
Figure 25: Population concentration within Cardiff and Vale – and access to health services



Access to other services such as Pharmacy and Dentist is also limited for more rural areas and options to look at how the wider delivery of services may be possible by having more integrated services or remote access opportunities.

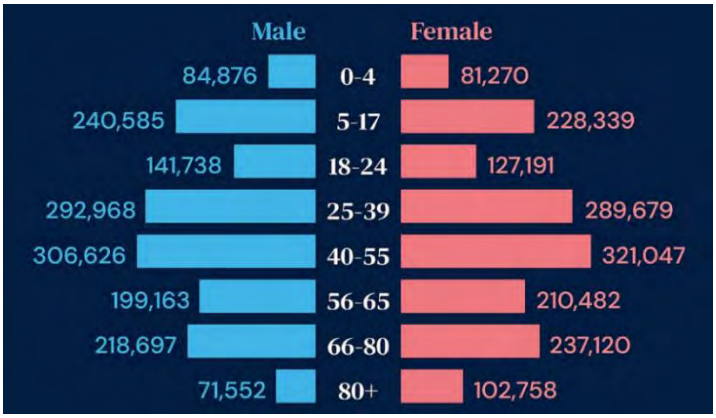
At the opposite end of the spectrum, the maps provided for each Health Board show where there may be clusters or higher are higher number of young children 0-4yrs in order to support planning for where services for young families may be best placed and how links to young people's services within a cluster should be assessed for future provision to achieve the best access to the best health and social value.

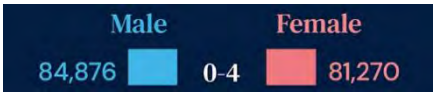
Figure 26: Concentrations of children 0-4 years



By using the map and linking it to growth estimations allows future predictions to be made. It is however essential that the impact of regeneration and local housing plans is known so that future planning and developments of services are designed in such a way to continue to meet local requirements and that where large developments are planned the need for provision of health services is considered.

Figure 27: Age and gender profiles





Whilst changing models within primary care is beginning to develop through clusters of practices working together, improving general practice resilience and capacity to deliver improved access to primary care services is a key priority. It is recognised that there are several challenges to this due to the continual growing pressure on the primary care estate which include some local practices seeing an increased demand for services and some practices struggling with their dated and limited estate capacity.

Developments in quality and capacity of the primary care estate will ensure that estates planning supports future service provision for overall local requirements and encourages individuals to better manage their own health. It will further enable co-location for out of hospital delivery of services and provide a step change in service provision locally demonstrating alignment with the wider system transformation plans to:

- Achieve the best outcomes for the local population enabling people to live better lives and manage their health and well-being effectively.
- Assessing local needs and adapting service provision to meet the needs of individual communities.
- Ensuring equity of provision, with standardised care models and reducing variation in outcomes.
- Constantly responding and adapting to support people effectively, with the aim to address their more complex needs in the right place first time.
- Creating integrated teams for delivery of Out of Hospital Care (i.e. primary / community / mental health / social care and the Community and Voluntary Sector).

Analysis of population need conclusions and recommendations

- By using the mapping of demographics and disease profiling individual Health Boards can analyse their local population needs and map the current provision of services against the future requirements to inform future planning.
- By aligning the principles of sustainable estates it will ensure investment plans are aligned with health improvements and access in order to be long term, prevention focused, and in support of integration.

3.3 Availability of estates data and Next Steps to address estates condition and suitability

Baseline estates data was collected from NHS Wales Shared Services Partnership – Specialist Estates Services and the individual Health Boards. This has been compiled into a core baseline data set. Appendix B contains the detailed analysis from this data set.

It is clear from this review that there is a wealth of often incomplete or outdated data of various types, held in a variety of data bases with no consistent way of collecting of data gathering, storage and analysis. There were significant gaps in list sizes and Gross Internal Floor Areas which prevents a detailed assessment of capacity against current and forecast demand.

Having access to the right primary and community care estate data is an essential element of developing robust investment plans and evaluating business cases.

The reported estimated spend for reimbursed rent for primary care estate in Wales is circa £22m per annum. To understand where future investment is required in line with the primary care estates agreed model, a robust understanding of the existing estate, size and condition is essential.

A nationally driven workstream to obtain a core data set for primary care would have a number of benefits for NHS Wales, as summarised below:

- Support investment decision making and prioritisation of primary care schemes against the proposed model for future primary care estate;
- Inform decision making with a clear understanding of capacity across the primary care estate;
- Provide an overview of the indicative cost of fit for purpose premises;
- Identify opportunities for effective and efficient use out of existing primary care infrastructure and to improve value for money from individual schemes;
- When used in conjunction with the Investment Evaluation Template, demonstrate the case for investment requests and disinvestments (service planning, refurbishment, new build, disposals) for Health Boards in support of their strategic needs to meet population health outcomes and long-term objectives.

In addition to the benefits to NHS Wales, there would also be direct benefits for GPs by engaging in this process. This will support their case for future investment into their estate, either by way of minor improvement grants or for the implementation of larger scale primary care developments.

The ultimate aim for all stakeholders should be the delivery of high-quality services for the people of Wales in suitable, fit for purpose, well maintained premises which aligns with the recommended future primary care estate model described in Section 2.

The construction of the roadmap is demonstrated by Appendix D, which is a suggested tool for constructing investment decisions in the Next Steps detail of requirements. It is calculated per Health Board, bringing together current demographic need, current service provision and expected need of the future population, enabling an informed approach to planning and investment options.

The table below summarises the gaps in the current baseline data across Wales, by Health Board. A significant amount of data centrally available was collected as early as 2003 and is no longer valid for various reasons, practices will have merged or relocated to new premises for example.

Table 2: Summary of Percentage of available premises data

	ABUHB	BCUHB	CVUHB	CTMUHB	HDUHB	PTHB	SBUHB
Total Number of Premises	***101***	***137***	***81***	***82***	***65***	***27***	***68***
Overall Completeness	***60%***	***52%***	***46%***	***53%***	***54%***	***55%***	***53%***

Data Section	Percentage of Data obtained for HB						
Primary Care Premises Details	84%	82%	74%	85%	87%	87%	84%
Organisational Relationships	50%	50%	49%	50%	49%	48%	49%
GP Contract	57%	36%	35%	40%	39%	39%	39%
Workforce	17%	17%	16%	17%	16%	16%	16%
Occupation	69%	65%	54%	67%	61%	69%	61%
Property Tenure	29%	22%	24%	19%	23%	18%	26%
Revenue Implications	25%	15%	17%	13%	15%	16%	21%
Building Construction	65%	72%	59%	72%	61%	92%	57%
Building Condition	86%	62%	46%	57%	53%	61%	55%

Lack of quality data remains a significant barrier to informed decision-making and driving through estates transformation in Wales. The existing datasets have significant gaps on primary care premises, with focus across all Health Boards on Workforce information, Property Tenure and premises conditions.

Currently, Wales is missing a credible, singular data source, containing information of all primary care estates, which is reimbursed by NHS Wales.

Current issues with the existing centrally held data set:

- No existing framework for mandatory national data collection;
- Variations in regional and local levels of data collected;
- An existing lack of resource to collect and manage data;
- Restrictions on ability to collect data directly from GP Practices;
- Access is required to data on platforms held outside NHS e.g. population growth and local transport links.

Primary care estates observations

- Three facet surveys (Physical Condition, Functional Suitability and Statutory Compliance) should be procured for all Health Board and GP owned/managed buildings to fully understand the extent of condition and operational performance of these buildings.
- A national collection of a common core estates data set would provide the essential data required to inform future investment prioritisation and decision making.
- The above data would then enable a detailed analysis of the estate by Health Board against the proposed primary care estate model.

Section 4. Ownership of the estate

4.1 Introduction

This review considers the various ownership models and structures across Wales and the neighbouring regions whereby governments, Health Boards and NHS organisations are:

- Exploring different approaches to improving the quality of primary care service delivery;
- Addressing longer term sustainability of primary care estate and its role within the healthcare landscape.

To obtain a robust indication of future direction of travel for Primary Care in Wales, it addresses:

- The current ownership structure in Wales;
- An alternative model of ownership;
- A review of the challenges for Wales;
- The wider context – in terms of what other governments are doing across the UK;
- The pros and cons of ownership models.

4.2 Current ownership structure in Wales

Currently across Wales and its Health Boards, premises ownership is split into the following models:

- GP owned;
- Health Board owned;
- Council owned;
- Private landlord owned;
- Third party development;
- Private Finance Initiative (PFI)
- Unknown structure.

Table 3: Summary estate ownership by ownership type from data provided

	GP-owned	UHB-owned	Council owned	Private Landlord	3rd Party Dev.	PFI	Unknown
Wales	**50%**	**4%**	**0%**	**10%**	**19%**	**0%**	**18%**
ABUHB	45%	7%	0%	15%	22%	1%	10%
BCUHB	38%	0%	0%	5%	28%	0%	29%
CVUHB	61%	0%	0%	5%	16%	0%	18%
CTMUHB	32%	0%	0%	5%	25%	0%	38%
HDUHB	60%	13%	0%	11%	9%	0%	6%
PTHB	59%	0%	0%	0%	21%	0%	20%
SBUHB	76%	1%	1%	18%	1%	0%	4%

The data above shows that:

- The majority of the primary care estate is owned by GPs, with a 50 percent proportion across the whole of Wales, ranging from 32 – 76 percent throughout the seven Health Boards. The second most employed ownership model is GP leased from third party development, private landlords and unknown. There are areas, such as in ABUHB and HDUHB, where 7 percent and 13 percent of the estate respectively is owned by the Health Boards themselves.
- The current predominant ownership models present a barrier to entry for new GPs, with many not wanting to commit to long ownership models. Furthermore, with premises not owned centrally, it is difficult to ensure the requisite capital investment is made to improve premises.

4.3 An alternative model

In the context of the ownership of the Primary Care estate, and the challenges the various models face, particularly with regards to recruitment of new GPs, the following organisation has embarked on a new path to create a Primary Care model that is different in its approach:

Wrexham Primary Care Model – daring to be different[14]

Community Care Collaborative (CCC) Community Interest Company (CIC) is a social enterprise that is endeavouring to redesign the way Primary Care services are delivered in Wrexham.

> *"Community Care Collaborative CIC is a social enterprise that aims to enable partnership working between the public, voluntary and private sectors to develop and deliver an innovative, person-centred, social model of care, transforming the traditional model of primary care in Wales. Working for the benefit of the community and as an asset locked organisation, any surpluses we make are reinvested into the enterprise.*
>
> *CCC's vision is to develop and deliver new models of community-based care taking a 'whole-person' approach to addressing people's physical health, mental health and social needs together. CCC does this through working collaboratively with statutory agencies, voluntary and community groups, patients and individuals."*

CCC was conceived as a way of meeting patient need in a better way but fuelled by the difficulties Wales is finding in recruiting doctors to GP practices, and combined with many Welsh doctors nearing retirement, increasing numbers of GP practices are finding themselves short of GPs.

An obstacle primary care is facing is that many GPs are working as temporary doctors known as locums. CCC has been able to employ some part time doctors, which is not sustainable for the future provision of Primary Care services. If in the event Primary Care ownership ratio's change, with greater take up of HB owned premises, there could be a provision for continued contracting of locums without building ownership to focus equally on service delivery.

[14] Community Care Hub Evaluation Summary, 2019: https://ccc-wales.org/wp-content/uploads/2019/07/ccc-hub-evaluation-summary-2019-eng.pdf

However, CCC's goal is to recruit more full-time salaried GPs throughout 2021, and the organisation is confident that this integrated model will provide a more sustainable model moving forward and prove attractive to GPs, as it gives them more opportunity to concentrate solely on medical needs and patients as they'll be able to access a much wider range of inhouse support.

CCC is currently concentrating its efforts on recruitment and building partnerships from within the Welsh Government's Foundational Economy Challenge Fund (FECF) Community of Practice, as well as other organisations that can help to replicate this model across Wales.

4.4 What is the situation across the UK?

At a practice level, ownership arrangements vary across the UK. Much of the primary care estate is owned by GPs. A minority of the primary care estate is owned by local authorities or NHS trusts. The rest, of the primary care estate, is owned by NHS Property Services, Community Health Partnerships in England, or primary care estates developed under third party developer schemes and owned by private landlords.

Where GPs own their properties, they can be reluctant to invest in maintaining and modernising them. This is typically because of the perceived risks of raising money in exchange for personal security, and with no guarantee of a return on investment through enhanced property value. There is also a lack of incentivisation, within contracting mechanisms, to include prospects of grant funding for energy efficient works, for example, particularly under the Premises Cost Directions for England and Wales. For similar reasons, including personal risk attached to the rent, GPs can also be reluctant to enter into long-term leases with third party developers, the NHS or local authorities.

Indeed, in our previous experience of working with Health Boards and clusters Archus have noticed a declining interest on the part of GPs to enter into partnership arrangements, which are typically tied to premises ownership. Particularly strong concerns persist around the risk of being the 'last partner standing', as well as around entering into lengthy lease terms, which, it is commonly assumed, will have implications for GPs upon retirement, and for GPs buying into a business.

England

As far back as the Second World War, the Government did not have the funding to own GP premises, so GPs paid for their own premises and the state provided an annual contribution towards the cost.

Fast-forward to 2021, and whilst times are very different, the majority (approximately 57%) of the GP premises in England are still owned by the partners. The drivers for change in Primary Care in England include the need to modernise facilities, the NHS Long Term Plan, new GP contracts, partners wanting to retire and the push for service integration.

There seem to be six GP ownership models across England, each with their own positive and negative aspects, including best value, most future-proofed or most innovative.

Model 1. GP Freehold

Key considerations include how decisions are made if not all partners own the property. Will partners want to invest money into the transforming the property, if there is no guarantee of a financial return in the form of equity uplift in the premises?

With greater control it will be easier for GPs to integrate the property and make sure the right changes happen, due in part from the freedom to make quick decisions without the time and legal process involved with seeking landlord permissions on leased premises. The issue with 'Last Partner Standing' remains with potentially limited succession planning in place.

Model 2. Private Ownership

Key considerations include whether it is beneficial for financial support to be available quickly, from landlords of leased premises. Would a GP be happy to work with an investors' preferred developers by way of a GP lease? Or will investors work with a GPs chosen developer?

Investors require a commercial return and to satisfy shareholders, so will the GP objectives for the premises align with the landlords? There is potential for approval processes to be more complex as more third parties are involved.

Model 3. NHS Trust Owned – GP Leased

There is far more scope to create greater understanding and share common interests as the landlord will be part of the integration process. There are also greater efficiencies to be seen by integrating budgets and resources. The big question with this model is "will the Trust's challenges including both financial and operational, outweigh plans for Primary Care provision"?

Model 4. NHS Property Services Owned – Leased to GPs

In England, several practices have found with relationships with NHS Property Services challenging. Many of the negative aspects of this relationship are borne out of the clarity and transparency (or lack of) around current and future charging of rent, rates, insurance, service charges and FM services.

Model 5. LIFT Owned – Subleased to GPs

There are examples of very high rental figures, which can mean bringing in new services from different budget pots may be difficult. However, it has often been beneficial to use LIFT companies' knowledge, expertise and commitment to the asset's requirements, and the pro-active management regime is able to protect and improve the standard of accommodation.

Model 6. GP Provider Propco

Key considerations for this model include whether concentrating non-clinical back-office functions into potentially fewer buildings could improve efficiencies? And could the property usage be planned out on an area-wide basis from the providers estate?

The role of VAT treatment is key in this model, the implications of VAT on notional rent and CMR and the rated VAT on development costs must be considered. These models can co-exist within one system or as part of a hub and spoke model, but it is essential that property planning is undertaken to enable integration.

Scotland

The Scottish Government have recognised the pressure on sustainability of general practice which is linked to liabilities arising from premises. We understand that approximately two-thirds of GP premises in Scotland are either owned by GPs or leased by them from third parties.

GP-owned premises

The Scottish Government have produced a Code of Practice for GP premises which sets out their plan to shift to a primary care model that does not include GPs owning their premises. The Code sets out:

- *'how the Scottish Government and Health Boards will enable the transition over a 25-year period to a model where GP contractors no longer own their premises;*
- *how the Scottish Government and Health Boards will support GPs who own their premises during the transition to the new model through the provision of interest-free secured loans;*
- *the actions that GP contractors who no longer wish to lease their premises from private landlords must take to allow Health Boards to take on that responsibility.' (ref-The National Code of Practice for GP Premises).*

We understand the Government had received strong demand from the BMA to acknowledge the pressure GPs are under, regarding premises responsibilities and liabilities on leased and owned premises.

To achieve the change in GP ownership, the Health Boards must as part of the strategy for primary care (in addition to providing GP Sustainability Loans as below) over the next 25 years either:

- purchase existing GP owned premises in a planned manner, or
- provide alternative premises to allow GPs to sell their existing premises – where that is in the best interests of the patients and provide GPs with the financial assistance with the relocation. The current take-up of this solution is unknown.
- GPs who wish to continue to provide their own premises are free to do so and will continue to receive rent reimbursement.

GP Premises Sustainability Fund

The Scottish Government has recently set up a loan scheme, committing £30m, to provide additional support to GP contractors who own or lease their premises. It will be used to fund GP Sustainability Loans and to ease the process of transferring responsibility for leasing premises to the Health Boards.

All GP contactors who own their premises will be eligible for an interest free loan including those in negative equity.

It is understood that loans are made available on the basis of 20% of the value (Existing Use Value) of the premises, and will be secured against the premises, (by way of a first legal charge) with the proportion of lending to increase over five-yearly cycles up to the full value

of the premises, whereby it is expected that the transition to the new model where GPs no longer own their premises is complete between 2038 and 2043.

Health Boards will have the power to top-up the amount of the loans, where there are exceptional circumstances. The loans will be repayable only if the premises are sold or no longer used by the GP contractor for the provision of PMS under contract with the Health Board.

The purpose of these loans is to increase the stability of GP practices which own their premises; for example, in the event of a retiring partner with capital invested, which may have a destabilising effect on the practice. A loan could significantly reduce this effect and the up-front cost to new partners of joining the practice. The same would be the case in the instance of a practice being in negative equity, whereby the loan could cover the existing mortgage, an incoming partner would not have to contribute capital to buy into the partnership, and the partnership agrees to make capital repayments on the reduced debt. Notional rent is now more likely to cover these repayments.

In the circumstance whereby the GP sell its premises and the sale price is not enough to pay off the full amount of the GP Sustainability Loan, the part which cannot be paid off will be written off by the Health Board. (Subject to proper open marketing, professional advice sought, not sold to connected persons etc.) We are however unaware as to how the Scottish Health Board are funded to account for written off loans.

GP Leased Premises from Private Landlords

The Scottish Government's long-term strategy is that no GP will need to enter a lease with a private landlord. Health Boards will, over the next 15 years take on the responsibility for negotiating and entering into leases with private landlords and the subsequent obligations for maintaining the premises from GPs who no longer want to lease privately. There are likely to be IFRS 16 implications for the HB entering into leases, but we have not undertaken a full assessment into the accounting structure and impact of IFRS 16.

Health Boards are ensuring that GPs are provided with fit-for-purpose premises, compliant with the Premises Direction policies. But before a GP agrees a new lease with a private landlord, it should consult the Health Board on the proposed terms.

There are currently three ways in which Health Boards can take on the responsibility of providing a GP with premises:

- *'Negotiating a new lease for the GP contractors' current premises, with the Health Board as the tenant and the GP as sub-tenant;*
- *Accepting as assignation of the GP contractor's current lease;*
- *Providing alternative accommodation for the GP contractor when its current lease expires.'*

Republic of Ireland

The majority of primary care and community services in Ireland are run the Health Service Executive and primary care mostly provided by GPs, generally operating as sole traders or as part of health centres.

A programme for developing 35 new Primary Care Centres was announced in 2012, with 14 PCCs having now been completed via the Public-Private Partnership mechanism and operational lease arrangements.

This PCC network will require approximately £2.5b investment and there is a need for the HSE to fast track delivery of these schemes whereby many are still in the planning process. There is also the requirement to simplify the leasing system with HSE as main tenant with GPs on sub-leases commensurate with service contracts, to ensure the schemes attract investors.

Many of the large specialist healthcare investors such as Primary Health Properties who currently own 514 primary care properties across the UK are continuing to be attracted by the state covenant and typically long lease terms.

Approximately 38 percent of Ireland's purpose-built primary care centres are now in private landlord ownership. These investors are interested in the modern purpose-built facility and the HSE as main tenant.

The original primary care centre model included extra space for new services, to reduce silos and increase integrated care but more modern developer led schemes do not allow for this and cannot deliver new services.

UK Primary Care – Key Points

- In England, majority of GP premises are owned by the practices.
- In Scotland, if the lease expires before 1 April 2023 (or within 5 years), the Health Board should negotiate a new lease or provide alternative premises.
- If the lease expires after 1 April 2023 (or in excess of 5 years), Health Boards will take on existing lease from GPs where the practice has ensured that the premises is suitable for delivery of PMS, is compliant with statutory obligations, can assign the lease with landlord consent, and has fulfilled its lease obligations etc.
- Ambition of Scottish Gov is for HBs to take on GP leases ad ownership, but we are not sure how the HBs will resource the organisation, administration and personnel in order to implement the plans.
- GP Sustainability Loans and to ease the process of transferring responsibility for leasing premises to the Health Boards.
- All GP contactors who own their premises will be eligible for an interest free loan including those in negative equity.
- Approximately 38 percent of Ireland's purpose-built primary care centres are now in private landlord ownership. These investors are interested in the modern purpose-built facility and the HSE as main tenant.

4.5 Overview of challenges and considerations

The key challenges and considerations from undertaking this review and from the various stakeholder meetings shows the following:

There is a lack of GP partners and or recruitment of new partners, which is influenced by factors including:

- Limited lending opportunities by banks / lenders;
- Premises security liability too high, many lenders require first legal charges of premises and Personal Guarantee liability;
- GP reluctance to sign long leases and risk of Last Partner Standing;
- Struggle to get GPs on salary to 'buy in' due in part to the perceived difficulties in securing lending;
- GMS contracts are not being challenged to provide constructive support for new GPs;
- Premises Cost Directions do not allow for enough flexibility and there could be more scope to change terms on a discretionary basis, particular around recommendations for fit for use premises;
- Energy efficiency grants are not eligible under the current PCDs.
- Lack of confidence in the Primary Care service;
- Perception that Locum GPs are paid more;
- Buildings are on the whole in poor condition or not fit for purpose plus there is a perceived lack of car parking;
- Lack of funding available for expansion and or refurbishment / modernisation of premises particularly to address Minimum Energy Efficiency standards;
- Education key for GPs and practice managers with training to be considered to shift mindset away from buildings and notional rent to business asset and premises income.

Last Partner Standing risk

This is where one or more partners retire from a practice that is unable to recruit any replacement partners, and the remaining partner becomes liable for the full term of the lease. This in turn means all the risk and liability held by the partnership can sit with the remaining individual. Much of the governance and mitigation of this risk should be covered within regularly modernised Partnership Agreements.

The risk of this occurrence has been addressed within the *WHC (2020) 018 Welsh Health Circular guidance – Last Person Standing support,* that provides non-mandatory guidance for GPs 'who are experiencing an immediate threat to the continued viability of their practice', and includes the following:

The circular sets out the support options that might be available for Health Boards to employ:

Option 1 – Side Letters

A side letter for the HB to state intentions to provide assurance to the GP tenant that the HB will continue to reimburse market rents but is non contractual in nature.

Option 2 – Rental 'Guarantee' Agreements and Joint Agreements

The Rental Guarantee Agreement satisfies the rent payable under the lease only. This will not confer any property rights to the Health Board, with the principal obligations the GP must comply with.

A Joint Agreement could be implemented on the termination of the GP contract, focussing on the exit and management of the premises with regard to a replacement GP.

Option 3 – Put/Call Option Agreement

This will enable the Health Board or the GP to assign their lease to the Health Board. These side letters, guarantees and put/call option agreements may mitigate the onerous impact of IFRS 16 on the treatment of lease transactions on the balance sheet.

Sale and Leaseback exit solution

This involves the freehold of the GP premises being sold to an investor and a lease being granted back to the practice partners. The partners continue to occupy the building and provide contracted medical services.

The practice will pay a lease rent to the investor and receive a notional rent reimbursement from the NHS. The purchase price is arrived at by undertaking a specialist valuation based upon the investment value of the property, by capitalising the notional rent and any other income.

Benefits of sale and leaseback

- Facilitates equity release, removing the burden of ongoing capital investment;
- Can help attract new GP partners, as no capital investment required;
- Enables partners who wish to retire to transfer their lease to a new partner;
- New landlord will often assist with financial premises improvements;
- Support for ongoing maintenance of the building allowing staff to concentrate on service delivery and patient care.

There are still underlying risks associated with this solution, namely the general reluctance for GPs to take on new leases, after the freehold interest has been sold.

Risk and benefit of buying in

It is essential that property ownership is treated separately within the Partnership agreement. A partnership is not a separate legal entity in its own right, in most cases each partner will hold a fixed share in the equity of the practice which (unlike a partnership share of profits) will not be variable.

A declaration of trust can be established to clarify what will happen to a partner's share upon retirement from the partnership. Many partnerships take the view that at the point of retirement, a partner should be obliged to sell his or her share in the practice to the continuing partners, who in turn should be under an obligation to buy the share.

It is common for a declaration of trust to provide for a grace period of perhaps 12 months from the date of retirement, during which time the continuing partners can raise the necessary finance (including possibly arranging a new mortgage) to pay for the share.

Such arrangements ensure the practice ownership is kept within the confines of the practising partnership. They also currently allow the retired partner to receive the benefit of Entrepreneur's Relief from Capital Gains Tax (assuming ownership of the share passes within three years of retirement).

In cases where this does not occur, and the ownership of the practice is thereby split between current and retired partners, it is not uncommon for tension to arise. This can be due to the fact that whilst some of the owners hold their shares as business assets, others view their shareholding purely as an investment.

In such cases it is in the interests of both the owners and the occupying partners (whether they be owners or not) to put a lease in place. This not only secures the practice's ongoing use of the practice, but also frees up the ability of the owning partners to sell their investment "subject to the lease", thereby maximising the return they will receive. Without a lease in place the investment is unlikely to be readily saleable, or only saleable at a significantly discounted value.

Unless proper arrangements are entered into, problems can arise with automatic buy-out arrangements if the practice in question has not given sufficient thought to succession planning.

Healthcare finance and lending

Whilst mortgage finance may be available based on the security of notional rent reimbursement under the practice's Service Contract, this does become increasingly tricky as partnership numbers diminish – and indeed many lenders will not lend to a sole contract holder given the risks if something were to happen to that individual. These risks can be managed with appropriate planning, but certainly partners should think carefully and take appropriate advice before buying into the GP premises and entering into binding commitments to purchase further shares when other partners retire.

Lending market

There is a general perception that GP borrowing is difficult to secure and there are limited bank and lenders willing to loan funds without significant personal security. However, there are a number of healthcare finance brokerages are seeing plenty of loan enquiries and applications from GPs. The main things GPs are required to consider are:

- Legal charges on premises. Many lenders will usually require the loan to secured against a 1st legal charge of the property. Some lenders will accept a second legal charge but will require additional personal security, usually in the form of a personal guarantee and a form of debenture over the business. Approximately 5 out of 6 loans will require the premises put up as security.
- 100% loans are available in some circumstances on rates of between 2.3-2.7 percent plus base rate;

- Notional Rent must be in excess of the mortgage payments. As part of a lender's affordability assessment of a borrower, the practice/business notional rent must be in excess of the mortgage repayments. Lenders we are aware of have not been clear on exact excess levels, but it is safe to assume that between 125-150 percent of the monthly or quarterly mortgage payments.
- General Medical Services contracts are preferred as opposed to shorter term Alternative Provider Medical Services (APMS) contracts that provide a more enhanced security of income from the lender's perspective.
- There is a risk of partners becoming jointly and severally liable for premises; whereby the liability is shared by two or more parties to a claim. In the event a claimant may pursue an obligation against any one party as if they were jointly liable and is becomes the responsibility of the GPs to sort out their respective proportions of liability and payment.
- New builds schemes are seen as far more flexible, with lenders needing to see up to 85 percent utilisation across the premises to be comfortable with the occupiers, leases and strength of covenants.
- Valuations – lenders relying on comparable method of valuation using hierarchy of evidence on the basis of Existing Use and Market Value. GPs need to consider the basis of value on which a lender will rely on, typically multiplier of the notional rent, and how the asset will be valued in the event of a disposal. There could be situations where these values will differ, from existing use to market value, given vacant possession value and alternative use etc.

Challenges and Considerations – Key Points

- Premises Cost Directions do not allow for enough flexibility and there could be more scope to change terms on a discretionary basis, particular around recommendations for fit for use premises;
- GMS contracts are not being challenged to provide conducive support for new GPs;
- Education is key for GPs and practice managers with training to be considered to shift mindset away from buildings and notional rent to business asset and premises income;
- Limited lending opportunities by banks/lenders; - basis of valuation key factor in realising value and return on initial GP investment. Existing use value over market value and potential differential on the exit and freehold disposal of an asset compared with notional rent multiplier;
- Premises security liability too high, many lenders require first legal charges of premises and Personal Guarantee liability;
- GP reluctance to sign long leases and risk of Last Partner Standing.

4.6 Premises ownership: Pros and cons

Archus set out below the pros and cons associated with the various premises ownership models discussed in this section. Further to our assessment of the Primary Care estate data, research into what other regions are doing with Primary Care estate, and previous experience of working on Primary Care projects, we're able to determine and clarify what we feel are pros and cons for each feasible ownership model in the context of Primary Care in Wales.

GP owned

Pros

- Greater level of control on GPs ability to lead integration and make the right changes happen;
- GPs with robust partnership agreements and a solid understanding of the share and ownership of the premises will still be able to safeguard capital investment;
- Greater perception of stability in the long-term partnership commitment and asset ownership;
- Scope for succession planning, possibly easier for GPs to plan family commitments, schooling and other personal investments.

Cons

- Daunting prospect of buying in and raising capital;
- No guaranteed return on the premises investment return on disposal or revaluation;
- Difficulties in exiting partnership if circumstances change;
- Greater potential for partnership disputes and dissolutions which can be costly;
- GMS contracts not supportive enough of GPs due to uncertainty around contract lengths
- Employers' responsibilities as a business owner can lead to stress and impact service delivery;
- Difficult recruiting new partners and impact of personal liability for the business;
- Potential for the premises to be in negative equity where debts can be greater than the value of the premises.
- Limited flexibility in current Premises Cost Directions.

Health Board owned or Head Lease

Pros

- Strong understanding of process;
- Beneficial approval process;
- Aligned objectives for the delivery of General Medical Services;
- Greater potential for favourable lease terms between GP / partnership and HB landlord;
- Reduces barrier to recruitment, making it more attractive for incoming GPs

- Flexibility and understanding the service can help improve sentiment around long leases;
- External repairing obligations can be transferred to the landlord;
- Makes process of moving practices or retiring more straight forward;
- Lease can be structured to allow for succession and mirror changes to the partnership;
- Rent reimbursement to cover lease rent.

Cons

- GPs showing reluctance to sign up to long leases; however we note that mutual break clauses are in place should contracts be resigned;
- GPs do not have an equity stake in the premises;
- Limited HB resource to manage negotiations and transactions
- Last Partner Standing risk. However can be mitigated through implementation of lease breaks and robust service succession

Private landlord owned

Pros

- Beneficial to GP tenants to have financial support available potentially quicker for improvement works; subject to availability
- Removes barrier to recruitment;
- Rent reimbursement to cover lease rent;
- Makes process of moving practices or retiring more straight forward;
- Lease can be structured to allow for succession and mirror changes to the partnership.

Cons

- Potentially onerous or restrictive lease terms such as alienation clauses;
- Reluctance of GPs to sign long leases;
- GPs may be at different stages of career with different aspirations and timelines;
- Short leases may mean higher rents;
- GPs do not have an equity stake in the premises;
- GPs will need to seek landlord permission to carry out any future refurbishment / improvement works;
- Last Partner Standing risk.

Third Party Development

Pros

- Bespoke design could make for greater premises flexibility;
- Lease can be structured to allow for succession and mirror changes to the partnership;
- Quality of accommodation and profile for the practice and the community;
- Rent reimbursement to cover lease rent.
- TIR only exemplar leases.

Cons

- High rents and running costs despite modern facility;
- Modern bespoke nature of facility does not lend itself well to conversion to alternative uses such as residential accommodation;
- Schemes designed to prevent surplus space for delivery of new services and expansion and training space;
- Building expansion space that is not rentalised, the cost is passed onto initial scheme rent
- Long leases that GPs are reluctant to enter into;
- Last Partner Standing risk;
- GPs do not have an equity stake in the premises;
- GPs will need to seek landlord permission to carry out any future refurbishment/improvement works.

Premises Ownership Pros and Cons – Key Points

- GP owned model would benefit from GMS contract, PCDs and partnership agreement review but still heavily reliant on RICS basis of valuation – Existing Use v Market Value.
- Health Board owned or head lease model would provide GPs with the most comfort but potential demand on resource to manage leasehold and freehold transaction appears limited at present.
- Health Board funding to acquire freehold premises appears limited.
- GP sub-leases in the event HBs take on head-lease roles with break clauses need to consider potential complications around rights of forfeiture on leases with nil/£1 rents.

4.7 Investment roadmap – a clinical / ownership blend

As part of the stakeholder engagement element of this project, various premises ownership themes were noted from meetings with the Health Boards as follows:

Themes from Health Board meetings: ownership / capital investment

- There is a requirement to take into account life cycle costs of new investment including robust property management in new facilities; allowing for greater reliance on technology, digital solutions and smart building functions to enable a more integrated estate;
- Utilisation and re-purposing of existing public estate is key to include premises such as community hospitals, leisure centres and libraries;
- There is an opportunity to encourage newly qualified GPs to invest in a partnership/ownership model with Welsh government support to secure capital/loans that do not require onerous forms of personal security like personal guarantees;
- Variable approach to functional suitability and condition responsibilities, requiring a consistent national approach to 3 and 6 facet surveys;
- Transparent and equitable access to improvement funds are required that tie in with current Premises Cost Directions. The current PCDs still do not permit improvement grants for energy efficiency works, making it harder to comply with Minimum Energy Efficiency standards;
- Standardised terms for lease/investment/notional rent incentives when moving practices into new accommodation; to include preferable alienation clauses, break clauses and service succession clauses obliging succeeding services to be delivered from the premises;
- Nationally procured property management contracts/services to ensure future management cost control; in addition to nationally benchmarked service and FM costs;
- New facilities must align with carbon-neutrality strategy, and this could be a driver for future investment to reach Net Zero for carbon emissions by 2030. The Decarbonisation Strategic Delivery Plan for NHS Wales sets out proposals which in require a fundamental shift in the approach to delivering healthcare;
- There is a challenge around owned practices with equity shortfalls (negative equity positions) moving into new facilities and diminished value of older clinical estate in residential and high street settings. Much of these perceived differentials are down to poorly managed buildings, a lack of maintenance and improvement in the asset, and the basis of valuation used by lenders valuers for determining Existing Use Value v Market Value, where a more standardised approach could lead to a reduced differential and less of a diminished return of older estate;
- Need a more coordinated approach to securing health facility investment as part of the planning process (LDP allocations/requirements, s106/CIL contributions, etc.). Limited flow through to health facilities observed versus education.

4.8 Potential way forward for future ownership

In light of the Scottish *National Code of Practice for GP Premises* and the NHS Wales Shared Services Partnership *Overview of General Medical Services Premises in Wales*, there are some aligned considerations that would provide feasible support to GPs in both owned and leased estate. Some of these considerations are as follows:

GP owned estate

- Consideration given to a more robust improvement grant scheme in select cases and on a discretionary basis, up to 100 percent grants;
- Grant scheme to be permitted to fund land and property and up-front design and professional fees;
- A Welsh Government loan / financing scheme for partnerships to support premises purchases and be transferable to contractor or owner;
- Loans to support practices in negative equity positions, for practices with retiring partners, premises whereby negative equity has occurred on interest only mortgages, and for poorly managed premises;
- Partnership Agreements to be linked to GMS contract and be a condition on granting new contracts that a robust and future proof Partnership Agreement to be put in place;
- A potential improvement fund could be set up to provide the opportunity for retiring GPs to reinvest sale proceeds into a fund for younger GPs to improve business premises.

GP leased estate

- Limited liability partnerships which seek to protect the members assets from the liabilities of the business. This can allow for greater flexibility in the management of the business due to the operation of the partnership and distribution of income. There may be tax benefits in registering as a company but will depend on personal circumstances;
- A limited liability partnership is not however as attractive to a commercial investor or private landlord as the rental reimbursement underwritten by personal liability of the GPs;
- The use of side letters or letter of intention can be used to provide assurance to the landlord that the Health Board will reimburse the current market rent, albeit in a non-binding measure;
- Rental Guarantee Agreements can also be used for the Health Board to guarantee the lease rent only, with the remaining lease obligations remaining with the GPs;
- Put/Call Option Agreements are also options that permit the assignment of the lease to the Health Board.

Reflecting the approach that the Scottish Government is taking with progressing a wholesale 25-year transition of estate from GP ownership and leased premises to Health Board owned and leased estate is ambitious and would resolve a number of the issues raised in this paper around existing ownership models.

A major consideration needs to be given to the resourcing of the Health Board if leases are being negotiated and transactions managed, sub-leases granted to GPs, the acquisition of alternative premises, and the acquisition of the freehold GP premises themselves. Consideration needs to be given to the funding of the programme, not from a capital funding point of view but the operational funding and resourcing of the HB organisation to follow through with an undertaking of similar ambition to the Scottish Governments plan.

With regard to the GP owned model, Archus considers that if the GMS contract structure, and the Premises Cost Directions were to be reviewed, with the assurance of robust Partnership Agreements, access to funding and property and business education for GPs and staff, the GP owned model could thrive.

Section 5. Roadmap to achieve optimum primary care estate across Wales

5.1 Introduction

The next step as part of the road map to achieve the optimum primary care estate across Wales will be to assess each Health Board's requirements based on the modelling examples of the local population, future demand by type, against the current facilities and future need. By using the standardized approach to facility type, size and service options available a road map can be planned and agreed. Once this is completed, opportunities to reduce the size and cost of the facilities described in section 2 can also be completed based again on the most appropriate offer of services needed for each area, and whether they should be remotely delivered or not (for example: larger numbers of younger people would benefit from accessibility to different amenities than areas of older populations – the use of virtual services may also be more widely accepted in some locations than others), these include:

- Increased virtual infrastructure for more flexible care delivery;
- Utilisation of the wider public estate;
- Widening access through uniform 7-day services provided by a multi-professional range of staff; putting national policy into practice across all facilities to ensure better utilisation available estate;
- Digitalisation and the impact this will have the total requirements of the primary care estate, by individual Health Board, using the 'step up' approach or facility types;
- Learning from the Covid 19 pandemic, consider balance of time within clinical facilities that could be accommodated for non-patient-facing workforce. Could a wider balanced model of home/practice working be explored that meets patient confidentiality requirements for reception, secretarial, care coordination and operational staff.

Next Steps Summary

- Greater degree of flexibility in hours of utilisation of capacity with cost and access advantages.
- Better digital enablement support for public and clinical staff.
- Confirm the true shortfall in community bases estate on a Health Board basis exploring its wider public assets that could be repurposed to support the proposed future mode of delivery of primary and community care.
- Completion of next steps plan by each Health Board.

5.2 Conclusions

In this report we have assessed the needs of the primary care estate and what is needed to deliver the right health care service in the right place for patients in Wales, that is both inclusive of and accessible to all and meets the standards as set out to meet the 10 commitments agreed in 'A Healthier Wales'.

The project is fully aligned to the principles of the Primary Care Model for Wales, in seeking to provide a whole system approach that demonstrates integration of health, local authority and voluntary sector services, and has facilitated collaboration and consultation to reach a consensus on the type of primary care provision that patients and staff would like to see that gives the best support to people, gives easy access to local services for care when needed and technological solutions to improve access to support self-care. Three important key principles for consideration of future developments include:

- Clusters of services should have a significant focus on how they will allow enhanced community-based services, through flexible facilities for multi-professional teams in accommodation that can house a broad range of local services and a widening of access for people to visible self-care. A significant focus for wellbeing services should be demonstrated to support key areas of need, such as for mental health.
- Analysis of the Nationally agreed direction of travel for health care in Wales has demonstrated that there is an overall view that Health Boards should take a population approach to developing clinical care services where there is evidence that local contexts and population health has been a fundamental consideration of how investment in services will meet residents' respective needs. In order for this to take place there should be;
- A nationally led system for regular review of the condition of the primary care estate to ensure that agreements for local primary care estates planning meets the motivations to deliver care differently and ensure the principles of sustainable estates provision are aligned with ambitions to be long term and in support of integration. A national collection of a common core estates data set would provide the essential data required to inform future investment prioritisation and decision making. The digital infrastructure is central to this and critical for a more efficient model of pandemic resilient estates capacity.

Building a baseline understanding for each Health Board of the current GP practice's and Health Centre's condition and capacity will enable prioritised actions and informed planning. Data will be key to helping the organisations understand their baseline levels of activity and assess their readiness to change. For larger premises baseline audits of activities already taking place can generate information on the use of the estates, practices behaviours and opportunity for change.

- By procuring 3-facet surveys for all Health Board and GP owned/managed buildings would give the full understanding of the extent of estate compliance and capability for future development. The data would enable a detailed analysis of the estate by Health Board against the cluster based proposed primary care estate model.

In exploring the range of opportunities to transform the estate to be capable of delivering this modern, optimised and accessible service a number of activities have taken place that provide an important foundation on which primary care services can be built. Central to this has been an extensive engagement programme to ensure the priorities being set for the primary care estate meet the understanding and requirements of local people. As a result of this, seven key principles were agreed including:

- The importance of establishing new facilities as a focus for the wider communities;
- The need to optimise use of the wider public estate;
- No one size fits all solution – there should be a menu of service offers depending on the type of facility;
- There is a need to move away from single partner pure GMS models in favour of more sustainable, collaborative, co-located multi-disciplinary services;
- The importance of equity for all patients in terms of access, service offer and environments;
- Recognition that urgent and community care pathways and care offers may need different pathways – co-located or otherwise;
- The solution to service challenges may not need to involve physical infrastructure.

It was also concluded from these discussions that organisations are all at different stages in embracing the changes to deliver services differently but where strategies are being adopted, they tend to be discrete and narrow in scope, rather than joined up as part of a cluster designed service and embedded as part organisational strategy. New approaches are often being applied in one area only and have not yet been evaluated systematically to understand how the spread of good practice will have the strongest impact on population outcomes.

Healthcare finance and lending has been assessed within the report looking across the range of models in place across the United Kingdom. A number of conclusions have been made including that Premises Cost Directions do not allow flexibility and that there may be more scope to change terms on a discretionary basis. The pros and cons of ownership models have also been explored giving a number of key points for Health Board consideration including that:

- A GP owned model would benefit from GMS contract, PCDs and partnership agreement review but it is still heavily reliant on RICS basis of valuation of the existing use vs the market value. A Health Board owned, or head lease model would provide GPs with the most comfort but that demand on resource to manage leasehold and freehold transactions appears limited at present along with Health Board funding to acquire freehold premises also appearing limited and if HBs take on head-lease roles with GP sub-leases, break clauses need to consider the potential complications around rights of forfeiture on leases with nil/£1 rents.

Whilst this report has identified a number of exemplar primary care services, it has observed the incredible range of exemplar programmes of new services and integrated care examples already in place within Wales, noting the excellent baseline to be built upon.

The importance of ensuring equitable access across a range of key groups has been a priority within these developments and has demonstrated how prioritisation has been met to achieve the best outcomes possible.

- When taking these models in to a cluster-based arrangement, it demonstrates that whilst the scale of those featured in every locality would not be a sustainable option for investment, they can be part of a group of services and facilities working together through a hub and spoke model to provide the range of services needed across a Health Board and localities within it.

This report has identified where opportunities for how practices working in clusters, both now and in the future can support a wider networked range of services for people no matter where they live, ensuring early and ease of access to health care. Adopting new ways of integrated working and agreeing what premises or services are needed in each Health Board will require careful planning and implementation. Investing in resources in areas of most need will require balancing of priorities to demonstrate how the improvements will be demonstrated.

High level examples of the use of mapping of demographics supported by disease profiling have been completed as a part of this report. This analysis will support individual Health Boards to create an accurate analyse of their local population densities and needs to plan how and where future service provision is best placed. By taking these maps and completing more detailed disease profiling, future planning of service delivery options and sites cannot only be planned in the short and longer term, but the sites of service delivery can also be assessed particularly in relation to alternative areas for the smaller services and where they may be delivered from, such as health facilities, pharmacies, local sports/wellbeing facilities, dentists and other local amenities.

- By affiliating the principles of sustainable estates across clusters, linking it to the population needs locally and the required health improvements it will ensure investment plans are aligned and meet short-term requirements and longer-term improvements to population health.

We have cited numerous resources and tools throughout this report to help put these into practice and develop a consistent approach for each Health Board.

Section 6. Recommendations

Recommendation 1 - Investment in a suitable platform for data analysis

Investment is required into a suitable platform to hold the Wales National Data set as to provide ongoing assessment at a national and local level. The SidM Health model has been trialled by the project team to support this first phase of work and it is recommended that the capabilities of this system are further explored to understand the benefits and opportunities such a system could deliver as part of the design for future investment prioritisation processes.

It is recognised that some of the information required within the data may be considered by the British Medical Association (BMA) as contractually sensitive. Therefore, a robust communications plan and explicit arrangements for carrying out data collection, including approach to managing statutory and/or contractual compliance failures are essential to engage with the BMA at an early stage to inform why this process is required, the benefits and risks for GPs and to seek their formal support.

The table below shows the recommended core national data fields in principle and the reasons why they should be collected.

Table 4: Recommended National Core Data Fields

Category	Sub-item	Why we need this
Tenure	Practice address and code	Location estate asset information will aid neighbourhood place based strategic planning and understanding of clusters
	Parent practice and branch	Location estate asset information will aid neighbourhood place based strategic planning and understanding of clusters
	Practice catchment and cluster boundaries	Illustrates approx. travel distances for registered patients to access primary care services. Will also identify cluster boundaries to support mapping and to inform strategic planning
	Age range of GPs and numbers of partners	Identifies sole traders and practices where partner/s are within 5 years of the national retirement age, which is a factor in practice longevity and informs workforce plans
	Freehold / leasehold / licence / undocumented	Highlights indicative commercial arrangements for asset ownership and outline of likely associated commercial approach to inform strategic planning
	Lease events (if documented)	Highlights any lease break clauses/ earliest opportunity to terminate/renew lease to inform strategic planning

Category	Sub-item	Why we need this
	Name of landlord and tenants (DV data)	Indicates Initial commercial complexities that will need to be considered if changes to primary care asset base is required
	Name of Freeholder	Understanding of third-party arrangements, not directly linked to NHS service contract
	Rent Review patterns	Basic estate information to identify potential future financial pressures
	Opening hours outside core hours/ any closures during core hours	Ability to alter operating hours to meet needs of local population / GP network contract
	Age of property (suggested bandings)	Pre 1948; 1948 to 1954; 1955 to 1964; 1965 to 1974; 1975 to 1984; 1985 to 1994; 1995 to 1999; 2000 to 2004; 2005 to 2014; 2015 to 2024
Building Information	Area, GIA, NIA	Ability to compare size against patient list size, thus enabling ability to carry out desk top study on potential utilisation levels
	Approved primary medical services space (GIA, NIA) - need clear definitions and in line with ERIC	Provides an understanding of capacity which may be available for service provision over and above that which is approved for GMS use
	Number and type of rooms / services	Highlights number of clinical rooms to meet needs of patient list size. Provides an understanding of the proportion of clinical space vs administration and patient circulation
	CQC commentary (majority do not focus on premises)	To assist with evaluating future funding requests and to inform sites at risk and non-compliant to inform strategic planning and capital investment
	Number of key rooms, consult / treatment / specialist i.e. minor injuries / X-ray etc.	Highlights number of clinical rooms to meet needs of patient list size. Provides opportunity to inform patient capacity and future design of primary care premises
	Number of key rooms, consult/treatment for primary medical service provision for registered patient list size	Highlights number of clinical rooms to meet needs of local cluster population. Provides opportunity to inform patient capacity and future design of primary care premises.
	Number of key rooms, consult/treatment/specialist/registered patients of the cluster	Highlights number of clinical rooms to meet needs of local cluster population. Provides opportunity to inform patient capacity and future design of primary care premises.
Estates Condition Information	3 facet information (physical condition, functional suitability & statutory compliance)	All 3 facets will be helpful. Full 6 facet will be reliant on additional data being provided by the GPs, which is likely to be met with resistance and will undoubtedly offer an incomplete return

Category	Sub-item	Why we need this
	Cost to bring up to condition B – needs to include fees, decant costs and VAT	Informs/ supports investment planning/ high level VFM testing
Occupancy Costs	Annual property cost	Revenue implications of infrastructure will inform high level planning cost implications.
	Rent reimbursement (rent, business rates, water and clinical waste)	Revenue implications of infrastructure for NHS England will inform high level planning cost implications
	Non-reimbursed costs, services charges etc.	Revenue implications of infrastructure will inform high level planning cost implications
GP Service Contract Information	Existing Contract Information	Maximum length of contract, including any service break clauses, identify any time limitations to contract arrangement.
	List size published by NHS England	Informs planning regarding number of GP's, size of practice at potential utilisation levels
	Weighted list size held by NHSE	Provides information to support use of premises and takes into account likely demands of registered patient list, according to public health/demographics
	List size of cluster held by NHSE	Provides information to support use of premises and takes into account likely demands of registered patients in the cluster, according to public health/demographics

Recommendation 2 – Individual next steps Health Board Primary Care Estates Plan

It is recommended that a geographical area is identified and piloted prior to roll out of a full-scale primary care estates and service planning project being commenced per Health Board.

The output of this will be to establish condition and capacity of current facilities by locality and by type. This detailed estate baseline will be supported by a health care planning assessment of demographic and disease profile analysis to profile healthcare need as well as projections to understand how that need may translate into demand with underlying activity projections. This analysis will specifically target the burden of chronic conditions in the community.

Through stakeholder discussions and structured 'co-creation' sessions, models of care and care pathways will be mapped out to demonstrate how that need and demand can best be met within a primary care setting. These models will illustrate the flow of activity into primary care settings to inform capacity and configuration of primary care facilities as well as setting out what can be delivered in a home environment. These models of care and underlying analysis across a Health Board will also set out the likely changes in demand for routine and specialist services.

Using the stepped approach to model types of facilities required (Hubs, local centres, at home etc) against these population requirements then the options for clustering services into different primary care facility types can be demonstrated.

Recommendation 3 – Construction of a prioritisation framework for investment

As described in the report appendices it is recommended that this framework is used as a part of the outputs of the data collection and facet surveys to enable future planning against these identified needs – as well as allowing assessment against existing health property options across Wales. This may be extended to view all options across Health and Council services to fully explore options for service delivery. The prioritisation framework can be adapted to suit individual Health Board needs and would be utilised as part of the recommended pilot.

Recommendation 4 – Create a Wales wide ownership strategy

The gap analysis has demonstrated options for future ownership of premises and the support services required. The appraisal of these options will lead to a Wales wide strategy and provide a trajectory for future ownership models. The Wales wide ownership strategy would provide a trajectory for where the form of Primary Care ownership could end up.

Four key models will be investigated with the policy and financial implications (including funds flow) mapped out for each. The four models to be analysed will be:

- NHS owned and leased (by Health Board);
- GP owned and reimbursed;
- Private sector landlord owned and leased;
- Joint Venture model between Health Board and Private Sector investor/developer (aligned with Mutual Investment Model).

For the private sector landlord model there will also be an illustration of funds flow and lease options where a GP Practice and/or Health Board leases premises in an existing building; for instance, in an ex-retail unit, where such models can help with revitalising high streets and attracting footfall and offering convenience.

The strategy would provide an assessment of what Health Boards would need to do to take on ownership of assets, plus the resource required to negotiate and manage the leasehold transactions to become head lease in the instance GPs enter into sub-leases. To manage the GP owned estate, guidance will be provided to determine potential changes to GMS contracting structure and prevailing Premises Cost Directions if freehold interests were retained by practices, in order to provide an environment that is more attractive for new GPs to seek funding and or buy into partnership agreements.

Recommendation 5 – Create a Wales wide funding and accounting review

To tie in with the Ownership Strategy, this funding and accounting review would investigate the provision of grant funding to GPs and how this aligns with Premises Cost Directions, particularly regarding energy efficiency works and compliance with MEEs. Alternative forms of lending that do not require onerous forms of personal security of the GPs, plus an accounting review to determine IFRS 16 implications on leasehold transactions, assignments and the use of side letters and put/call options agreements for example.

The JV model will be assessed against the contractual and commercial structures set out in the Mutual Investment Model and will establish whether this approach is appropriate and applicable for primary care investment across Wales.

The final element of the review would be to assess VAT implications of GP 'propco' led new schemes from a capital cost and notional rent perspective, versus third party development and privately owned estate.

Schedule of figures

Schedule of tables

Archus

The healthcare infrastructure specialist

Appendices

Appendix A – Health Board Summaries

Contents

Health Boards – Summary findings

Health Board and Local Authority meetings were undertaken to understand the status of their estate strategies and consider any opportunities for co-location of facilities in the future. Surveys captured the views of the public and GPs on current primary care premises and service provision. They were issued via Welsh Government and NHS Wales Shared Services Partnership.

Aneurin Bevan University Health Board

Population factors

The demographics of Gwent are varied and include rural countryside areas, urban centres and the most easterly of the South Wales valleys, in which 6 in every 10 were of working age. The population is distributed throughout the region as follows:

- **Blaenau Gwent**
  - Population of 69,674;
  - With identified high levels of unemployment and high percentage of people who are dependent on benefits.
- **Caerphilly**
  - Largest population in Gwent of with 179,941 residents;
  - People widely dispersed amongst fifty small towns and villages with significant levels of unemployment and poor health.
- **Monmouthshire**
  - Population of 92,336;
  - Lowest level of unemployment in Gwent but with pockets of significant deprivation.
- **Newport City**
  - Third largest urban centre in Wales with a population of 146,841;
  - Second largest number of people from minority ethnic communities of all the Welsh counties (after Cardiff).
- **Torfaen**
  - Population of 91,609;
  - Largest number of traveller caravans recorded during January 2016 Bi-annual Gypsy and Traveller count.

The population aged under 16 has decreased by 2,700 between 2005 and 2014, from 114,000 to 108,300 with nearly 1 in 5 were aged under 16. Overall Gwent has an aging population, this is lower than the national rate increasing age profile and with significant residential development in the suburbs of Newport likely to see an ongoing increase in migration among working age families.

Health and well-being

Overall, the health status of the population across Gwent is slightly worse with 22% of people describing their health status as being fair or poor compared to Wales (19%).

17% of the Gwent population identified that their day-to-day activities were limited due to health problems or disability lasting (or expected to last) at least 12 months - this is compared to a Wales figure of 15%.

The burden of health needs for the region is broadly aligned with the national average with the Gwent wide population reporting 52% of adults reported currently being treated for an illness (compared with Welsh average of 50%) with:

- 21% of adults currently being treated for high blood pressure (Wales 20%);
- 15% for a respiratory illness (Wales 14%);
- 14% for arthritis (Wales 12%);
- 14% for a mental illness (Wales 13%);
- 9% for diabetes (Wales 7%).

A key observation relating to epidemiological factors for families is that, for some children with complex health needs, suitable/specialised provision of support is sometimes only available out of their county which can be:

- Very costly to local authorities;
- Become isolated from their professional and social networks;
- In some cases, for children placed away from their homes;
- Children and families benefit from services being delivered as close to home as possible to maintain essential and important connections with support networks, and other local services.

Older people

As identified through ONS data, the number of people aged over 85 in the UK has doubled in the past three decades and by **2030, one in five people** will be over 65. Wales already has a higher proportion of people over 85 than other parts of the UK, so the need for change is more significant:

- the percentage of 85-year-olds is set to increase by 90% by 2030
- growth of 30-44% of people living with dementia
- significant decrease in the under-75 mortality rate:
  - 17.1% for males;
  - 17.4% for females.

Current local estates challenges

The Health Board are in the process of establishing the current condition of their primary care estate but have already identified likely requirements for building expansions. A significant proportion of the existing primary Care premises are not felt to be adequate either in terms of condition or functional suitability as many services are housed in building built in the 1960s-70s.

Practice sustainability has become less of a concern in recent years, but the Health Board continues to monitor closely the status of single- handed practice and would be in favour of developing a sustainability matrix to evaluate the status of local provision.

Other challenges reported include:

- Variable access to reliable highspeed WIFI and integrated digital systems solutions;
- Community projects have been hampered by limited access to carer support for those with additional needs especially for personal care when visiting community facilities;
- Cultural and design factors have had an adverse impact on establishing integrated provider models. Not possible to share areas due to how the buildings are structured which is in discussion to redesign the space;
- Larger properties do not benefit from single management arrangements for communal space and so this is not always well maintained or utilised.

Opportunities and priority investment areas

The ABUHB primary care estates strategy focuses on Transforming Clinical Services, in particular:

- The provision of care as locally as possible – out of hospital services;
- Integration of services from across health and social care;
- Co-location of services alongside other public sector services such as libraries, citizens advice bureaus, community cafés to create a hub model with fewer 'front-doors' to access services;
- Development of 'Hubs' – with support from wider health services and Community Resource Teams aligned to each hub/place to enable closer working with primary care services.

The Health Board hopes to move away from isolated single-handed practices and to increase the skill mix in Primary Care; with an aim to ultimately reduce the gap in GP provision generated vacancies and reliance of locum and agency staff; finally, the hope to build on the current emerging models of effective care navigation to ensure patient access to services in the 'Right place, first time'. Work to date in this area includes:

- Ensuring equitable local access via a visible local directory of services;
- Service staff have specialist care navigation training.

The Health Board has also focused significant investment in care coordinators to help people before going to GPs. These care coordinators sit in the practices and the Health Board pays the practices to employ them in the end. Further work is required to assess and evidence the overall health benefits of this service.

In order to pursue a period of transparent estates rationalisation the Health Board aims to assess the impact of LDPs and population growth and take steps to determine sub-NCN 'places' where primary care and community services can determine clear boundaries and collaborate, reducing duplication and share resources.

Digital innovation and technological enablement

Over the course of the pandemic there has been a concerted effort to promote digital solutions, but it has taken both clinicians and the public a while to get used to virtual models of care. Digital equipment has been given out on loan to support more isolated members of the public and the provision of Echodot stye devices have proved efficacious in reducing loneliness, appointment attendance through programmed reminders and supporting users to access food and nutrition advice.

There has also been positive feedback regarding the virtual coffee groups and virtual crochet groups established but there are challenges establishing these groups as self-run once set up by public sector bodies.

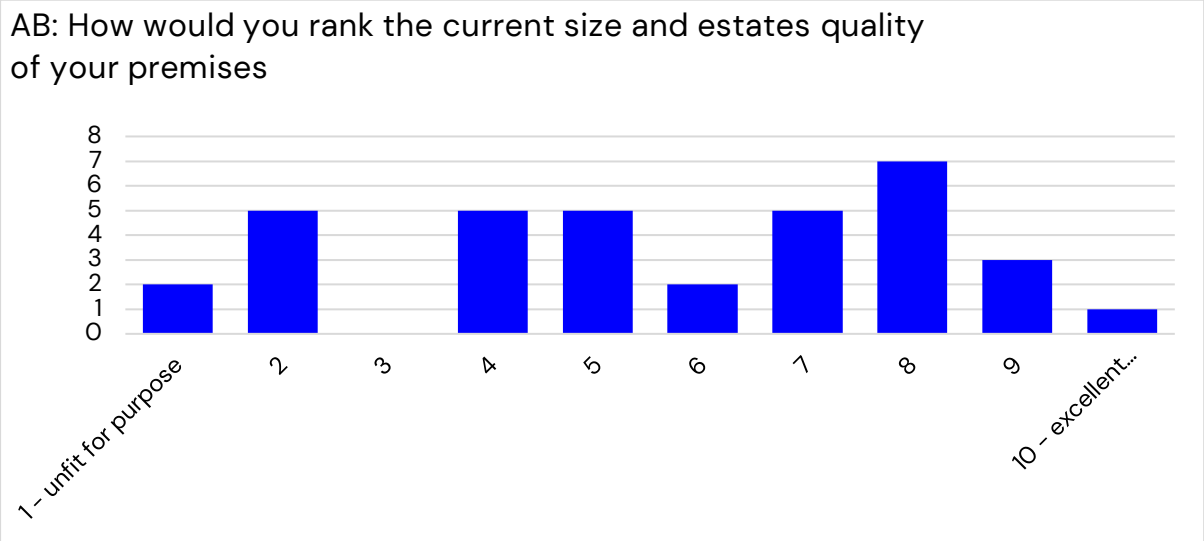
Frailty programme in Gwent

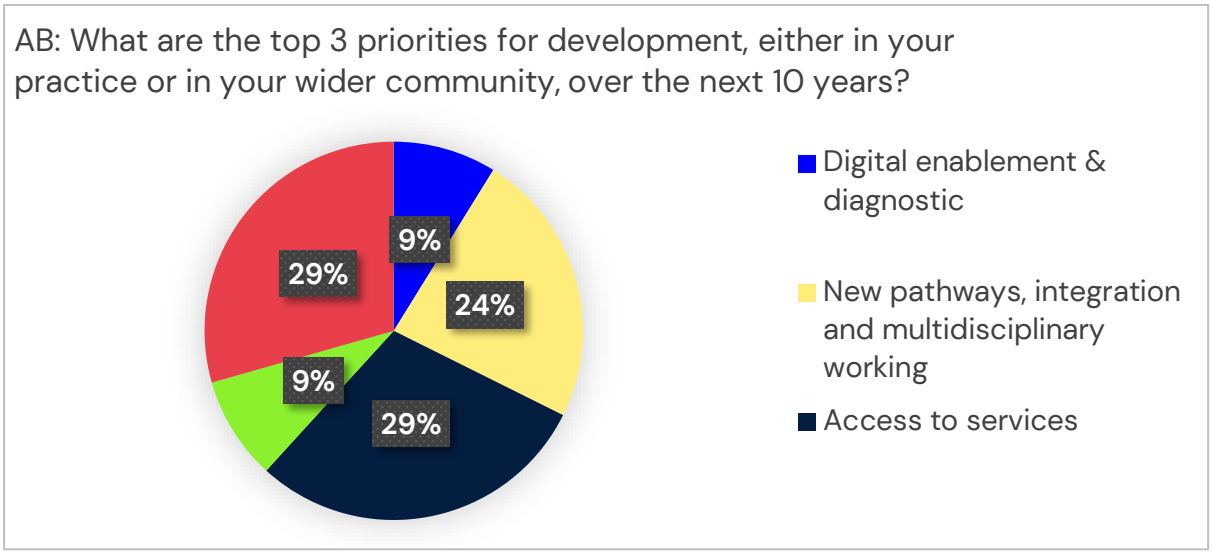
This scheme seeks to establish extended roles to support GPs, under a rapid response model facilitated by MDTs and AMPs. Frailty assessment beds can be freed up in hospitals where it is suitable for patients to be assessed at home. Further education on optimal referrals routes and discharge liaison is still required.

In addition to these identified areas, wider priority outcomes that have been identified from engaging with citizens, partners and through formal consultations include:

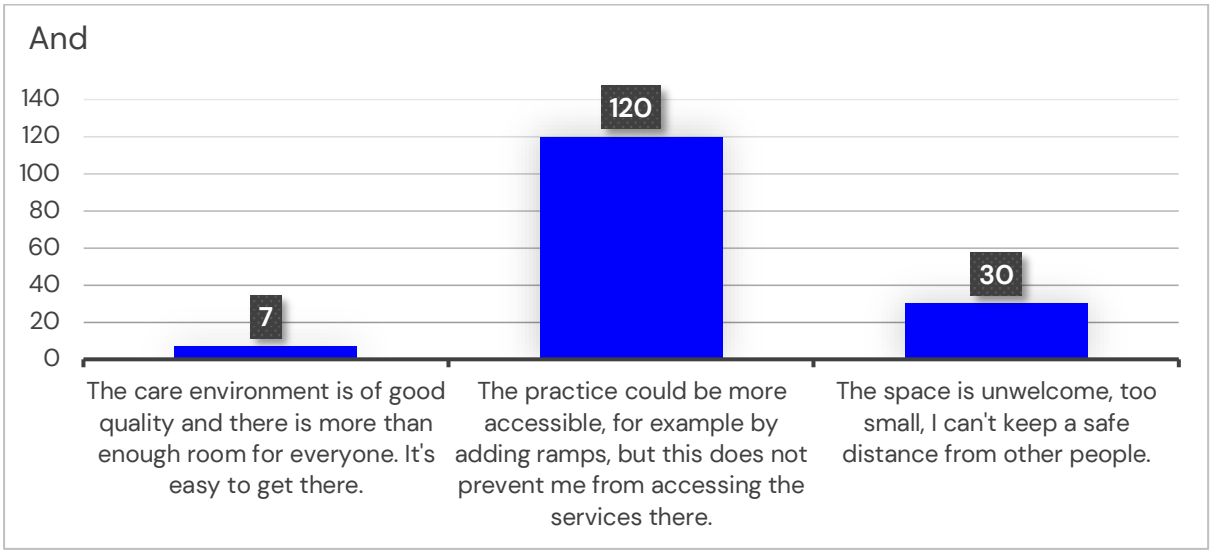
- To improve outcomes for children and young people with complex needs through intervention, community-based support and placements closer to home.
- To ensure good mental health and emotional well-being for children or young people through effective partnership working.
- To support disabled people through an all-age approach to live independently in appropriate accommodation and access community-based services, including transport.
- To help people reduce the risk of poor health and well-being through earlier intervention and community support.
- To improve emotional well-being for older people by reducing loneliness and social isolation with earlier intervention and community resilience.
- To improve outcomes for people living with dementia and their carers
- Appropriate housing and accommodation for older people.

GP Engagement





Public Engagement



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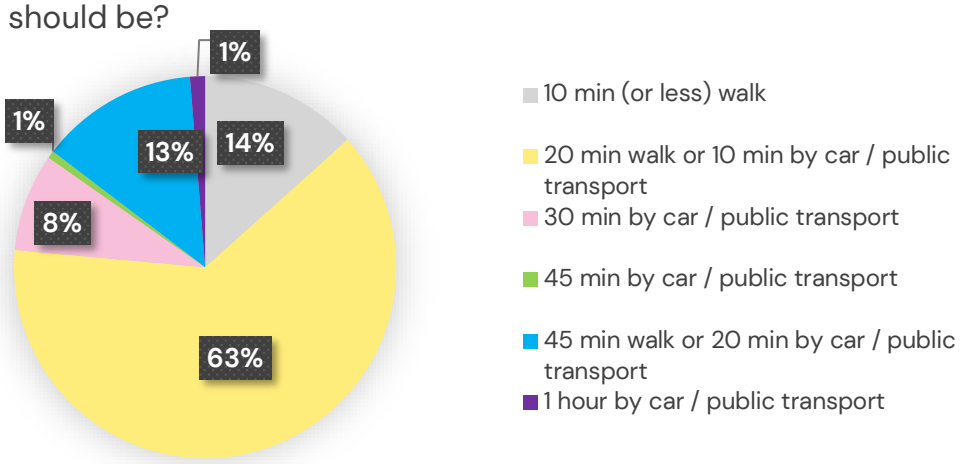

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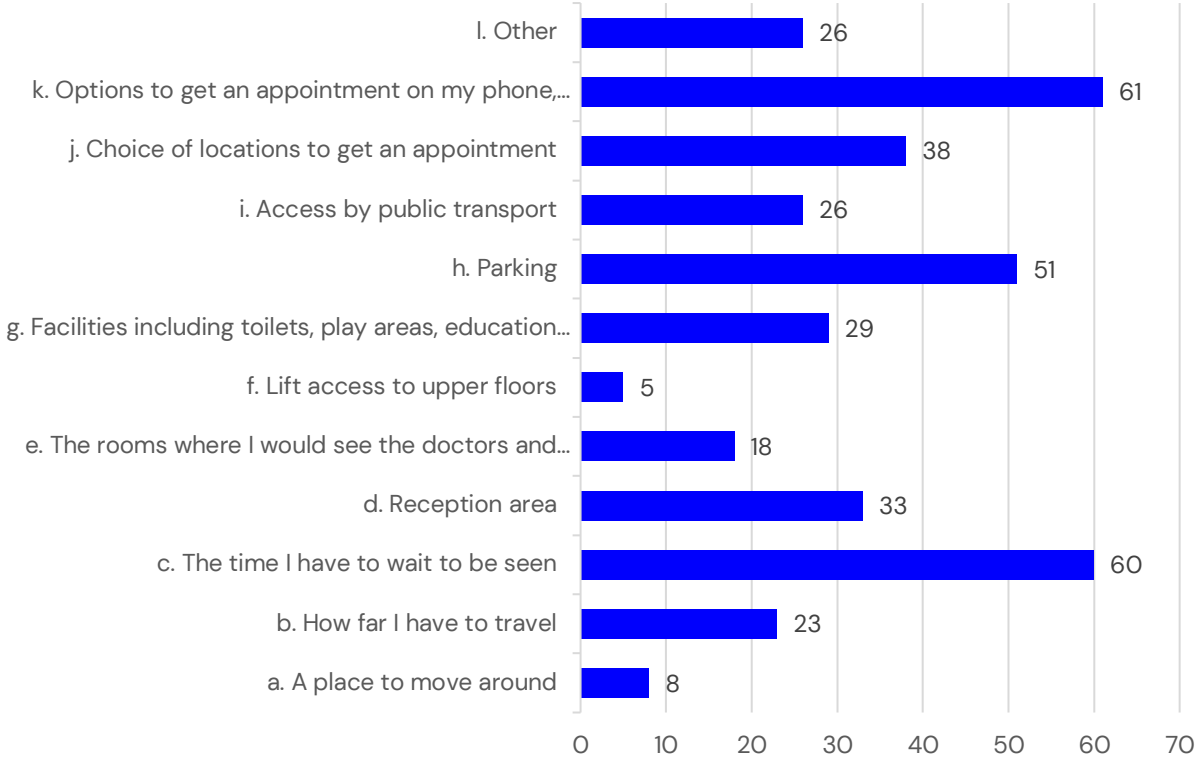


Betsi Cadwaladr University Health Board

Population factors

Approximately 690,000 residents live in Betsi Cadwaladr, made up of 6 localities; Anglesey, Denbighshire, Conwy, Gwynedd, Wrexham and Flintshire; the most densely populated area. Projections predict an increasing ageing population, showing a 155% increase in the population aged over 85, whilst the proportion of people under 16 decreases.

Overall life expectancy is higher than the average in Wales, but an inequality gap remains; 12% of the population live in the most deprived communities, compared to 19% across Wales.

Children and Young People

With regards children and young people, there are a number of important population health and wellbeing observations:

- 5% of babies in Betsi Cadwaladr (BC) are born with a low birth weight;
- Betsi Cadwaladr has the second highest rate of infant mortality across Wales and is just above the Welsh average;
- 25% of children within the region are overweight or obese;
- More than a quarter of 16 to 24 year olds smoke; among 11 to 16 year olds, 3% of boys and 4% of girls smoke. This is considerably higher than both national and UK averages;
- The rate of children in need was lower in BC than across Wales; 200 children per 10,000 vs 260 children per 10,000.

Mental health

People in Betsi Cadwaladr report slightly better mental health than in Wales overall. In contrast it is predicted that the number of adults with ill mental health is likely to increase from 93,000 to 99,000 by 2035, which may be worsened by unemployment and reduced incomes initiated by the recession caused by the pandemic.

The rate of patients being admitted to mental health facilities is reducing, yet it is anticipated that a high number of people with mental health problems do not seek help or may be unable to a be unable to access support in via the route they would prefer.

Older people

There are more than 150,000 people aged over 65 living in Betsi Cadwaladr, which is projected to increase to 210,000 by 2039.

- Rates of dementia in BC are predicted to affect 11,000 patients, based on dementia-registered patients and projections.
- Rural and coastal areas are heavily populated by the retired population.

- There are approximately 40 available places in care homes per 1,000 of the population over 65 years.

Current local estates challenges

Services are delivered from 173 properties across North Wales, challenges include:

- Age, design and resilience of the engineering infrastructure is not fit for purpose, up to standards (i.e. infection control) for several sites, e.g. Ysbyty Gwynedd (YG) and Wrexham Maelor hospital (WMH);
- Abergele and Llandudno hospital are at risk of inability to sustain surgical interventions;
- The current challenges and risks for many of the sites, together with the size of the portfolio and the expected future funding means that the current estate is not sustainable or viable in the long term and will not support the implementation of Living Healthier; Staying Well;
- Identified comparative weaknesses in the public transport infrastructure across the region but strong community transport (but not consistent across the areas).

There is a reported ageing workforce of GPs and this may translate to an increasing of ending contracts in future years. A concern has been raised that the COVID period may result in an increasing rate of retirements. The Health Board monitor the age profile of the clinical workforce closely as a matter of high priority sustainability risk.

Lastly there is a challenge regarding the provision of cluster prioritised multi-professional services as there are still a number of small facilities that are not conducive to hosting non-GMS services.

Opportunities and Priority Investment Areas

The BCUHB primary care Vision is to "lead the way on integrated care, supporting health improvement for the population now and in the future". In March 2018, the Board approved its long-term strategy – entitled Living Healthier, Staying Well (LHSW; defines our future models of care delivery) - based on 3 based on three overlapping major programmes:

- Improving health and reducing inequalities: delivered in a range of settings including public community facilities, e.g. libraries;
- Care closer to home: designed to fit with the primary care clusters and meet the population need;
- Excellent hospital care: 3 main sites Bangor - Ysbyty Gwynedd (YG), Bodelwyddan - Ysbyty Glan Clwyd (YGC) and Wrexham Maelor Hospital (WMH).

LHSW aims for an integrated approach working with local authorities and third sector, with 14 primary care clusters providing access to more specialist services avoiding

hospital attendances. In addition to this core programme a number of other priority areas for development have been identified:

- Mental health, learning disabilities and substance misuse: mental health strategy promotes a model of care that seeks to support prevention, early intervention and support within the community;
- Maximising the utilisation of clinical support assets and consideration of estates reconfiguration impact upon other major capital assets, such as Linacs replacement, MRI and CT capacity and replacement programmes;
- Corporate estate and reducing impact on the environment;
- Integration / co-location of public sector hubs – asset management group are currently looking into where public sector estates can be collaborated in North Wales;
- Service transformation plans are on-going with respect to Stroke, Urology, Breast, Ophthalmology and Pathology services.

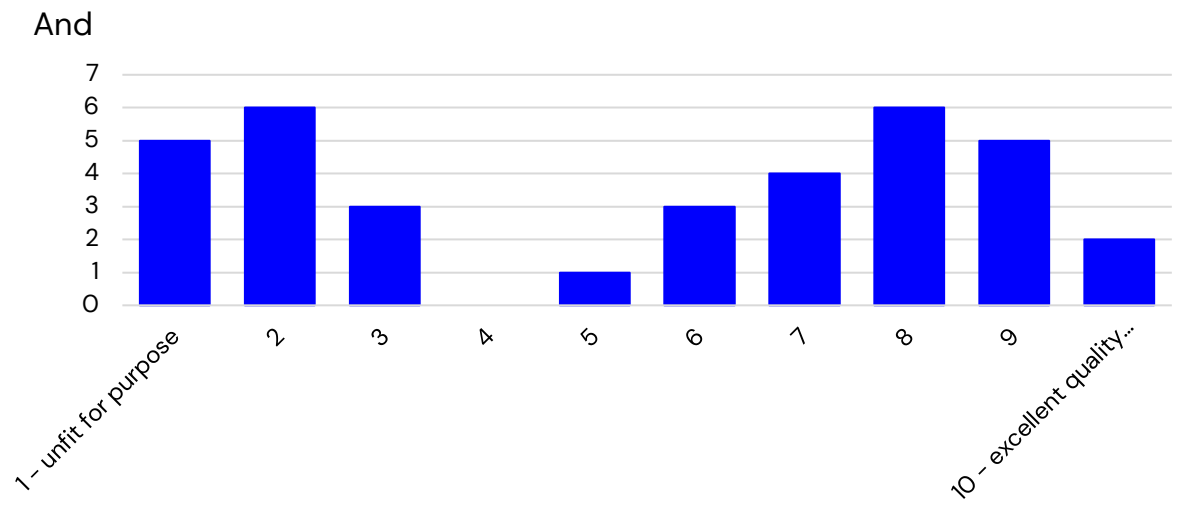
There are numerous exemplar schemes already underway across the region including:

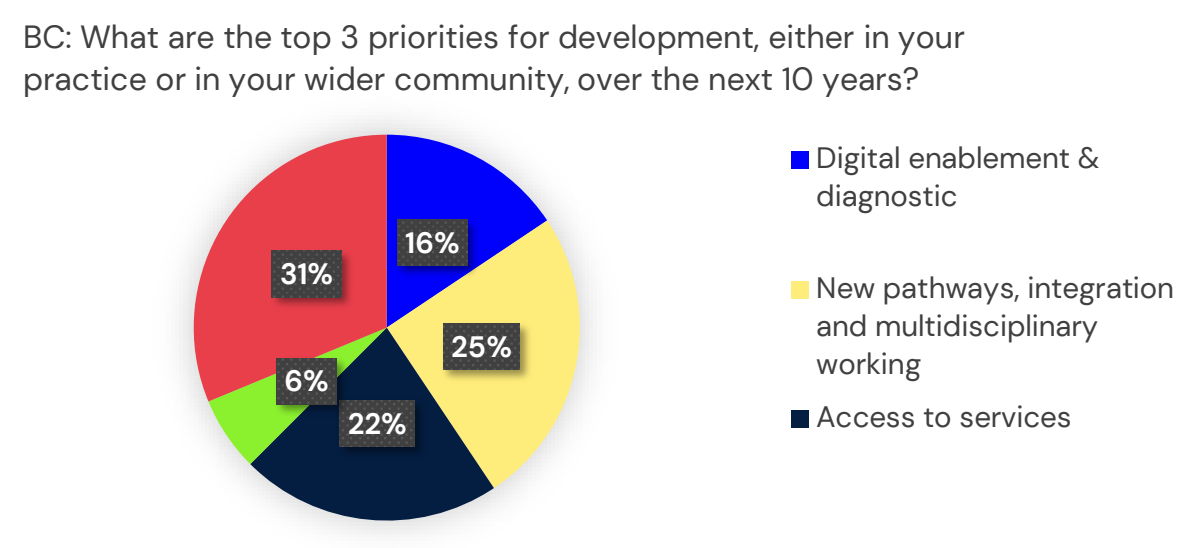
- Primary and community care academy – sustainability of workforce; developing workforce for PC (specialist), recruitment/retention, research and innovation.
- Healthy Prestatyn (large managed practice) – 3 Practices ended contracts simultaneously. This then led to the development of a model of care on NBTs and social model of care which fed into primary care for Wales.
- Strong relationships with LAs: community resource teams take a holistic view at cluster level.

Digital Innovation and Technological Enablement

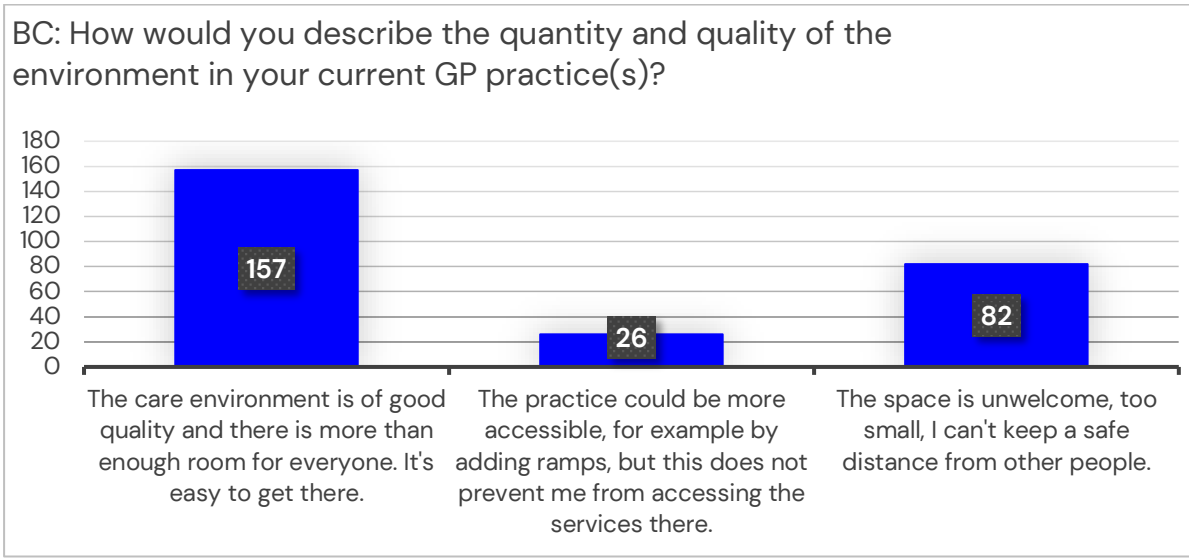
There is ongoing consideration of importance of facilities/estates in comparison to digitally delivered services. Lessons have been learned over the course of the pandemic: mixed response to digital engagement has been observed, with a 20% increase in engagement during the Pandemic (including digital consultation).

GP Engagement





Public Engagement



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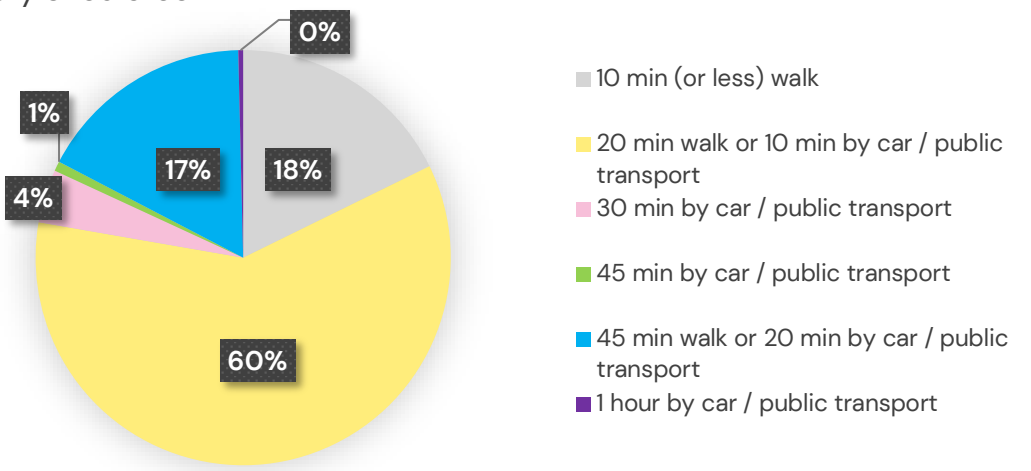

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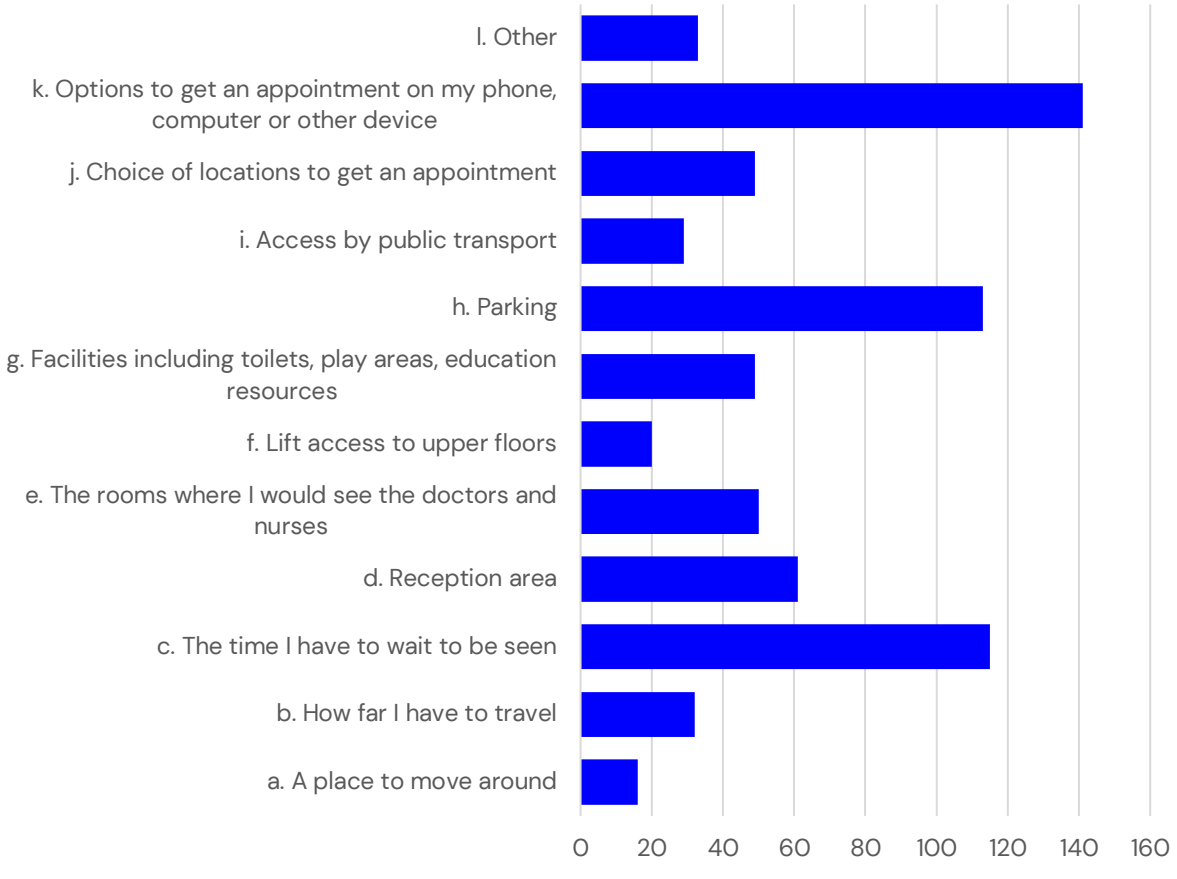


Cardiff and Vale University Health Board

Population factors

In 2015, the estimated population in Cardiff was 357,160 and 127,592 in the Vale of Glamorgan, with the population in the Vale and Cardiff projected to increase by around 1% and 10% over the next 10 years, respectively. In general, Cardiff has a younger population, reflecting a significant number of students who study in Cardiff, while the Vale's population has a larger older age population more in line with the Wales average. In both areas however, there is projected to be a continued increase in the number of people aged over 65, and over 85. The Vale has a relatively stable population size which reflects a low net migration rate, and roughly equal birth and death rates.

Forecast growth indicates that an extra 35,000 people will live in and require access to health and well-being services. The population of South Cardiff is ethnically very diverse compared with the rest of Wales, with a wide range of cultural backgrounds and languages spoken.

The tables below highlight the projected percentage increase in population over 3,5 and 10 years from 2016. (2014-based projections).

Cardiff

	Projection year		
Age group	2019	2021	2026
0-4	1.1	3.8	11.7
5-16	6.4	10.3	16.0
17-64	1.5	2.5	5.4
65-84	5.7	9.5	23.1
>84	7.2	12.5	26.6
All	2.7	4.6	9.8

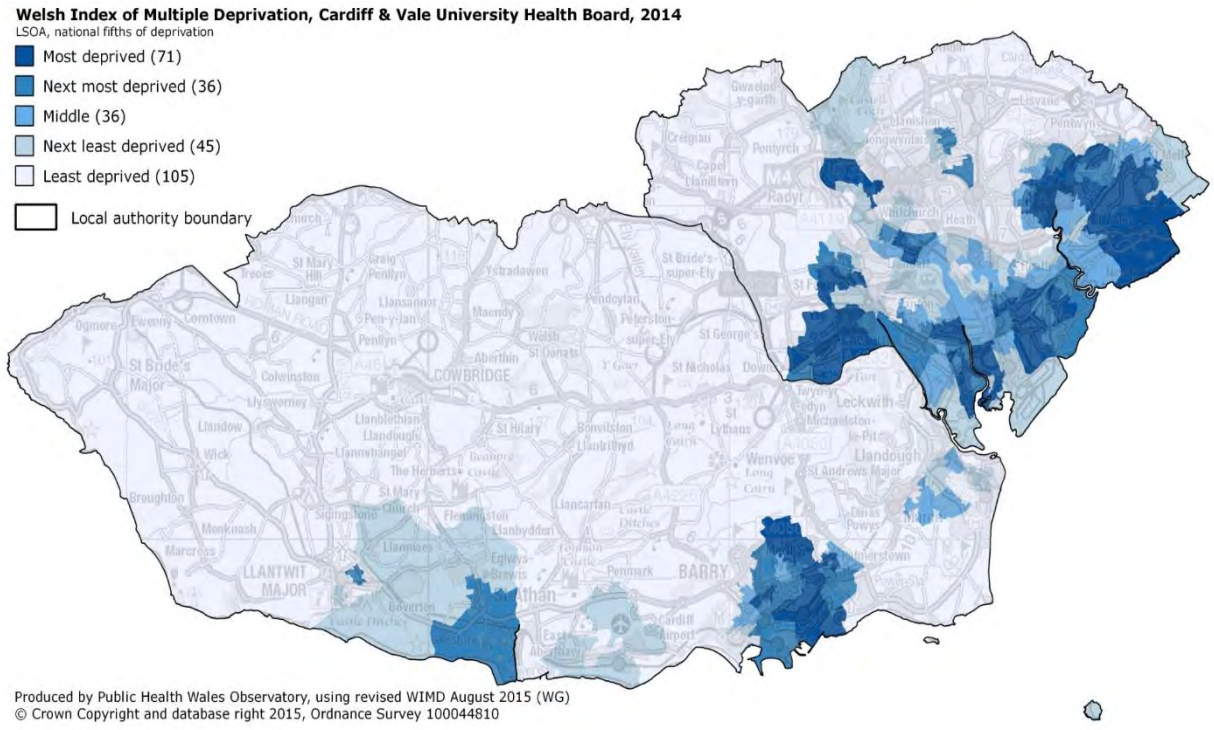
Vale of Glamorgan

	Projection year		
Age group	2019	2021	2026
0-4	-3.2	-3.4	-3.8
5-16	1.4	2.2	-0.3
17-64	-1.6	-2.8	-5.5
65-84	5.9	9.7	19.5
>84	7.1	13.0	36.2
All	0.3	0.6	1.0

Inequalities

While Cardiff and the Vale are home to some of the most affluent parts of Wales, they each also have area of significant deprivation, with the gap showing no signs of reduction. Cardiff has the third highest proportion of most deprived local areas out of all local authorities in Wales, behind Blaenau went and Newport, with over 1 in 6 people in Cardiff living in these areas.

For young people under 18, this proportion rises to nearly a quarter. Many of the more deprived areas are in and around south Cardiff, contrasting with the northern half of the City. Within the Vale, 14% of local areas are among the most deprived in Wales, clustered in the central Vale around Barry, but there are also significant pockets in the Western Vale too.



Inequalities are seen across health behaviours and outcomes, too. For childhood immunisations, for example, there is a significant variation in uptake by area of residence. People living in more deprived areas are more likely to attend the Emergency Department than those in less deprived areas.

Burden of Disease, Health Conditions and Physical Disabilities

At the most reported period, over 30,000 people in both classified themselves in 'bad' or 'very bad' health, a rate of 6.4%. Within Cardiff, many parts of South Cardiff have higher recorded rates of disease than the Wales average, with particularly high rates of diabetes recorded in Cardiff City and South. In the Vale, Eastern and Western Vale have lower rates of chronic illness than the Wales average, in marked contrast to Central Vale, which is above the average for all chronic diseases, with the exception of heart failure. In terms of specific categories of disease:

- Heart disease, lung cancer and cerebrovascular disease are the leading causes of death in men and women.
- There are a number of people living with dementia, which is projected to rise significantly. The driver for this is mostly the increase in the over 85 population.
- Around 1-in-5 adults have visited their GP within a two-week period; and nearly three quarters visit a pharmacy over a year period. The highest rates of attendance at the Emergency Department are from people living in more deprived areas of Cardiff and Vale. Regarding the relationship with wider care services:
- In 2015-16, there were 54 delayed transfers of care in the Vale of Glamorgan, and 263 in Cardiff. In December 2016, this equated to 3% of Cardiff and Vale UHB beds which were occupied as a result of a delayed transfer of care.

- The rate of delayed transfers of care was higher in Cardiff (17.8 per 10,000 people aged 75+) and the Vale (18.1 per 10,000 people aged 75+) compared with Wales (15.1 per 10,000 people aged 75+) The rate was particularly high for mental health beds.
- The Cardiff Council Reablement service helped around three quarters (76.6%) of people achieve independence who accessed the service. In the Vale of Glamorgan, 80% of people who access the service report increased independence.

Mental Health and Wellbeing

The self-reported mental well-being in Cardiff and Vale UHB area is in line with the Wales average, although this doesn't factor in the slightly lower score in Cardiff compared with the Vale. Consistent with this, UK-wide self-reported happiness scores in 2015-16 were slightly above the average of 7.5 out of 10 in the Vale of Glamorgan (7.68) but below the average in Cardiff (7.41). However, these figures are subject to considerable annual fluctuation.

In contrast, benchmarking data in 2014 showed that the Adult Community Mental Health Team caseload per 10,000 people (weighted population) was 147 within Cardiff and Vale, similar to the UK average of 140.

Within the service, there were 252 contacts per whole time equivalent member of staff, compared to 240 across the UK. The number of admissions per 100,000 people was 245 locally, compared to 234 across the UK. Bed occupancy in Cardiff and Vale was 115%, whereas across the UK it was 91% on average. Rates of hospital admissions for mental health issues in Cardiff and the Vale (26.3 per 10,000) are below the Wales average (31.6 per 10,000 population).

Current local estates challenges

The Shaping Our Future Wellbeing programme business case sets out a number of core priority areas to be addressed by the planned developments:

- **Need to improve patient experience** accessing hospital focused outpatient services;
- **Further co-ordination across care pathways** and organisations;
- **Need to make provision of additional support** for people in the community;
- **Workforce largely designed to deliver a traditional hospital focused service;**
- **Technology requires advancement** to meet needs of a modern health service;
- **Poor condition and functionality** of much of the community estate;
- **Poor location of Health Centres** not located to support population growth;
- **Insufficient physical capacity of many GP surgeries**.

In terms of the current ownership models there is limited confidence as to who is paying for what part of the Primary Care premises. There is a view that GPs may not be paying the true cost as they are not paying for the extra service provisions. The rent gap is felt to be substantial from relocation between sub-optimal health centre locations to brand new, purpose built, facilities. The Health Board has in many cases absorbed these costs.

Challenges have been identified regarding GPs ability to meet statutory backlog maintenance responsibilities and the GPs have increasingly requested support in meeting these and are reluctant in some cases to self-funded upkeep of the buildings. There is a view that GPs should be responsible for the engagement of the leases with 3rd party but, in some cases, practices have deferred to the Health Board to provide these service functions or advisory support.

Analysis of primary care data showed that a large proportion of GP practices were made from single GPs, providing services in older domestic buildings of converted semi-detached or terraced houses. Practices of single GPs are finding it increasingly difficult to provide a wide breadth of services as this would require purpose-built buildings, however, GPs are opposed to holding a head lease for 3rd party buildings.

LDP discussions with Cardiff Council have considered the extent to which the demands of the increasing population can be absorbed into the current public sector premises, however the challenge is securing funding for the development of premises and implementation. Population growth is an increasing pressure in North and West Cardiff.

Significant pockets of acute deprivation including Barry and Butetown. Provision should not be based on average coverage but on community specific need.

Opportunities and priority investment areas

The 'Shaping our Futures' Programme vision is that "***a person's chance of leading a healthy life is the same wherever they live and whoever they are***". The Future Wellbeing Strategy has the desire to achieve joined up care based on home first; whilst avoiding harm, waste and variation, empowering people and delivering outcomes that matter to them.

In considering how to shape future wellbeing, Health Boards have focused on health and care needs of the local population, working collaboratively with partners to provide sustainable services.

They recognise their role as provider of specialist services for Wales and understand their responsibility to maximise resources between specialist hospitals and wider care settings. The Health Board has indicated a recognition that the core GMS delivery model is changing:

1. Separate urgent and non-urgent (routine).
2. GP premises co-locate together to support surge management and triage.
3. GPs will increasingly be part of multi-professional primary and community care models.

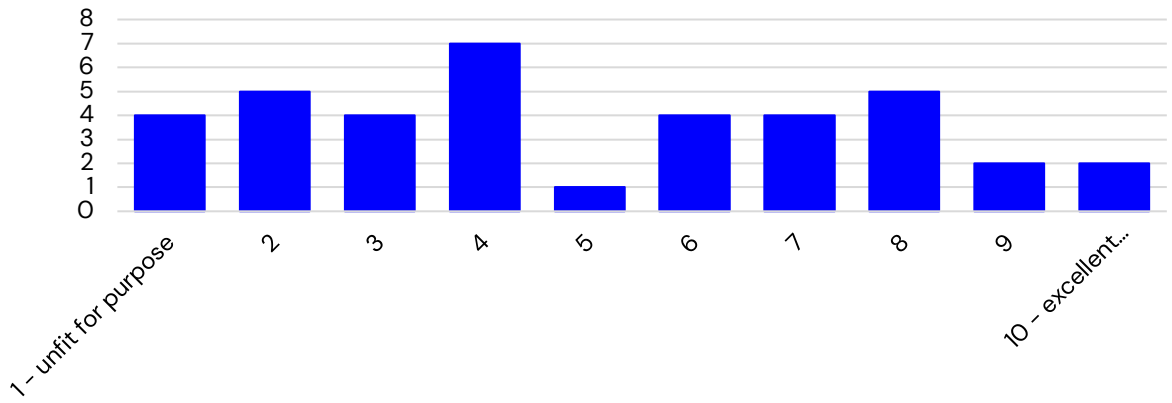
It has been highlighted from engagement with GPs that flexible drop-in capacity is an essential element of new developments as Community health teams require a base. Digital consulting has developed rapidly due to the measures taken throughout the COVID-19 pandemic, however investment in digital access is required to enhance

consultations available. Although public engagement highlighted patients' expectation for availability of face-to-face consultations.

Opportunity to build on local pilots of models, including Pathfinders, a pilot of urgent primary care hub in the Vale, demonstrate the importance of providing complementary services in care facilities.

GP Engagement

CV: How would you rate the current size and estates quality of your premises?



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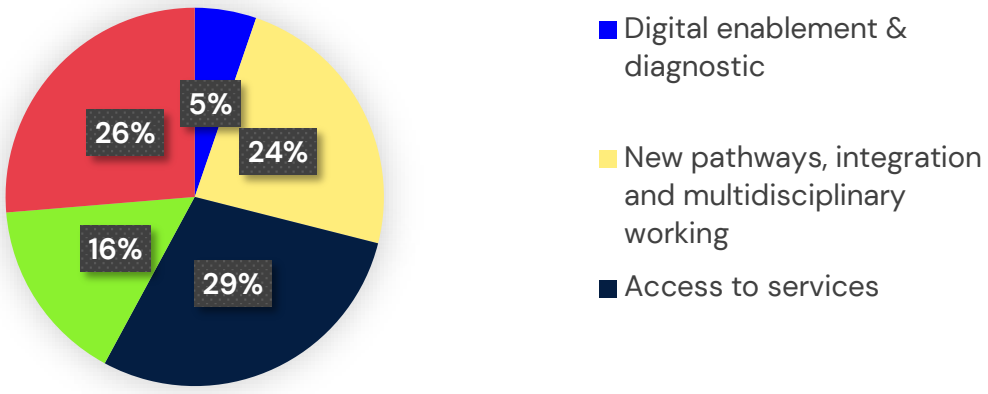

Public Engagement

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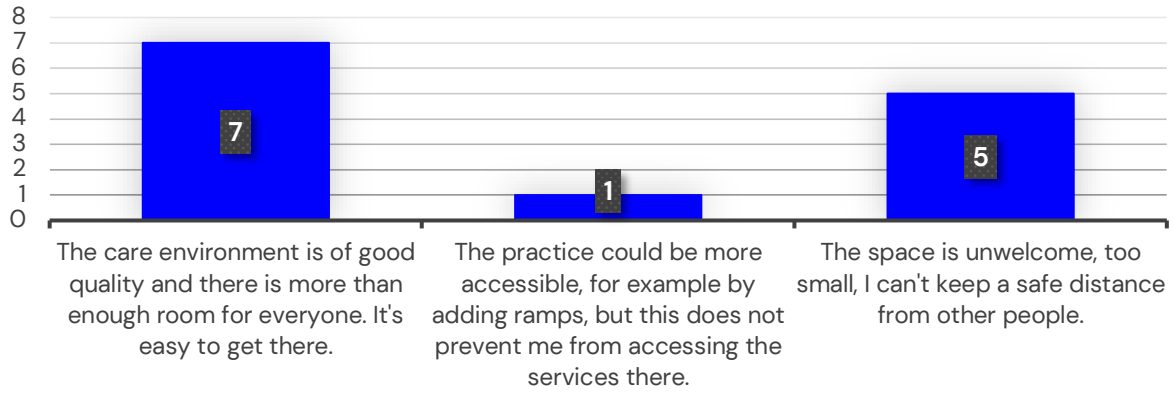

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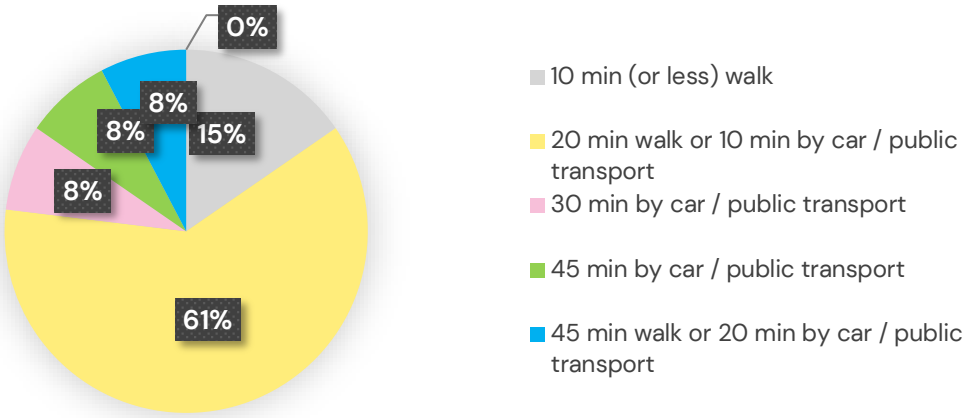

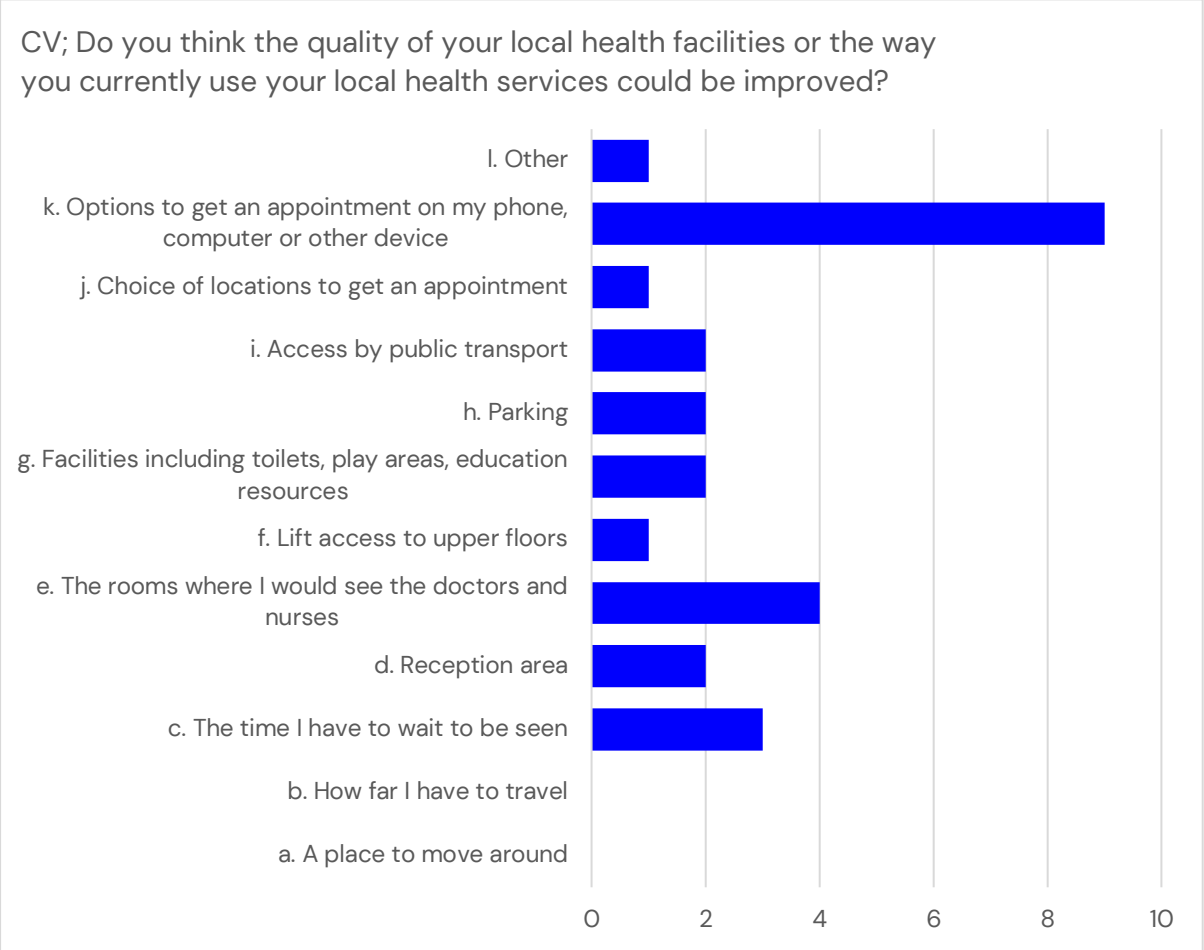
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Cwm Taf Morgannwg University Health Board

Population factors

Cwm Taf University Health Board serves a population of approx. 450,000 people, located within five localities; Merthyr, Cynon, Rhondda, Taff Ely and Bridgend. It is approximately the smallest Health Board in Wales yet has the second highest density of people per square Km. Merthyr Tydfil contains the smallest population while Rhondda Cynon Taf has the second largest population among all authorities in Wales. Central and Northern areas of Cwm Taf share similar deprivation and health profiles, whereas South Taff Ely experience less deprivation and better overall health.

- The Cwm Taf population is projected to growth by 2.1% by 2026; age groups of 65-84 and 85+ are projected to have the largest increase by 2036;
- The population age profile is similar to Wales but with slightly higher proportion of those aged under 5 years, 20-44 years and over 60 years;
- At 31%, Cwm Taf has the highest proportion of population living in the most deprived areas of Wales; Merthyr, Cynon, Rhondda Valley;
- As a result of deprivation, the population in Cwm Taf are living shorter lives than any other Health Board in Wales and are spending a greater proportion of their lives with a disability or long-term illness.

Children and young people

Children in need rates are the highest in Wales but, with a concerted effort to focus on supporting families in the region, but they are declining. 60% of referrals to social services in Cwm Taf are due to abuse or neglect (2015). There are a number of persistent challenges for the region including:

- Rates of child obesity in Cwm Taf is the highest across Wales, at 13.2%;
- Consumption of fruit and vegetables is below the Welsh average in Cwm Taf, as well as physical activity levels.

There are some positive trends for children and young people, including, 90% of children aged 4 have completed scheduled vaccines, which is above the Wales national average.

Mental health

Cwm Taf has the highest levels of mental illness and poor well-being amongst adults in Wales. Projected increase in our old-age population will lead to increased levels of dementia and care required.

Older people and health conditions

In the next 15 years, the population aged over 65 is expected to grow by 30% and those over 80 years to grow by 70%. 44.5% of people over 75 years old live alone and 7 to 17% of older adults are affected by social isolation and loneliness. It is predicted that the number of people with dementia over the age of 65 will increase by 53.7% and will

become a significant issue in the future. Following a projection of an increasing older population, it is predicted that chronic diseases will increase, such as; cardiovascular, respiratory and cancers.

41,560 people in Cwm Taf have registered as having a physical disability/sensory impairment, although this is thought be underestimated.

Current local estates challenges

Single and small partners practices resilience:

Various initiatives are being implemented to support the development of other primary care professionals, e.g. the Workforce and Development Training Cymru. Development of MDTs is being encouraged within the clusters and new Roles are being tested such as Occupational Therapists, Physician Associates, Health and Wellbeing Coordinators and GPSOs and wrap around services such as MIND and Physiotherapy services. In addition to these areas the Health Board aims to continue the development of flexible roles and sessional contracts to improve sustainability.

Addressing inequalities

At 31%, the highest proportion of population living in the most deprived areas of Wales. This aligns with indications regarding shorter life expectancy and greater proportion of lives spent with a disability or LT illness.

Estates management

The Health Board has identified challenges regarding fragmented management of properties; with significant variation between old/new buildings condition and general levels of utilisation.

Some premises do not meet disability accessibility requirements and are not strategically located for optimised access and multi-disciplinary models of care. The Health Board has plans to reduce the overall number of premises and replace with a small number of large facilities.

Geographical challenges

Significant geographical challenges have been identified. The public show a strong preference towards having local services, rather than travelling to access care from one large centre. Patients are willing to flow down the Valleys to access care, but not up.

Access to both independent transportation and public transport is a significant issue. Public transport provision has been rationalised, but this has resulted in higher deprivation areas being subject to high costs of public transportation. Community/voluntary services are available for non-emergency patient transport, which is looking to expand nationally.

Geographical factors mean that suitable greenfield/development site land is not available in the Rhondda Valleys for new builds, so the option remaining is smaller primary care centre builds.

Opportunities and priority investment areas

The development of Health Parks provides high quality accommodation, suitable for the delivery of a wider range of Primary Care and Community based services and will facilitate delivery of services on behalf of all practices in each respective Cluster (YCC, YCR and Keir Hardie Health Park).

The Health Board aims to commence condition surveys which are due to start imminently, depending on COVID circumstances, but should provide evidence for the previously estimated condition.

The Inverse Care Law Programme is aimed at reducing the gap in life expectancy between the most and least deprived areas in Cwm Taf and Aneurin Bevan UHBs. An implementation plan is being developed for Cwm Taf, starting with cardiovascular disease. Another area of focus is services for the younger generation particularly in regard to improving access and signposting to health and wellbeing support available to them.

A small number of practices have handed contracts back, leading to 2 practices being directly managed; There is a desire to keep developing a more integrated practice model and it is felt to be beneficial to have training practices at the top of the valleys. The long-term strategy is to utilise strong clinical leadership, and multi-professional teams, with teaching status; looking toward the development of a Bromley by bow model.

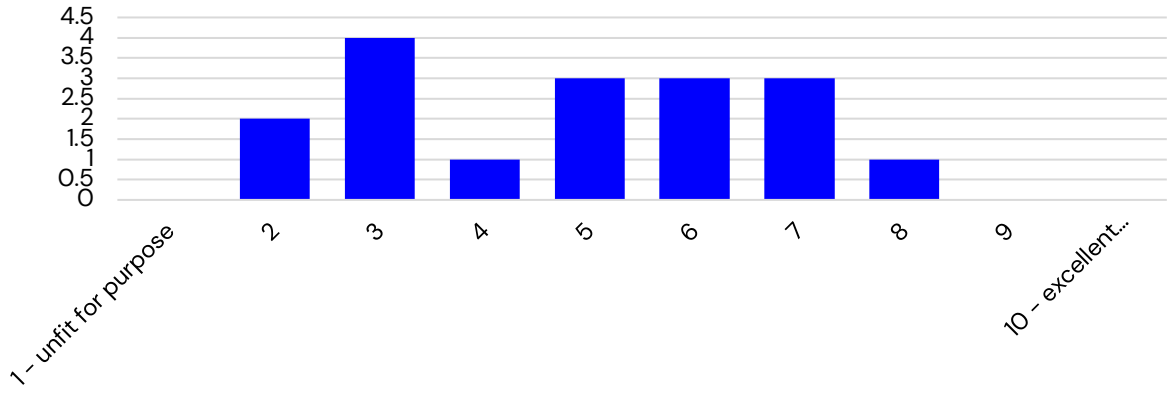
The Health Board is in discussions with two other practices to rationalise into separating into 2 premises with access for community/3rd sector/some specialist services.

Digital innovation and technological enablement

There continues to be positive progress to develop the infrastructure for remote consultations, but this will lead to a variety of capital investment costs due to limited device/WiFI access in areas of significant deprivation.

GP engagement

CTM: How would you rate the current size and estates quality of your premises?



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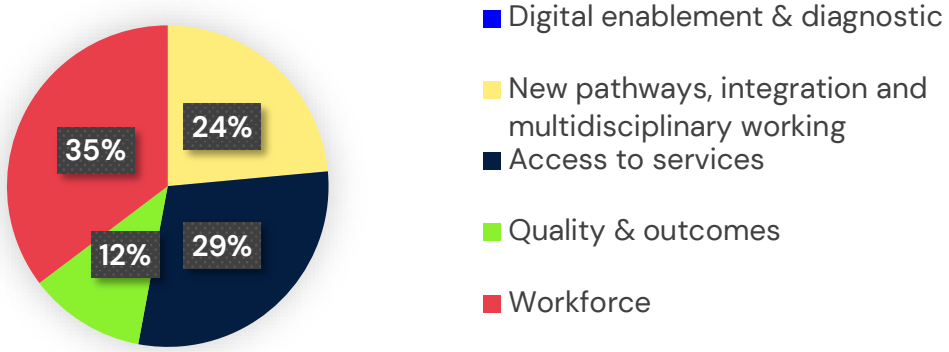

Public Engagement

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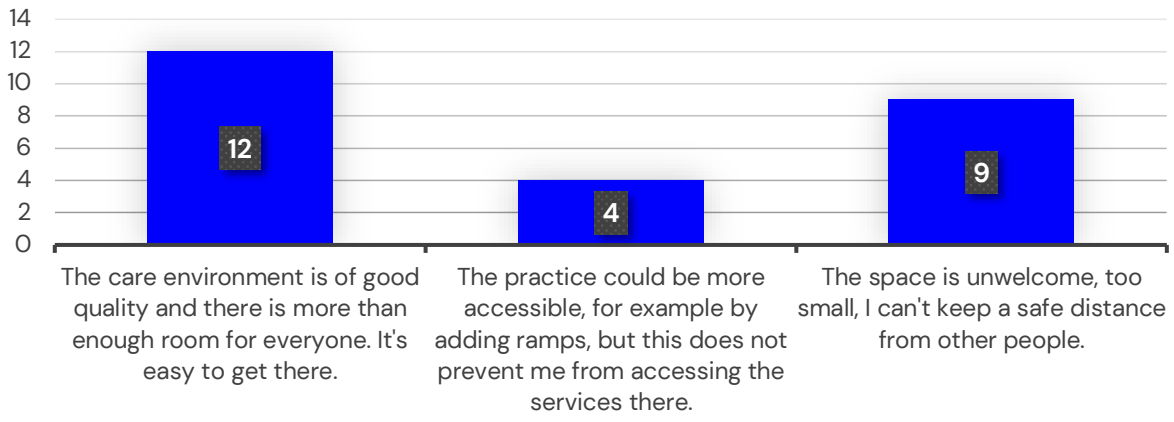

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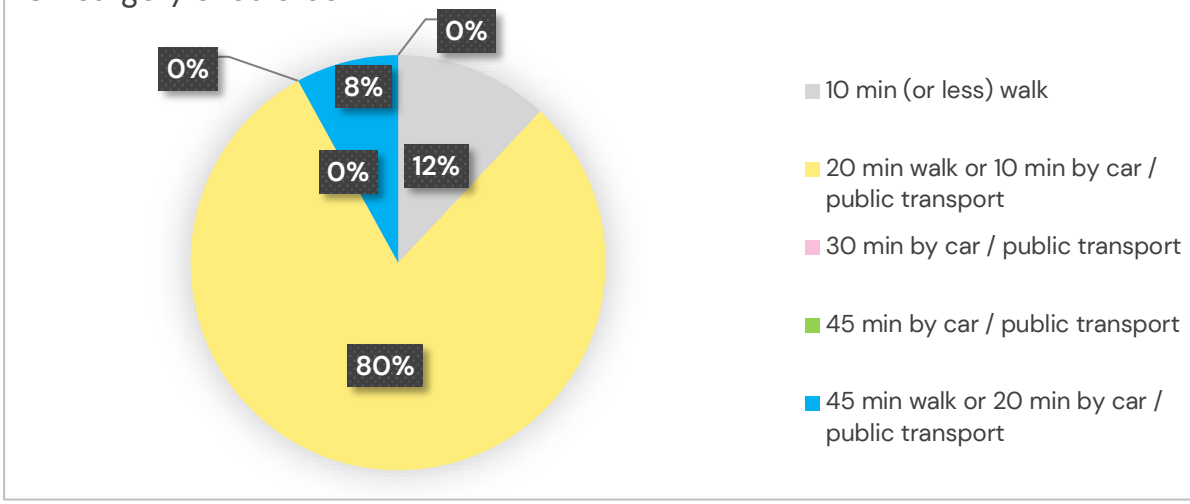

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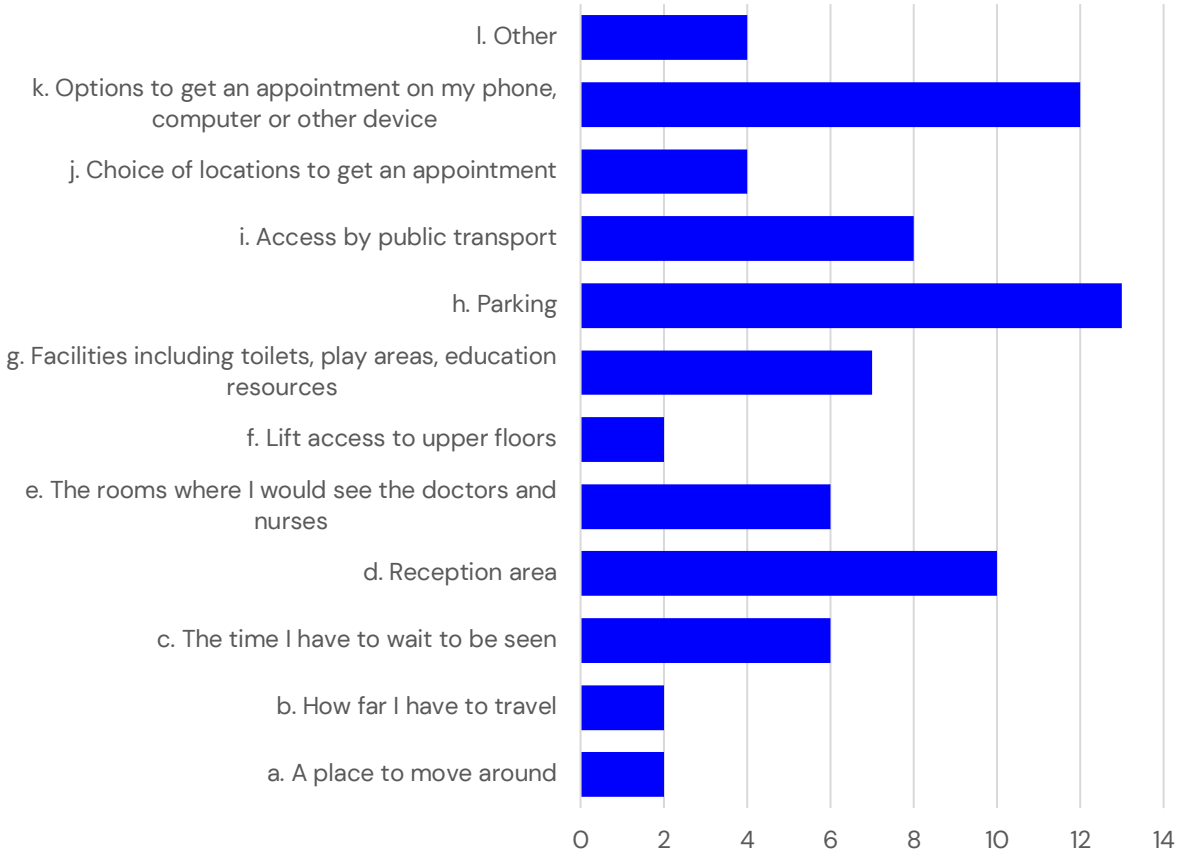


Hywel Dda University Health Board

Population factors

Hywel Dda University Health Board serves a population of approx. 385,000 people, in three localities; Carmarthenshire, Ceredigion and Pembrokeshire. Ceredigion contains the smallest population (approx. 73,000), with almost an even population in both Carmarthenshire (approx. 187,000) and Pembrokeshire (approx. 125,000). The population is predicted to rise to 425,000 by 2033.

A higher proportion of the population is aged over 55 years, compared to the average in Wales. Life expectancy is broadly in line with the rest of Wales at 78.9 and 82.7 years for males and females respectively. People living in Hywel Dda have healthier lifestyles than the rest of Wales, but also have higher rates of alcohol consumption and obesity.

Children and young people

22.2% of the population in Hywel Dda are children and young people, which is projected to remain relatively stable over 15 years. Local Authorities indicate that 464 children and young people live with a disability, projected to remain constant until 2030.

Older people

Current projections suggest a 60% increase in people aged over 65 years by 2035. A significant increase is also suggested in those aged over 85 years at 122%. Over 55% of the over 65 population reports having a long-term illness/disability. Hywel Dda has the lowest rate of dementia diagnosis in Wales at 37.2%, although a significant increase is predicted by up to 44% in 2035. A significant percentage of older people in Hywel Dda provide unpaid care to support family or friends; with the greatest predicted increase in those over 85 years providing more than 50 hours of unpaid care of 122% by 2035.

Burden of disease, health conditions and physical disabilities

1.1% of the population aged between 18 and 64 years are reported to have a disability; 1,679 have a physical disability and 1,744 have physical and sensory disabilities. 25% of people aged 16-64 living with a chronic disability, have a neurological condition. 23,656 people are living with a life limiting illness in Hywel Dda, which is predicted to fall by 4% by 2030.

Current local estates challenges

Estates quality

Increasing the workforce is key to coping with the current pressures, but this is challenged by the restriction of space available for recruitment of new staff. The calculation of space required does not reflect the new model of integrated care. A six-facet survey needs to be recommended, to confirm current estate quality and improvement areas of the estates.

Technology

Local community care services currently run multiple different IT infrastructures. Ease of use to the staff and patients is needed for an efficient, one-stop-shop, clear patient pathway.

Opportunities and priority investment areas

Integration

Integration pathways are a key focal point. There has been some difficulty with collaboration between GPs, with no appetite to merge services. However, community services work across GPs, and there is scope for merging back office and community services. Collaboration of clusters between GPs and primary care services has been more apparent during the Pandemic, sharing experiences and work, and this needs to be optimised and used. Highly developed integration with Local Authorities, primary and community care is key, but sharing and moving resources to accommodate this, may be difficult. Models of previous initiatives and scaling-up of cluster plans are available.

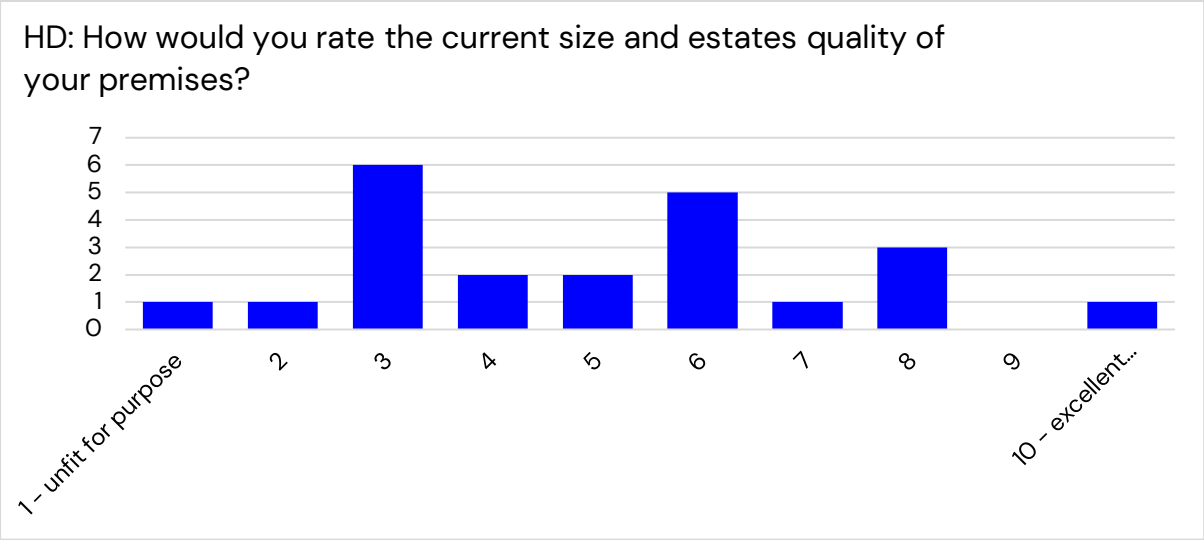
Digital

Digital services are a key priority, especially during the COVID-19 Pandemic, encountering fast-paced changes, which should be taken further.

Communication

Stakeholders identified a key priority of providing the public with better information regarding access to care. The patient pathway must be transparent and user friendly. A strong message to the public is needed to control expectations and behaviours i.e. to not revert back to normal operations pre-COVID.

GP engagement



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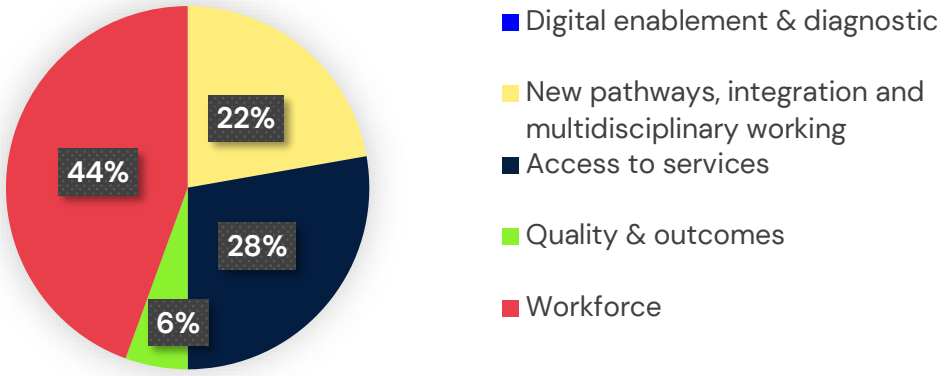

Public Engagement

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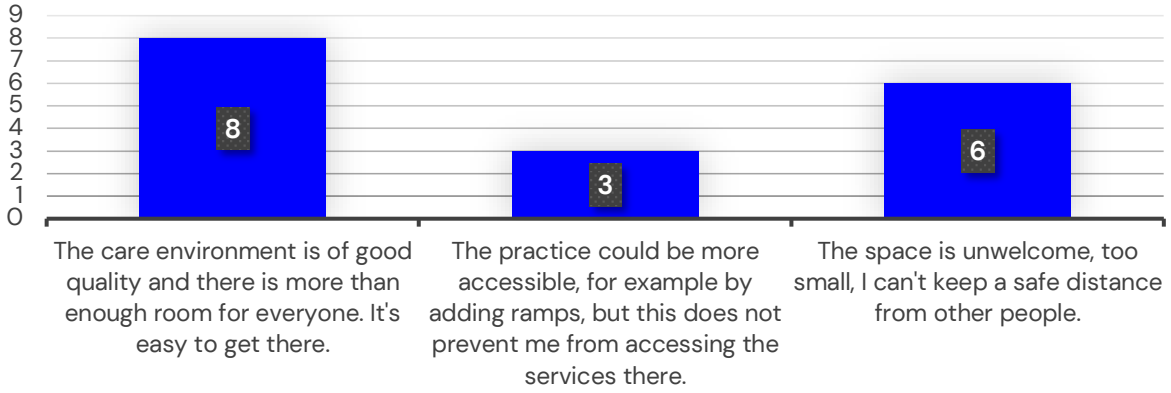

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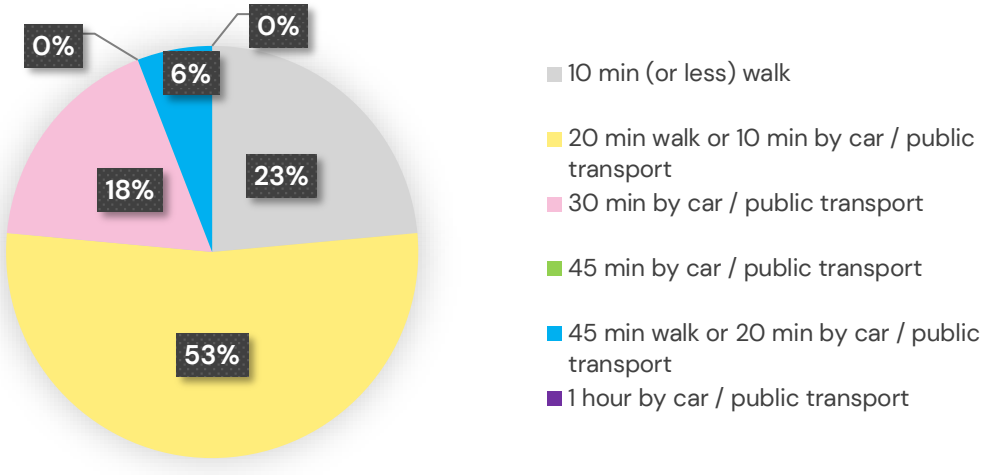

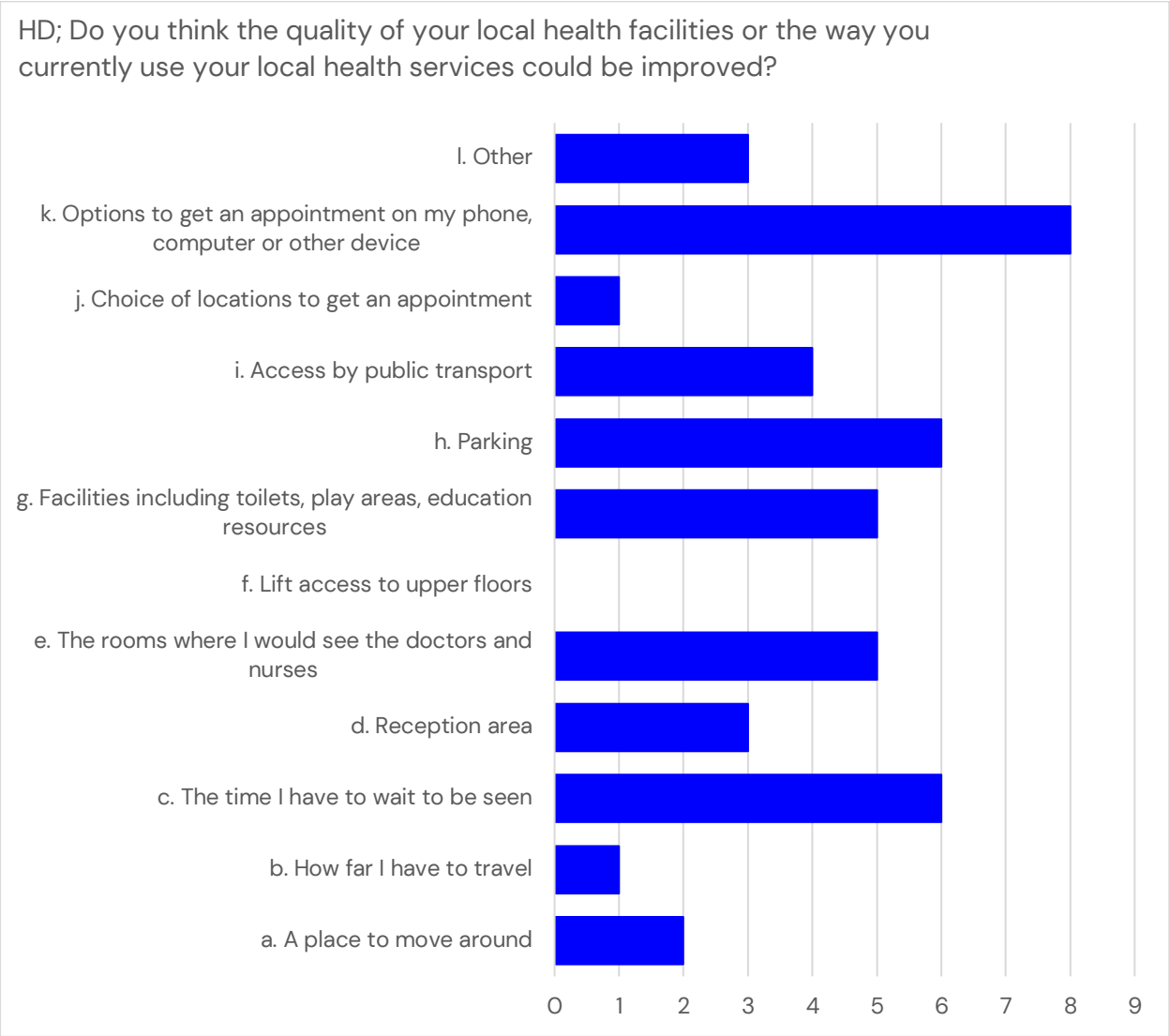
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Powys Teaching Health Board

Demographic and population health insights are as follows:

Population factors

Powys population insights are dissimilar to those of other Health Boards, as it is the most rural county in Wales with only 26 people per squared Km, covering a quarter of the landmass of Wales with less than 5% of the population.

The 26 to 64 population in Powys is currently the highest proportion of the 132,000-population, with only 25% over 65 years and 3% over 85 years. The total population is projected to decline by 8% by 2039, whilst the proportion of over 65 years predicted to increase by 38% by 2036, which is higher than the Wales average. The number of children and young people in Powys is projected to decrease further due to the ongoing trend of the younger generation leaving Powys for urban areas, as well as a reduced birth rate.

Inequality

Among the Health Boards Powys ranks first of the Welsh Index of Multiple Deprivation, having the most deprived 10% LSOAs in Wales. Areas of Ystradgynlais, Newtown and Welshpool are highlighted as very deprived in comparison to the rest of Wales.

Whilst children living in poverty in Powys (13%) is below the Wales average (21.9%), only **10% of children in Powys are eligible for free school meals** compared with the Welsh average of 16.8%. A greater proportion of adults in Powys engage in healthy behaviours compared with Wales:

- **20%** of adults currently smoke (Wales 20%)
- **39%** of adults report drinking above guidelines one day in the week (Wales 40%)
- **36%** report eating 5 or more portions of fruit or vegetables in the previous day (Wales 32%)
- **39%** report being physically active on 5 or more days in the past week (Wales 31%)
- **58%** of adults are overweight or obese (Wales 59%).

In Powys a lower proportion of the adult population report being treated for illness and long terms conditions compared with Wales. Although, the population engage with healthier behaviours, a significant improvement remains to reduce demand on the health and social care system.

The older population in Powys also reports a lower proportion of treatment for long term conditions. However, the increasing older population is likely to increase complex illnesses and aligns with the expected 84% increase in dementia by 2035. 6 to 13% of the over 50 years population that live alone suffer with loneliness and social isolation, with 19,000 of 60,000 households occupied by a single person.

Current local estates challenges

The Health Board is currently seeking to incorporate primary care services into the Health Board remit as there is difficulty in establishing the current condition of the primary care estate as several practices are GP owned and managed with no interest in physical evaluation. Fragility of practices is being identifies as an increasing proportion of premises are being transferred back to the Health Board's management.

The current estate has mainly purpose-built premises constructed between the 1970s and 90s, with space being fully utilised across all practices. Although, potential for development has been identified for the majority of locations.

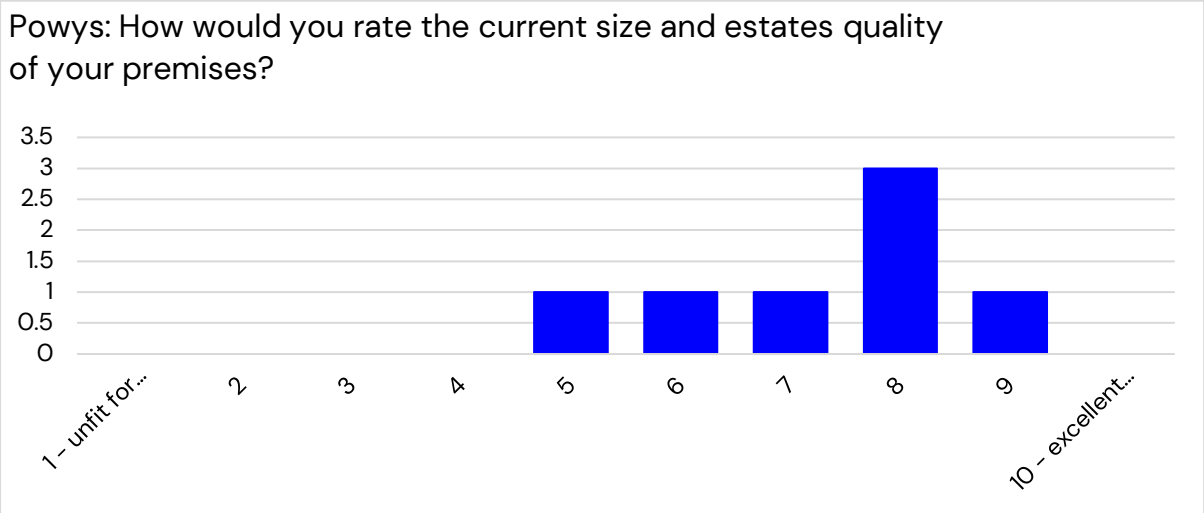
Transport providing accessibility to care services is weak among Powys. Although community transport volunteers provide a level of access, sustainability and consistency of provision across Powys is not equal. Improvement grants have been allocated to Powys over the previous years by Welsh Government directed at accessibility.

Opportunities and priority investment areas

The Health Board has been developing an evidence-base for creating Community Hubs where GPs, hospitals, council and community spaces are integrated or co-located. Consideration of home-working, telemedicine and digital futures has been included in conversations to reduce areas needed for now remote working. Powys Health and Care Strategy focuses on integration and digitalisation, with focus on:

- Developing a 'community hub' to provide a holistic approach to community and primary care;
- Provision of digitally enabled care services and access to information to support independent self-management of health;
- Strengthening of collaboration and integration between individuals, voluntary and business sectors to improve access and range of care.

GP engagement



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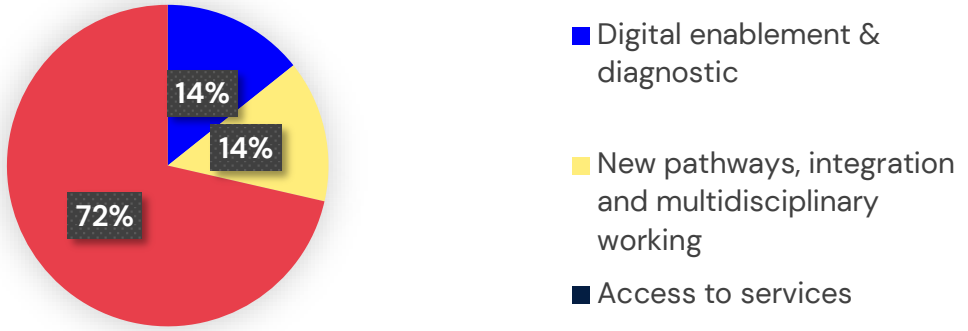

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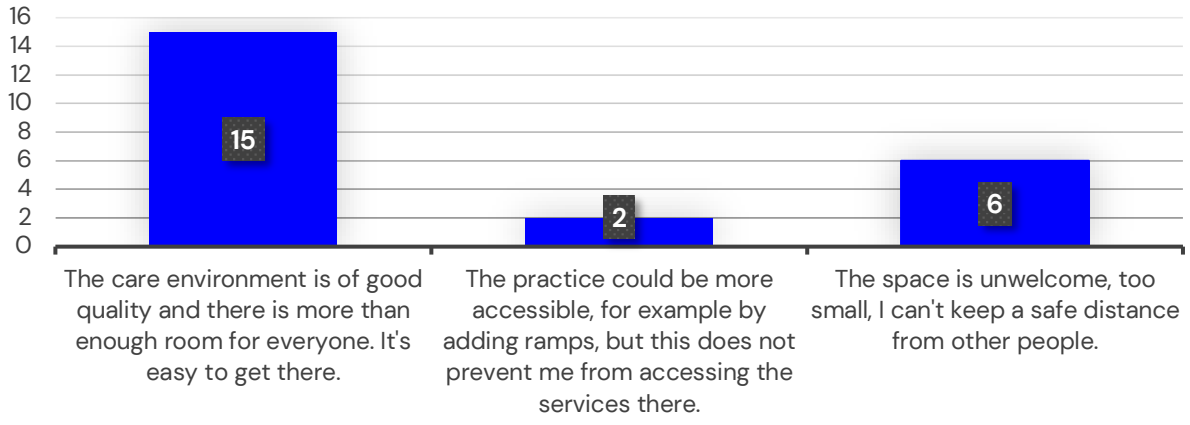

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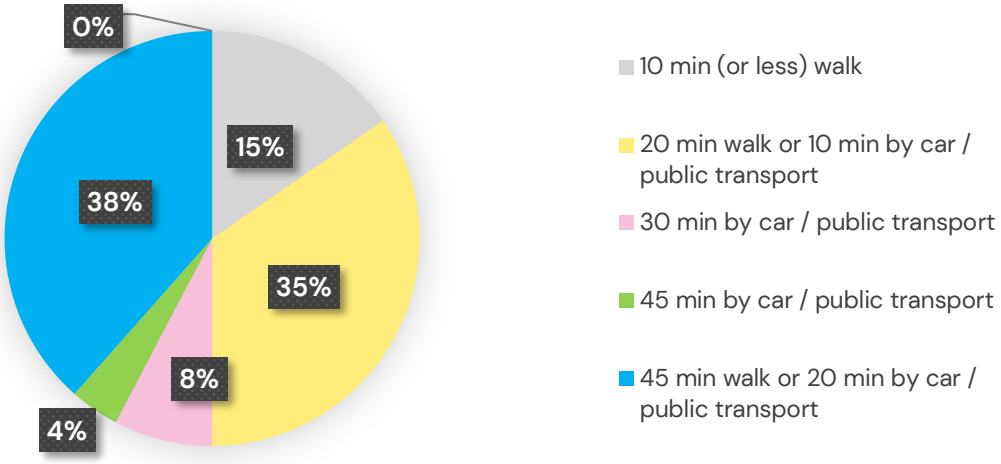

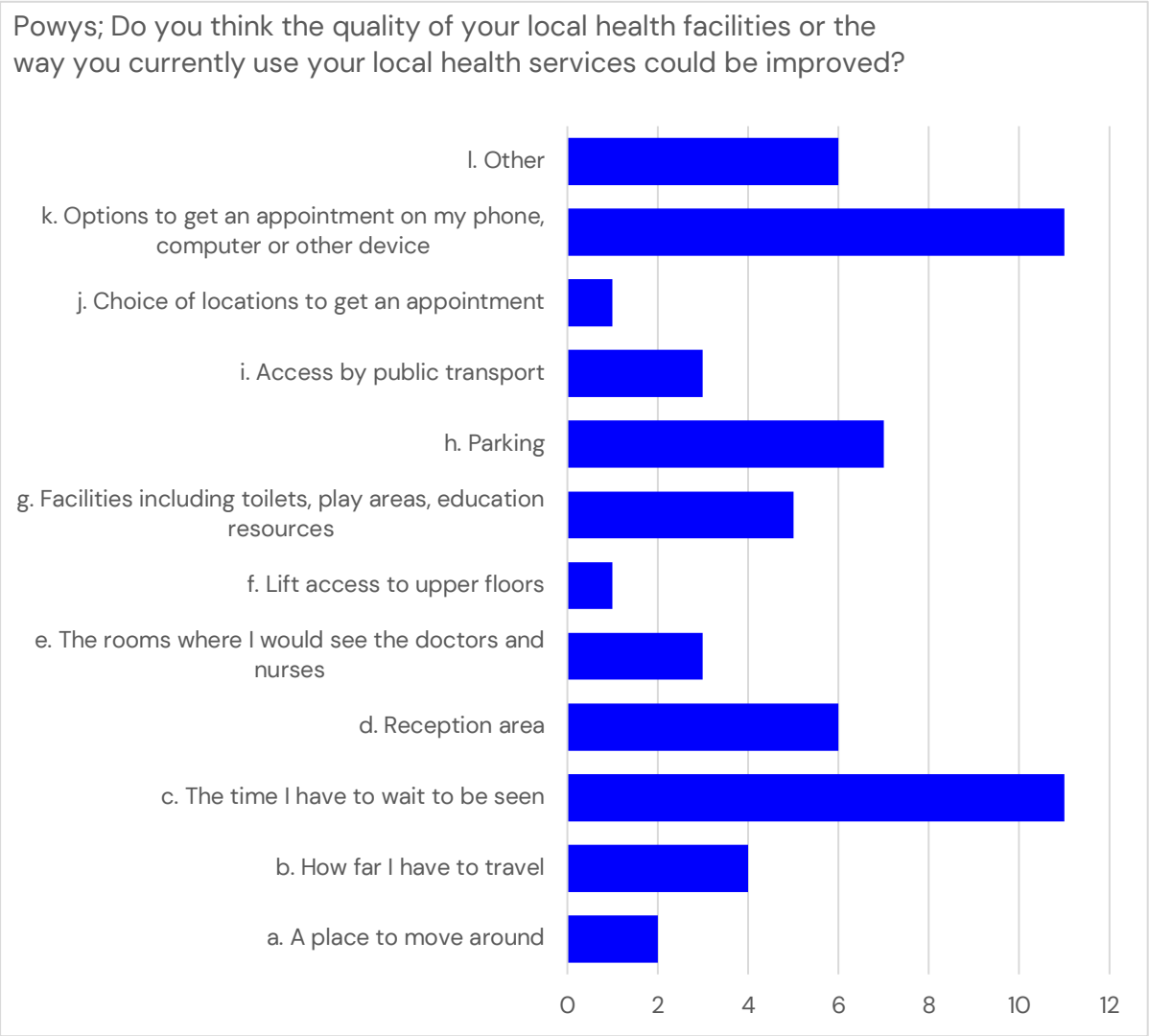
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Swansea Bay University Health Board

Demographic and population health insights are as follows:

Population factors

Swansea Bay University Health Board serves a population of approx. 390,000 people, covering Swansea and Neath Port Talbot areas. Swansea Bay University Health Board and the Local Authorities of Neath Port Talbot County Borough Council and Swansea Council are working together through the West Glamorgan Regional Partnership, with third and independent sector partners. The primary purpose of the collaborative is to provide a strategic mechanism for co-ordinating a programme of change in a suite of projects and work streams that partners have identified as a common priority. The joint population is approximately 529,000, covering Bridgend, Neath Port Talbot and Swansea areas.

A projected increase in population is forecast by an additional 9% in Swansea, with a rise in the older population and a fall in working-age adults.

Inequalities

There is a large life expectancy gap between the most and least deprived areas, equivalent to approx. 9.7 years and over 20 years difference in 'healthy life' expectancy. Swansea Bay has an above average proportion of deprived areas compared to other Health Boards in Wales. Swansea is one of the top 25 areas with the highest levels of child poverty. As a result of the ageing population, 45% of over 65-year-olds will be living alone and 33% will suffer from a fall each year.

The Western Bay population projection estimates an increase in the population by 6.4% by 2036. 27% of Lower Super Output Areas in Western Bay are among the most deprived in Wales, whilst 23% are in the least deprived fifth. The projected number of people with at least one mental disorder is estimated at 103,000, compared with 100,000 in 2015.

Neath Port Talbot has the highest number of children in need, of the three local authorities: 470 children in need per 10,000 children. All three local authorities have experienced a growth in the rate of children looked after by the local authorities. Performance of children's education is below the Welsh average.

Burden of disease, health conditions and physical disabilities

28.1% of adults in Western Bay are physically active, which is lower than the Welsh average of 29.9%. Obesity in Western Bay exceeds the Welsh average, with 99,000 obese adults. Healthy eating habits of people in Western Bay are declining with projections that 84% of adults will have a poor diet by 2025. 60% of the population are overweight/obese and the rate of suicide is disproportionate to Wales. Rates of physically active adults is below the average in Wales with a declining projection of poor diet.

Mental health and wellbeing

The diagnosis rate of dementia is slightly lower in Western Bay, at 53.2%, compared to the Wales average of 54.6%. This is projected to rise by 48% by 2030. Hospital admissions of older people are 35% higher in more deprived areas, with more hip fractures in Neath Port Talbot than in any other Welsh local authority (2013). Cardiovascular disease, cancer and respiratory disease are the largest cause of death and premature death within the area.

Current local estates challenges

The Valleys area is difficult for patients to access services, as public transport only runs once or twice a day, however, the voluntary sector may be able to help with this.

There are many independently owned small practices scattered across a large area (approx. 30 practices). It is felt by the Health Board that these premises would be better if they were more consolidated, which would mean alignment with the clusters, and this would also contribute to workforce efficiencies. Having larger and fewer practices could pose issues with residents e.g. access may be limited.

Most of the estate is at a higher risk of dilapidation, as they are built in early 1960s and many are in need of refurbishments for roofing, guttering, downpipes, energy conservations etc. With regards to statutory compliance, some DDA access needs to be improved and investment in carbon reduction needs to be considered. A full 6 facet survey has been recommended for all Health Board primary care premises.

Opportunities and priority investment areas

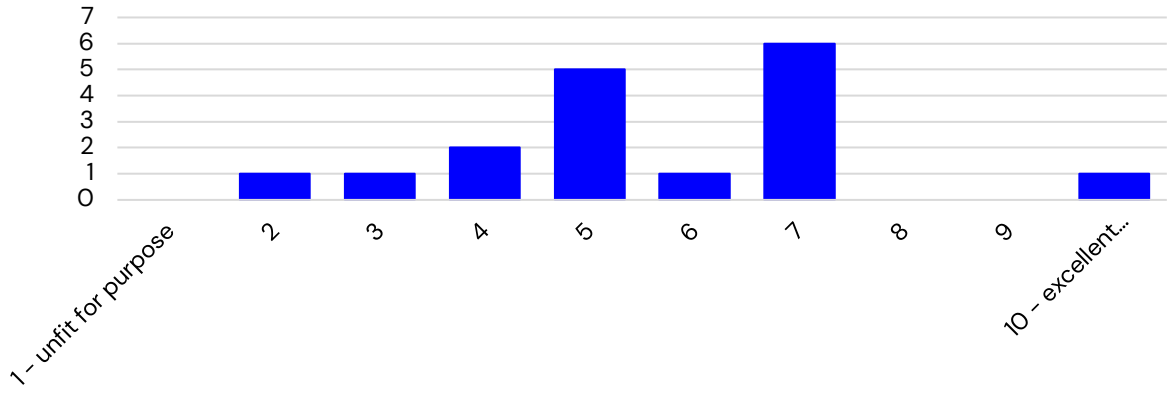
Scale up and integrate primary and community services to improve outcomes, achieve greater efficiencies and provide more responsive care which meets the needs of the growing population.

Cluster Networks will provide community services on an individual level. The plan is for 11 cluster network teams to manage and deliver community services, creating resilient communities which support wellbeing of citizens via improved access to services i.e. care closer to home.

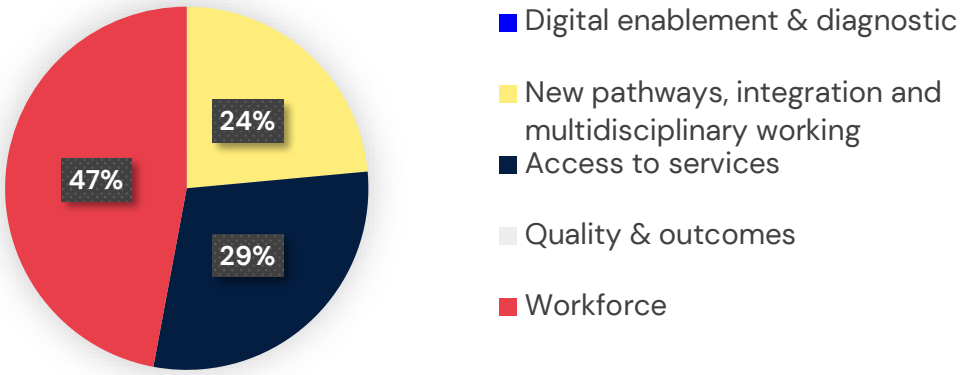
Community teams will integrate primary and community services, using a holistic approach including primary, community and social care services, thus reducing pressure on GPs and improving patient access.

GP engagement

SB: How would you rate the current size and estates quality of your premises?

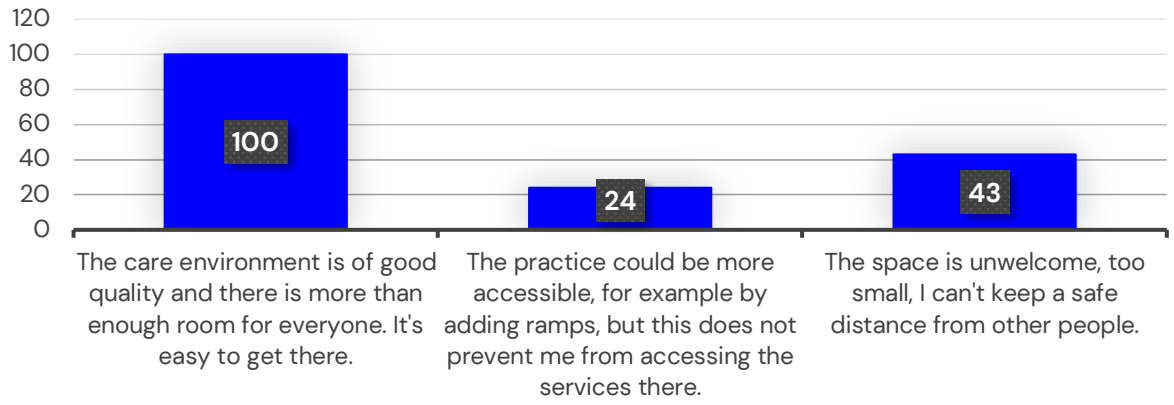


SB: What are the top 3 priorities for development, either in your practice or in your wider community, over the next 10 years?

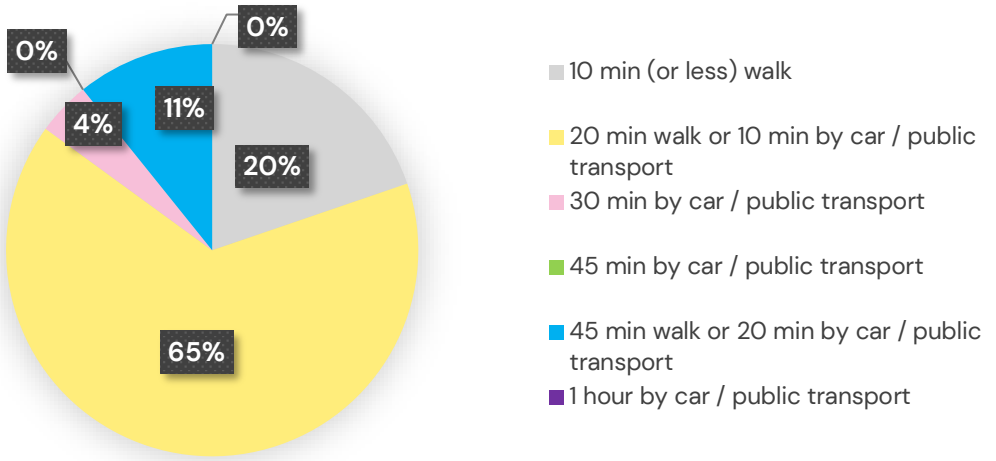


Public Engagement

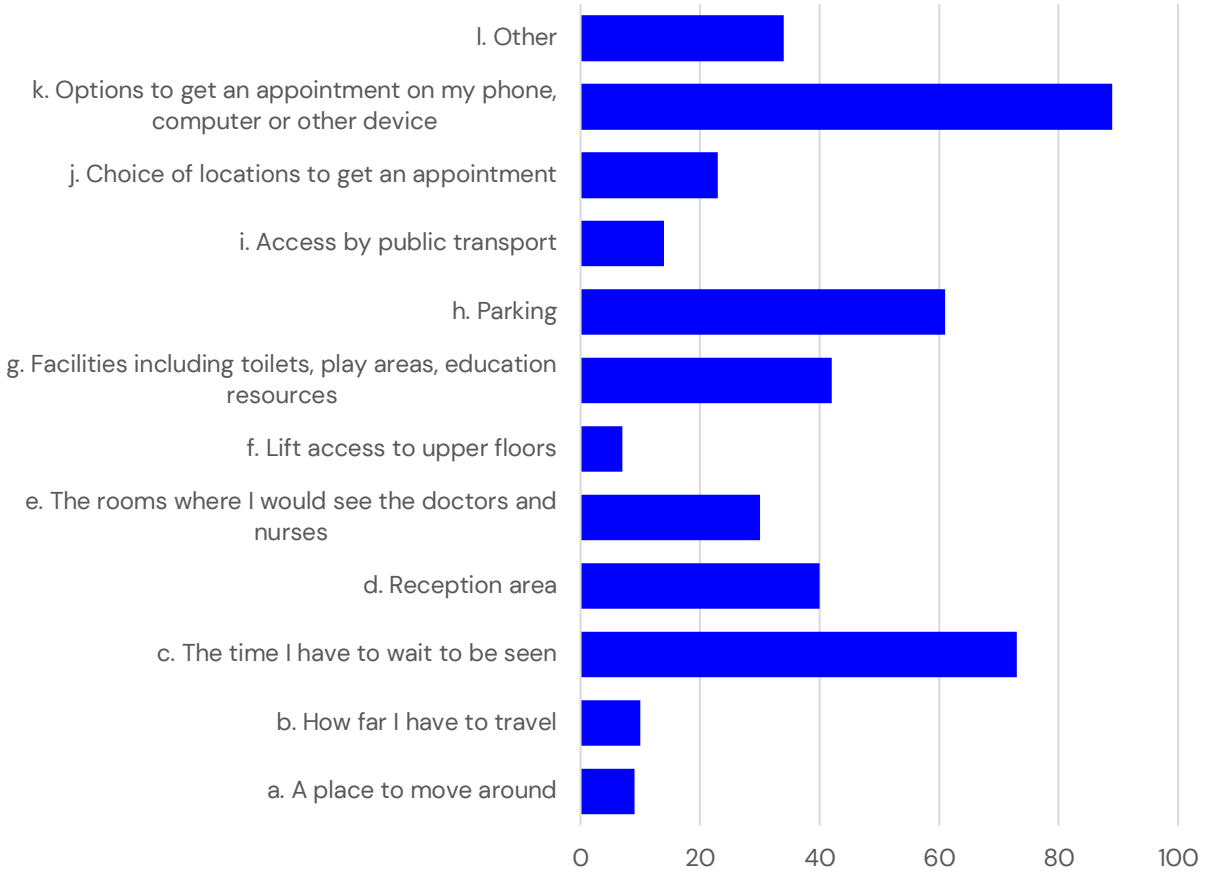
SB: How would you describe the quantity and quality of the environment in your current GP practice(s)?



SB: What do you think the MAXIMUM travel time to your local GP surgery should be?



SB; Do you think the quality of your local health facilities or the way you currently use your local health services could be improved?



Stakeholder Engagement

Overview of Health Board and LA engagement

Health Boards engaged	Local Authorities engaged
Aneurin Bevan	Aneurin Bevan Public Health Team (Torfaen Council), Newport, Blaenau Gwent, Caerphilly, Monmouthshire
Betsi Cadwaladr	Conwy, Wrexham, Denbighshire, Isle of Anglesea
Cardiff and Vale	Cardiff and Vale, Vale of Glamorgan
Cwm Taff Morgannwg	Merthyr Tydfil, Rhondda Cynon Taf
Hywel Dda	Pembrokeshire
Powys	Powys
Swansea Bay	Not available for interview

Wider stakeholder meetings

The following 1:1 meetings were held:

- Chief Therapies (Allied Health Professions) Adviser; Ruth Crowder;
- National Allied Health Professions (AHP) Lead for Primary and Community Care; Kerrie Phipps;
- Optometry Wales; Sali Davies (CEO);
- Welsh Optometric Committee; Barbara Ryan (Joint Chair), Bryn Jones (Joint Chair);
- Community Pharmacy; Russel Goodway (CEO), Jason Carroll (Chair; Medicines Management Pharmacist at Powys Teaching Health Board);
- Audiology; Philip Reardon-Smith (Primary Care and Health Science), Anne Thomas, Jonathan Arthur ;
- BMA (British Medical Association); Phil White (Chair), Dulaine Mulcahy (Committee Executive Officer) and Gareth Williams (Senior Policy Executive);
- RCGP (Royal College of General Practitioners); Professor Robert Morgan;
- Pharmacy;
- HEIW (Health Education and Improvement Wales); Phil Matthews (Professor);
- HEIW Pharmacy Team; Michelle Yeates, Michele Sehrawat, Kathryn Johnson;
- CHC (Community Health Councils) Board; Alyson Thomas (CEO);
- Primary Care One Team:
    - Sue Morgan (National Director and Strategic Programme Lead for Primary and Community Care/Primary Care One Strategic Programme Board Chair);
    - Kerrie Phipps (National Allied Health Professions (AHP) Lead for Primary and Community Care);

- Alan Lawrie (Programme Advisor: National Strategic Programme for PC and Director for Primary and Community care and Mental health);
- Alistair Roeves (Executive Medical Director);
- Chiquita Cusins (National Nursing Lead for Primary and Community Care / Corporate Services).

Appendix B – Estates Analysis

Contents

1 Introduction

The following process was undertaken to analyse data on the existing estate:

- A review of the baseline data available from Welsh Government [source: 20.06.30.04 Primary Care Database 2002-2003];
- An initial gap analysis;
- A request for more recent/additional data, issued to each of the Health Boards.

Where practice GIA or list size was not provided, premises capacity could not be assessed and these sites have been excluded from subsequent analysis.

Where a single list size was provided for a combination of main and branch surgeries, the total space has been included in the analysis.

Data completeness

The table below shows the level of data completeness arising from this exercise. The key message is that where there is found to be insufficient data to do any meaningful analysis, it is recommended that a national primary care data collection, including Estatecode condition facet surveys, is undertaken as soon as is practicable.

Overall completeness of data – percentage per Health Board

Health Board	Overall Data %
All Wales	**56**
AB UHB	61
BC UHB	54
CV UHB	49

Health Board	Overall Data %
CTM UHB	56
HD UHB	56
Powys THB	61
SB UHB	56

A breakdown of data per Health Board was undertaken for the following categories:

- Area (list size/GIA);
- Ownership (tenure; landlord; leasing arrangements; dates of expiry/lease break);
- Revenue (rent reimbursement; non-reimbursed costs; other costs);
- Building construction (construction);
- Building condition (physical condition; statutory compliance; DDA compliance; functional suitability; quality; environmental management).

Some data categories had nil returns - see the table below:

Detailed breakdown of data completeness, by category, per Health Board

Health Board		ABUHB	BCUHB	CVUHB	CTMUHB	HDUHB	PTHB	SBUHB
Area	List Size	100%	100%	100%	100%	100%	100%	96%
	GIA	97%	88%	74%	89%	82%	93%	84%
Ownership	Tenure	93%	60%	68%	52%	86%	56%	91%
	Landlord	80%	58%	68%	52%	86%	52%	91%
	Leasing Arrangements	0%	0%	0%	0%	0%	0%	0%
	Dates of Expiry / Lease Break	0%	0%	0%	0%	0%	0%	0%
Revenue	Rent reimbursement	100%	61%	68%	52%	60%	52%	85%
	Non-Reimbursed costs	0%	0%	0%	0%	0%	0%	0%
	Other Costs	0%	0%	0%	0%	0%	0%	0%
Building Construction		78%	86%	72%	89%	18%	96%	84%
Building Condition	Physical Condition	92%	99%	70%	88%	82%	96%	82%
	Statutory Compliance	84%	0%	0%	0%	0%	0%	0%
	DDA Compliance	78%	99%	72%	89%	82%	96%	84%
	Space Utilisation	93%	99%	72%	37%	82%	96%	84%
	Functional Suitability	93%	99%	72%	88%	71%	96%	84%
	Quality	84%	0%	0%	0%	0%	0%	0%
	Environmental Mgmt	0%	0%	0%	0%	0%	0%	0%

2 Facet condition surveys

Wales Health Building Note (WHBN) 00-08 Estatecode Wales (2018), recommends that five facet condition surveys should be undertaken.

The Health Boards have reported varying local circumstances, as follows:

Cardiff and Vale UHB

- CVUHB has recently undertaken surveys of Health Board owned premises but did not provide any evidence or findings to inform this report.
- It does not intend to commission surveys of wider practices at this stage.

Aneurin Bevan UHB

- ABUHB commissioned surveys in 2019 and reviewed the results with the local authorities' colleagues to inform its local estate strategy.
- These reports have been provided to enable detailed analysis.

Betsi Cadwaladr UHB

- BCUHB commissioned condition surveys in 2016.
- The summary findings report has been provided and reviewed.

Cwm Taf Morganwg UHB

- CTMUHB reported that condition surveys are due to start imminently, depending on pandemic factors.
- These should provide future evidence to support current risk management records.

Hywel Dda UHB

- HDHB reported that current estates quality is unknown.
- Representatives agreed that a 5/6 facet survey should be commissioned to identify the required improvement areas across the wider the estate.
- This will be pursued by the Health Board subject to access to central funding.

Powys THB

- PTHB reported that the physical state of practices was currently unconfirmed due to premises being GP owned and managed.

Swansea Bay UHB

- SBUHB reported significant motivation to undertake 5/6 facet surveys but reported challenges regarding cost & access to practices.
- It would support a Welsh Government recommendation for periodic 5/6 facet surveys as part of practice contractual terms.

Health Boards– availability of condition facet surveys (per facet)

	Physical Condition	Statutory Compliance	Space Utilisation	Functional Suitability	Quality	Env. Mgmt
ABUHB	Yes (2019)	Yes (2019)	Yes (2019)	Yes (2019)	Yes (2019)	Yes (2019)
BCUHB	Yes (2016)	No, only DDA Compliance from 2016	Yes (2016)	Yes (2016)	Yes (2016)	No
CVUHB	Yes (2002)	No, only DDA Compliance from 2002	Yes (2002)	Yes (2002)	No	No
CTMUHB	Yes (2002)	No, only DDA Compliance from 2002	Yes (2002)	Yes (2002)	No	No
HDUHB	Yes (2002)	No, only DDA Compliance from 2002	Yes (2002)	Yes (2002)	No	No
PTHB	Yes (2002)	No, only DDA Compliance from 2002	Yes (2002)	Yes (2002)	No	No
SBUHB	Yes (2002)	No, only DDA Compliance from 2002	Yes (2002)	Yes (2002)	No	No

Key to RAG rating:

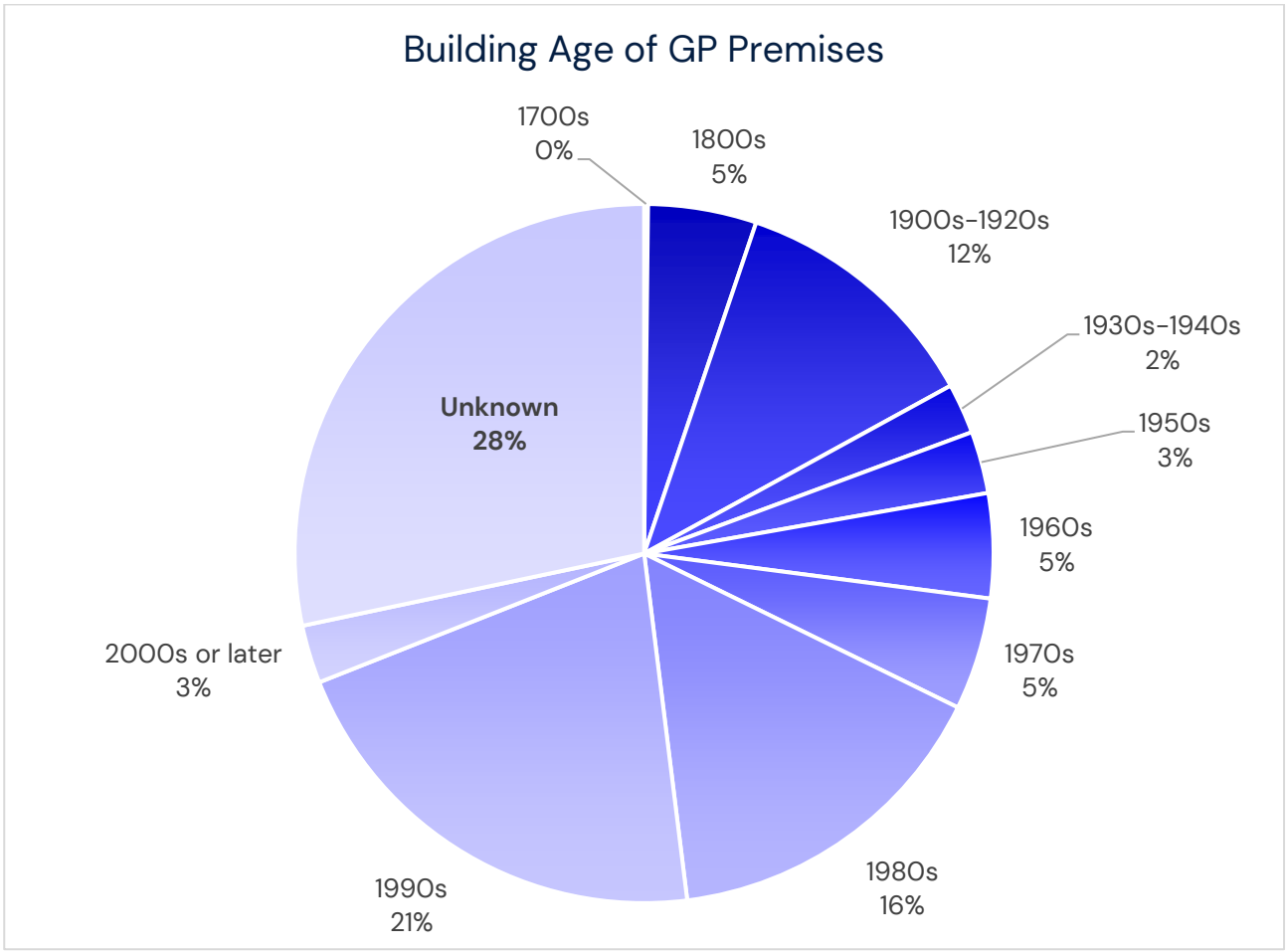
R	No information available
A	Survey information available but needs updating (older than 5 years)
G	Recent survey information available (within last 5 years)

3 Summary estates data analysis nationally

Building age

It is notable that the category with the highest percentage (28%) is "unknown".

Building age – all-Wales



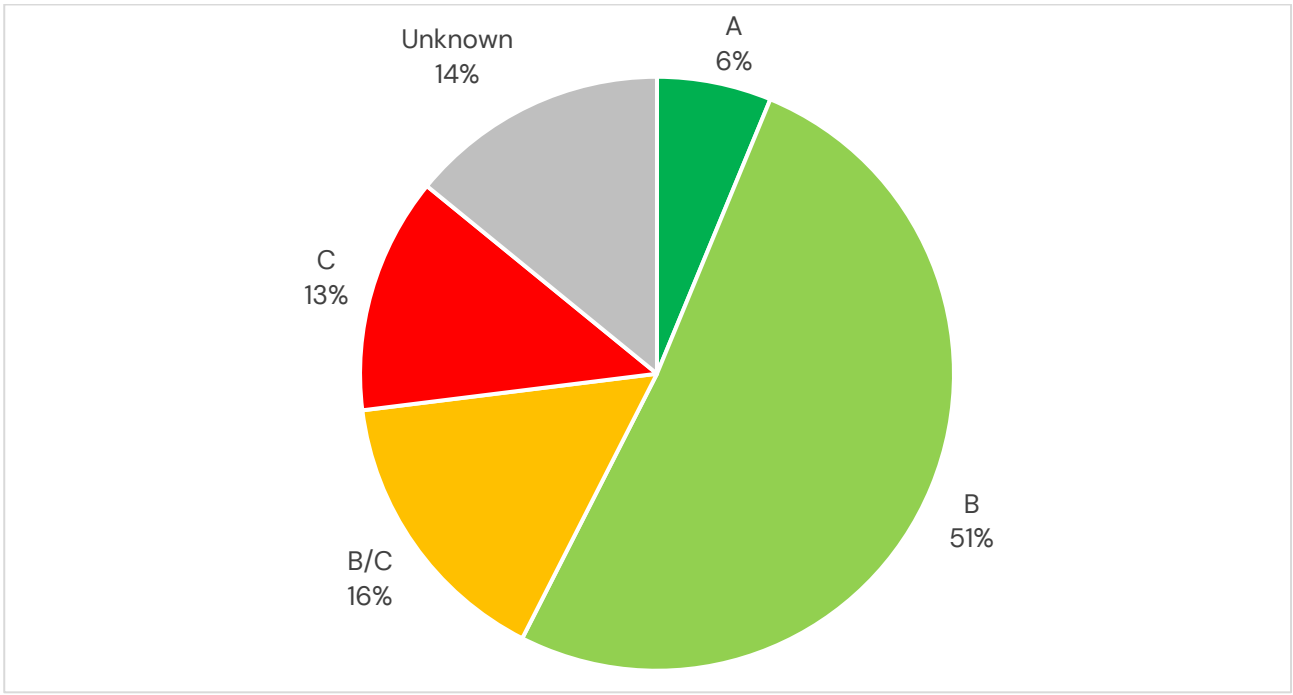
Physical condition

Estatecode rates physical condition as follows:

A	As new
B	Sound, operationally safe and exhibits only minor deterioration
B/C	Items currently condition B but will fall to condition C within 5 years period
C	Operational but major repair or replacement needed soon
D	Inoperable or serious risk of failure or breakdown
X	Added to C or D cannot be repaired must be replaced

Just over half of the national estate is reported at **Condition B:**

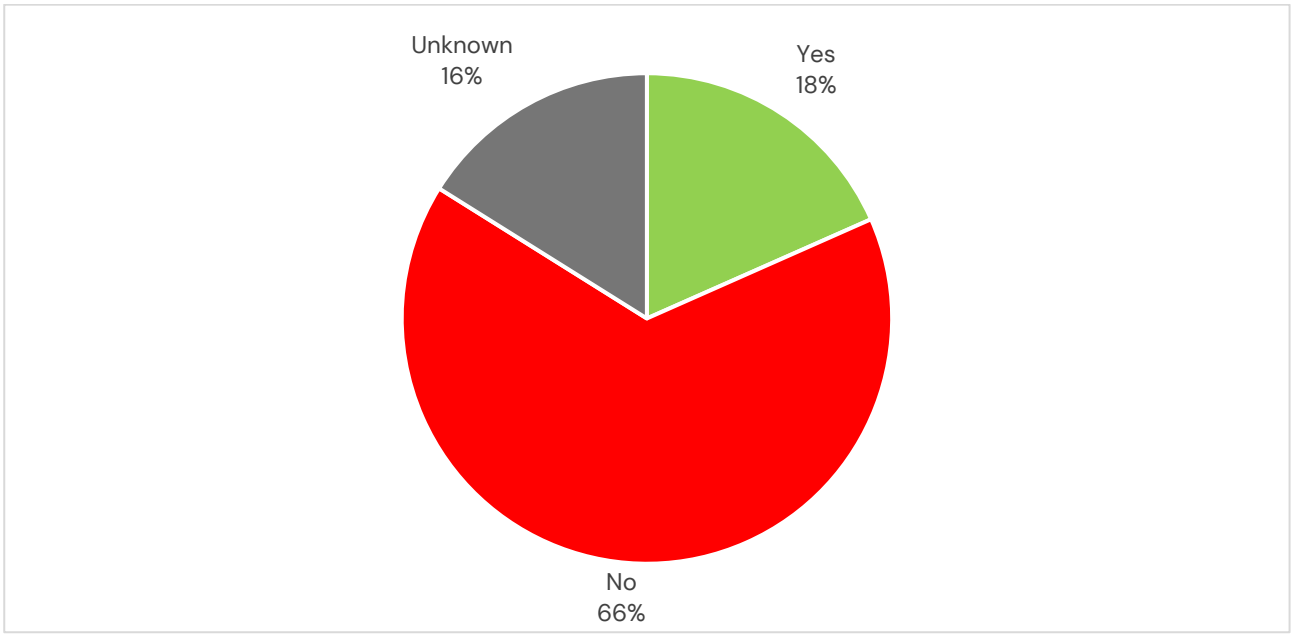
Physical condition – all-Wales



DDA compliance

The majority of GP premises in Wales are understood to be non-compliant with DDA:

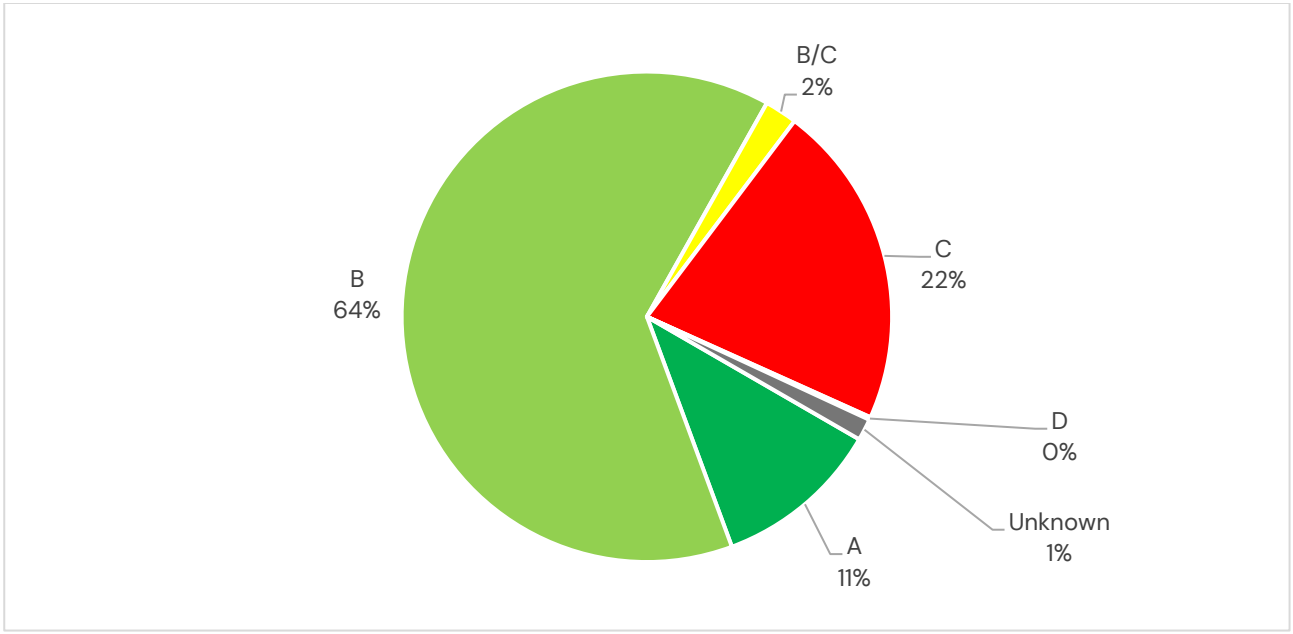
DDA Compliance – all-Wales



Functional suitability

64% of the estate is shown to be functionally suitable:

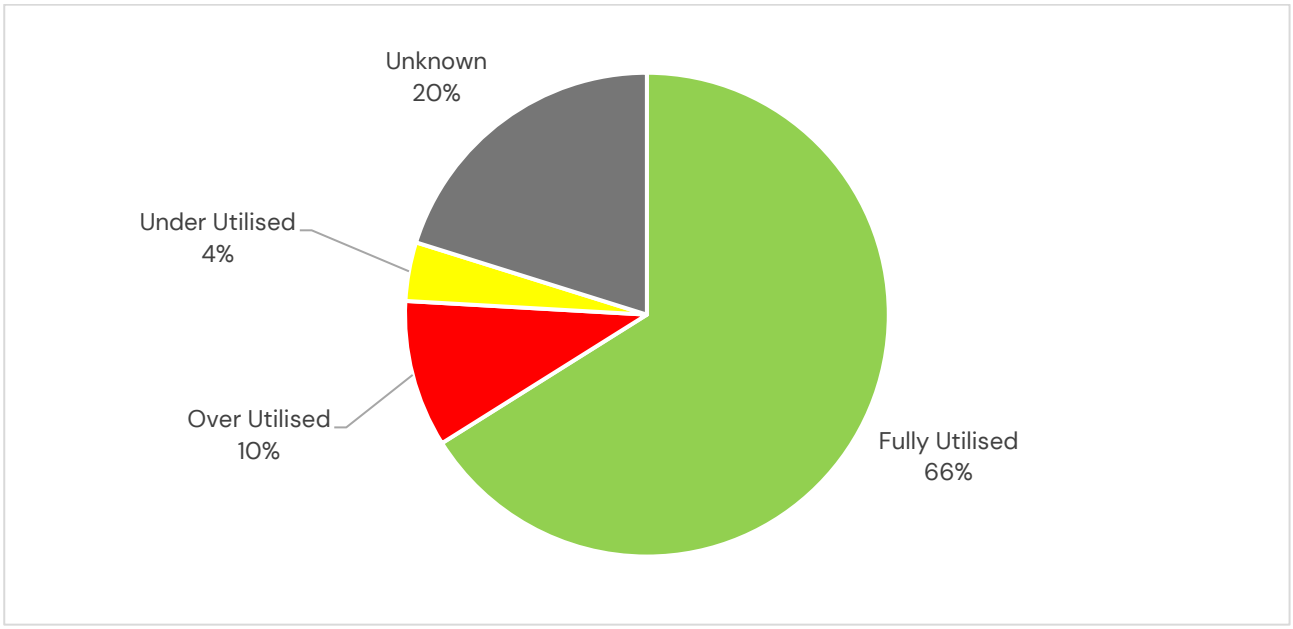
Functional Suitability of All Wales GP Premises



Space utilisation

66% of the estate is shown to be fully-utilised:

Space Utilisation of All Wales GP Premises

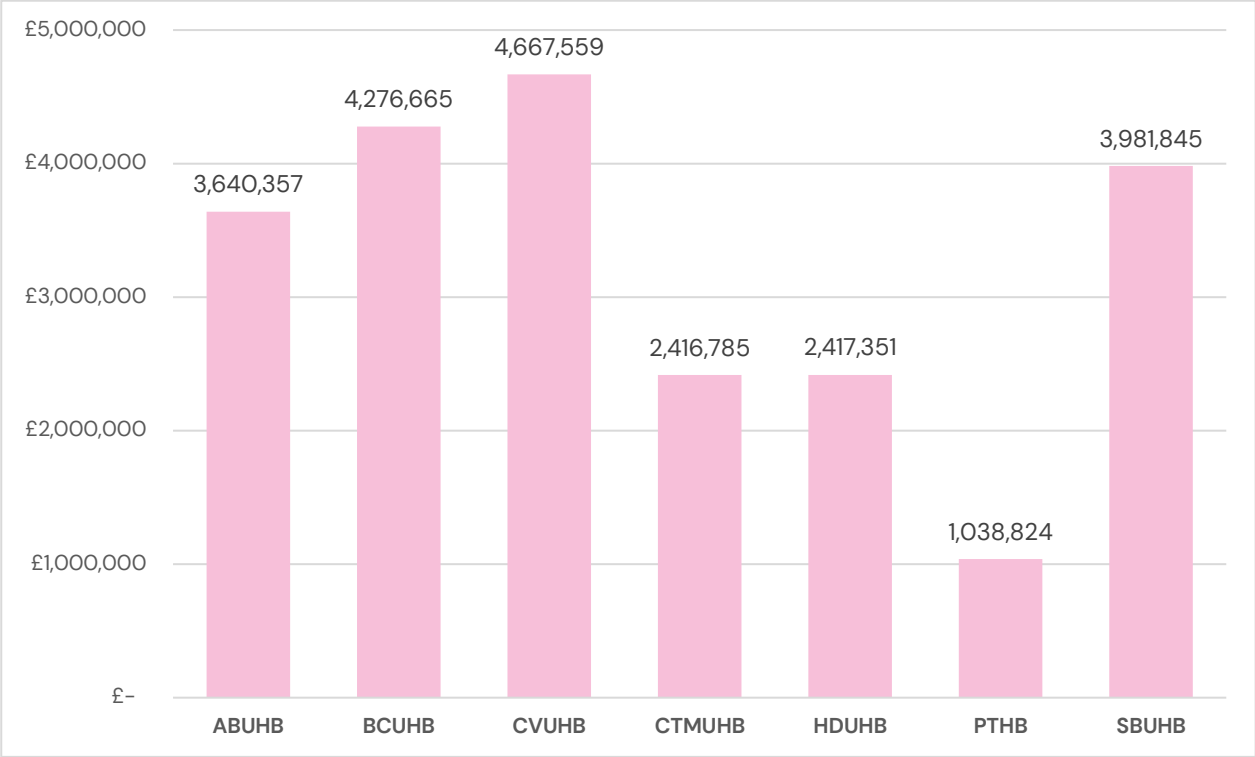


4 Summary estates data analysis per Health Board

Rent reimbursements

The data analysed shows rent reimbursements per Health Board ranging from £1,038,824 to £4,667,559:

Rent reimbursement per Health Board



Minor Improvement Grants

Minor Improvement Grants received in each HB range from £230,224 to £526,996:

Minor Improvement Grant Funding 2020/21 summary per Health Board

Health Board	Total Cost of All Facets to Condition B (£)	MIG Amount (£)	% MIG Against Total Cost to Condition B
All Wales	**26.1 m**	**1.9 m**	**8%**
ABUHB	15.3 m	0.5 m	3%
BCUHB	7.7 m	0.3 m	5%
CVUHB	0.4m	0.2 m	58%
CTMUHB	1.1 m	0.2 m	22%
HDUHB	0.7 m	0.2 m	35%
PTHB	0.3 m	0.1 m	34%
SBUHB	0.5 m	0.2 m	42%

Average age of buildings

The average age of buildings varies greatly, having been built between 1750 and 2002, ranging between 20 and 270 years old:

Average age of buildings per Health Board/all-Wales

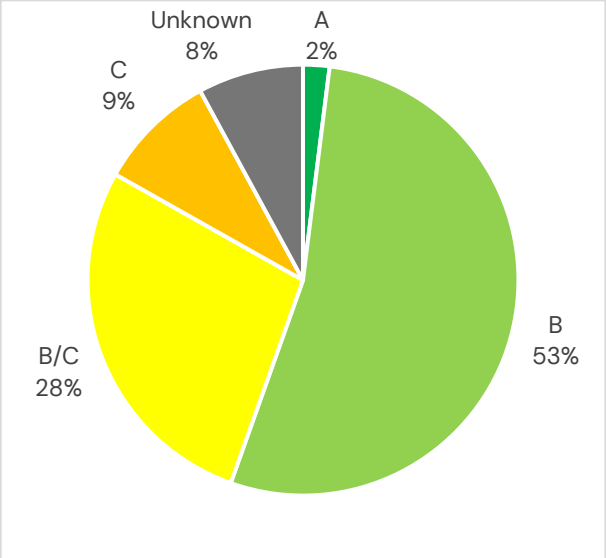
	Total No. Premises	No. Bldg Ages available	Average build date	Built date range
All-Wales	**562**	**399**	**1960**	**1750-2002**
ABUHB	101	78	1969	1830-2002
BCUHB	137	107	1946	1750-2002
CVUHB	80	54	1950	1800-2001
CTMUHB	82	68	1964	1800-2000
HDUHB	65	12	1982	1938-2001
PTHB	27	26	1983	1890-2002
SBUHB	70	54	1967	1860-1998

Physical condition

ABUHB

Just over half the estate is shown to be Condition B:

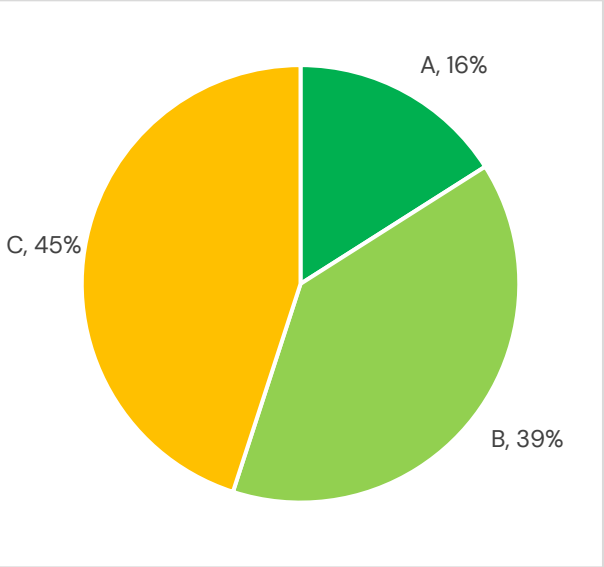
Physical condition of GP premises– ABUHB



BCUHB

45% of estate is Condition C:

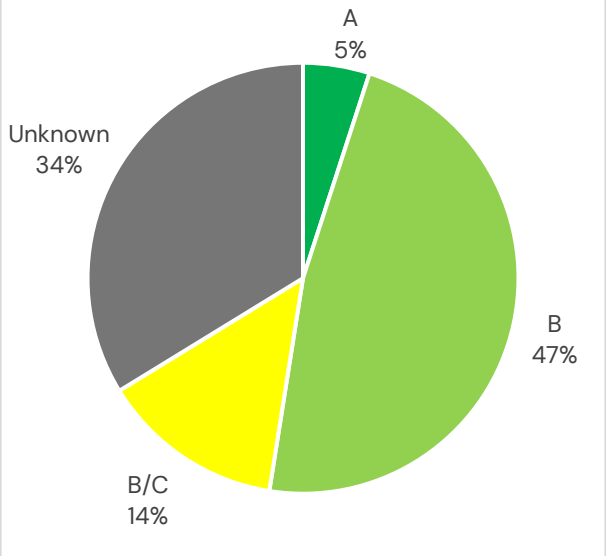
Physical condition of GP premises – BCUHB



CVUHB

Just under half estate is Condition B:

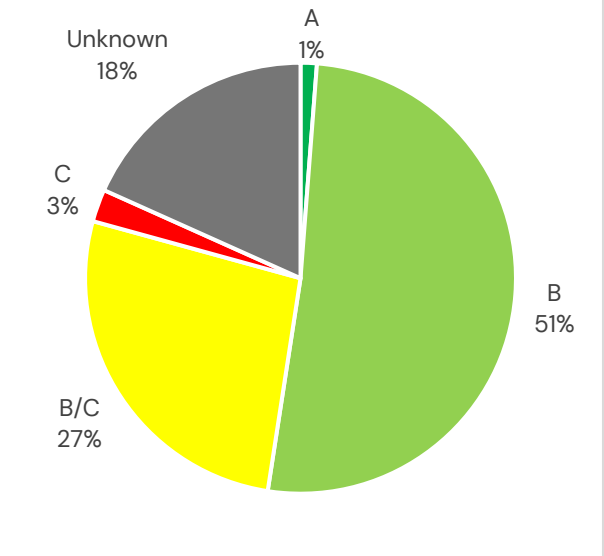
Physical condition of GP premises – CVUHB



CTMUHB

Just over half estate is Condition B:

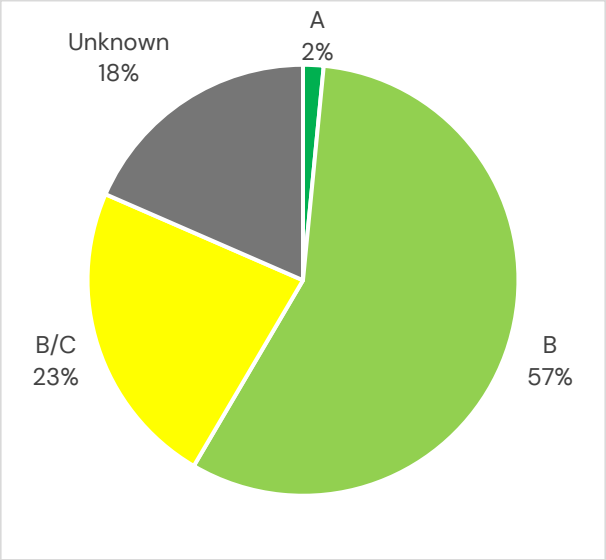
Physical condition of GP premises – CTMUHB



HDUHB

80% of the estate is Condition B or B/C:

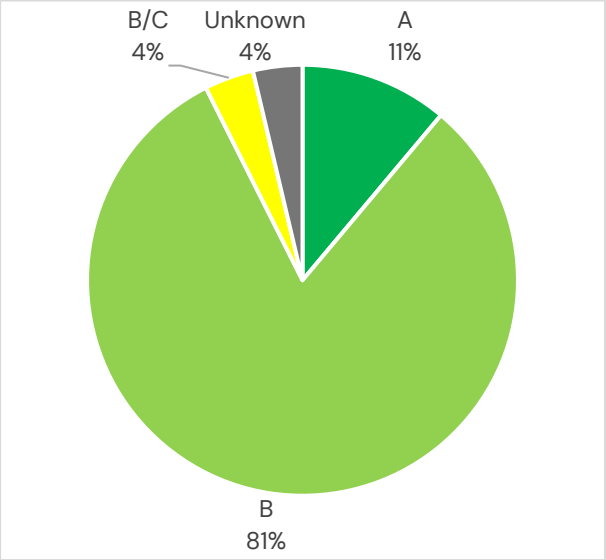
Physical condition of GP premises – HDUHB



PTHB

81% of the estate is Condition B:

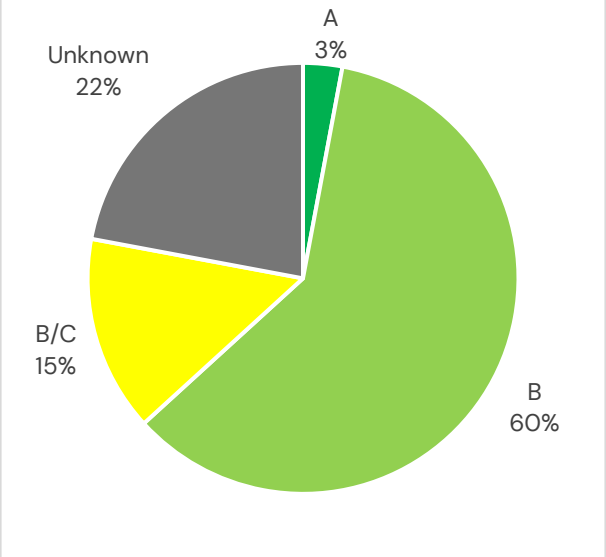
Physical condition of GP premises – PTHB



SBUHB

60% of the estate is condition B:

Physical condition of GP premises – SBUHB

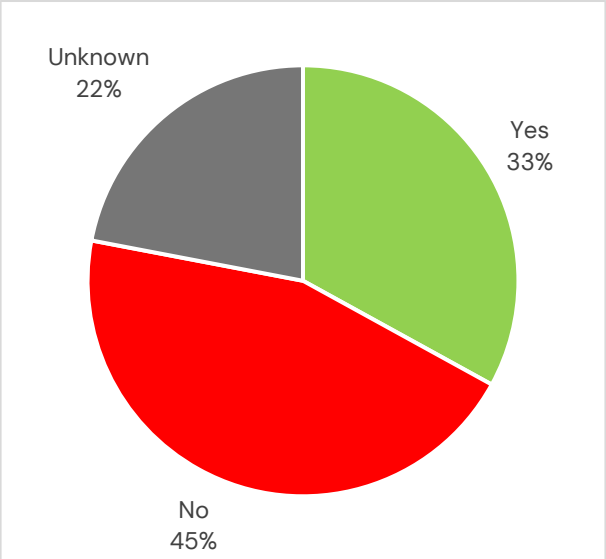


DDA Compliance

ABUHB

33% of the estate is shown to be compliant:

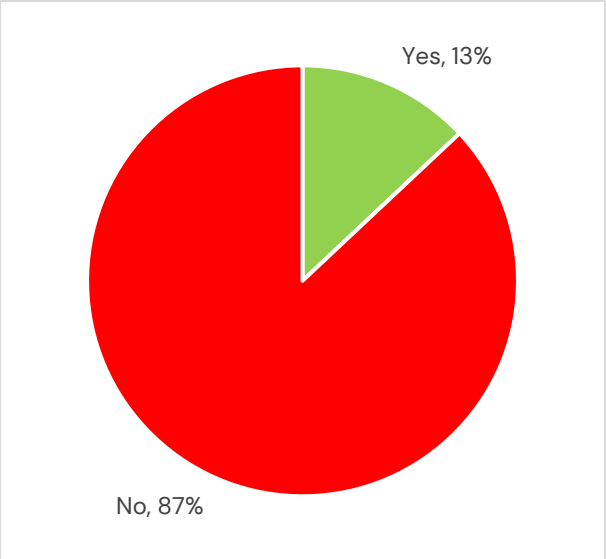
DDA Compliance of GP premises – ABUHB



BCUHB

13% of the estate is shown to be compliant:

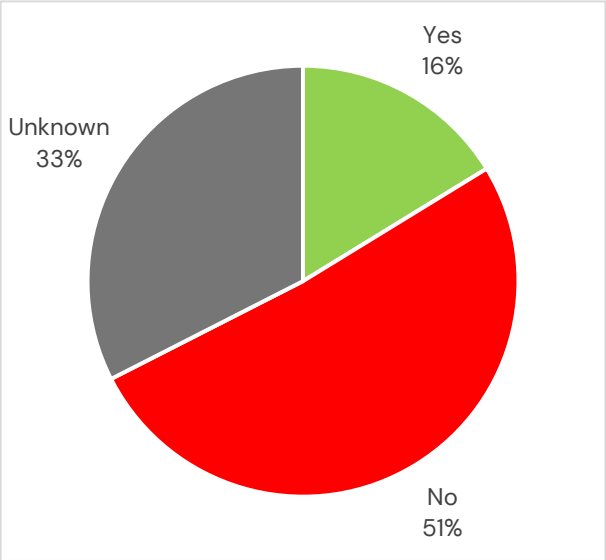
DDA Compliance of GP premises – BCUHB



CVUHB

16% of the estate is shown to be compliant:

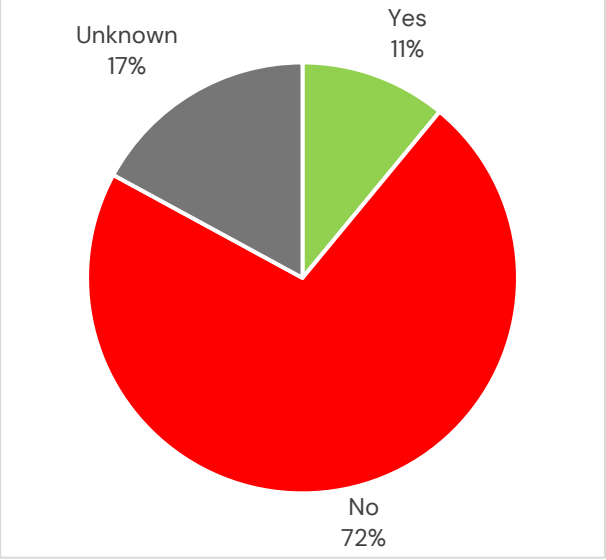
DDA Compliance of GP premises – CVUHB



CTMUHB

11% of the estate is shown to be compliant:

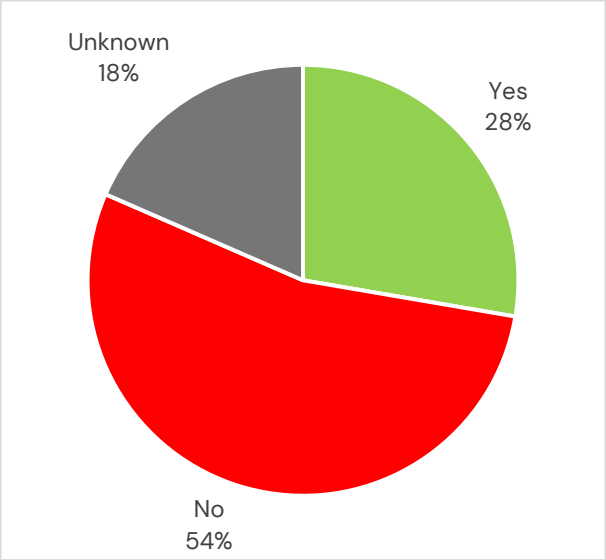
DDA compliance of GP premises – CTMUHB



HDUHB

28% of the estate is shown to be compliant:

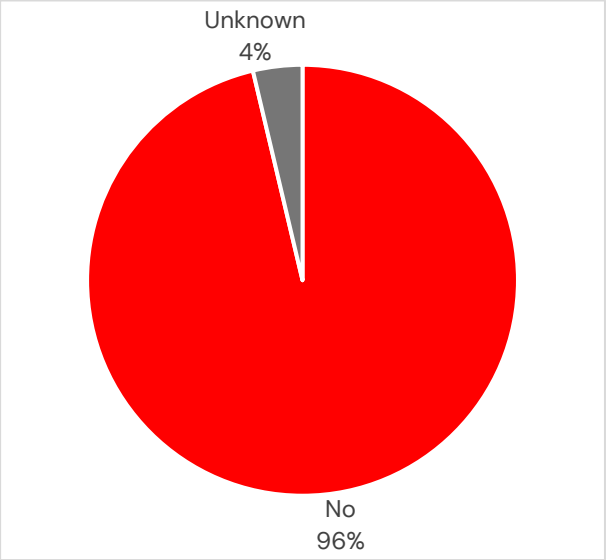
DDA Compliance of GP premises - HDUHB



PTHB

None of the estate is shown to be compliant:

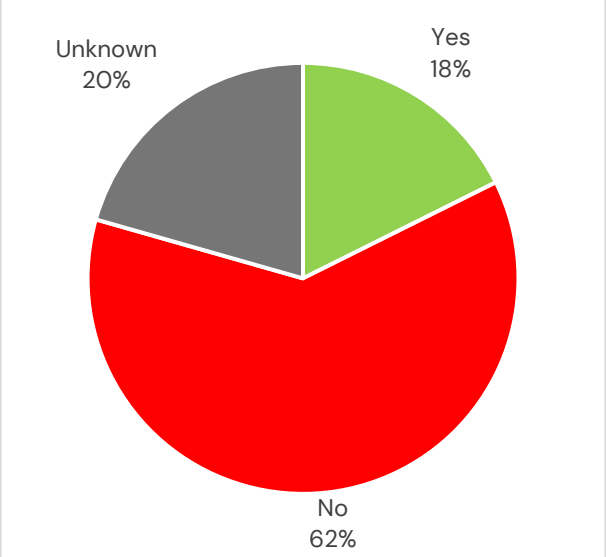
DDA Compliance of GP premises - PTHB



SBUHB

18% of the estate is shown to be DDA-compliant:

DDA Compliance of GP premises - SBUHB

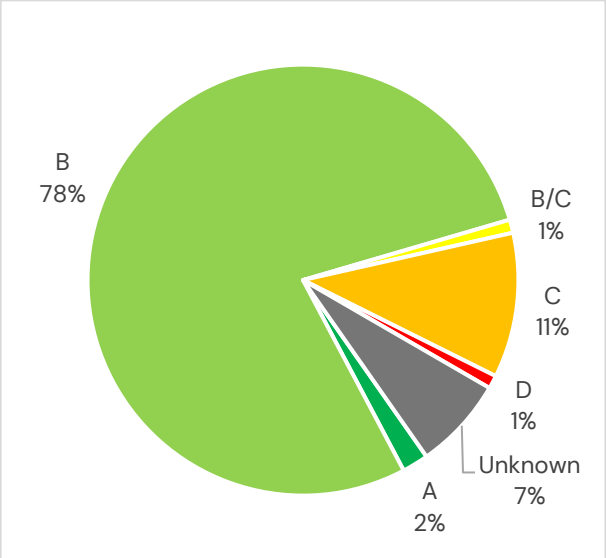


Functional suitability

ABUHB

78% of premises are shown to be Condition B; 2% Condition A:

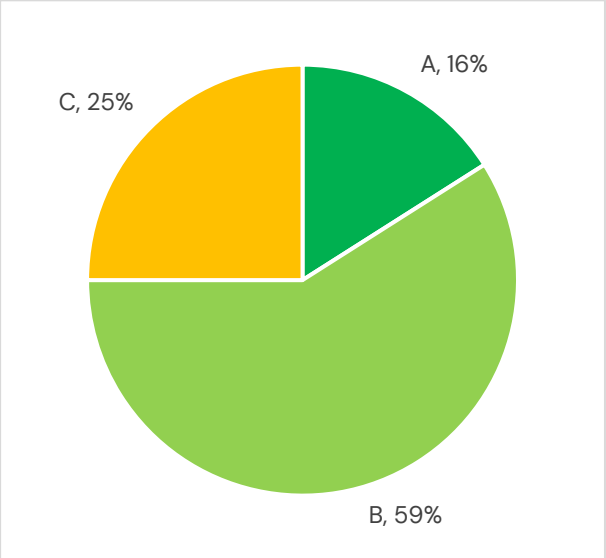
Functional suitability of GP premises - ABUHB



BCUHB

59% of premises are shown to be Condition B; 16% Condition A:

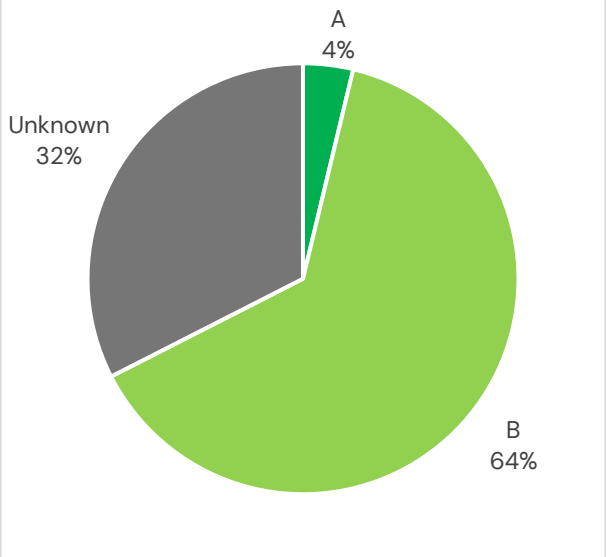
Functional suitability of GP premises - BCUHB



CVUHB

64% of premises are shown to be Condition B; 4% Condition A:

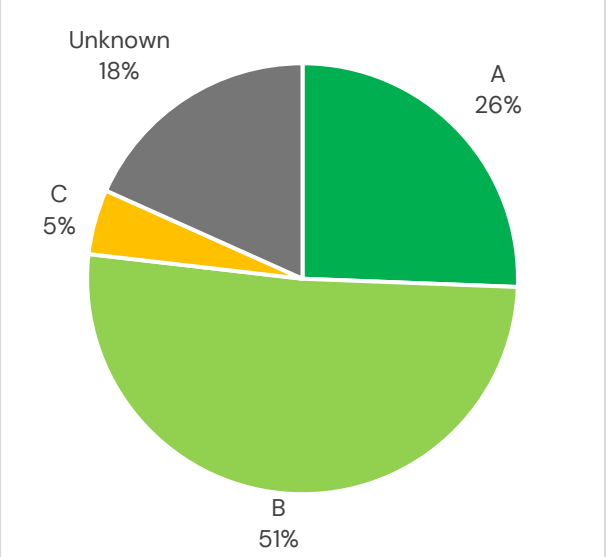
Functional suitability of GP premises - CVUHB



CTMUHB

51% of premises are shown to be Condition B; 26% Condition A:

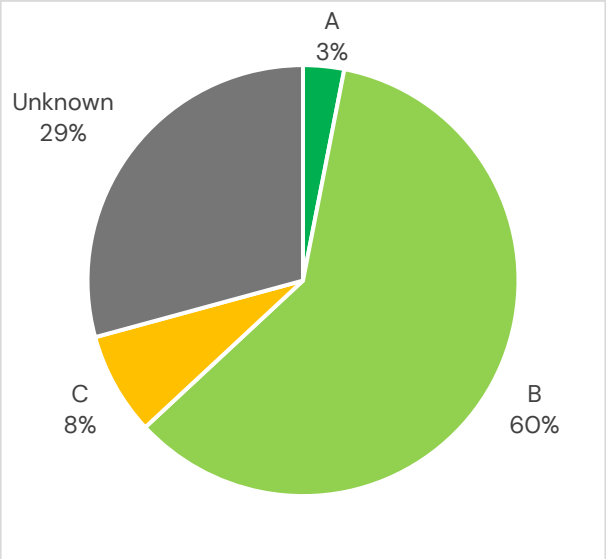
Functional suitability of GP premises - CTMUHB



HDUHB

60% of premises are shown to be Condition B; 3% Condition A:

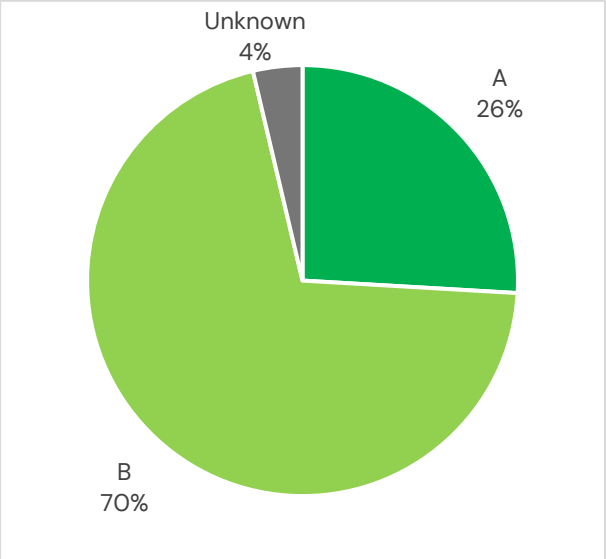
Functional suitability of GP premises - HDUHB



PTHB

70% of premises are shown to be Condition B; 26% Condition A:

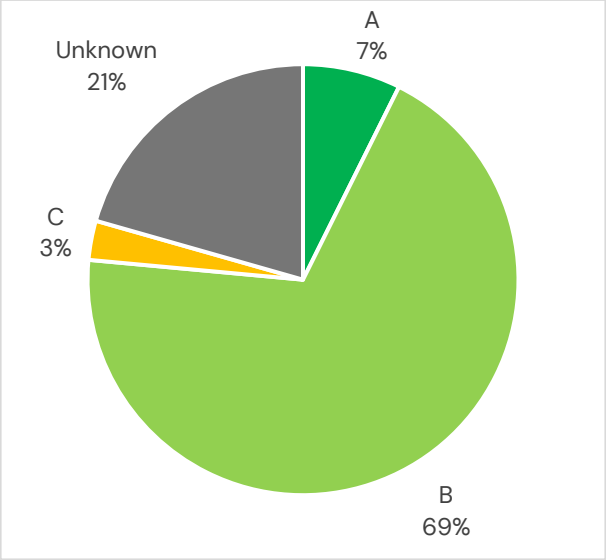
Functional suitability of GP premises - PTHB



SBUHB

69% of premises are shown to be Condition B; 7% Condition A:

Functional suitability of GP premises - SBUHB

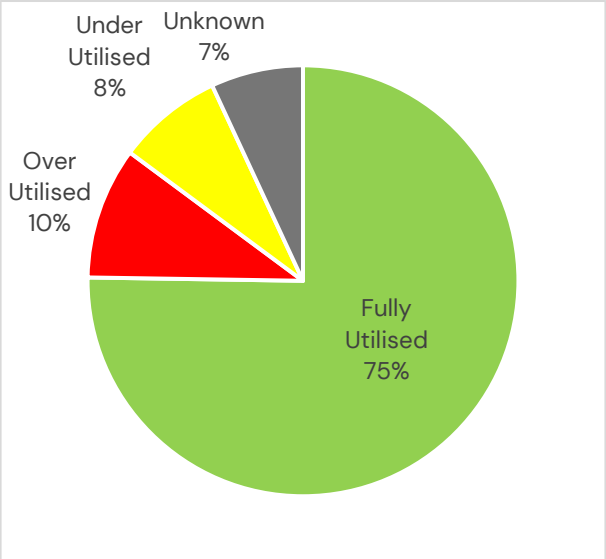


Space utilisation

ABUHB

75% is shown to be fully utilised:

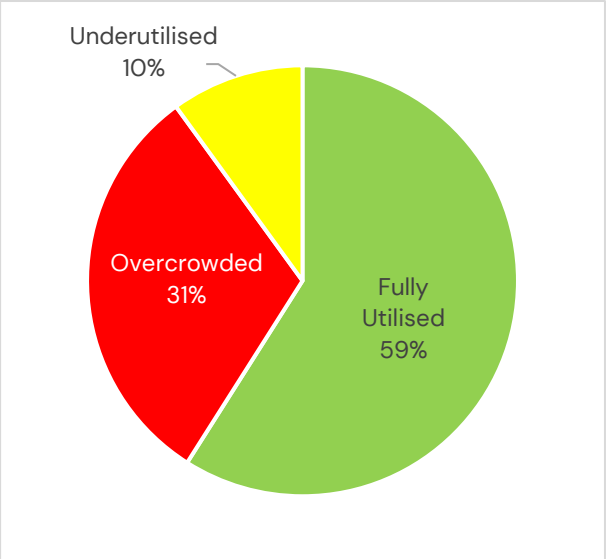
Space utilisation of GP premises - ABUHB



BCUHB

59% is shown to be fully utilised:

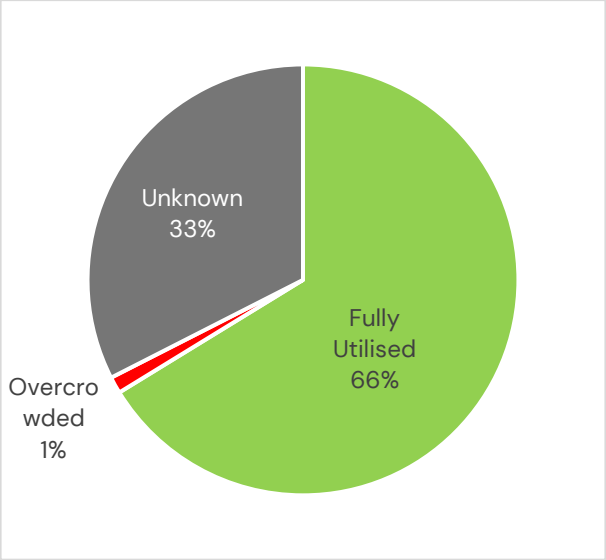
Space utilisation of GP premises - BCUHB



CVUHB

66% is shown to be fully utilised:

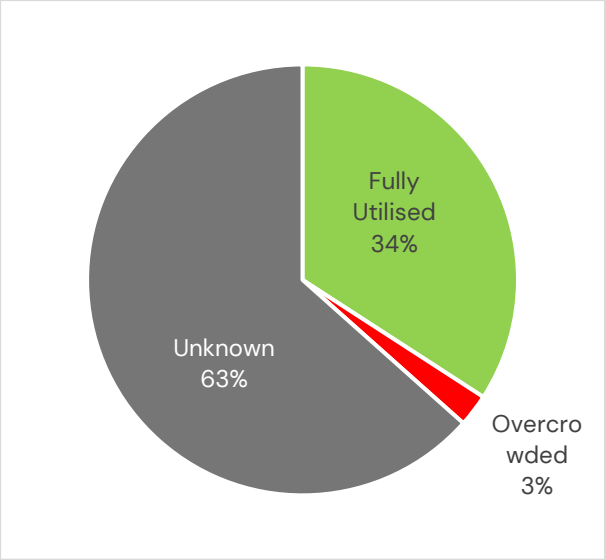
Space utilisation of GP premises - CVUHB



CTMUHB

34% is shown to be fully utilised:

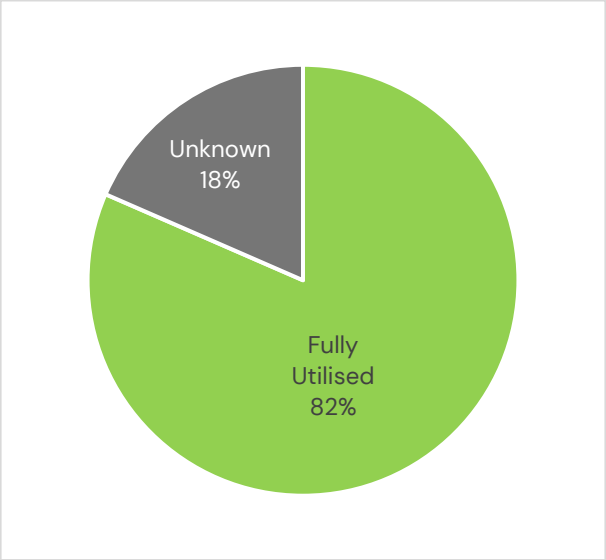
Space utilisation of GP premises - CTMUHB



HDUHB

82% is shown to be fully utilised:

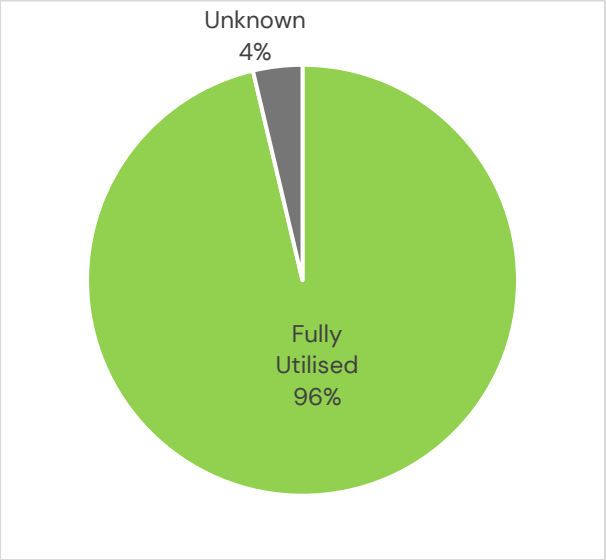
Space utilisation of GP premises - HDUHB



PTHB

96% is shown to be fully utilised:

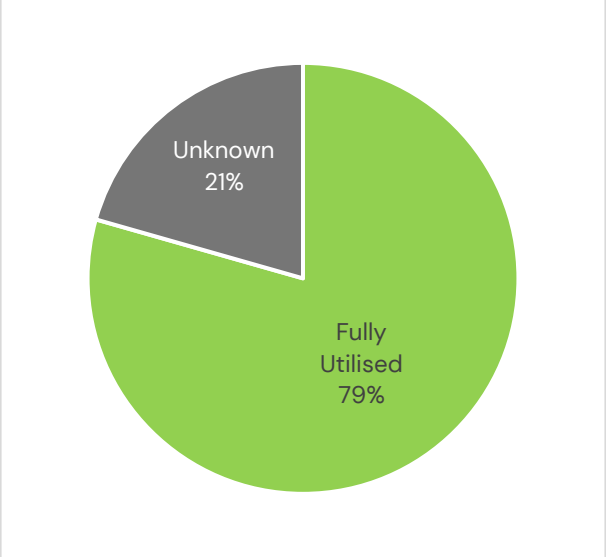
Space utilisation of GP premises - PTHB



SBUHB

79% is shown to be fully utilised:

Space utilisation of GP premises - SBUHB



Known costs

Six facet survey – known cost to achieve Condition B

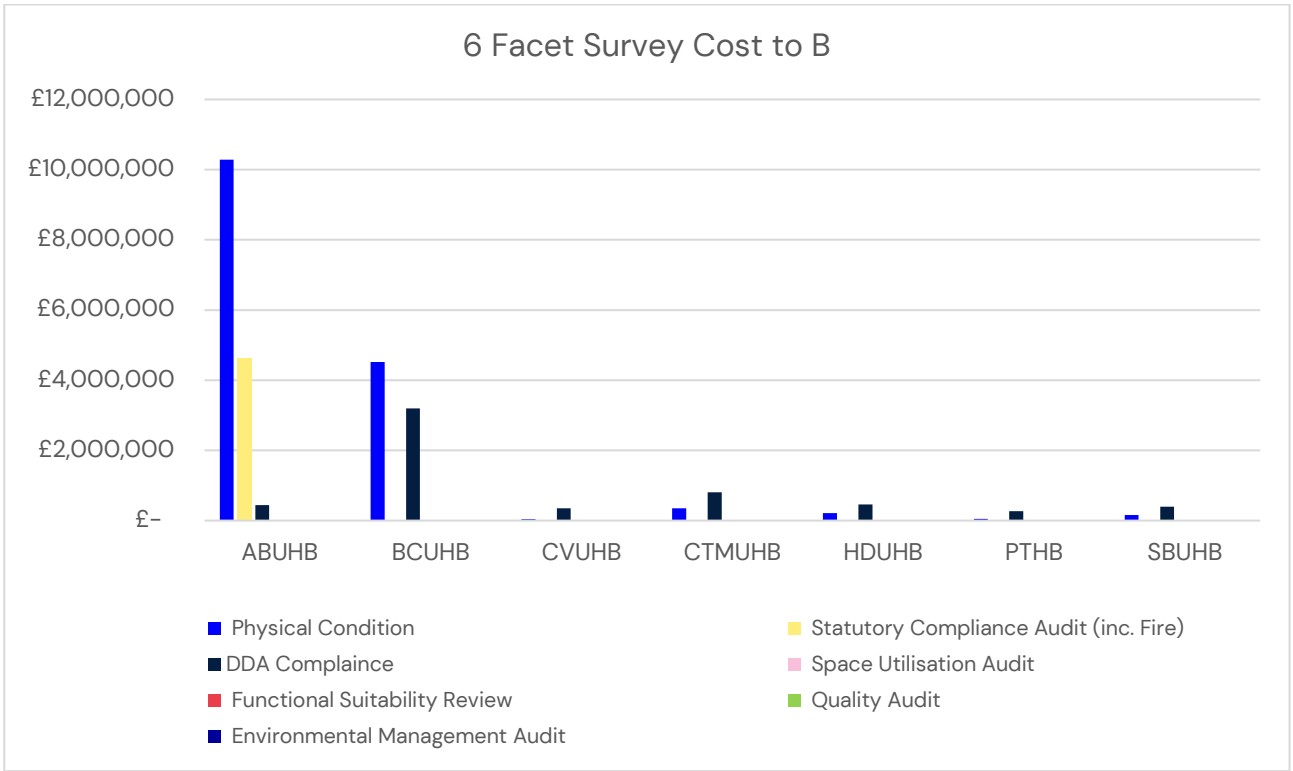
There is not sufficient data to estimate the true cost. The known cost to achieve Condition B per Health Board is as follows:

Known costs to achieve Condition B by facet,per Health Board

	Physical Condition	Statutory Comp.	DDA Comp.	Space Utilisation	Functional Suitability	Quality	Env. Mgmt	total
ABUHB	£10,281,843	£4,638,807	£439,752					**£15,360,402**
BCUHB	£4,521,276		£3,200,000					**£7,721,276**
CVUHB	£41,890		£353,761					**£395,651**
CTMUHB	£349,373	Not provided	£804,663	Not provided	Not provided	Not provided	Not provided	**£1,154,036**
HDUHB	£211,553		£455,442					**£666,995**
PTHB	£50,907		£268,250					**£319,157**
SBUHB	£160,193		£396,926					**£557,119**

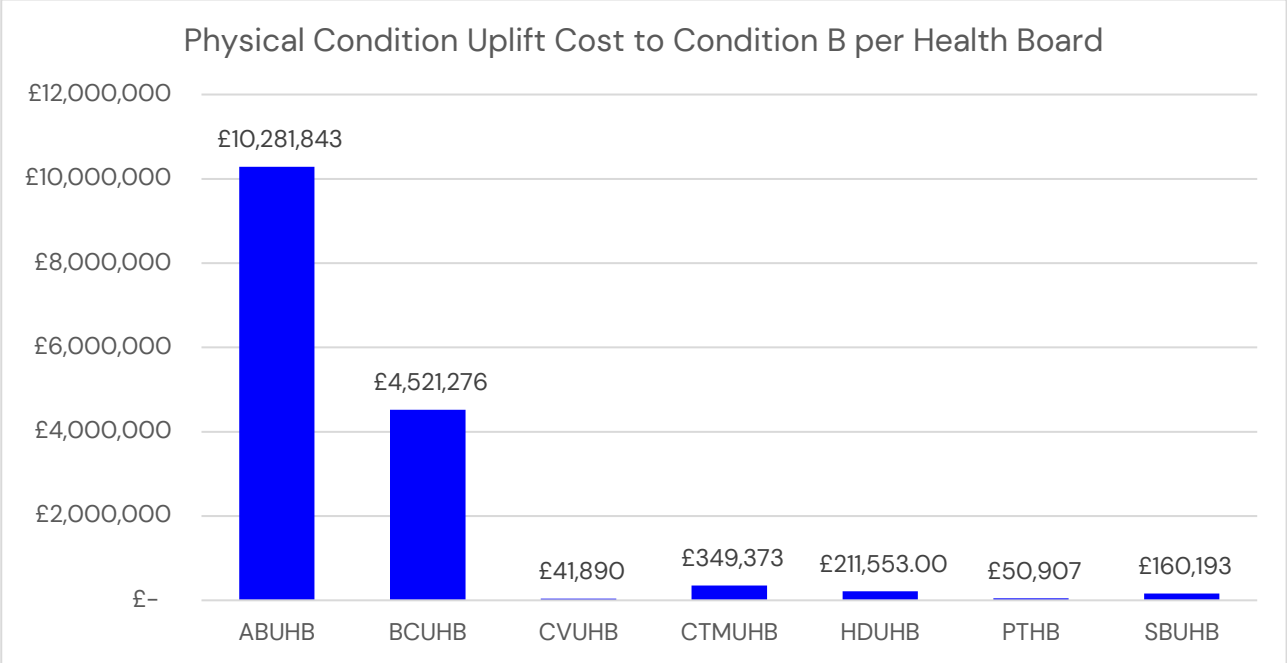
Uplift costs to Condition B

Health Board known costs to condition B across the facets, range from £41,890 to £10,281,843:



Uplift costs to Physical Condition B

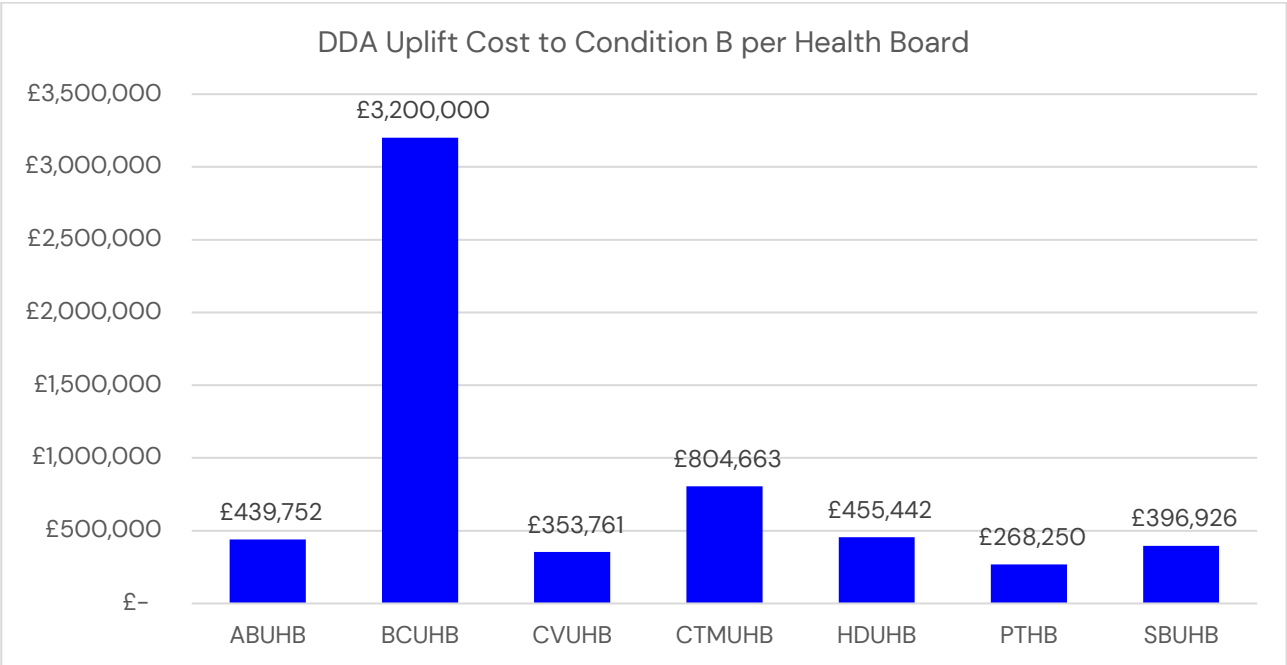
Cost to achieve Physical Condition B per Health Board



Uplift costs to DDA compliance condition B

Known costs to DDA condition B range from £268,250 to £3,200,000:

Cost to achieve Physical Condition B per Health Board



Appendix C - Health Board Demographic Maps (and introduction)

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Appendix C0 – Introduction to Mapping

May 2021

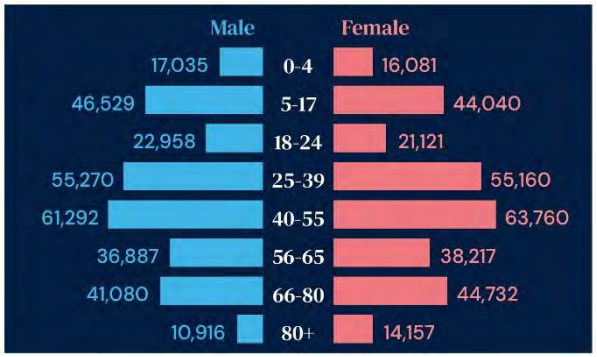
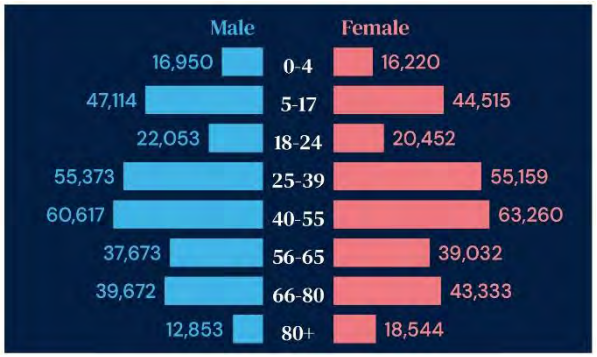
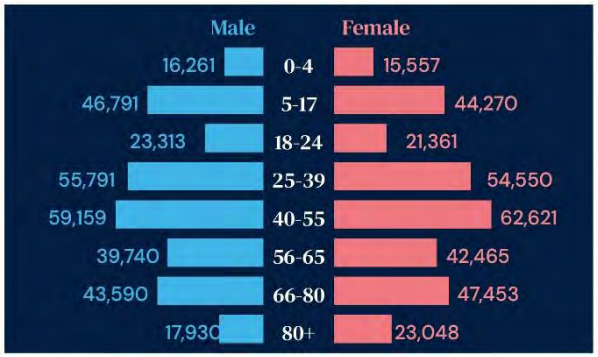
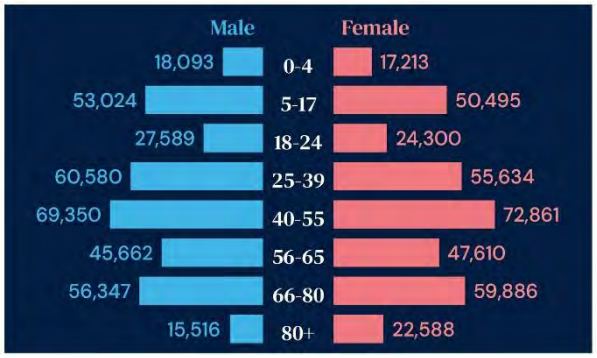
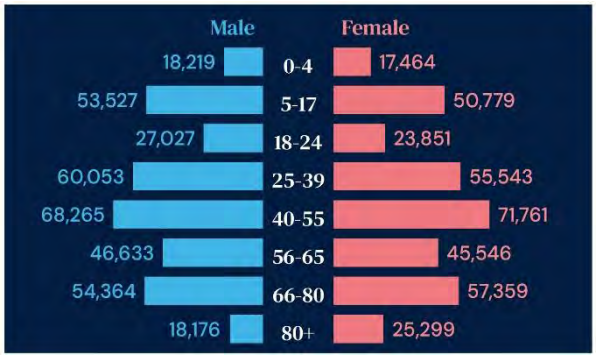
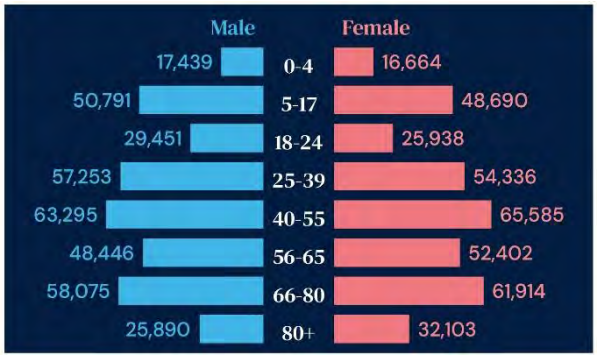
Contents

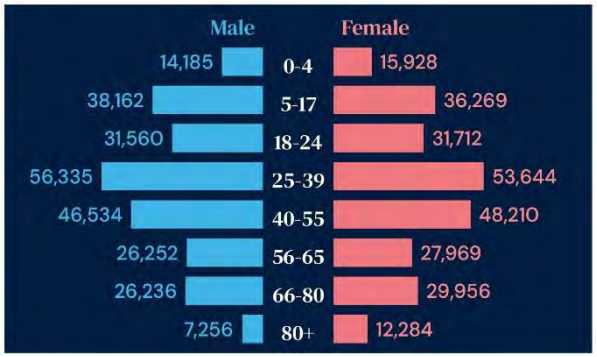
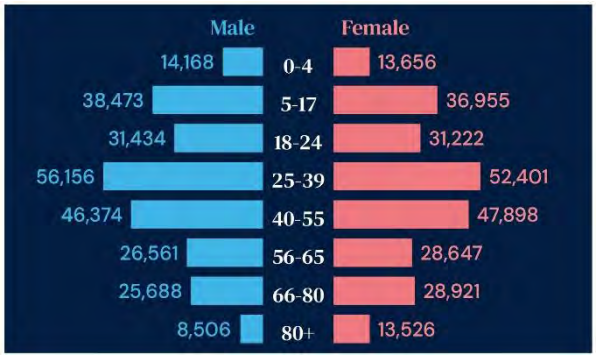
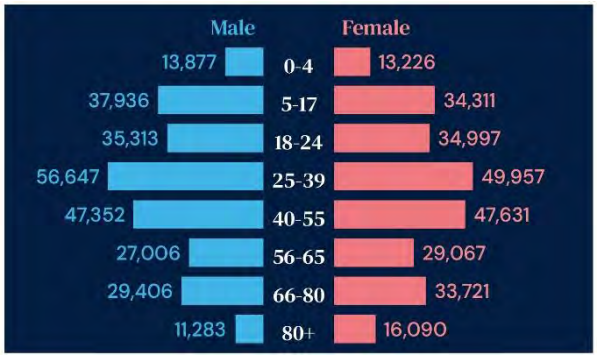
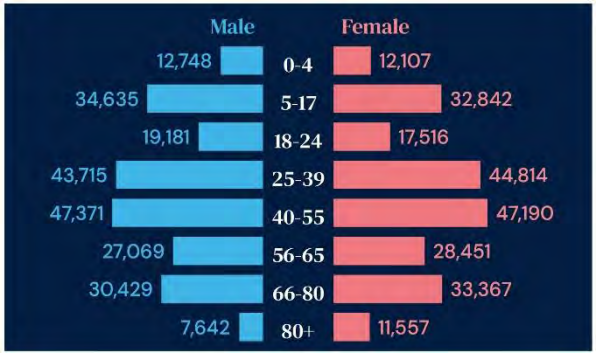
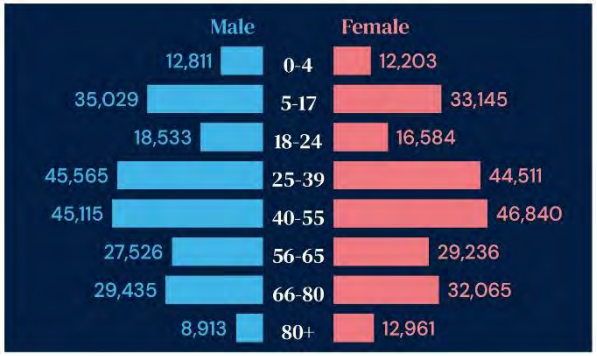
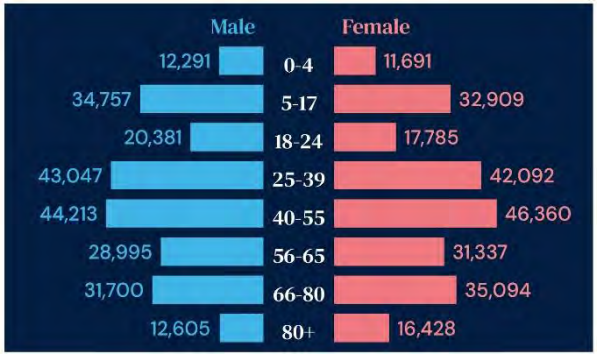
1 Introduction

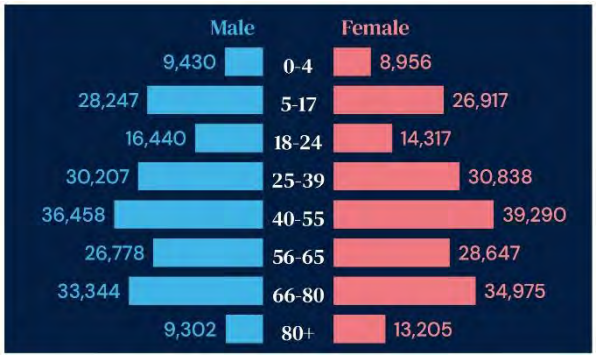
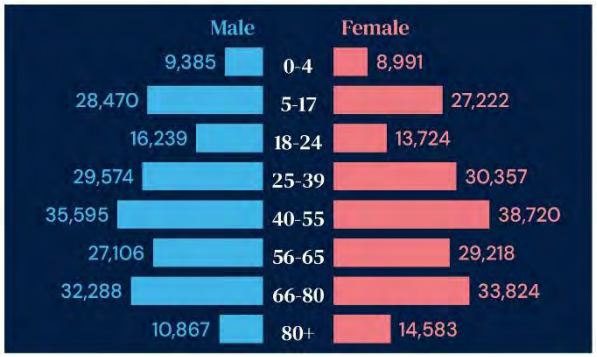
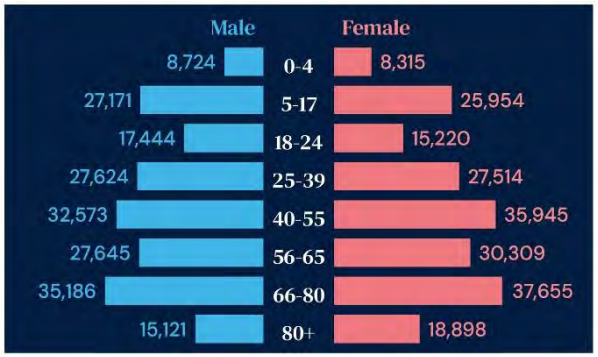
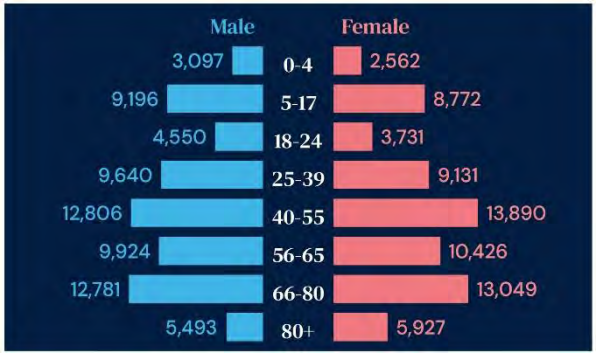
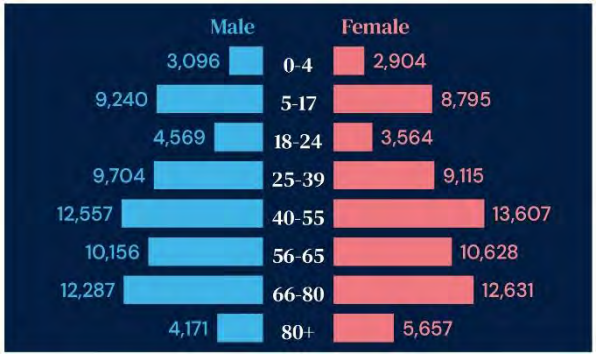
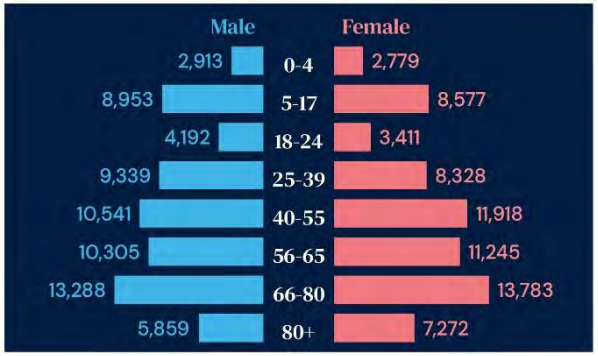
The population growth and changes can be seen below with the charts showing the growth by age group from 2019 – 2021. This is followed by projected growth assessed by individual Health Board in the next 20 years. Whilst there are some general observations particularly around the increase in people over the age of 66 years and again in people aged 80 years plus, there are some differences evident each Health Board that can be used to profile the health needs of local populations.

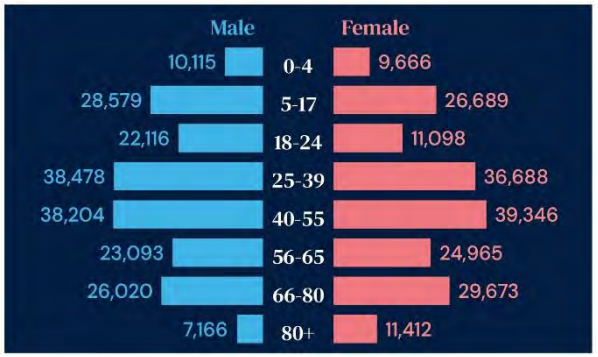
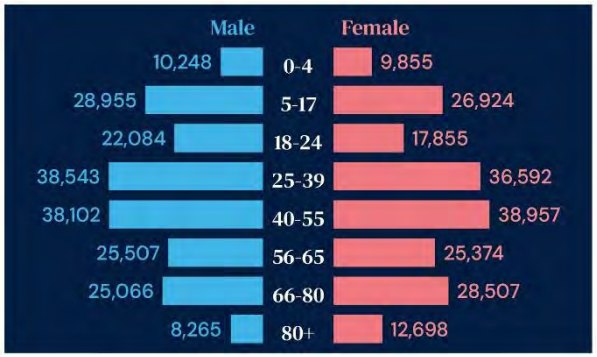
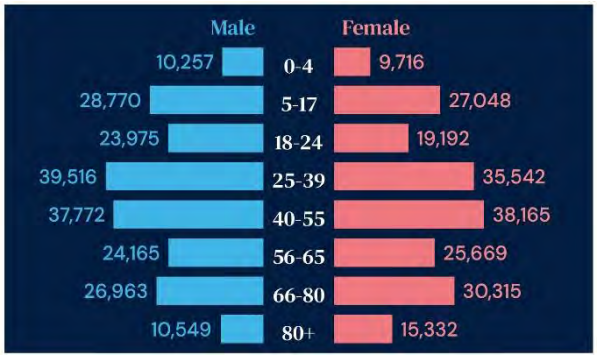
The individual Health Board sections show these differences split by age groups, concentrations of those age groups for health planning purposes and access to health and wellbeing options.

2 Population forecasts

	Population 2019	Population changes by 2021	Estimated growth over 20 years
Aneurin Bevan UHB			
Betsi Cadwaladr UHB			

	Population 2019	Population changes by 2021	Estimated growth over 20 years
Cardiff and Vale UHB			
Cwm Taf Morgannwg UHB			

	Population 2019	Population changes by 2021	Estimated growth over 20 years
Hywel Dda UHB			
Powys THB			

	Population 2019	Population changes by 2021	Estimated growth over 20 years
Swansea Bay UHB			

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Appendix C1 – Aneurin Bevan Health Board mapping

May 2021

Contents

1 Introduction

1.1 Demographic Observations

Review of the Demographic profile below shows that there have been high levels of growth over recent years. This growth will continue but is shown to be significantly higher in the numbers of people over the age of 66 years.

In 2021 the numbers of 0-4 years have been seen to have dropped and the numbers of 5-17 years increasing; these numbers of people can also be seen in different concentrations of high to low numbers in different areas within the Health Boards profile. This information will assist in ensuring that different types of healthcare are delivered in the right areas and services can be planned appropriately for future growth for instance the needs within areas with high levels of young people will differ than those where concentrations of elderly populations over 80 years can be seen.

1.2 Patient Need

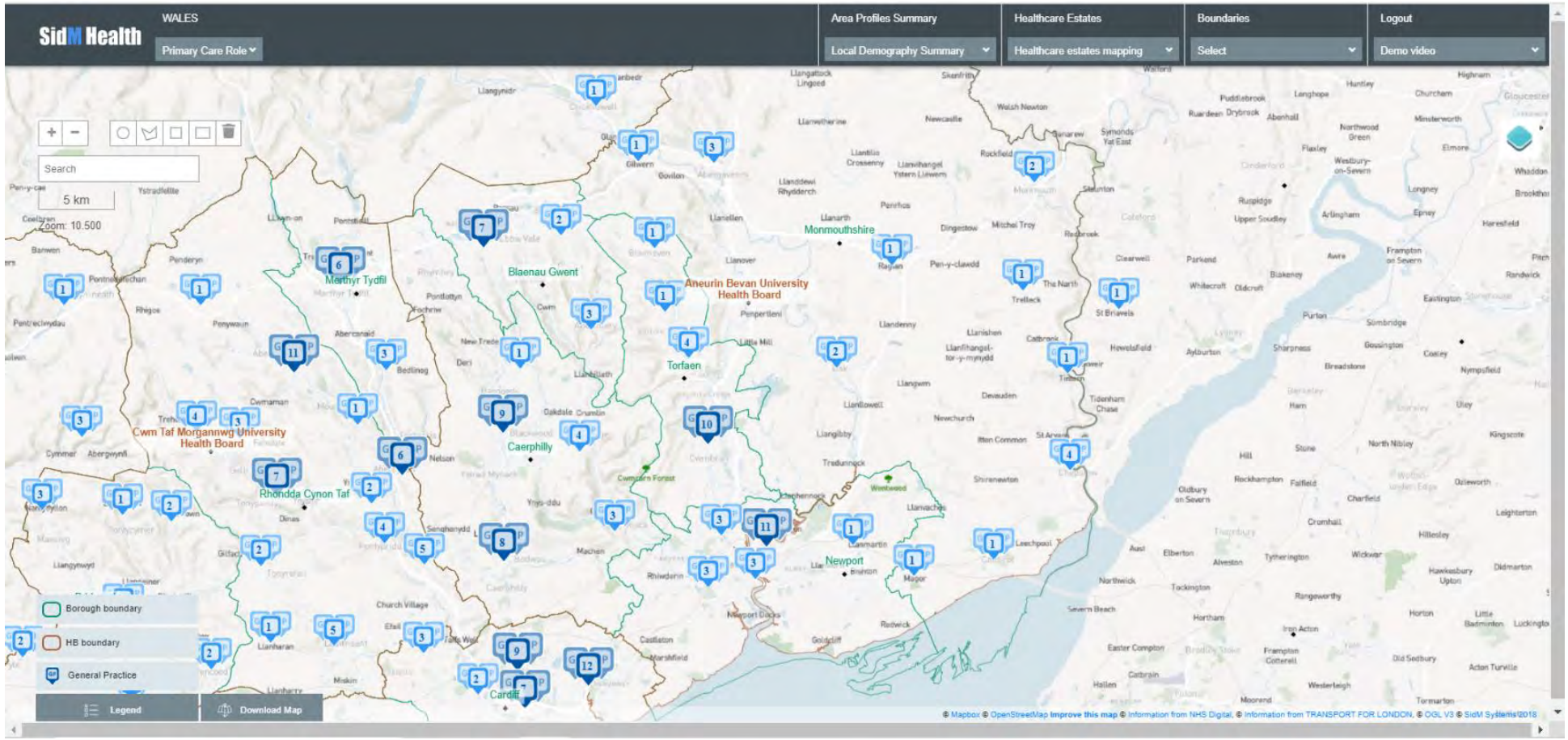
Since the population in areas of the Health Board has grown and the numbers of aging patients who have a higher requirement for health services has increased, there will be a growing impact on primary care in these areas. Several key observations for the Health Board can be seen:

- The numbers of people aged 66+ will continue to increase for the next 20 years. It is noticeable in recent increases and future projections that the numbers of females are significantly higher.
- Deprivation scores across the area are average but where deprivation scores are higher key service provision assessments can be made ensuring all needs are met across all ages – addressing the entire spectrum of people's physical, mental and social needs.
- The numbers of 0-4 years have decreased but new housing development planning agreements should be assessed to link expected growth projections.
- Analysis of access to the wider services such as pharmacies, dentists and leisure allows an assessment of the best options to provide an integrated approach to health and social care enabling people with more complex conditions to be offered screening and secondary prevention reflecting their higher risk of poor physical health.

1.3 Mapping and Statistics

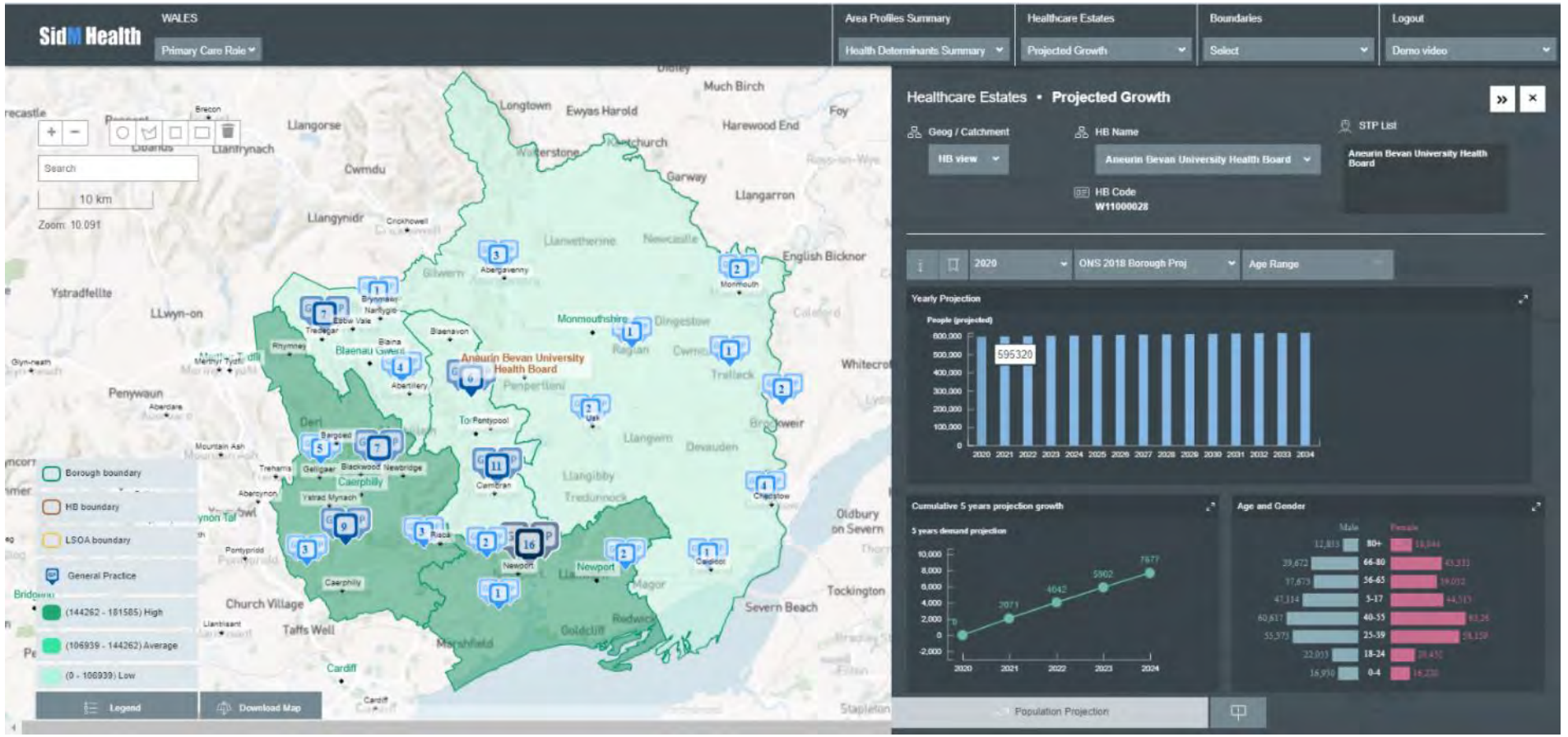
The maps below give a detailed view of the current and future population growth by age. Areas of population concentration can be identified via the heat maps, as well as access to services such as, General Practice, acute units, wider health service needs and leisure. Overall deprivation by borough is displayed against General Practice provision in section 7. Distance of travel to General Practices are demonstrated on the final map, in section 8, via an 8km catchment area

2 General Practice Location Map

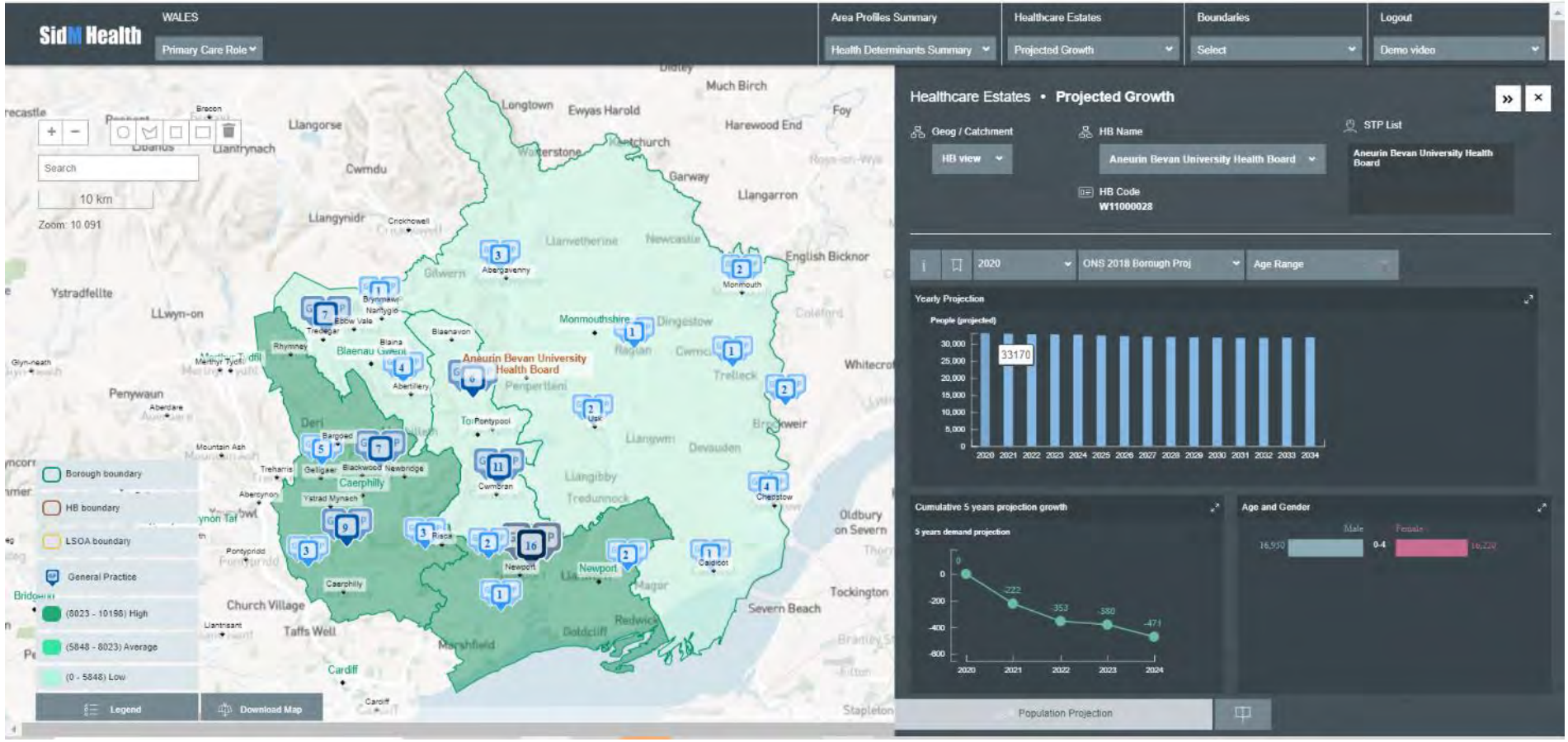


3 Population Projection by Local Authority 2020

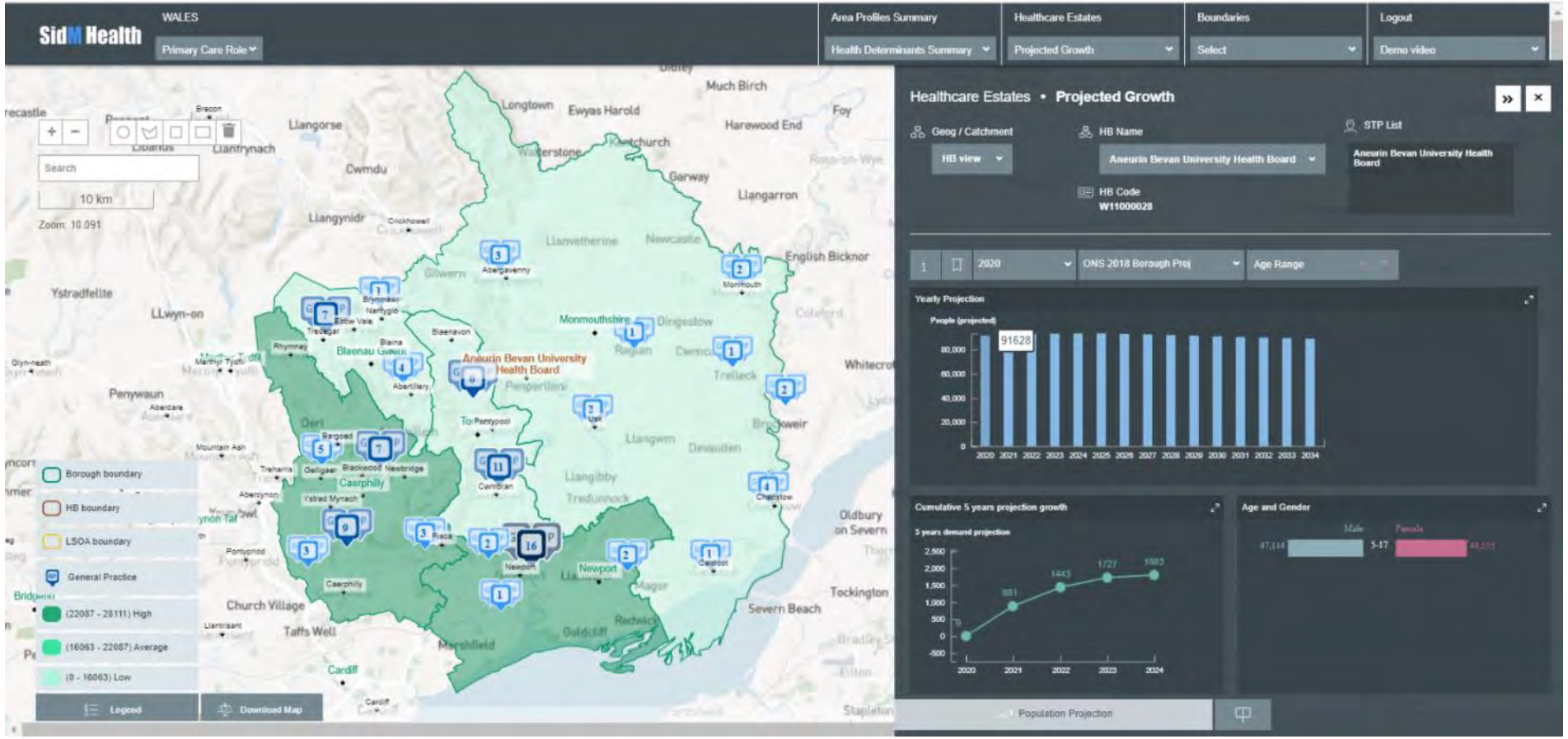
3.1 All Ages



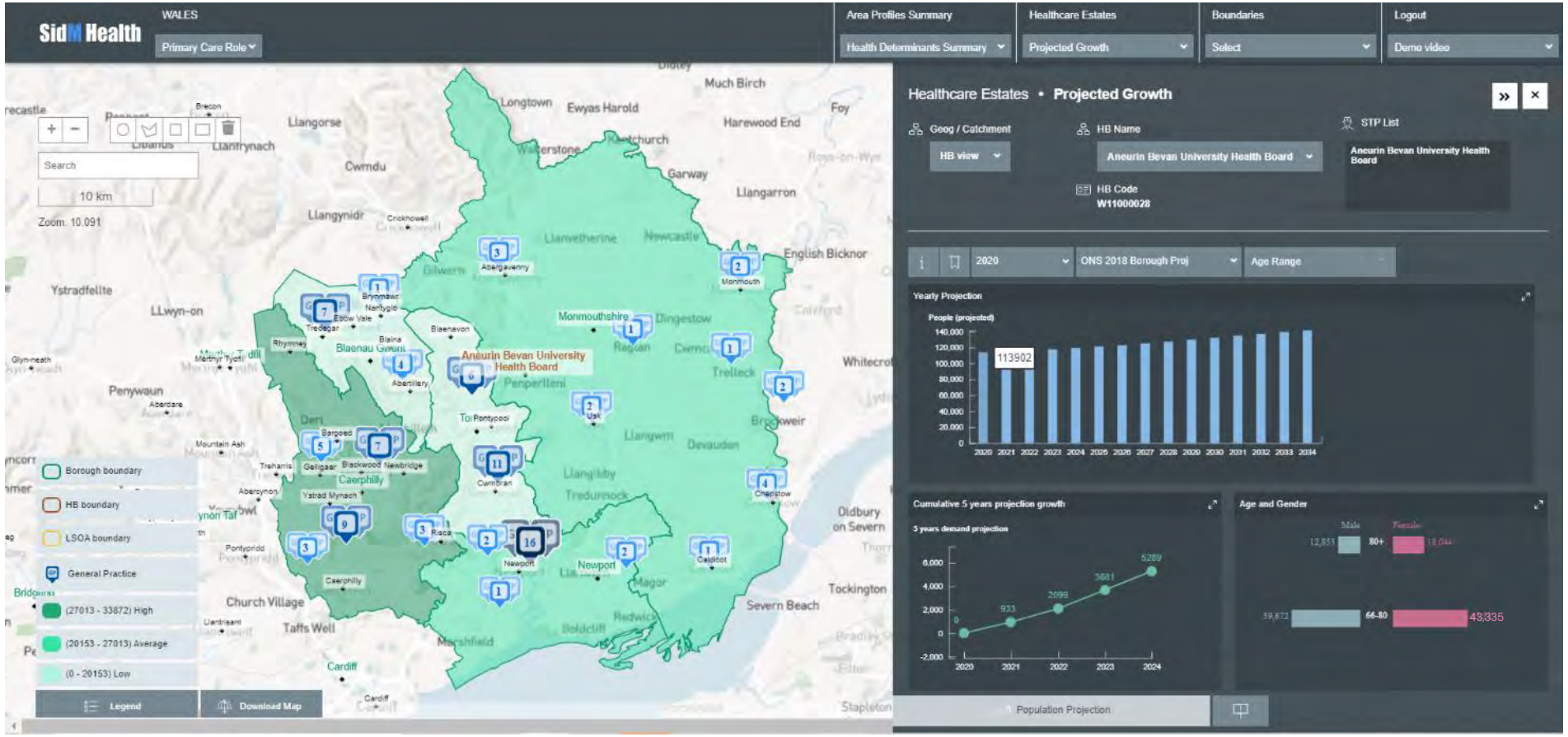
3.2 Ages 0 – 4


SidM Health
WALES
Primary Care Role
Area Profiles Summary
Health Determinants Summary
Healthcare Estates
Projected Growth
Boundaries
Select
Logout
Demo video
Search
10 km
Zoom: 10.091
Aneurin Bevan University Health Board
Borough boundary
HB boundary
LSOA boundary
General Practice
(8023 - 10198) High
(5848 - 8023) Average
(0 - 5848) Low
Legend
Download Map
Healthcare Estates • Projected Growth
Geog / Catchment
HB view
HB Name
Aneurin Bevan University Health Board
STP List
HB Code
W11000028
2020
ONS 2018 Borough Proj
Age Range
Yearly Projection
People (projected)
33170
Cumulative 5 years projection growth
5 years demand projection
Age and Gender
Male
Female
0-4
Population Projection

3.3 Ages 5 – 17

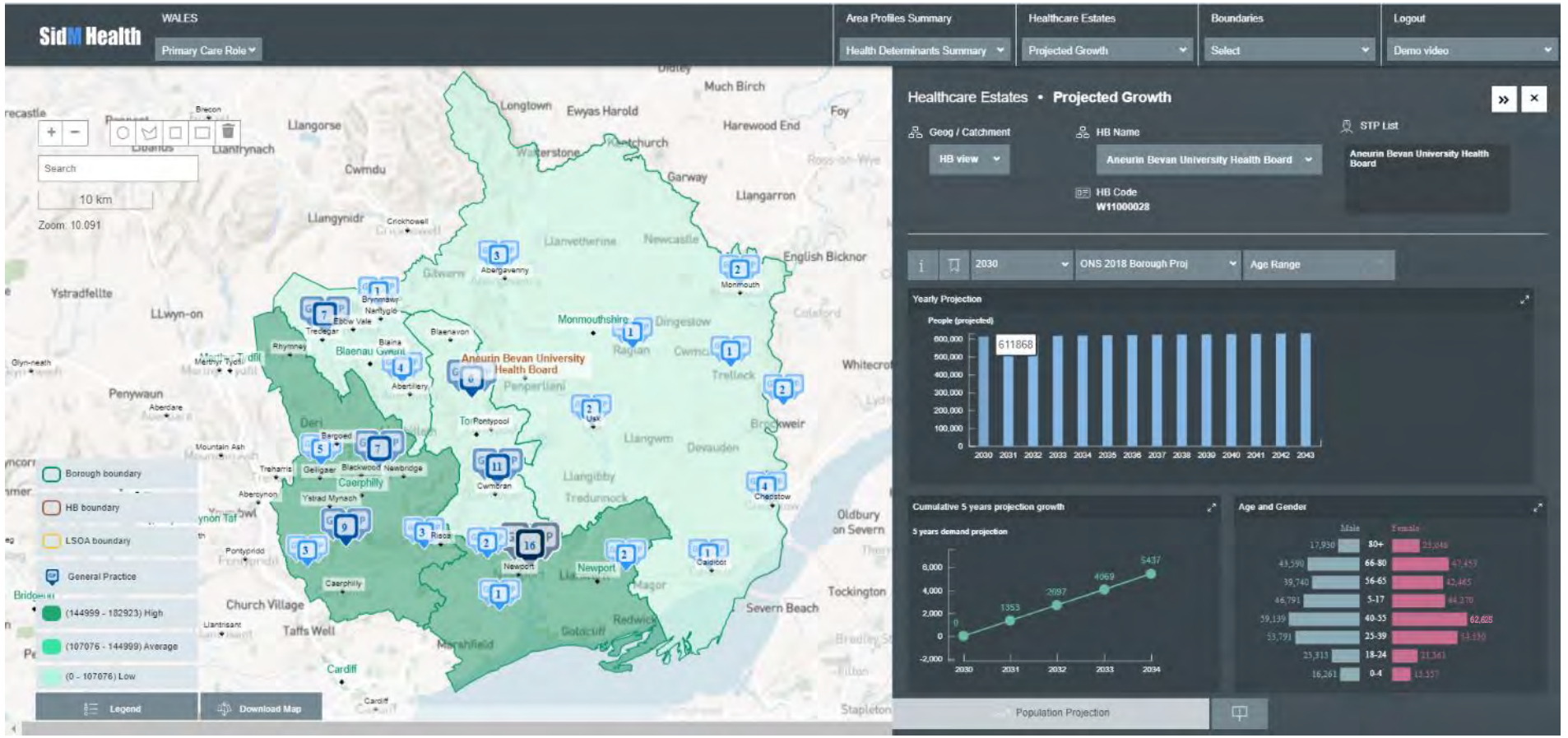

SidM Health
WALES
Primary Care Role
Area Profiles Summary
Health Determinants Summary
Healthcare Estates
Projected Growth
Boundaries
Select
Logout
Demo video
Healthcare Estates • Projected Growth
Geog / Catchment
HB view
HB Name
Aneurin Bevan University Health Board
STP List
Aneurin Bevan University Health Board
HB Code
W11000028
2020
ONS 2018 Borough Proj
Age Range
Yearly Projection
People (projected)
91628
Cumulative 5 years projection growth
5 years demand projection
Age and Gender
Male
Female
5-17
Aneurin Bevan University Health Board
Borough boundary
HB boundary
LSOA boundary
General Practice
(22087 - 28111) High
(16063 - 22087) Average
(0 - 16063) Low
Legend
Download Map
Population Projection

3.4 Ages 66+

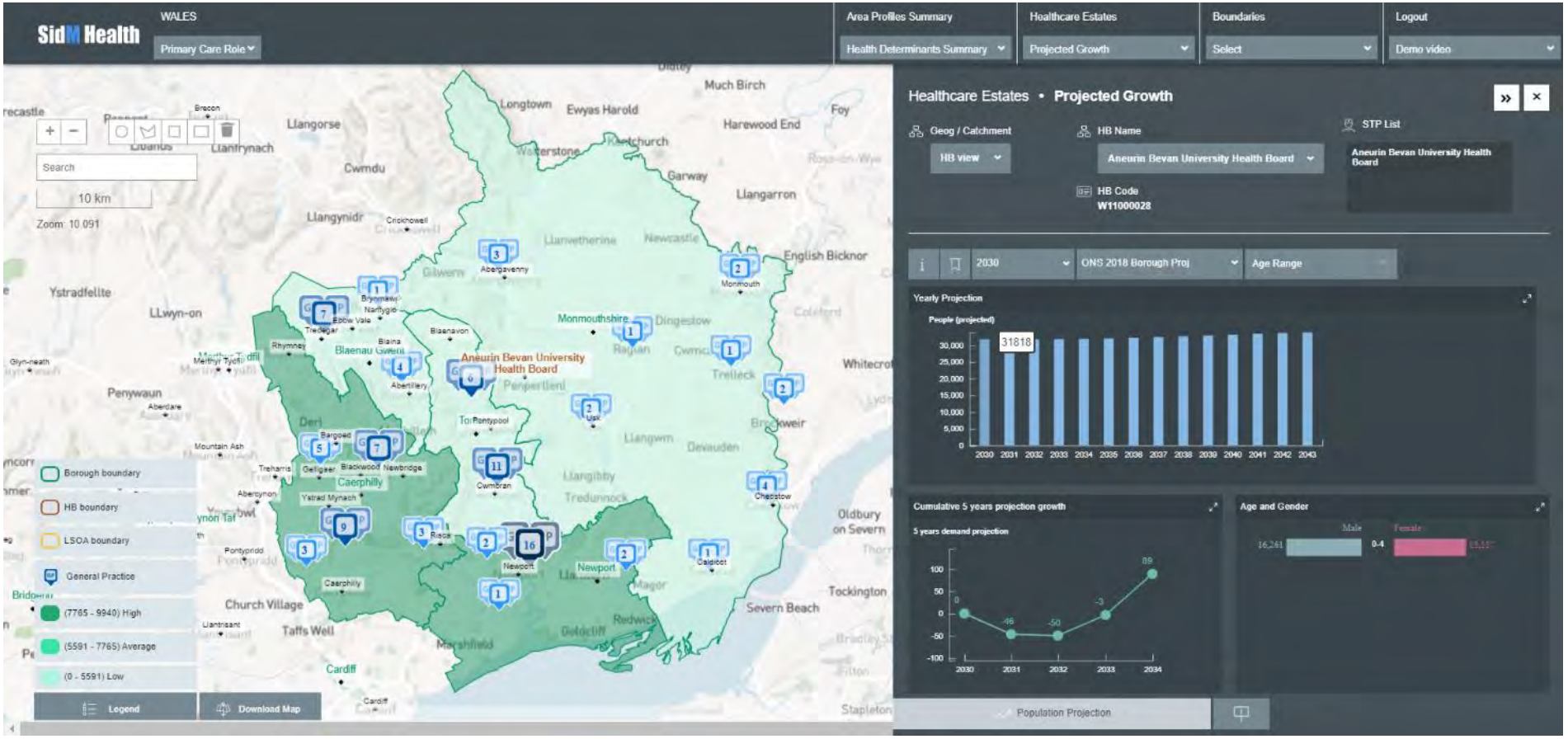

SidH Health
WALES
Primary Care Role
Area Profiles Summary
Health Determinants Summary
Healthcare Estates
Projected Growth
Boundaries
Select
Logout
Demo video
Healthcare Estates • Projected Growth
Geog / Catchment
HB view
HB Name
Aneurin Bevan University Health Board
STP List
Aneurin Bevan University Health Board
HB Code
W11000028
2020
ONS 2018 Borough Proj
Age Range
Yearly Projection
People (projected)
113902
Cumulative 5 years projection growth
5 years demand projection
933
2099
3681
5289
Age and Gender
Male
Female
80+
12,853
18,044
66-80
59,672
43,335
Population Projection
Aneurin Bevan University Health Board
Borough boundary
HB boundary
LSOA boundary
General Practice
(27013 - 33872) High
(20153 - 27013) Average
(0 - 20153) Low
Legend
Download Map
Search
10 km
Zoom: 10.091

4 Population Projection 2030, by Local Authority

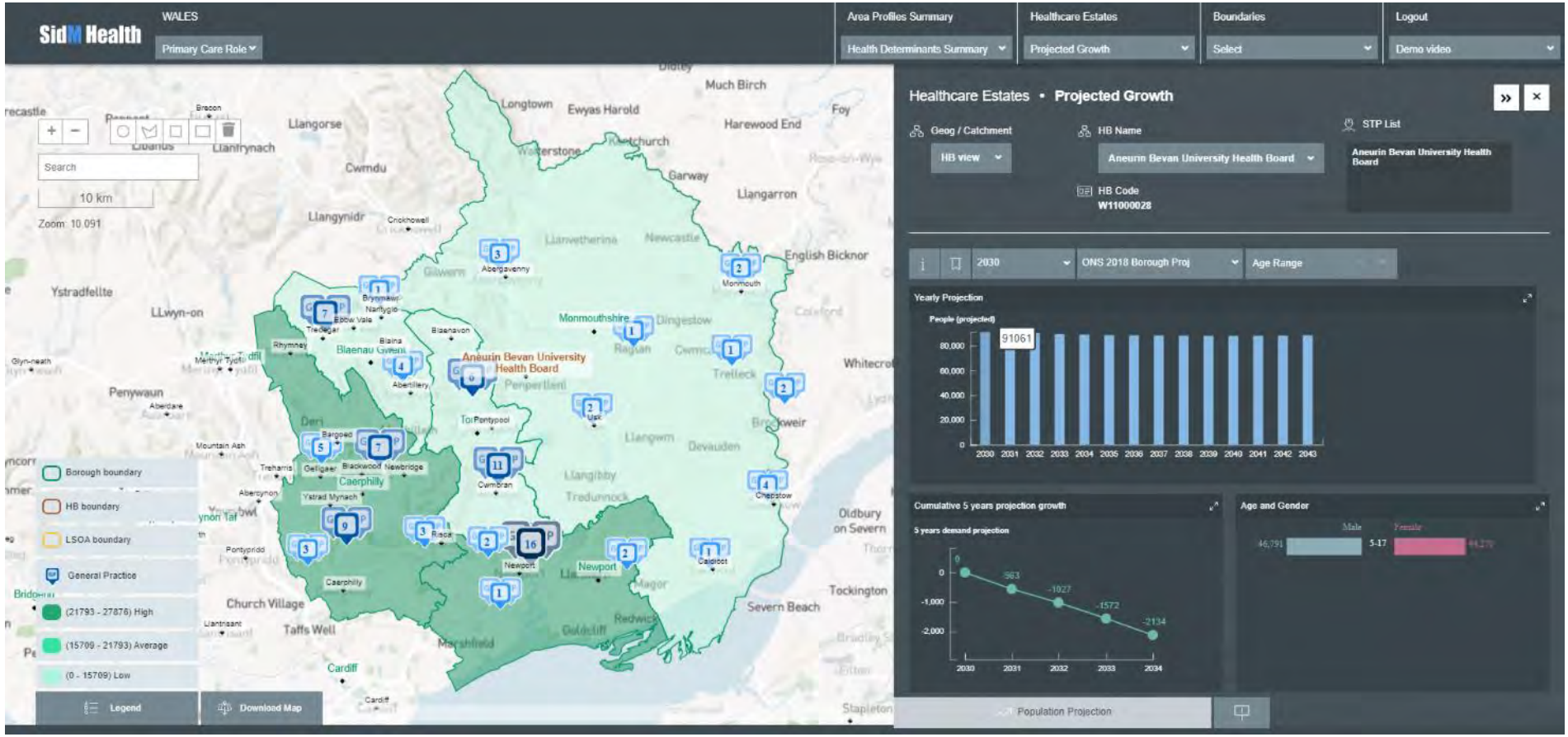
4.1 All Ages



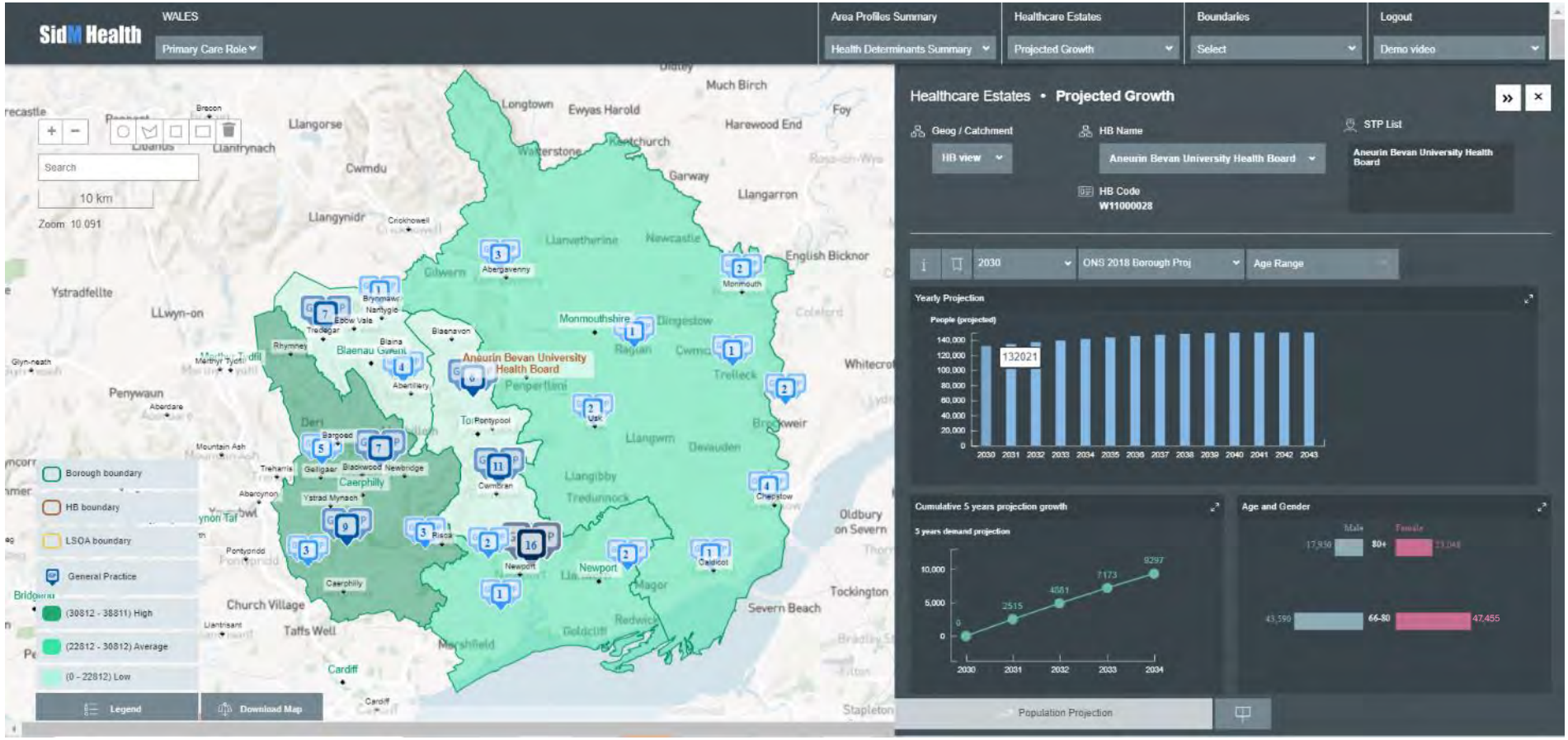
4.2 Ages 0 – 4


SidM Health
WALES
Primary Care Role
Area Profiles Summary
Health Determinants Summary
Healthcare Estates
Projected Growth
Boundaries
Select
Logout
Demo video
Healthcare Estates • Projected Growth
Geog / Catchment
HB view
HB Name
Aneurin Bevan University Health Board
STP List
Aneurin Bevan University Health Board
HB Code
W11000028
2030
ONS 2018 Borough Proj
Age Range
Yearly Projection
People (projected)
31818
Cumulative 5 years projection growth
5 years demand projection
Age and Gender
Male
Female
0-4
Population Projection
Aneurin Bevan University Health Board
Borough boundary
HB boundary
LSOA boundary
General Practice
(7765 - 9940) High
(5591 - 7765) Average
(0 - 5591) Low
Legend
Download Map
Search
10 km
Zoom: 10.091

4.3 Ages 5 – 17


SidM Health
WALES
Primary Care Role
Area Profiles Summary
Health Determinants Summary
Healthcare Estates
Projected Growth
Boundaries
Select
Logout
Demo video
Healthcare Estates • Projected Growth
Geog / Catchment
HB view
HB Name
Aneurin Bevan University Health Board
STP List
Aneurin Bevan University Health Board
HB Code
W11000028
2030
ONS 2018 Borough Proj
Age Range
Yearly Projection
People (projected)
91061
Aneurin Bevan University Health Board
Cumulative 5 years projection growth
5 years demand projection
Age and Gender
Male
Female
5-17
Borough boundary
HB boundary
LSOA boundary
General Practice
(21793 - 27876) High
(15709 - 21793) Average
(0 - 15709) Low
Legend
Download Map
Population Projection

4.4 Ages 66+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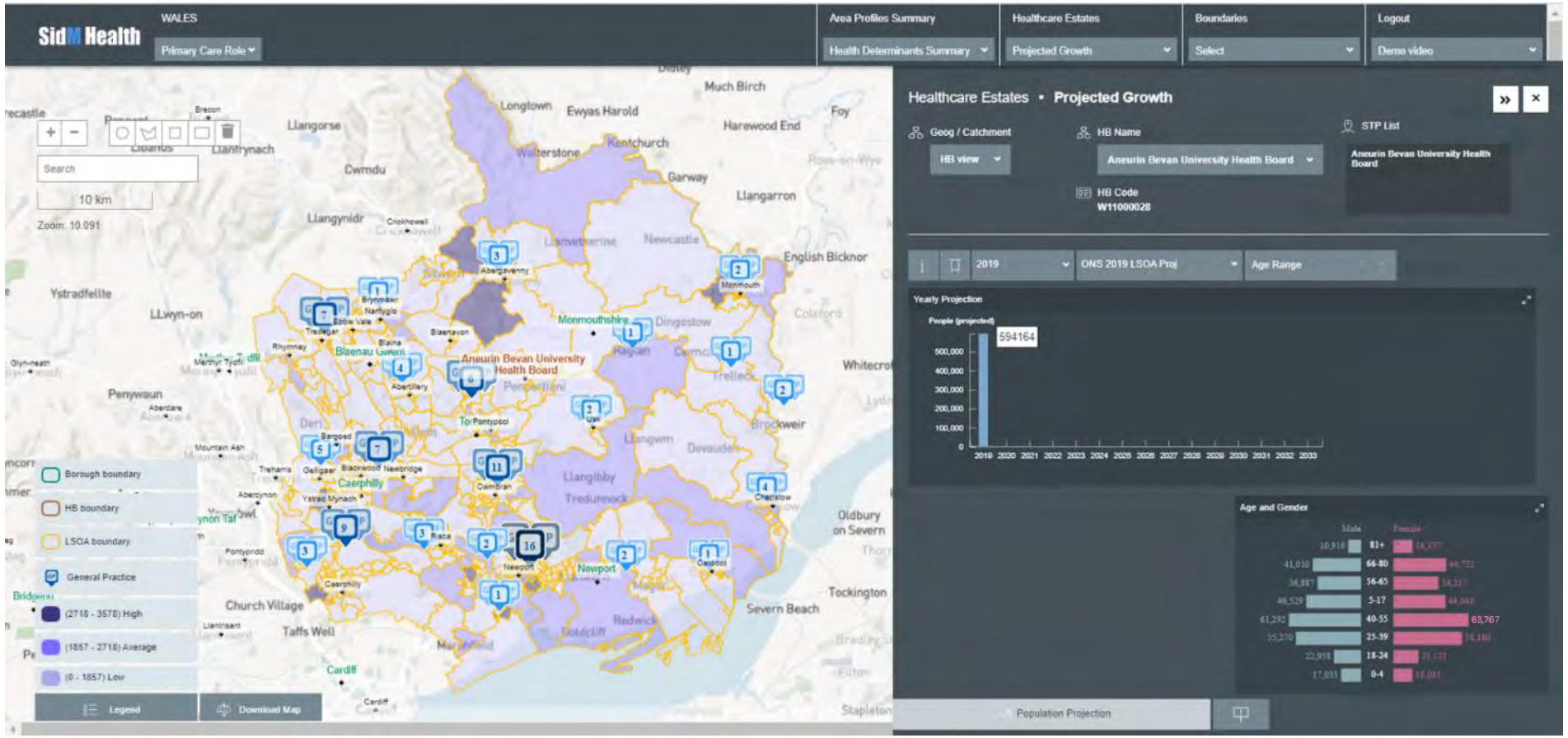
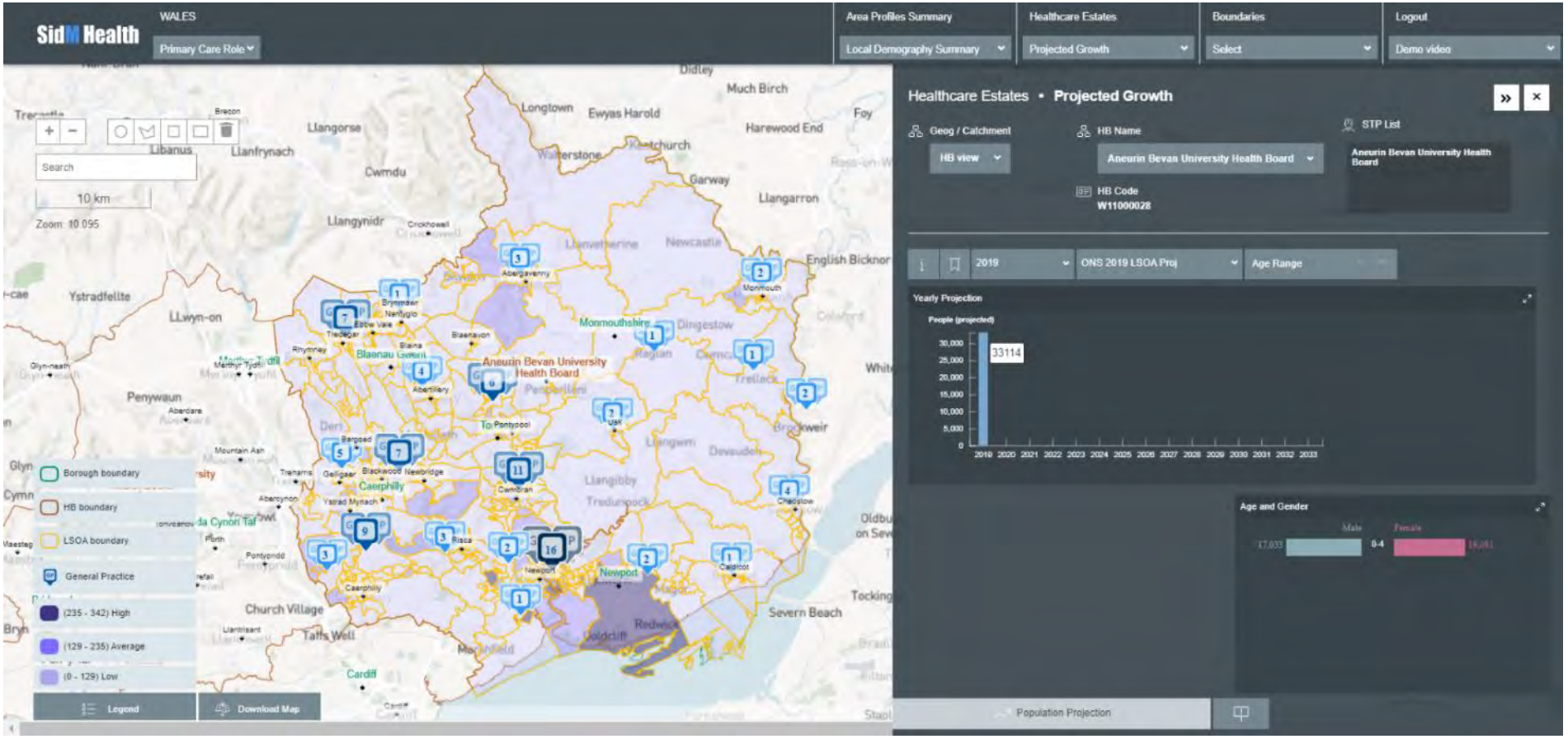
Primary Care Role
Area Profiles Summary
Health Determinants Summary
Healthcare Estates
Projected Growth
Boundaries
Select
Logout
Demo video
Healthcare Estates • Projected Growth
Geog / Catchment
HB view
HB Name
Aneurin Bevan University Health Board
STP List
Aneurin Bevan University Health Board
HB Code
W11000028
2030
ONS 2018 Borough Proj
Age Range
Yearly Projection
People (projected)
132021
Cumulative 5 years projection growth
5 years demand projection
Age and Gender
Male
Female
80+
66-80
47,455
Population Projection
Aneurin Bevan University Health Board
Search
10 km
Zoom: 10.091
Borough boundary
HB boundary
LSOA boundary
General Practice
(30812 - 38811) High
(22812 - 30812) Average
(0 - 22812) Low
Legend
Download Map

5 Population Projection by LSOAs

5.1 All Ages



5.2 Ages 0 – 4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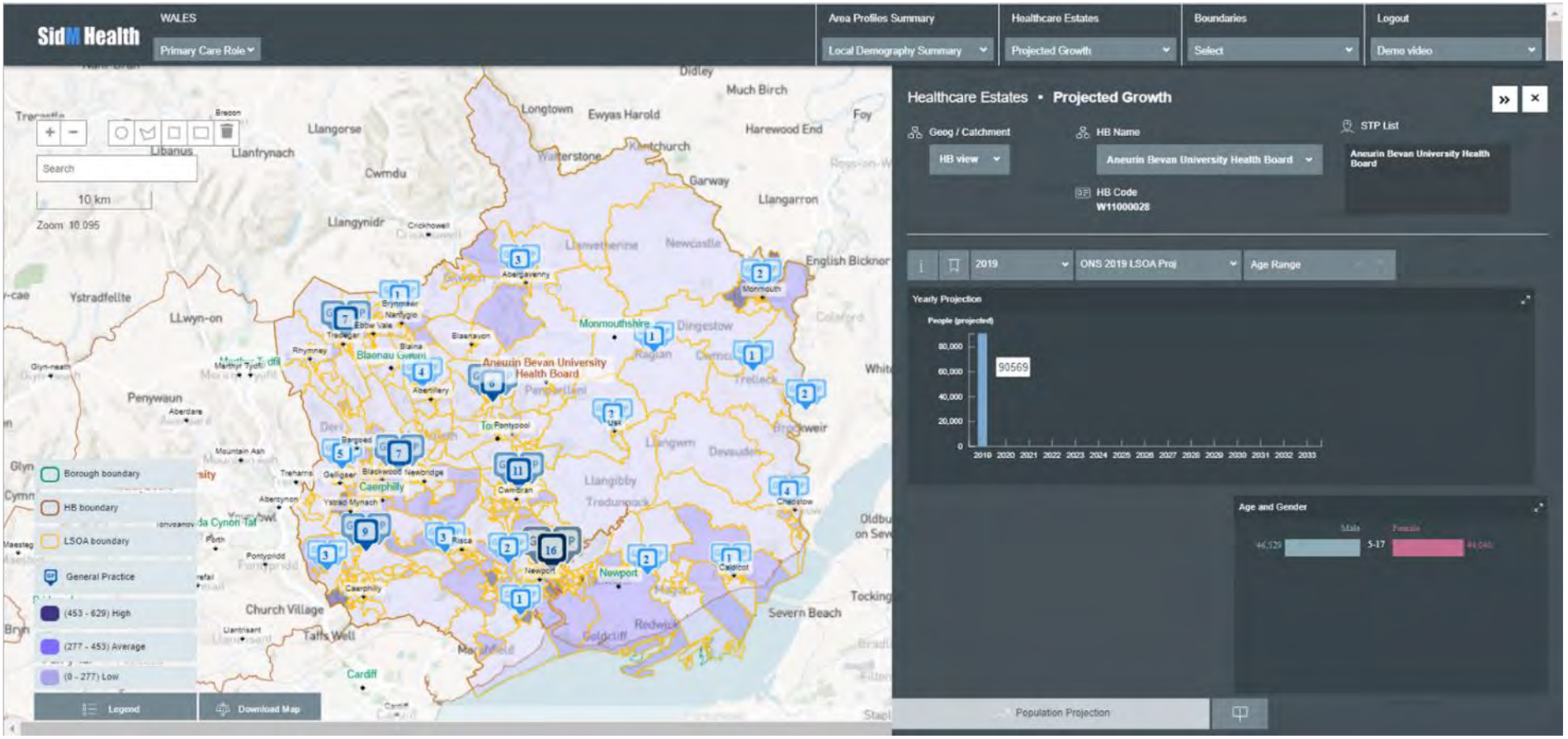
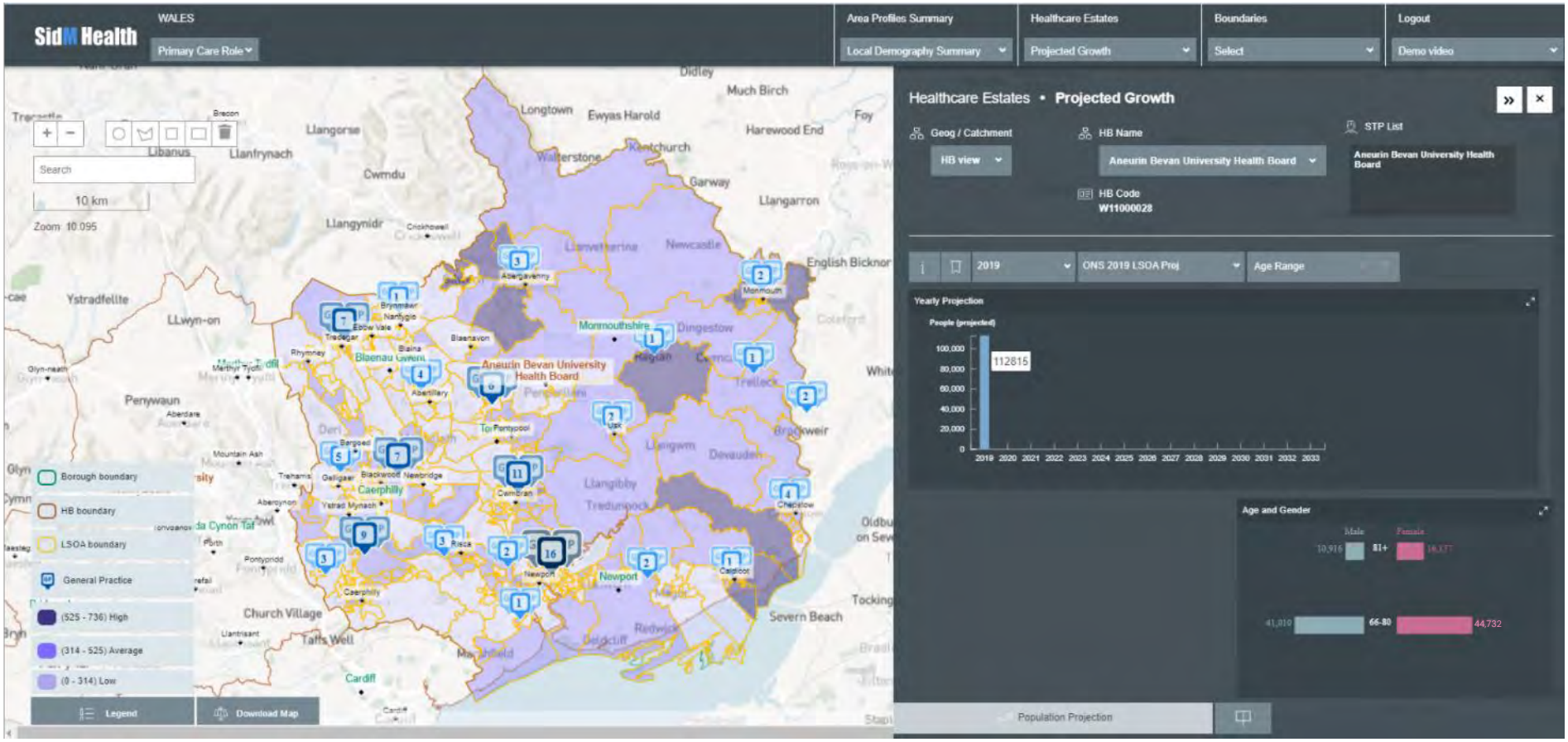
WALES
Primary Care Role
Area Profiles Summary
Local Demography Summary
Healthcare Estates
Projected Growth
Boundaries
Select
Logout
Demo video
Healthcare Estates • Projected Growth
Geog / Catchment
HB view
HB Name
Aneurin Bevan University Health Board
STP List
Aneurin Bevan University Health Board
HB Code
W11000028
2019
ONS 2019 LSOA Proj
Age Range
Yearly Projection
People (projected)
33114
Age and Gender
Male
Female
0-4
Population Projection
Aneurin Bevan University Health Board
Search
10 km
Zoom: 10.095
Borough boundary
HB boundary
LSOA boundary
General Practice
(235 - 342) High
(129 - 235) Average
(0 - 129) Low
Legend
Download Map

5.3 Ages 5 – 17

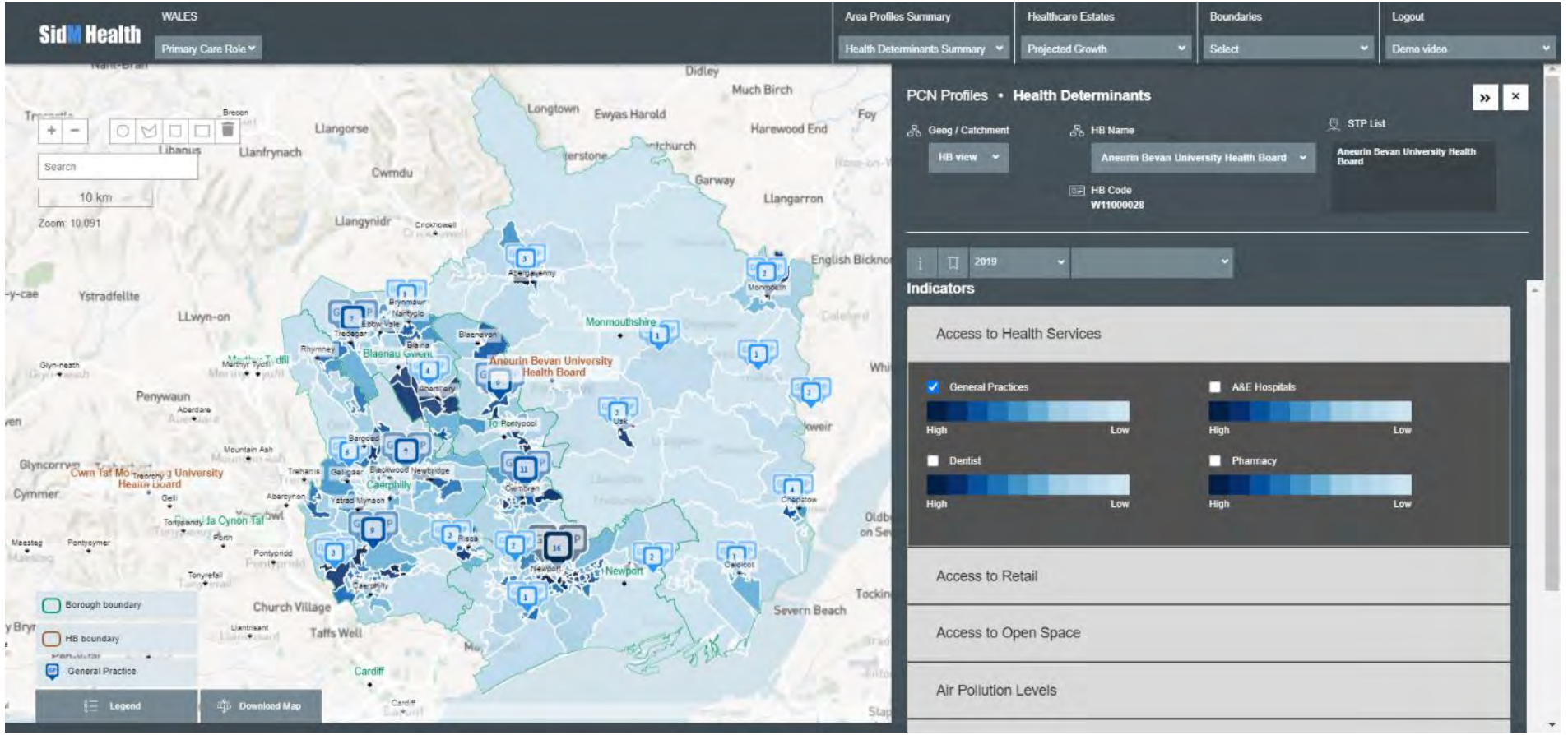

SidM Health
WALES
Primary Care Role
Area Profiles Summary
Local Demography Summary
Healthcare Estates
Projected Growth
Boundaries
Select
Logout
Demo video
Healthcare Estates • Projected Growth
Geog / Catchment
HB view
HB Name
Aneurin Bevan University Health Board
STP List
Aneurin Bevan University Health Board
HB Code
W11000028
2019
ONS 2019 LSOA Proj
Age Range
Yearly Projection
People (projected)
90569
Age and Gender
Male
Female
5-17
Population Projection
Search
10 km
Zoom 10.095
Borough boundary
HB boundary
LSOA boundary
General Practice
(453 - 629) High
(277 - 453) Average
(0 - 277) Low
Legend
Download Map
Aneurin Bevan University Health Board
Monmouthshire
Newport
Cardiff
Caerphilly

5.4 Ages 66+

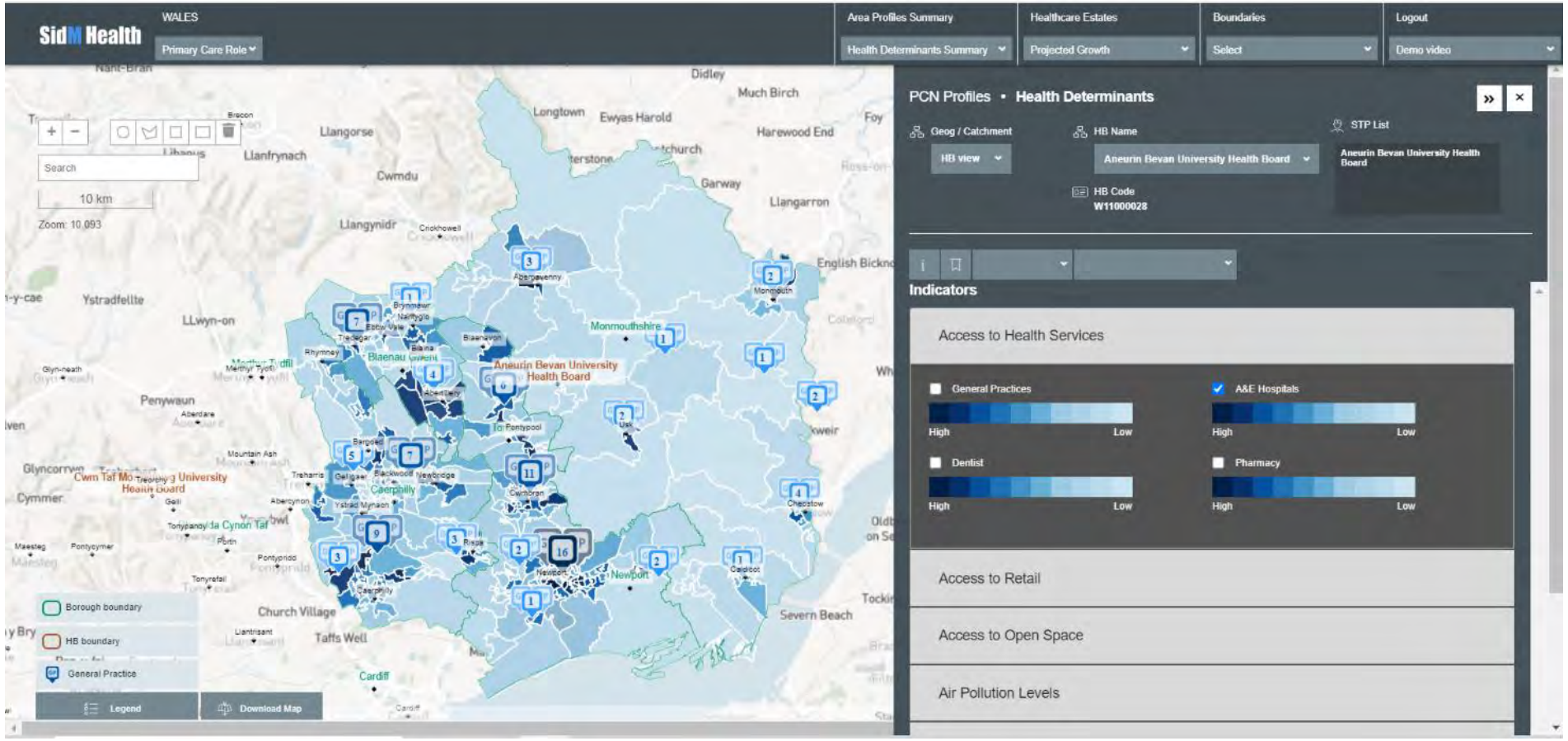

SidM Health
WALES
Primary Care Role
Area Profiles Summary
Local Demography Summary
Healthcare Estates
Projected Growth
Boundaries
Select
Logout
Demo video
Healthcare Estates • Projected Growth
Geog / Catchment
HB view
HB Name
Aneurin Bevan University Health Board
STP List
Aneurin Bevan University Health Board
HB Code
W11000028
2019
ONS 2019 LSOA Proj
Age Range
Yearly Projection
People (projected)
112815
Age and Gender
Male
Female
81+
66-80
44,732
Population Projection
Aneurin Bevan University Health Board
Monmouthshire
Newport
Cardiff
Caerphilly
Borough boundary
HB boundary
LSOA boundary
General Practice
(525 - 736) High
(314 - 525) Average
(0 - 314) Low
Legend
Download Map

6 Access

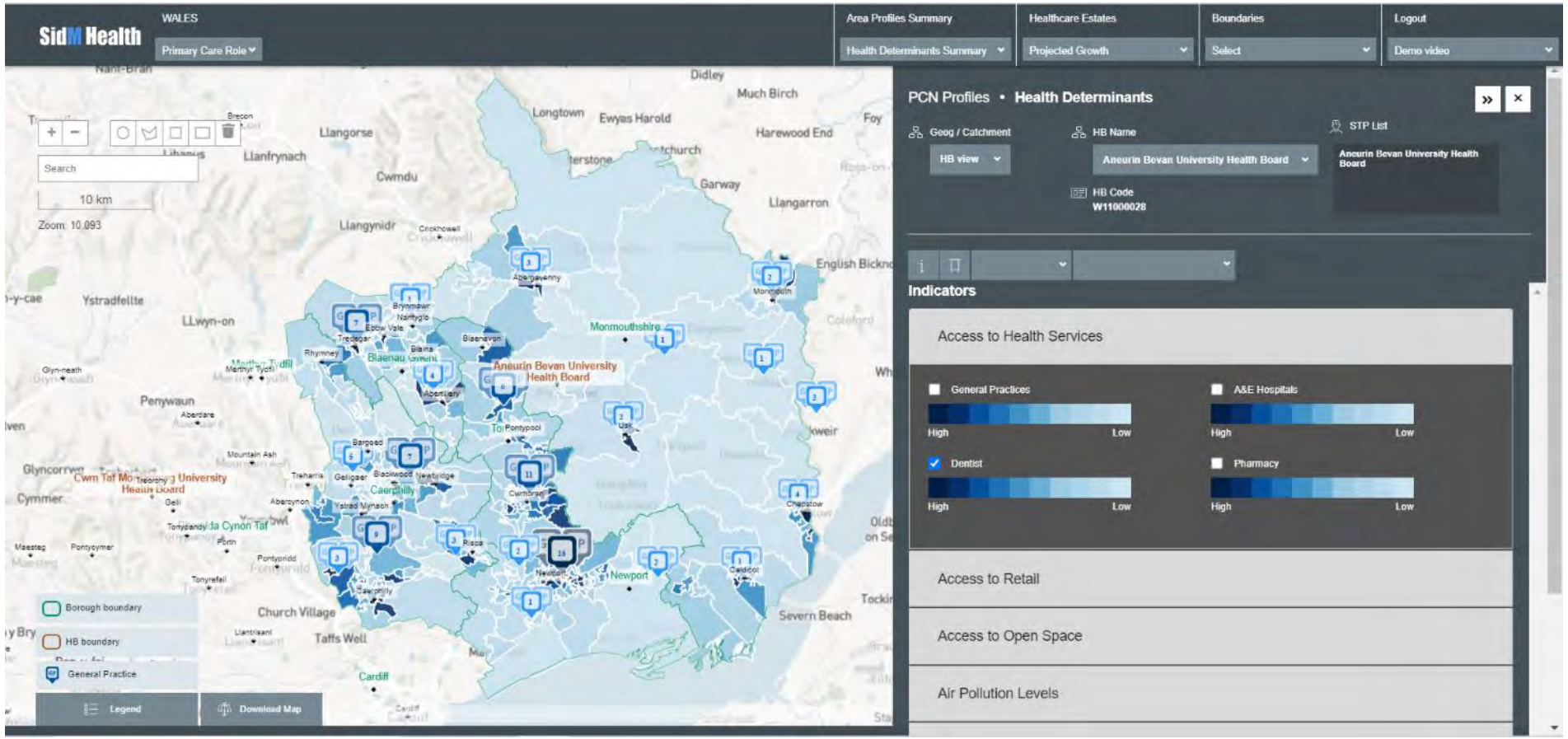
6.1 General Practices



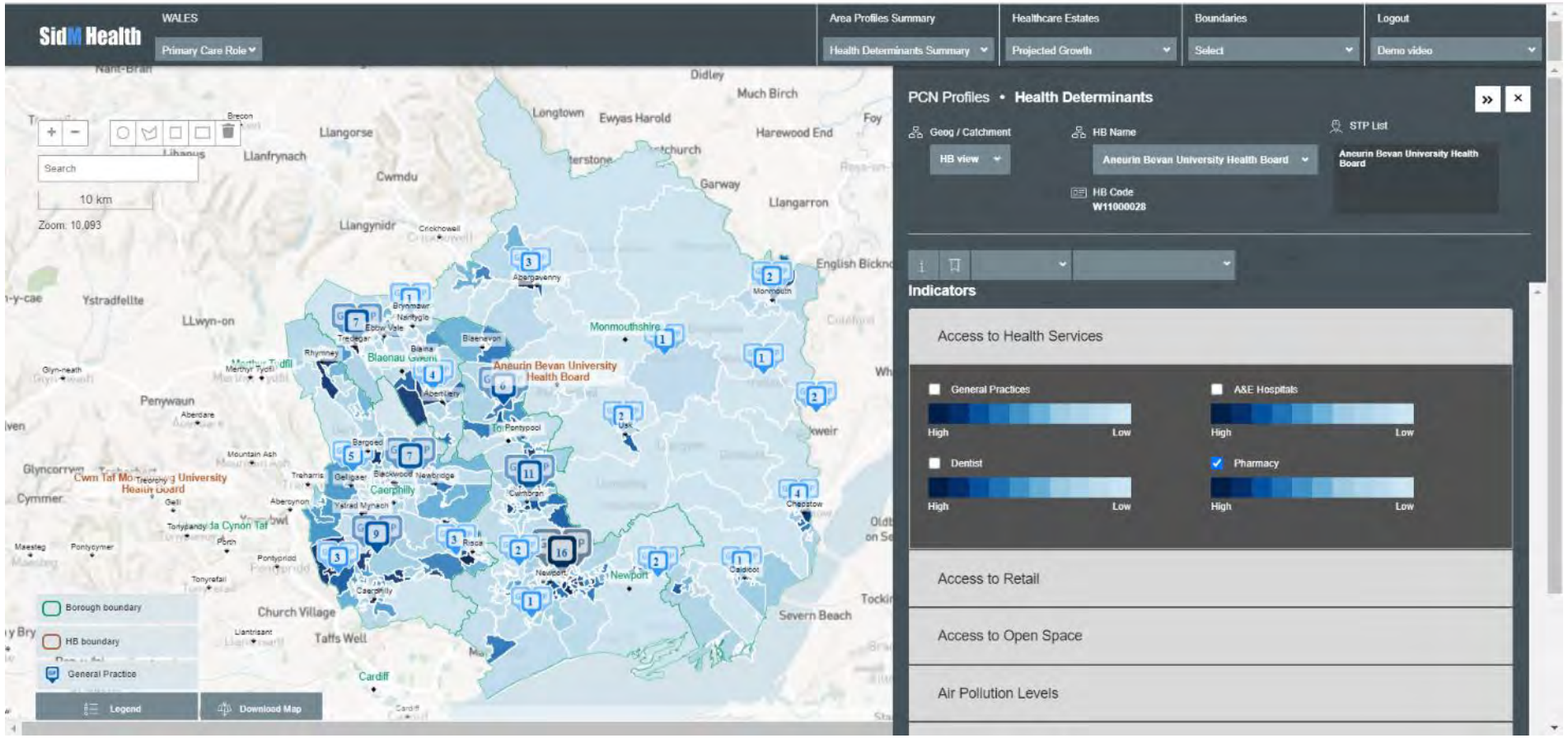
6.2 A&E Hospitals



6.3 Dentists


SidM Health
WALES
Primary Care Role
Area Profiles Summary
Health Determinants Summary
Healthcare Estates
Projected Growth
Boundaries
Select
Logout
Demo video
PCN Profiles • Health Determinants
Geog / Catchment
HB view
HB Name
Aneurin Bevan University Health Board
STP List
Aneurin Bevan University Health Board
HB Code
W11000028
Indicators
Access to Health Services
General Practices
A&E Hospitals
Dentist
Pharmacy
High
Low
Access to Retail
Access to Open Space
Air Pollution Levels
Search
10 km
Zoom: 10.093
Borough boundary
HB boundary
General Practice
Legend
Download Map
Aneurin Bevan University Health Board
Monmouthshire
Newport
Cardiff
Caerphilly
Church Village
Taffs Well
Severn Beach

6.4 Pharmacy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WALES
Primary Care Role
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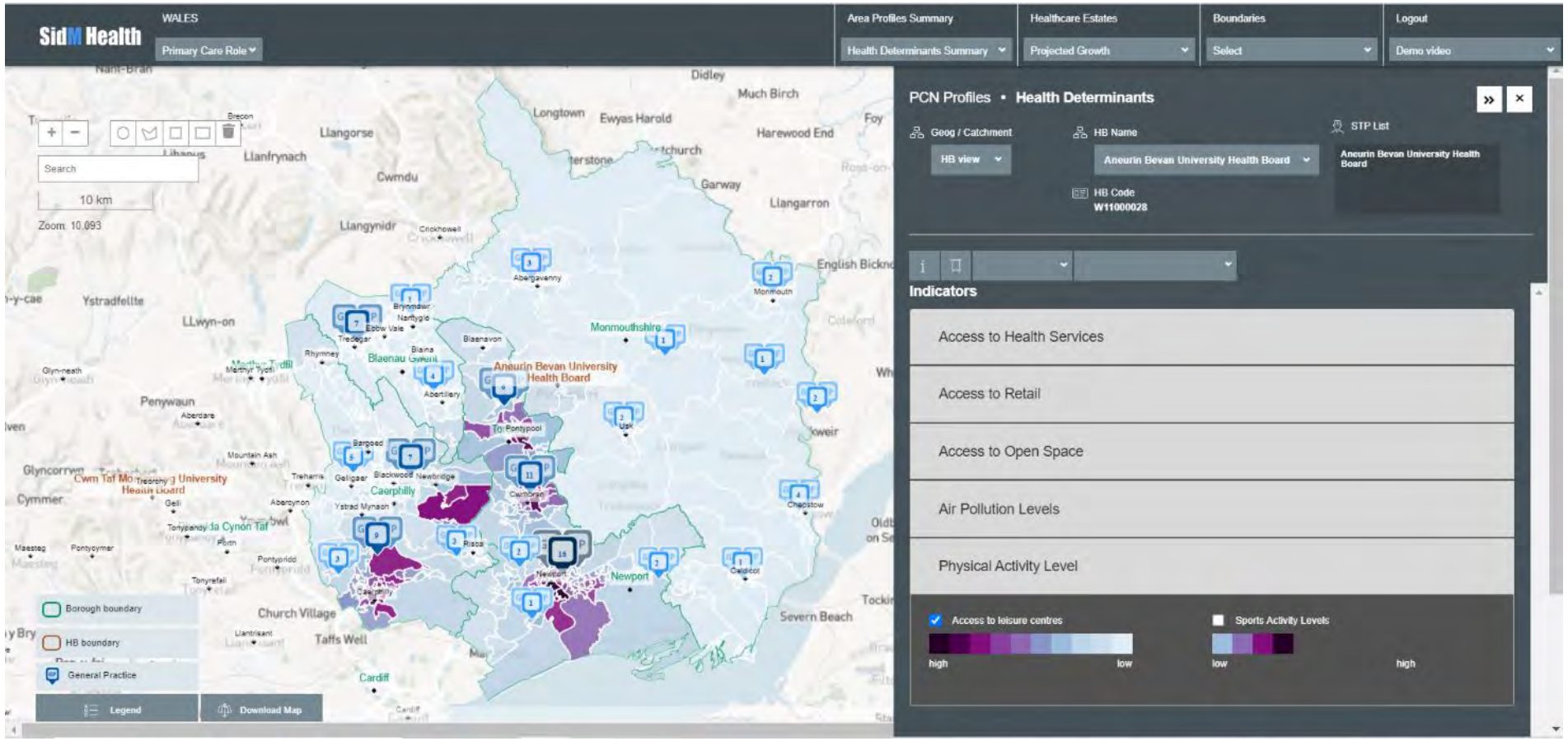
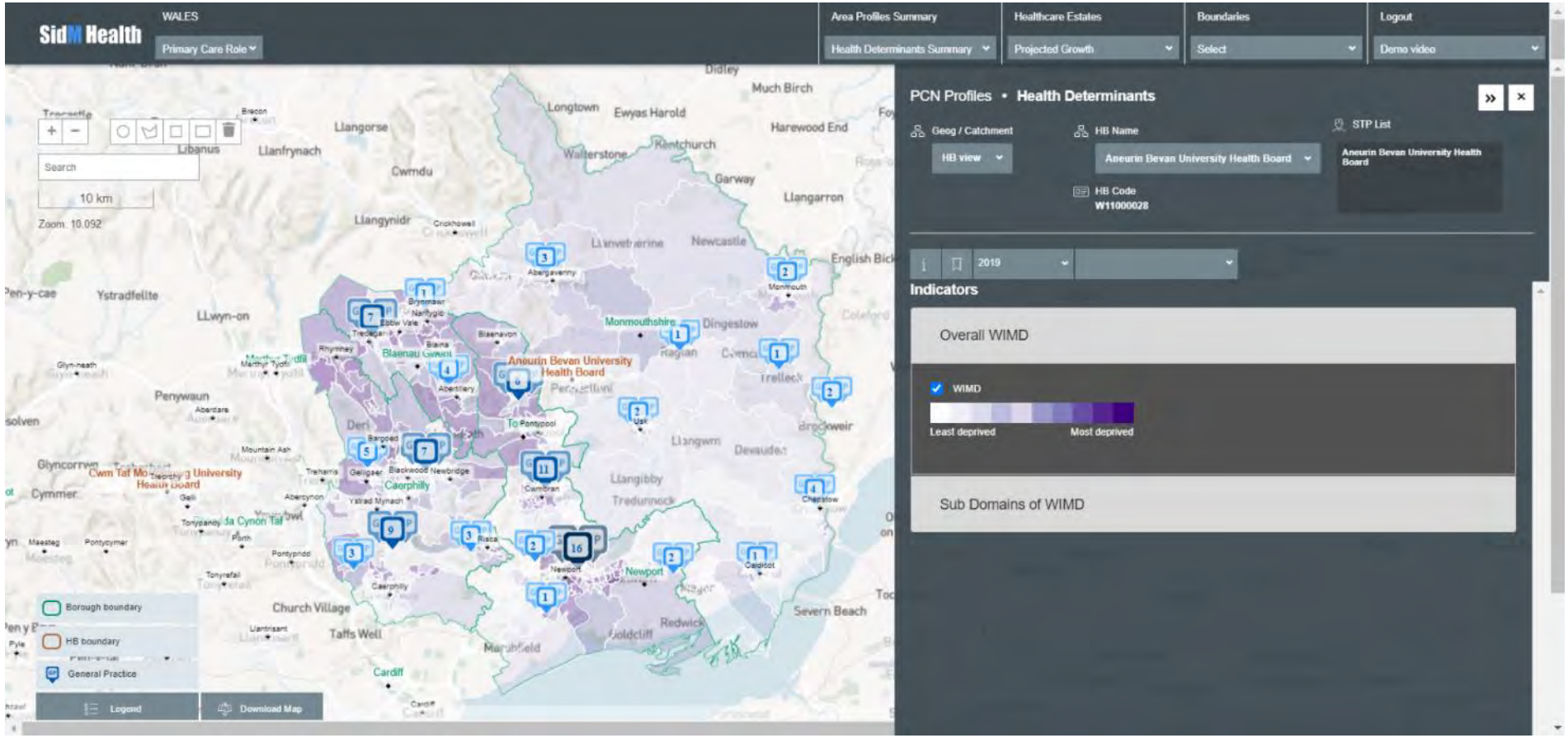
Health Determinants Summary
Healthcare Estates
Projected Growth
Boundaries
Select
Logout
Demo video
PCN Profiles • Health Determinants
Geog / Catchment
HB view
HB Name
Aneurin Bevan University Health Board
STP List
Aneurin Bevan University Health Board
HB Code
W11000028
Indicators
Access to Health Services
General Practices
A&E Hospitals
Dentist
Pharmacy
High
Low
Access to Retail
Access to Open Space
Air Pollution Levels
Search
10 km
Zoom: 10,093
Aneurin Bevan University Health Board
Monmouthshire
Newport
Cardiff
Caerphilly
Borough boundary
HB boundary
General Practice
Legend
Download Map

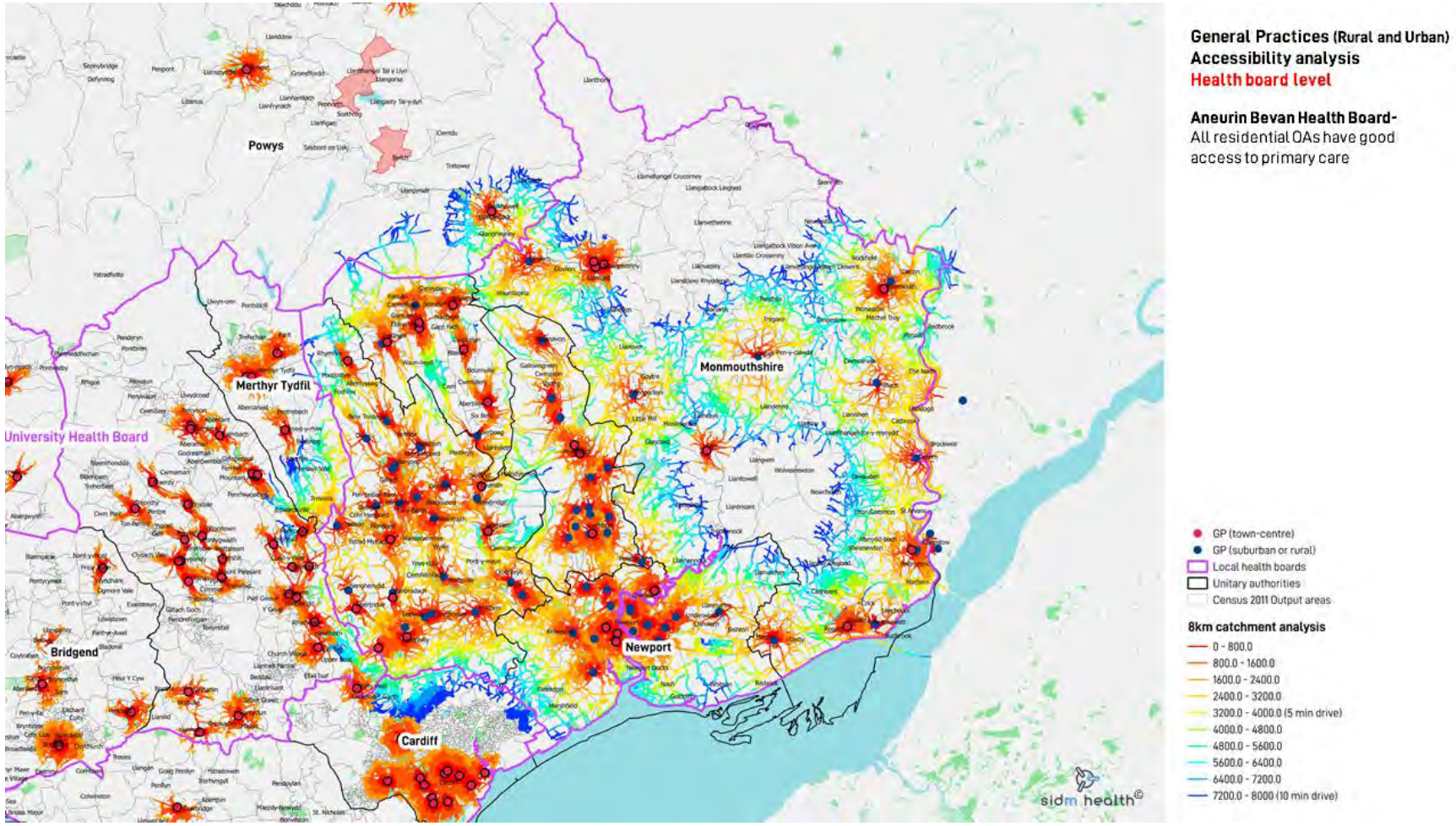
6.5 Leisure Centres



7 Overall Deprivation Score



8 Travel Distances



Archus

The healthcare infrastructure specialist

Appendix C2 – Betsi Cadwaladr University Health Board mapping

May 2021

Contents

1 Introduction

1.1 Demographic Observations

Review of the Demographic profile below shows moderate levels of growth over recent years. This growth will continue but is shown to be significantly higher in the numbers of people over the age of 66 years and those aged 80 plus years.

In 2021 the numbers of 0-4 years have dropped over recent years but will increase and the numbers of 5-17 years are increasing but will slow after 2023 and continues to drop further.

There are different concentrations by age of people from high to low numbers in distinct areas within the Health Boards profile. Different types of healthcare will be required for changes to the population demographic to ensure access for people with different needs to assist planning and ensure it is appropriate for future growth.

1.2 Patient Need

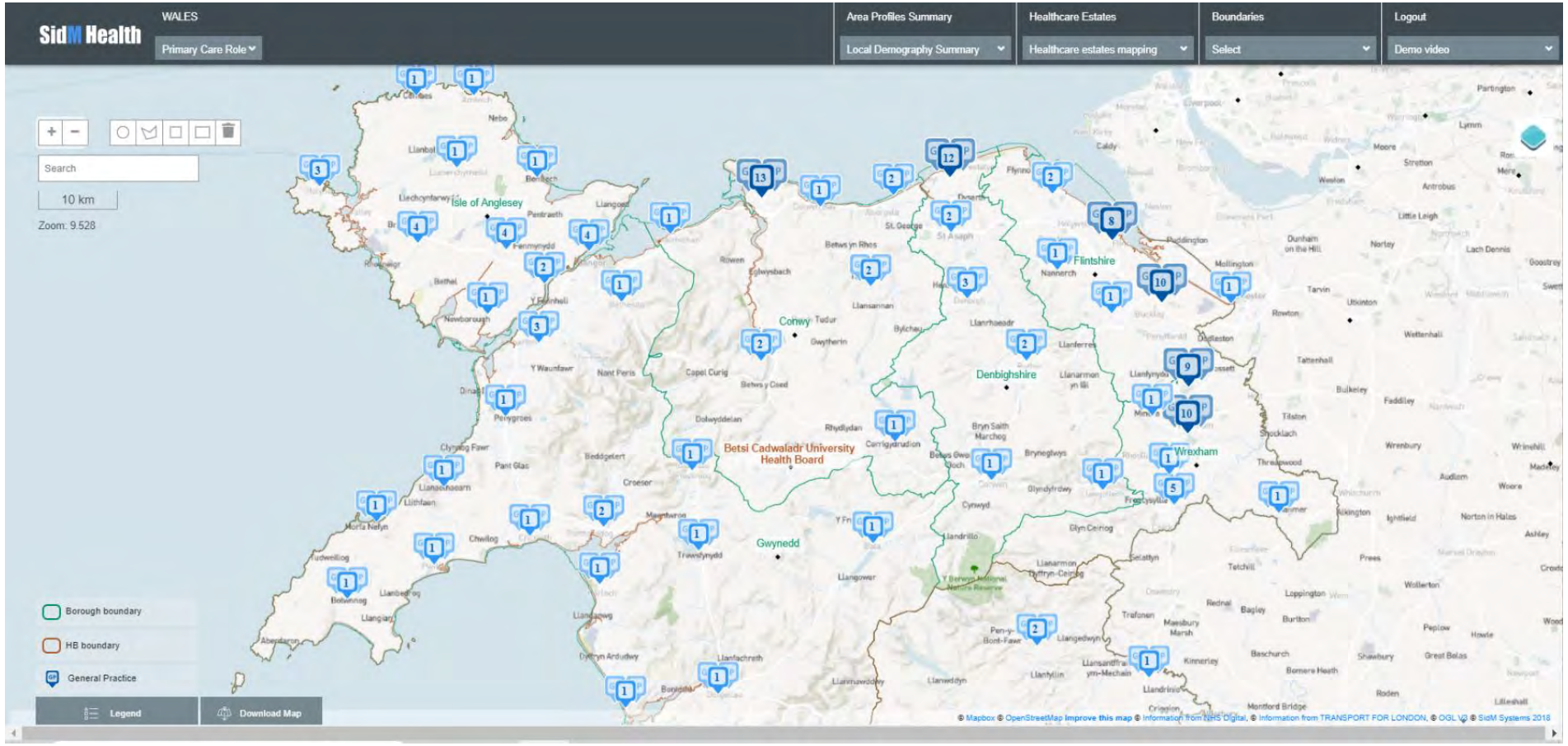
Since the population in areas of the Health Board has grown and the numbers of aging patients who have a higher requirement for health services has increased, there will be a growing impact on primary care in these areas. Several key observations for the Health Board can be seen:

- The numbers of people aged 66+ will continue to increase for the next 20 years. It is noticeable in recent increases and future projections that the numbers of females are significantly higher.
- Deprivation scores across the area are low to medium but where deprivation scores are higher key service provision assessments can be made ensuring all needs are met across all ages – addressing the entire spectrum of people's physical, mental, and social needs.
- The numbers of 0-4 years have slowed but will increase within 5 years. New housing development planning agreements should be assessed to link further growth projections.
- Analysis of access to the wider services such as pharmacies, dentists and leisure allows an assessment of the best options to provide an integrated approach to health and social care enabling people with more complex conditions to be offered screening and secondary prevention reflecting their higher risk of poor physical health.

1.3 Mapping and Statistics

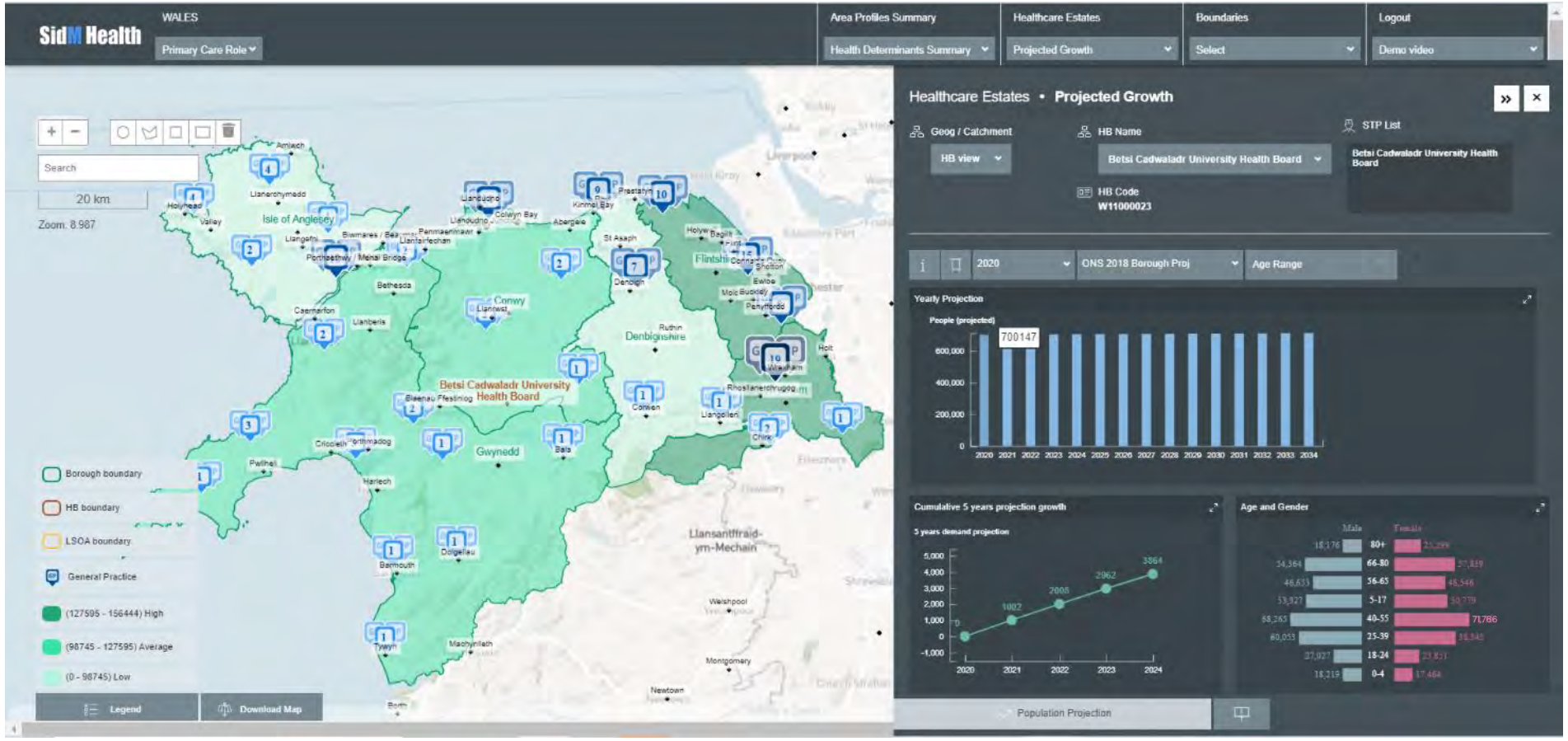
The maps below give a detailed view of the current and future population growth by age. Areas of population concentration can be identified via the heat maps, as well as access to services such as, General Practice, acute units, wider health service needs and leisure. Overall deprivation by borough is displayed against General Practice provision in section 7. Distance of travel to General Practices are demonstrated on the final map, in section 8, via an 8km catchment area.

2 General Practice Location Map

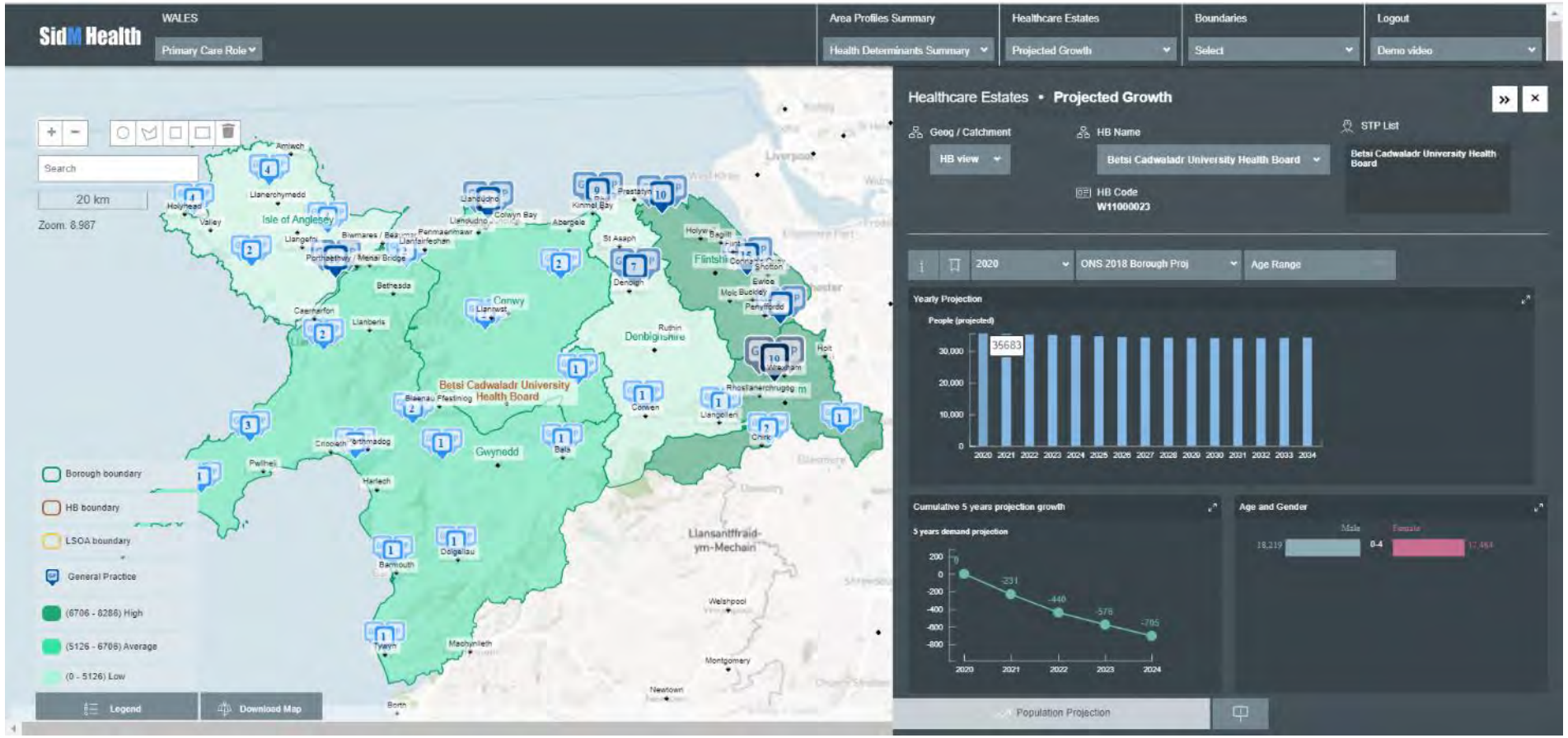


3 Population Projection by Local Authority 2020

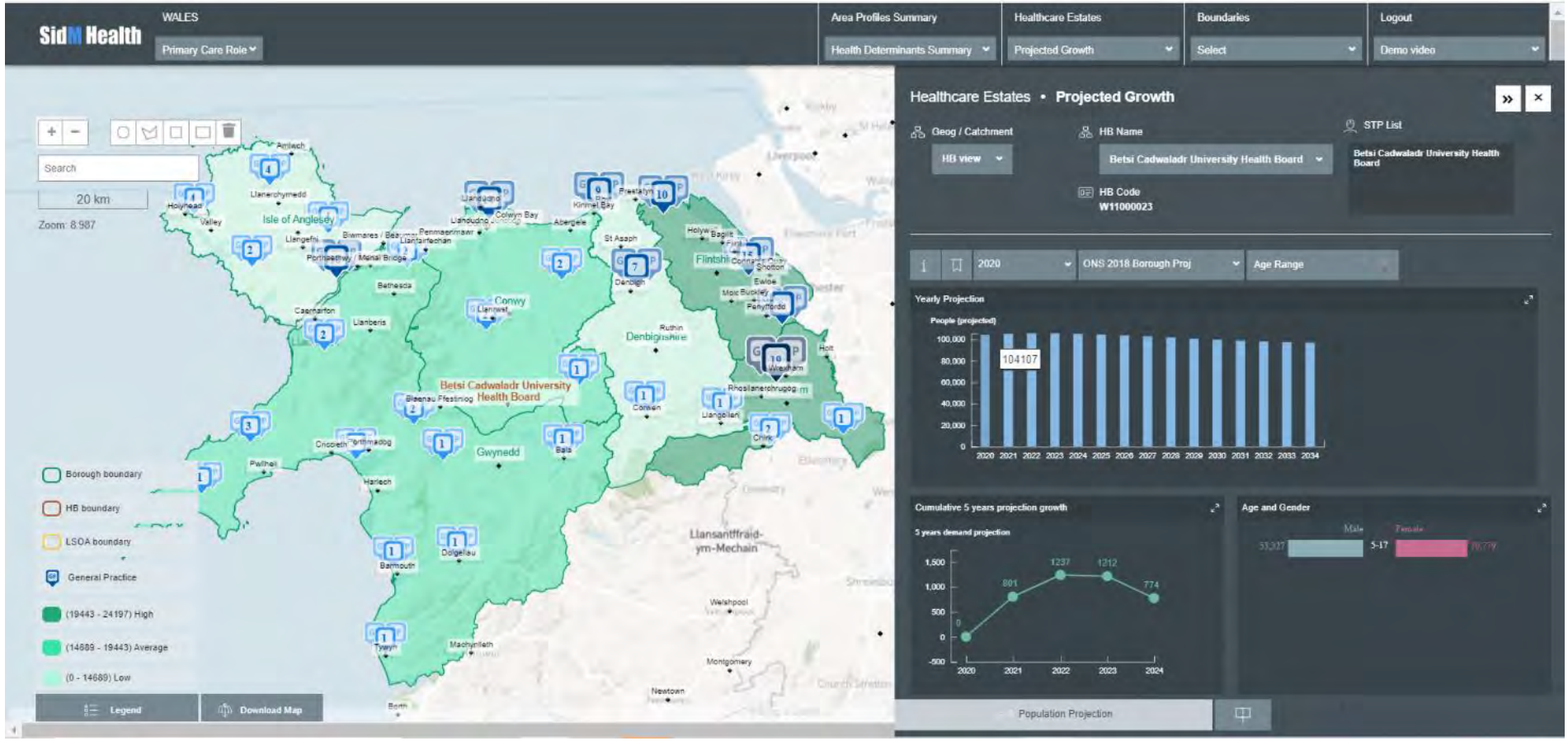
3.1 All Ages



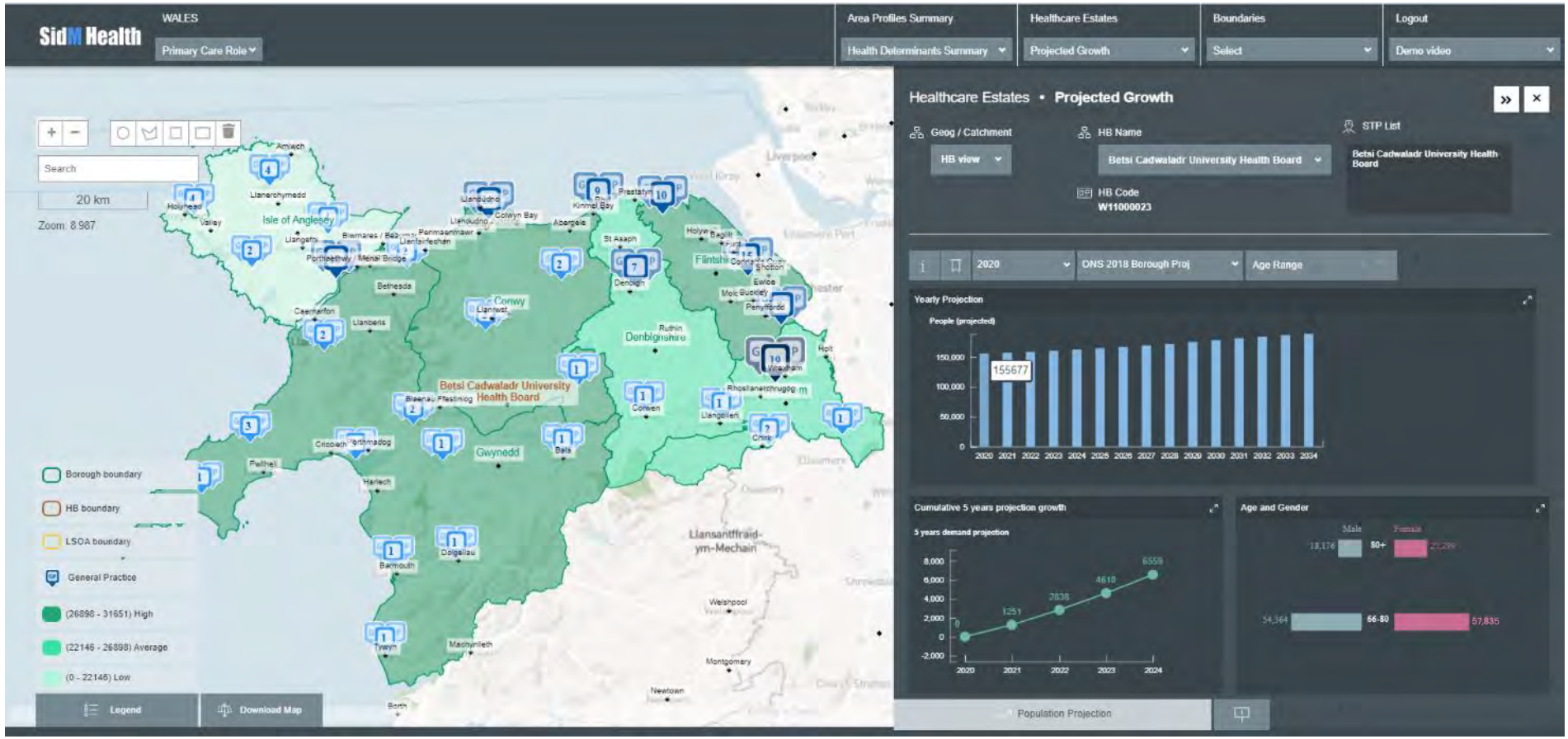
3.2 Ages 0 – 4


SidM Health
WALES
Primary Care Role
Area Profiles Summary
Health Determinants Summary
Healthcare Estates
Projected Growth
Boundaries
Select
Logout
Demo video
Search
20 km
Zoom: 8.987
Betsi Cadwaladr University Health Board
Borough boundary
HB boundary
LSOA boundary
General Practice
(6706 - 8286) High
(5126 - 6706) Average
(0 - 5126) Low
Legend
Download Map
Healthcare Estates • Projected Growth
Geog / Catchment
HB view
HB Name
Betsi Cadwaladr University Health Board
STP List
HB Code
W11000023
2020
ONS 2018 Borough Proj
Age Range
Yearly Projection
People (projected)
35683
Cumulative 5 years projection growth
5 years demand projection
-231
-440
-578
-795
Age and Gender
Male
Female
18,219
0-4
17,464
Population Projection

3.3 Ages 5 – 17

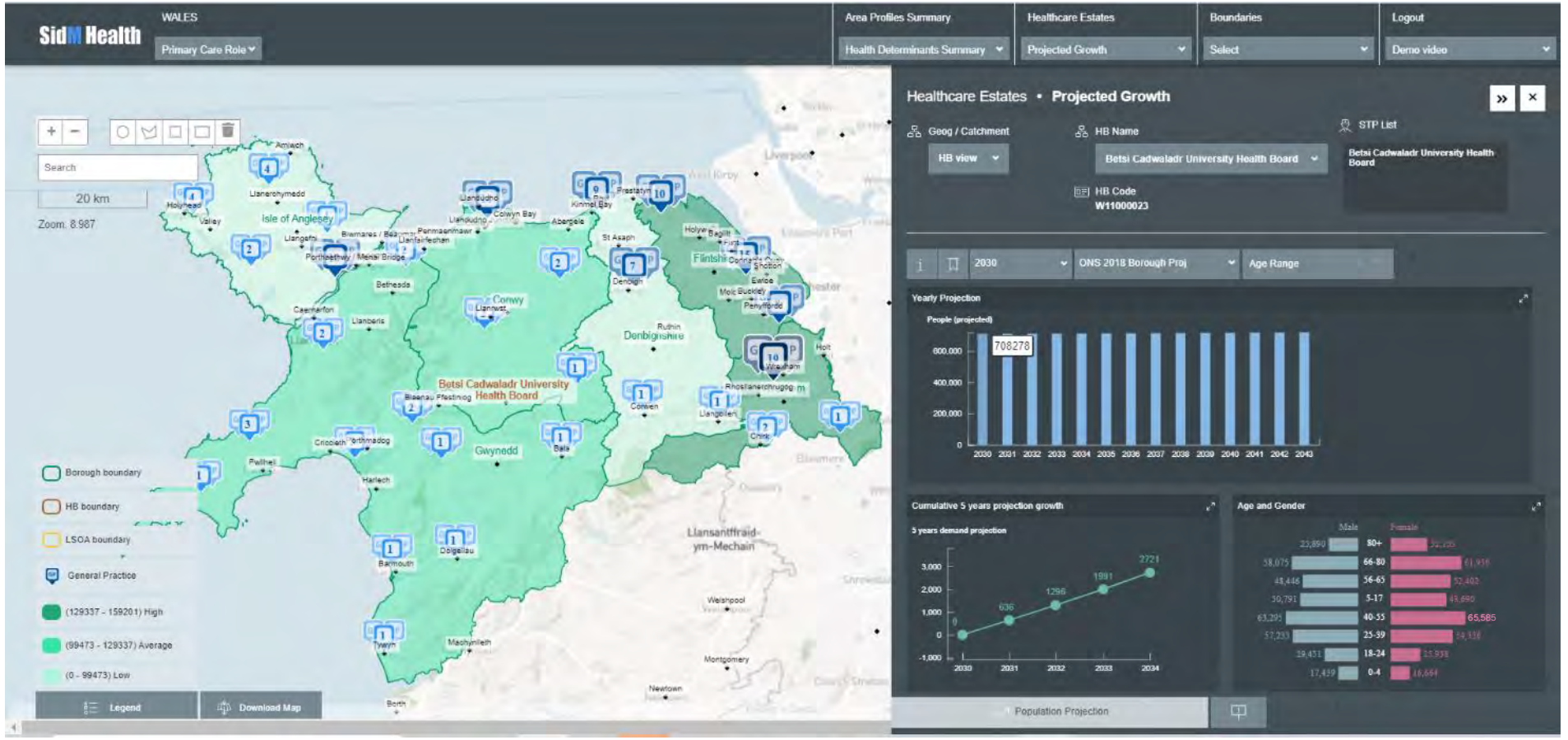

SidM Health
WALES
Primary Care Role
Area Profiles Summary
Health Determinants Summary
Healthcare Estates
Projected Growth
Boundaries
Select
Logout
Demo video
Search
20 km
Zoom: 8.987
Betsi Cadwaladr University Health Board
Gwynedd
Conwy
Denbighshire
Isle of Anglesey
Flintshire
Wrexham
Borough boundary
HB boundary
LSOA boundary
General Practice
(19443 - 24197) High
(14689 - 19443) Average
(0 - 14689) Low
Legend
Download Map
Healthcare Estates • Projected Growth
Geog / Catchment
HB view
HB Name
Betsi Cadwaladr University Health Board
HB Code
W11000023
STP List
2020
ONS 2018 Borough Proj
Age Range
Yearly Projection
People (projected)
104107
Cumulative 5 years projection growth
5 years demand projection
801
1237
1212
774
Age and Gender
Male
Female
5-17
Population Projection

3.4 Ages 66+

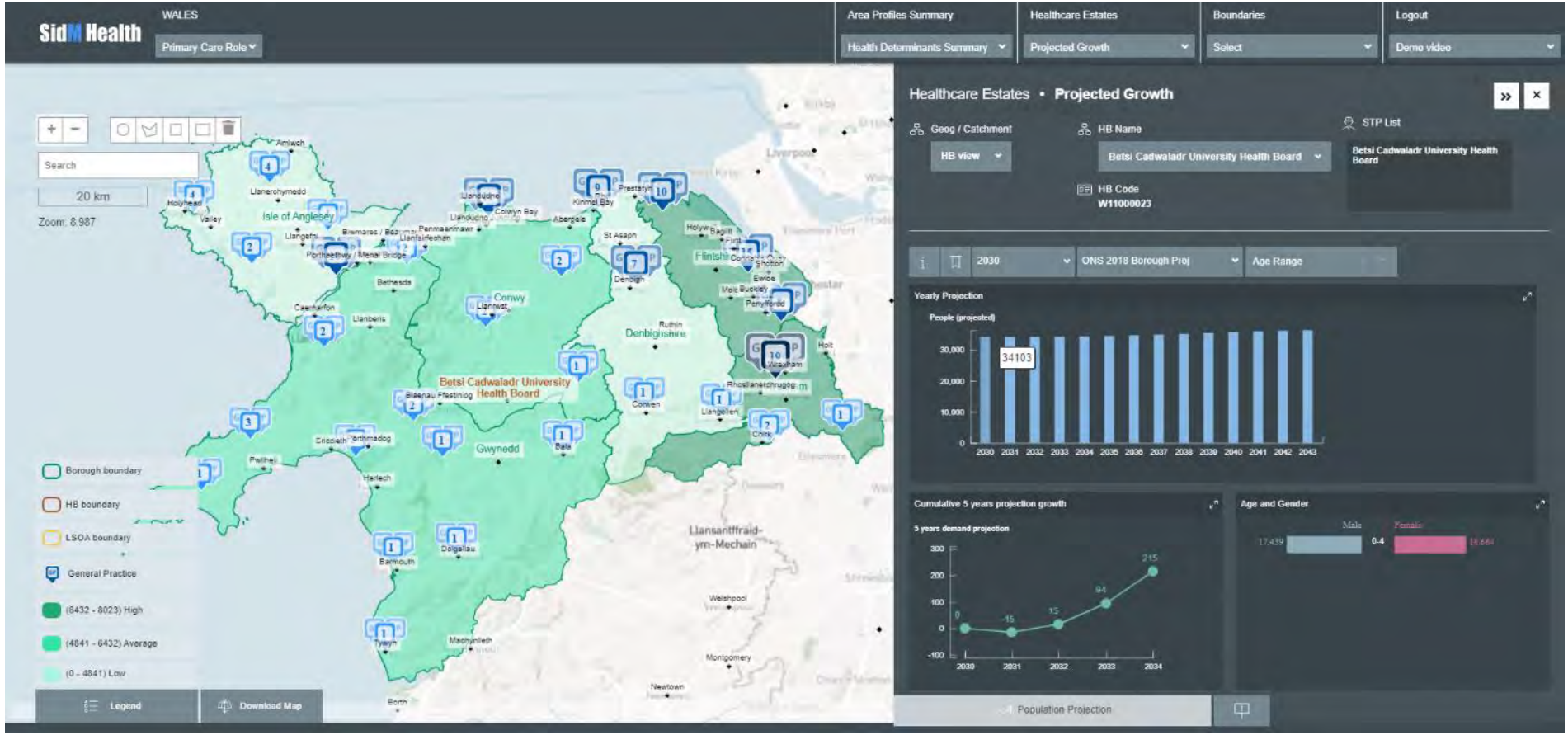

SidM Health
WALES
Primary Care Role
Area Profiles Summary
Health Determinants Summary
Healthcare Estates
Projected Growth
Boundaries
Select
Logout
Demo video
Healthcare Estates • Projected Growth
Geog / Catchment
HB view
HB Name
Betsi Cadwaladr University Health Board
STP List
Betsi Cadwaladr University Health Board
HB Code
W11000023
2020
ONS 2018 Borough Proj
Age Range
Yearly Projection
People (projected)
155677
Cumulative 5 years projection growth
5 years demand projection
Age and Gender
Male
Female
66-80
Population Projection
Search
20 km
Zoom: 8.987
Betsi Cadwaladr University Health Board
Borough boundary
HB boundary
LSOA boundary
General Practice
(26898 - 31651) High
(22146 - 26898) Average
(0 - 22146) Low
Legend
Download Map

4 Population Projection 2030, by Local Authority

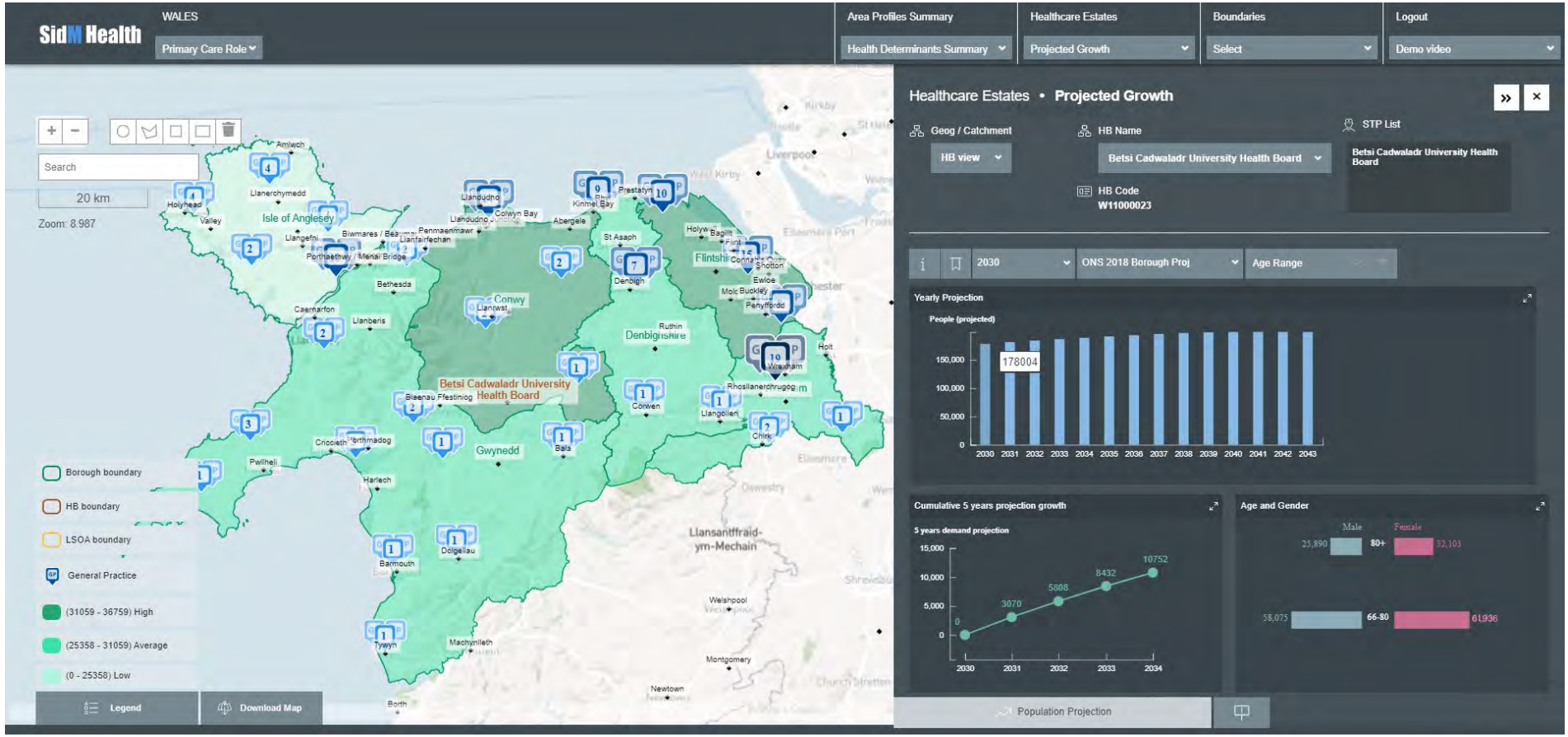
4.1 All Ages



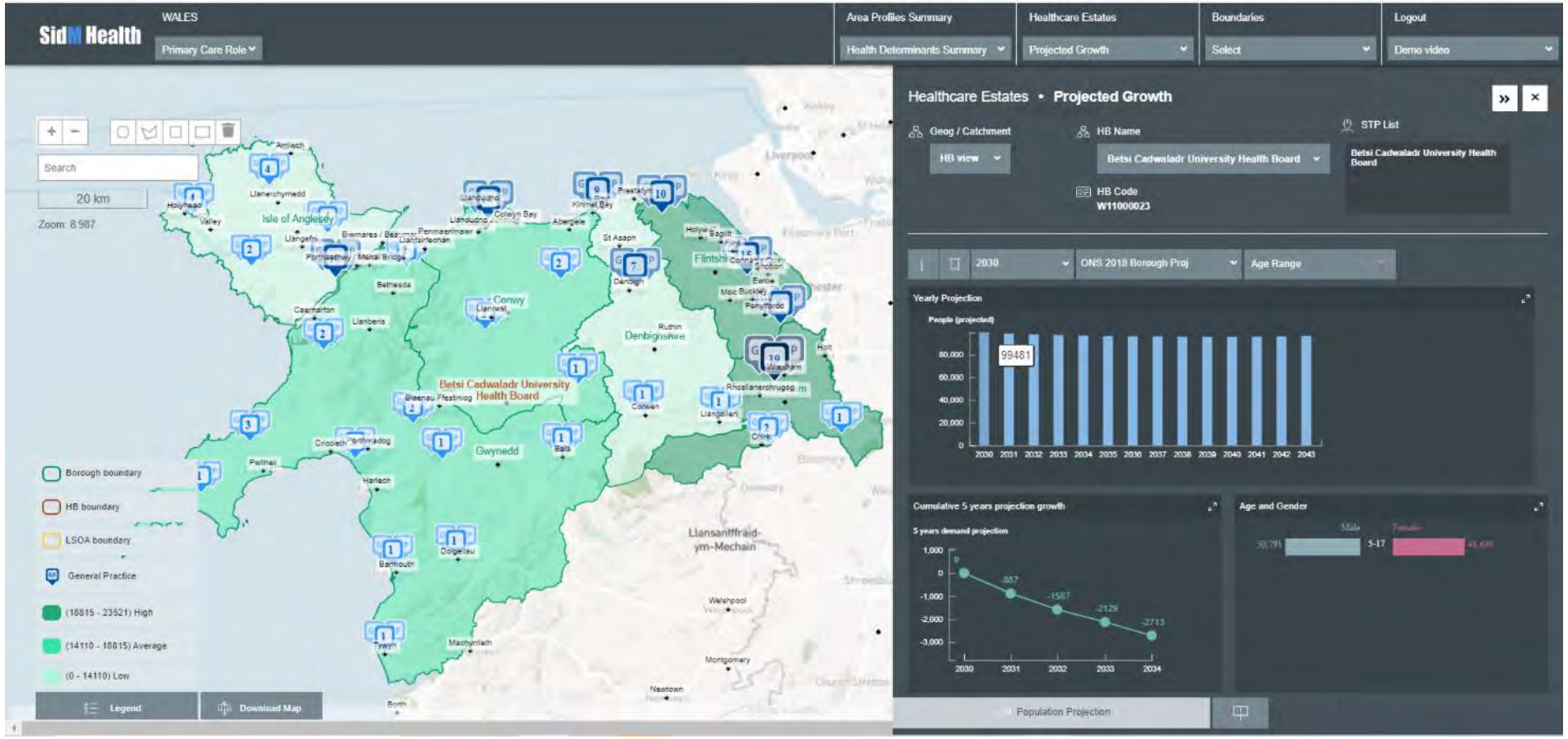
4.2 Ages 0 – 4


SidM Health
WALES
Primary Care Role
Area Profiles Summary
Health Determinants Summary
Healthcare Estates
Projected Growth
Boundaries
Select
Logout
Demo video
Healthcare Estates • Projected Growth
Geog / Catchment
HB view
HB Name
Betsi Cadwaladr University Health Board
STP List
Betsi Cadwaladr University Health Board
HB Code
W11000023
2030
ONS 2018 Borough Proj
Age Range
Yearly Projection
People (projected)
34103
Cumulative 5 years projection growth
5 years demand projection
Age and Gender
Male
Female
Search
20 km
Zoom: 8.987
Betsi Cadwaladr University Health Board
Isle of Anglesey
Conwy
Denbighshire
Gwynedd
Flintshi
Wrexham
Borough boundary
HB boundary
LSOA boundary
General Practice
(6432 - 8023) High
(4841 - 6432) Average
(0 - 4841) Low
Legend
Download Map
Population Projection

4.3 Ages 5 – 17

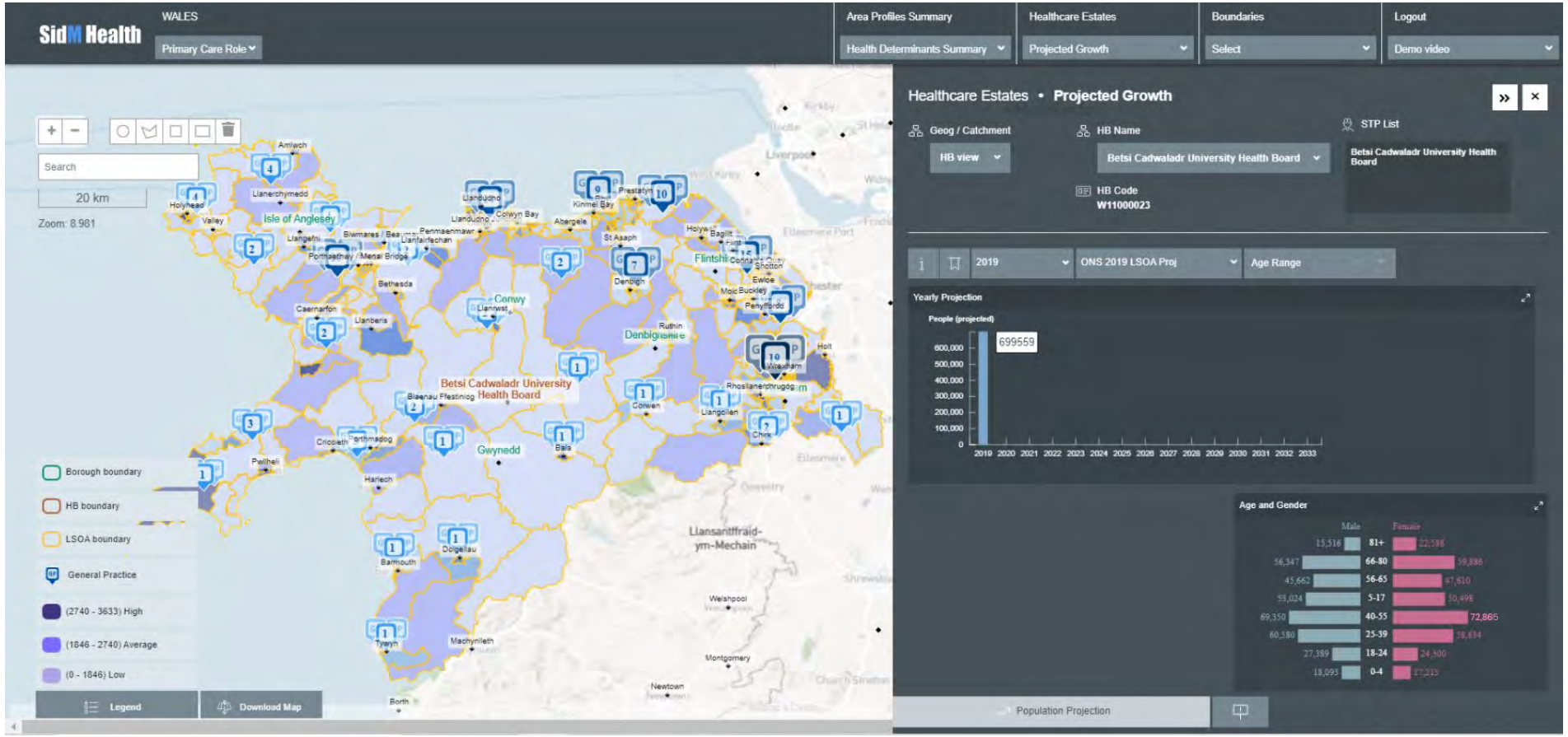

SidM Health
WALES
Primary Care Role
Area Profiles Summary
Health Determinants Summary
Healthcare Estates
Projected Growth
Boundaries
Select
Logout
Demo video
Search
20 km
Zoom: 8.987
Betsi Cadwaladr University Health Board
Borough boundary
HB boundary
LSOA boundary
General Practice
(31059 - 36759) High
(25358 - 31059) Average
(0 - 25358) Low
Legend
Download Map
Healthcare Estates • Projected Growth
Geog / Catchment
HB view
HB Name
Betsi Cadwaladr University Health Board
STP List
Betsi Cadwaladr University Health Board
HB Code
W11000023
2030
ONS 2018 Borough Proj
Age Range
Yearly Projection
People (projected)
178004
Cumulative 5 years projection growth
5 years demand projection
Age and Gender
Male
Female
Population Projection

4.4 Ages 66+

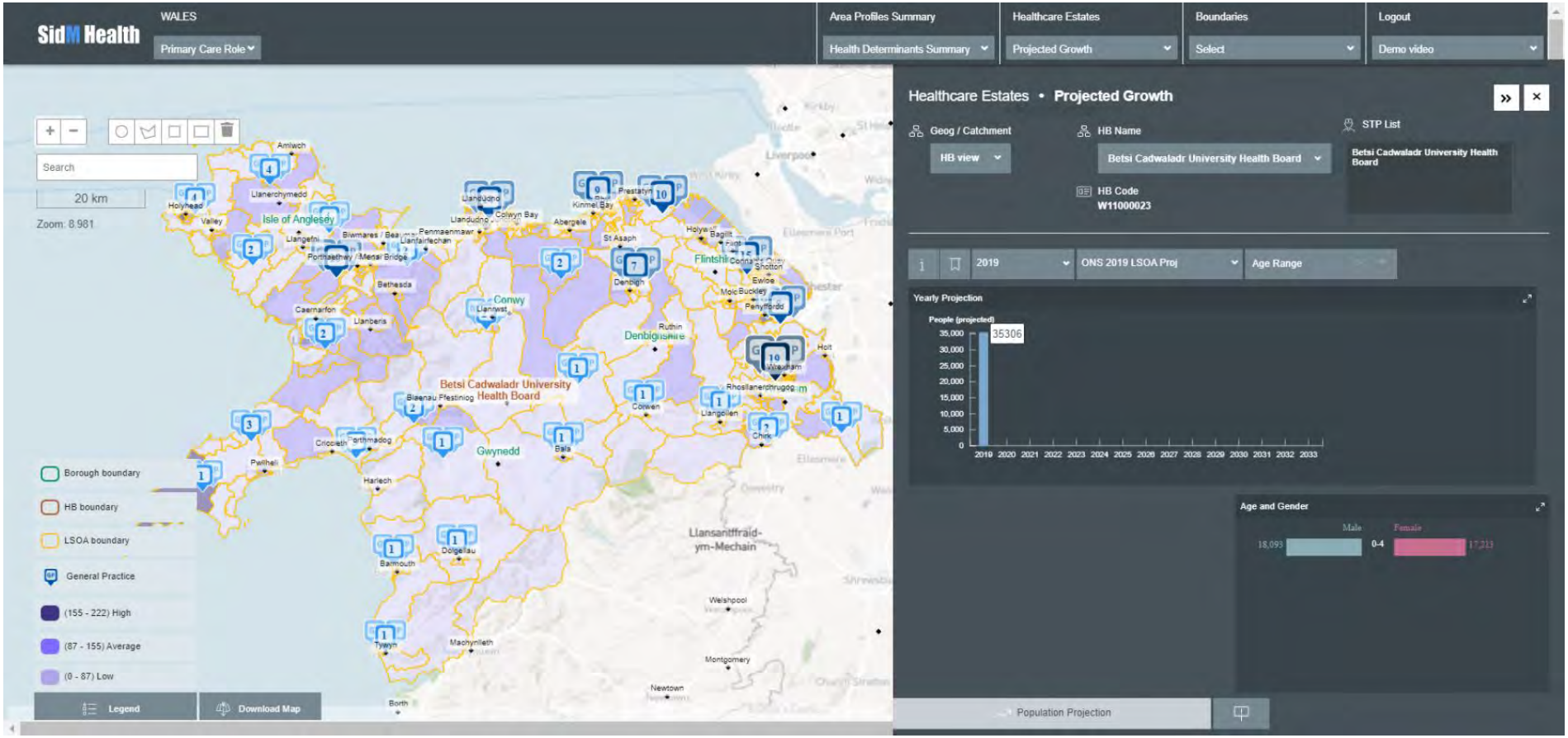

SidM Health
WALES
Primary Care Role
Area Profiles Summary
Health Determinants Summary
Healthcare Estates
Projected Growth
Boundaries
Select
Logout
Demo video
Search
20 km
Zoom: 8.987
Betsi Cadwaladr University Health Board
Borough boundary
HB boundary
LSOA boundary
General Practice
(18815 - 23521) High
(14110 - 18815) Average
(0 - 14110) Low
Legend
Download Map
Healthcare Estates • Projected Growth
Geog / Catchment
HB view
HB Name
Betsi Cadwaladr University Health Board
STP List
HB Code
W11000023
2030
ONS 2018 Borough Proj
Age Range
Yearly Projection
People (projected)
99481
Cumulative 5 years projection growth
5 years demand projection
-887
-1587
-2129
-2713
Age and Gender
Male
Female
5-17
Population Projection

5 Population Projection by LSOAs

5.1 All Ages



5.2 Ages 0 – 4


SidM Health
WALES
Primary Care Role
Area Profiles Summary
Health Determinants Summary
Healthcare Estates
Projected Growth
Boundaries
Select
Logout
Demo video
Search
20 km
Zoom: 8.981
Betsi Cadwaladr University Health Board
Borough boundary
HB boundary
LSOA boundary
General Practice
(155 - 222) High
(87 - 155) Average
(0 - 87) Low
Legend
Download Map
Healthcare Estates • Projected Growth
Geog / Catchment
HB view
HB Name
Betsi Cadwaladr University Health Board
STP List
HB Code
W11000023
2019
ONS 2019 LSOA Proj
Age Range
Yearly Projection
People (projected)
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Age and Gender
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Female
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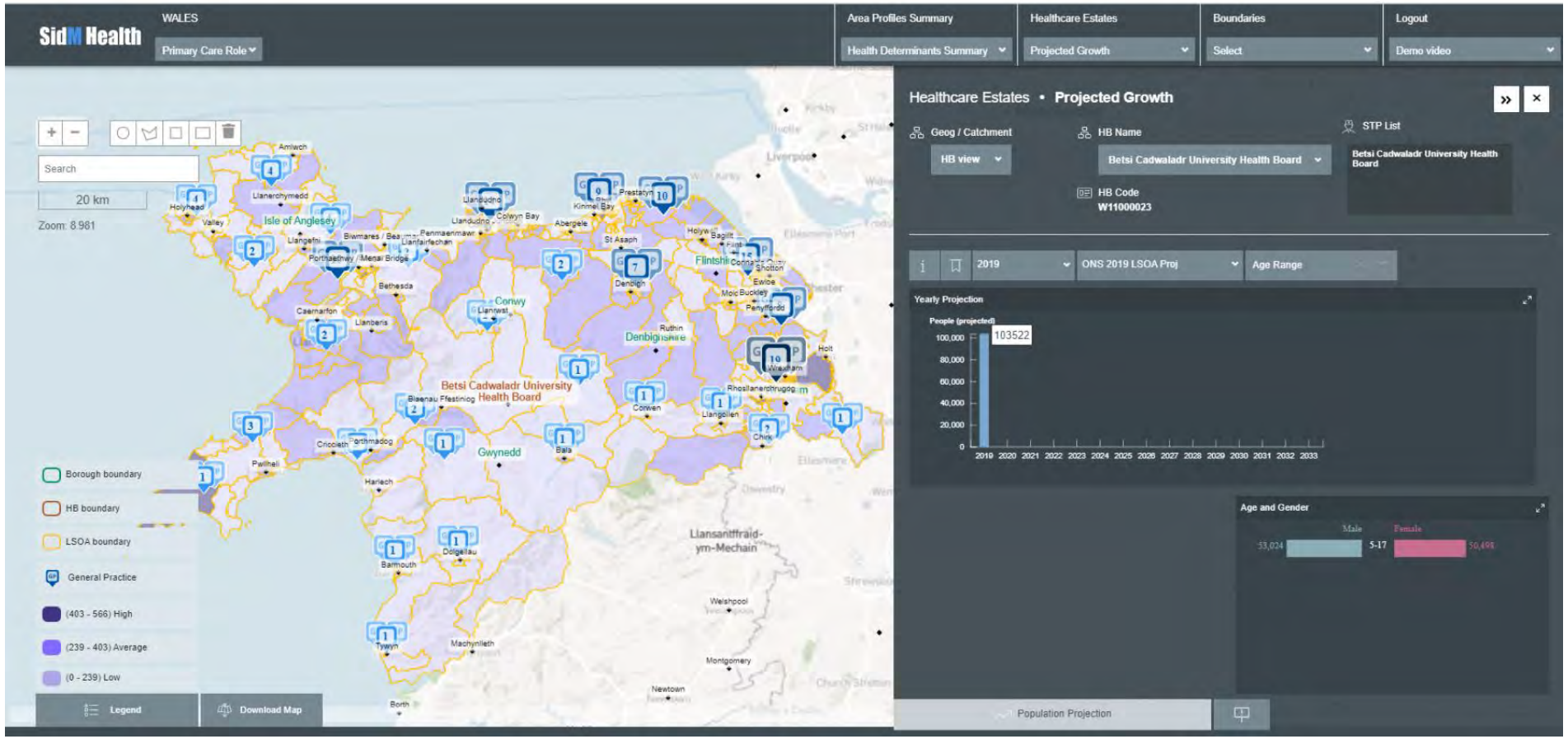
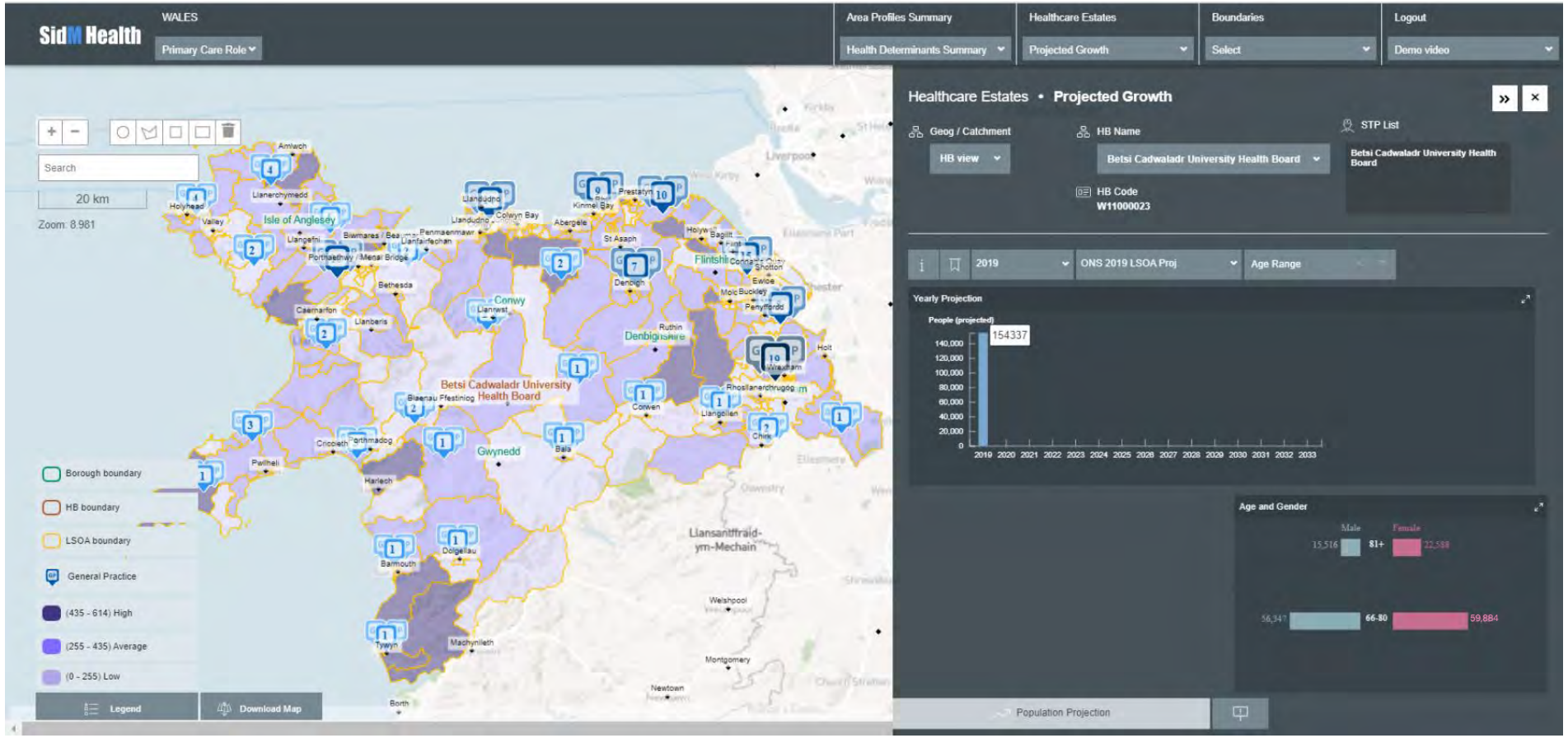
0-4
17,213
Population Projection

5.3 Ages 5 – 17


SidM Health
WALES
Primary Care Role
Area Profiles Summary
Health Determinants Summary
Healthcare Estates
Projected Growth
Boundaries
Select
Logout
Demo video
Search
20 km
Zoom: 8.981
Healthcare Estates • Projected Growth
Geog / Catchment
HB view
HB Name
Betsi Cadwaladr University Health Board
STP List
Betsi Cadwaladr University Health Board
HB Code
W11000023
2019
ONS 2019 LSOA Proj
Age Range
Yearly Projection
People (projected)
103522
Age and Gender
Male
Female
5-17
Borough boundary
HB boundary
LSOA boundary
General Practice
(403 - 566) High
(239 - 403) Average
(0 - 239) Low
Legend
Download Map
Population Projection
Betsi Cadwaladr University Health Board
Isle of Anglesey
Conwy
Denbighshire
Flintshire
Wrexham
Gwynedd

5.4 Ages 66+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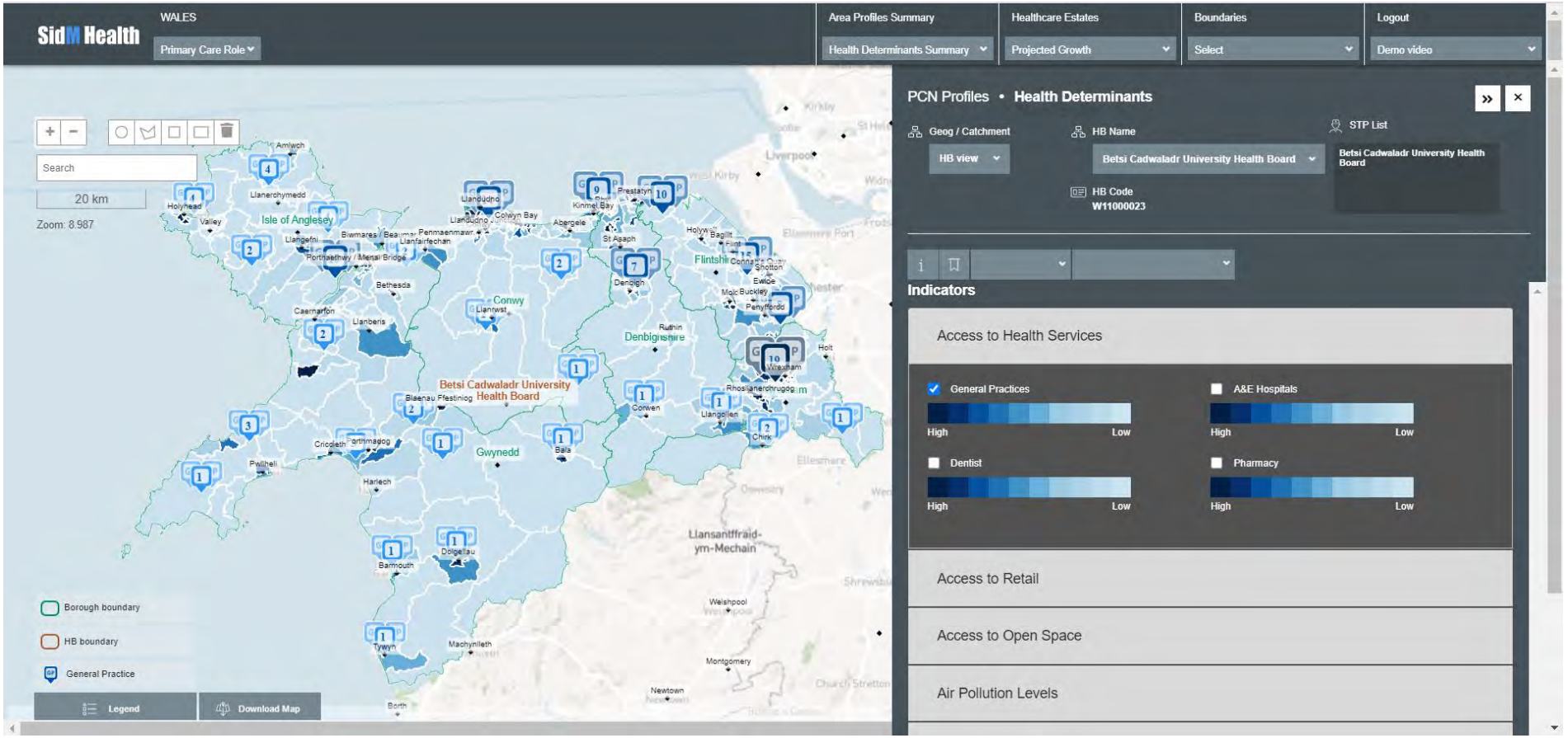
WALES
Primary Care Role
Area Profiles Summary
Health Determinants Summary
Healthcare Estates
Projected Growth
Boundaries
Select
Logout
Demo video
Search
20 km
Zoom: 8.981
Borough boundary
HB boundary
LSOA boundary
General Practice
(435 - 614) High
(255 - 435) Average
(0 - 255) Low
Legend
Download Map
Betsi Cadwaladr University Health Board
Healthcare Estates • Projected Growth
Geog / Catchment
HB view
HB Name
Betsi Cadwaladr University Health Board
STP List
Betsi Cadwaladr University Health Board
HB Code
W11000023
2019
ONS 2019 LSOA Proj
Age Range
Yearly Projection
People (projected)
154337
Age and Gender
Male
Female
Population Projection

6 Access

6.1 General Practices



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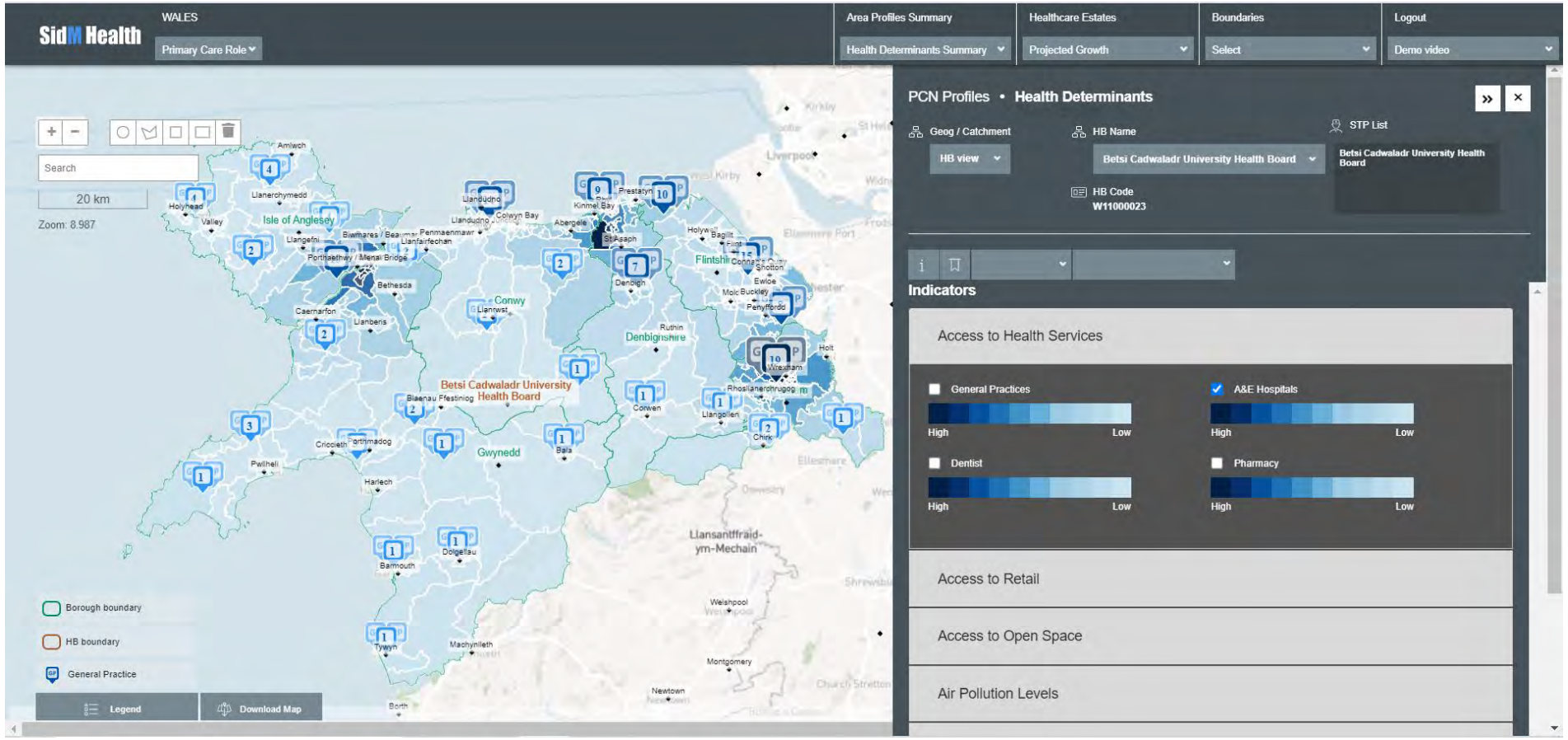
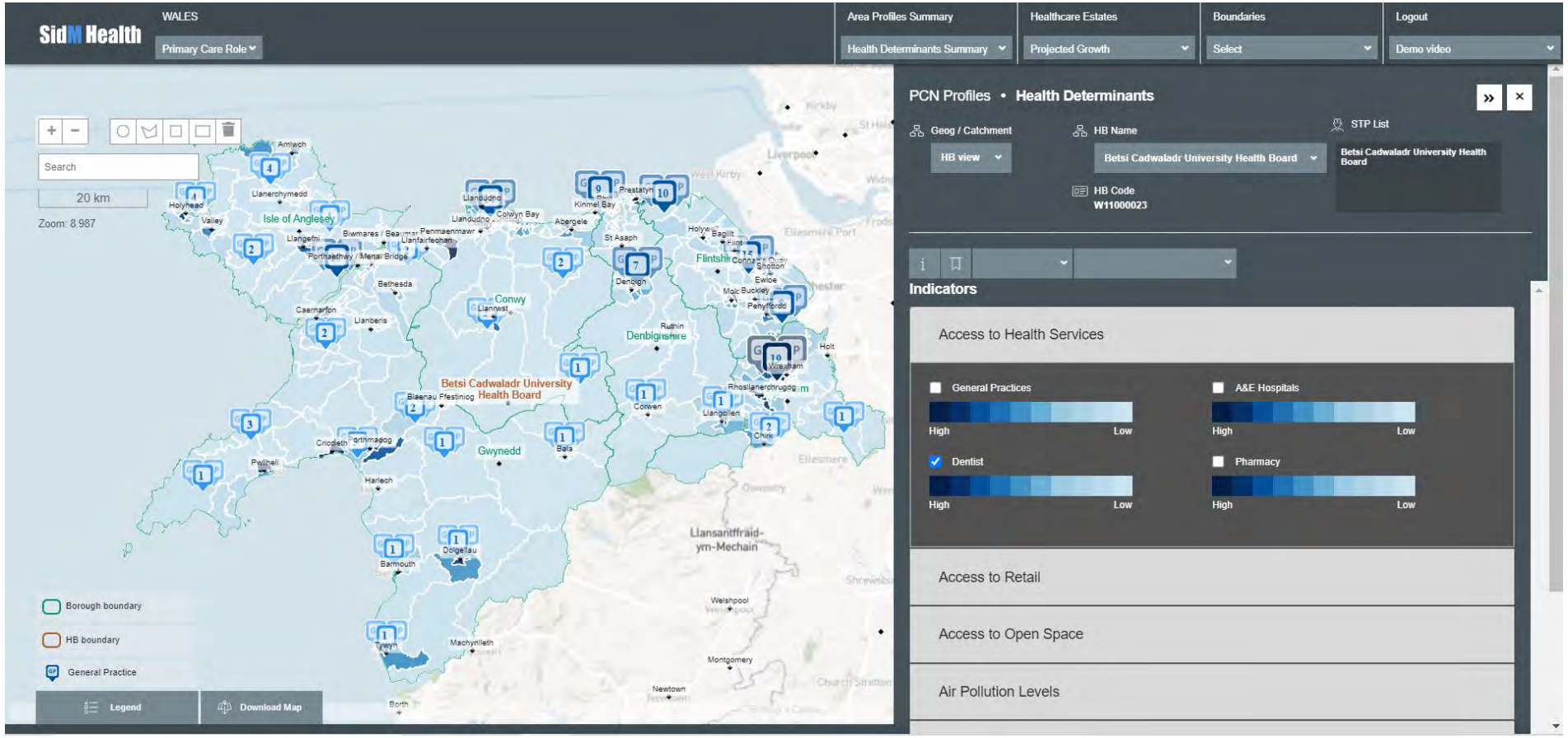
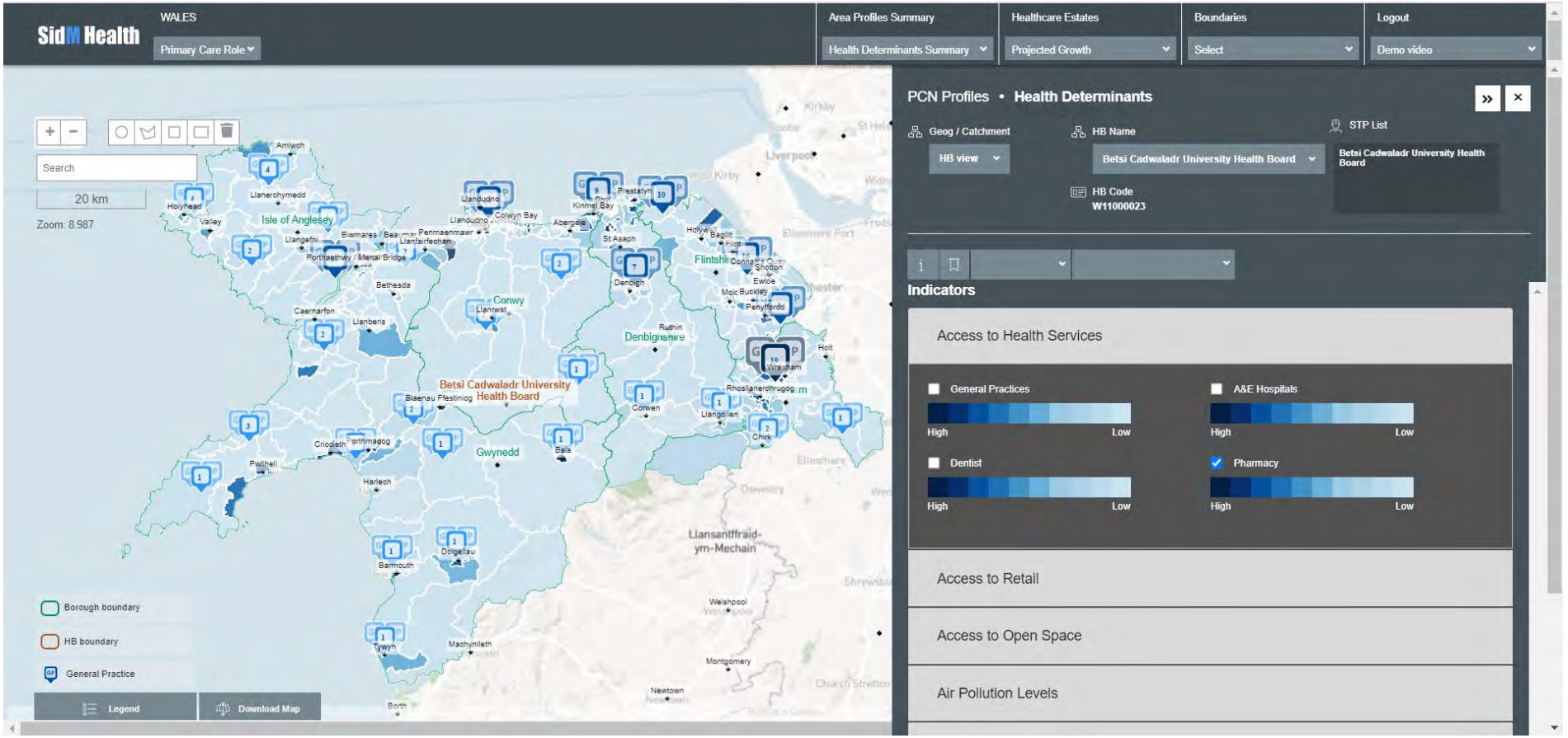


6.3 Dentists


SidM Health
WALES
Primary Care Role
Area Profiles Summary
Health Determinants Summary
Healthcare Estates
Projected Growth
Boundaries
Select
Logout
Demo video
PCN Profiles • Health Determinants
Geog / Catchment
HB view
HB Name
Betsi Cadwaladr University Health Board
STP List
Betsi Cadwaladr University Health Board
HB Code
W11000023
Indicators
Access to Health Services
General Practices
A&E Hospitals
Dentist
Pharmacy
High
Low
Access to Retail
Access to Open Space
Air Pollution Levels
Search
20 km
Zoom: 8.987
Isle of Anglesey
Conwy
Denbighshire
Flintshire
Gwynedd
Betsi Cadwaladr University Health Board
Borough boundary
HB boundary
General Practice
Legend
Download Map

6.4 Pharmacy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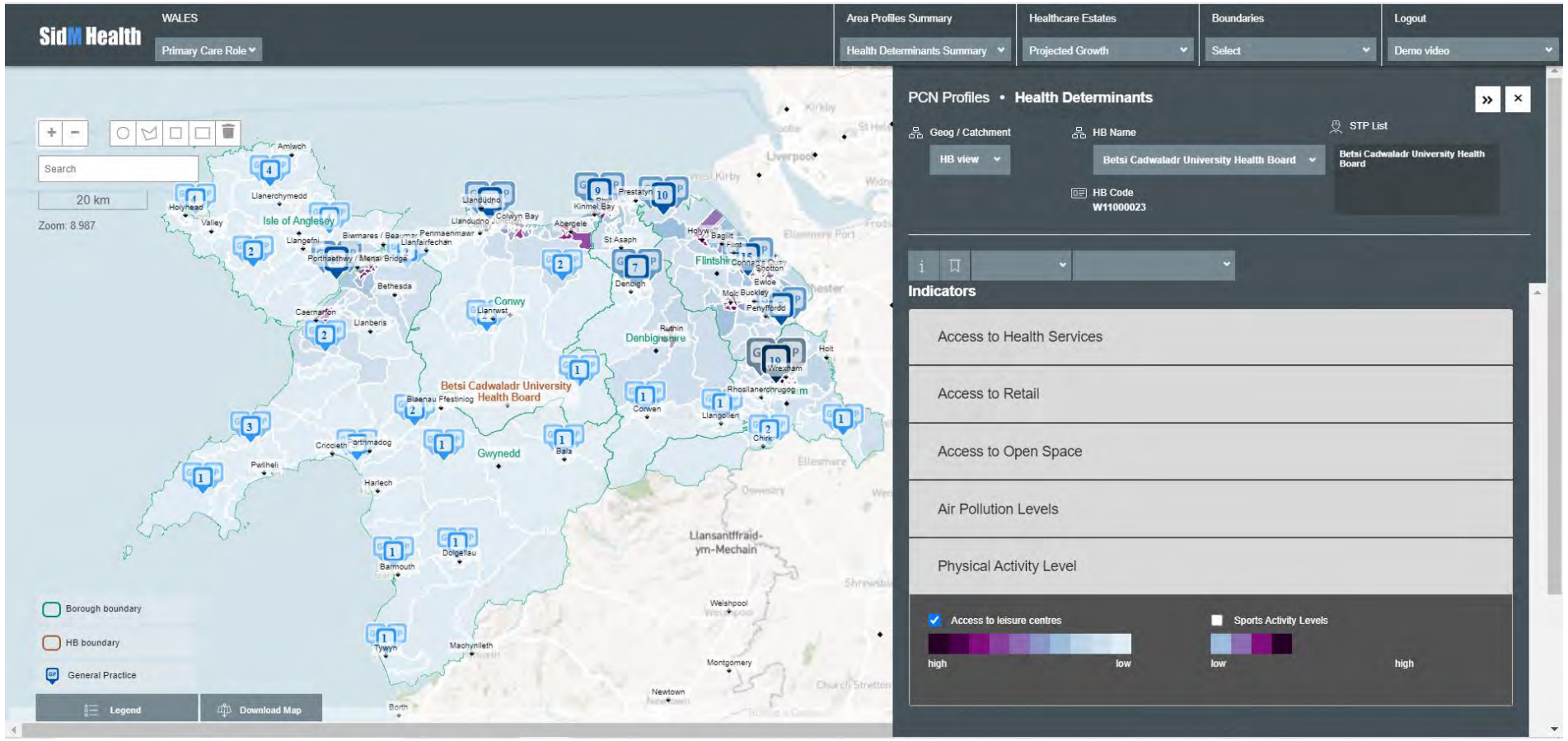
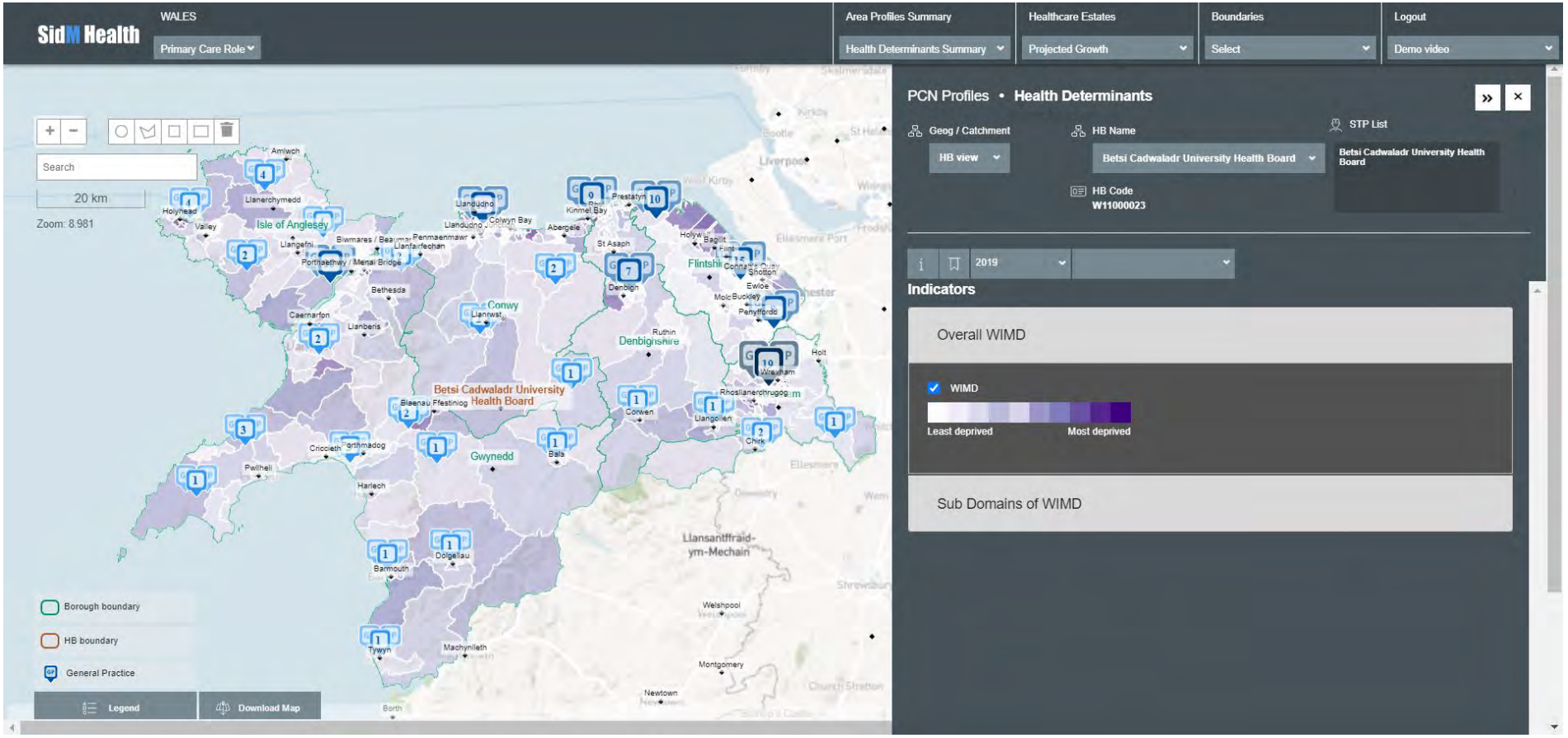
WALES
Primary Care Role
Area Profiles Summary
Health Determinants Summary
Healthcare Estates
Projected Growth
Boundaries
Select
Logout
Demo video
PCN Profiles • Health Determinants
Geog / Catchment
HB view
HB Name
Betsi Cadwaladr University Health Board
STP List
Betsi Cadwaladr University Health Board
HB Code
W11000023
Indicators
Access to Health Services
General Practices
A&E Hospitals
Dentist
Pharmacy
High
Low
Access to Retail
Access to Open Space
Air Pollution Levels
Search
20 km
Zoom: 8.987
Isle of Anglesey
Conwy
Denbighshire
Flintshire
Betsi Cadwaladr University Health Board
Gwynedd
Llansantffraid-ym-Mechain
Borough boundary
HB boundary
General Practice
Legend
Download Map

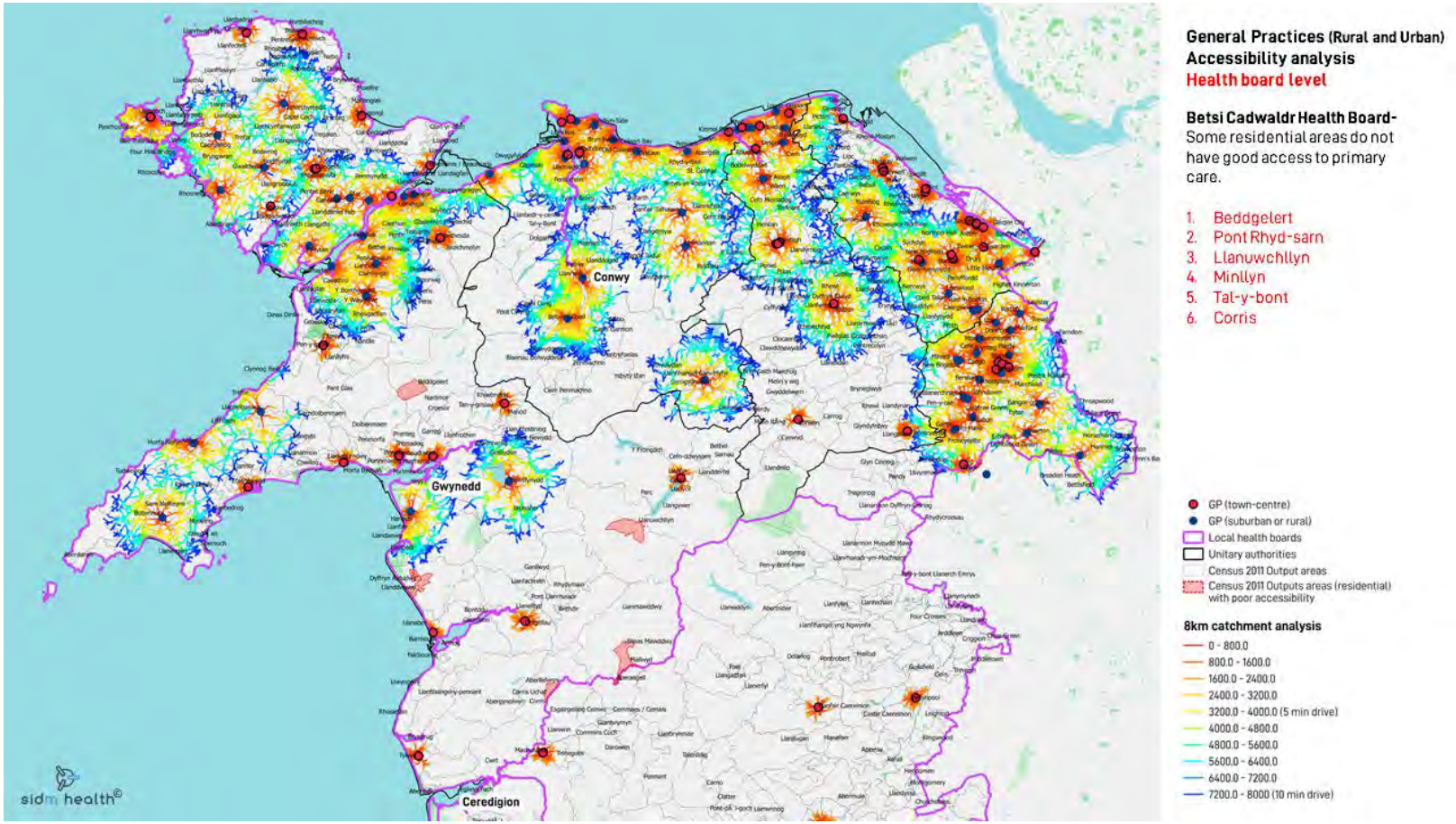
6.5 Leisure Centres



7 Overall Deprivation Score



8 Travel Distances



Archus

The healthcare infrastructure specialist

Appendix C3 – Cardiff and Vale University Health Board mapping

May 2021

Contents

1 Introduction

1.1 Demographic Observations

Review of the Demographic profile below shows that there are moderate levels of growth over recent years. This growth will continue but is shown to be in key ages within the population and significantly higher in the numbers of people over the age of 66 years and 80 years plus

In 2021 the numbers of 0-4 years have been seen to have dropped, this will not continue but the future increases will be lower than in previous years. The numbers of 5-17 years have grown and will continue to do so until 2023 when the growth will drop off. Younger people can be seen in different concentrations of high to low numbers in areas within the Health Boards profile. By overlapping the deprivation map to this, current access and different types of healthcare needed can be seen to see where the gaps are. This will ensure future planning of services are linked to both need and future growth.

The increase in older people also means that future service provision may need to be different. It is particularly noticeable when overlapping the age profile and current health provision, that there is low access in areas where concentrations of older people is increasing such as within the wider area of the Vale of Glamorgan.

1.2 Patient Need

Since the population in areas of the Health Board has grown and the numbers of aging patients who have a higher requirement for health services has increased, there will be a growing impact on primary care in these areas. Several key observations for the Health Board can be seen:

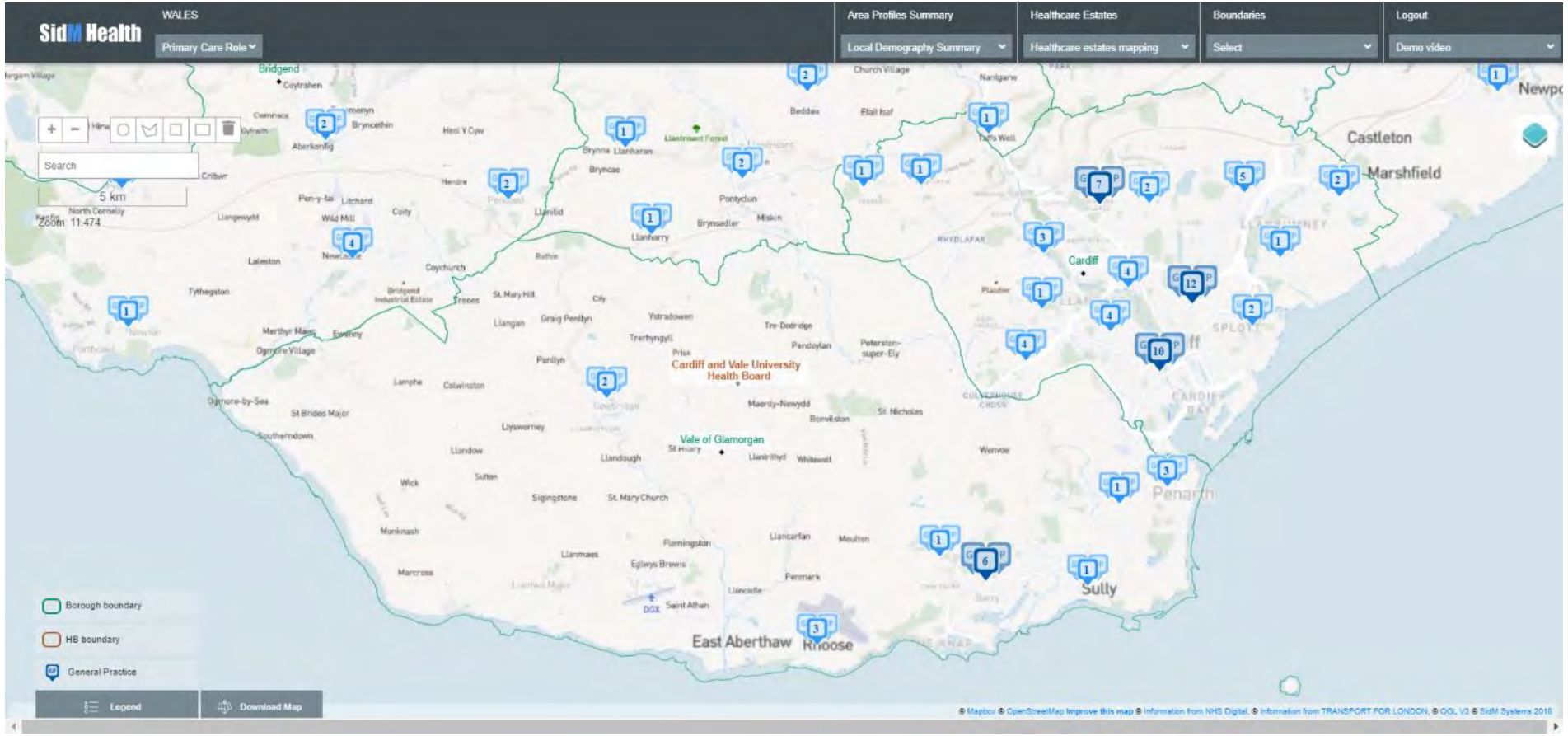
- The numbers of people aged 66+ will continue to increase for the next 20 years. This will include a marked rise in the numbers of people aged 80 plus years
- In some areas where there are higher concentrations and growing numbers of older people, access to health care provision is low.
- Where deprivation scores are seen to be higher key service provision assessments can be made ensuring health needs are met across all ages – addressing the entire spectrum of people's physical, mental, and social needs.
- The numbers of 0-4 years have slowed but will increase in future years. New housing development planning agreements should be assessed to link expected growth projections.
- The numbers of young people have increased and will continue to do so until 2023 when growth will slow down.

- Analysis of access to the wider services such as pharmacies, dentists and leisure allows an assessment of gaps in service provision and the best options to provide an integrated approach to health and social care enabling people with more complex conditions to be offered screening and secondary prevention reflecting their higher risk of poor physical health.

1.3 Mapping and Statistics

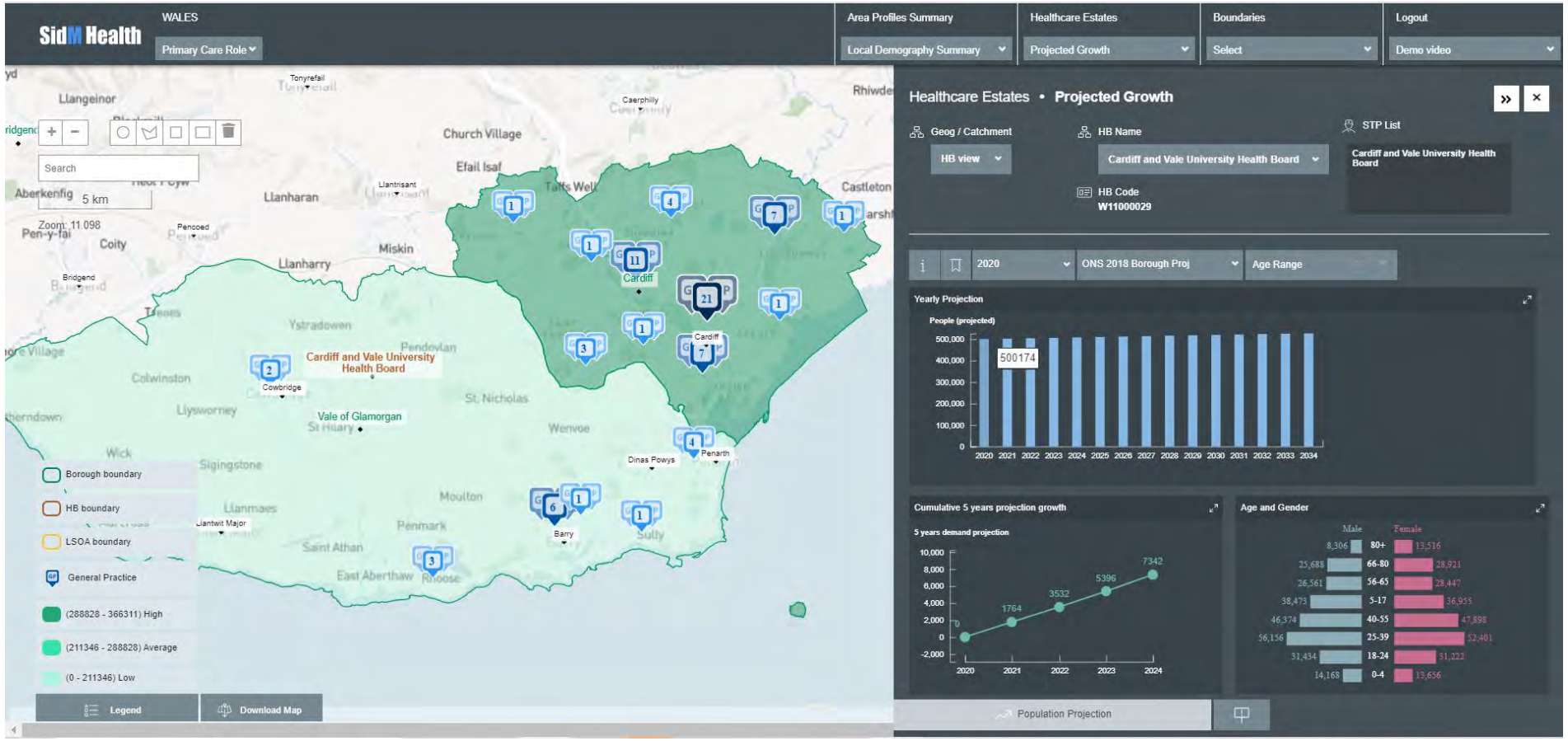
The maps below give a detailed view of the current and future population growth by age. Areas of population concentration can be identified via the heat maps, as well as access to services such as, General Practice, acute units, wider health service needs and leisure. Overall deprivation by borough is displayed against General Practice provision in section 7. Distance of travel to General Practices are demonstrated on the final map, in section 8, via an 8km catchment area.

2 General Practice Location Map

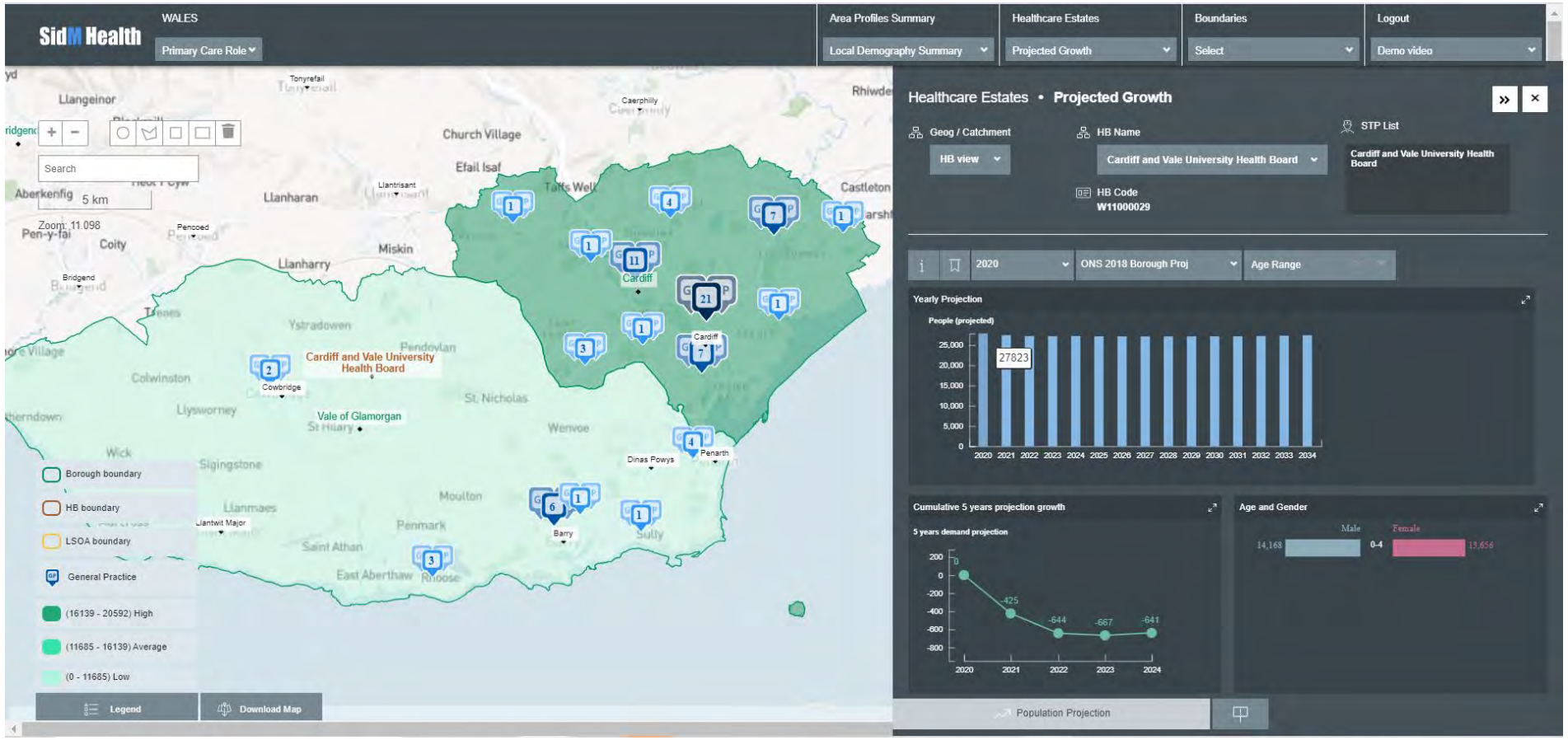


3 Population Projection by Local Authority 2020

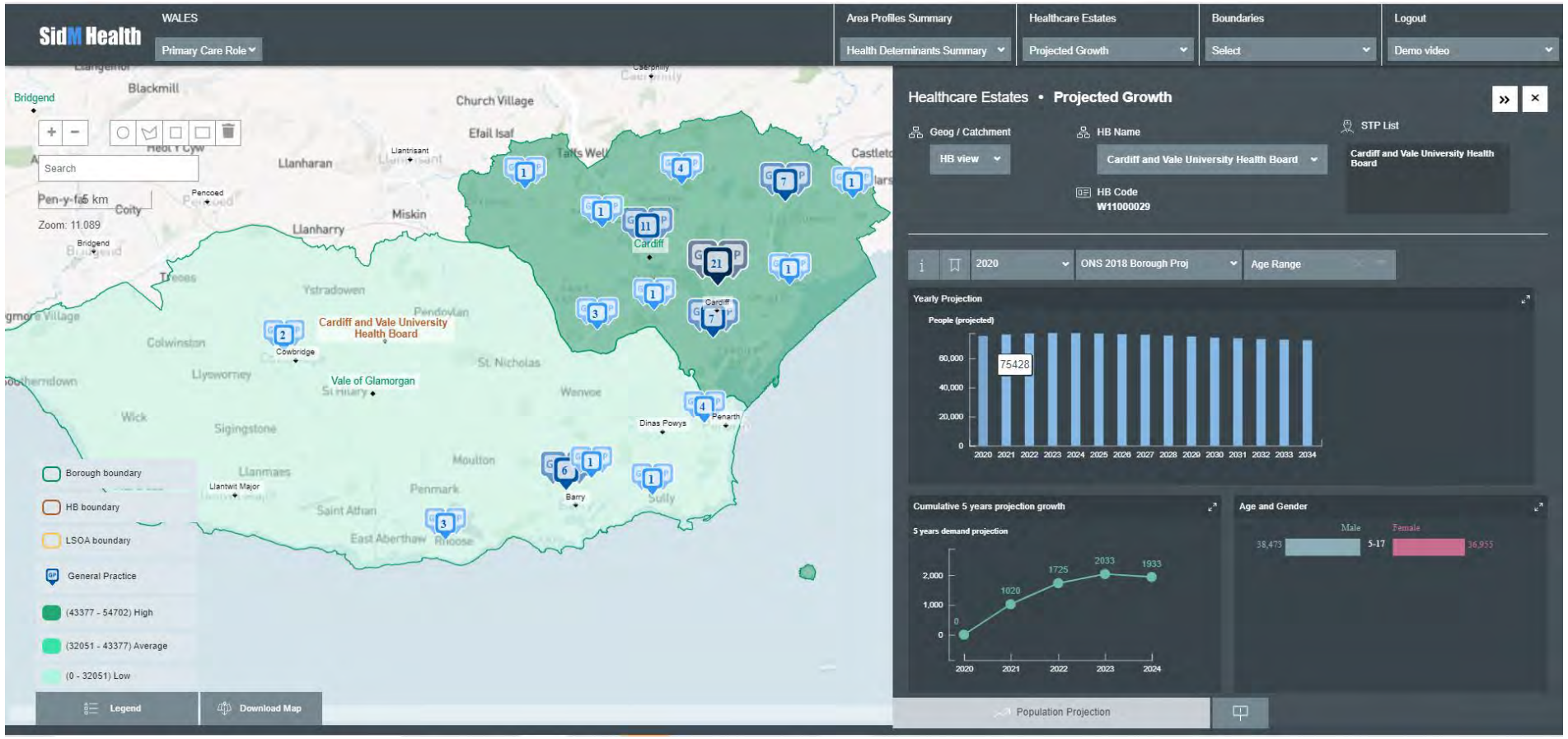
3.1 All Ages



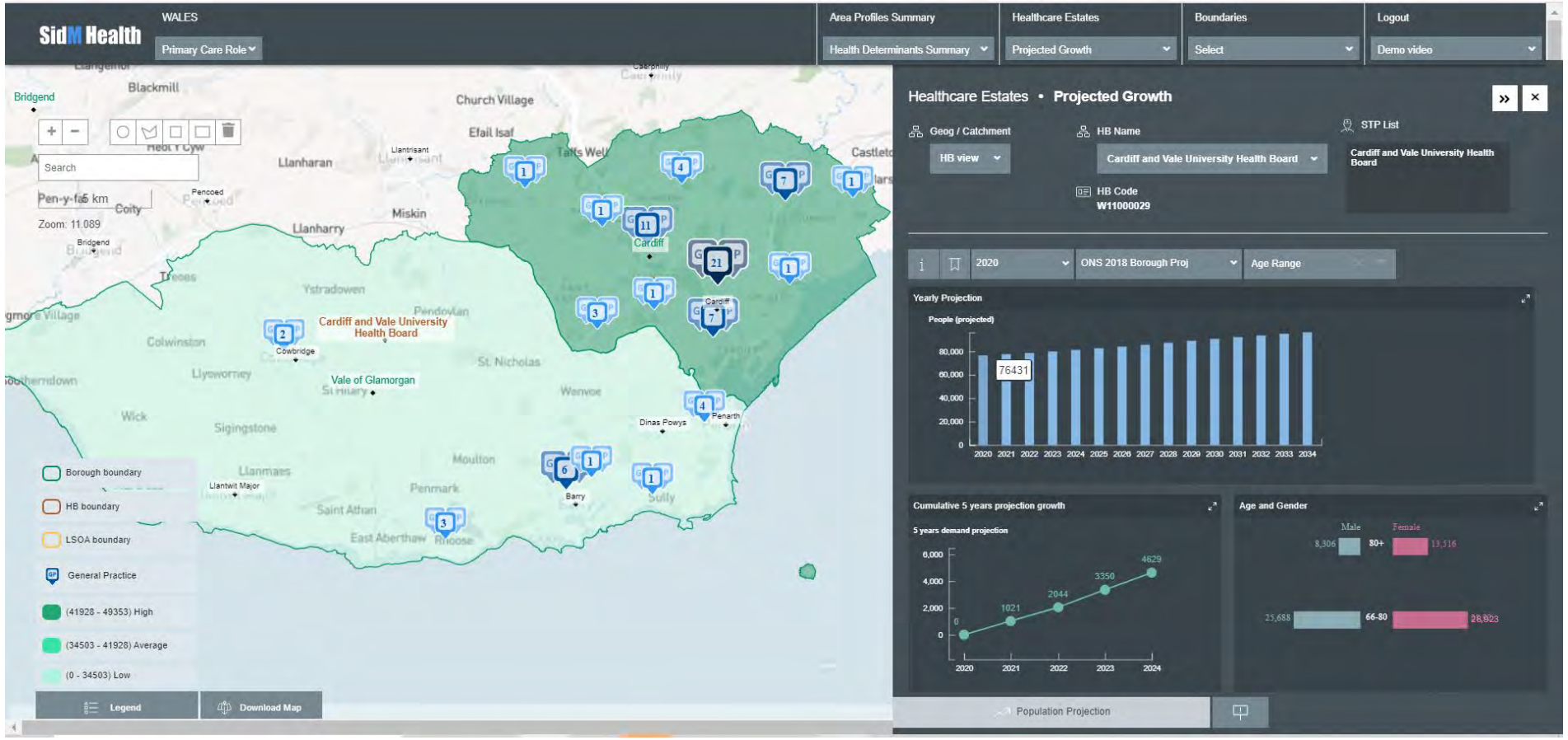
3.2 Ages 0 – 4


SidM Health
WALES
Primary Care Role
Area Profiles Summary
Local Demography Summary
Healthcare Estates
Projected Growth
Boundaries
Select
Logout
Demo video
Healthcare Estates • Projected Growth
Geog / Catchment
HB view
HB Name
Cardiff and Vale University Health Board
HB Code
W11000029
STP List
Cardiff and Vale University Health Board
2020
ONS 2018 Borough Proj
Age Range
Yearly Projection
People (projected)
27823
Cumulative 5 years projection growth
5 years demand projection
Age and Gender
Male
Female
14,168
0-4
13,656
Population Projection
Cardiff and Vale University Health Board
Vale of Glamorgan
Borough boundary
HB boundary
LSOA boundary
General Practice
(16139 - 20592) High
(11685 - 16139) Average
(0 - 11685) Low
Legend
Download Map

3.3 Ages 5 – 17


SidM Health
WALES
Primary Care Role
Area Profiles Summary
Health Determinants Summary
Healthcare Estates
Projected Growth
Boundaries
Select
Logout
Demo video
Healthcare Estates • Projected Growth
Geog / Catchment
HB view
HB Name
Cardiff and Vale University Health Board
STP List
Cardiff and Vale University Health Board
HB Code
W11000029
2020
ONS 2018 Borough Proj
Age Range
Yearly Projection
People (projected)
75428
Cumulative 5 years projection growth
5 years demand projection
Age and Gender
Male
Female
38,473
5-17
36,955
Cardiff and Vale University Health Board
Vale of Glamorgan
Borough boundary
HB boundary
LSOA boundary
General Practice
(43377 - 54702) High
(32051 - 43377) Average
(0 - 32051) Low
Legend
Download Map
Population Projection

3.4 Ages 66+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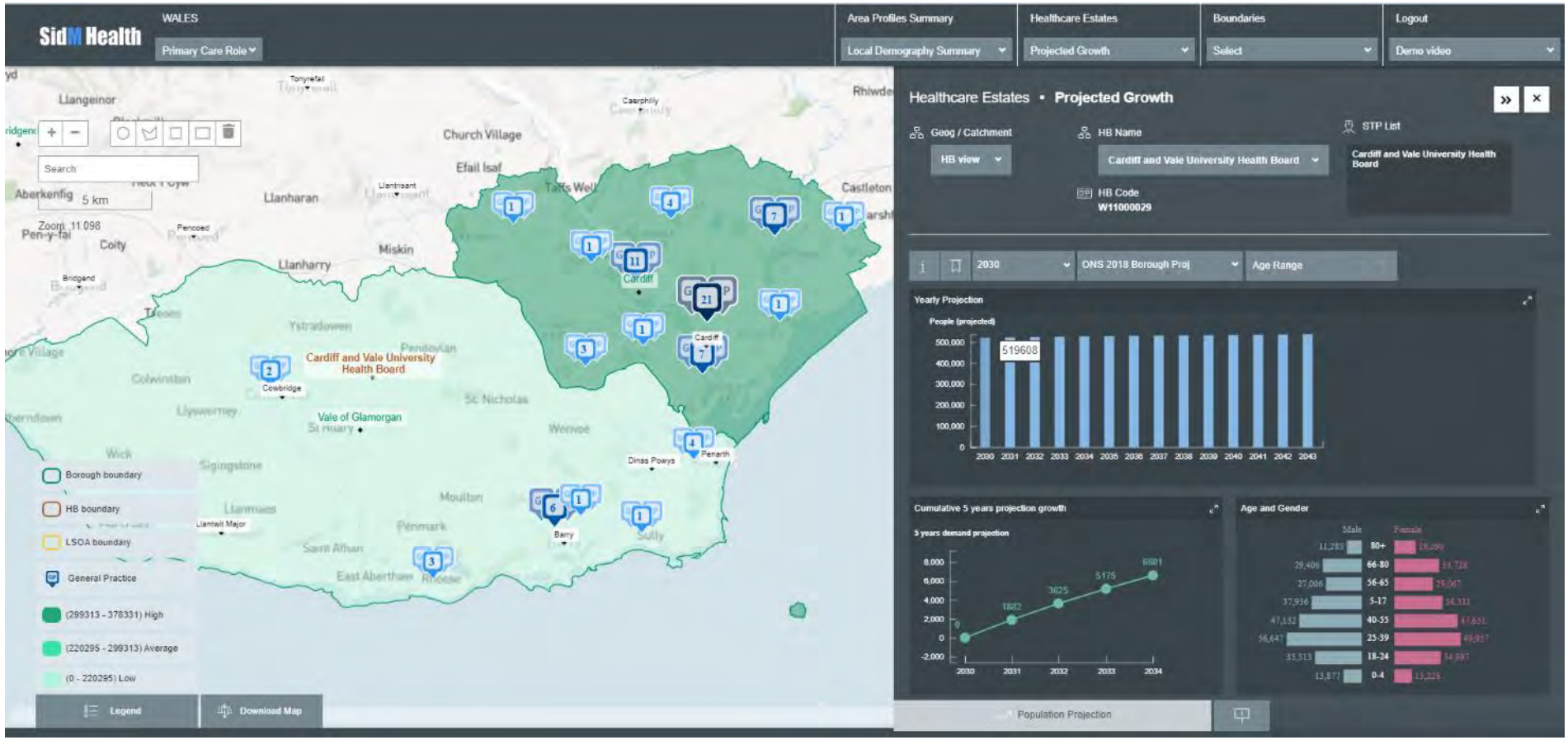
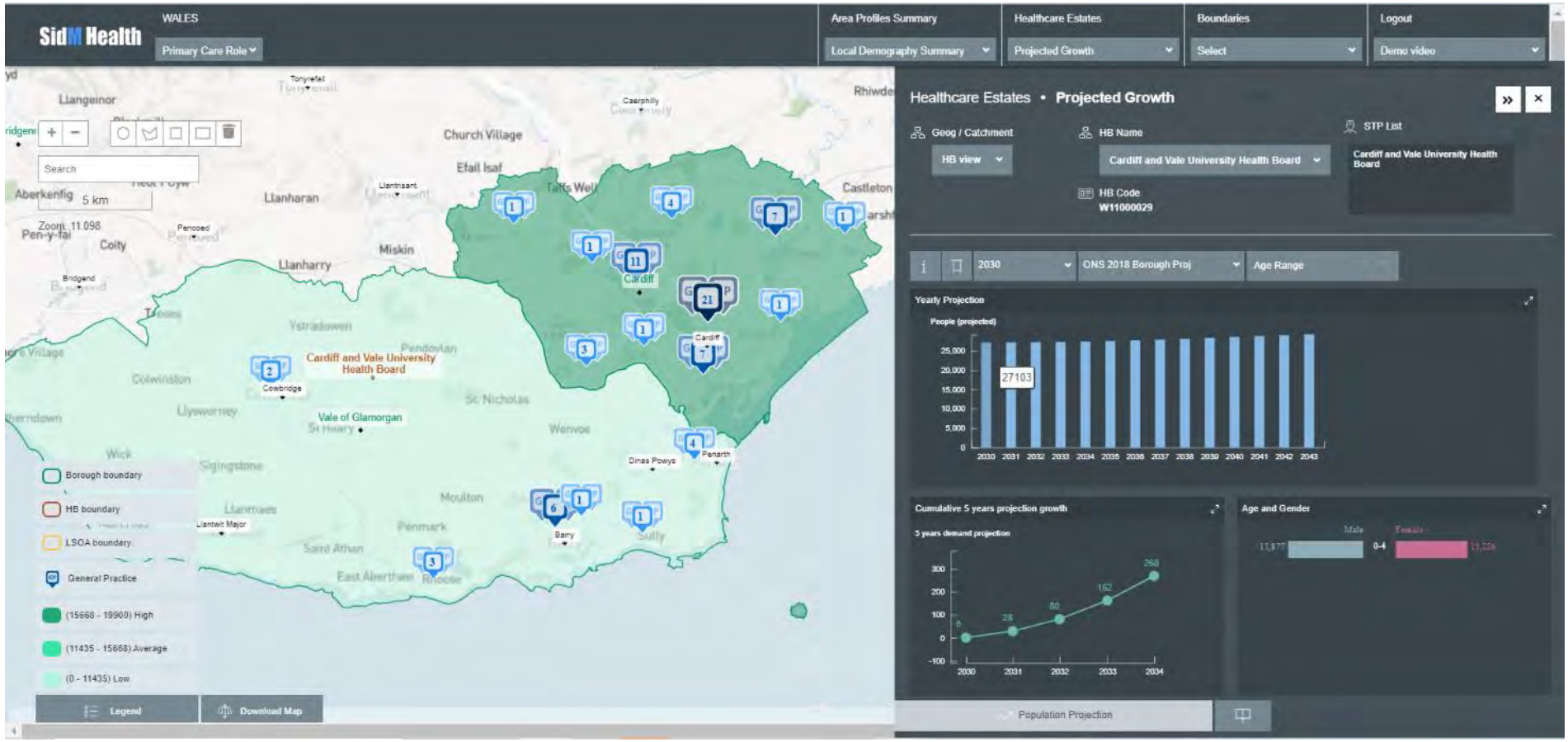
WALES
Primary Care Role
Area Profiles Summary
Health Determinants Summary
Healthcare Estates
Projected Growth
Boundaries
Select
Logout
Demo video
Healthcare Estates • Projected Growth
Geog / Catchment
HB view
HB Name
Cardiff and Vale University Health Board
STP List
Cardiff and Vale University Health Board
HB Code
W11000029
2020
ONS 2018 Borough Proj
Age Range
Yearly Projection
People (projected)
76431
Cumulative 5 years projection growth
5 years demand projection
Age and Gender
Male
Female
Cardiff and Vale University Health Board
Vale of Glamorgan
Borough boundary
HB boundary
LSOA boundary
General Practice
(41928 - 49353) High
(34503 - 41928) Average
(0 - 34503) Low
Legend
Download Map
Population Projection

4 Population Projection 2030, by Local Authority

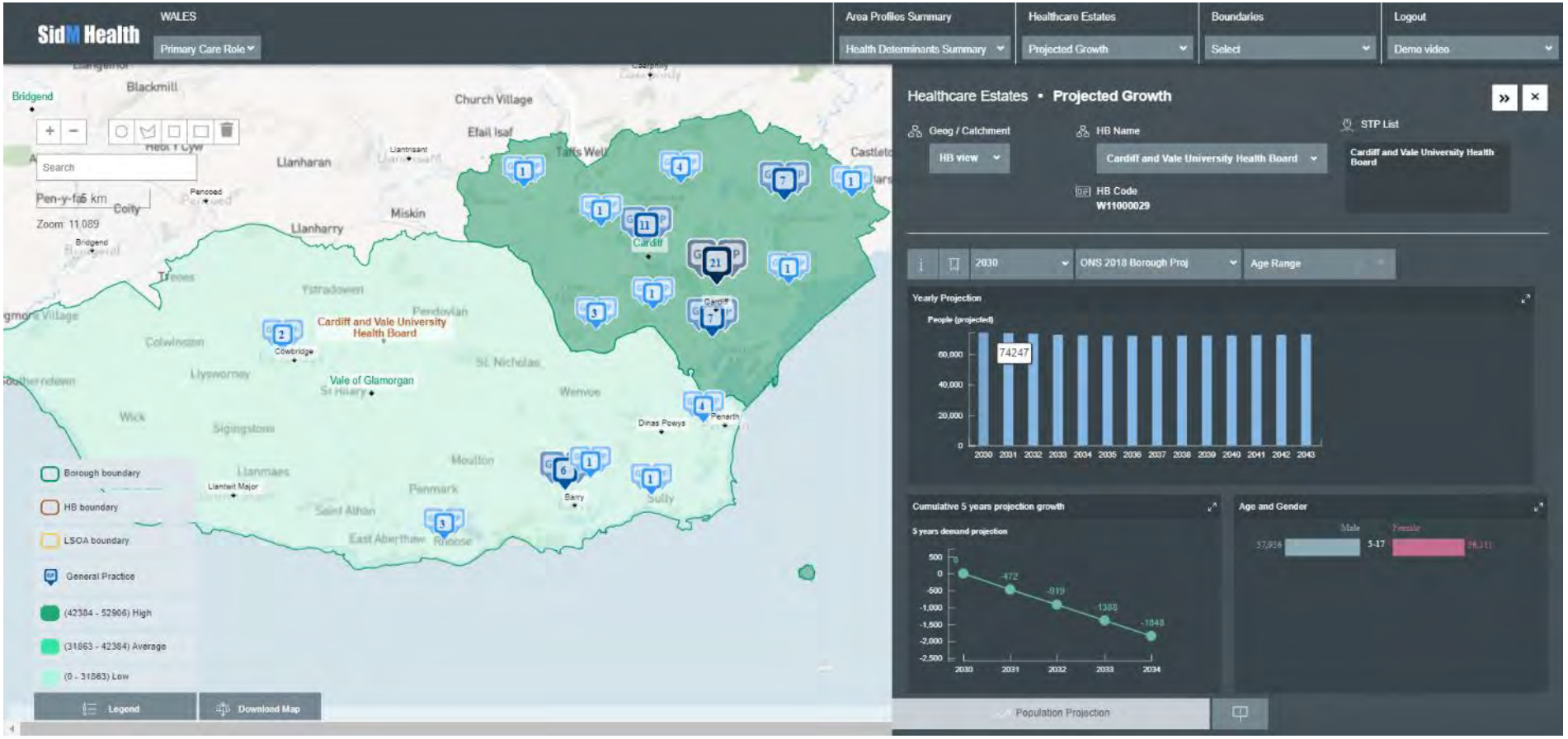
4.1 All Ages



4.2 Ages 0 – 4


SidM Health
WALES
Primary Care Role
Area Profiles Summary
Local Demography Summary
Healthcare Estates
Projected Growth
Boundaries
Select
Logout
Demo video
Healthcare Estates • Projected Growth
Geog / Catchment
HB view
HB Name
Cardiff and Vale University Health Board
HB Code
W11000029
STP List
Cardiff and Vale University Health Board
2030
ONS 2018 Borough Proj
Age Range
Yearly Projection
People (projected)
27103
Cumulative 5 years projection growth
5 years demand projection
Age and Gender
Male
Female
0-4
Population Projection
Cardiff and Vale University Health Board
Vale of Glamorgan
Borough boundary
HB boundary
LSOA boundary
General Practice
(15668 - 19900) High
(11435 - 15668) Average
(0 - 11435) Low
Legend
Download Map

4.3 Ages 5 – 17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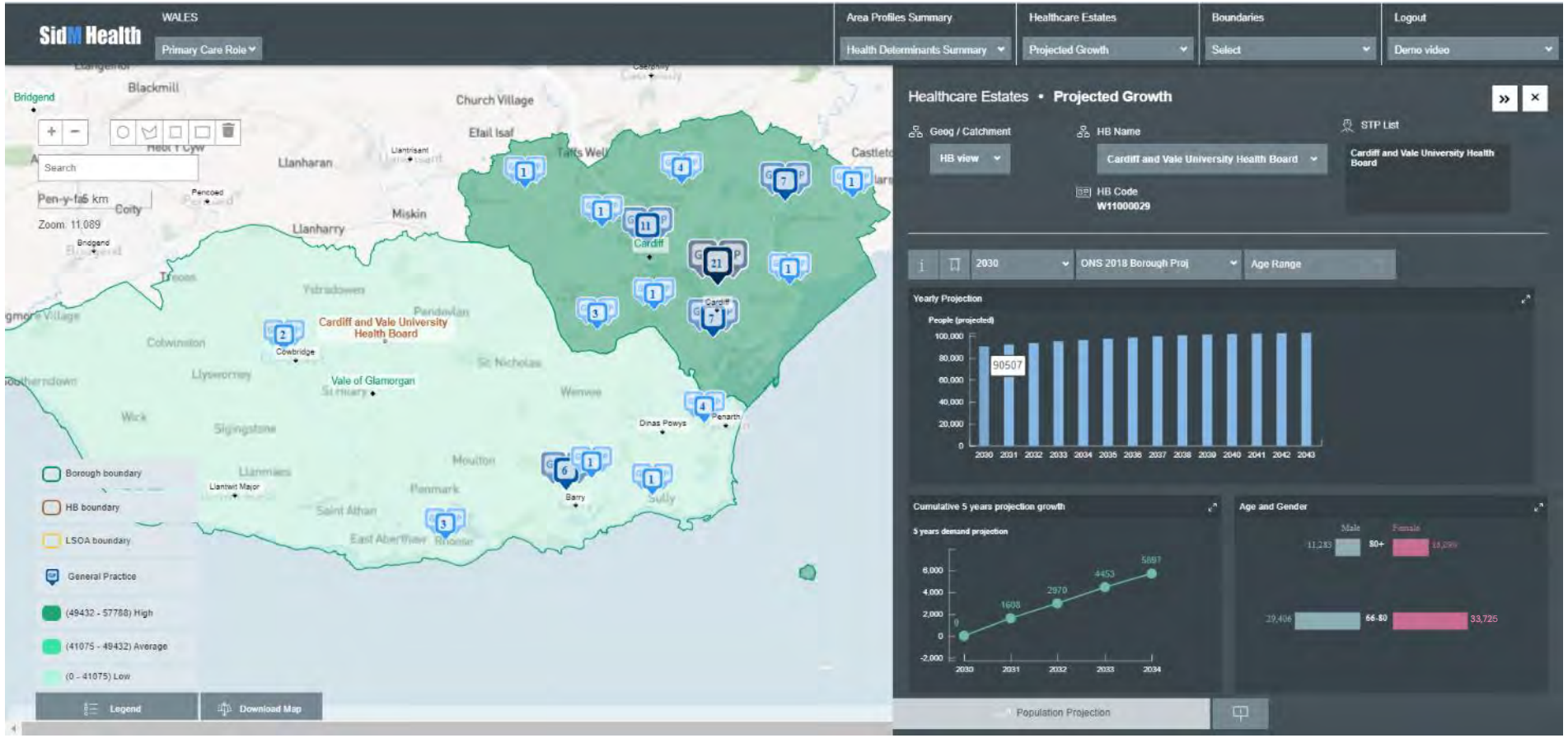
Primary Care Role
Area Profiles Summary
Health Determinants Summary
Healthcare Estates
Projected Growth
Boundaries
Select
Logout
Demo video
Healthcare Estates • Projected Growth
Geog / Catchment
HB view
HB Name
Cardiff and Vale University Health Board
STP List
Cardiff and Vale University Health Board
HB Code
W11000029
2030
ONS 2018 Borough Proj
Age Range
Yearly Projection
People (projected)
74247
Cardiff and Vale University Health Board
Vale of Glamorgan
Borough boundary
HB boundary
LSOA boundary
General Practice
(42384 - 52906) High
(31863 - 42384) Average
(0 - 31863) Low
Legend
Download Map
Cumulative 5 years projection growth
5 years demand projection
Age and Gender
Male
Female
5-17
Population Projection

4.4 Ages 66+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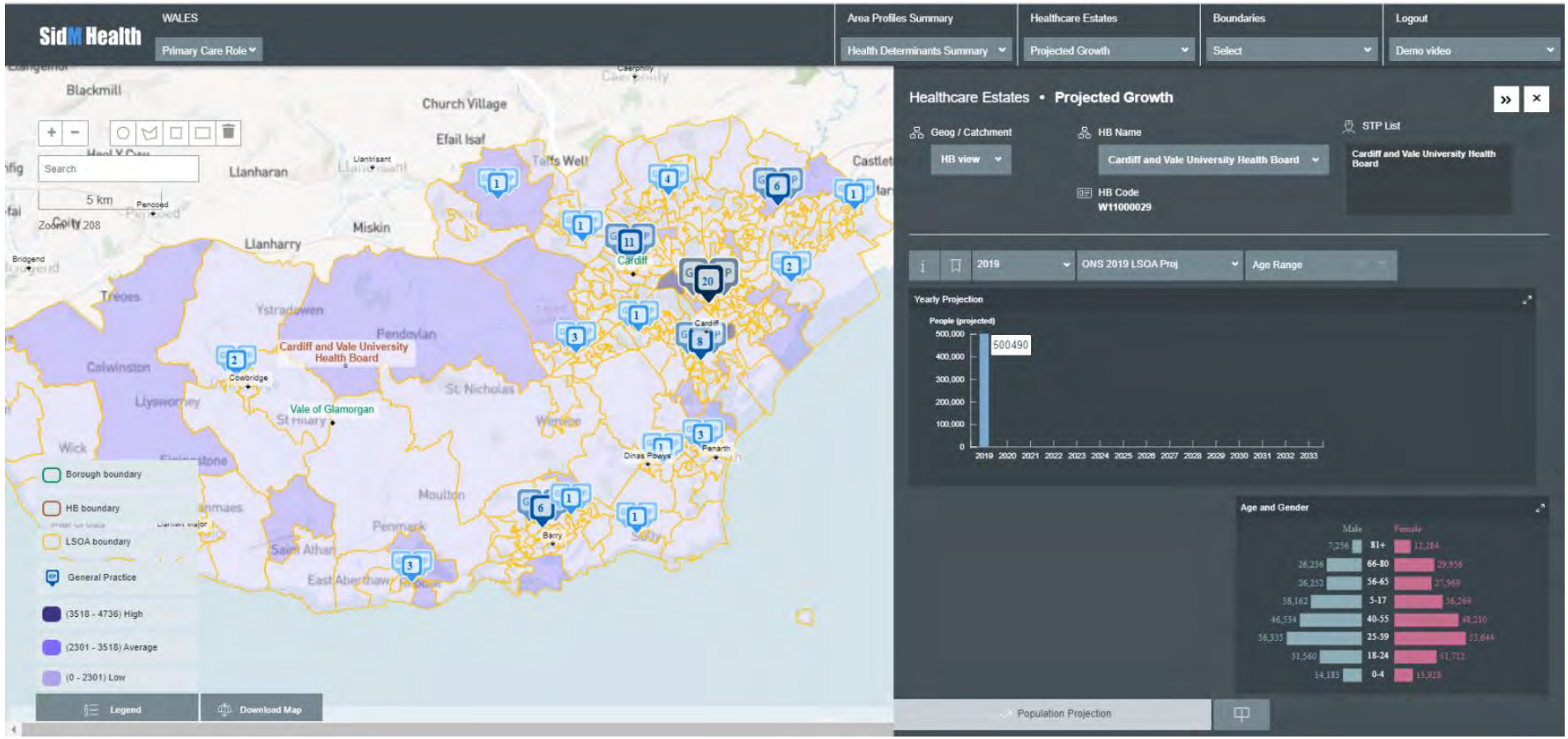
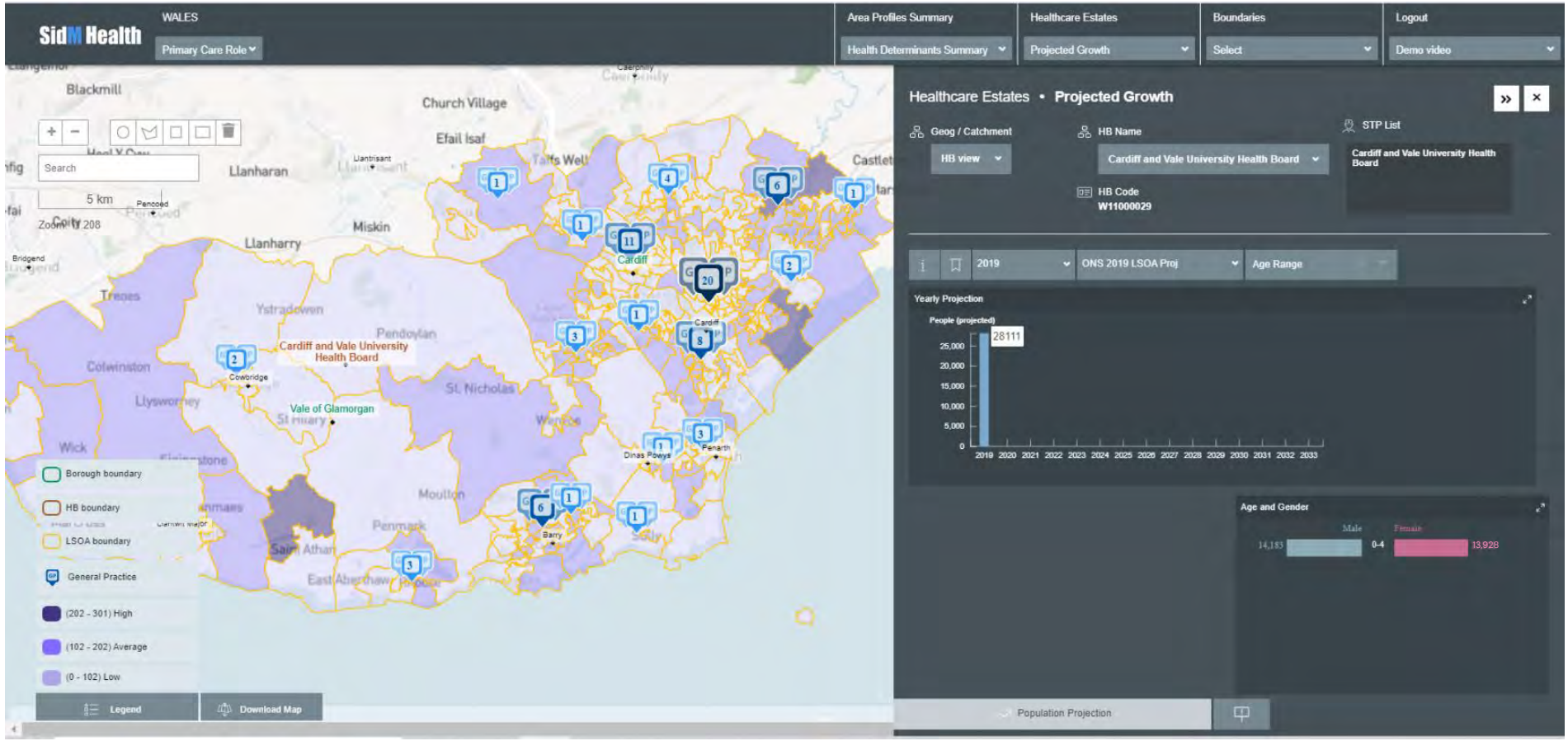
WALES
Primary Care Role
Area Profiles Summary
Health Determinants Summary
Healthcare Estates
Projected Growth
Boundaries
Select
Logout
Demo video
Healthcare Estates • Projected Growth
Geog / Catchment
HB view
HB Name
Cardiff and Vale University Health Board
STP List
Cardiff and Vale University Health Board
HB Code
W11000029
2030
ONS 2018 Borough Proj
Age Range
Yearly Projection
People (projected)
90507
Cumulative 5 years projection growth
5 years demand projection
Age and Gender
Male
Female
80+
66-80
33,725
Cardiff and Vale University Health Board
Borough boundary
HB boundary
LSOA boundary
General Practice
(49432 - 57788) High
(41075 - 49432) Average
(0 - 41075) Low
Legend
Download Map
Population Projection

5 Population Projection by LSOAs

5.1 All Ages



5.2 Ages 0 – 4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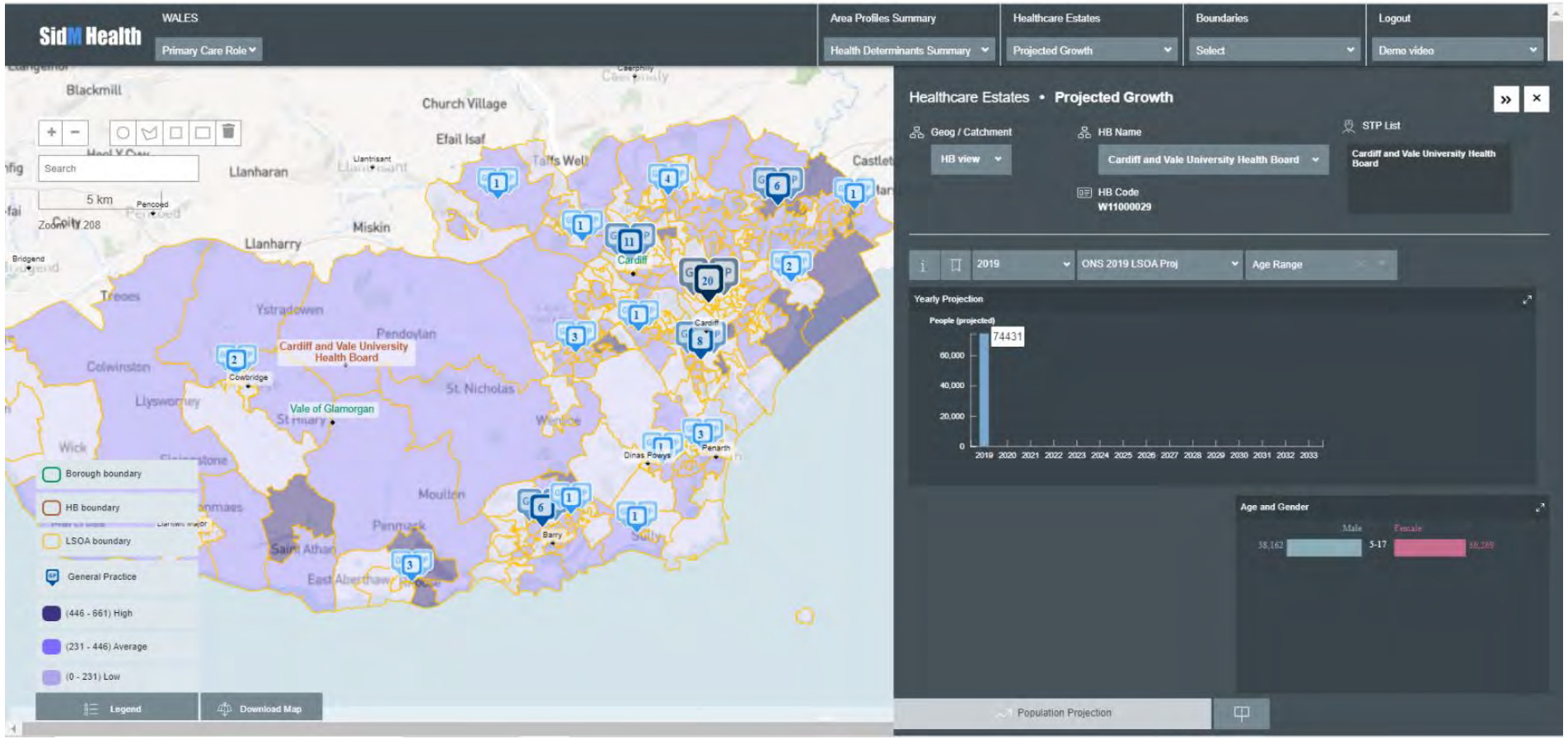
Area Profiles Summary
Health Determinants Summary
Healthcare Estates
Projected Growth
Boundaries
Select
Logout
Demo video
Healthcare Estates • Projected Growth
Geog / Catchment
HB view
HB Name
Cardiff and Vale University Health Board
STP List
Cardiff and Vale University Health Board
HB Code
W11000029
2019
ONS 2019 LSOA Proj
Age Range
Yearly Projection
People (projected)
28111
Age and Gender
Male
Female
14,185
0-4
13,928
Population Projection
Cardiff and Vale University Health Board
Vale of Glamorgan
Borough boundary
HB boundary
LSOA boundary
General Practice
(202 - 301) High
(102 - 202) Average
(0 - 102) Low
Legend
Download Map

5.3 Ages 5 – 17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Health Determinants Summary
Healthcare Estates
Projected Growth
Boundaries
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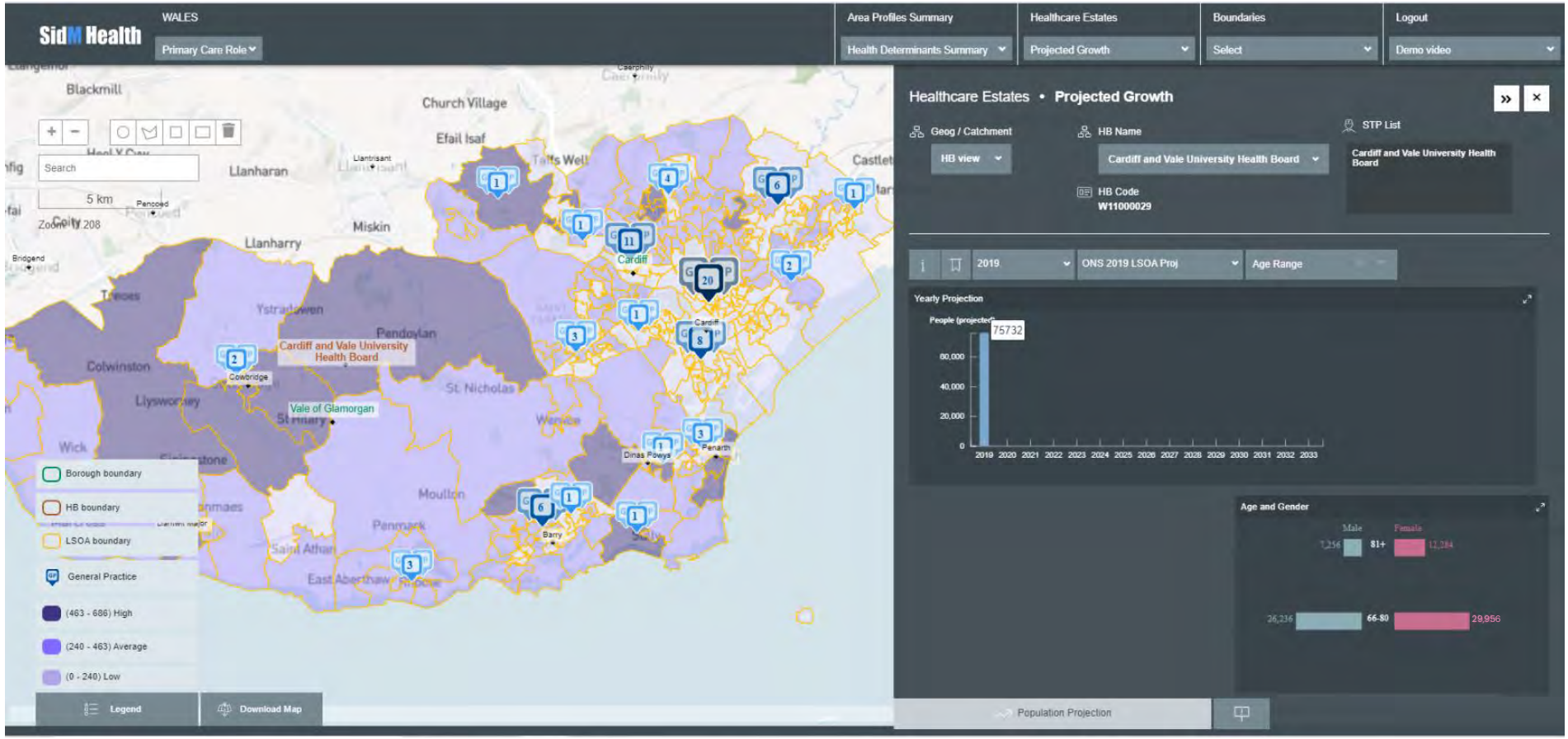
Demo video
Healthcare Estates • Projected Growth
Geog / Catchment
HB view
HB Name
Cardiff and Vale University Health Board
STP List
Cardiff and Vale University Health Board
HB Code
W11000029
2019
ONS 2019 LSOA Proj
Age Range
Yearly Projection
People (projected)
74431
Age and Gender
Male
Female
5-17
Cardiff and Vale University Health Board
Vale of Glamorgan
Borough boundary
HB boundary
LSOA boundary
General Practice
(446 - 661) High
(231 - 446) Average
(0 - 231) Low
Legend
Download Map
Population Projection

5.4 Ages 66+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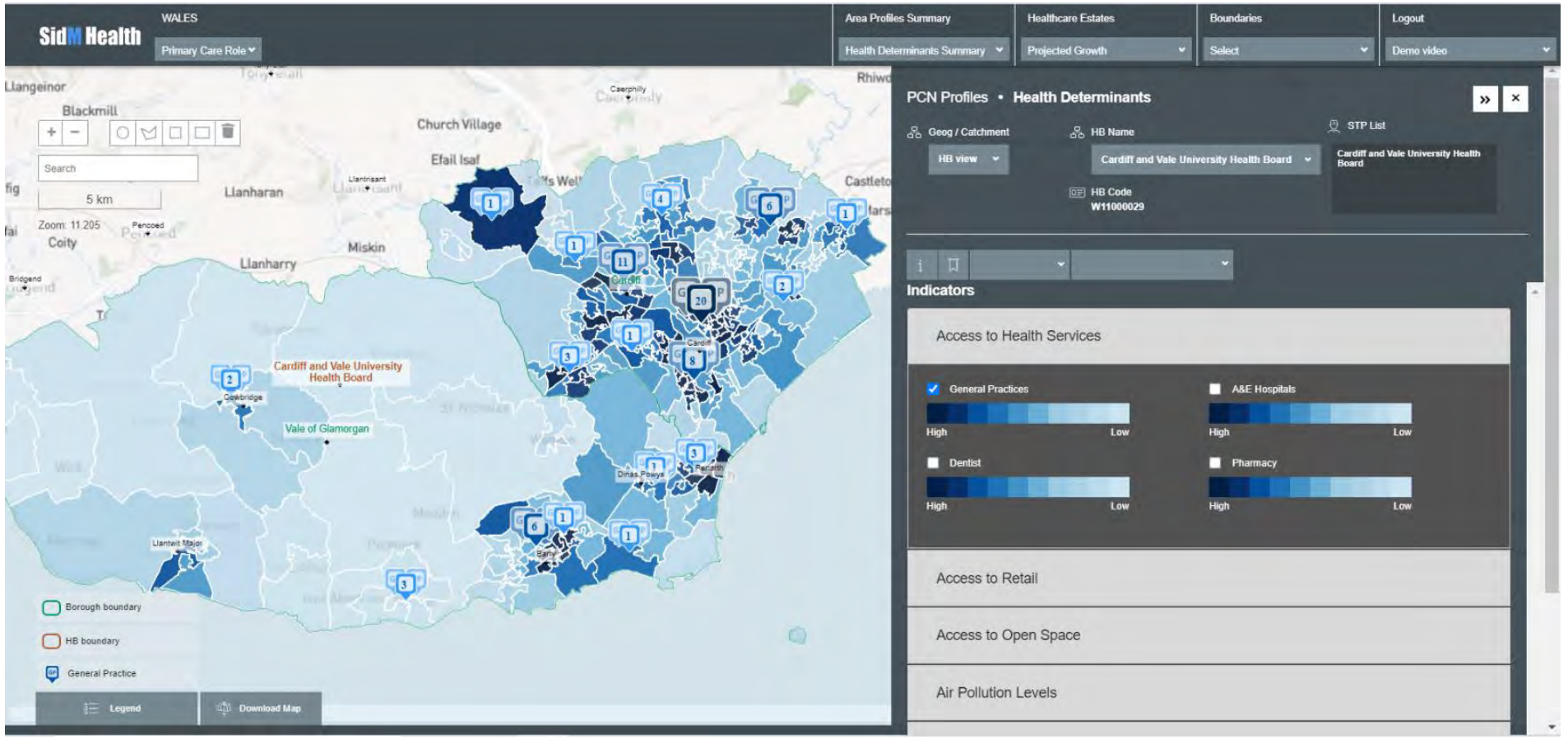
WALES
Primary Care Role
Area Profiles Summary
Health Determinants Summary
Healthcare Estates
Projected Growth
Boundaries
Select
Logout
Demo video
Healthcare Estates • Projected Growth
Geog / Catchment
HB view
HB Name
Cardiff and Vale University Health Board
STP List
Cardiff and Vale University Health Board
HB Code
W11000029
2019
ONS 2019 LSOA Proj
Age Range
Yearly Projection
People (projected)
75732
Age and Gender
Male
Female
81+
66-80
Cardiff and Vale University Health Board
Borough boundary
HB boundary
LSOA boundary
General Practice
(463 - 686) High
(240 - 463) Average
(0 - 240) Low
Legend
Download Map
Population Projection

6 Access

6.1 General Practices



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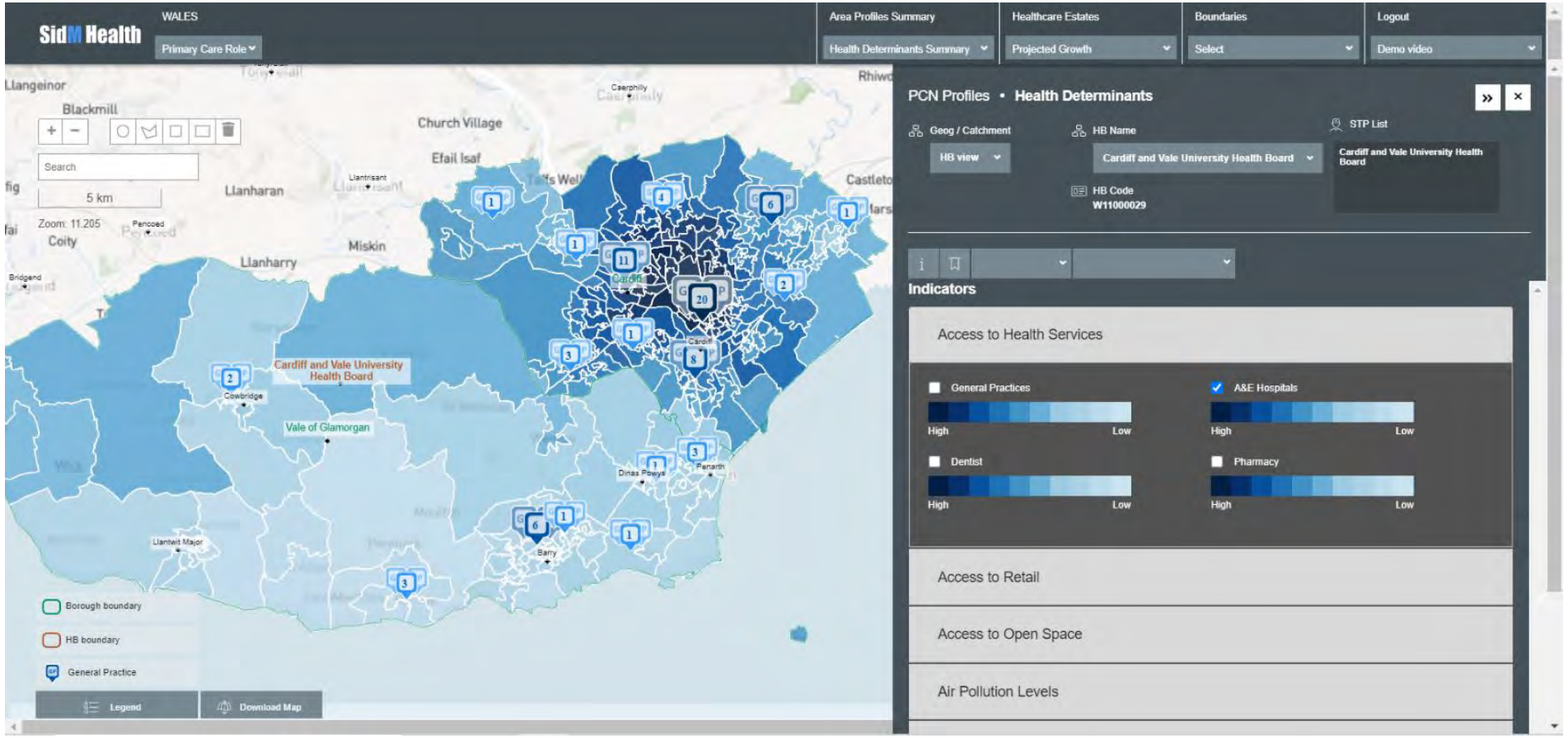

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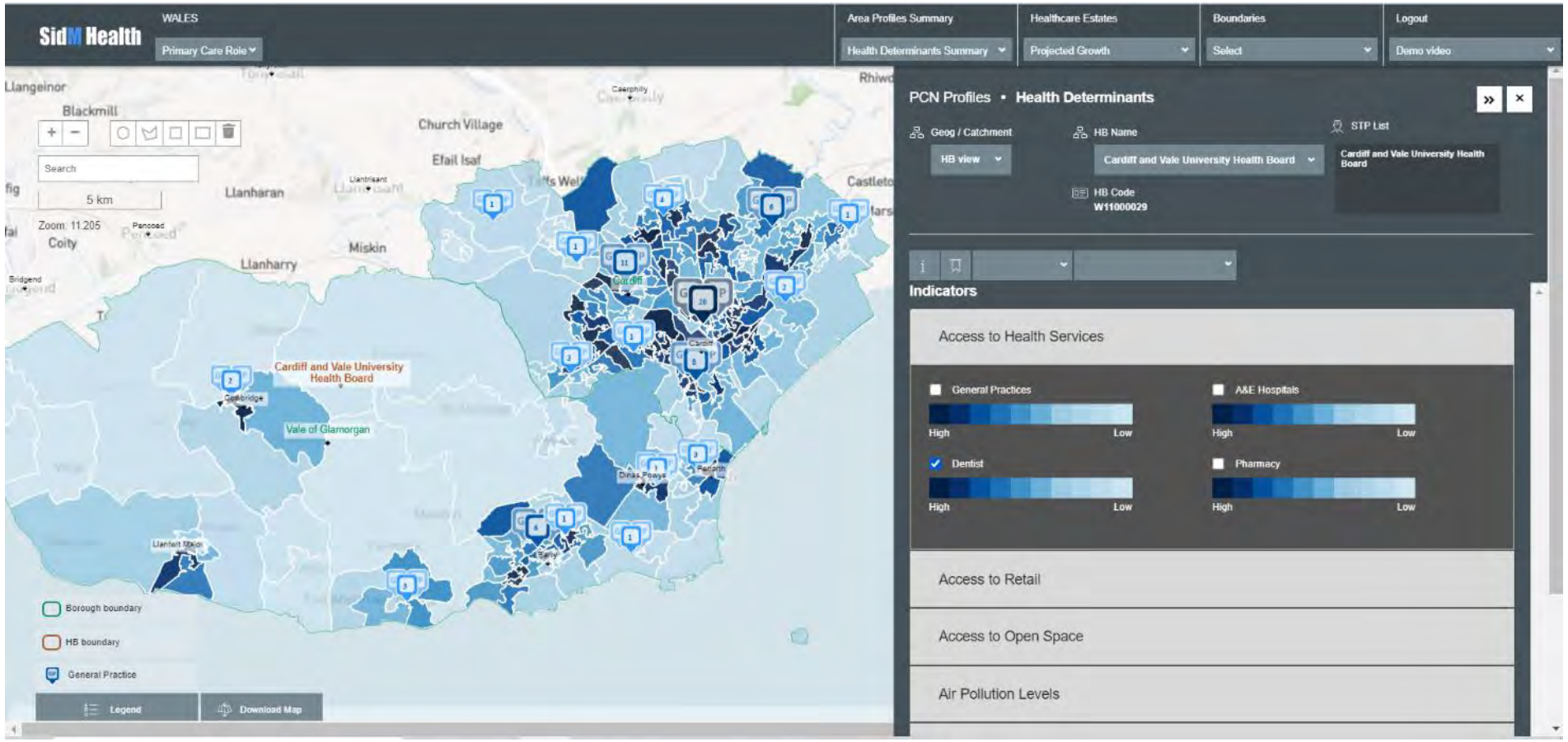
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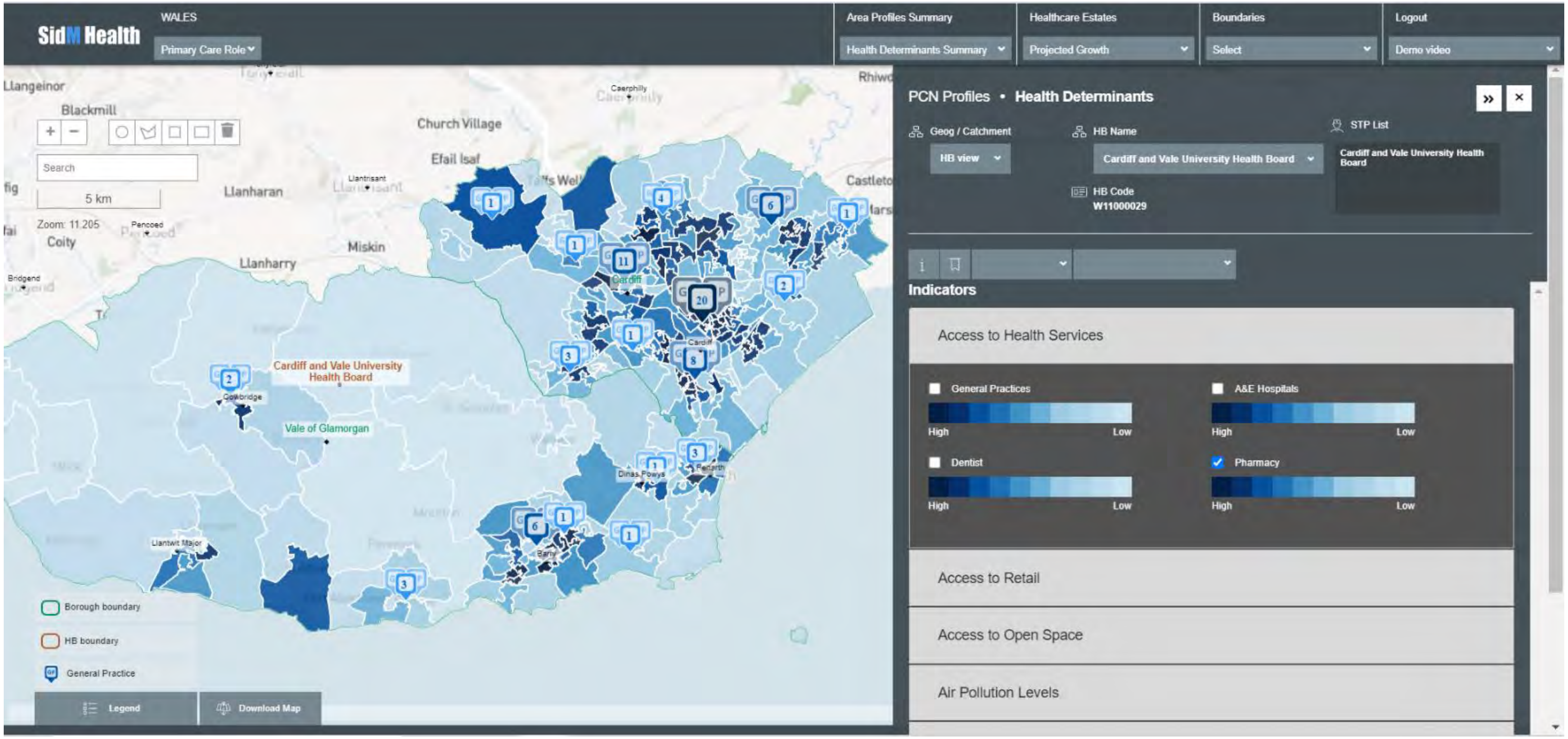
Primary Care Role
Area Profiles Summary
Health Determinants Summary
Healthcare Estates
Projected Growth
Boundaries
Select
Logout
Demo video
Search
5 km
Zoom: 11.205
Cardiff and Vale University Health Board
Vale of Glamorgan
Borough boundary
HB boundary
General Practice
Legend
Download Map
PCN Profiles • Health Determinants
Geog / Catchment
HB view
HB Name
Cardiff and Vale University Health Board
STP List
HB Code
W11000029
Indicators
Access to Health Services
General Practices
A&E Hospitals
Dentist
Pharmacy
High
Low
Access to Retail
Access to Open Space
Air Pollution Levels

6.4 Pharmacy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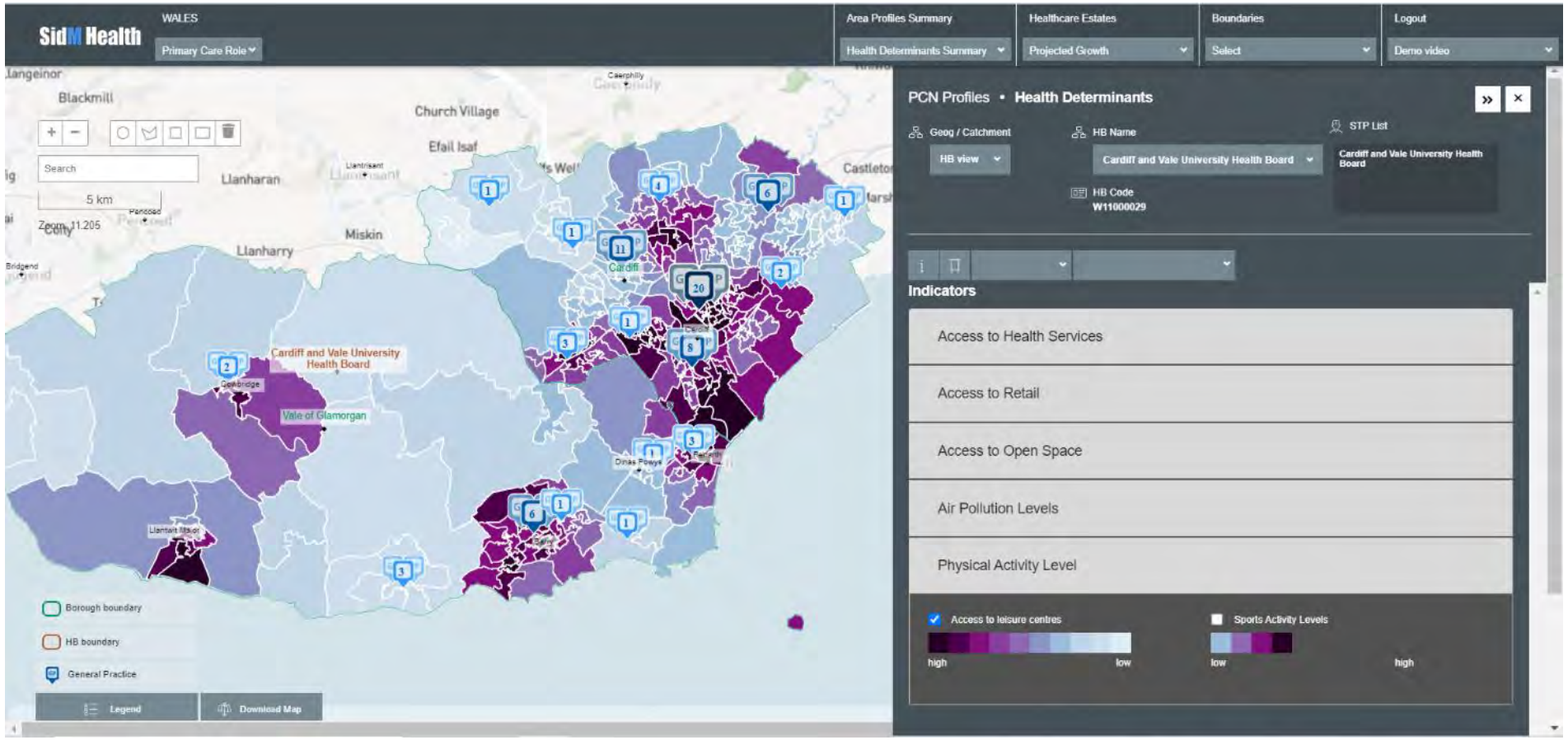
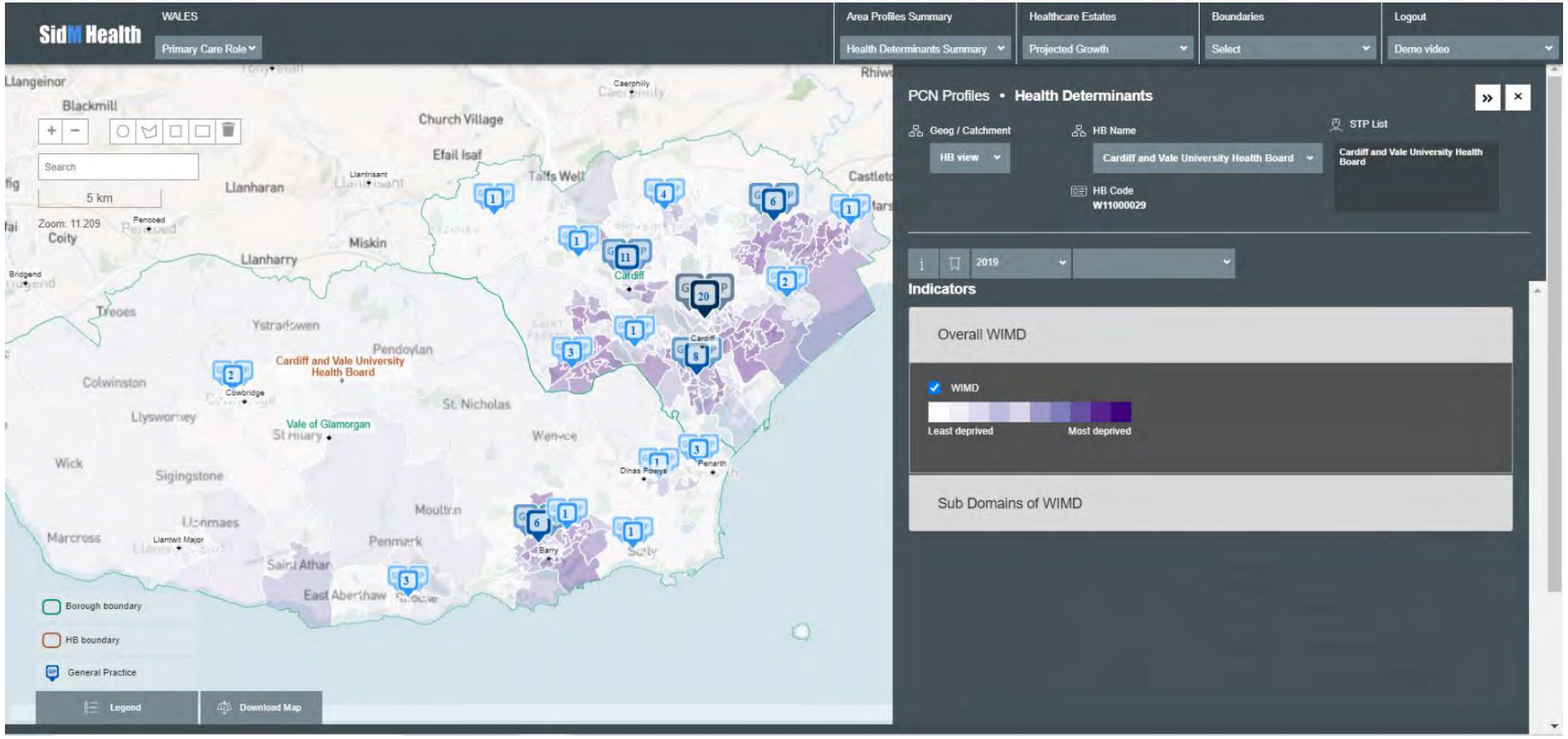
WALES
Primary Care Role
Area Profiles Summary
Health Determinants Summary
Healthcare Estates
Projected Growth
Boundaries
Select
Logout
Demo video
PCN Profiles • Health Determinants
Geog / Catchment
HB view
HB Name
Cardiff and Vale University Health Board
STP List
Cardiff and Vale University Health Board
HB Code
W11000029
Indicators
Access to Health Services
General Practices
A&E Hospitals
Dentist
Pharmacy
High
Low
Access to Retail
Access to Open Space
Air Pollution Levels
Cardiff and Vale University Health Board
Vale of Glamorgan
Church Village
Efail Isaf
Llanharan
Llanharry
Miskin
Blackmill
Llangeinor
Coity
Search
5 km
Zoom: 11.205
Borough boundary
HB boundary
General Practice
Legend
Download Map

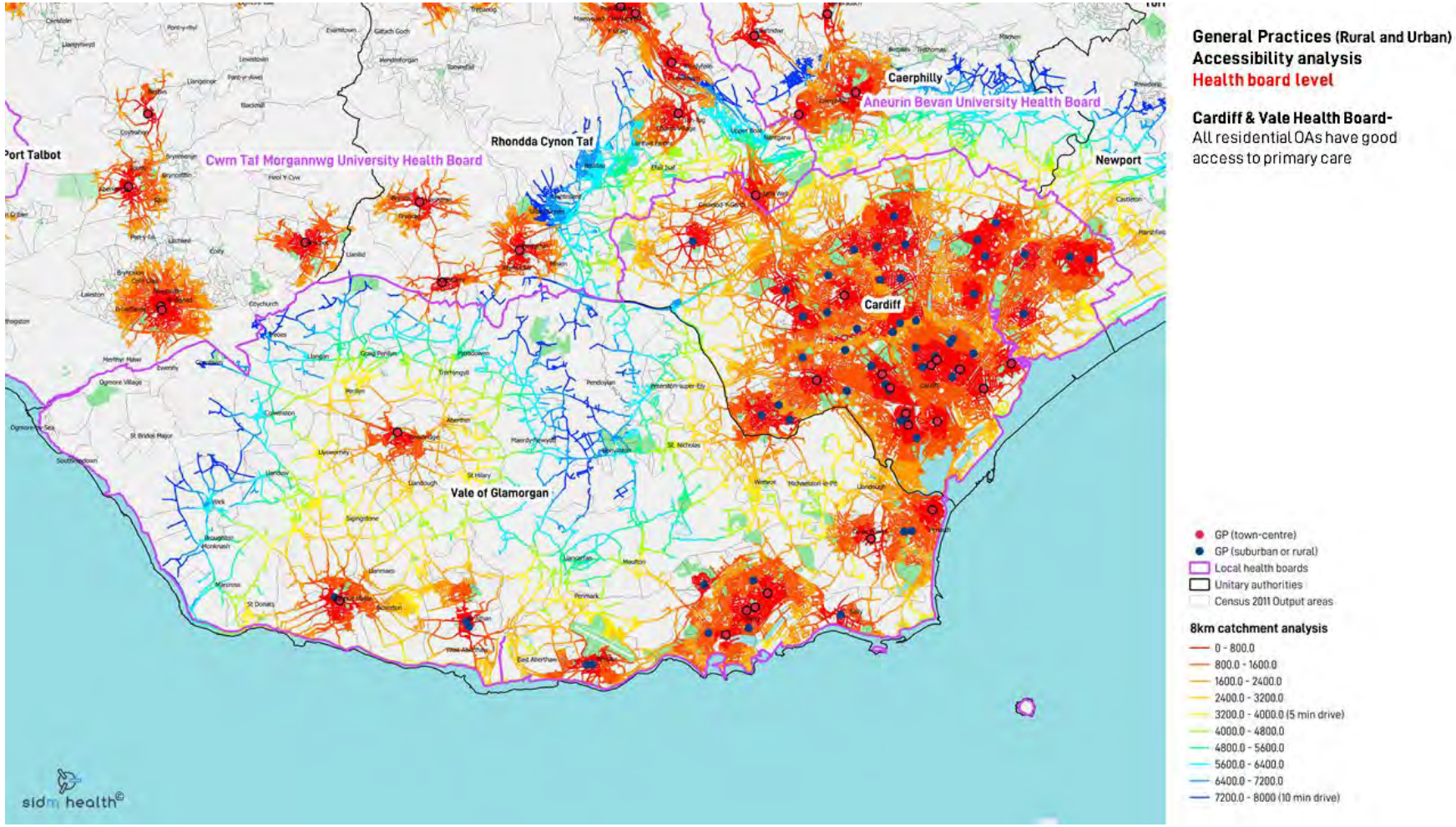
6.5 Leisure Centres



7 Overall Deprivation Score



8 Travel Distances



Archus

The healthcare infrastructure specialist

Appendix C4 – Cwm Taf Morgannwg University Health Board mapping

May 2021

Contents

1 Introduction

1.1 Demographic Observations

Review of the Demographic profile below shows the age groups where the highest population growth can be seen over recent years with demonstrated increasing numbers of people over 66 years of age. The numbers of people 80+ years is also significant. The graphs show the high population densities and distribution by these age groups; for example, within Bridgend and Porthcawl. Linked to this, the least and most deprived areas can be seen along with access to General Practice and other Health facilities such as Pharmacies and Leisure being low.

In 2021 the numbers of 0-4 years have only increased slowly, and 5-17 years have not changed, however young people are seen in different concentrations of high to low numbers in different areas within the Health Boards profile – planned housing growth but this information will assist in ensuring that different types of healthcare are delivered in the right areas and services can be planned appropriately.

1.2 Patient Need

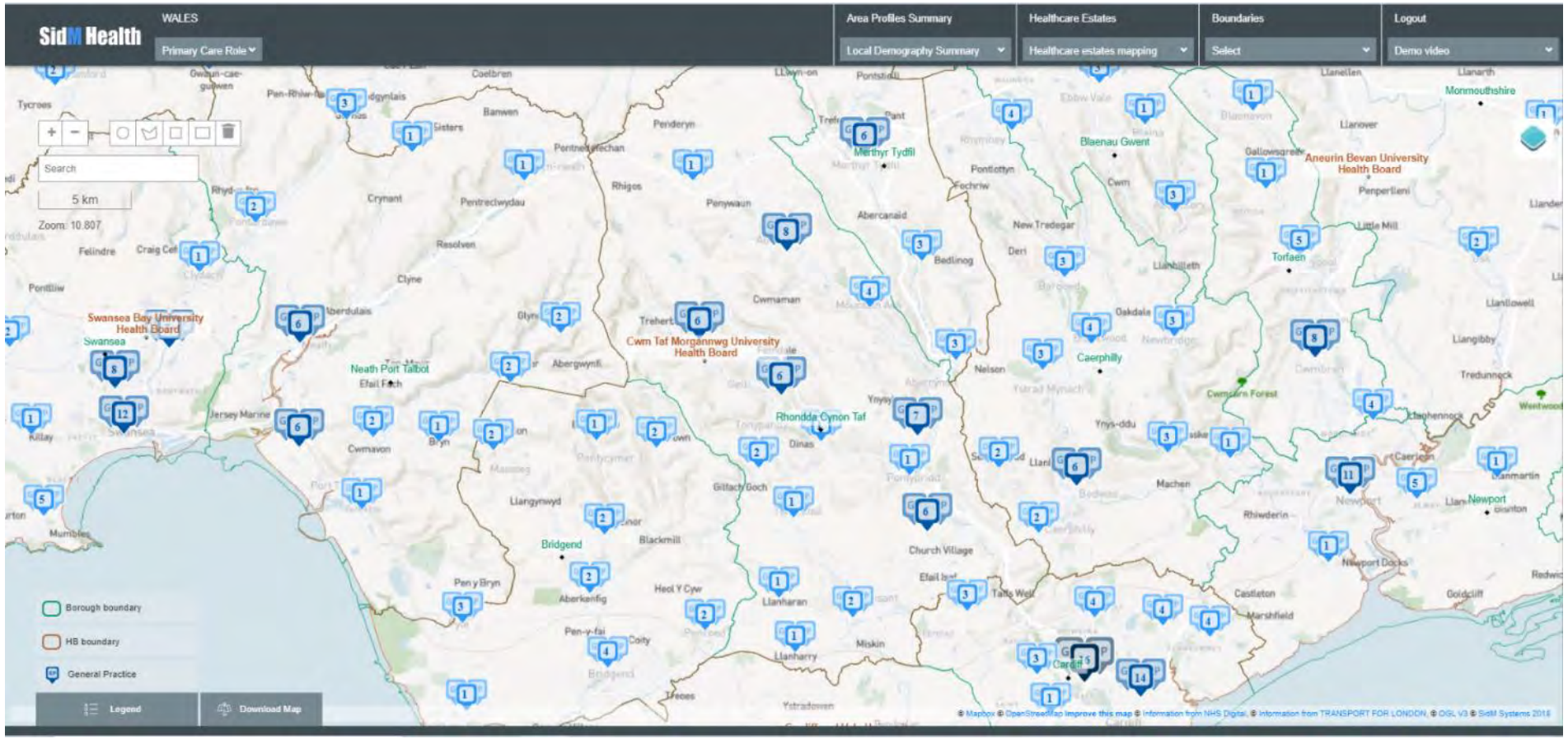
The numbers of aging patients who have a higher requirement for health services has increased and there will be a growing impact on primary and community care in these areas. Several key observations for the Health Board can be seen:

- The numbers of people aged 66+ will continue to increase for the next 20 years. It is noticeable in recent increases and future projections. Delivery of services for people with more complex health conditions is likely to need to be delivered in different ways to ensure equitable accessibility for all.
- There are areas of higher-than-average deprivation indexes, and within some of these areas access to health care provision appears to be low and may not currently be addressing the entire spectrum of people's physical, mental, and social needs.
- The numbers of 0-4 years have decreased but new housing development planning agreements should be assessed to link expected growth projections.
- Analysis of access to the wider services such as pharmacies, dentists and leisure allows an assessment of the best options to provide an integrated approach to health and social care enabling people with more complex conditions to be offered screening and secondary prevention reflecting their higher risk of poor physical health.

1.3 Mapping and Statistics

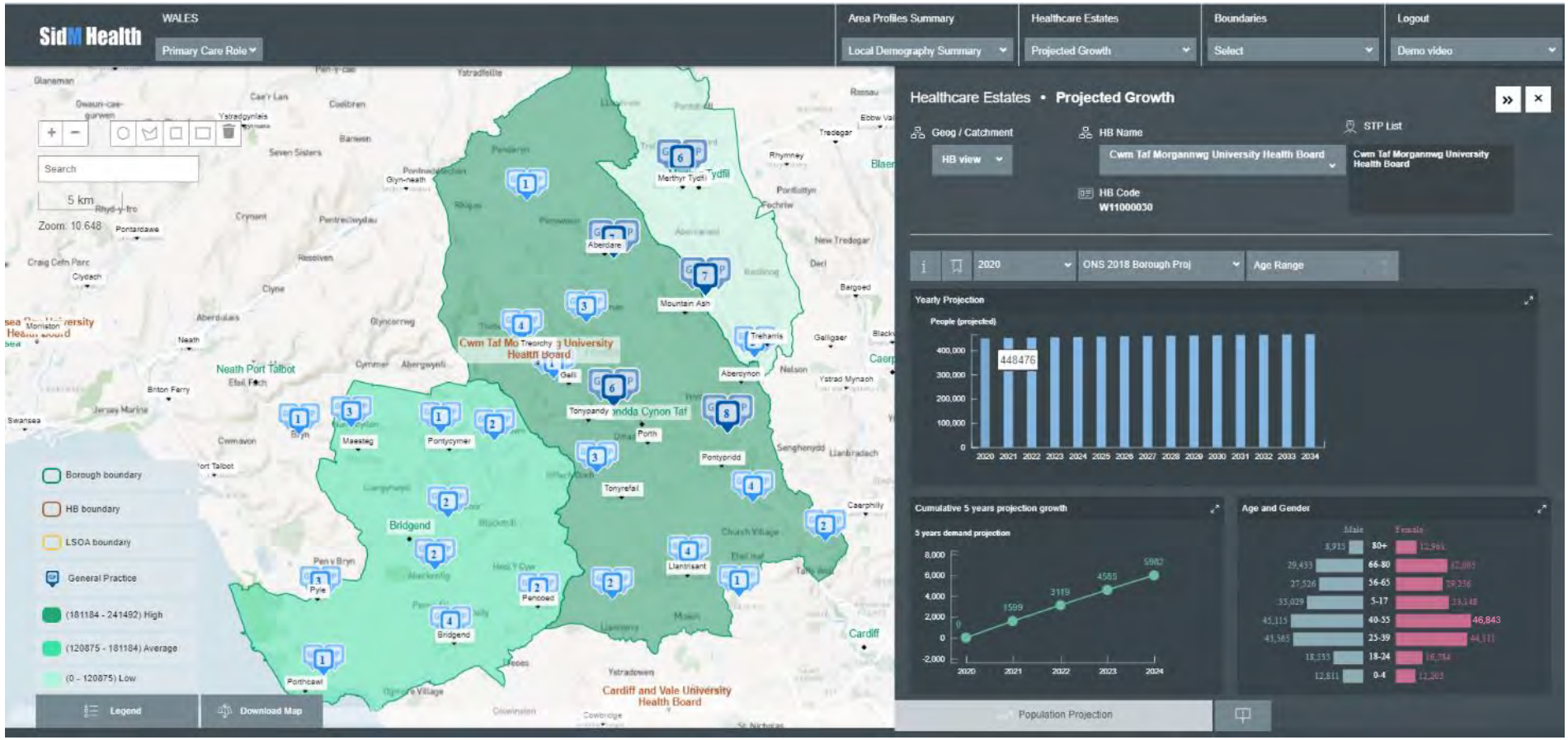
The maps below give a detailed view of the current and future population growth by age. Areas of population concentration can be identified via the heat maps, as well as access to services such as, General Practice, acute units, wider health service needs and leisure. Overall deprivation by borough is displayed against General Practice provision in section 7. Distance of travel to General Practices are demonstrated on the final map, in section 8, via an 8km catchment area.

2 General Practice Location Map

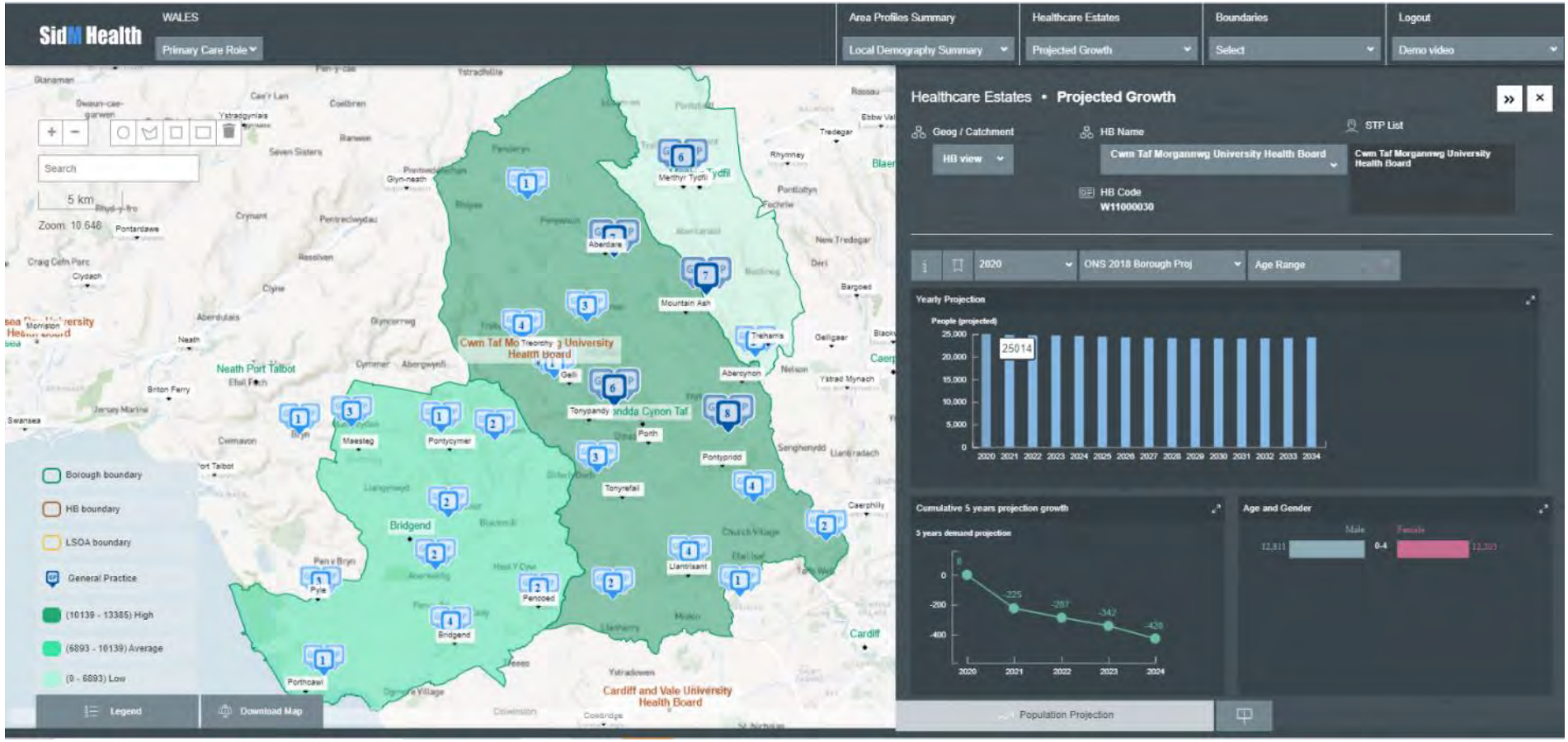


3 Population Projection by Local Authority 2020

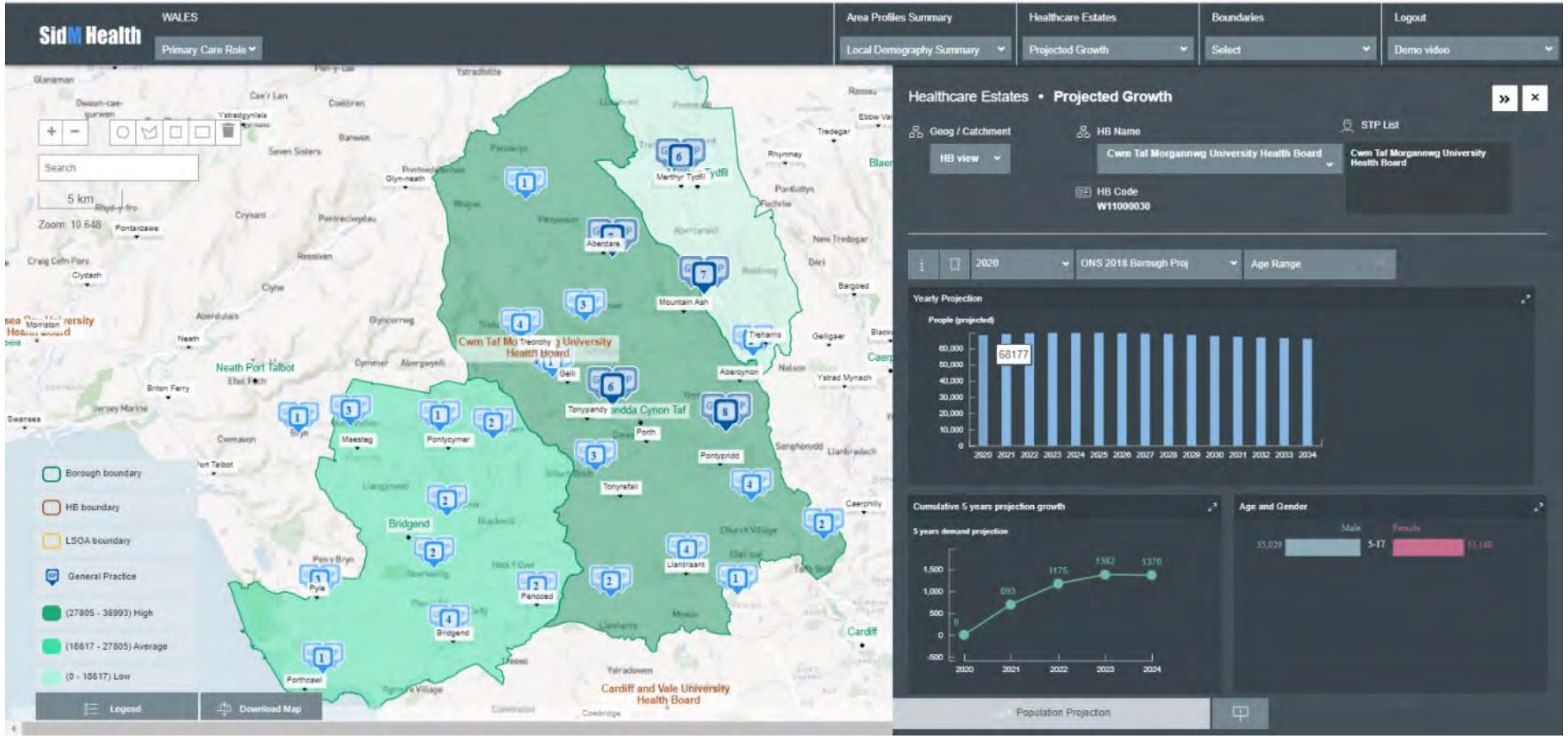
3.1 All Ages



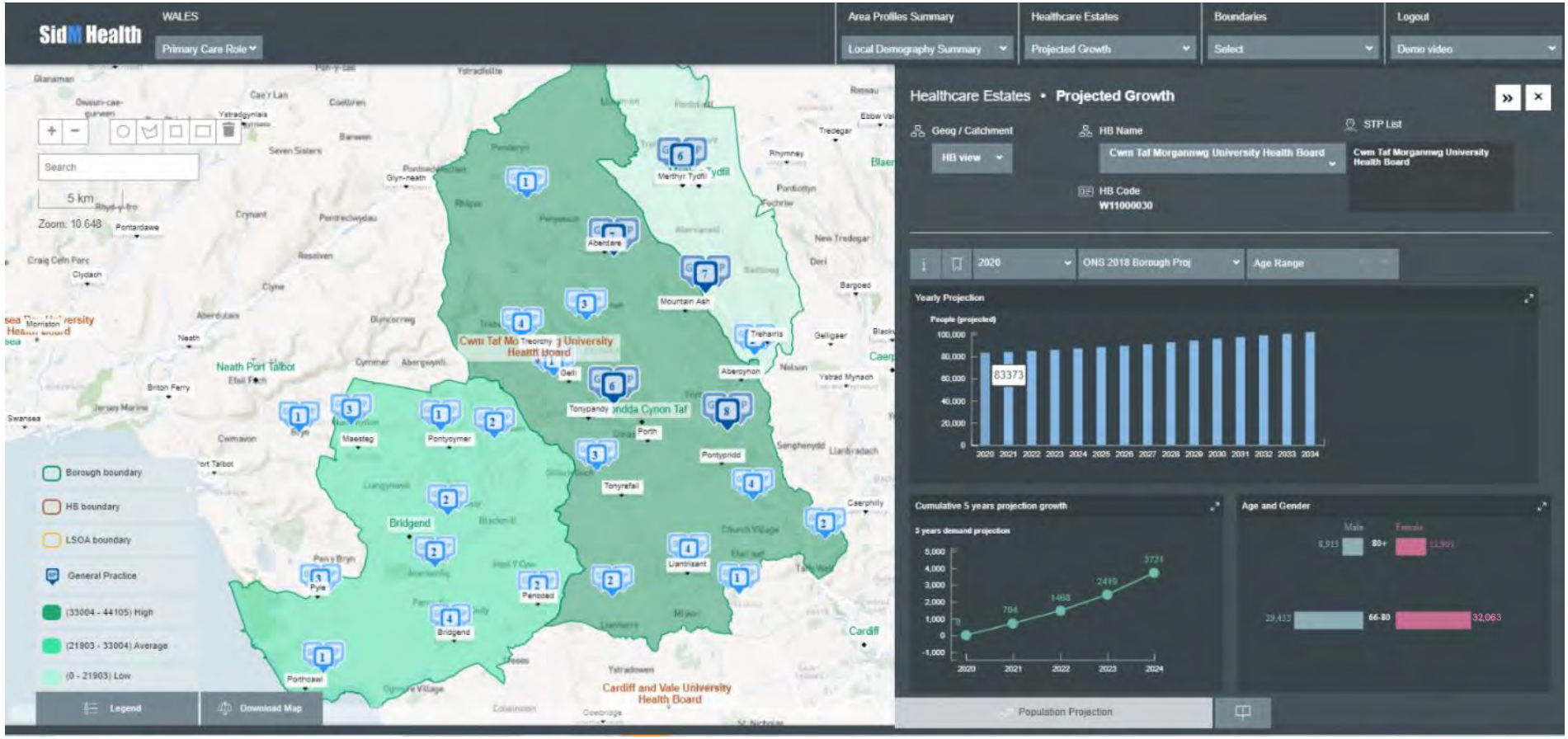
3.2 Ages 0 – 4


SidH Health
WALES
Primary Care Role
Area Profiles Summary
Local Demography Summary
Healthcare Estates
Projected Growth
Boundaries
Select
Logout
Demo video
Search
5 km
Zoom: 10.646
Borough boundary
HB boundary
LSOA boundary
General Practice
(10139 - 13385) High
(6893 - 10139) Average
(0 - 6893) Low
Legend
Download Map
Healthcare Estates • Projected Growth
Geog / Catchment
HB view
HB Name
Cwm Taf Morgannwg University Health Board
STP List
Cwm Taf Morgannwg University Health Board
HB Code
W11000030
2020
ONS 2018 Borough Proj
Age Range
Yearly Projection
People (projected)
25014
Cumulative 5 years projection growth
5 years demand projection
Age and Gender
Male
Female
0-4
Population Projection
Cwm Taf Morgannwg University Health Board
Cardiff and Vale University Health Board
Neath Port Talbot
Bridgend
Cardiff

3.3 Ages 5 – 17


SidM Health
WALES
Primary Care Role
Area Profiles Summary
Local Demography Summary
Healthcare Estates
Projected Growth
Boundaries
Select
Logout
Demo video
Healthcare Estates • Projected Growth
Geog / Catchment
HB view
HB Name
Cwm Taf Morgannwg University Health Board
STP List
Cwm Taf Morgannwg University Health Board
HB Code
W11000030
2020
ONS 2018 Borough Proj
Age Range
Yearly Projection
People (projected)
68177
Cumulative 5 years projection growth
5 years demand projection
Age and Gender
Male
Female
5-17
Borough boundary
HB boundary
LSOA boundary
General Practice
(27805 - 38993) High
(16617 - 27805) Average
(0 - 16617) Low
Legend
Download Map
Population Projection
Cwm Taf Morgannwg University Health Board
Cardiff and Vale University Health Board
Neath Port Talbot
Bridgend
Cardiff

3.4 Ages 66+


SidM Health
WALES
Primary Care Role
Area Profiles Summary
Local Demography Summary
Healthcare Estates
Projected Growth
Boundaries
Select
Logout
Demo video
Search
5 km
Zoom: 10.648
Borough boundary
HB boundary
LSOA boundary
General Practice
(33004 - 44105) High
(21903 - 33004) Average
(0 - 21903) Low
Legend
Download Map
Healthcare Estates • Projected Growth
Geog / Catchment
HB view
HB Name
Cwm Taf Morgannwg University Health Board
STP List
Cwm Taf Morgannwg University Health Board
HB Code
W11000030
2020
ONS 2018 Borough Proj
Age Range
Yearly Projection
People (projected)
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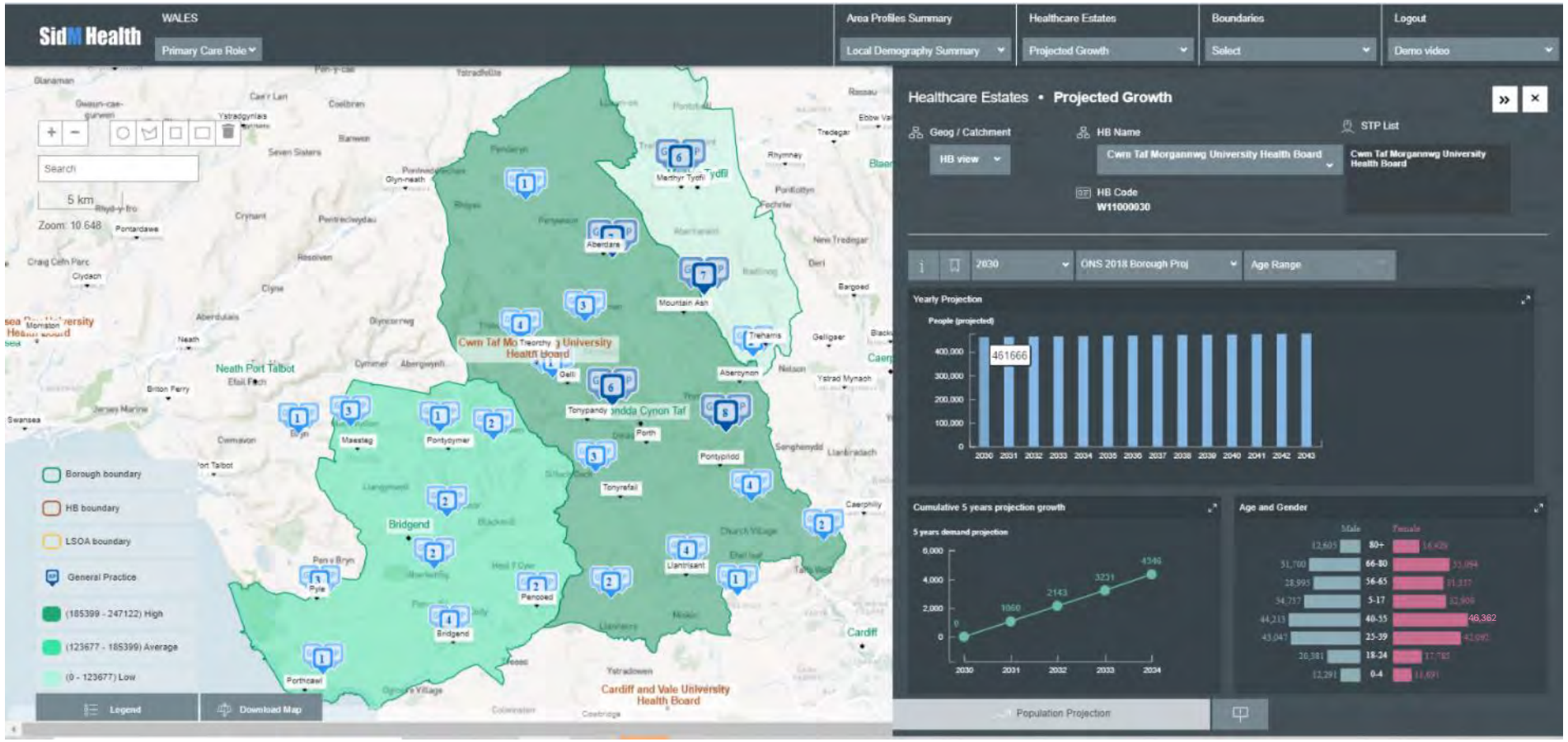
Cumulative 5 years projection growth
5 years demand projection
704
1468
2419
3721
Age and Gender
Male
Female
80+
66-80
32,063
Population Projection
Cwm Taf Morgannwg University Health Board
Cardiff and Vale University Health Board
Neath Port Talbot
Bridgend
Cardiff

4 Population Projection 2030, by Local Authority

4.1 All Ages



4.2 Ages 0 – 4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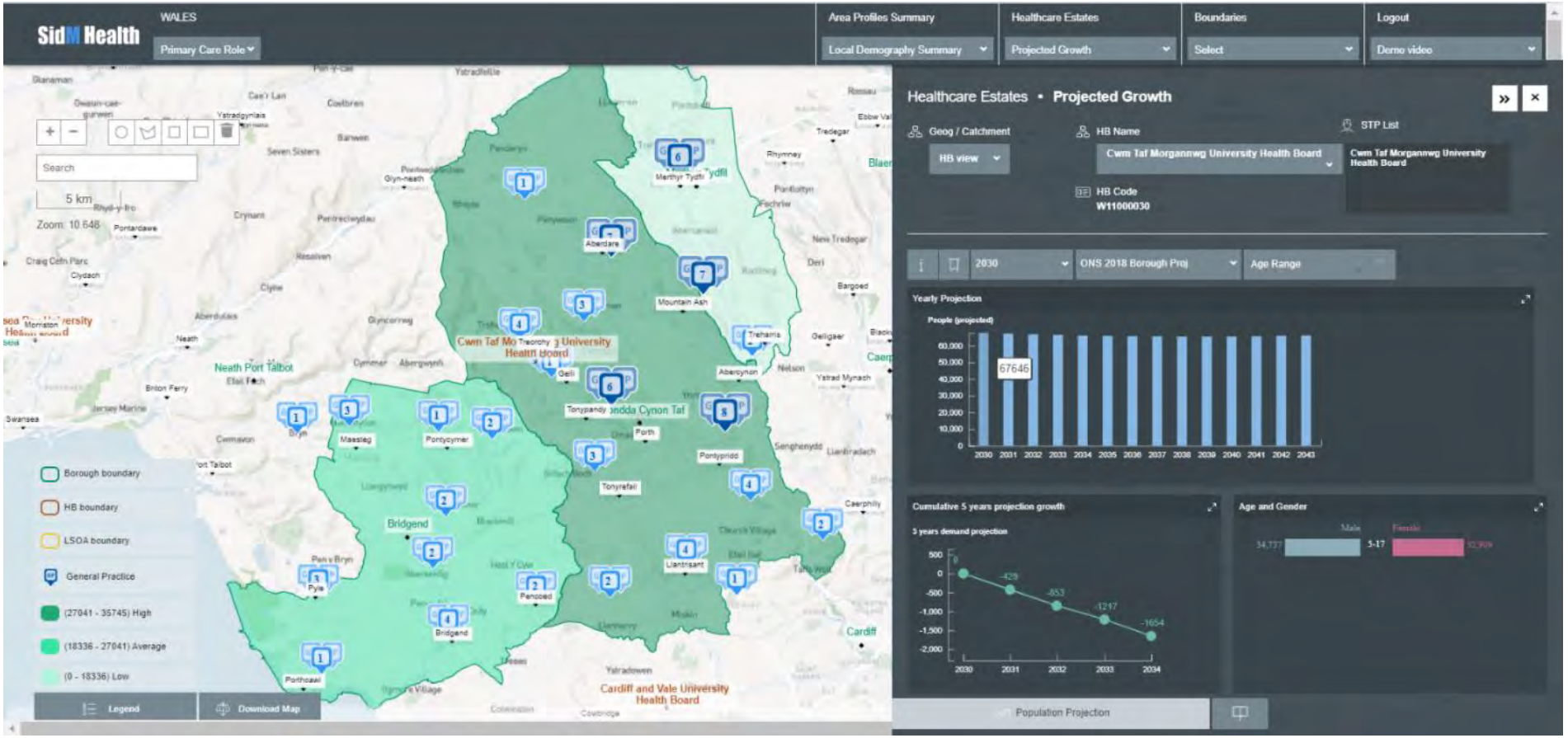
WALES
Primary Care Role
Area Profiles Summary
Local Demography Summary
Healthcare Estates
Projected Growth
Boundaries
Select
Logout
Demo video
Healthcare Estates • Projected Growth
Geog / Catchment
HB view
HB Name
Cwm Taf Morgannwg University Health Board
STP List
Cwm Taf Morgannwg University Health Board
HB Code
W11000030
2030
ONS 2018 Borough Proj
Age Range
Yearly Projection
People (projected)
23962
Cumulative 5 years projection growth
5 years demand projection
Age and Gender
Male
Female
0-4
Population Projection
Search
5 km
Zoom: 10.648
Borough boundary
HB boundary
LSOA boundary
General Practice
(9778 - 12996) High
(6560 - 9778) Average
(0 - 6560) Low
Legend
Download Map
Cwm Taf Morgannwg University Health Board
Cardiff and Vale University Health Board
Neath Port Talbot
Bridgend
Cardiff

4.3 Ages 5 – 17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Primary Care Role
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Local Demography Summary
Healthcare Estates
Projected Growth
Boundaries
Select
Logout
Demo video
Search
5 km
Zoom: 10.648
Borough boundary
HB boundary
LSOA boundary
General Practice
(27041 - 35745) High
(18336 - 27041) Average
(0 - 18336) Low
Legend
Download Map
Cwm Taf Morgannwg University Health Board
Cardiff and Vale University Health Board
Healthcare Estates • Projected Growth
Geog / Catchment
HB view
HB Name
Cwm Taf Morgannwg University Health Board
STP List
Cwm Taf Morgannwg University Health Board
HB Code
W11000030
2030
ONS 2018 Borough Proj
Age Range
Yearly Projection
People (projected)
67646
Cumulative 5 years projection growth
5 years demand projection
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-1217
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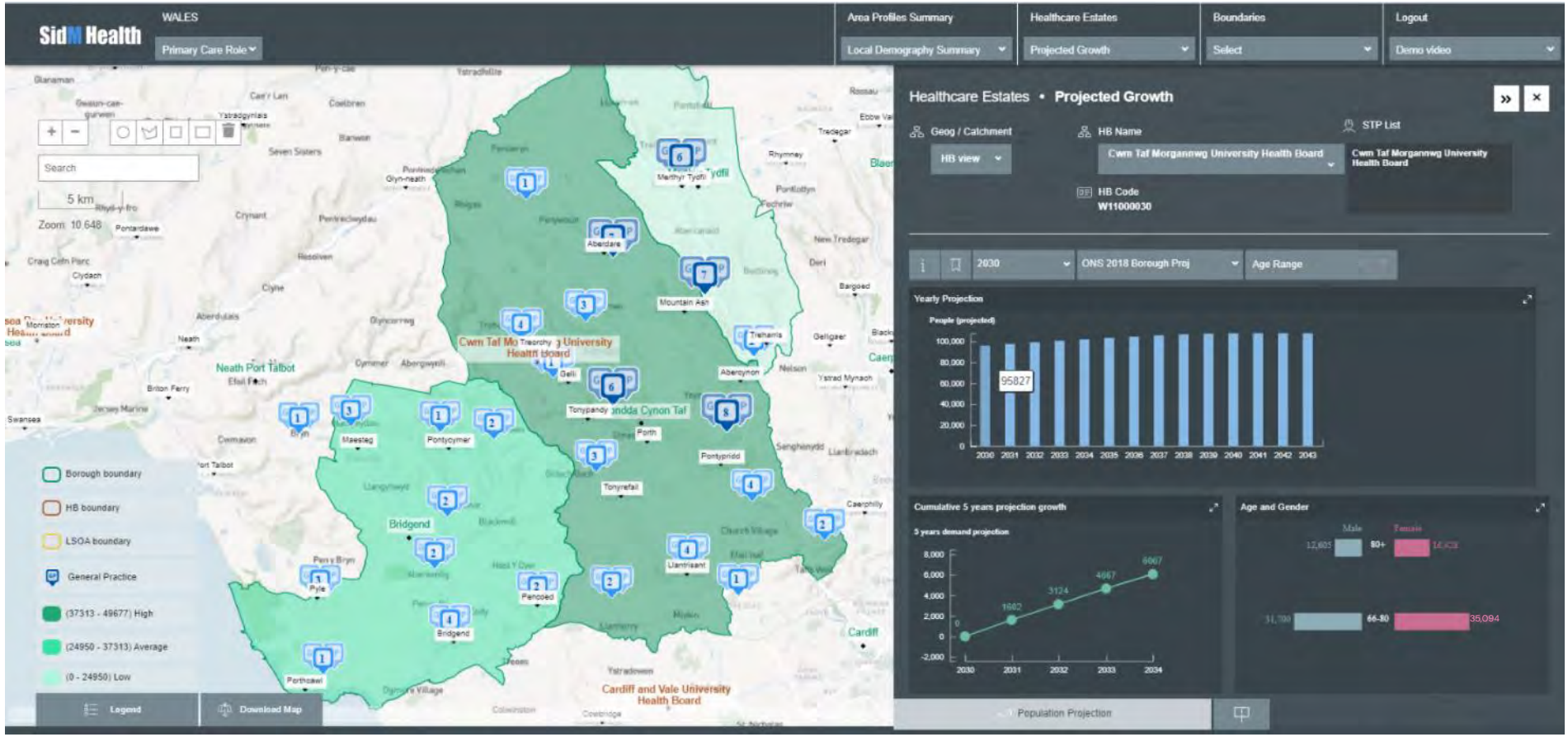
Age and Gender
Male
Female
5-17
Population Projection

4.4 Ages 66+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Local Demography Summary
Healthcare Estates
Projected Growth
Boundaries
Select
Logout
Demo video
Search
5 km
Zoom: 10.648
Borough boundary
HB boundary
LSOA boundary
General Practice
(37313 - 49677) High
(24950 - 37313) Average
(0 - 24950) Low
Legend
Download Map
Cwm Taf Morgannwg University Health Board
Cardiff and Vale University Health Board
Healthcare Estates • Projected Growth
Geog / Catchment
HB view
HB Name
Cwm Taf Morgannwg University Health Board
STP List
Cwm Taf Morgannwg University Health Board
HB Code
W11000030
2030
ONS 2018 Borough Proj
Age Range
Yearly Projection
People (projected)
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Cumulative 5 years projection growth
5 years demand projection
Age and Gender
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Female
80+
66-80
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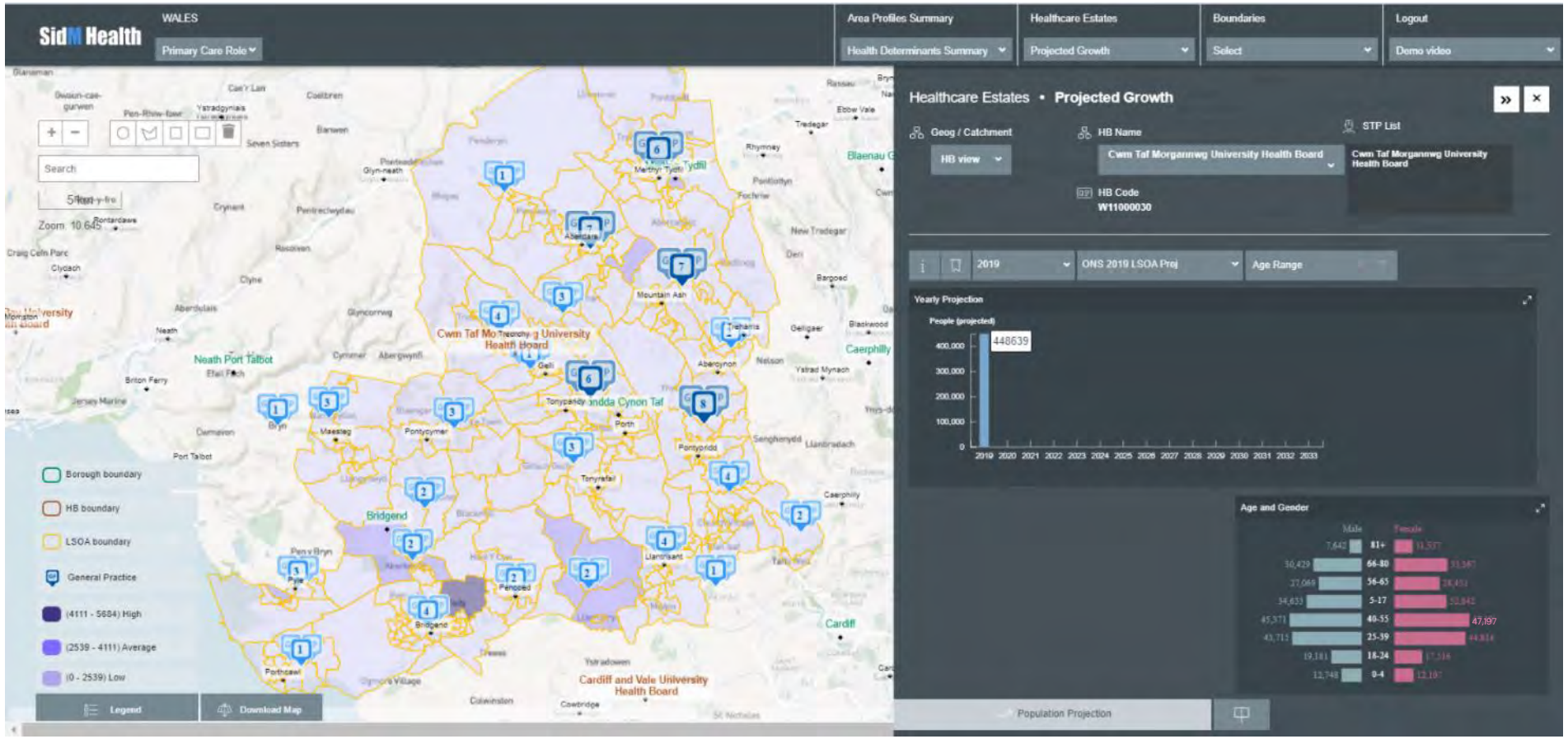
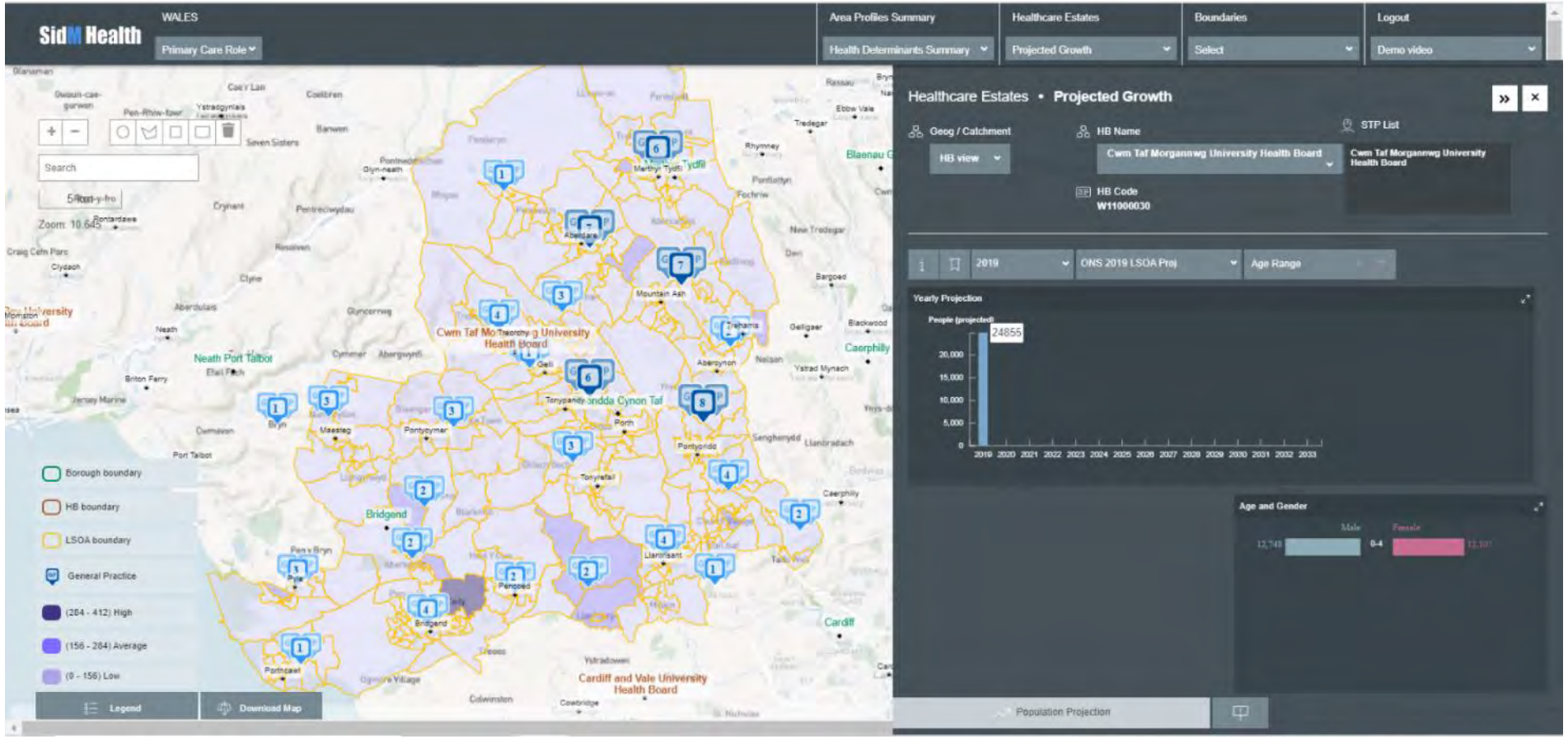
Population Projection

5 Population Projection by LSOAs

5.1 All Ages



5.2 Ages 0 – 4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Logout
Demo video
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Geog / Catchment
HB view
HB Name
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STP List
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HB Code
W11000030
2019
ONS 2019 LSOA Proj
Age Range
Yearly Projection
People (projected)
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20,000
15,000
10,000
5,000
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2019 2020 2021 2022 2023 2024 2025 2026 2027 2028 2029 2030 2031 2032 2033
Age and Gender
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Female
0-4
Population Projection
Search
Zoom: 10.645
Borough boundary
HB boundary
LSOA boundary
General Practice
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(0 - 156) Low
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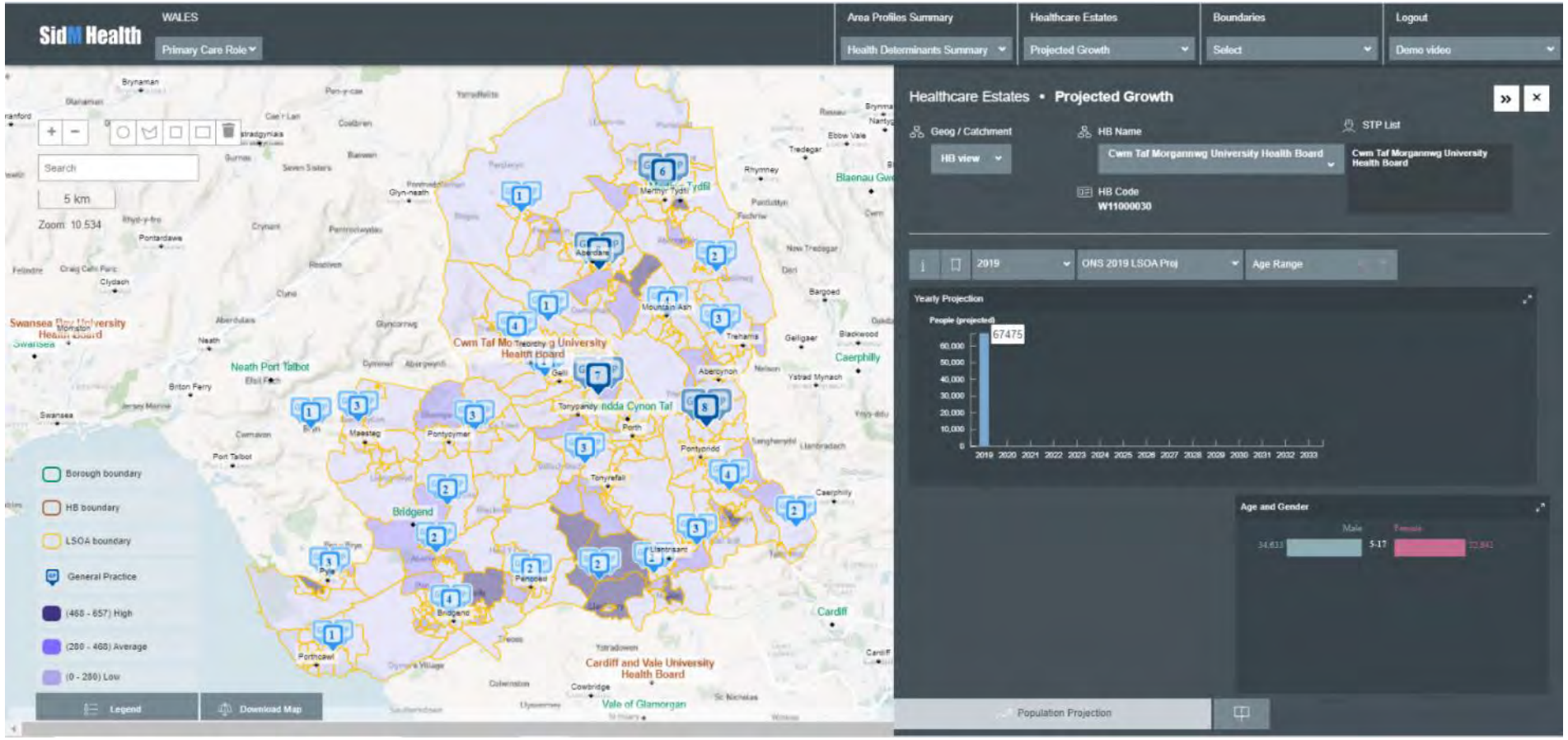
Cardiff and Vale University Health Board
Neath Port Talbot
Bridgend
Cardiff
Caerphilly

5.3 Ages 5 – 17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Primary Care Role
Area Profiles Summary
Health Determinants Summary
Healthcare Estates
Projected Growth
Boundaries
Select
Logout
Demo video
Search
5 km
Zoom: 10.534
Borough boundary
HB boundary
LSOA boundary
General Practice
(468 - 657) High
(280 - 468) Average
(0 - 280) Low
Legend
Download Map
Healthcare Estates • Projected Growth
Geog / Catchment
HB view
HB Name
Cwm Taf Morgannwg University Health Board
STP List
Cwm Taf Morgannwg University Health Board
HB Code
W11000030
2019
ONS 2019 LSOA Proj
Age Range
Yearly Projection
People (projected)
67475
Age and Gender
Male
Female
5-17
Population Projection
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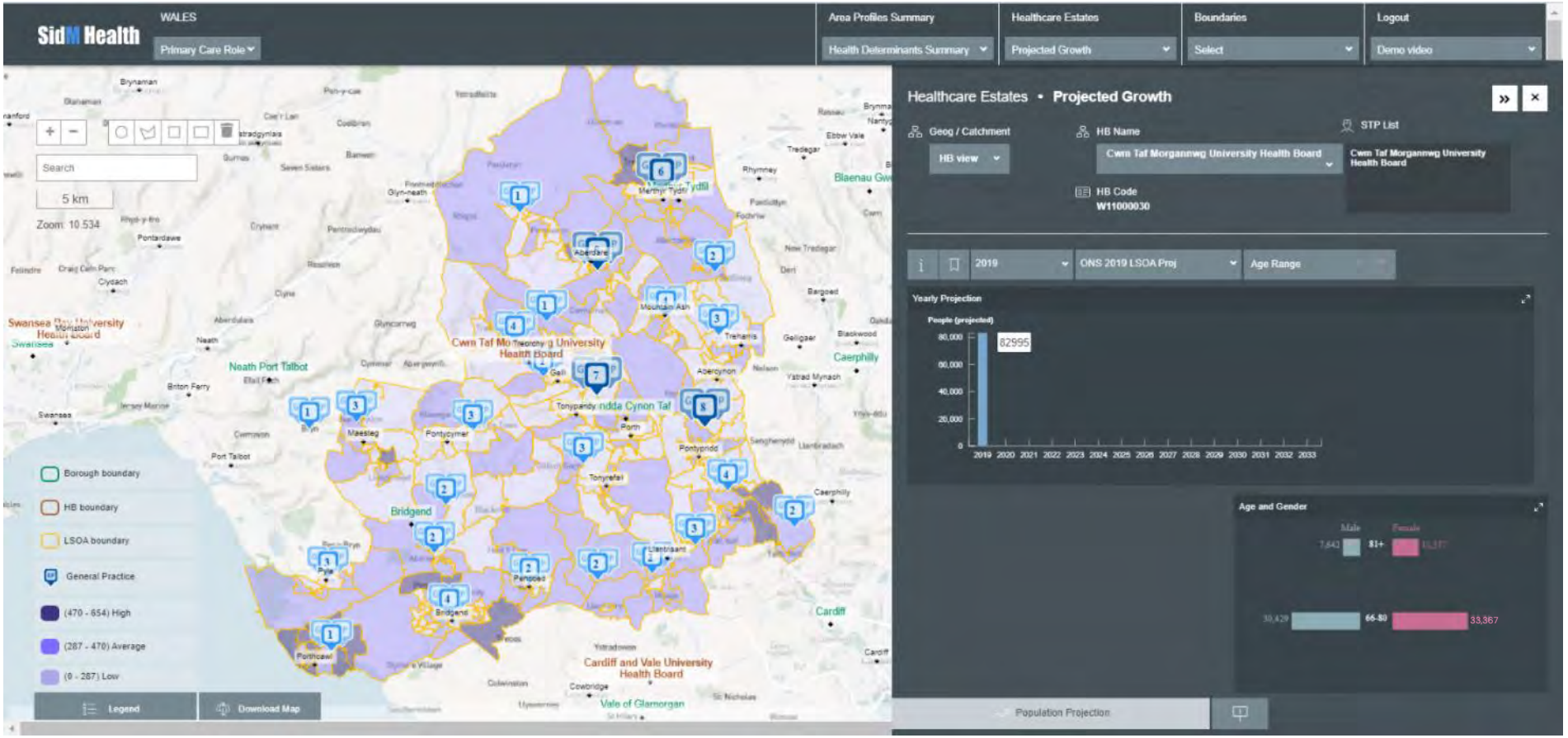
Bridgend
Caerphilly
Cardiff
Vale of Glamorgan

5.4 Ages 66+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Area Profiles Summary
Health Determinants Summary
Healthcare Estates
Projected Growth
Boundaries
Select
Logout
Demo video
Search
5 km
Zoom: 10.534
Borough boundary
HB boundary
LSOA boundary
General Practice
(470 - 654) High
(287 - 470) Average
(0 - 287) Low
Legend
Download Map
Cwm Taf Morgannwg University Health Board
Cardiff and Vale University Health Board
Swansea Bay University Health Board
Neath Port Talbot
Bridgend
Caerphilly
Cardiff
Vale of Glamorgan
Healthcare Estates • Projected Growth
Geog / Catchment
HB view
HB Name
Cwm Taf Morgannwg University Health Board
STP List
Cwm Taf Morgannwg University Health Board
HB Code
W11000030
2019
ONS 2019 LSOA Proj
Age Range
Yearly Projection
People (projected)
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Age and Gender
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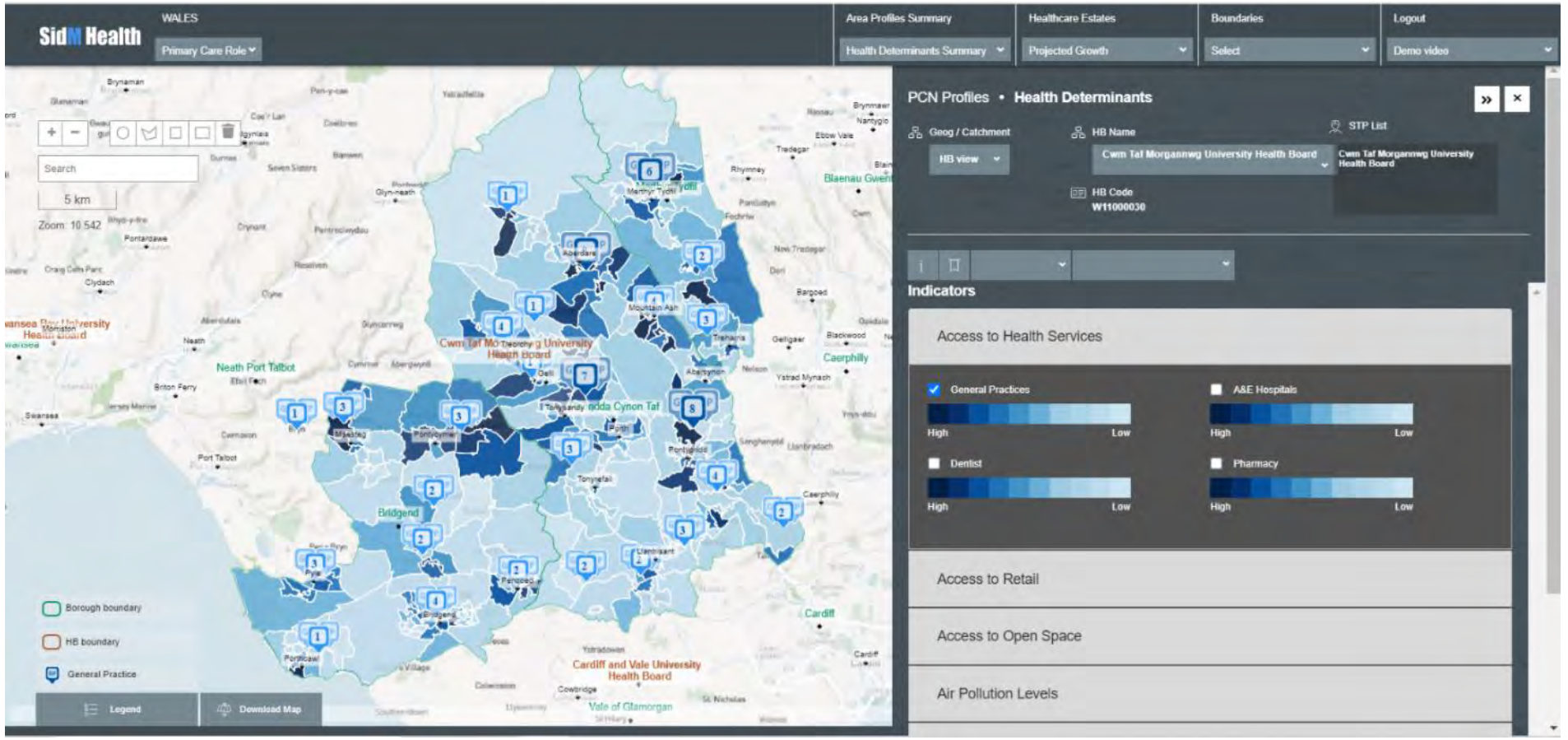
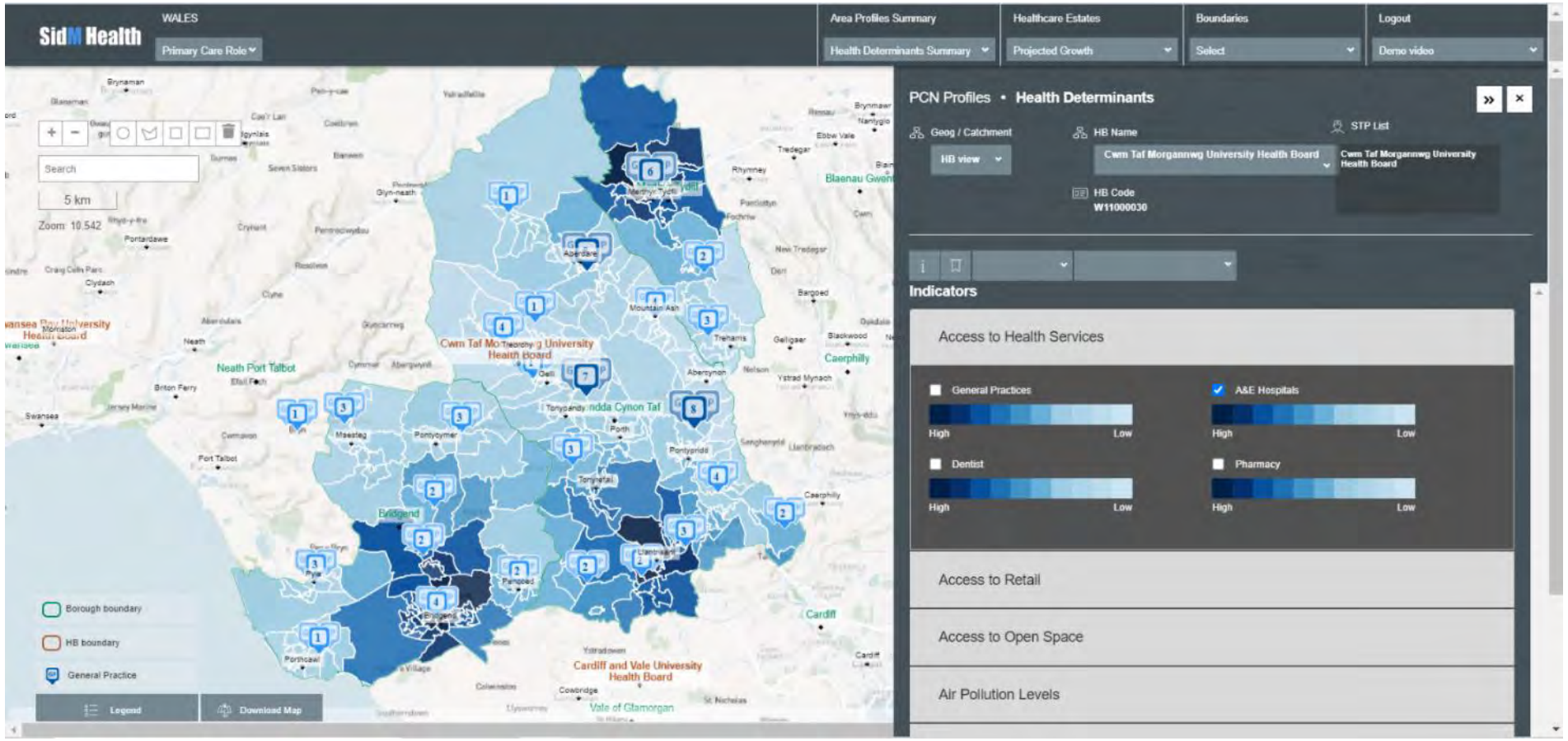
Female
81+
66-80
33,367
Population Projection

6 Access

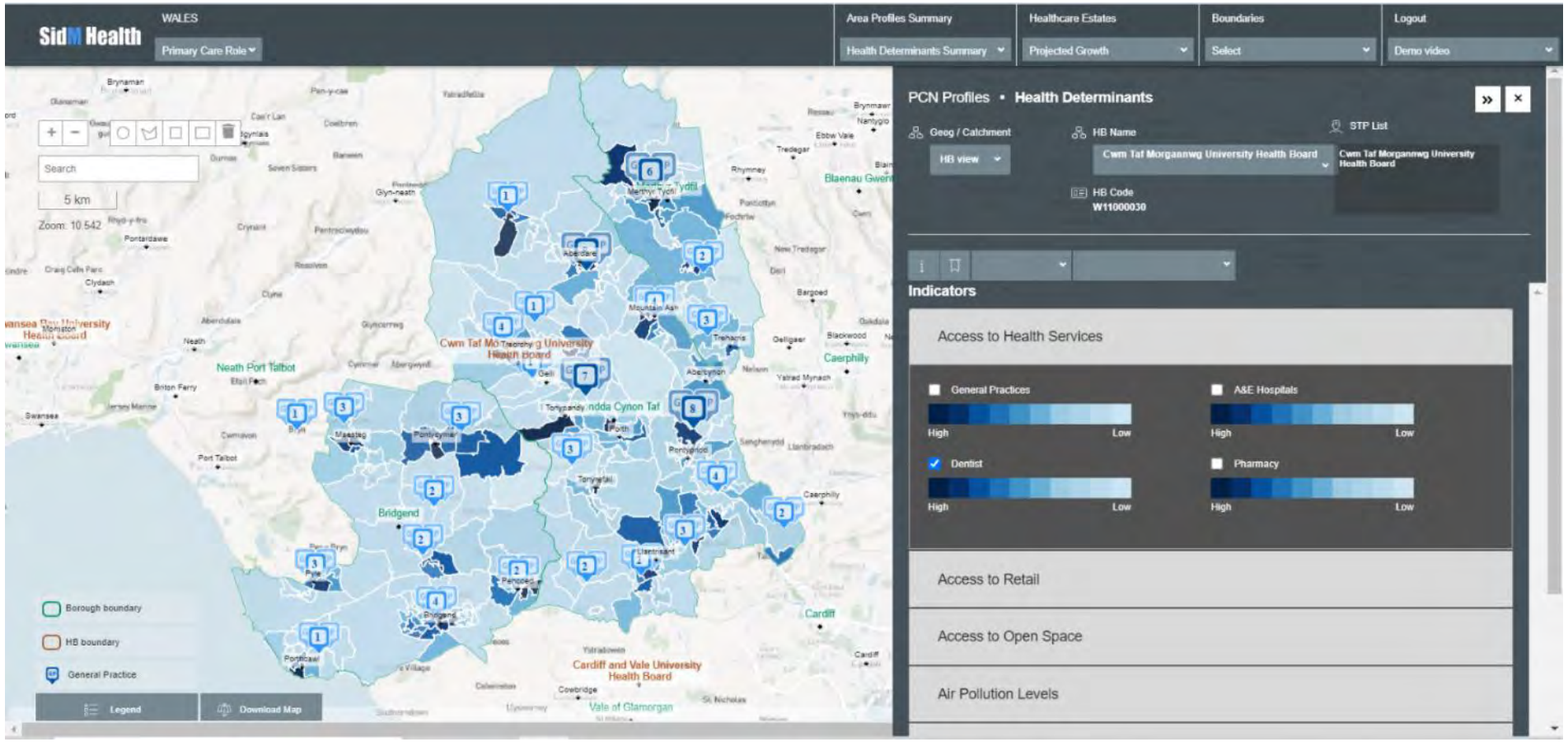
6.1 General Practices



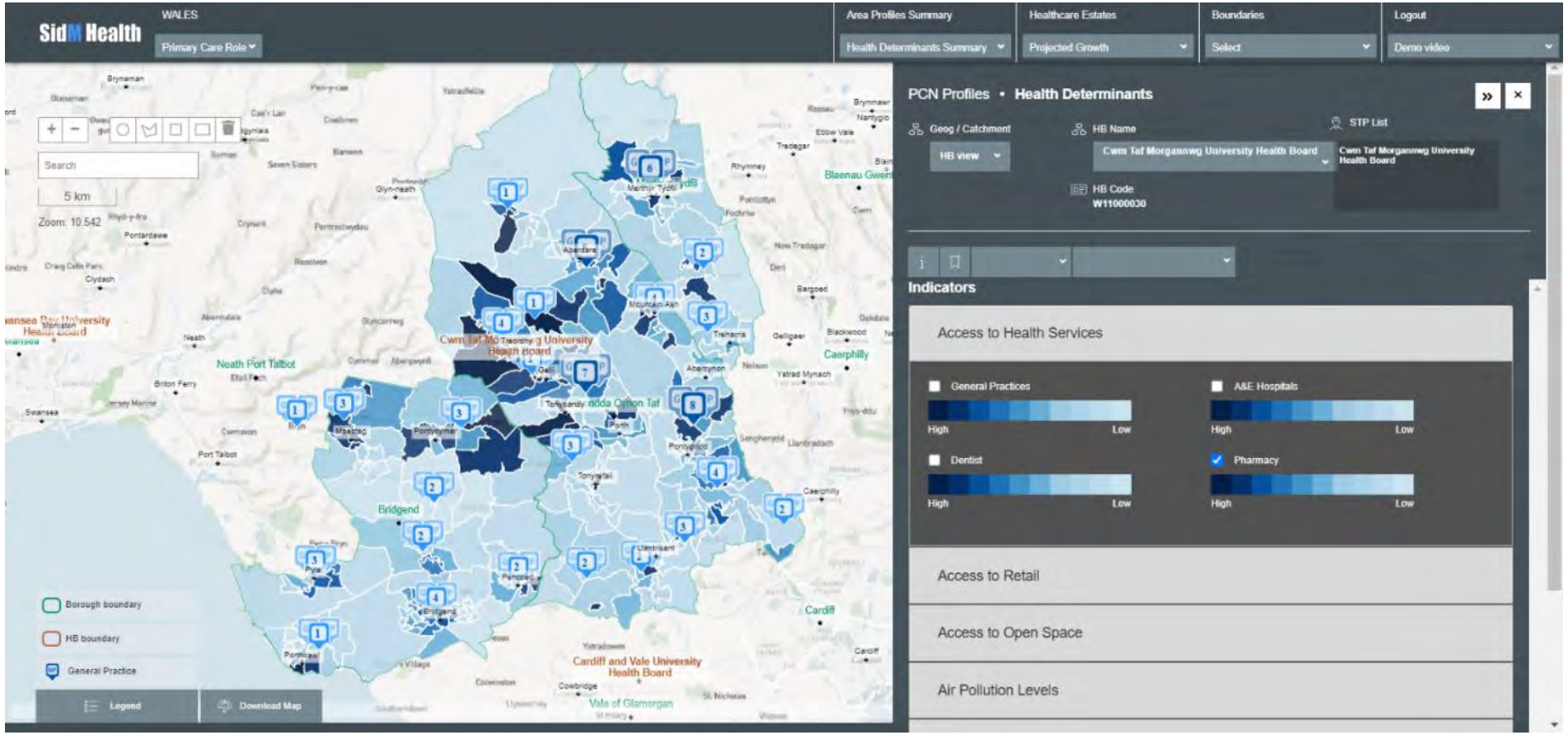
6.2 A&E Hospitals



6.3 Dentists


SidH Health
WALES
Primary Care Role
Area Profiles Summary
Health Determinants Summary
Healthcare Estates
Projected Growth
Boundaries
Select
Logout
Demo video
PCN Profiles • Health Determinants
Geog / Catchment
HB view
HB Name
Cwm Taf Morgannwg University Health Board
STP List
Cwm Taf Morgannwg University Health Board
HB Code
W11000030
Indicators
Access to Health Services
General Practices
A&E Hospitals
Dentist
Pharmacy
High
Low
Access to Retail
Access to Open Space
Air Pollution Levels
Search
5 km
Zoom: 10.542
Borough boundary
HB boundary
General Practice
Legend
Download Map
Cwm Taf Morgannwg University Health Board
Cardiff and Vale University Health Board
Neath Port Talbot
Bridgend
Caerphilly
Cardiff
Vale of Glamorgan

6.4 Pharmacy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Primary Care Role
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Health Determinants Summary
Healthcare Estates
Projected Growth
Boundaries
Select
Logout
Demo video
PCN Profiles • Health Determinants
Geog / Catchment
HB view
HB Name
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STP List
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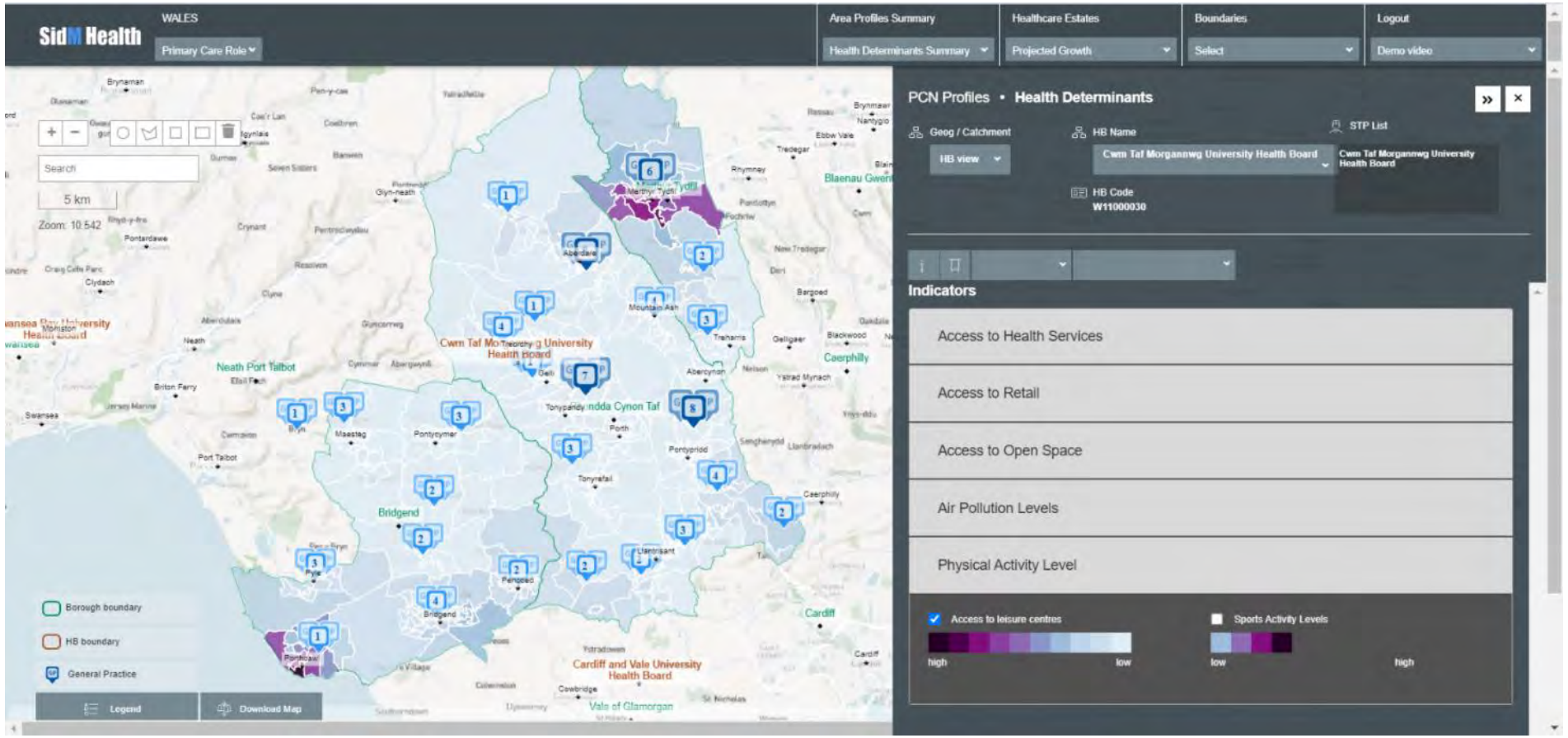
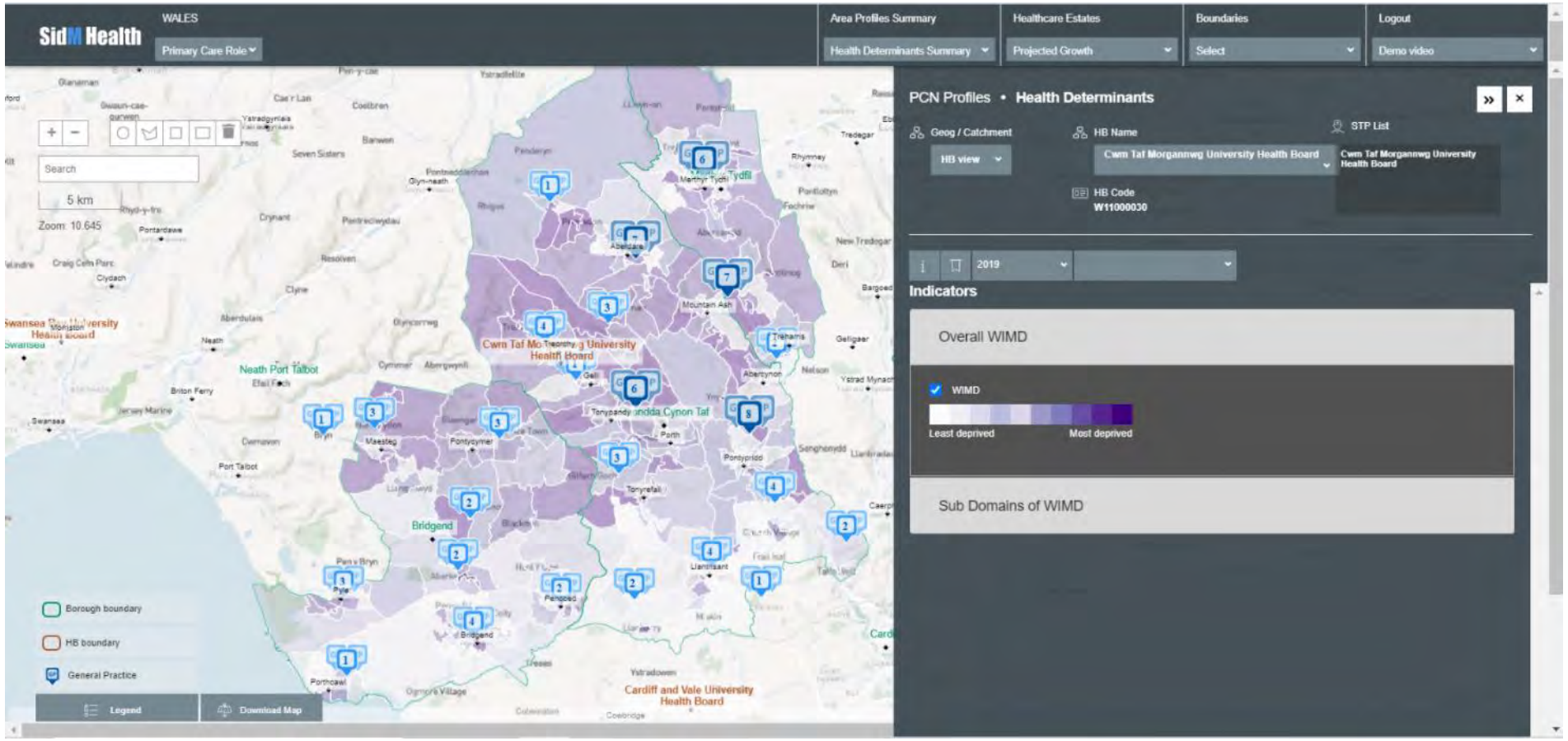
HB Code
W11000030
Indicators
Access to Health Services
General Practices
A&E Hospitals
Dentist
Pharmacy
High
Low
Access to Retail
Access to Open Space
Air Pollution Levels
Search
5 km
Zoom: 10.542
Borough boundary
HB boundary
General Practice
Legend
Download Map
Cwm Taf Morgannwg University Health Board
Cardiff and Vale University Health Board
Vale of Glamorgan
Neath Port Talbot
Bridgend
Cardiff
Caerphilly
Swansea

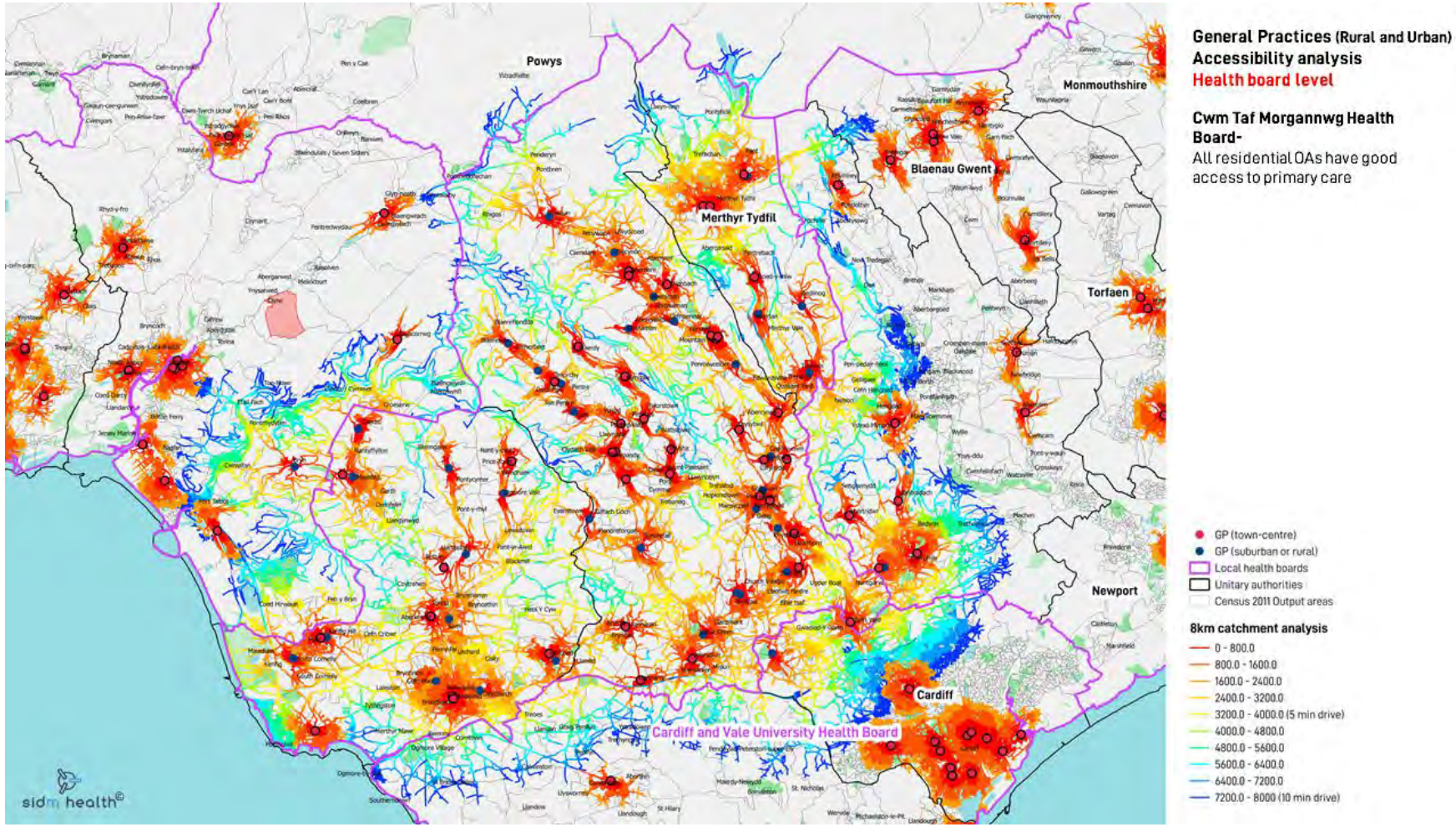
6.5 Leisure Centres



7 Overall Deprivation Score



8 Travel Distances



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Appendix C5 – Hywel Dda University Health Board mapping

May 2021

Contents

1 Introduction

1.1 Demographic Observations

Review of the Demographic profile below shows that there have been steady levels of growth over recent years for most age groups but considerable increase in the numbers of people in older age groups over 66 years and particularly noticeable future growth in people over 80 years of age. The numbers of females in these age brackets are high.

In 2021 the numbers of 0-4 years have been seen to increase but projections show decreases by 2023; by reviewing the age concentrations by area Carmarthenshire has higher numbers than some other districts. The numbers of 5-17 years have increased, which continues until 2023 and then drops off with numbers of young people seen in different concentrations in different areas within the Health Boards profile. Deprivation scores for the area are generally low to medium but there is also a generally low access to leisure facilities and therefore sports activity classified as low.

1.2 Patient Need

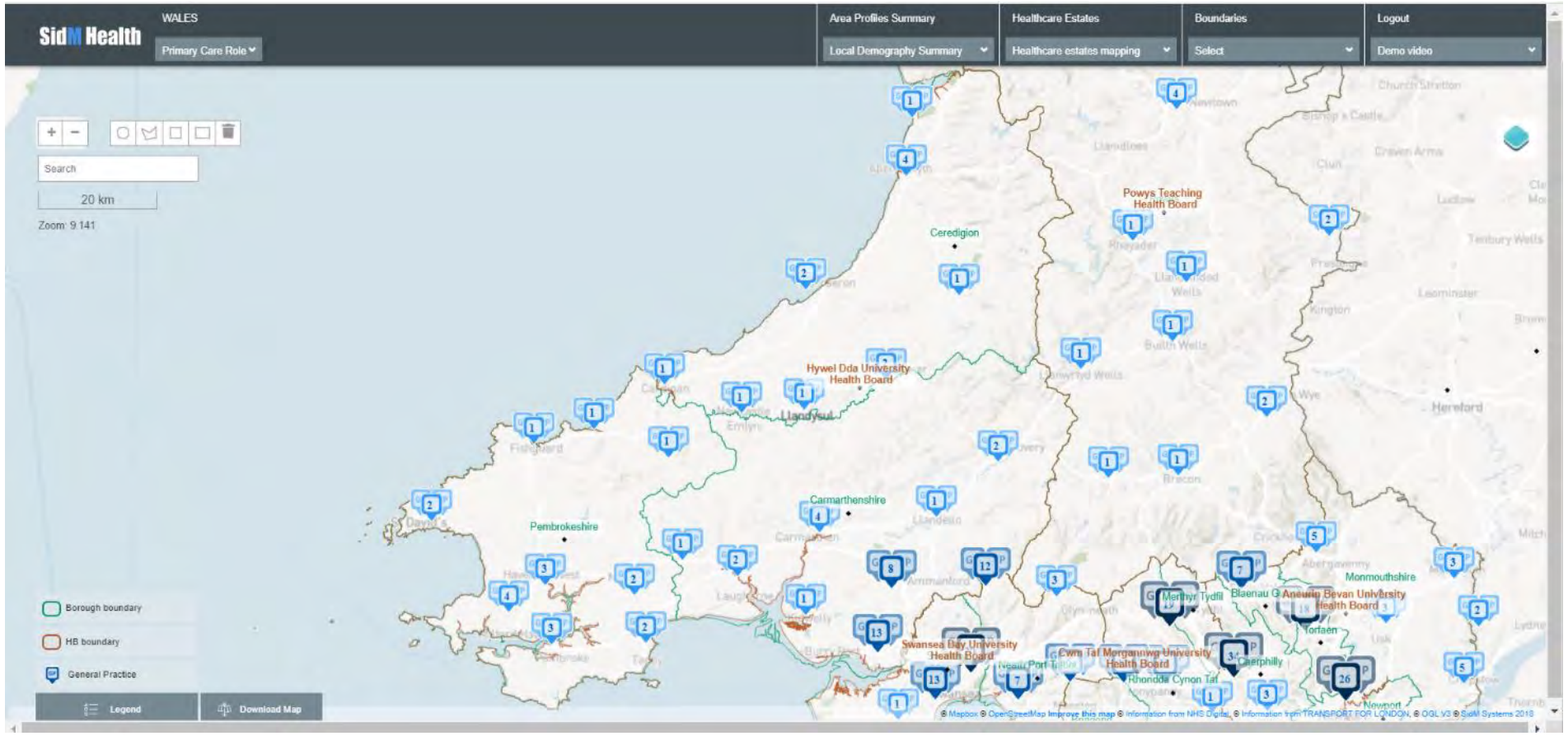
There are increasing numbers of older people who will have a higher requirement for health services which will have a growing impact on primary and community care in kay areas. Several key observations for the Health Board can be seen:

- The numbers of people aged 66+ will continue to increase for the next 20 years. It is noticeable in recent increases and future projections that the numbers of females are significantly higher.
- Deprivation scores across the area are average but where deprivation scores are higher, service provision assessments can be made ensuring needs are met across all ages – addressing the entire spectrum of people's physical, mental and social needs.
- The numbers of 0-4 years will reduce but new housing development planning agreements should be assessed to link expected growth projections for future planning.
- Analysis of access to the wider services such as pharmacies, dentists and leisure allows an assessment of the best options to provide an integrated approach to health and social care enabling people with more complex conditions to be offered screening and secondary prevention reflecting their higher risk of poor physical health.

1.3 Mapping and Statistics

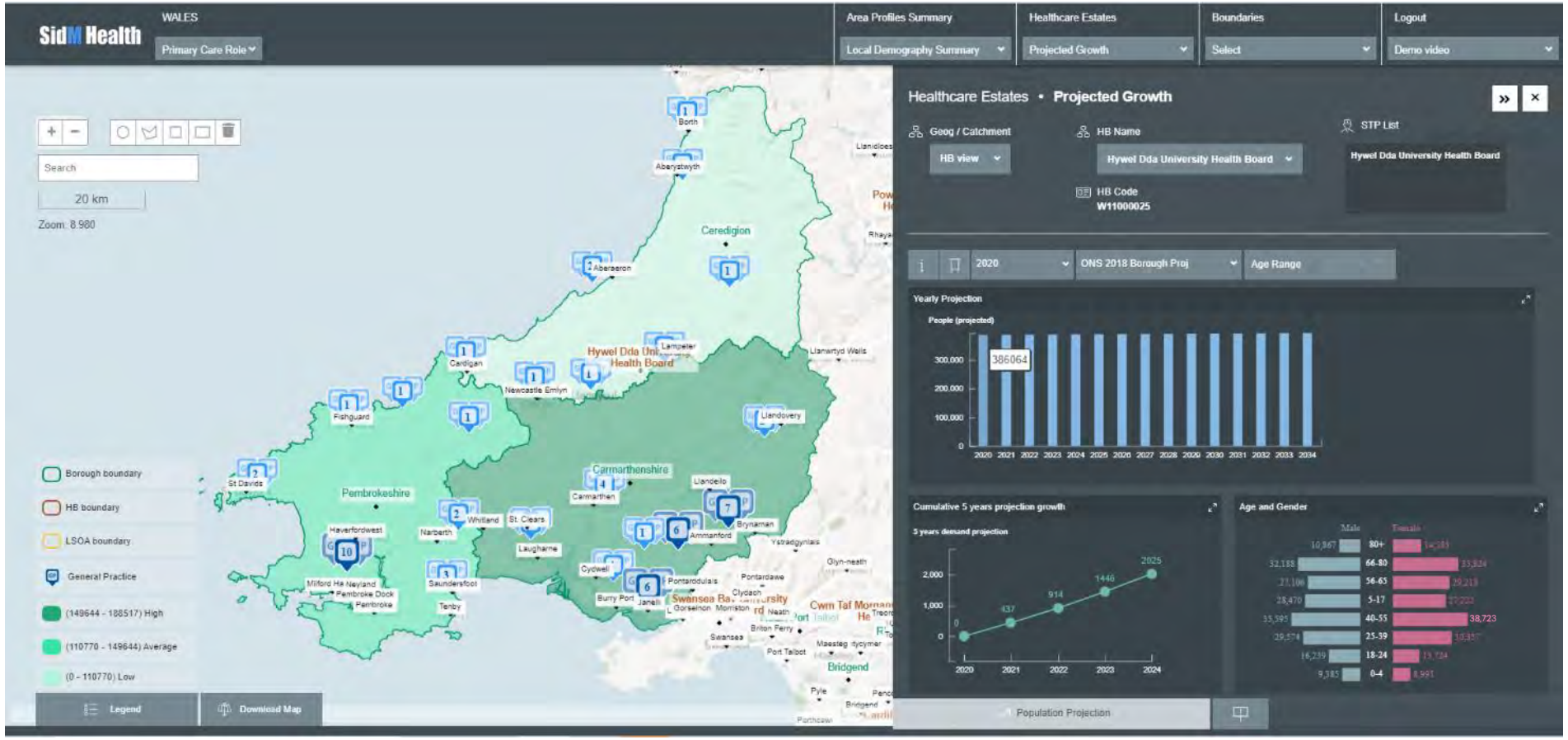
The maps below give a detailed view of the current and future population growth by age. Areas of population concentration can be identified via the heat maps, as well as access to services such as, General Practice, acute units, wider health service needs and leisure. Overall deprivation by borough is displayed against General Practice provision in section 7. Distance of travel to General Practices are demonstrated on the final map, in section 8, via an 8km catchment area.

2 General Practice Location Map

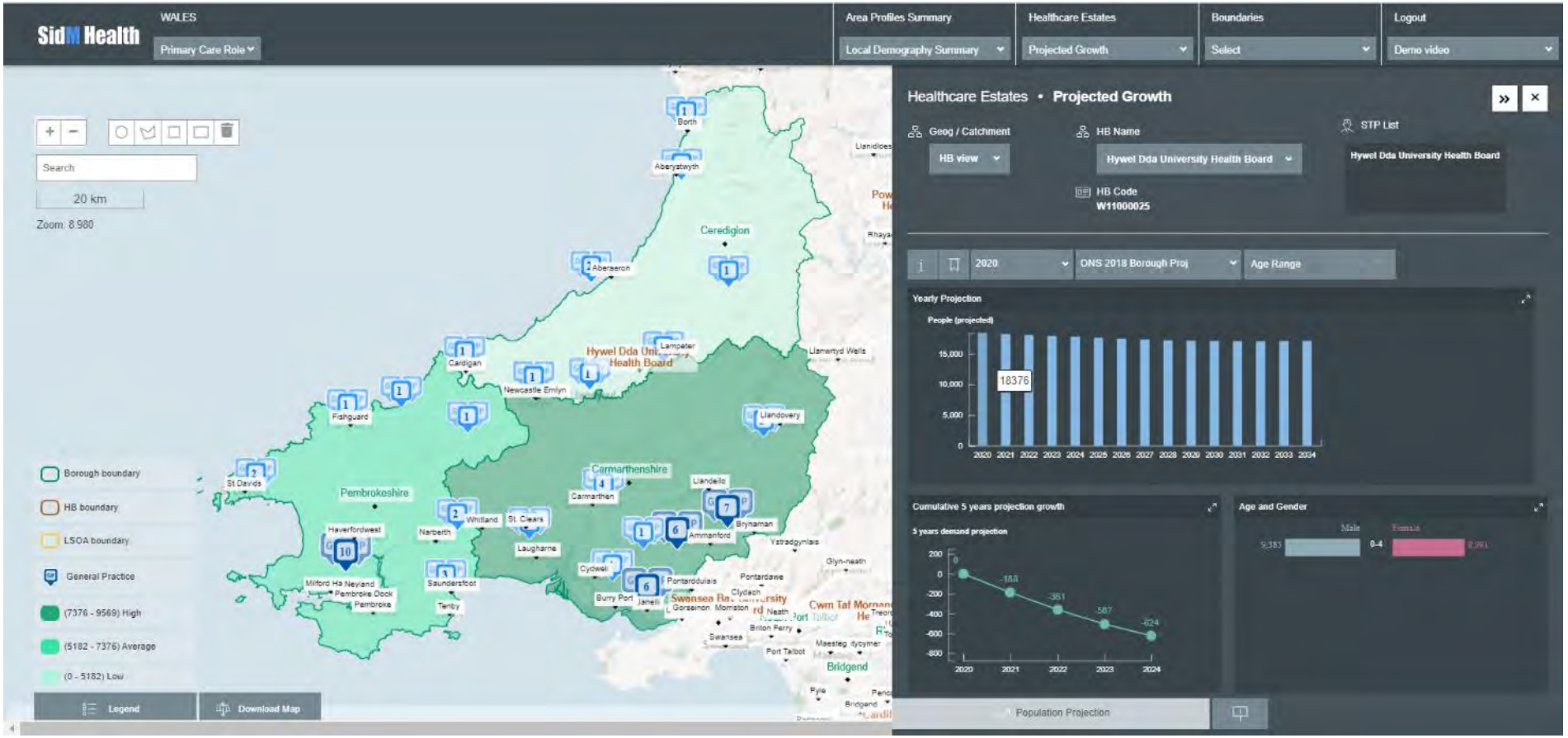


3 Population Projection by Local Authority 2020

3.1 All Ages



3.2 Ages 0 – 4


SidM Health
WALES
Primary Care Role
Area Profiles Summary
Local Demography Summary
Healthcare Estates
Projected Growth
Boundaries
Select
Logout
Demo video
Search
20 km
Zoom: 8.980
Borough boundary
HB boundary
LSOA boundary
General Practice
(7376 - 9569) High
(5182 - 7376) Average
(0 - 5182) Low
Legend
Download Map
Healthcare Estates • Projected Growth
Geog / Catchment
HB view
HB Name
Hywel Dda University Health Board
STP List
Hywel Dda University Health Board
HB Code
W11000025
2020
ONS 2018 Borough Proj
Age Range
Yearly Projection
People (projected)
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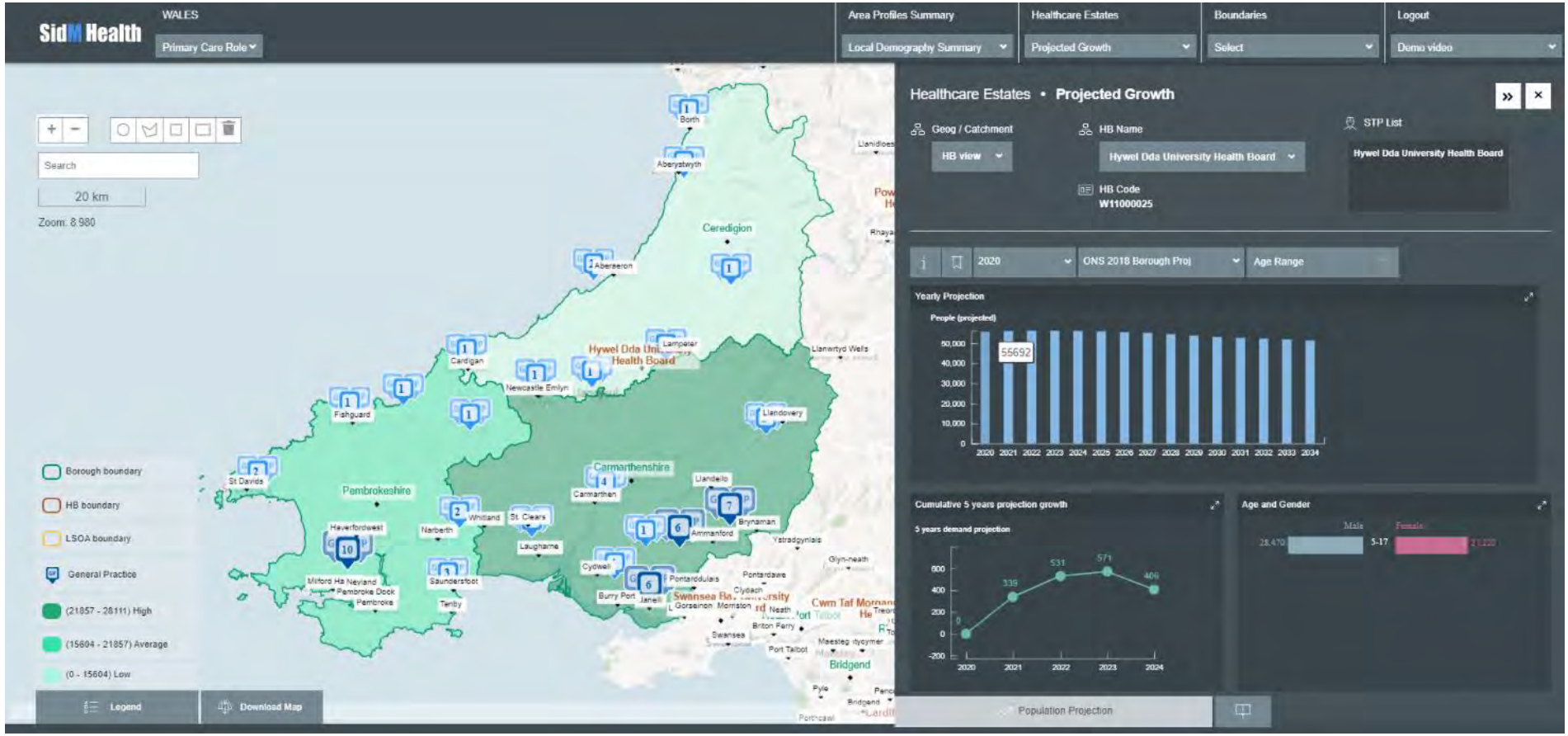
Cumulative 5 years projection growth
5 years demand projection
Age and Gender
Male
Female
0-4
Population Projection

3.3 Ages 5 – 17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WALES
Primary Care Role
Area Profiles Summary
Local Demography Summary
Healthcare Estates
Projected Growth
Boundaries
Select
Logout
Demo video
Search
20 km
Zoom: 8.980
Ceredigion
Hywel Dda University Health Board
Carmarthenshire
Pembrokeshire
Borough boundary
HB boundary
LSOA boundary
General Practice
(21857 - 28111) High
(15604 - 21857) Average
(0 - 15604) Low
Legend
Download Map
Healthcare Estates • Projected Growth
Geog / Catchment
HB view
HB Name
Hywel Dda University Health Board
HB Code
W11000025
STP List
Hywel Dda University Health Board
2020
ONS 2018 Borough Proj
Age Range
Yearly Projection
People (projected)
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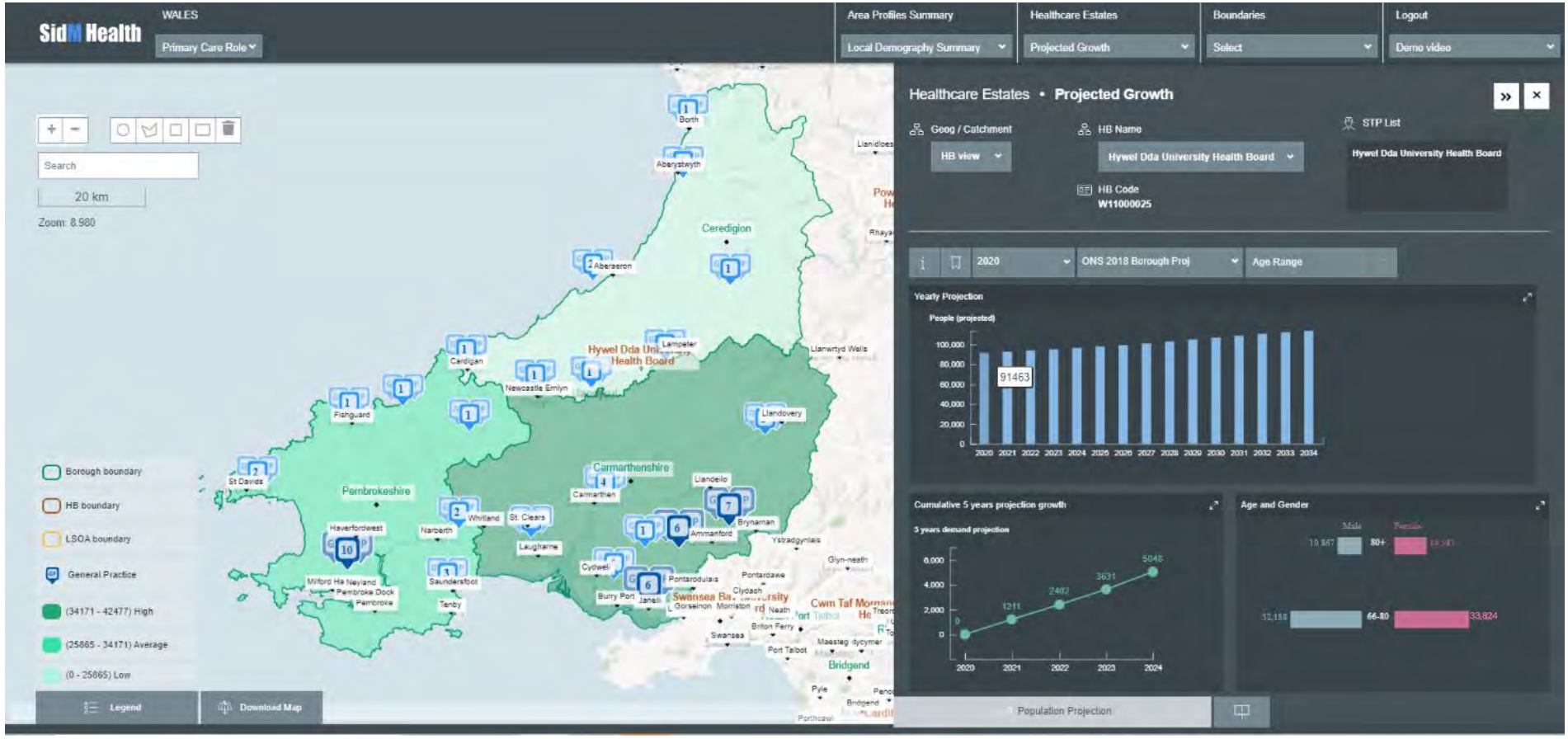
Cumulative 5 years projection growth
5 years demand projection
Age and Gender
Male
Female
5-17
Population Projection

3.4 Ages 66+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Area Profiles Summary
Local Demography Summary
Healthcare Estates
Projected Growth
Boundaries
Select
Logout
Demo video
Search
20 km
Zoom: 8.980
Borough boundary
HB boundary
LSOA boundary
General Practice
(34171 - 42477) High
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(0 - 25865) Low
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Download Map
Healthcare Estates • Projected Growth
Geog / Catchment
HB view
HB Name
Hywel Dda University Health Board
HB Code
W11000025
STP List
Hywel Dda University Health Board
2020
ONS 2018 Borough Proj
Age Range
Yearly Projection
People (projected)
91463
Cumulative 5 years projection growth
5 years demand projection
1211
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Age and Gender
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Female
80+
66-80
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Population Projection

4 Population Projection 2030, by Local Authority

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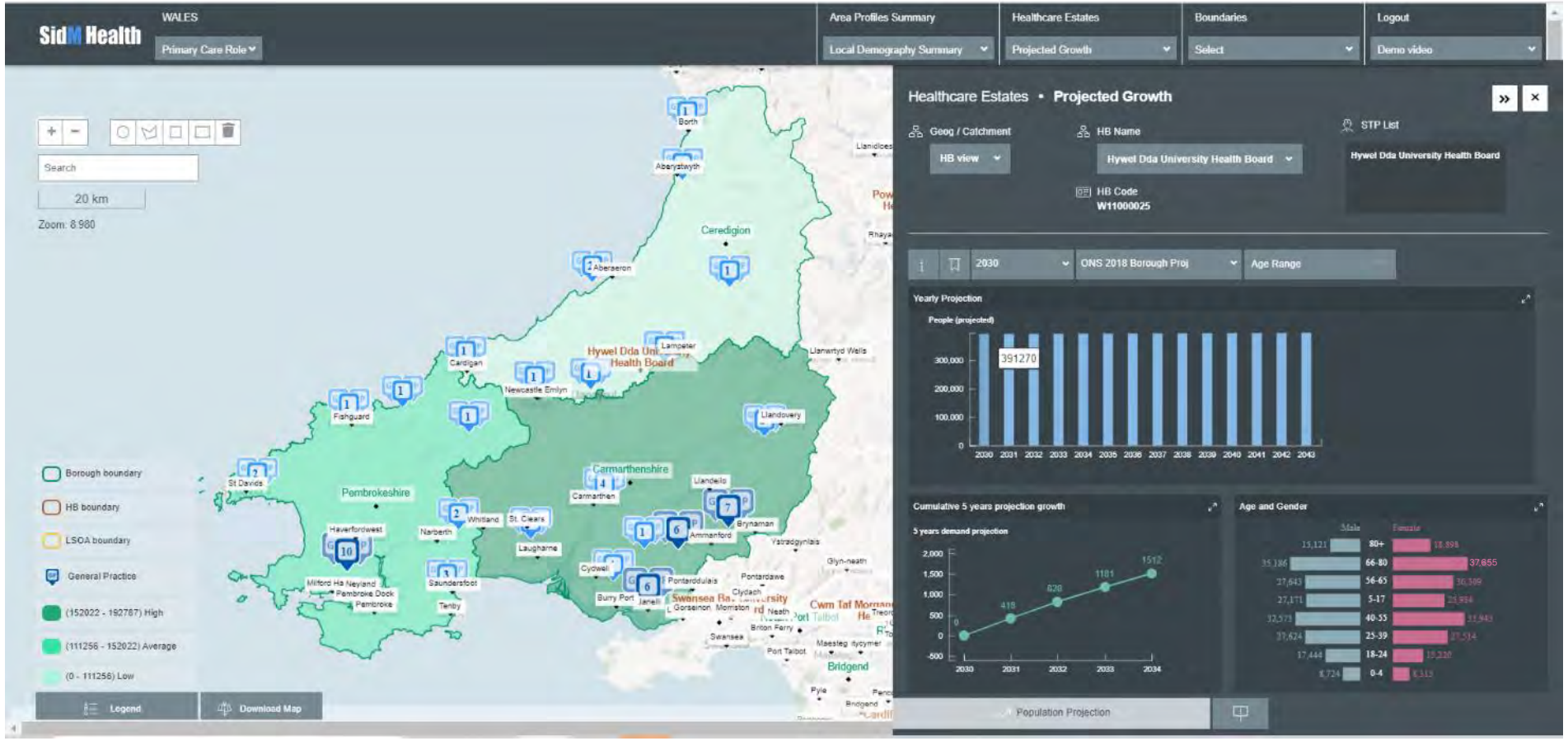
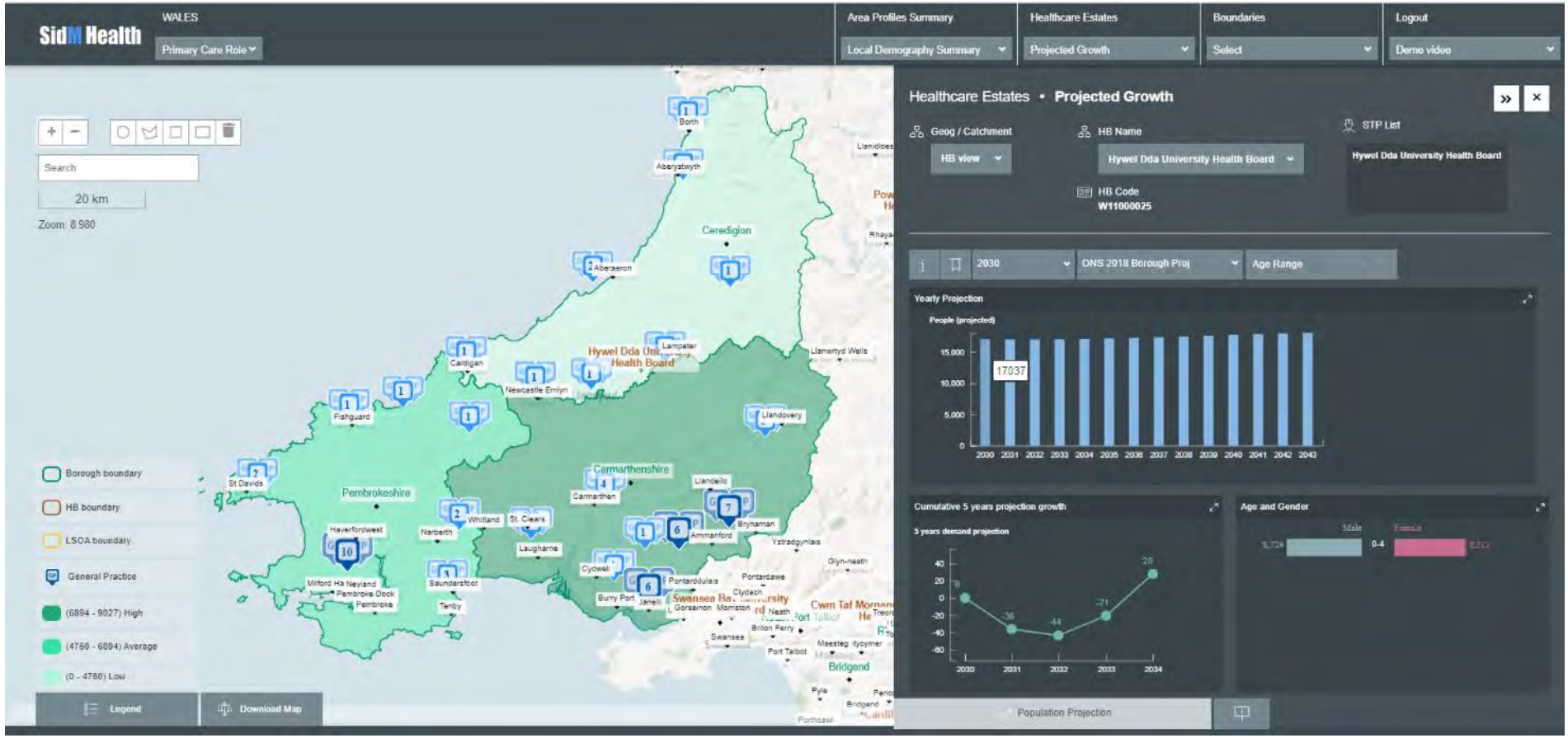


4.2 Ages 0 – 4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Primary Care Role
Area Profiles Summary
Local Demography Summary
Healthcare Estates
Projected Growth
Boundaries
Select
Logout
Demo video
Search
20 km
Zoom: 8.980
Borough boundary
HB boundary
LSOA boundary
General Practice
(6894 - 9027) High
(4760 - 6894) Average
(0 - 4760) Low
Legend
Download Map
Healthcare Estates • Projected Growth
Geog / Catchment
HB view
HB Name
Hywel Dda University Health Board
HB Code
W11000025
STP List
Hywel Dda University Health Board
2030
ONS 2018 Borough Proj
Age Range
Yearly Projection
People (projected)
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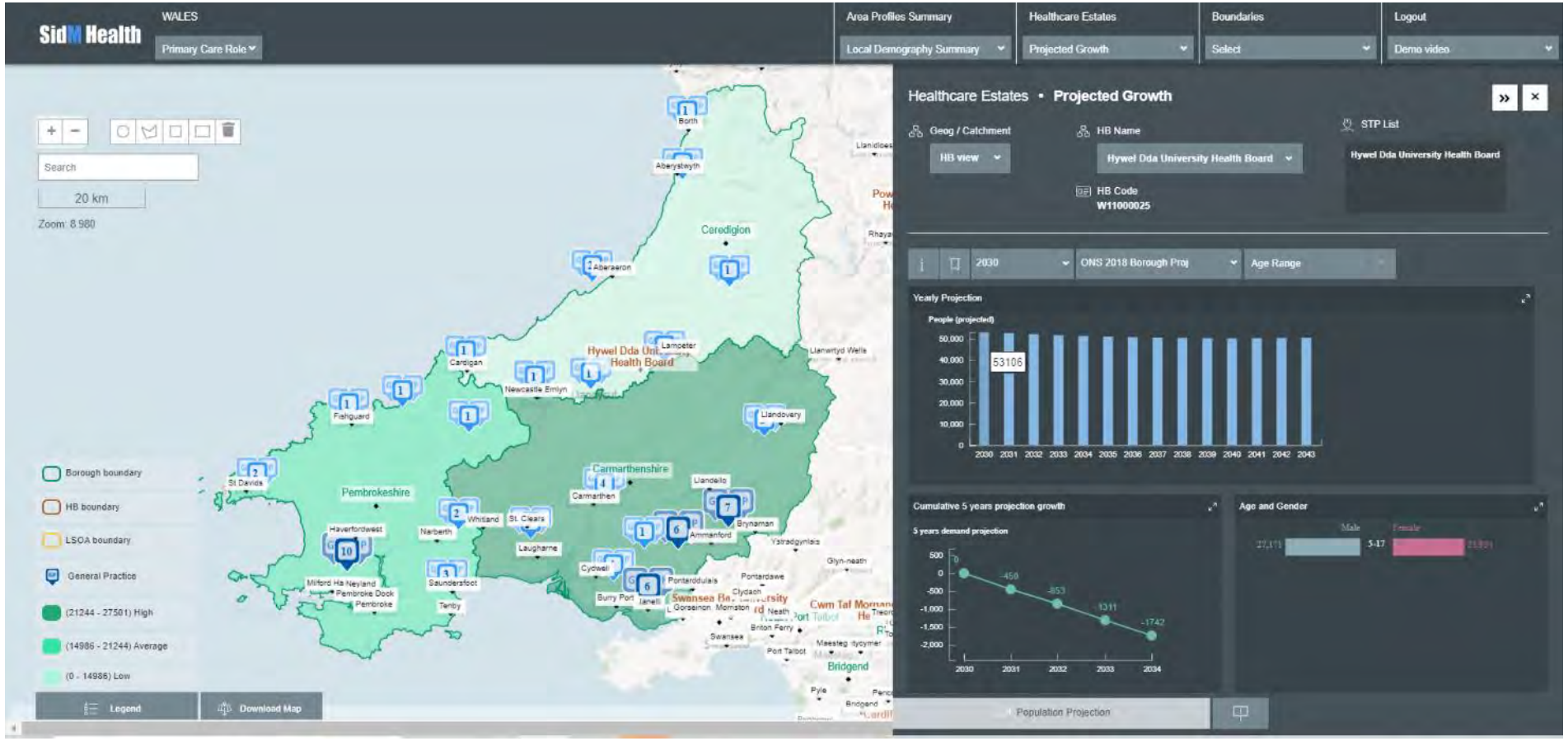
Cumulative 5 years projection growth
5 years demand projection
Age and Gender
Male
Female
0-4
Population Projection

4.3 Ages 5 – 17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Healthcare Estates
Projected Growth
Boundaries
Select
Logout
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20 km
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Borough boundary
HB boundary
LSOA boundary
General Practice
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(14986 - 21244) Average
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Legend
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Ceredigion
Carmarthenshire
Pembrokeshire
Healthcare Estates • Projected Growth
Geog / Catchment
HB view
HB Name
Hywel Dda University Health Board
STP List
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HB Code
W11000025
2030
ONS 2018 Borough Proj
Age Range
Yearly Projection
People (projected)
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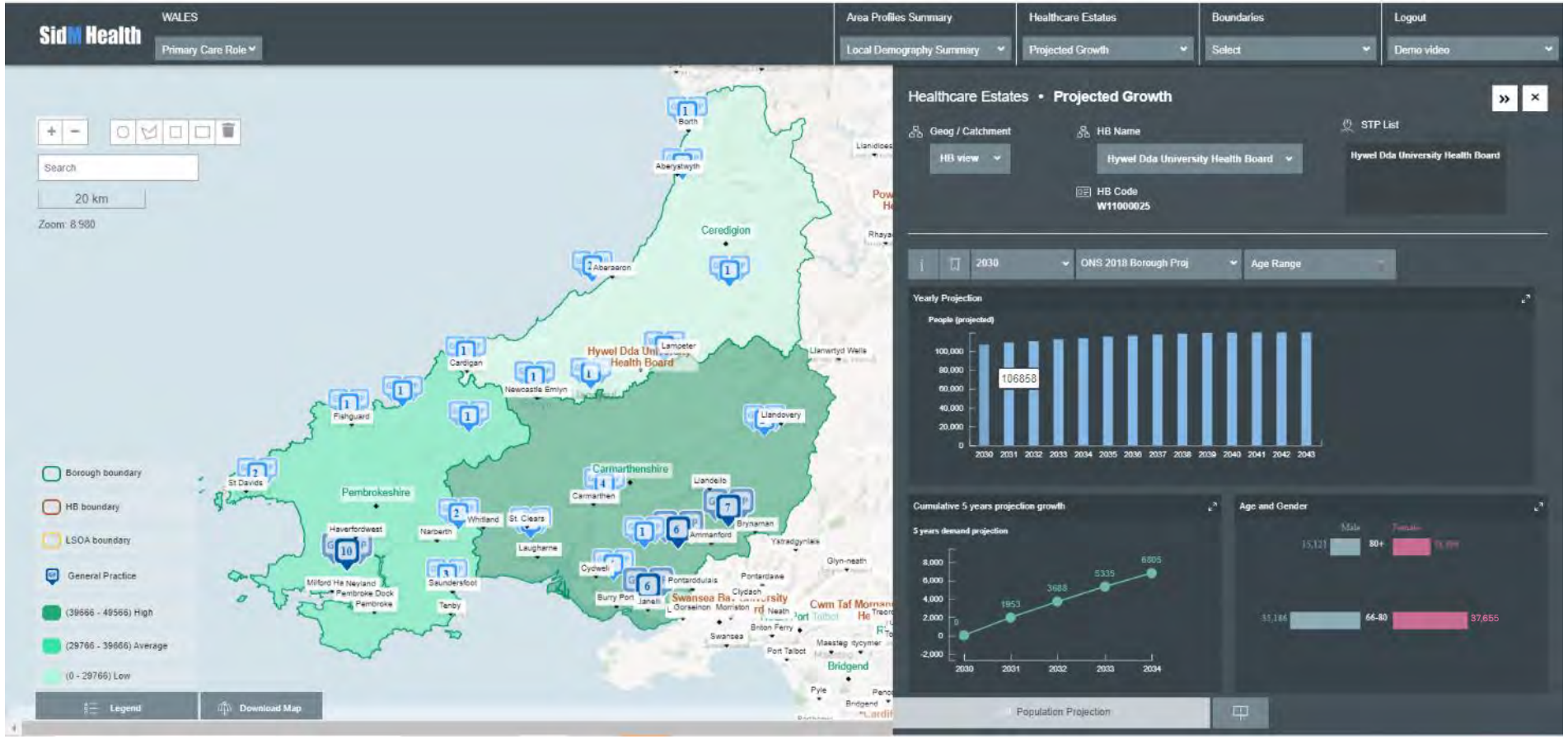
Cumulative 5 years projection growth
5 years demand projection
Age and Gender
Male
Female
5-17
Population Projection

4.4 Ages 66+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Projected Growth
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Logout
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20 km
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Borough boundary
HB boundary
LSOA boundary
General Practice
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(29766 - 39666) Average
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Healthcare Estates • Projected Growth
Geog / Catchment
HB view
HB Name
Hywel Dda University Health Board
STP List
Hywel Dda University Health Board
HB Code
W11000025
2030
ONS 2018 Borough Proj
Age Range
Yearly Projection
People (projected)
106858
Cumulative 5 years projection growth
5 years demand projection
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6805
Age and Gender
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Female
80+
66-80
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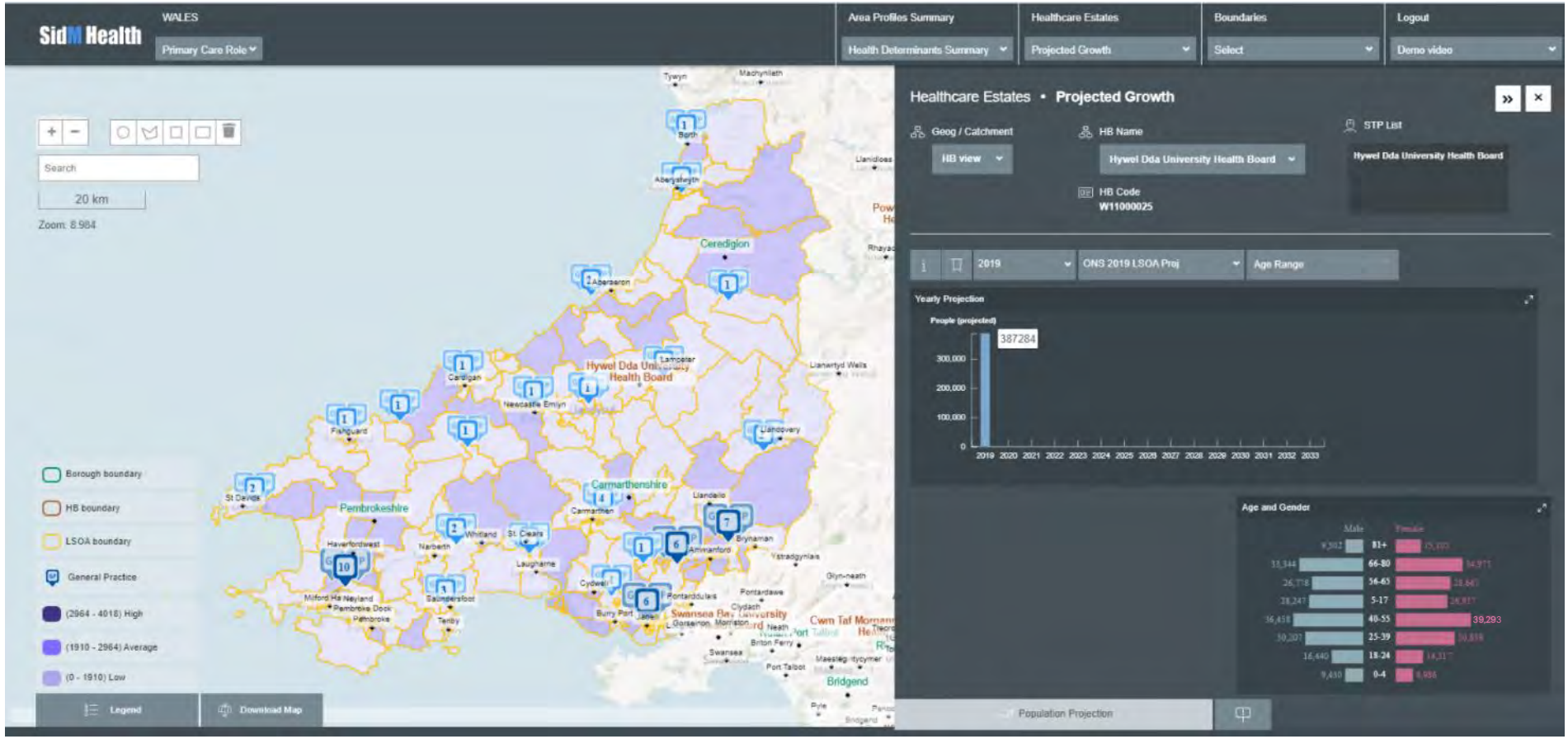
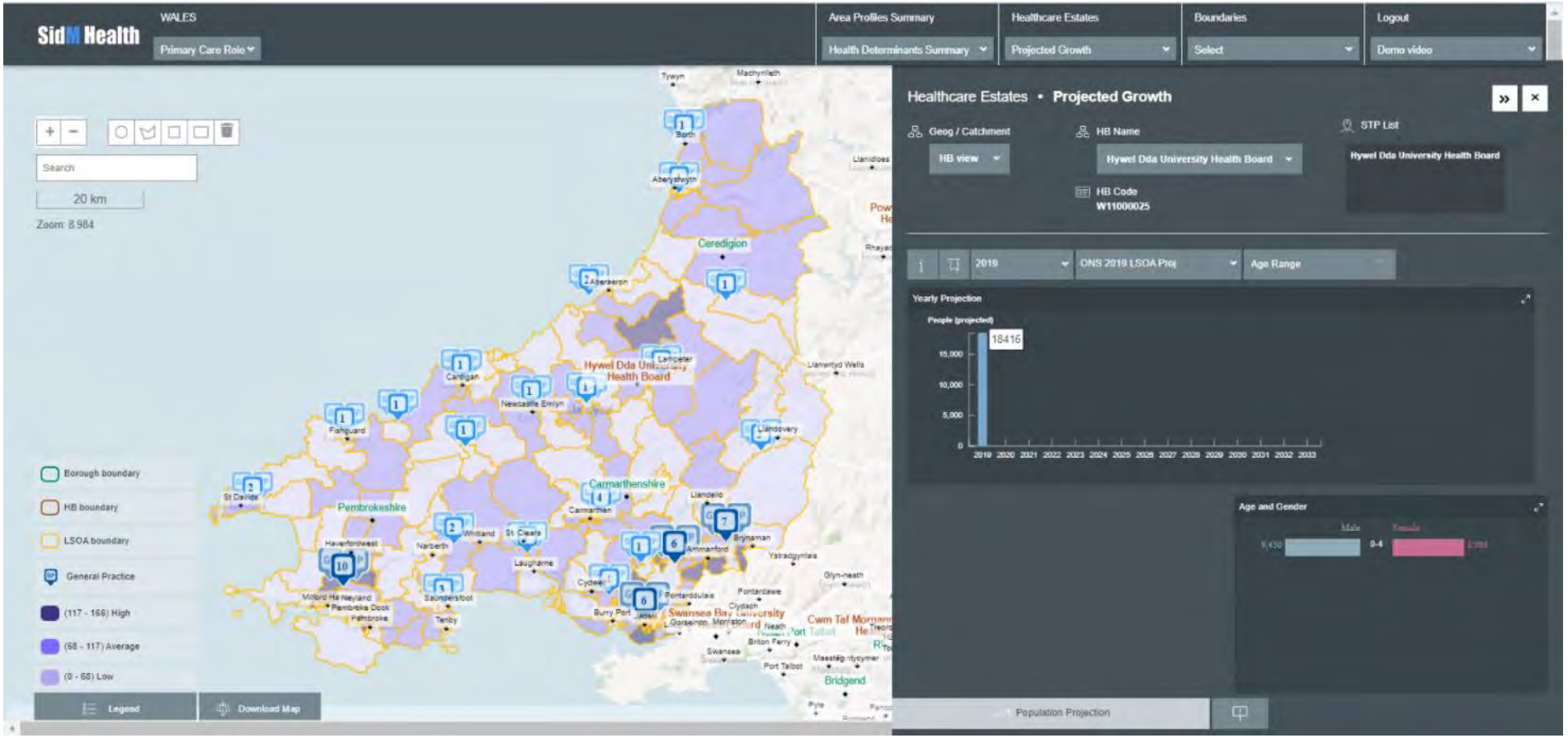
Population Projection

5 Population Projection by LSOAs

5.1 All Ages



5.2 Ages 0 – 4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Health Determinants Summary
Healthcare Estates
Projected Growth
Boundaries
Select
Logout
Demo video
Search
20 km
Zoom: 8.984
Borough boundary
HB boundary
LSOA boundary
General Practice
(117 - 166) High
(58 - 117) Average
(0 - 58) Low
Legend
Download Map
Ceredigion
Carmarthenshire
Pembrokeshire
Hywel Dda University Health Board
Healthcare Estates • Projected Growth
Geog / Catchment
HB view
HB Name
Hywel Dda University Health Board
STP List
Hywel Dda University Health Board
HB Code
W11000025
2019
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Age Range
Yearly Projection
People (projected)
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Age and Gender
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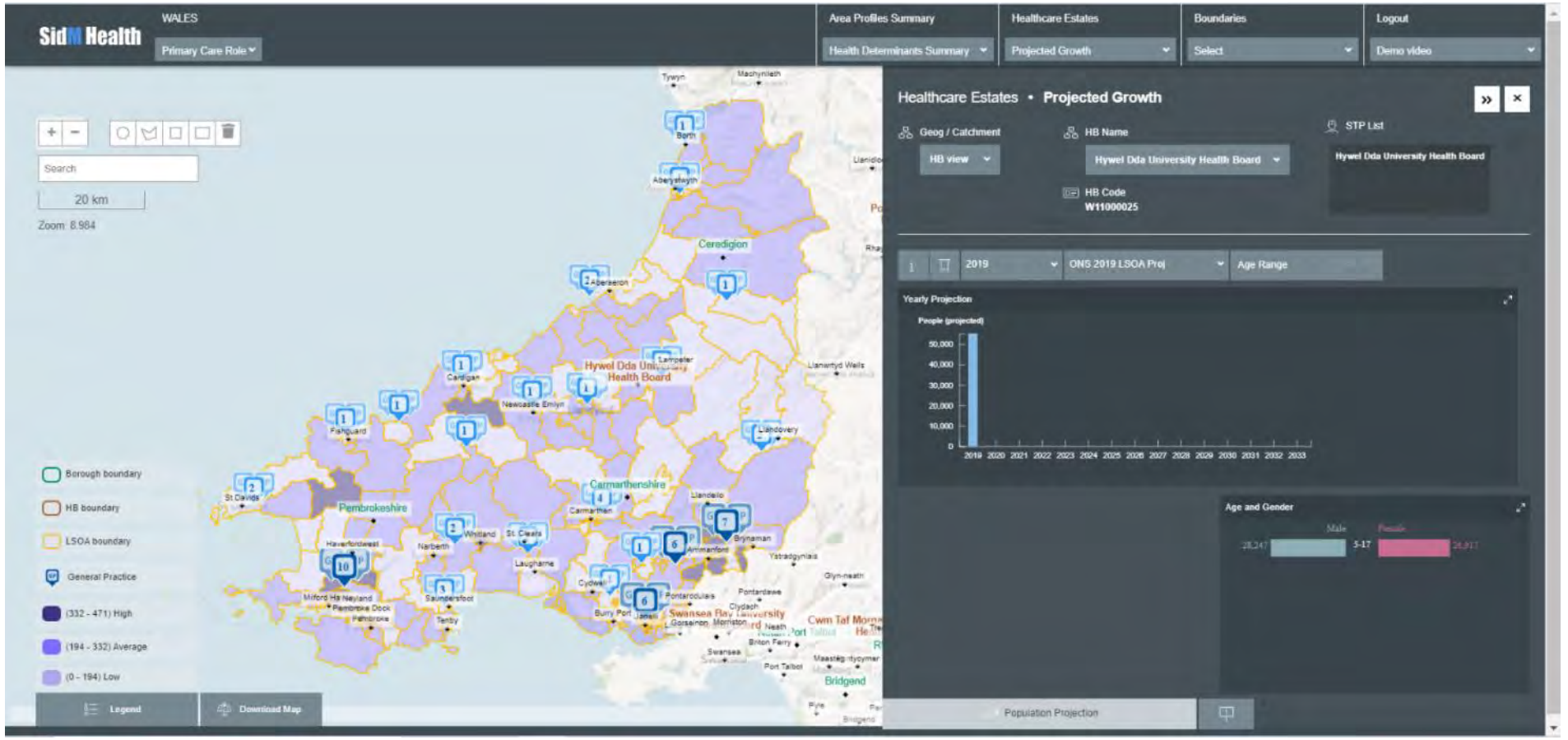
Female
0-4
Population Projection

5.3 Ages 5 – 17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Zoom: 8.984
Healthcare Estates • Projected Growth
Geog / Catchment
HB view
HB Name
Hywel Dda University Health Board
HB Code
W11000025
STP List
Hywel Dda University Health Board
2019
ONS 2019 LSOA Proj
Age Range
Yearly Projection
People (projected)
50,000
40,000
30,000
20,000
10,000
0
2019 2020 2021 2022 2023 2024 2025 2026 2027 2028 2029 2030 2031 2032 2033
Age and Gender
Male
Female
5-17
Borough boundary
HB boundary
LSOA boundary
General Practice
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(194 - 332) Average
(0 - 194) Low
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Population Projection
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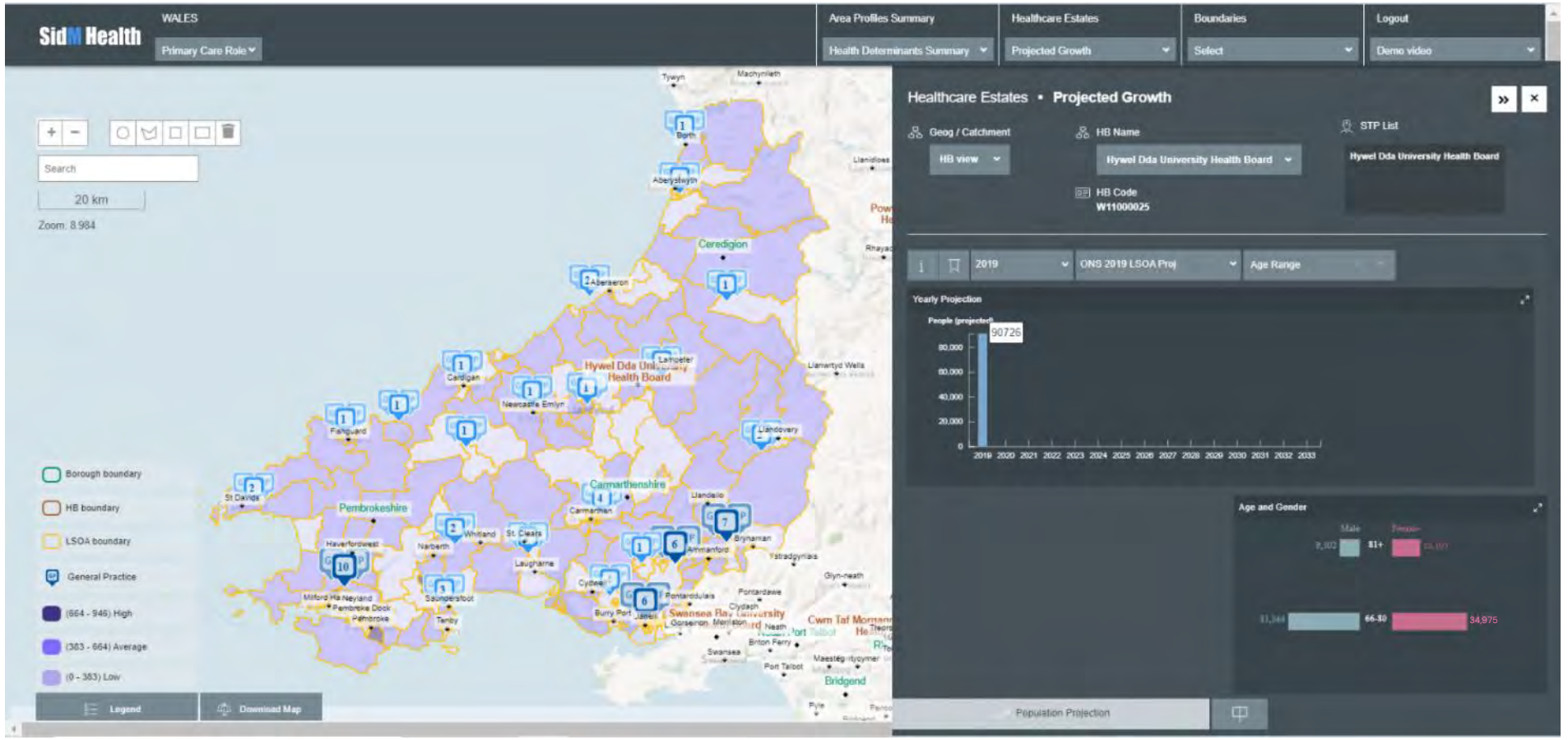
Carmarthenshire
Pembrokeshire
Swansea
Bridgend

5.4 Ages 66+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Area Profiles Summary
Health Determinants Summary
Healthcare Estates
Projected Growth
Boundaries
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Logout
Demo video
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20 km
Zoom: 8.984
Borough boundary
HB boundary
LSOA boundary
General Practice
(664 - 946) High
(383 - 664) Average
(0 - 383) Low
Legend
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Healthcare Estates • Projected Growth
Geog / Catchment
HB view
HB Name
Hywel Dda University Health Board
HB Code
W11000025
STP List
Hywel Dda University Health Board
2019
ONS 2019 LSOA Proj
Age Range
Yearly Projection
People (projected)
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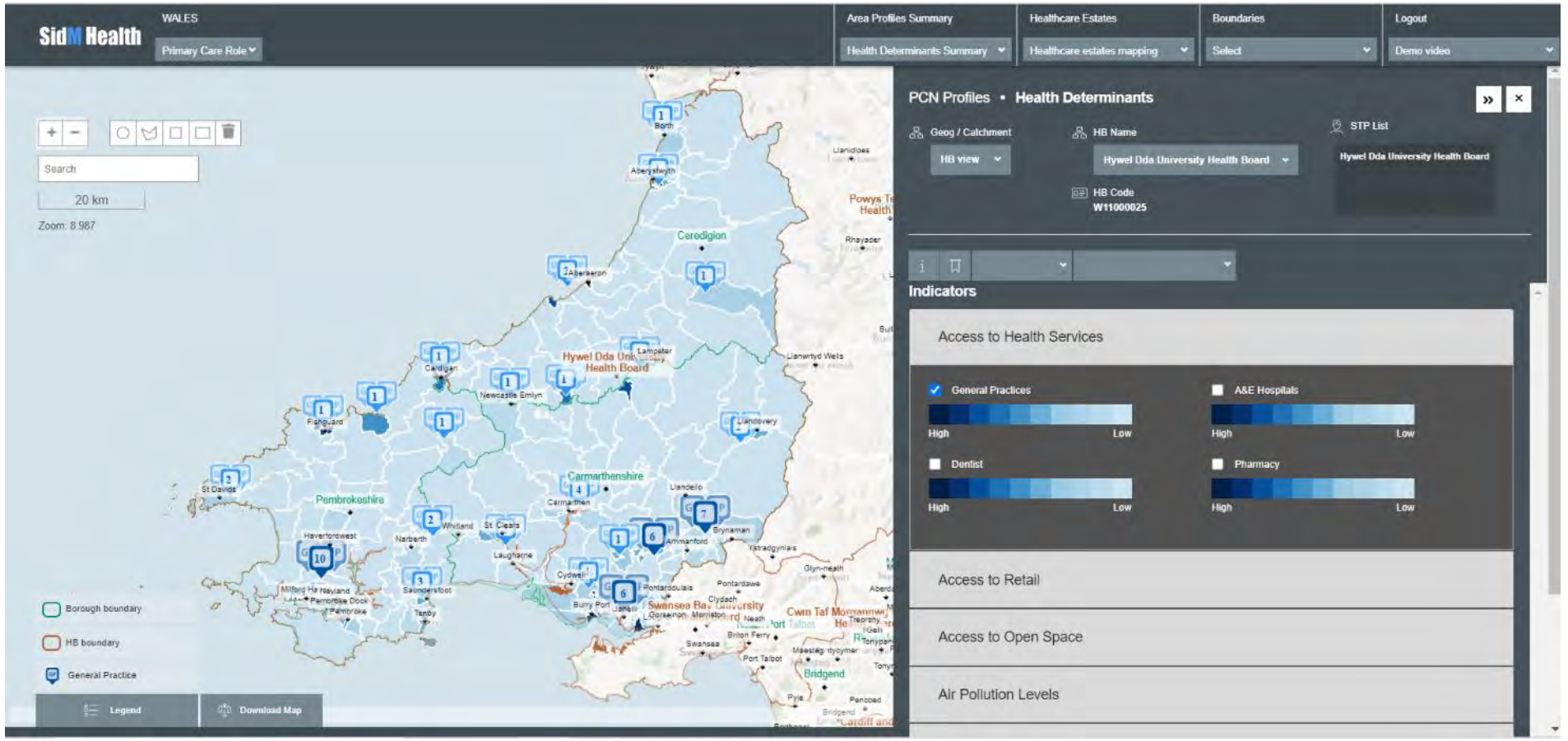
Age and Gender
Male
Female
81+
66-80
34,975
Population Projection

6 Access

6.1 General Practices



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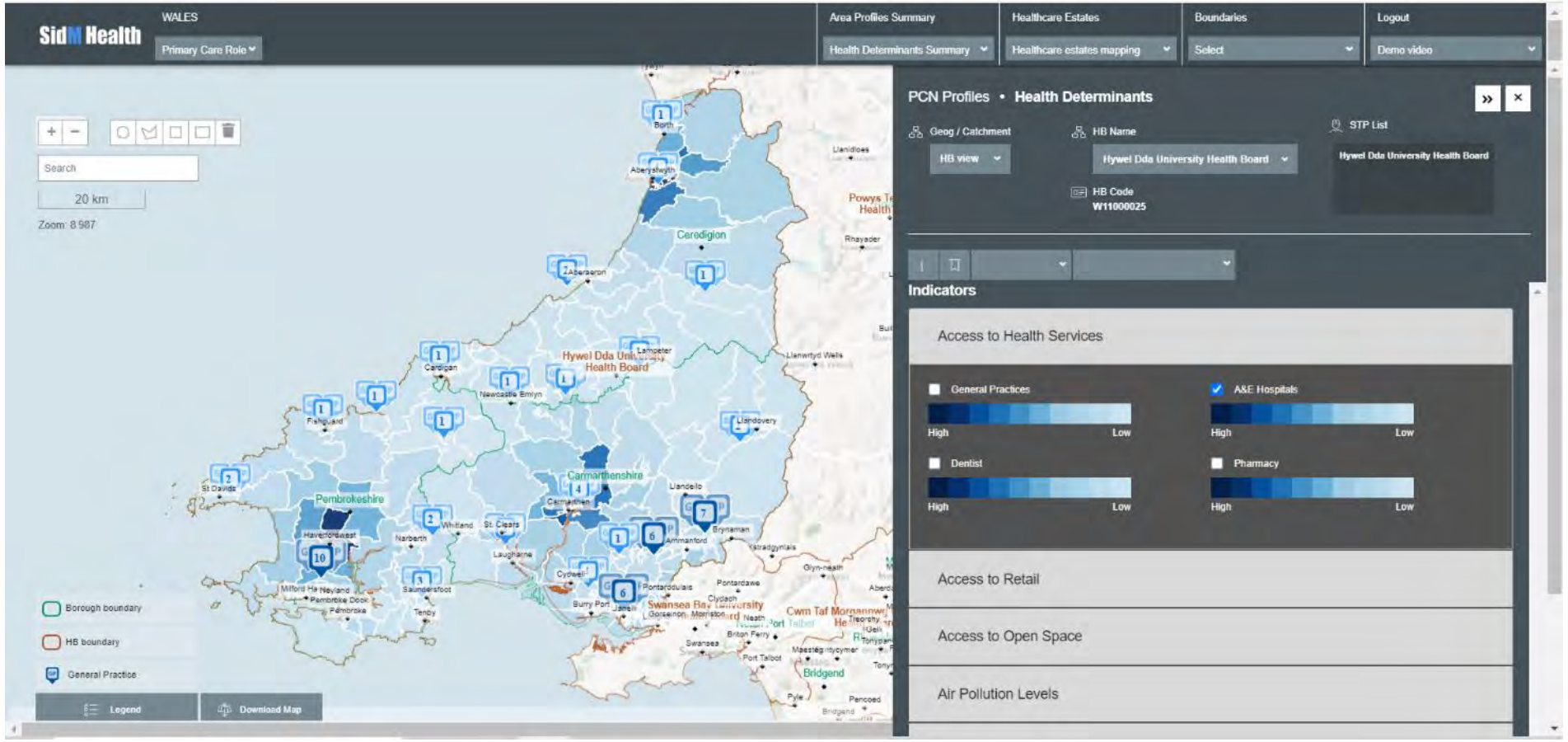

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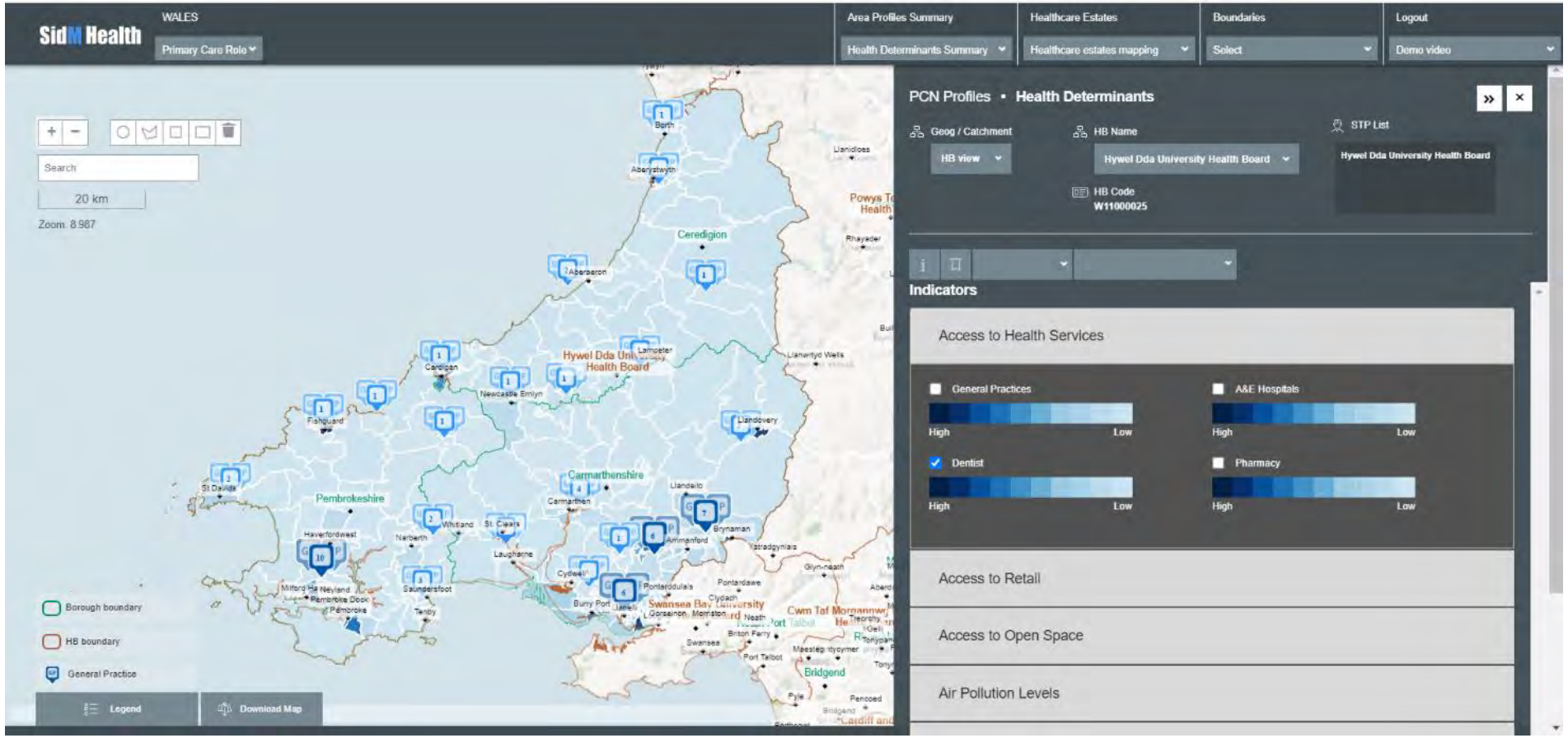
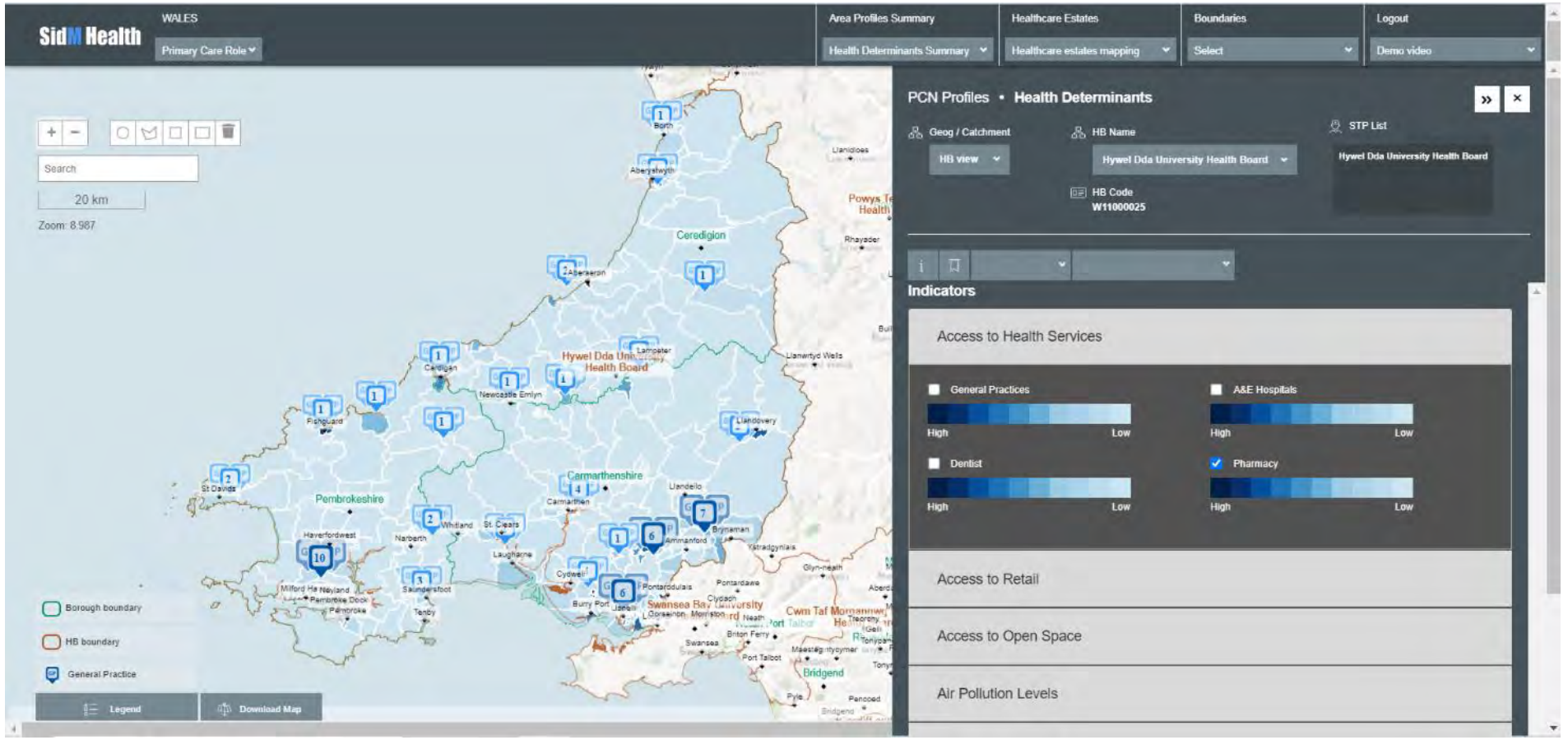
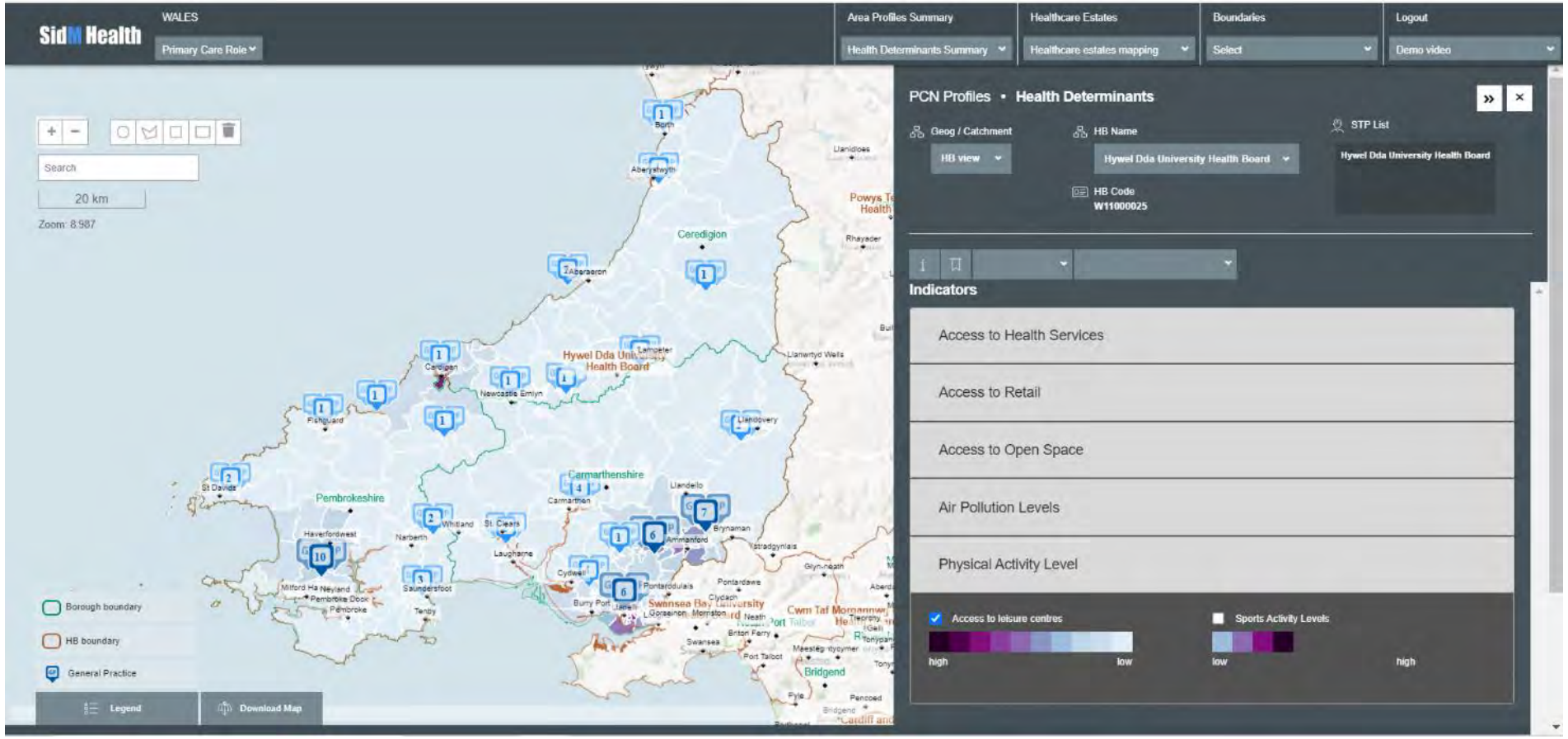

SidM Health
WALES
Primary Care Role
Area Profiles Summary
Health Determinants Summary
Healthcare Estates
Healthcare estates mapping
Boundaries
Select
Logout
Demo video
Search
20 km
Zoom: 8.987
PCN Profiles • Health Determinants
Geog / Catchment
HB view
HB Name
Hywel Dda University Health Board
STP List
Hywel Dda University Health Board
HB Code
W11000025
Indicators
Access to Health Services
General Practices
A&E Hospitals
Dentist
Pharmacy
High
Low
Access to Retail
Access to Open Space
Air Pollution Levels
Borough boundary
HB boundary
General Practice
Legend
Download Map
Ceredigion
Carmarthenshire
Pembrokeshire
Hywel Dda University Health Board
Swansea Bay University
Bridgend

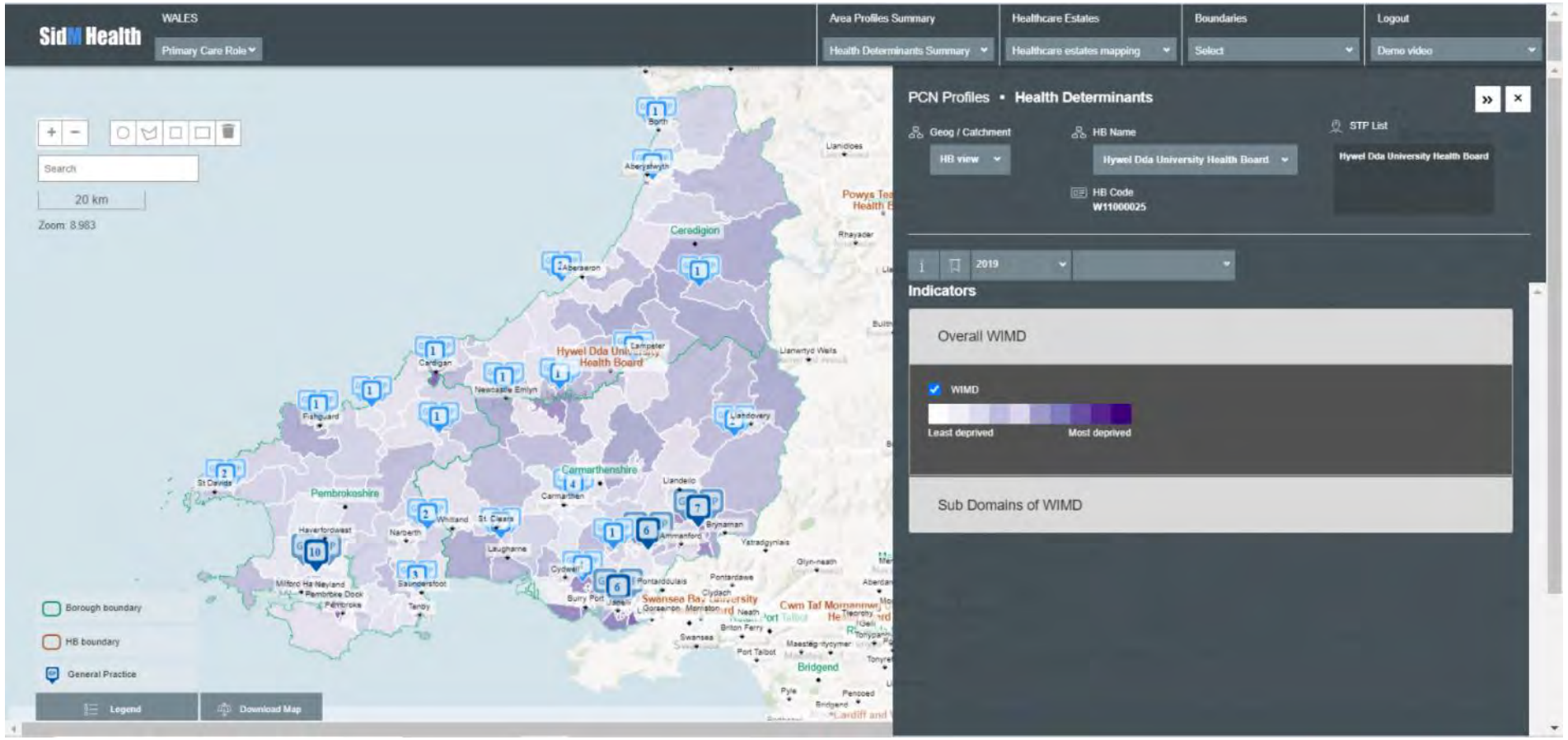
6.4 Pharmacy


SidM Health
WALES
Primary Care Role
Area Profiles Summary
Health Determinants Summary
Healthcare Estates
Healthcare estates mapping
Boundaries
Select
Logout
Demo video
Search
20 km
Zoom: 8.987
PCN Profiles • Health Determinants
Geog / Catchment
HB view
HB Name
Hywel Dda University Health Board
STP List
Hywel Dda University Health Board
HB Code
W11000025
Indicators
Access to Health Services
General Practices
A&E Hospitals
Dentist
Pharmacy
High
Low
Access to Retail
Access to Open Space
Air Pollution Levels
Borough boundary
HB boundary
General Practice
Legend
Download Map
Ceredigion
Pembrokeshire
Carmarthenshire
Bridgend

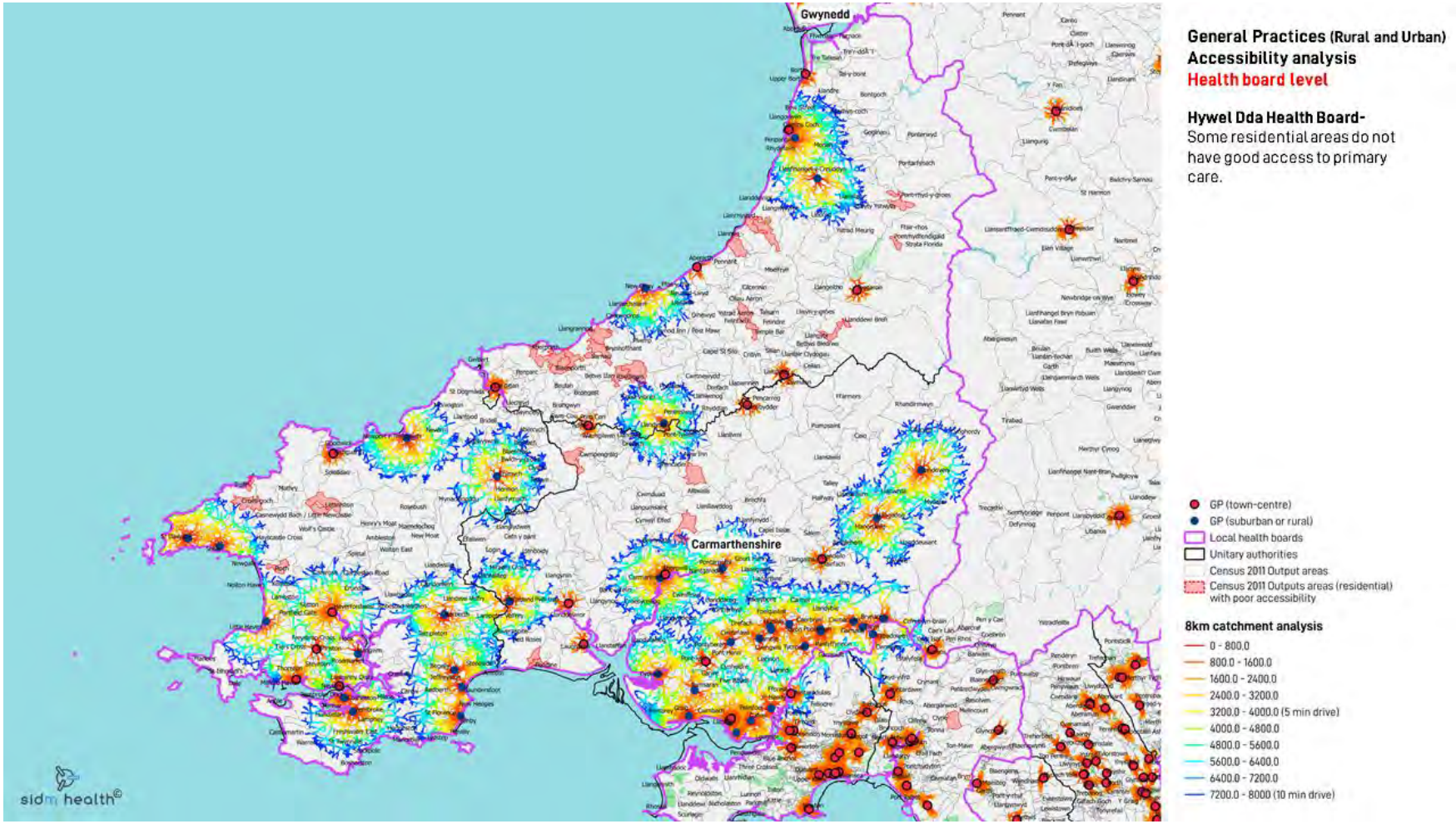
6.5 Leisure Centres



7 Overall Deprivation Score



8 Travel Distances



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Appendix C6 – Powys Teaching Health Board mapping

May 2021

Contents

1 Introduction

1.1 Demographic Observations

Review of the Demographic profile below shows that there have been steady levels of growth over recent years. This growth will continue but is shown to be particularly higher in ages 40-55 years; also, for people 66 years and older and significantly higher in the numbers of people over the age of 80 years.

In 2021 the numbers of 0-4 years have reduced but concentrations of the very young seen in key areas such as Rhayader. The numbers of 5-17 years are also seen to drop after 2022.

The changing age profile will be an important consideration for provision of future services as concentrations of older people are seen in the northern areas where access to the full range of services is low in some neighbourhoods where the population needs are changing for instance the needs within areas with high levels of younger people will differ than those where higher concentrations of elderly populations over 80 years can be seen.

1.2 Patient Need

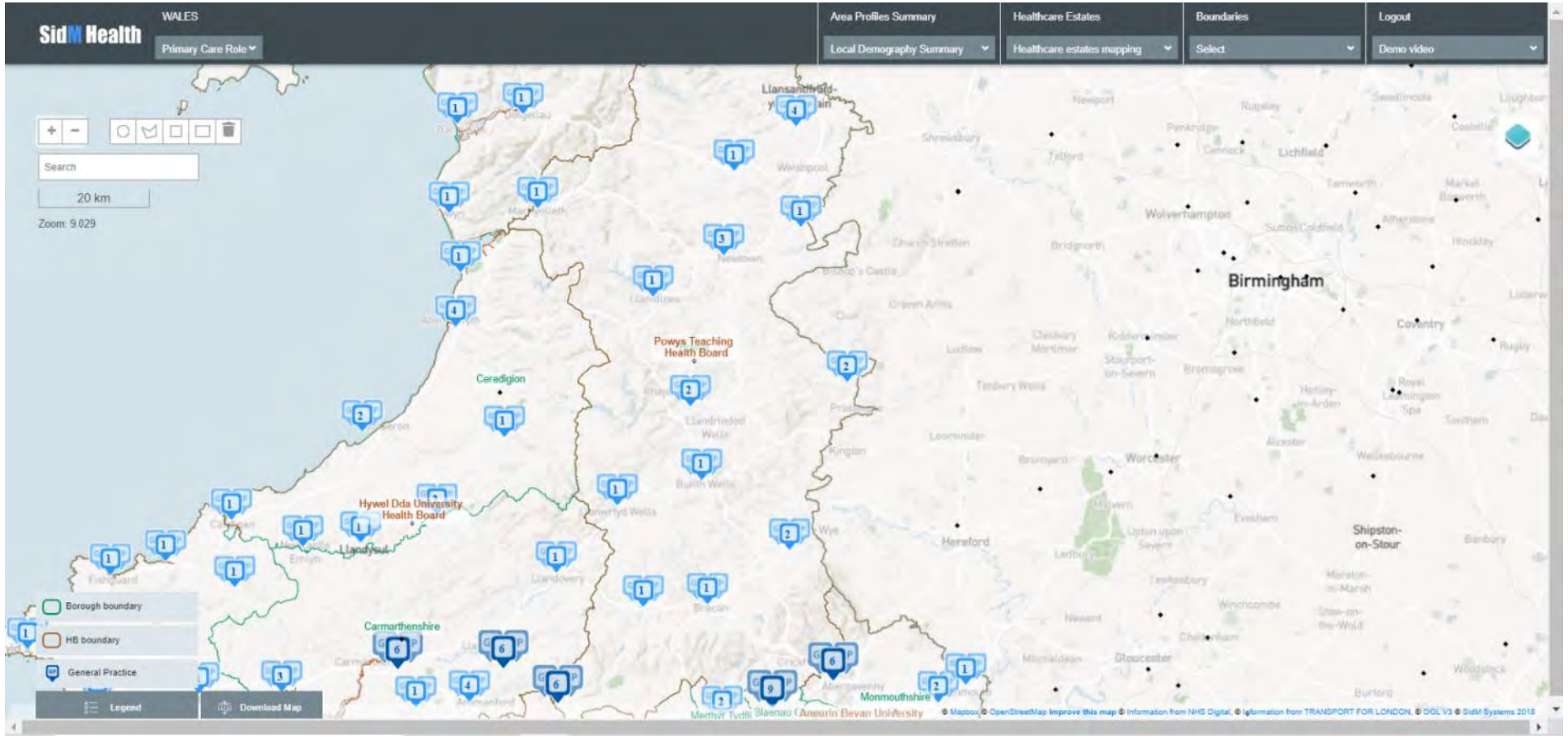
Since the population in areas of the Health Board has grown and the numbers of aging patients who have a higher requirement for health services has increased, there will be a growing impact on primary care in these areas. Several key observations for the Health Board can be seen:

- The numbers of people aged 66+ will continue to increase for the next 20 years. This increase can also be seen in the 80 plus age group and future projections showing that the numbers of females are higher in both groups.
- Deprivation scores across the area are low to medium but where deprivation scores are higher key service provision assessments can be made ensuring health requirements are met across all ages – addressing the entire spectrum of people's physical, mental, and social needs.
- The numbers of 0-4 years and 5-17 years shows slow growth, but new housing development planning agreements should be assessed to link expected growth projections in the longer term.
- There are areas of the Health Board where there are higher concentrations of older people and lower access to health and social care and to the wider services such as pharmacies, dentists and leisure.

1.3 Mapping and Statistics

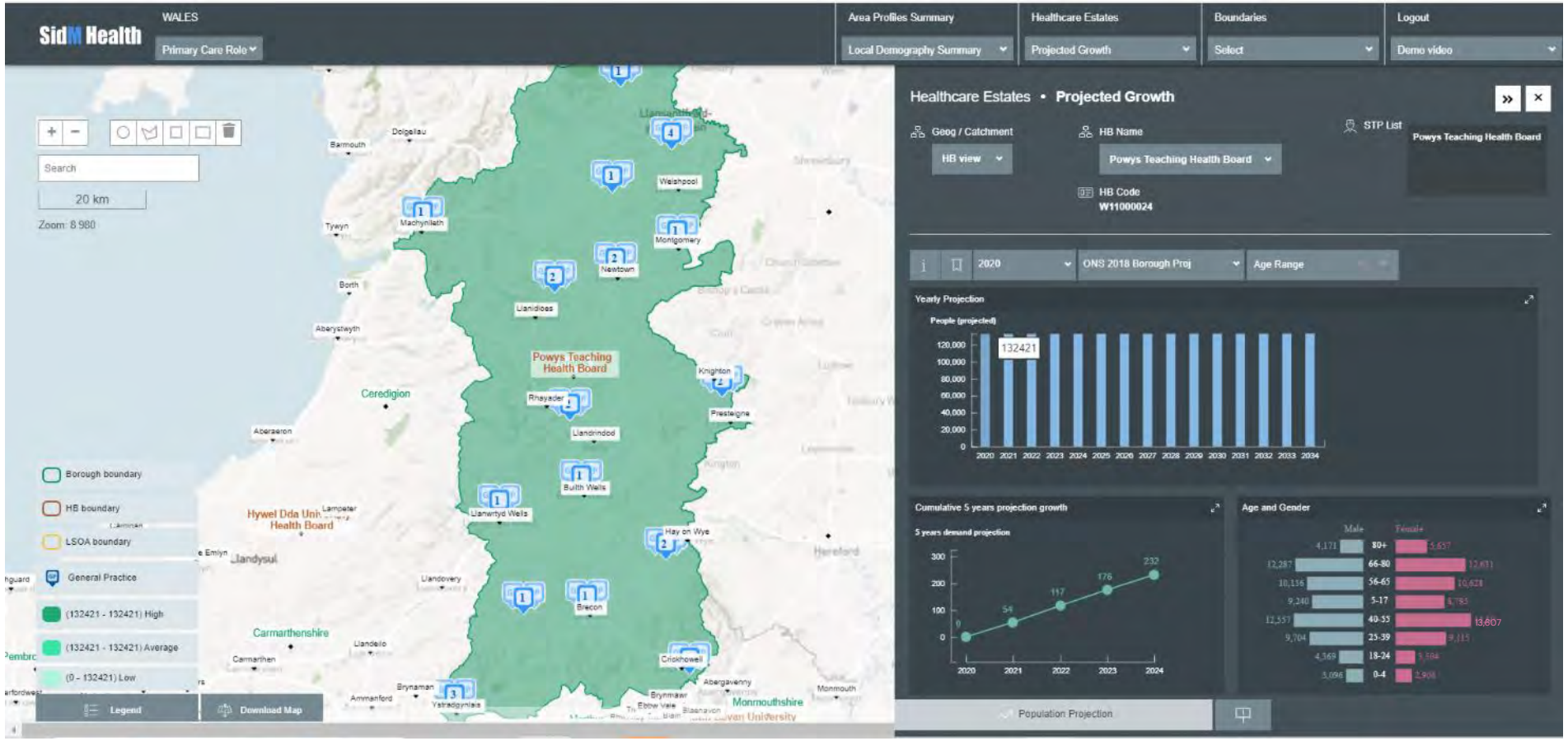
The maps below give a detailed view of the current and future population growth by age. Areas of population concentration can be identified via the heat maps, as well as access to services such as, General Practice, acute units, wider health service needs and leisure. Overall deprivation by borough is displayed against General Practice provision in section 7. Distance of travel to General Practices are demonstrated on the final map, in section 8, via an 8km catchment area.

2 General Practice Location Map

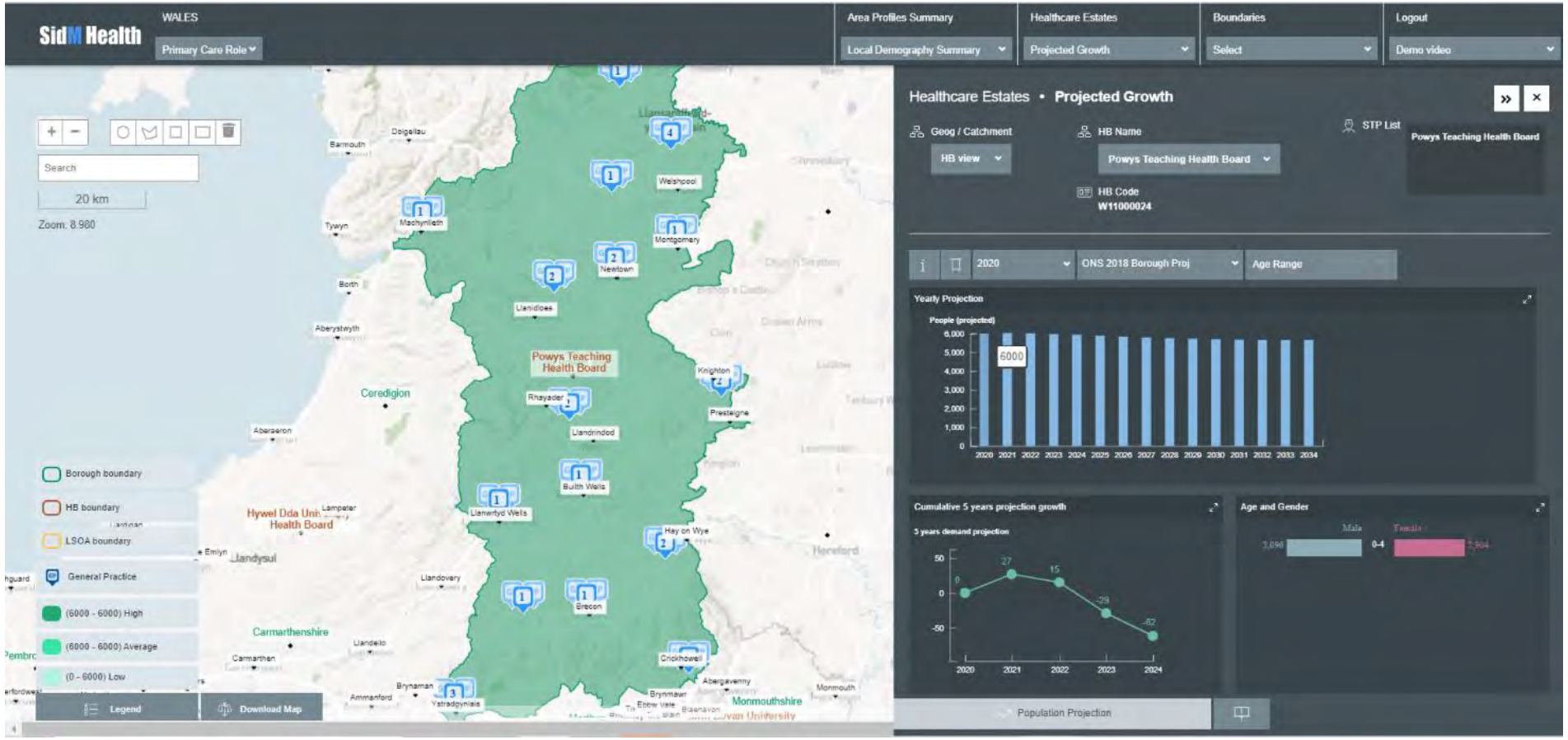


3 Population Projection by Local Authority 2020

3.1 All Ages



3.2 Ages 0 – 4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Local Demography Summary
Healthcare Estates
Projected Growth
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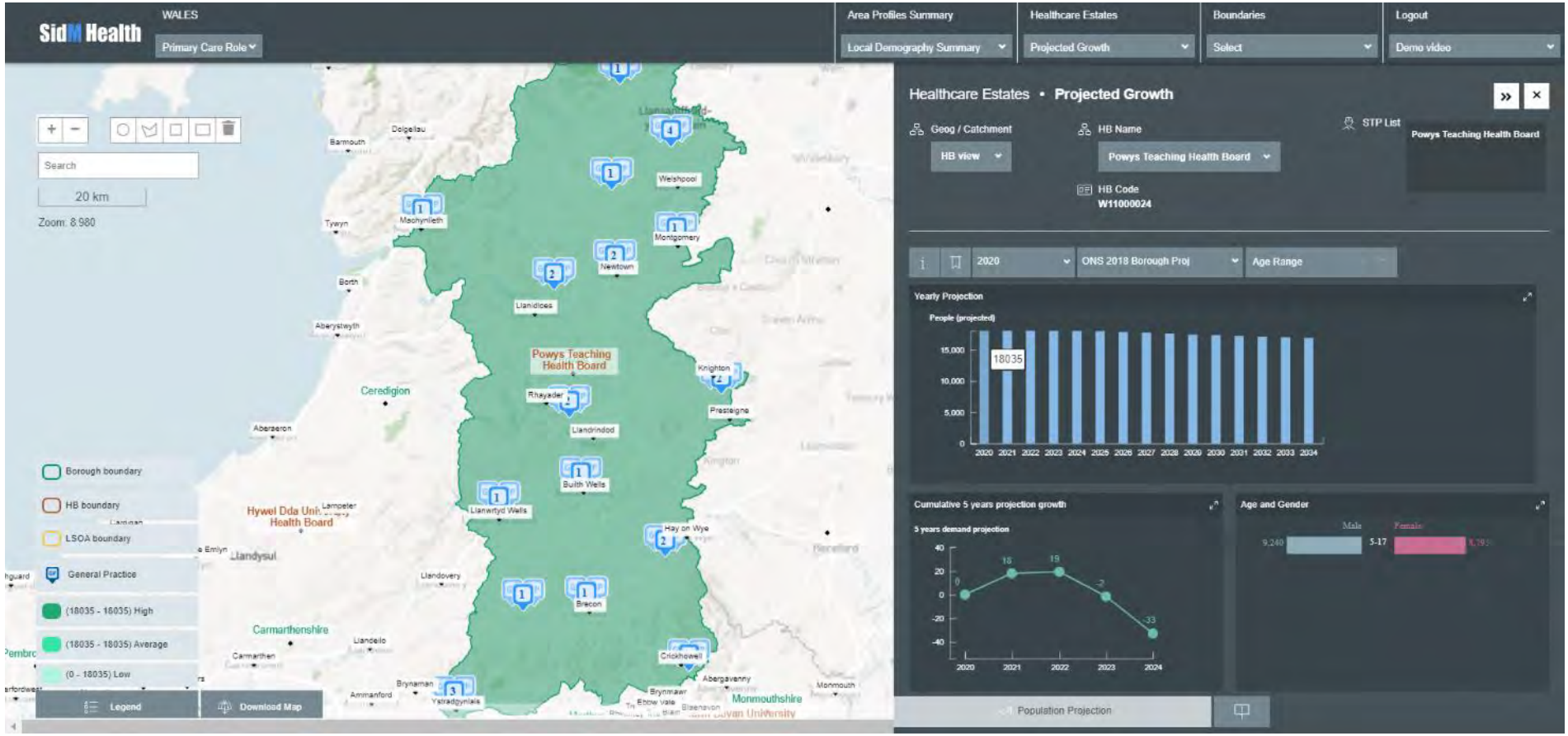
Zoom: 8.980
Powys Teaching Health Board
Ceredigion
Carmarthenshire
Hywel Dda Uni Health Board
Monmouthshire
Borough boundary
HB boundary
LSOA boundary
General Practice
(6000 - 6000) High
(6000 - 6000) Average
(0 - 6000) Low
Legend
Download Map
Healthcare Estates • Projected Growth
Geog / Catchment
HB view
HB Name
Powys Teaching Health Board
HB Code
W11000024
STP List
Powys Teaching Health Board
2020
ONS 2018 Borough Proj
Age Range
Yearly Projection
People (projected)
6000
Cumulative 5 years projection growth
5 years demand projection
Age and Gender
Male
Female
0-4
Population Projection

3.3 Ages 5 – 17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WALES
Primary Care Role
Area Profiles Summary
Local Demography Summary
Healthcare Estates
Projected Growth
Boundaries
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Logout
Demo video
Search
20 km
Zoom: 8.980
Powys Teaching Health Board
Ceredigion
Carmarthenshire
Monmouthshire
Hywel Dda Uni Health Board
Borough boundary
HB boundary
LSOA boundary
General Practice
(18035 - 18035) High
(18035 - 18035) Average
(0 - 18035) Low
Legend
Download Map
Healthcare Estates • Projected Growth
Geog / Catchment
HB view
HB Name
Powys Teaching Health Board
STP List
Powys Teaching Health Board
HB Code
W11000024
2020
ONS 2018 Borough Proj
Age Range
Yearly Projection
People (projected)
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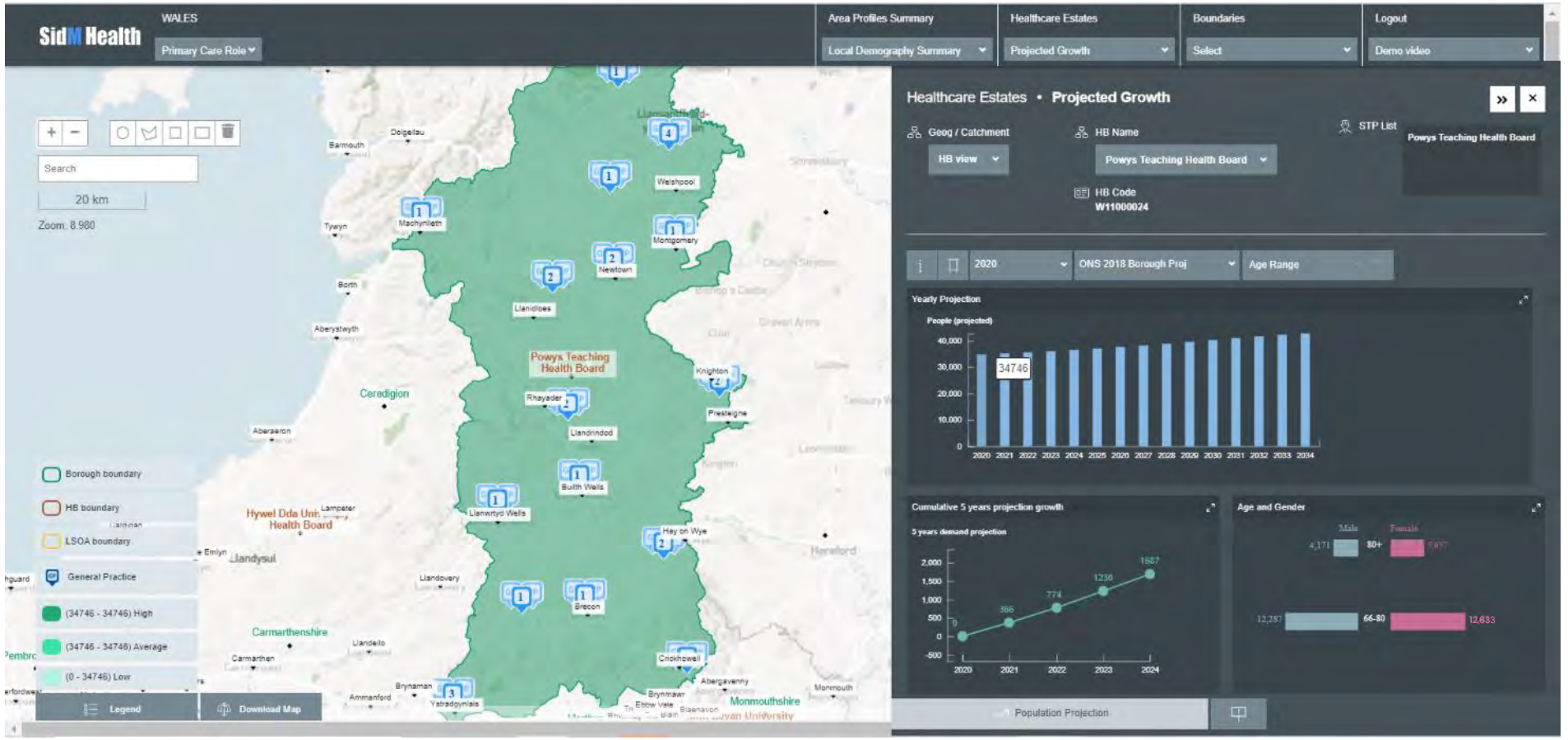
Cumulative 5 years projection growth
5 years demand projection
Age and Gender
Male
Female
5-17
Population Projection

3.4 Ages 66+


SidM Health
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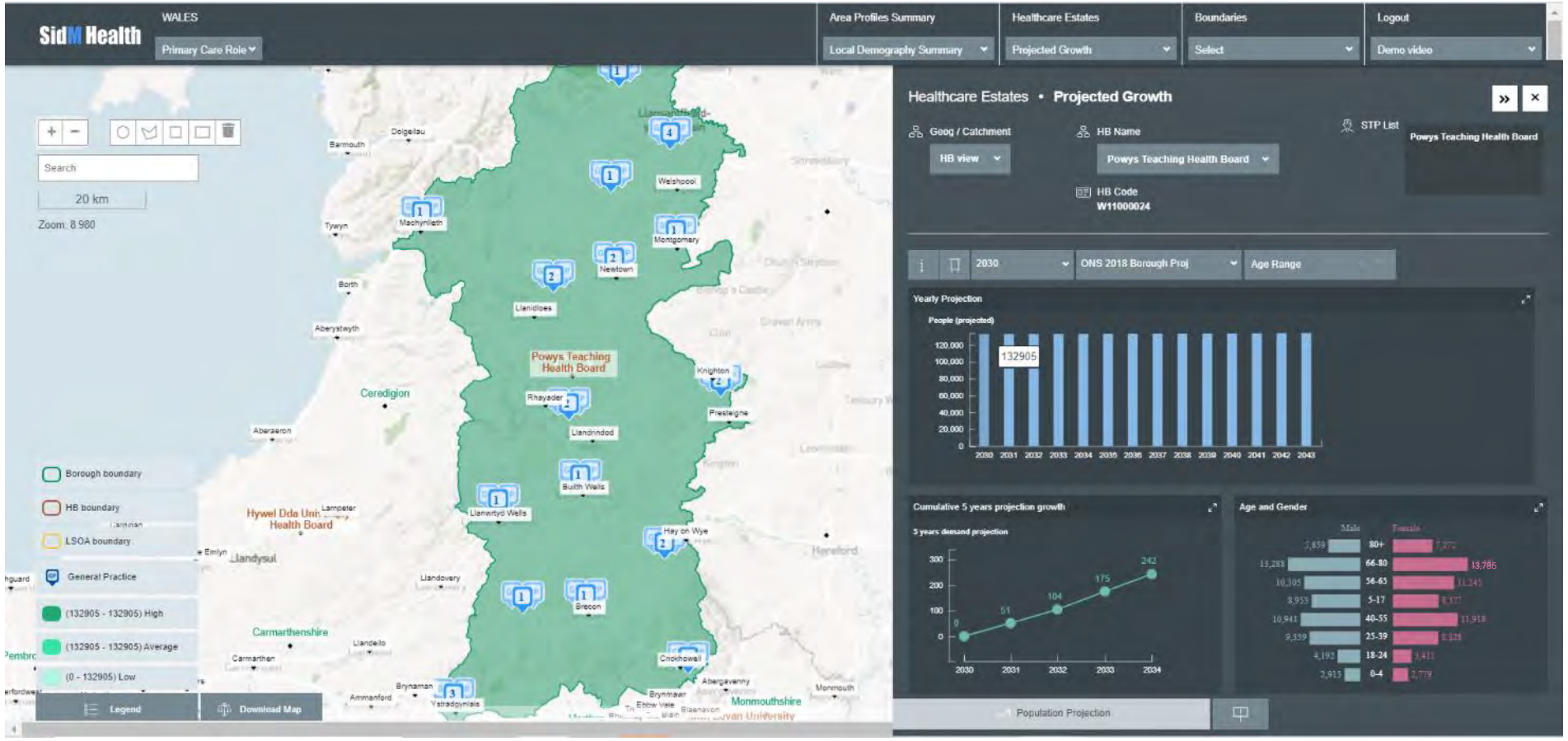
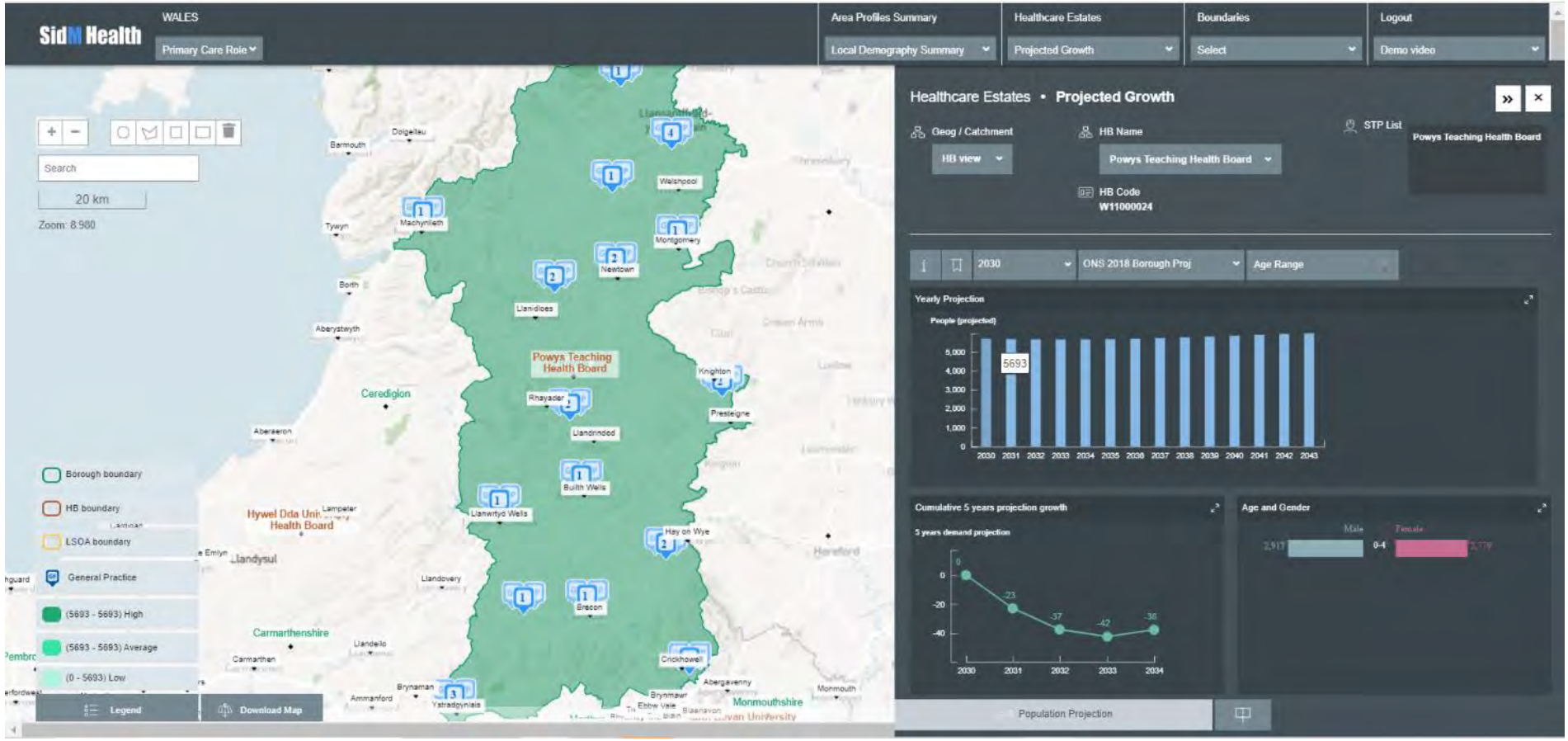
Primary Care Role
Area Profiles Summary
Local Demography Summary
Healthcare Estates
Projected Growth
Boundaries
Select
Logout
Demo video
Healthcare Estates • Projected Growth
Geog / Catchment
HB view
HB Name
Powys Teaching Health Board
STP List
Powys Teaching Health Board
HB Code
W11000024
2020
ONS 2018 Borough Proj
Age Range
Yearly Projection
People (projected)
34746
Cumulative 5 years projection growth
5 years demand projection
Age and Gender
Male
Female
80+
66-80
12,633
Population Projection
Search
20 km
Zoom: 8.980
Borough boundary
HB boundary
LSOA boundary
General Practice
(34746 - 34746) High
(34746 - 34746) Average
(0 - 34746) Low
Legend
Download Map
Powys Teaching Health Board
Ceredigion
Carmarthenshire
Monmouthshire
Hywel Dda Uni Health Board

4 Population Projection 2030, by Local Authority

4.1 All Ages



4.2 Ages 0 – 4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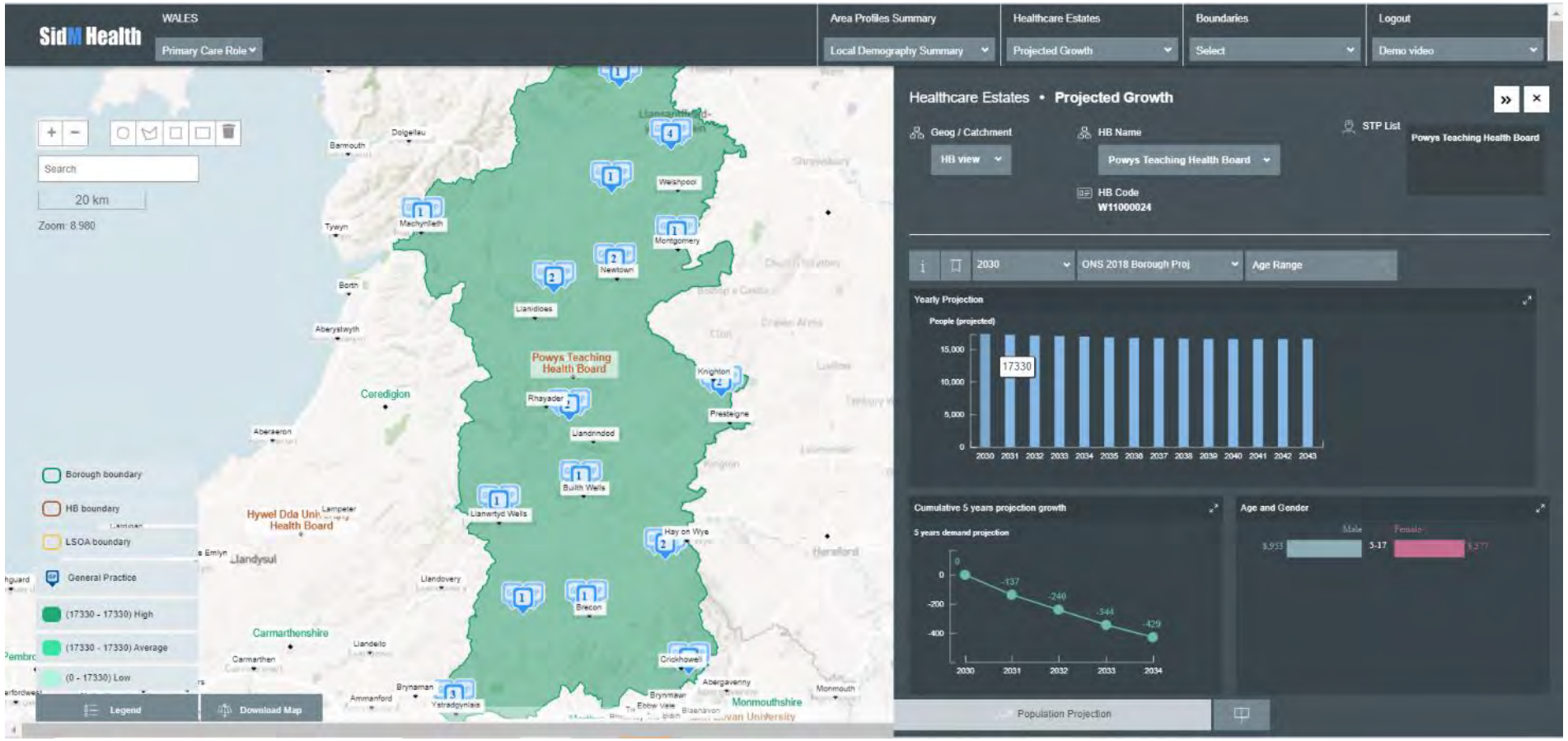
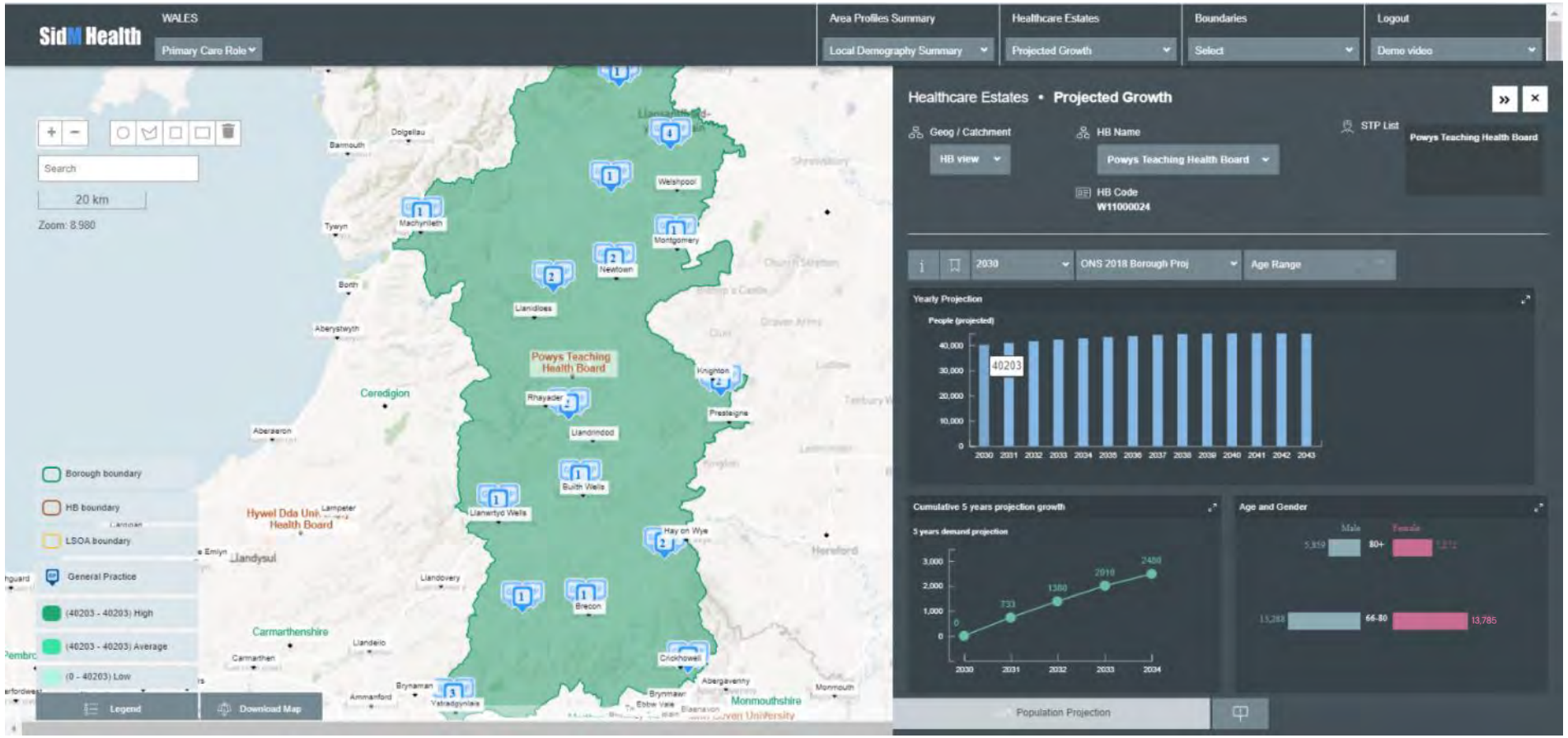
WALES
Primary Care Role
Area Profiles Summary
Local Demography Summary
Healthcare Estates
Projected Growth
Boundaries
Select
Logout
Demo video
Healthcare Estates • Projected Growth
Geog / Catchment
HB view
HB Name
Powys Teaching Health Board
STP List
Powys Teaching Health Board
HB Code
W11000024
2030
ONS 2018 Borough Proj
Age Range
Yearly Projection
People (projected)
5693
Cumulative 5 years projection growth
5 years demand projection
Age and Gender
Male
Female
0-4
Population Projection
Search
20 km
Zoom: 8.980
Borough boundary
HB boundary
LSOA boundary
General Practice
(5693 - 5693) High
(5693 - 5693) Average
(0 - 5693) Low
Legend
Download Map
Powys Teaching Health Board
Ceredigion
Hywel Dda University Health Board
Carmarthenshire
Monmouthshire

4.3 Ages 5 – 17

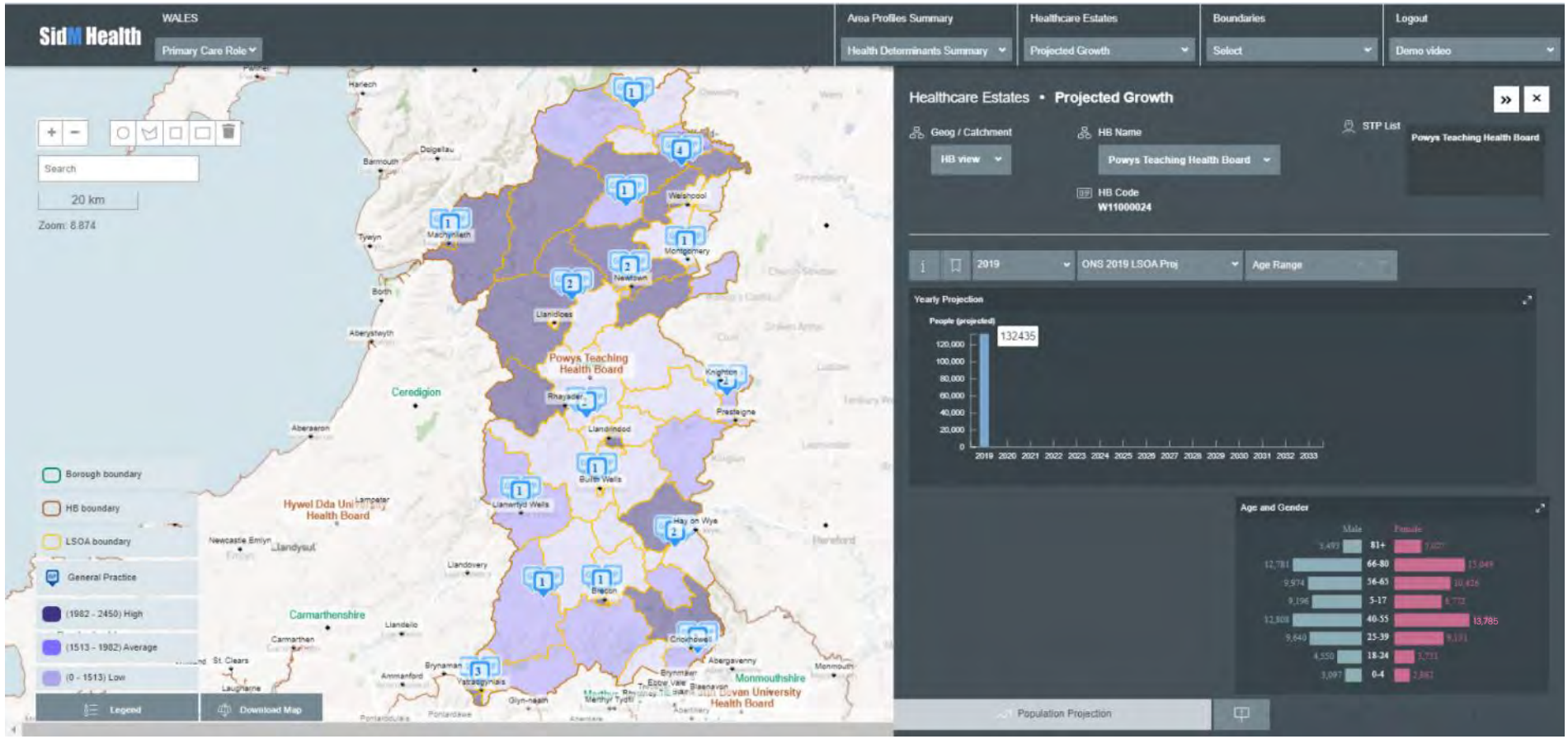

SidM Health
WALES
Primary Care Role
Area Profiles Summary
Local Demography Summary
Healthcare Estates
Projected Growth
Boundaries
Select
Logout
Demo video
Search
20 km
Zoom: 8.980
Borough boundary
HB boundary
LSOA boundary
General Practice
(17330 - 17330) High
(17330 - 17330) Average
(0 - 17330) Low
Legend
Download Map
Powys Teaching Health Board
Hywel Dda University Health Board
Ceredigion
Carmarthenshire
Monmouthshire
Healthcare Estates • Projected Growth
Geog / Catchment
HB view
HB Name
Powys Teaching Health Board
HB Code
W11000024
STP List
Powys Teaching Health Board
2030
ONS 2018 Borough Proj
Age Range
Yearly Projection
People (projected)
17330
Cumulative 5 years projection growth
5 years demand projection
-137
-240
-344
-429
Age and Gender
Male
Female
5-17
Population Projection

4.4 Ages 66+

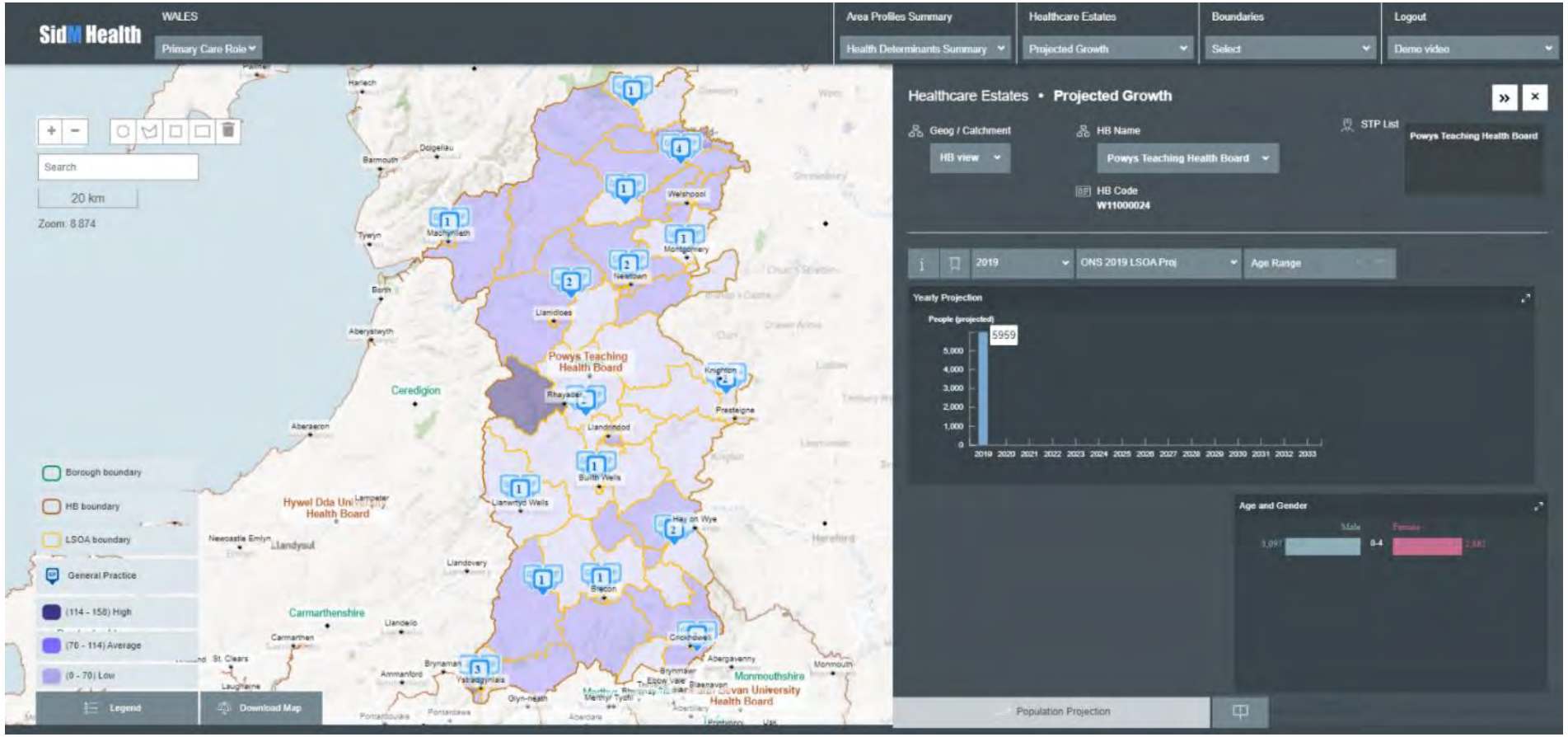

SidM Health
WALES
Primary Care Role
Area Profiles Summary
Local Demography Summary
Healthcare Estates
Projected Growth
Boundaries
Select
Logout
Demo video
Search
20 km
Zoom: 8.980
Powys Teaching Health Board
Hywel Dda Uni Health Board
Ceredigion
Carmarthenshire
Monmouthshire
Borough boundary
HB boundary
LSOA boundary
General Practice
(40203 - 40203) High
(40203 - 40203) Average
(0 - 40203) Low
Legend
Download Map
Healthcare Estates • Projected Growth
Geog / Catchment
HB view
HB Name
Powys Teaching Health Board
HB Code
W11000024
STP List
Powys Teaching Health Board
2030
ONS 2018 Borough Proj
Age Range
Yearly Projection
People (projected)
40203
Cumulative 5 years projection growth
5 years demand projection
733
1380
2010
2480
Age and Gender
Male
Female
80+
66-80
13,785
Population Projection

5 Population Projection by LSOAs

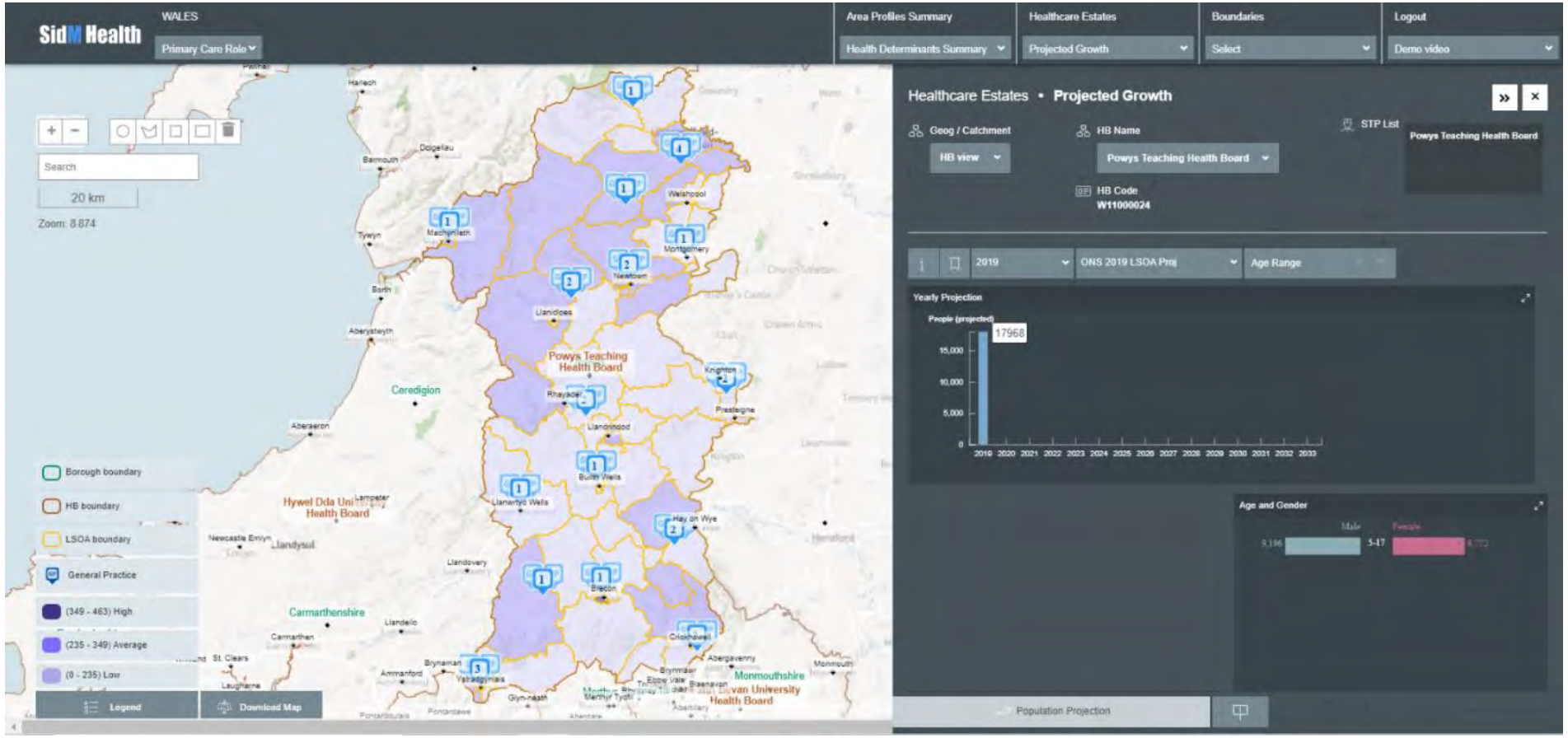
5.1 All Ages



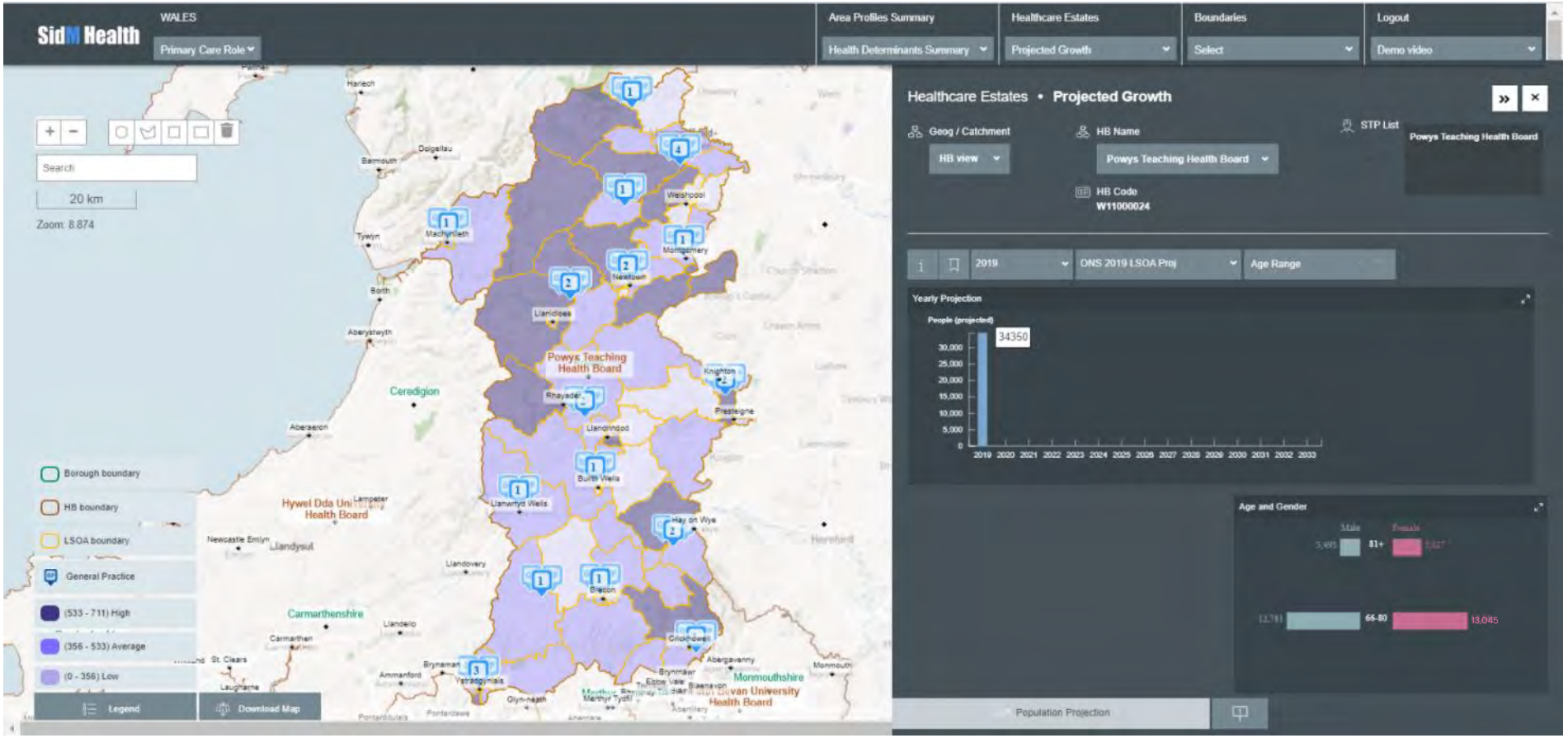
5.2 Ages 0 – 4


SidM Health
WALES
Primary Care Role
Area Profiles Summary
Health Determinants Summary
Healthcare Estates
Projected Growth
Boundaries
Select
Logout
Demo video
Healthcare Estates • Projected Growth
Geog / Catchment
HB view
HB Name
Powys Teaching Health Board
STP List
Powys Teaching Health Board
HB Code
W11000024
2019
ONS 2019 LSOA Proj
Age Range
Yearly Projection
People (projected)
5959
Age and Gender
Male
Female
0-4
Population Projection
Search
20 km
Zoom: 8.874
Powys Teaching Health Board
Ceredigion
Carmarthenshire
Monmouthshire
Hywel Dda University Health Board
Borough boundary
HB boundary
LSOA boundary
General Practice
(114 - 158) High
(70 - 114) Average
(0 - 70) Low
Legend
Download Map

5.3 Ages 5 – 17


SidM Health
WALES
Primary Care Role
Area Profiles Summary
Health Determinants Summary
Healthcare Estates
Projected Growth
Boundaries
Select
Logout
Demo video
Healthcare Estates • Projected Growth
Geog / Catchment
HB view
HB Name
Powys Teaching Health Board
STP List
Powys Teaching Health Board
HB Code
W11000024
2019
ONS 2019 LSOA Proj
Age Range
Yearly Projection
People (projected)
17968
Age and Gender
Male
Female
5-17
Population Projection
Search
20 km
Zoom: 8.874
Powys Teaching Health Board
Ceredigion
Carmarthenshire
Monmouthshire
Hywel Dda University Health Board
Borough boundary
HB boundary
LSOA boundary
General Practice
(349 - 463) High
(235 - 349) Average
(0 - 235) Low
Legend
Download Map

5.4 Ages 66+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Primary Care Role
Area Profiles Summary
Health Determinants Summary
Healthcare Estates
Projected Growth
Boundaries
Select
Logout
Demo video
Search
20 km
Zoom: 8.874
Powys Teaching Health Board
Ceredigion
Carmarthenshire
Monmouthshire
Hywel Dda University Health Board
Swansea University Health Board
Borough boundary
HB boundary
LSOA boundary
General Practice
(533 - 711) High
(356 - 533) Average
(0 - 356) Low
Legend
Download Map
Healthcare Estates • Projected Growth
Geog / Catchment
HB view
HB Name
Powys Teaching Health Board
HB Code
W11000024
STP List
Powys Teaching Health Board
2019
ONS 2019 LSOA Proj
Age Range
Yearly Projection
People (projected)
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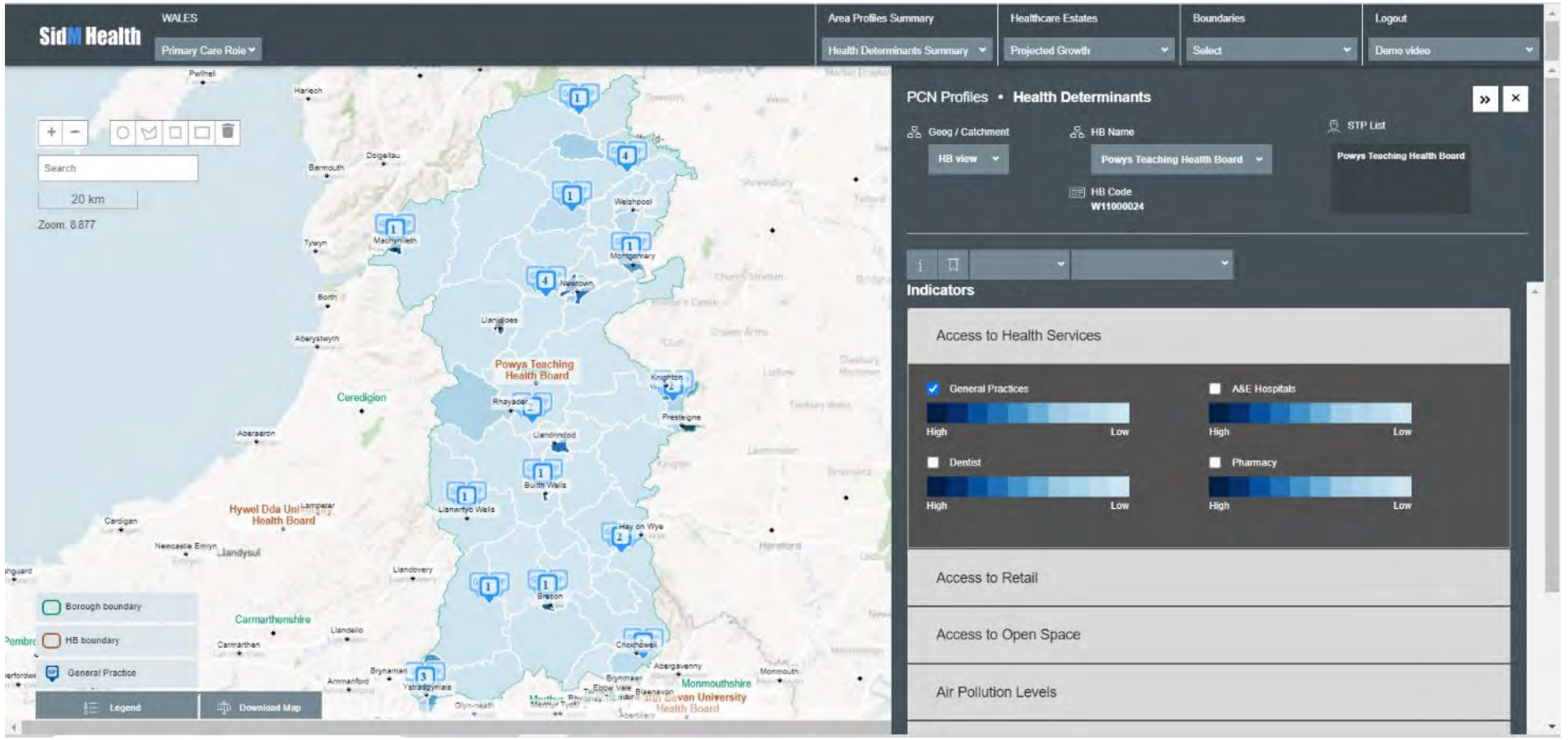
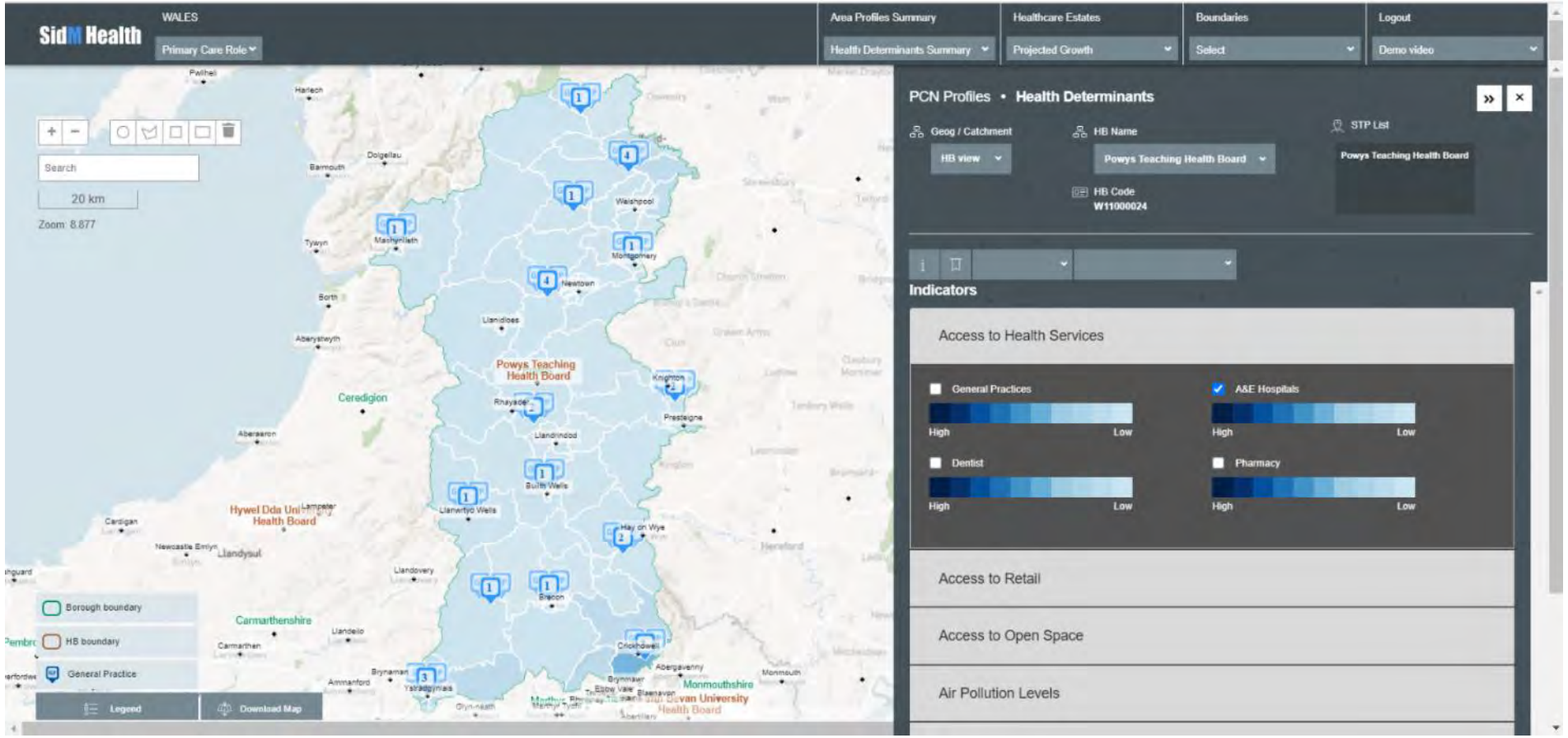
Age and Gender
Male
Female
81+
66-80
13,045
Population Projection

6 Access

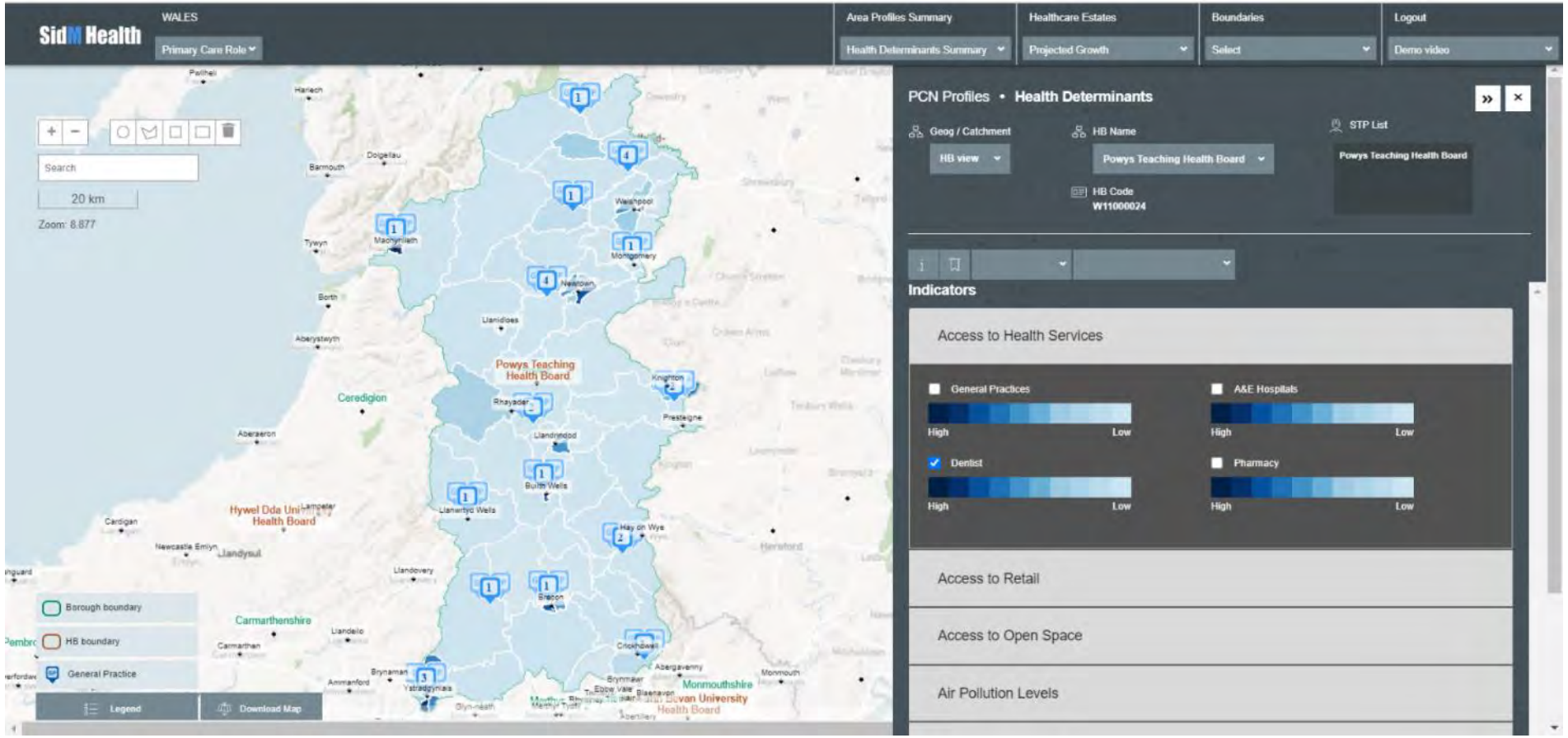
6.1 General Practices



6.2 A&E Hospitals



6.3 Dentists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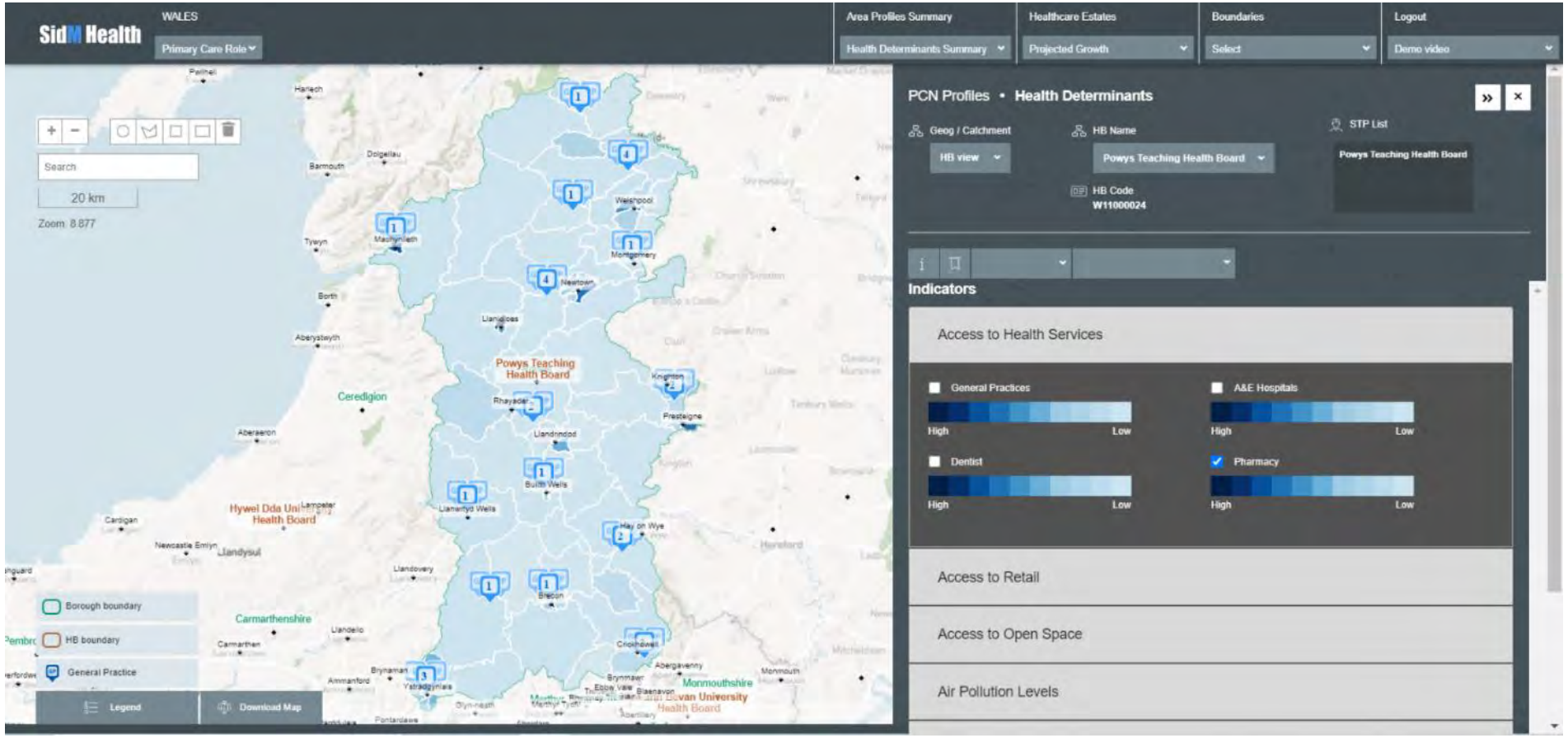
WALES
Primary Care Role
Area Profiles Summary
Health Determinants Summary
Healthcare Estates
Projected Growth
Boundaries
Select
Logout
Demo video
PCN Profiles • Health Determinants
Geog / Catchment
HB view
HB Name
Powys Teaching Health Board
STP List
Powys Teaching Health Board
HB Code
W11000024
Indicators
Access to Health Services
General Practices
A&E Hospitals
Dentist
Pharmacy
High
Low
Access to Retail
Access to Open Space
Air Pollution Levels
Search
20 km
Zoom: 8.877
Powys Teaching Health Board
Hywel Dda Uni Health Board
Ceredigion
Carmarthenshire
Monmouthshire
Borough boundary
HB boundary
General Practice
Legend
Download Map

6.4 Pharmacy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WALES
Primary Care Role
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Health Determinants Summary
Healthcare Estates
Projected Growth
Boundaries
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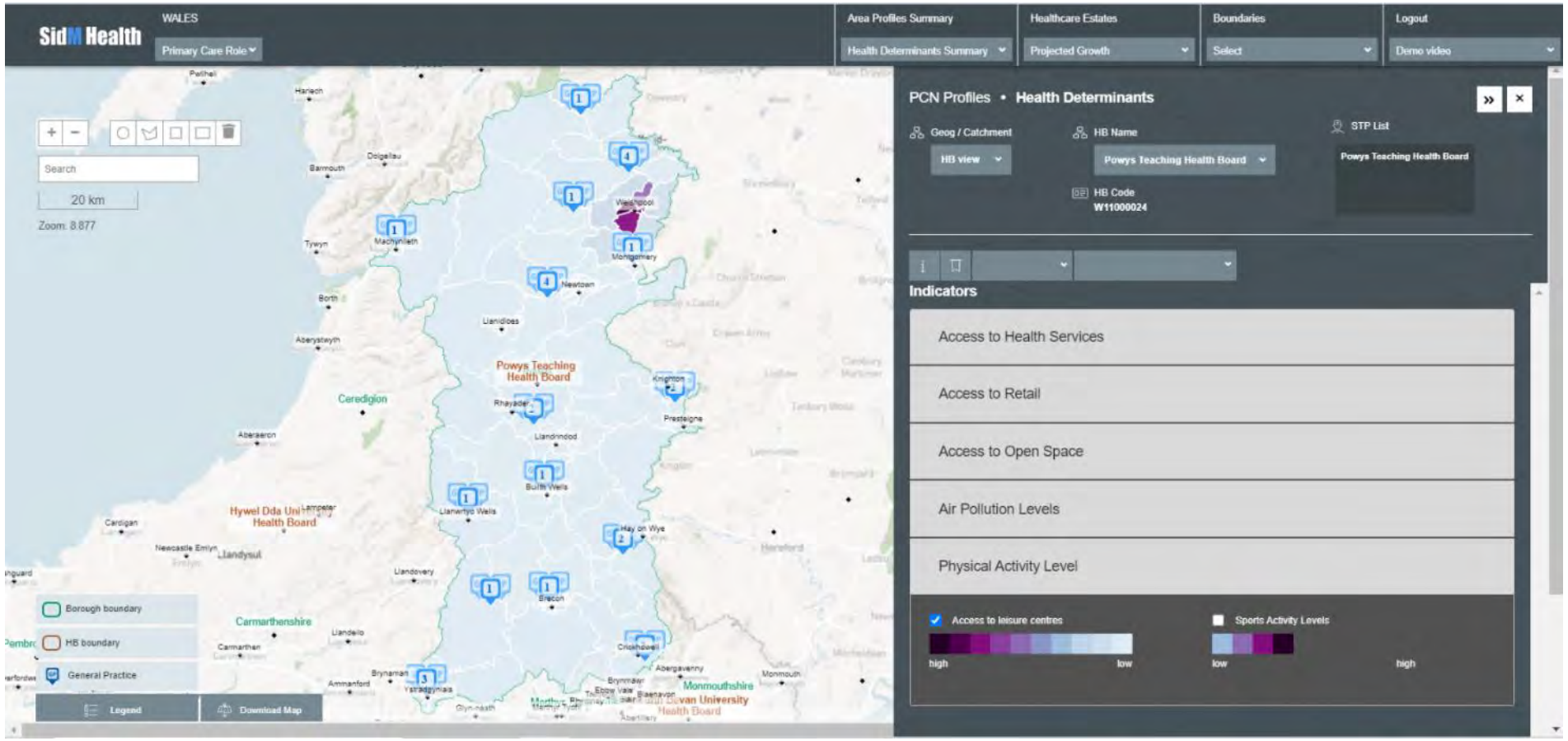
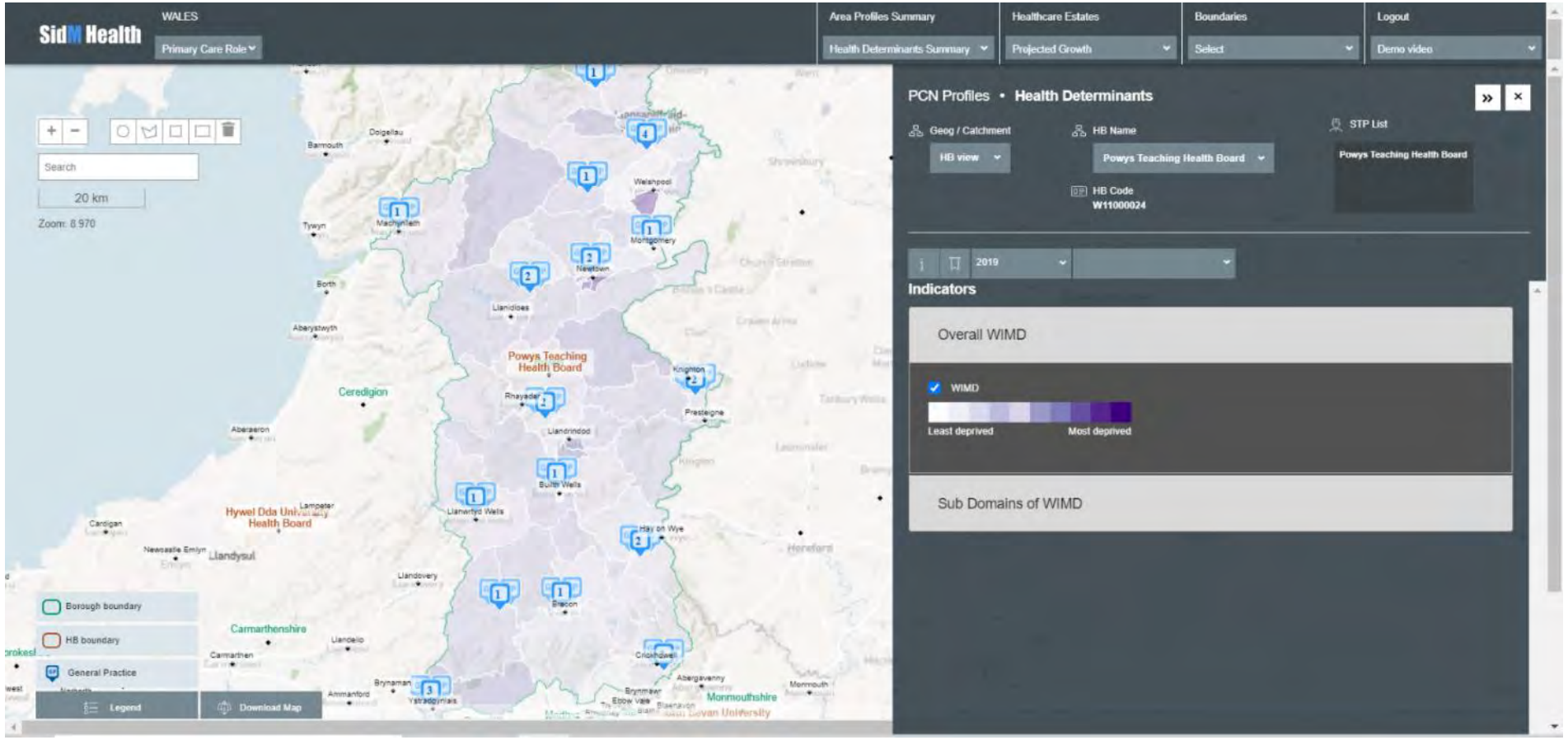
Logout
Demo video
PCN Profiles • Health Determinants
Geog / Catchment
HB view
HB Name
Powys Teaching Health Board
STP List
Powys Teaching Health Board
HB Code
W11000024
Indicators
Access to Health Services
General Practices
A&E Hospitals
Dentist
Pharmacy
High
Low
Access to Retail
Access to Open Space
Air Pollution Levels
Search
20 km
Zoom: 8.877
Powys Teaching Health Board
Ceredigion
Carmarthenshire
Hywel Dda University Health Board
Monmouthshire
Borough boundary
HB boundary
General Practice
Legend
Download Map

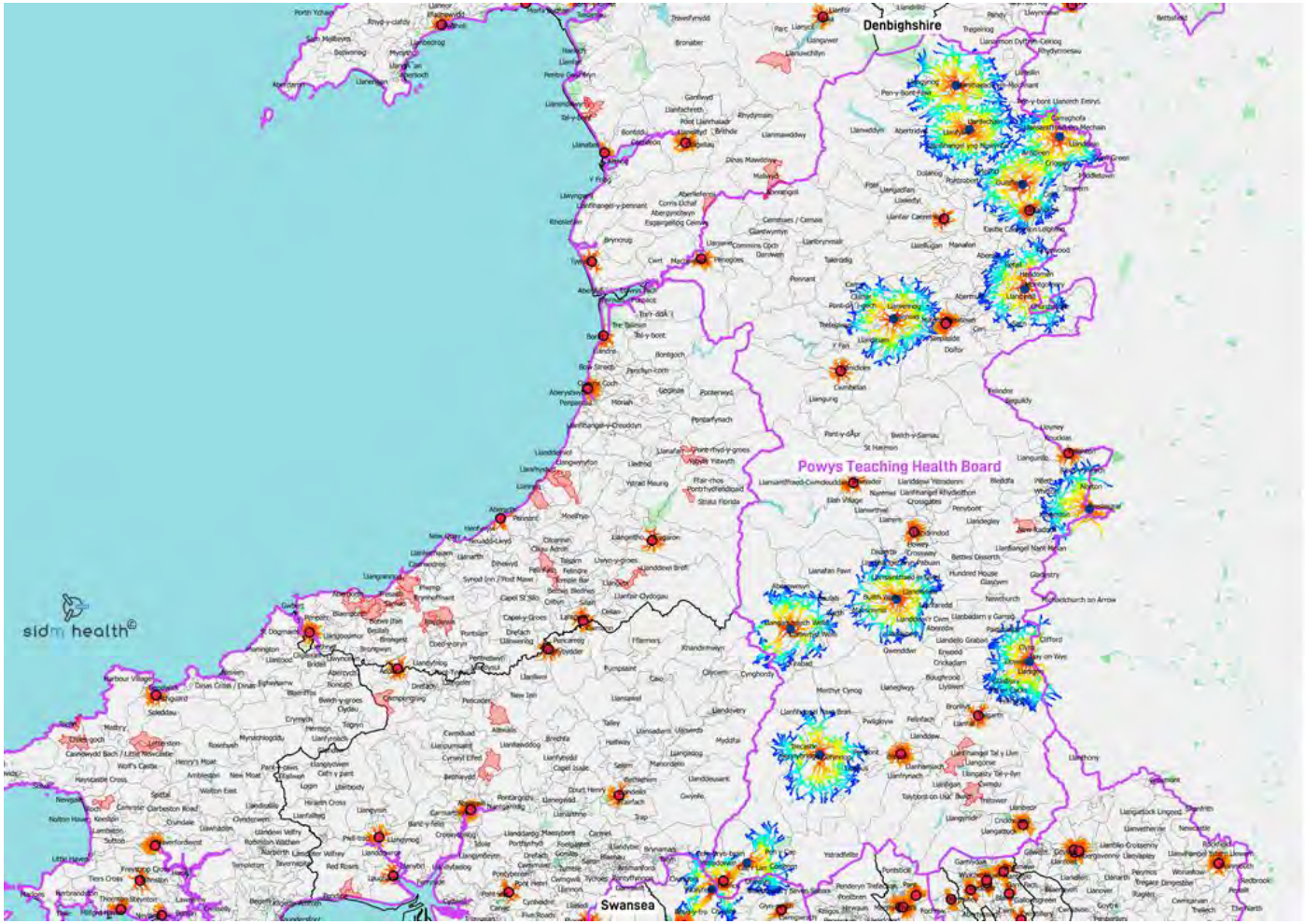
6.5 Leisure Centres



7 Overall Deprivation Score



8 Travel Distances



General Practices (Rural and Urban)
Accessibility analysis
Health board level

Powys Health Board-
Some residential areas do not have good access to primary care.

- GP (town-centre)
- GP (suburban or rural)
- Local health boards
- Unitary authorities
- Census 2011 Output areas
- Census 2011 Outputs areas (residential) with poor accessibility

8km catchment analysis

- 0 - 800.0
- 800.0 - 1600.0
- 1600.0 - 2400.0
- 2400.0 - 3200.0
- 3200.0 - 4000.0 (5 min drive)
- 4000.0 - 4800.0
- 4800.0 - 5600.0
- 5600.0 - 6400.0
- 6400.0 - 7200.0
- 7200.0 - 8000 (10 min drive)

Archus

The healthcare infrastructure specialist

Appendix C7 – Swansea Bay University Health Board mapping

May 2021

Contents

1 Introduction

1.1 Demographic observations

Review of the Demographic profile below shows that there have been high levels of growth over recent years. This growth is shown in the 25-55 years age group and 5-17 years begins to increase from 2021. The numbers of people over 66 years of age shows has increased; this will continue with a notable rise in the numbers of people over 80 years of age.

In 2021 the numbers of 0-4 years have reduced but then will show a gradual increase. This increase is not higher than it has been previously.

People within different age groups can also be seen in different concentrations of high to low numbers within the Health Boards profile; this can be overlaid by assessing deprivation indexes to assess overall population needs. It is noted that the deprivation index is high in some areas which will assist future planning for different types of healthcare to be delivered in the right areas, for instance, areas with high levels of young people will differ than those where concentrations of elderly populations over 80 years can be seen.

1.2 Patient Need

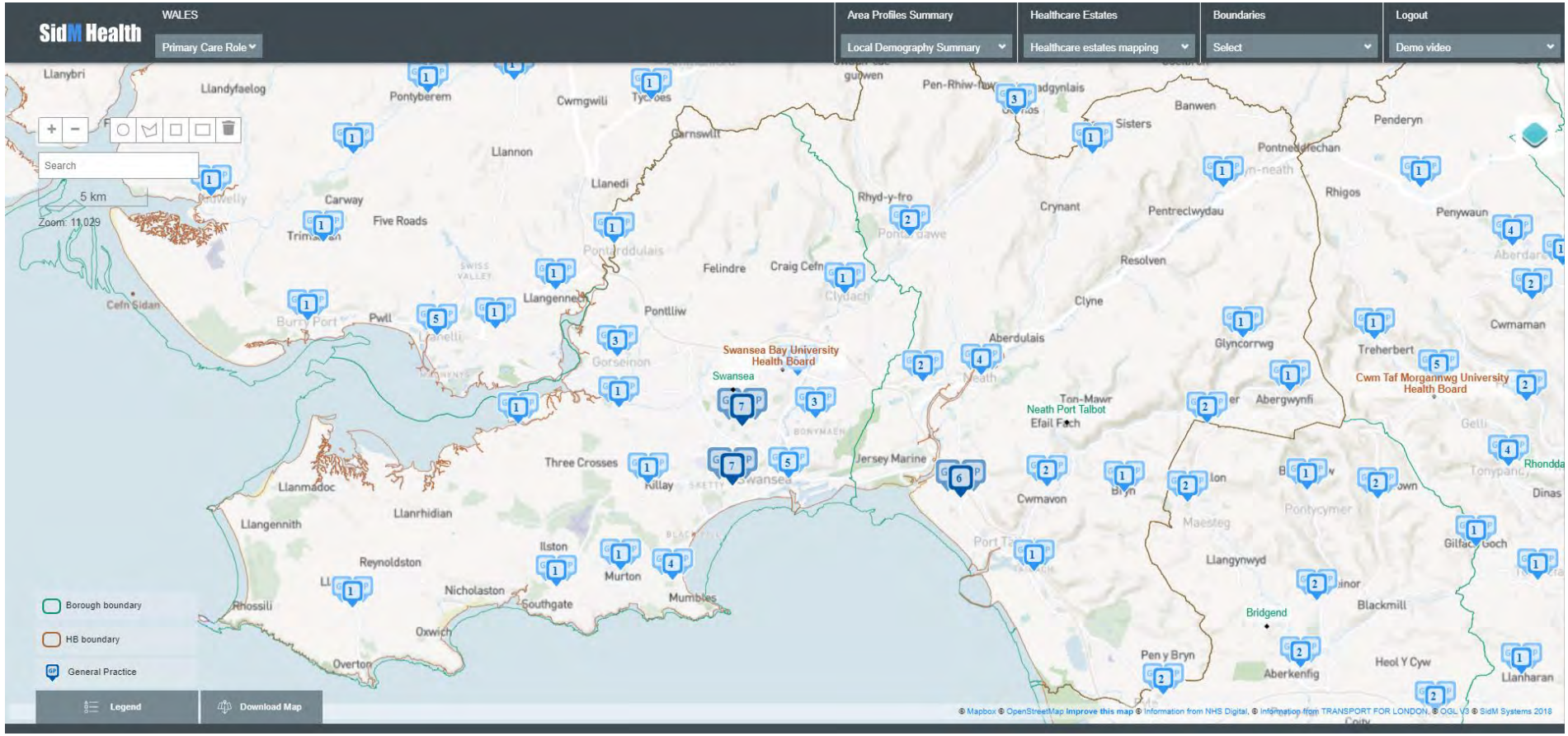
Since the population in areas of the Health Board has grown and the numbers of aging patients who have a higher requirement for health services has increased, there will be a growing impact on primary care in these areas. Several key observations for the Health Board can be seen:

- The numbers of people aged 66+ will continue to increase for the next 20 years. It is noticeable in future projections that the numbers of people over 80 years of age increases.
- Deprivation scores across the area are average but where deprivation scores are higher future service requirements may be assessed by overlapping the age profile.
- The numbers of 0-4 years will gradually increase after 2021. New housing development planning will be linked to further growth projections.
- The concentrated growth areas of older people are generally where there is a lower access to the wider health provision limiting access to secondary prevention to support people's higher people's physical, mental, and social needs.

1.3 Mapping and statistics

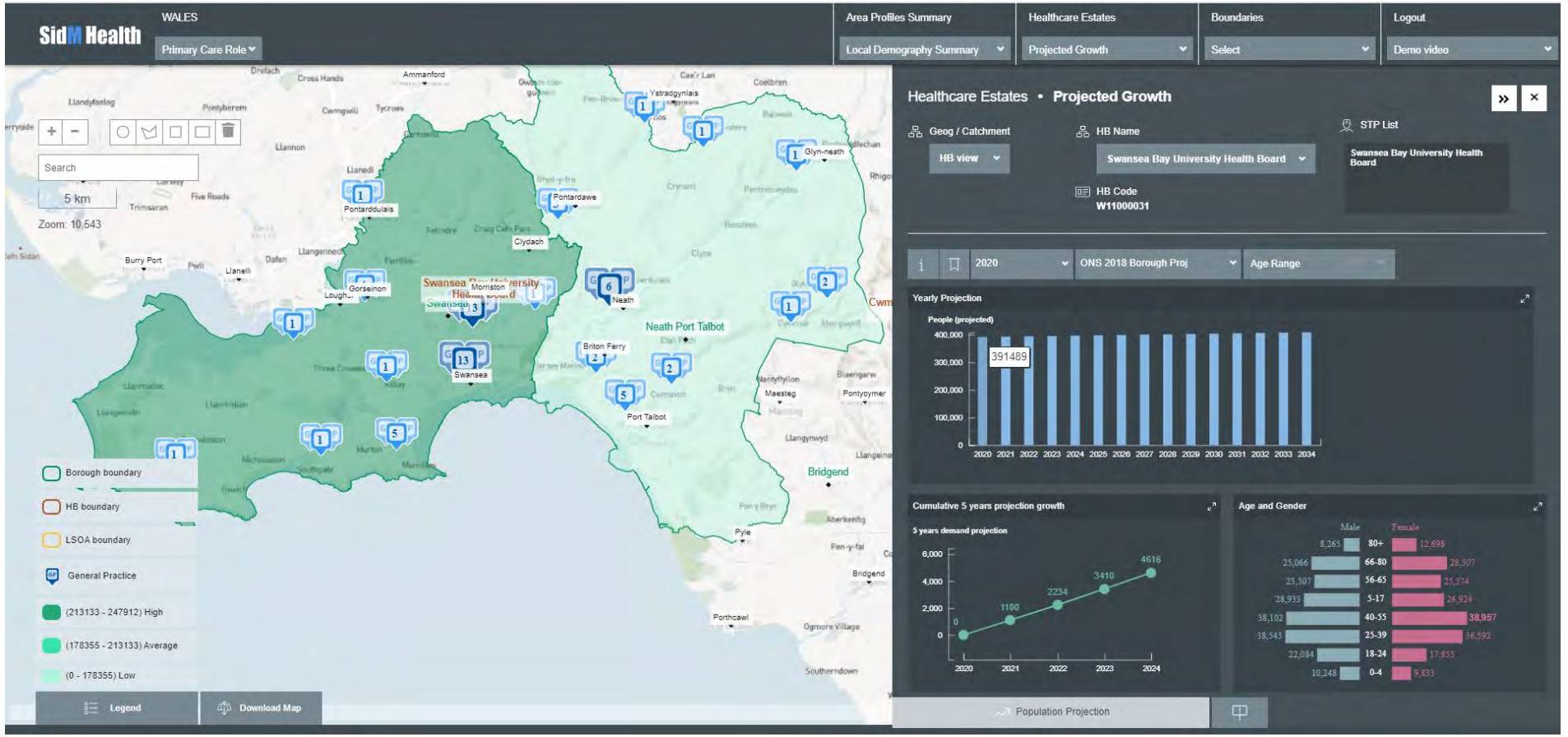
The maps below give a detailed view of the current and future population growth by age. Areas of population concentration can be identified via the heat maps, as well as access to services such as, General Practice, acute units, wider health service needs and leisure. Overall deprivation by borough is displayed against General Practice provision in section 7. Distance of travel to General Practices are demonstrated on the final map, in section 8, via an 8km catchment area.

2 General Practice Location Map

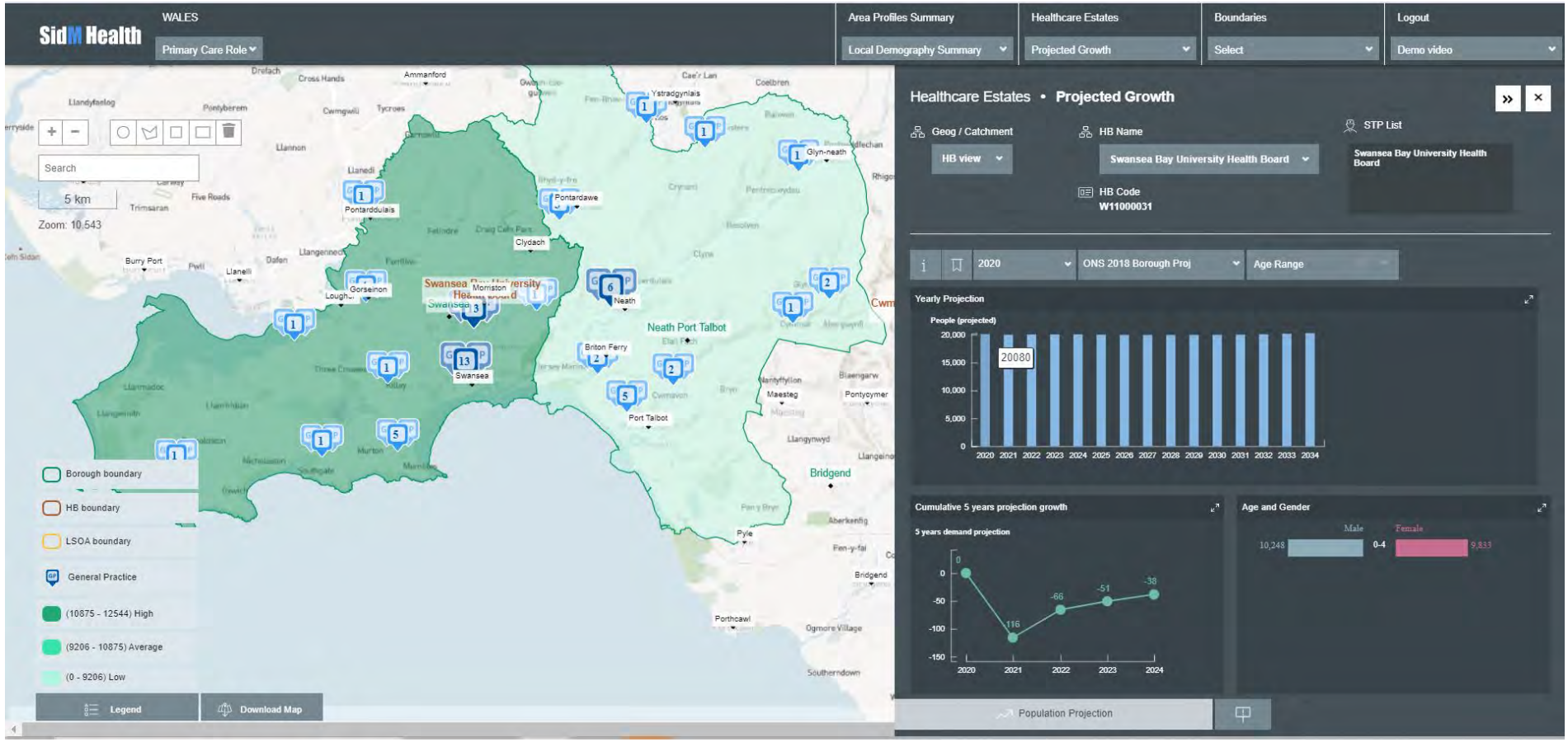


3 Population Projection by Local Authority 2020

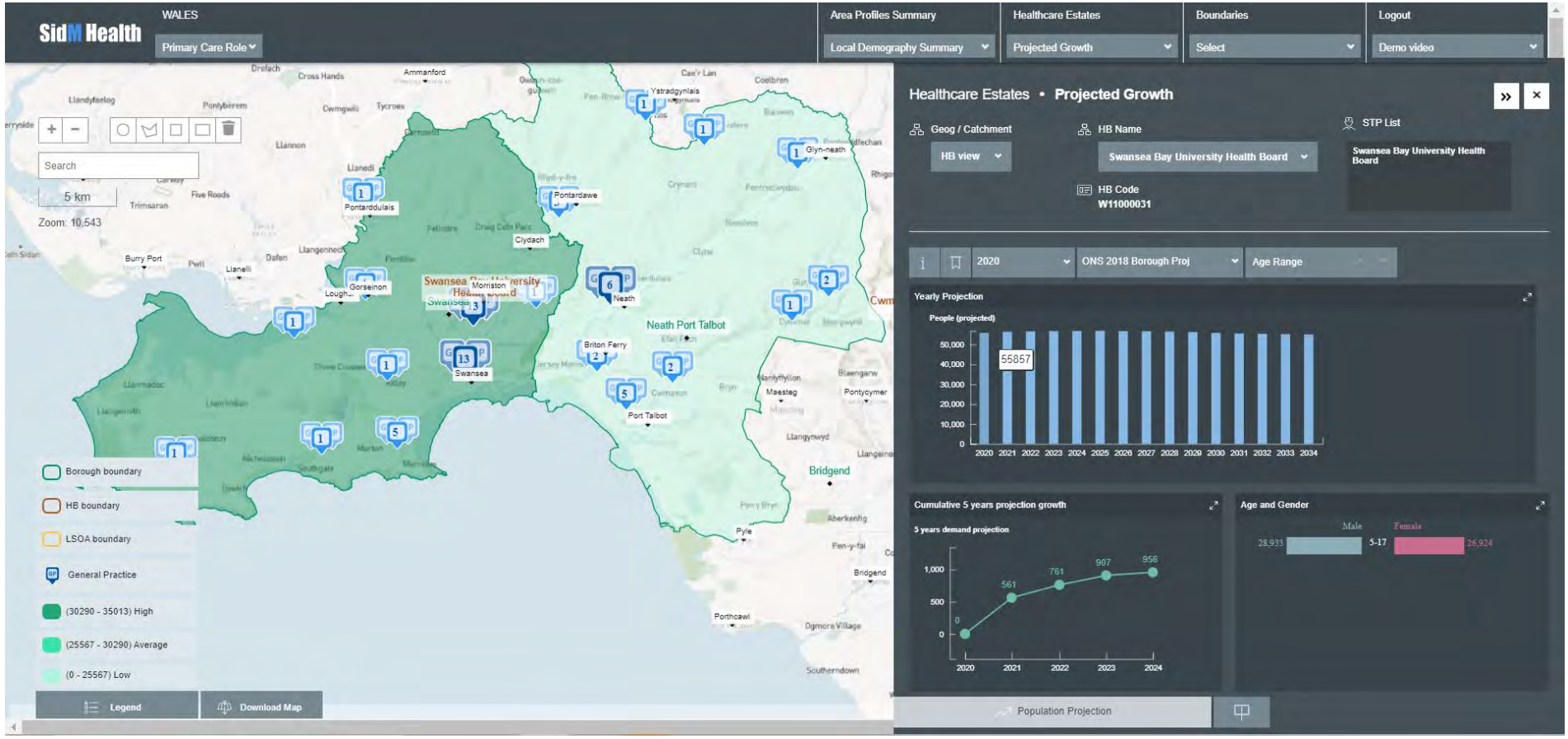
3.1 All Ages



3.2 Ages 0 – 4


SidM Health
WALES
Primary Care Role
Area Profiles Summary
Local Demography Summary
Healthcare Estates
Projected Growth
Boundaries
Select
Logout
Demo video
Search
5 km
Zoom: 10.543
Borough boundary
HB boundary
LSOA boundary
General Practice
(10875 - 12544) High
(9206 - 10875) Average
(0 - 9206) Low
Legend
Download Map
Healthcare Estates • Projected Growth
Geog / Catchment
HB view
HB Name
Swansea Bay University Health Board
HB Code
W11000031
STP List
Swansea Bay University Health Board
2020
ONS 2018 Borough Proj
Age Range
Yearly Projection
People (projected)
20080
Cumulative 5 years projection growth
5 years demand projection
Age and Gender
Male
Female
10,248
0-4
9,833
Population Projection

3.3 Ages 5 – 17


SidM Health
WALES
Primary Care Role
Area Profiles Summary
Local Demography Summary
Healthcare Estates
Projected Growth
Boundaries
Select
Logout
Demo video
Search
5 km
Zoom: 10.543
Borough boundary
HB boundary
LSOA boundary
General Practice
(30290 - 35013) High
(25567 - 30290) Average
(0 - 25567) Low
Legend
Download Map
Healthcare Estates • Projected Growth
Geog / Catchment
HB view
HB Name
Swansea Bay University Health Board
HB Code
W11000031
STP List
Swansea Bay University Health Board
2020
ONS 2018 Borough Proj
Age Range
Yearly Projection
People (projected)
55857
Cumulative 5 years projection growth
5 years demand projection
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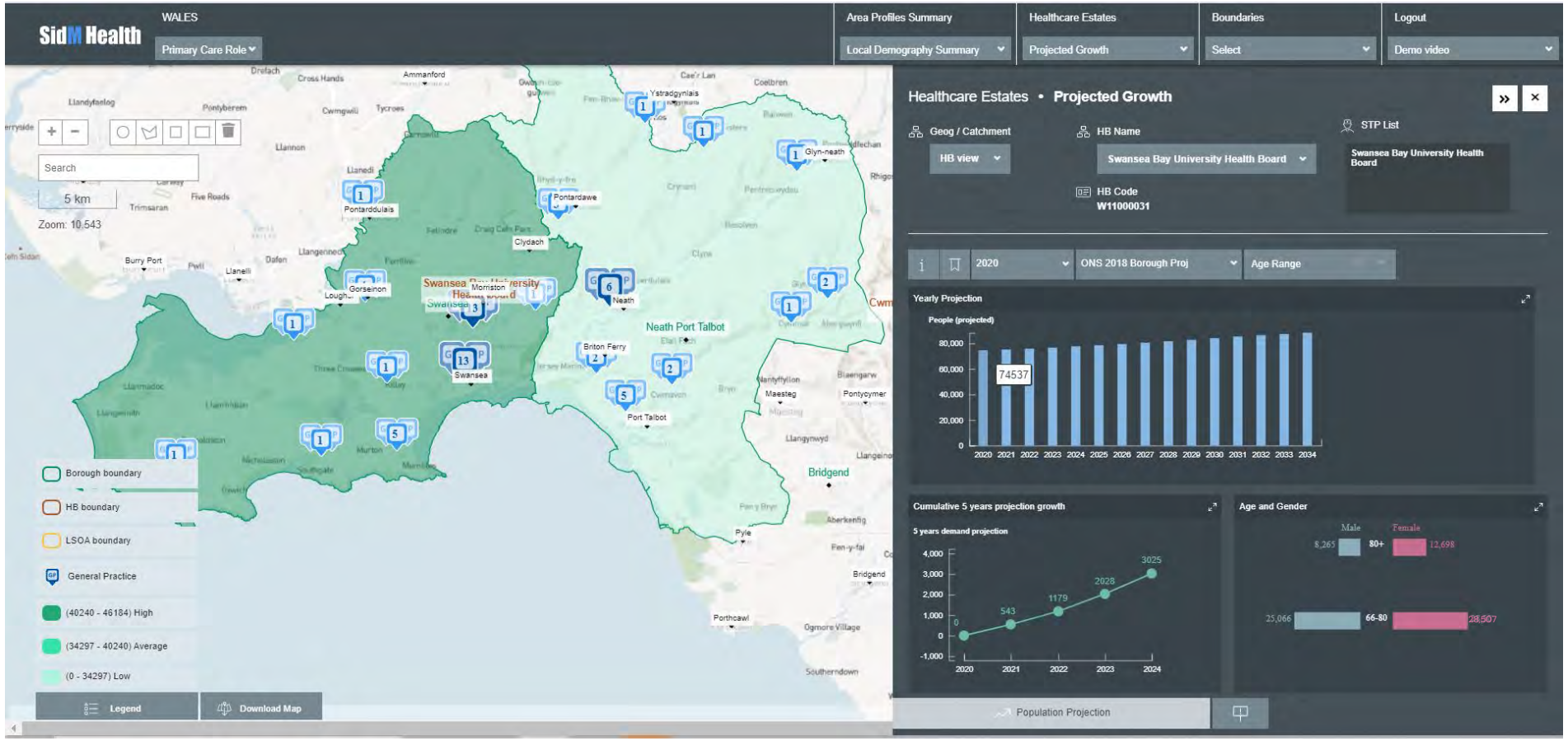
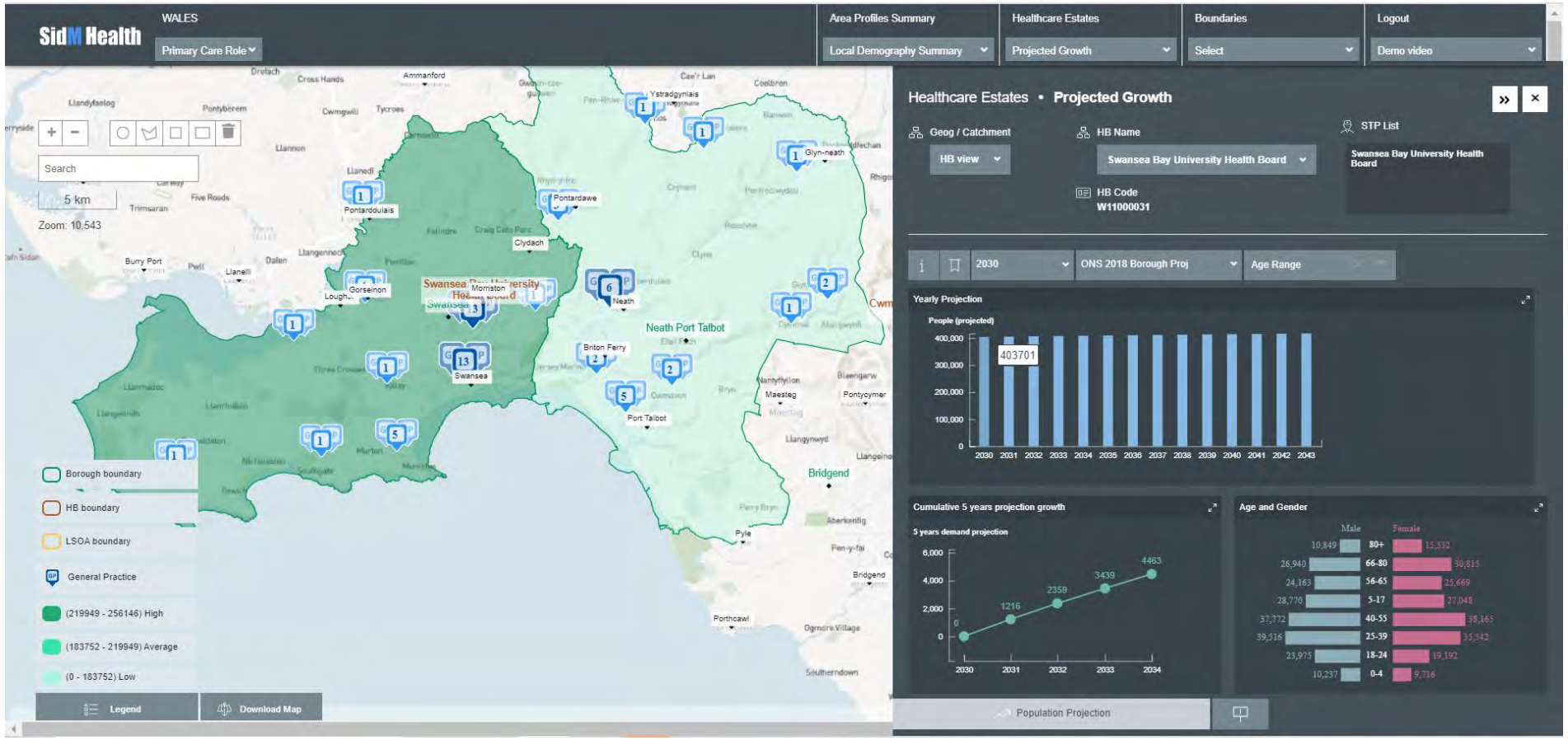
761
907
956
Age and Gender
Male
Female
28,933
5-17
26,924
Population Projection

3.4 Ages 66+

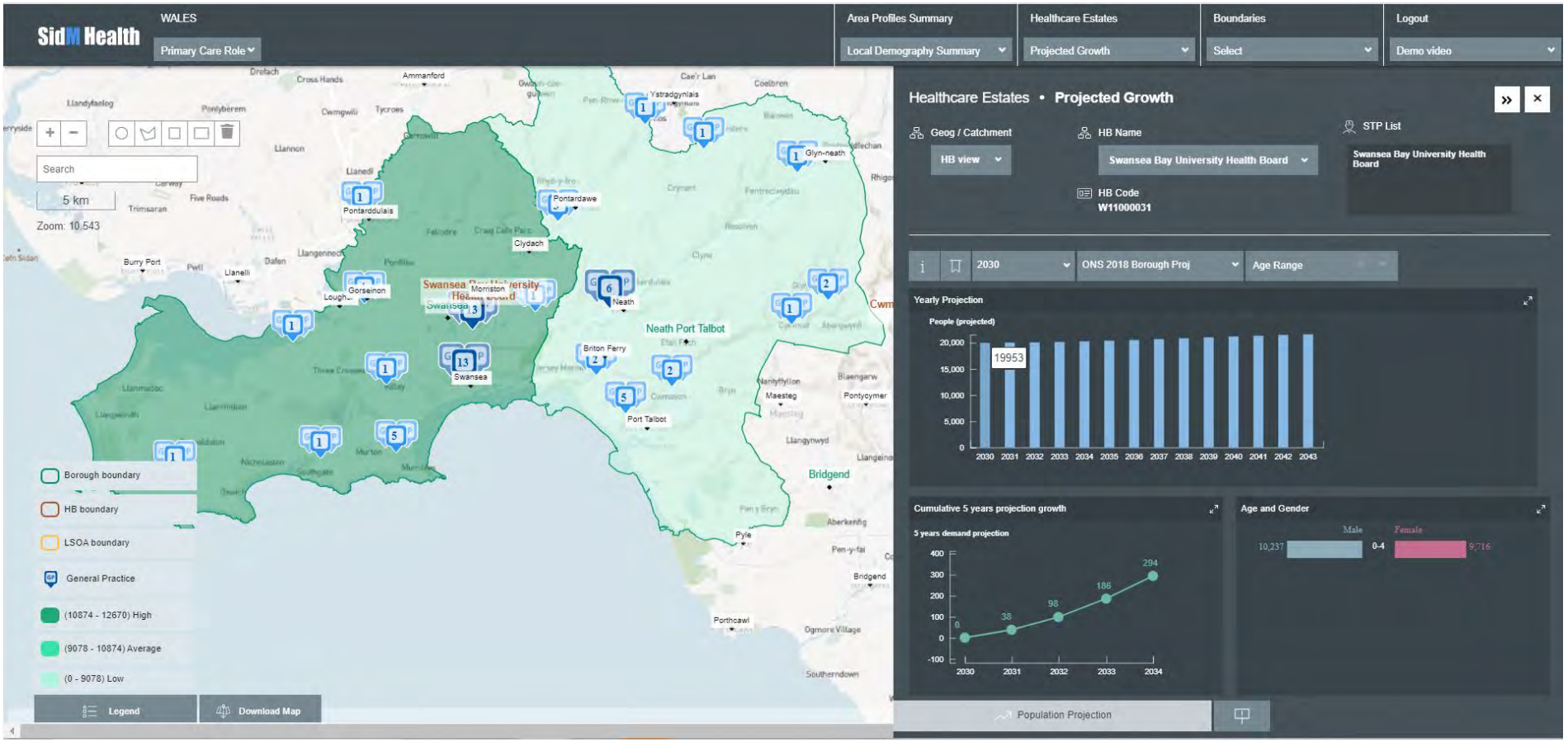

SidM Health
WALES
Primary Care Role
Area Profiles Summary
Local Demography Summary
Healthcare Estates
Projected Growth
Boundaries
Select
Logout
Demo video
Search
5 km
Zoom: 10.543
Borough boundary
HB boundary
LSOA boundary
General Practice
(40240 - 46184) High
(34297 - 40240) Average
(0 - 34297) Low
Legend
Download Map
Healthcare Estates • Projected Growth
Geog / Catchment
HB view
HB Name
Swansea Bay University Health Board
HB Code
W11000031
STP List
Swansea Bay University Health Board
2020
ONS 2018 Borough Proj
Age Range
Yearly Projection
People (projected)
74537
Cumulative 5 years projection growth
5 years demand projection
543
1179
2028
3025
Age and Gender
Male
Female
8,265
80+
12,698
25,066
66-80
28,507
Population Projection

4 Population Projection 2030, by Local Authority

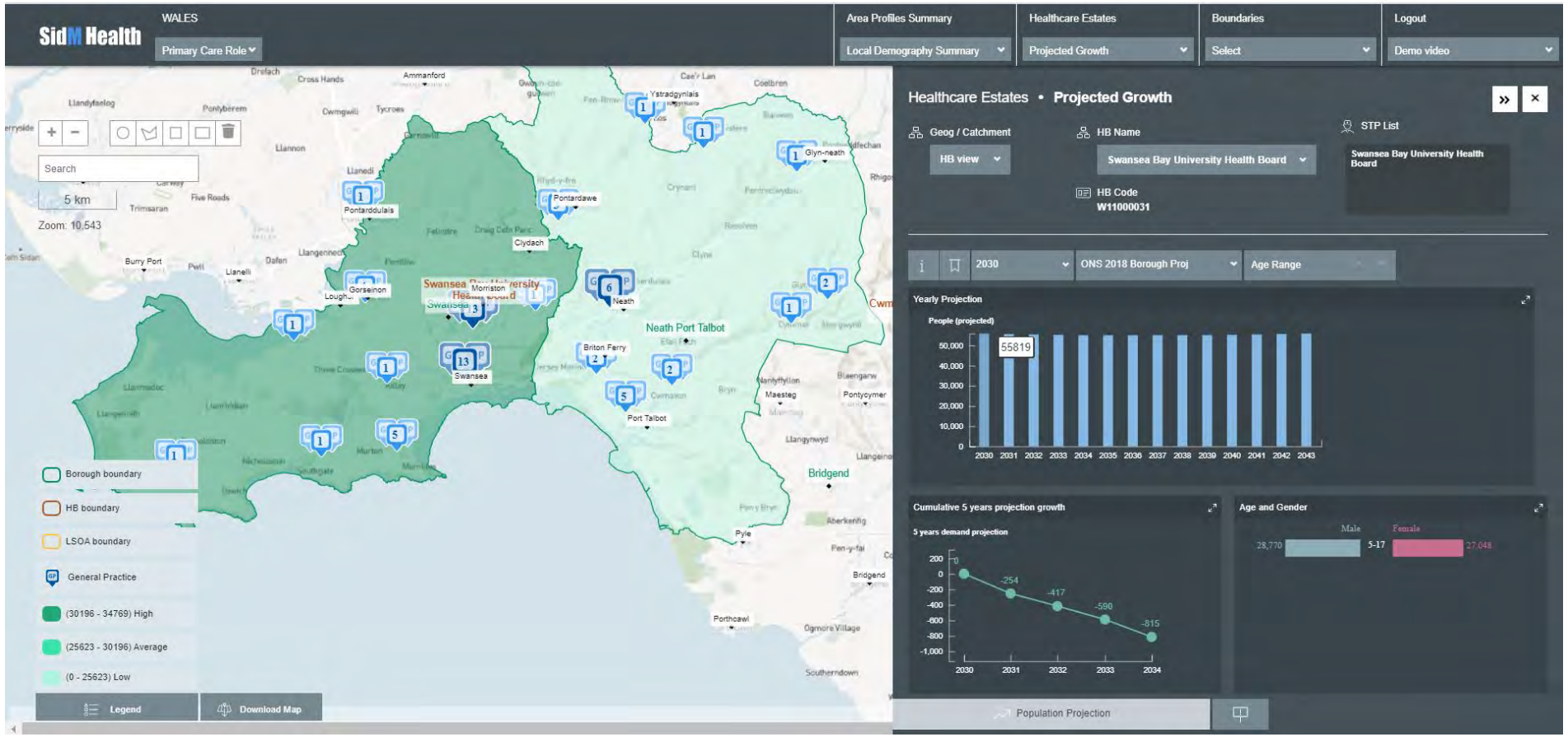
4.1 All Ages



4.2 Ages 0 – 4


SidM Health
WALES
Primary Care Role
Area Profiles Summary
Local Demography Summary
Healthcare Estates
Projected Growth
Boundaries
Select
Logout
Demo video
Search
5 km
Zoom: 10.543
Borough boundary
HB boundary
LSOA boundary
General Practice
(10874 - 12670) High
(9078 - 10874) Average
(0 - 9078) Low
Legend
Download Map
Healthcare Estates • Projected Growth
Geog / Catchment
HB view
HB Name
Swansea Bay University Health Board
STP List
Swansea Bay University Health Board
HB Code
W11000031
2030
ONS 2018 Borough Proj
Age Range
Yearly Projection
People (projected)
19953
Cumulative 5 years projection growth
5 years demand projection
Age and Gender
Male
Female
10,237
0-4
9,716
Population Projection

4.3 Ages 5 – 17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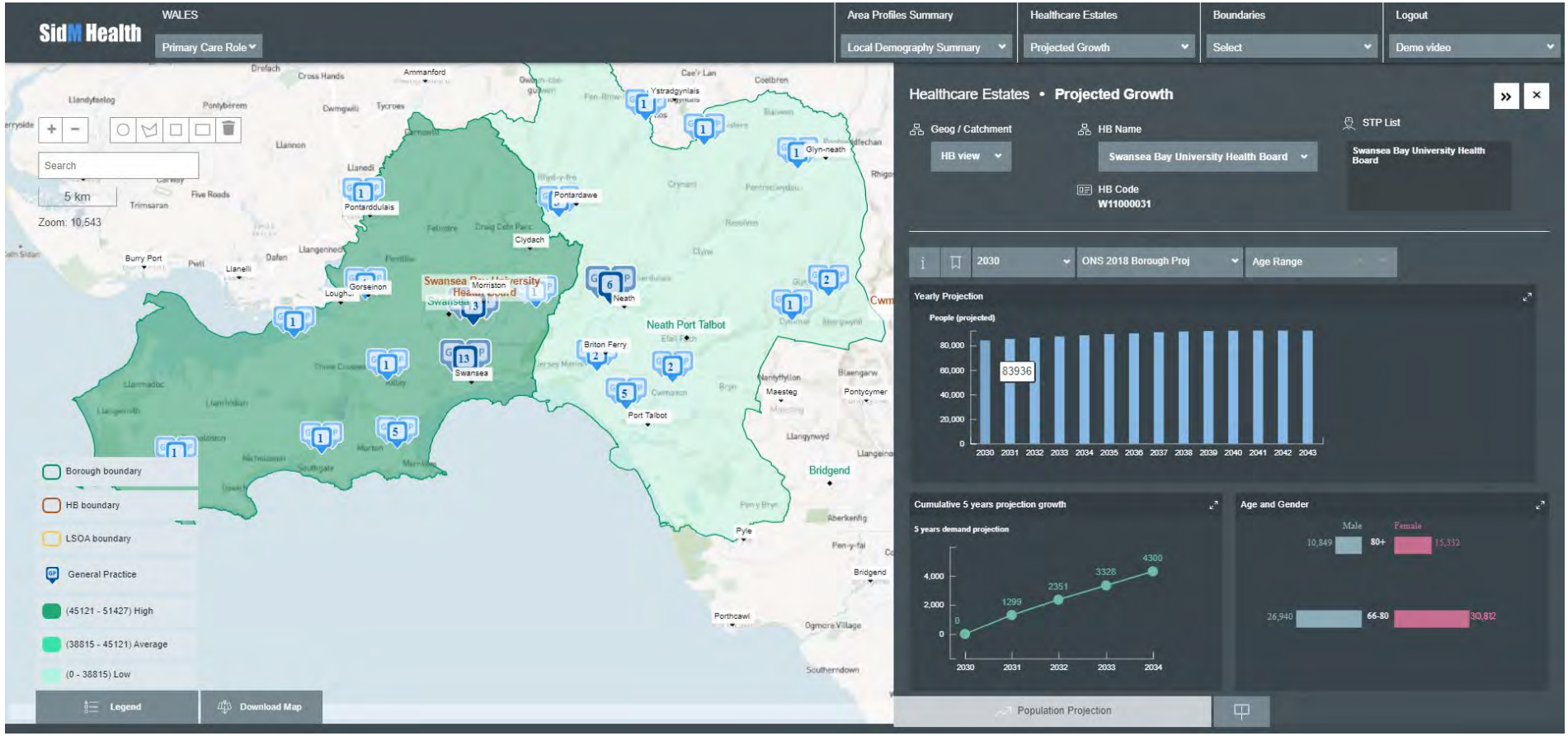
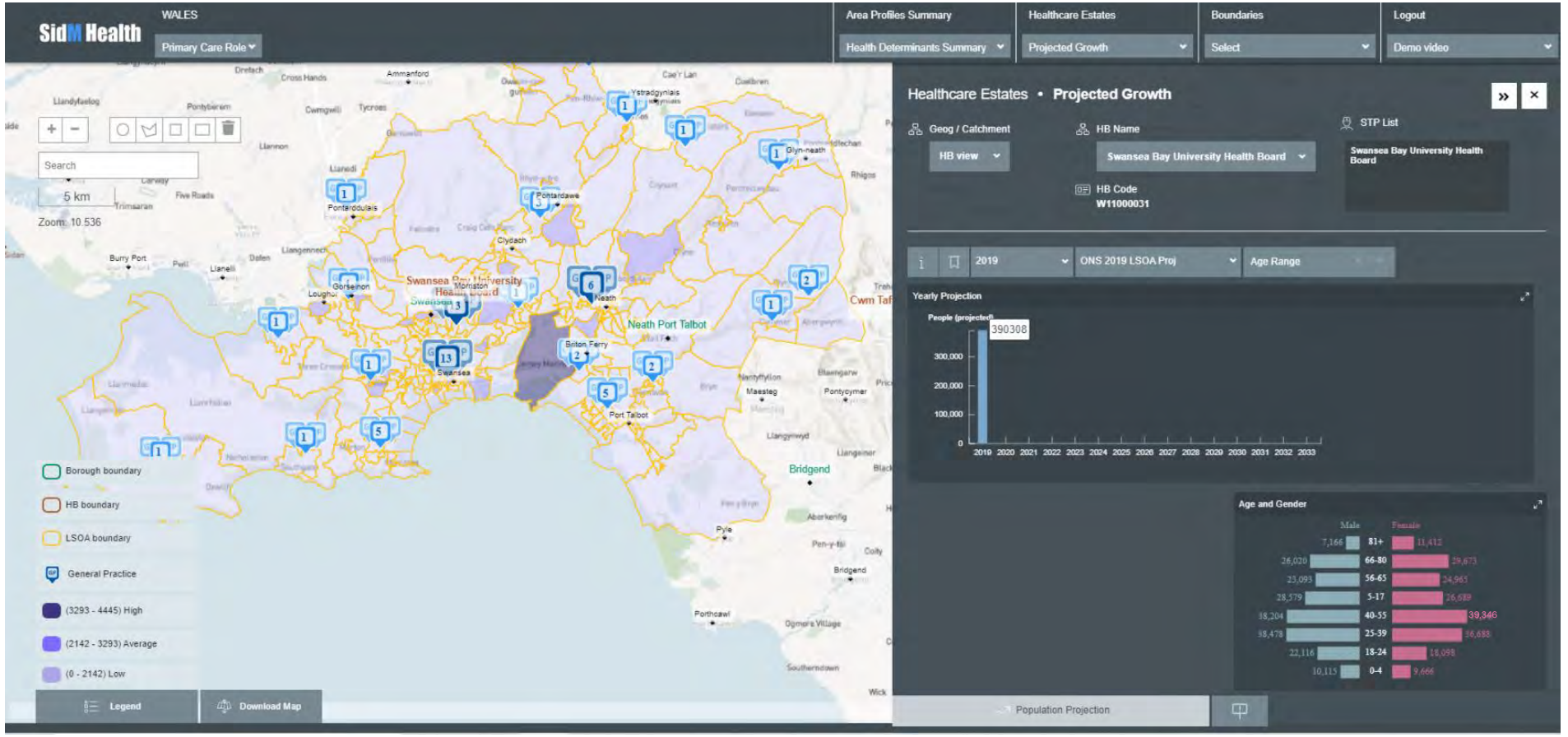
WALES
Primary Care Role
Area Profiles Summary
Local Demography Summary
Healthcare Estates
Projected Growth
Boundaries
Select
Logout
Demo video
Search
5 km
Zoom: 10.543
Borough boundary
HB boundary
LSOA boundary
General Practice
(30196 - 34769) High
(25623 - 30196) Average
(0 - 25623) Low
Legend
Download Map
Healthcare Estates • Projected Growth
Geog / Catchment
HB view
HB Name
Swansea Bay University Health Board
HB Code
W11000031
STP List
Swansea Bay University Health Board
2030
ONS 2018 Borough Proj
Age Range
Yearly Projection
People (projected)
55819
Cumulative 5 years projection growth
5 years demand projection
0
-254
-417
-590
-815
Age and Gender
Male
Female
28,770
5-17
27,048
Population Projection

4.4 Ages 66+

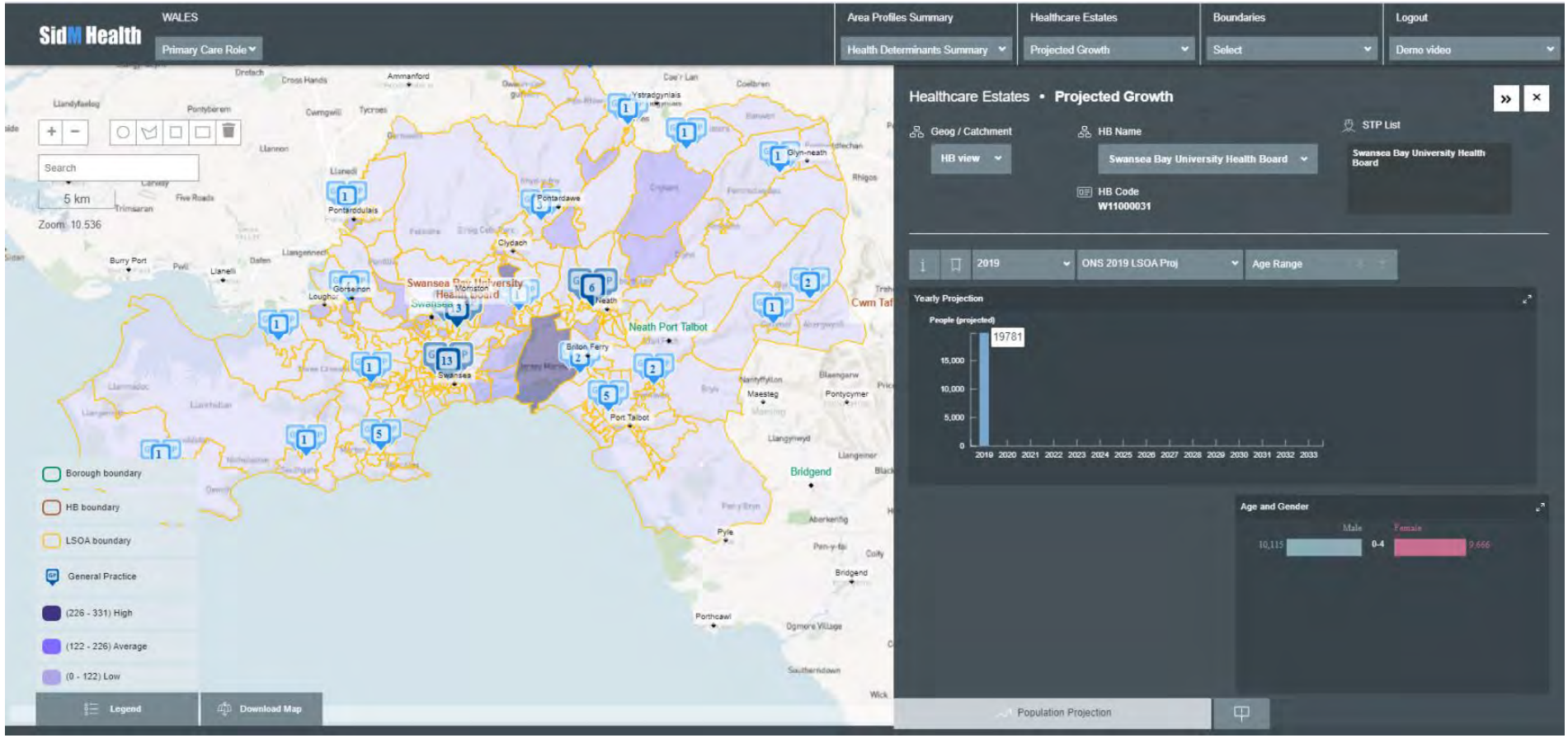

SidM Health
WALES
Primary Care Role
Area Profiles Summary
Local Demography Summary
Healthcare Estates
Projected Growth
Boundaries
Select
Logout
Demo video
Search
5 km
Zoom: 10.543
Borough boundary
HB boundary
LSOA boundary
General Practice
(45121 - 51427) High
(38815 - 45121) Average
(0 - 38815) Low
Legend
Download Map
Healthcare Estates • Projected Growth
Geog / Catchment
HB view
HB Name
Swansea Bay University Health Board
STP List
Swansea Bay University Health Board
HB Code
W11000031
2030
ONS 2018 Borough Proj
Age Range
Yearly Projection
People (projected)
83936
Cumulative 5 years projection growth
5 years demand projection
Age and Gender
Male
Female
10,849
80+
15,332
26,940
66-80
30,812
Population Projection

5 Population Projection by LSOAs

5.1 All Ages



5.2 Ages 0 – 4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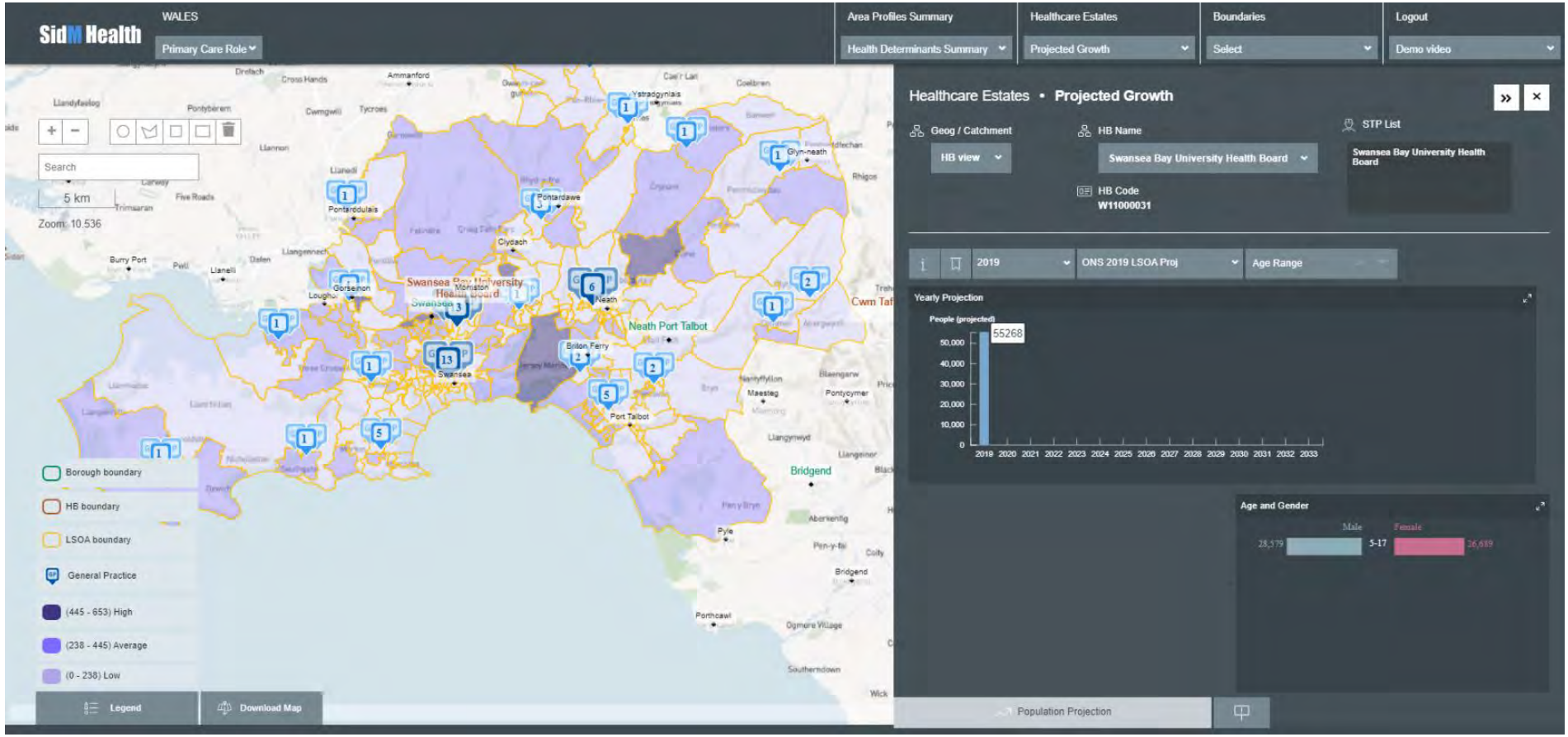
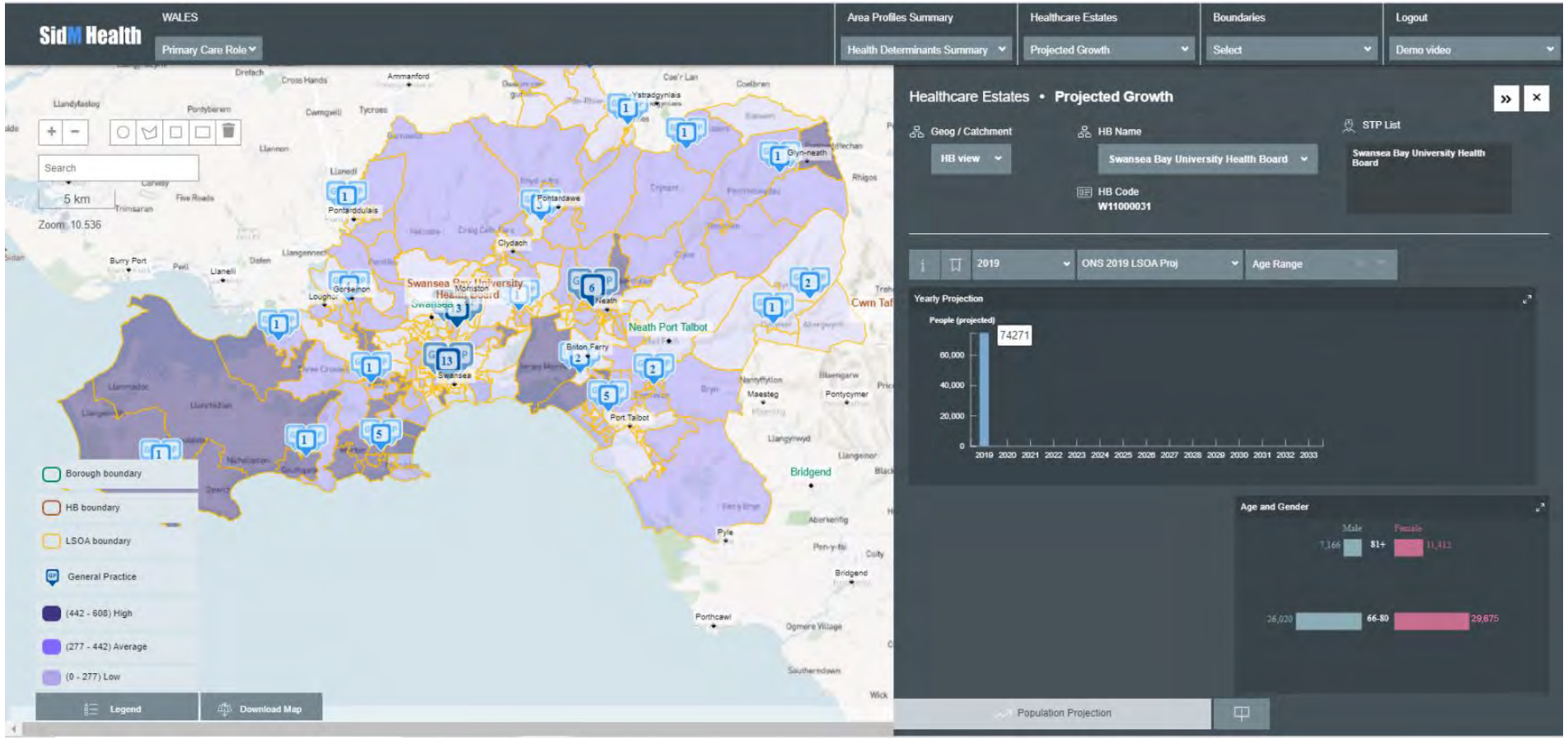
WALES
Primary Care Role
Area Profiles Summary
Health Determinants Summary
Healthcare Estates
Projected Growth
Boundaries
Select
Logout
Demo video
Search
5 km
Zoom: 10.536
Healthcare Estates • Projected Growth
Geog / Catchment
HB view
HB Name
Swansea Bay University Health Board
STP List
Swansea Bay University Health Board
HB Code
W11000031
2019
ONS 2019 LSOA Proj
Age Range
Yearly Projection
People (projected)
19781
15,000
10,000
5,000
0
2019 2020 2021 2022 2023 2024 2025 2026 2027 2028 2029 2030 2031 2032 2033
Age and Gender
Male
Female
10,115
0-4
9,666
Borough boundary
HB boundary
LSOA boundary
General Practice
(226 - 331) High
(122 - 226) Average
(0 - 122) Low
Legend
Download Map
Population Projection
Swansea Bay University Health Board
Neath Port Talbot
Bridgend
Swansea
Port Talbot
Pontardawe
Pontardulais
Clydach
Neath
Briton Ferry
Maesteg
Pontycymer
Porthcawl
Pyle

5.3 Ages 5 – 17

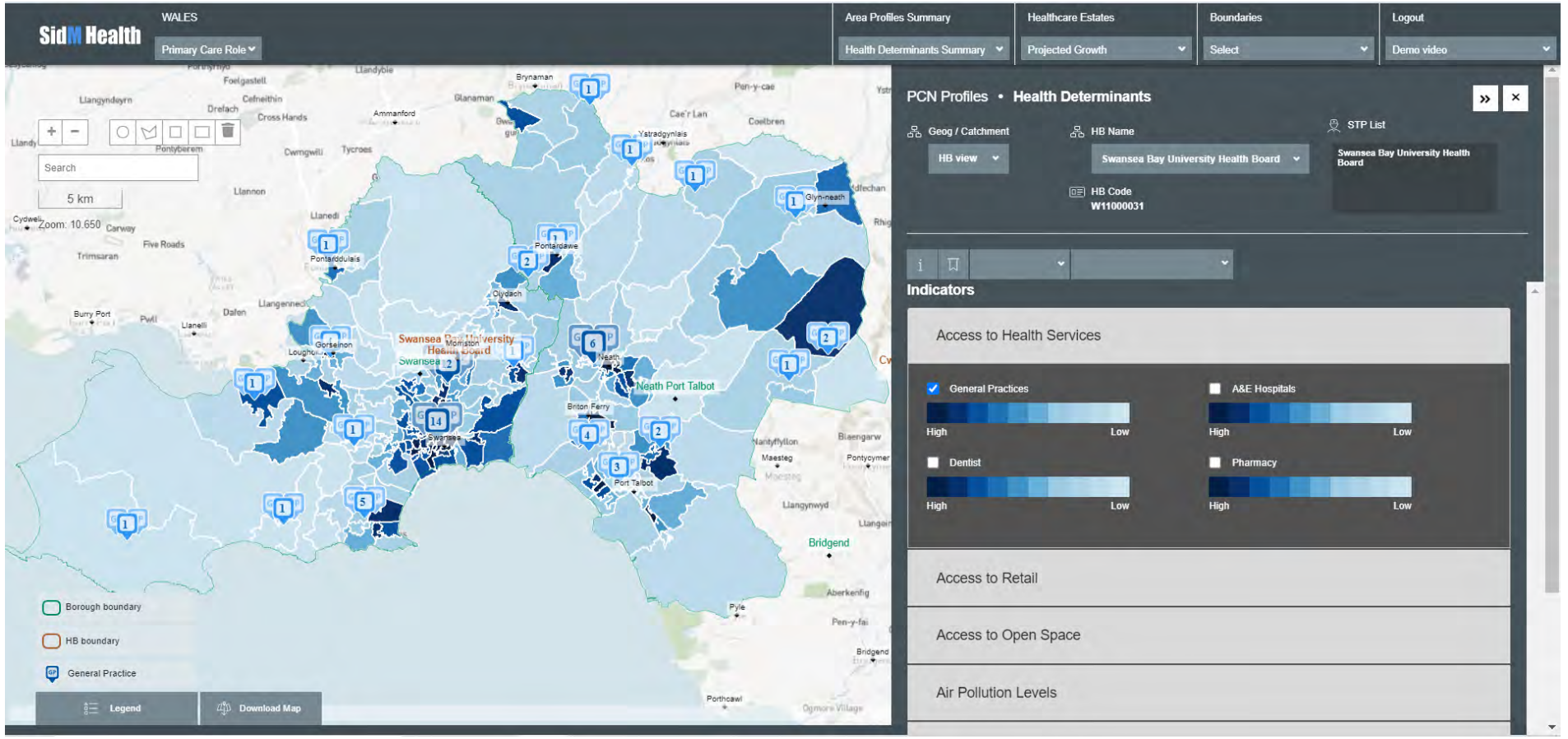

SidM Health
WALES
Primary Care Role
Area Profiles Summary
Health Determinants Summary
Healthcare Estates
Projected Growth
Boundaries
Select
Logout
Demo video
Search
5 km
Zoom: 10.536
Healthcare Estates • Projected Growth
Geog / Catchment
HB view
HB Name
Swansea Bay University Health Board
STP List
Swansea Bay University Health Board
HB Code
W11000031
2019
ONS 2019 LSOA Proj
Age Range
Yearly Projection
People (projected)
55268
50,000
40,000
30,000
20,000
10,000
0
2019 2020 2021 2022 2023 2024 2025 2026 2027 2028 2029 2030 2031 2032 2033
Age and Gender
Male
Female
28,579
5-17
26,689
Borough boundary
HB boundary
LSOA boundary
General Practice
(445 - 653) High
(238 - 445) Average
(0 - 238) Low
Legend
Download Map
Population Projection
Neath Port Talbot
Swansea
Bridgend
Port Talbot

5.4 Ages 66+

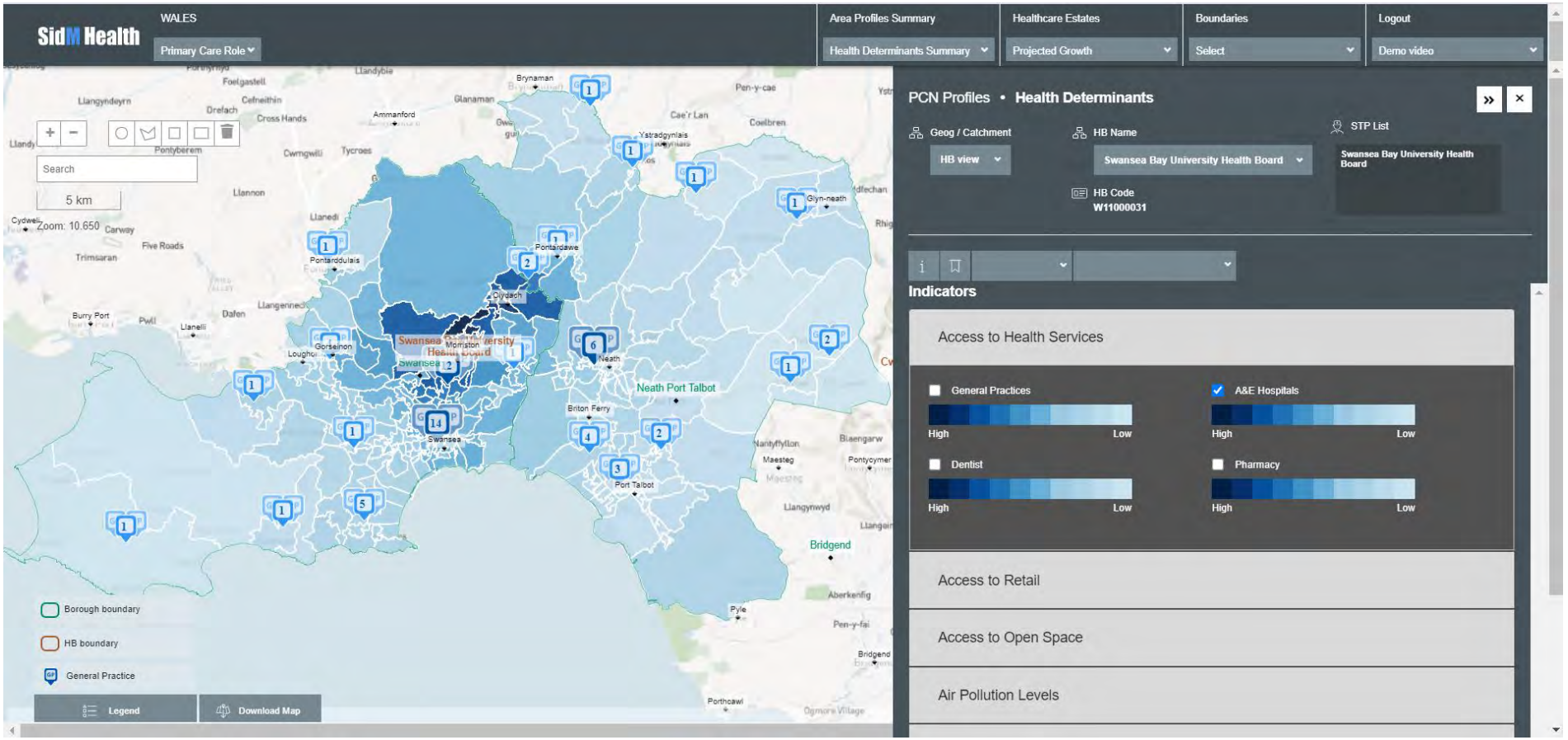

SidM Health
WALES
Primary Care Role
Area Profiles Summary
Health Determinants Summary
Healthcare Estates
Projected Growth
Boundaries
Select
Logout
Demo video
Search
5 km
Zoom 10.536
Borough boundary
HB boundary
LSOA boundary
General Practice
(442 - 608) High
(277 - 442) Average
(0 - 277) Low
Legend
Download Map
Healthcare Estates • Projected Growth
Geog / Catchment
HB view
HB Name
Swansea Bay University Health Board
HB Code
W11000031
STP List
Swansea Bay University Health Board
2019
ONS 2019 LSOA Proj
Age Range
Yearly Projection
People (projected)
74271
60,000
40,000
20,000
0
2019 2020 2021 2022 2023 2024 2025 2026 2027 2028 2029 2030 2031 2032 2033
Age and Gender
Male
Female
7,166
81+
11,413
26,020
66-80
29,675
Population Projection
Neath Port Talbot
Bridgend
Swansea
Port Talbot
Briton Ferry
Pontardawe
Pontarddulais
Gorseinon
Glyn-neath

6 Access

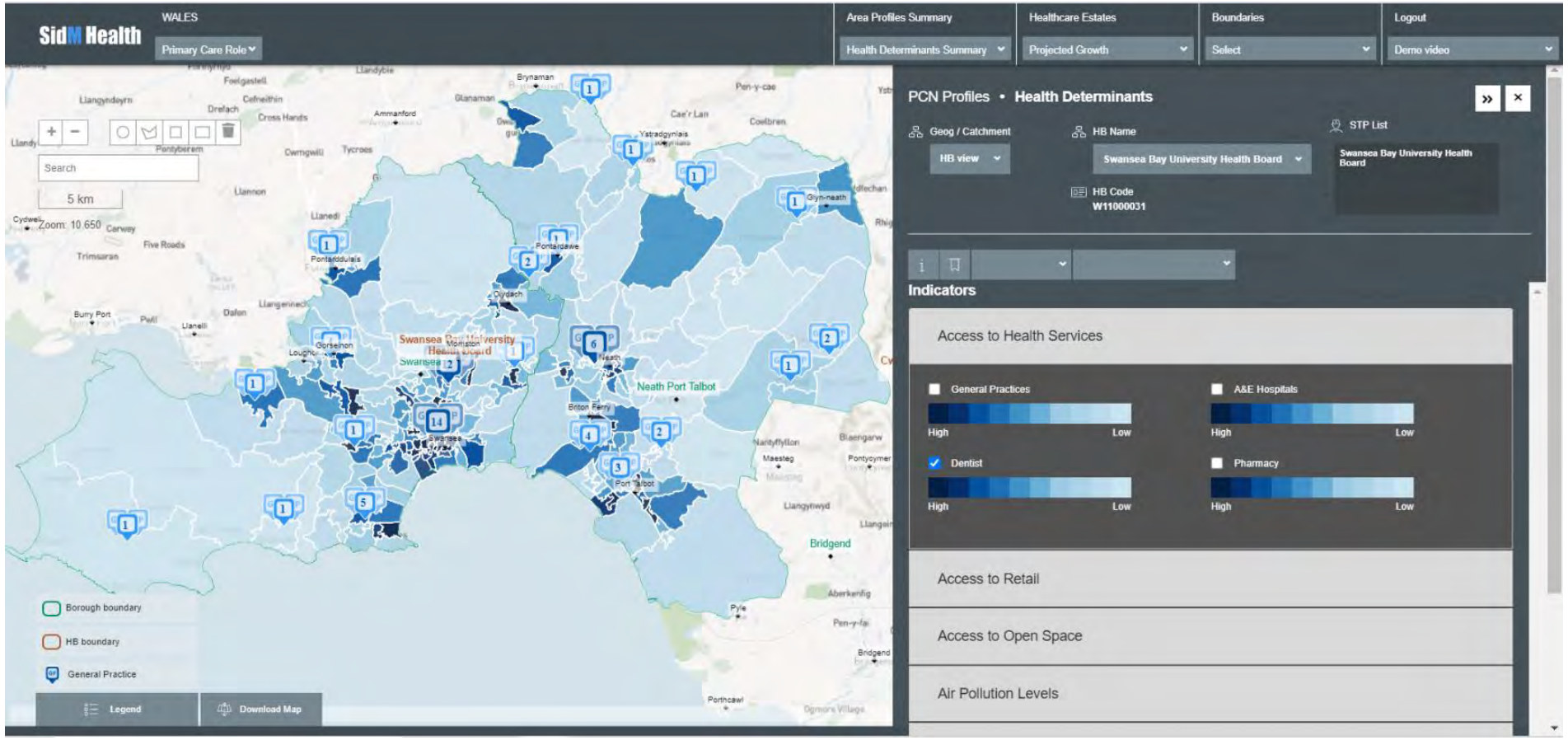
6.1 General Practices



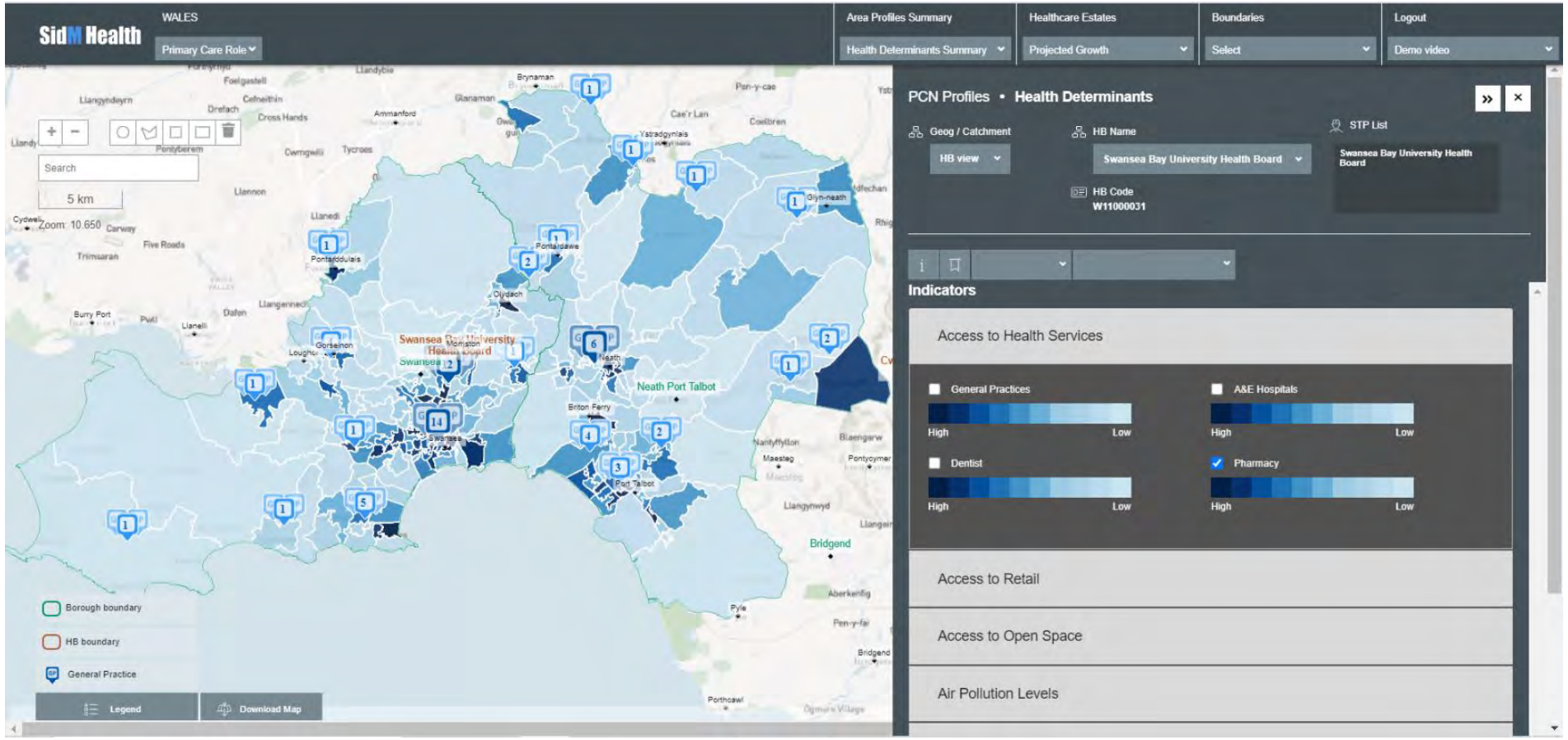
6.2 A&E Hospitals



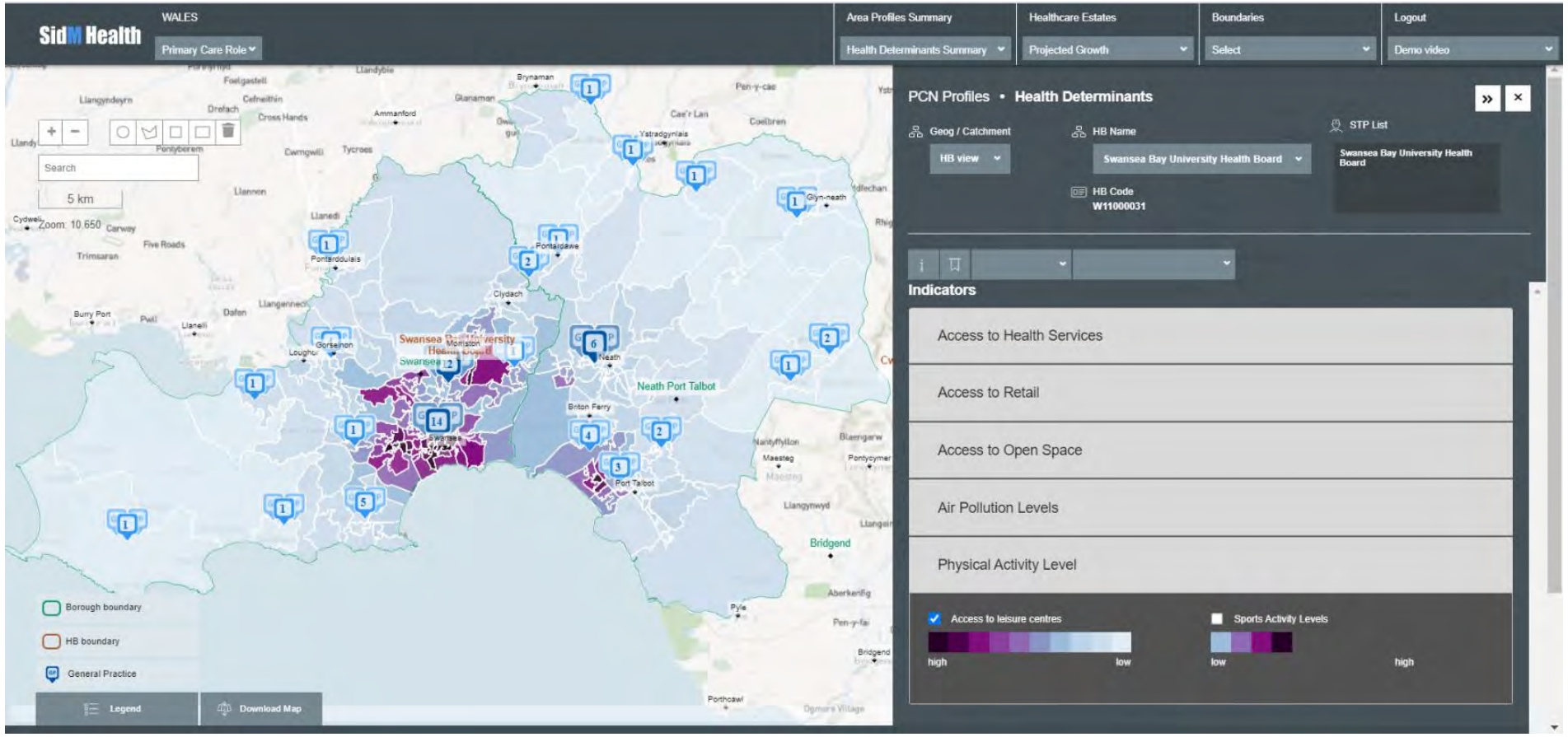
6.3 Dentists


SidM Health
WALES
Primary Care Role
Area Profiles Summary
Health Determinants Summary
Healthcare Estates
Projected Growth
Boundaries
Select
Logout
Demo video
PCN Profiles • Health Determinants
Geog / Catchment
HB view
HB Name
Swansea Bay University Health Board
STP List
Swansea Bay University Health Board
HB Code
W11000031
Indicators
Access to Health Services
General Practices
A&E Hospitals
Dentist
Pharmacy
High
Low
Access to Retail
Access to Open Space
Air Pollution Levels
Search
5 km
Zoom: 10.650
Borough boundary
HB boundary
General Practice
Legend
Download Map
Neath Port Talbot
Bridgend

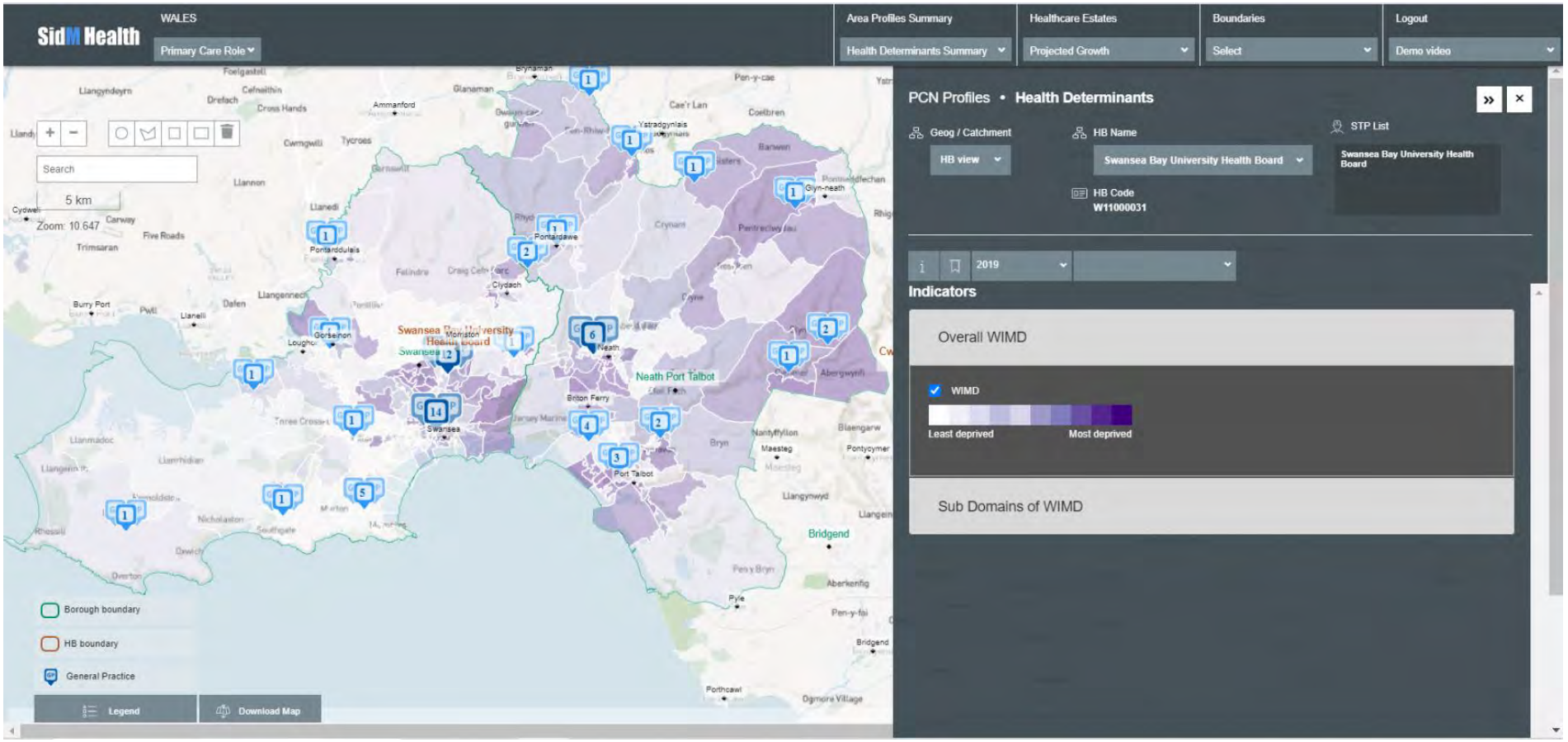
6.4 Pharmacy


SidM Health
WALES
Primary Care Role
Area Profiles Summary
Health Determinants Summary
Healthcare Estates
Projected Growth
Boundaries
Select
Logout
Demo video
PCN Profiles • Health Determinants
Geog / Catchment
HB view
HB Name
Swansea Bay University Health Board
STP List
Swansea Bay University Health Board
HB Code
W11000031
Indicators
Access to Health Services
General Practices
A&E Hospitals
Dentist
Pharmacy
High
Low
Access to Retail
Access to Open Space
Air Pollution Levels
Search
5 km
Zoom: 10.650
Swansea Bay University Health Board
Neath Port Talbot
Bridgend
Borough boundary
HB boundary
General Practice
Legend
Download Map

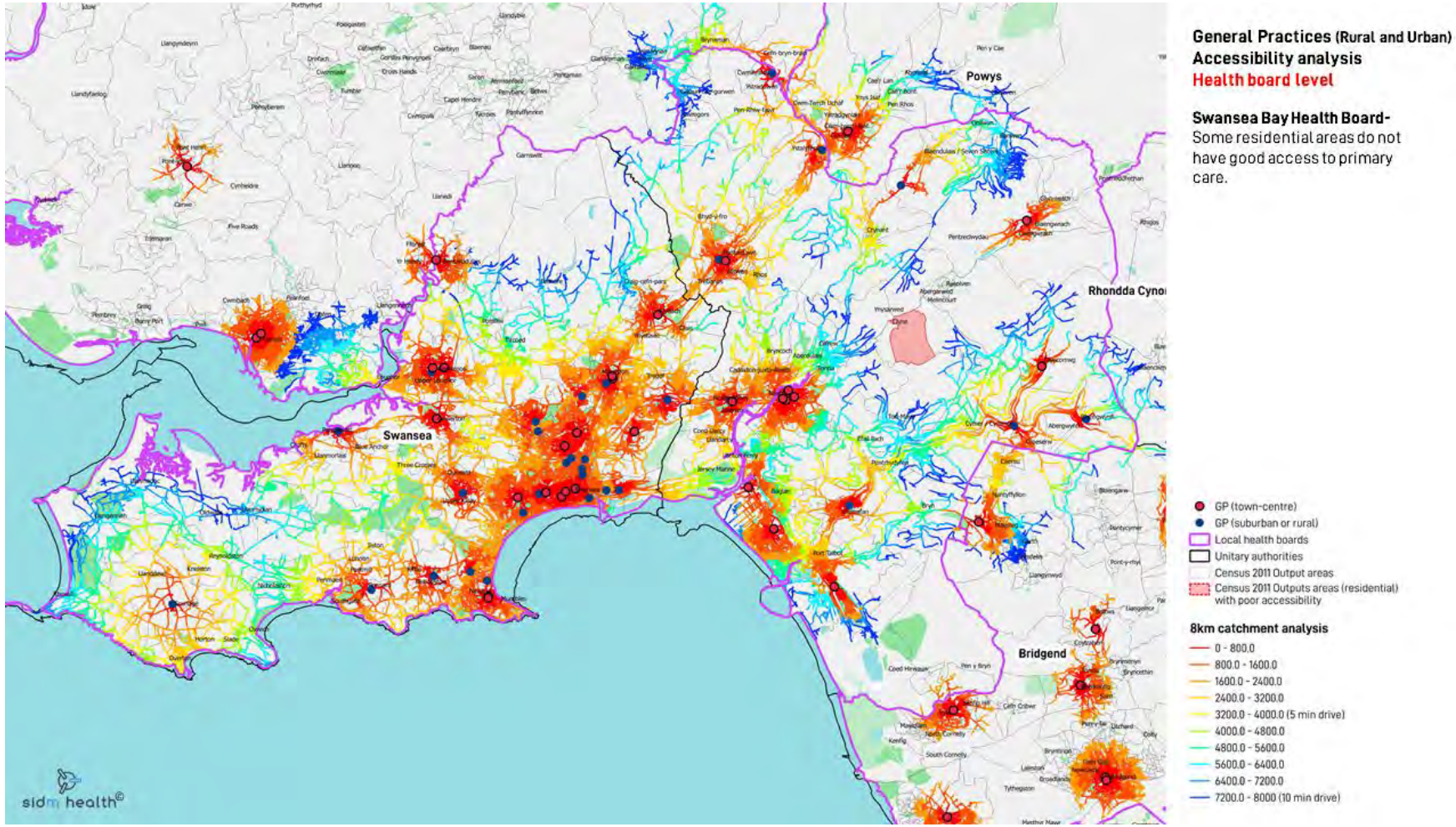
6.5 Leisure Centres



7 Overall Deprivation Score



8 Travel Distances



Archus

The healthcare infrastructure specialist

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UK Company Registration No. 6937095

Appendix D - Roadmap / Prioritisation Tool

(The working version of this spreadsheet is attached separately)

05 May 2021

Health Board
Capital Prioritisation Criteria

Contents

Health Board Capital Prioritisation Criteria

Scheme Prioritisation

Quality check

Rev	Status	Prepared by	Checked by	Date
0.1	Draft			
0.2	Draft			

Appendix D - Prioritisation Tool

Prioritisation

Scheme Prioritisation

Scheme Name	Rank - Score	Gross Estimated Capital Cost , £m	Value for Money Ratio	Revenue Savings as a proportion of initial Cap Ex	PID/SOC	Estimated recurrent net revenue benefit £000
0	1					
0	1					
0	1					
0	1					
0	1					
0	1					
0	1					
0	1					
0	1					
0	1					
0	1					
0	1					
0	1					
0	1					
0	1					
		£ -				

Appendix D - Prioritisation Tool
Scoring Template

Assessment Criteria	Detailed Criteria		Area Breakdown	Good Evidence consists off	Required evidence / documentation	Weight	Raw score for each scheme Total													Scorer 1											
							1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
																				0	0	0	0	0	0	0	0	0	0	0	0
Required criterias for scheme consideration	Alignment with STP Strategy requirements		Estates Strategy & prioritisation	Clear consistency with wider Health Board estates strategy, clear priority and planning issues fully addressed.			0	0	0	0	0	0	0	0	0	0	0	0	0													
			Clinical Strategy Plan - alignment with plan and high priority from a service perspective	Strong evidence of consistency with overall Welsh Governmen clinical strategy and a main priority of the Health Board.			0	0	0	0	0	0	0	0	0	0	0	0	0													
			Property management	Welsh Government strategy identifies how schemes meet or exceed investment and disposals benchmark.			0	0	0	0	0	0	0	0	0	0	0	0	0													
1. Leadership and Capacity to deliver Current Weighting TBC %	Deliverability	1a	Identified source of funding	Appropriate range of options considered by the Health Board and rationale for preferred option explained. Business case develoipment as required		TBC	0	0	0	0	0	0	0	0	0	0	0	0	0													
		1b	Disposals to partially fund scheme directly	Strong evidence that all possible site disposals to fund the scheme have been considered, factored into the proposal and robustly valued.		example 4.714%	0	0	0	0	0	0	0	0	0	0	0	0	0													
		1c	Financial viability	Has the project(s) been assesed against its financial viability? Return for taxpayers on investment.			0	0	0	0	0	0	0	0	0	0	0	0	0													
		1d	Return on Investment (ROI) and Value for Money (VFM)	Individual projects (funding bids) must be able to articulate a healthy cost and savings plan, evidence of a reasonable payback period, and positive impacts on financial sustainability and cost improvement programmes, as well as wider benefits to taxpayers.																											
	Plans for delivery of capital investment schemes must be very robust, with clear actions and milestones in place, and be able to withstand the close scrutiny of the Welsh Government.	1e	Timeline	Detailed plan with clear key achievable milestones that meet the deadline for delivery.			0	0	0	0	0	0	0	0	0	0	0	0	0													
		1f	Deliverability - Project Management	Good evidence of delivery capability and PMO arrangement and appropriate governance that will support delivery.			0	0	0	0	0	0	0	0	0	0	0	0	0													
	Evidence support and Engagement from the key stakeholders	1g	Stakeholder Engagement	Strong evidence of comprehensive stakeholder engagement and a high degree of support and discussion around arising issues.			0	0	0	0	0	0	0	0	0	0	0	0	0													
2. Demand Management Current Weighting TBC %	Schemes should quantify, with supporting evidence how thye will improve access across the whole health system	2a	Scheme delivers service improvements for patients and staff	Strong evidence on delivering service and quality improvements for patients - convincing narrative and data to show performance will improve materially against the current baseline.			0	0	0	0	0	0	0	0	0	0	0	0	0													
		2b	Quantified Demand Reductions / Better Management of Service Demand	Data is clear and mechanisms are explained in terms of demand management, and the data points convincingly to comparatively high impact.			0	0	0	0	0	0	0	0	0	0	0	0	0													
		2c	Activity Savings	Should make a quantifiable contribution to annual efficiency savings.			0	0	0	0	0	0	0	0	0	0	0	0	0													
	Population Growth [do we need to include this for GM?]	2d	Population Growth pressure /demand	The scheme targets areas of population growth/increasing demand and demographic health need. Section will be completed based on Evidence mapping of population growth areas by the supporting team.			0	0	0	0	0	0	0	0	0	0	0	0	0													
3. Transformation, Patient Benefit and Workforce benefits	Advances new models of care to deliver improved health outcomes.	3a	Transformation	Scheme will substantially transform the service model, patient care or integration, or is key to enabling transformation across clinical pathways. Demonstrates a positive impact on demand reduction in acute care			0	0	0	0	0	0	0	0	0	0	0	0	0													
	Workforce environment improvements	3b	Delivers improvements in healthcare service and performance	Delivers workforce environment improvements (agile working, single data entry, reduced walking/travelling, greater patient contact hours).			0	0	0	0	0	0	0	0	0	0	0	0	0													
	Scheme supports wider	3c	Example - access to other health	Delivers a range of healthcare services (as appropriate to size of scheme)			0	0	0	0	0	0	0	0	0	0	0	0	0													

Appendix D - Prioritisation Tool

Scoring Template

Assessment Criteria	Detailed Criteria		Area Breakdown	Good Evidence consists off	Required evidence / documentation	Weight	Raw score for each scheme Total													Scorer 1													
							1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
																				0	0	0	0	0	0	0	0	0	0	0	0	0
Workforce benefits **Current Weighting TBC %**	**populaiton health**	**3d**	facilities	Delivers high quality integrated services																												
	Improved Service Accessibility	**3e**	Accessibility	Improves accessibility for local residents (geographical/travel times) Provides flexibility of use to meet resident's needs (right place).			0	0	0	0	0	0	0	0	0	0	0	0	0														
		3f		Improves accessibility for local residents; extended opening hours - weekend and evening opening. Provides flexibility of use to meet resident's needs (right time); reduce waiting time.			0	0	0	0	0	0	0	0	0	0	0	0	0														
4. Estates / Infrastruture **Currrent Weighting TBC %**	**Contributes to improving the utilisation and condition of existing health and social care facilities in the localities of the Health Board**	**4a**	Improved Condition and Compliance requirements	Scheme will substantially improve the condition of our estate, offering better patient care. Scheme supporting the Health & Safety, Minimum Standards and Statutory Compliance requirements.			0	0	0	0	0	0	0	0	0	0	0	0	0														
		4b	Improved Utilisation	Reduces Commissioner or Provider void risk and associated cost. Intensifies the asset utilisation in meeting targets set within the overall Estates Plan.			0	0	0	0	0	0	0	0	0	0	0	0	0														
		4c		Scheme is optimising the use of estates and is evidencing ongoing affordability. Creates opportunities to reduce overall estates running costs.		**%**	0	0	0	0	0	0	0	0	0	0	0	0	0														
		4d		Creates additional capacity to address an existing lack of capacity - does something need to be reflected in relation to Variation processes and reconfiguration/alteration of premises along with costs, extended use and flexible occupation terms for occupiers?			0	0	0	0	0	0	0	0	0	0	0	0	0														
Total						**0.00%**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Appendix D - Prioritisation Tool

Prioritisation by Scorer

	Overall		Scorer 1		Scorer 2		Scorer 3		Scorer 4		Scorer 5		Scorer 6		Scorer 7		Scorer 8		Scorer 9		Scorer 10		Scorer 11		Scorer 12	
	Rank	Score	Rank	Score	Rank	Score	Rank	Score	Rank	Score	Rank	Score	Rank	Score	Rank	Score	Rank	Score	Rank	Score	Rank	Score	Rank	Score	Rank	Score
0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0
0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0
0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0
0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0
0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0
0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0
0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0
0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0
0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0
0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0
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0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1	0

Appendix E – Schedules of Accommodation

Contents

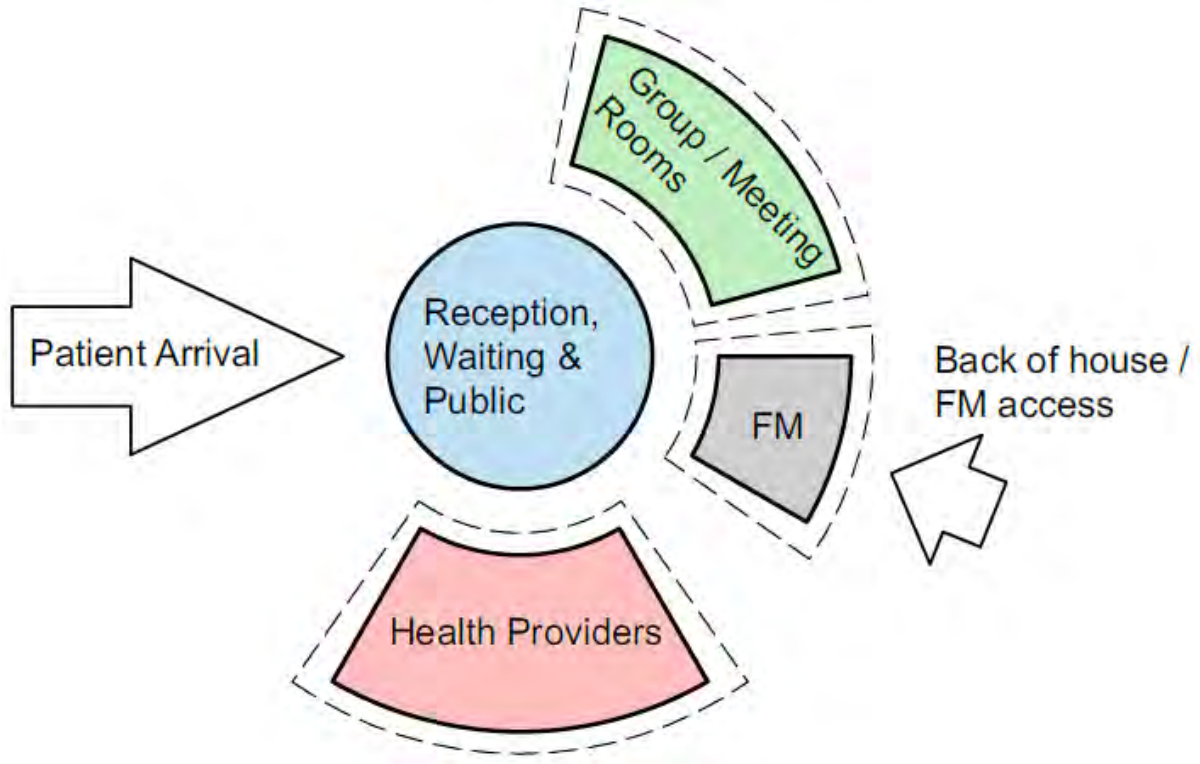
1 Level 1a

Total Population catchment	1500
Travel time (upper limit)	15min
Fixed clinical consultation spaces	0 - flexible
Wider clinical rooms	0 – flexible
Estimated Gross Internal Area	250-300m^2

Urban / rural location	Predominantly Rural
Current no. comparable facilities in Wales	None currently
No. practices with sufficient reported GIA to deliver this model	

Level 1a Exemplar Layout Illustration – with zoning for different health provisions

The Level 1 facility example is a single storey concept, based on patients and visitors arriving at a central public core, providing reception, waiting and public facilities. Accommodation is then split into discreet 'zones' that are accessed from the central core, including clinical and support zones. The clinical zones include group rooms and other health and social care providers. Separate access is provided to the FM area for deliveries etc.



Area	Example room descriptions within a designated facility	No.
Public Zone		
	Entrance Foyer and way finding	1
	Reception Area (Public / Shared)	1
	WC: semi-ambulant	2
	WC: independent wheelchair	1
	Baby change	1
	Infant feeding room	1
	Large Meeting room	1
	Resource storage	1
Other Health & Social Care Provider Zone		
	Advice Resources Lobby and Digital Library (4 computers and displays)	1
	Visiting Advisor desk	1
	Digital Consultations PODs (one bookable / one drop in)	2
	Small Meeting / Counselling Room- Social care and IAPT	2
	Mini Kitchens	1
	Administrative hot -desk spaces	1
	Facility Manager office	1
Facilities Management space		
	Cleaners' stores	1

2 Level 1b

Total Population catchment	1500
Travel time (upper limit)	20min
Fixed clinical consultation spaces	2 rooms
Wider clinical rooms	1 Room
Estimated Gross Internal Area	300-370m^2

Urban / rural location	Mixed but mostly rural
Current no. comparable facilities in Wales	TBC
No. practices with sufficient reported GIA to deliver this model	TBC

Level 1b Exemplar Layout Illustration – see Level 1a

Area	Room	No.
Public Zone		
	Entrance Foyer and way finding	1
	Reception Area (Public/Shared)	1
	WC: semi-ambulant	2
	WC: independent wheelchair	1
	Nappy changing room	1
	Infant feeding room	1
	Pushchair/Loan Wheelchair Parking bay	1
	Large Meeting room	1
	Large Therapies Gym/group rooms	1
	Resource storage	1
Other Health & Social Care Provider Zone		
	Consult/Exam	2
	Consult/Treatment or Minor surgery	1
	Advice Resources Lobby and Digital Library (4 computers and displays)	1
	Visiting Advisor desk	1
	Digital Consultations PODs (one bookable/one drop in)	2
	Small Meeting/Counselling Room- Social care and IAPT	2
	Mini Kitchens	1
	Administrative hot desk spaces	1
	Facility Manager office	1
Facilities Management Space		
	Cleaners' store	1

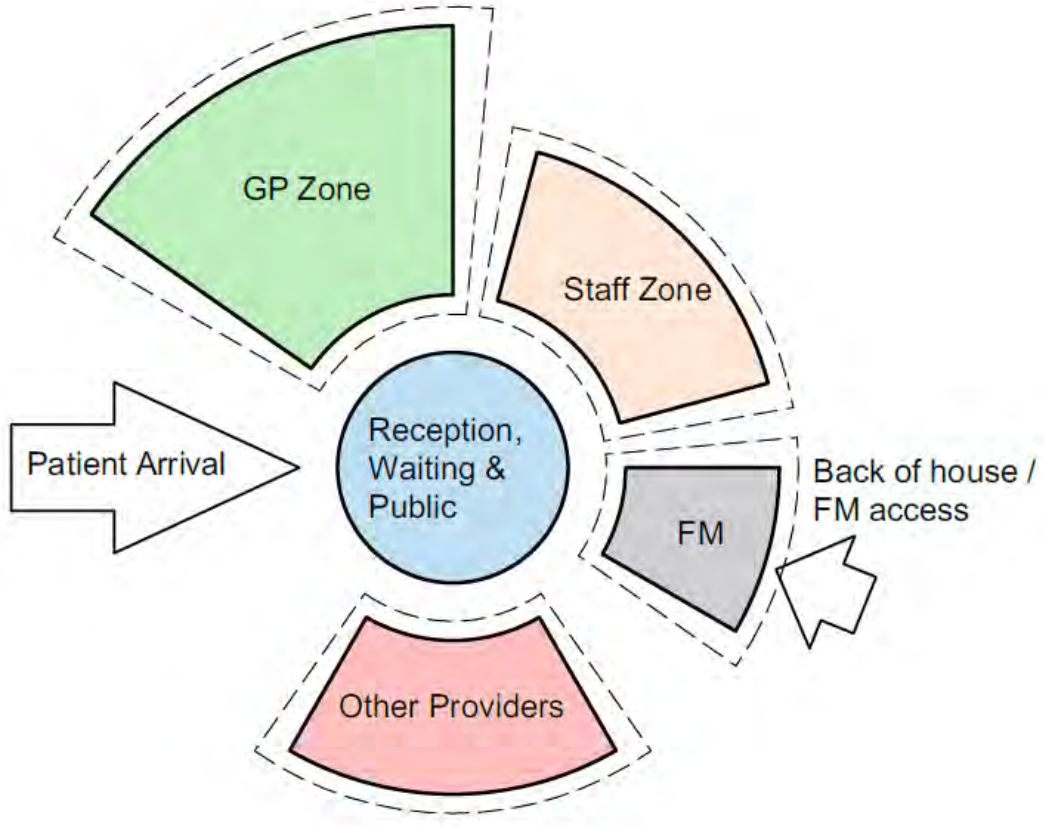
3 Level 2

Total Population catchment	6,000
Travel time (upper limit)	20min
Fixed clinical consultation spaces	4-6 (inc. Training)
Wider clinical rooms	10
Estimated Gross Internal Area	650-750m^2

Urban / rural location	Equally distributed - all settings (unless there is a level 4/5 Facility)
Current no. comparable facilities in Wales	TBC
No. practices with sufficient reported GIA to deliver this model	TBC

Level 2 Exemplar Layout Illustration

The Level 2 facility example is a single storey concept, based on patients and visitors arriving at a central public core, providing reception, waiting and commercial facilities. Accommodation is then split into discreet 'zones' that are accessed from the central core, including clinical, staff and support zones. The clinical zones include GPs and other health and social care providers. Separate access is provided to the FM area for deliveries etc.



Area	Room	No.
Public Zone		
	Entrance Foyer and way finding	1
	Clinical area signposting and self-checking space	1
	Reception Area (Public/Shared)	1
	Waiting Room	1
	WC: semi-ambulant	2
	WC: independent wheelchair	1
	Nappy changing room	1
	Infant feeding room	1
	Push Chair/Loan Wheelchair Parking bay	1
GP Zone		
	Consult / Exam	4
	Consult / Treatment/ Minor surgery	2
	Digital consultation pods	2
	Near Patient Testing Capacity	1
	Training Room(s)	1
	Large Therapies Gym/group rooms	1
	Therapies storage	1
Other Health & Social Care Provider Zone		
	Counselling Room- Social care and IAPT	2
	OPD Clinical Room/Private consultation rooms "drop in space"	2
	Phlebotomy room/Measurements	1
	Health and Wellbeing Advisor Space	1
	Health Visitor/ Community teams drop in desks	2
	Third sector open plan Hub/Wellbeing advice Hub	1
Community Interactive Spaces		
	Resource centre with Digital enablement suite (4 PCs, 2 consultation PODs)	1
Staff Space		
	Multi-disciplinary team mtg / Learning and Development VR Training room	1
	Toilets, Changing area, showers and staff room	1
	Staff rest/ beverage bay	1
	Staff Kitchens	1
	Administrative hot desk spaces	5
	Practice Manager Office	1
Facilities Management Space		
	Storage and records management desk	1
	Clean utility	3
	Cleaner's store	2

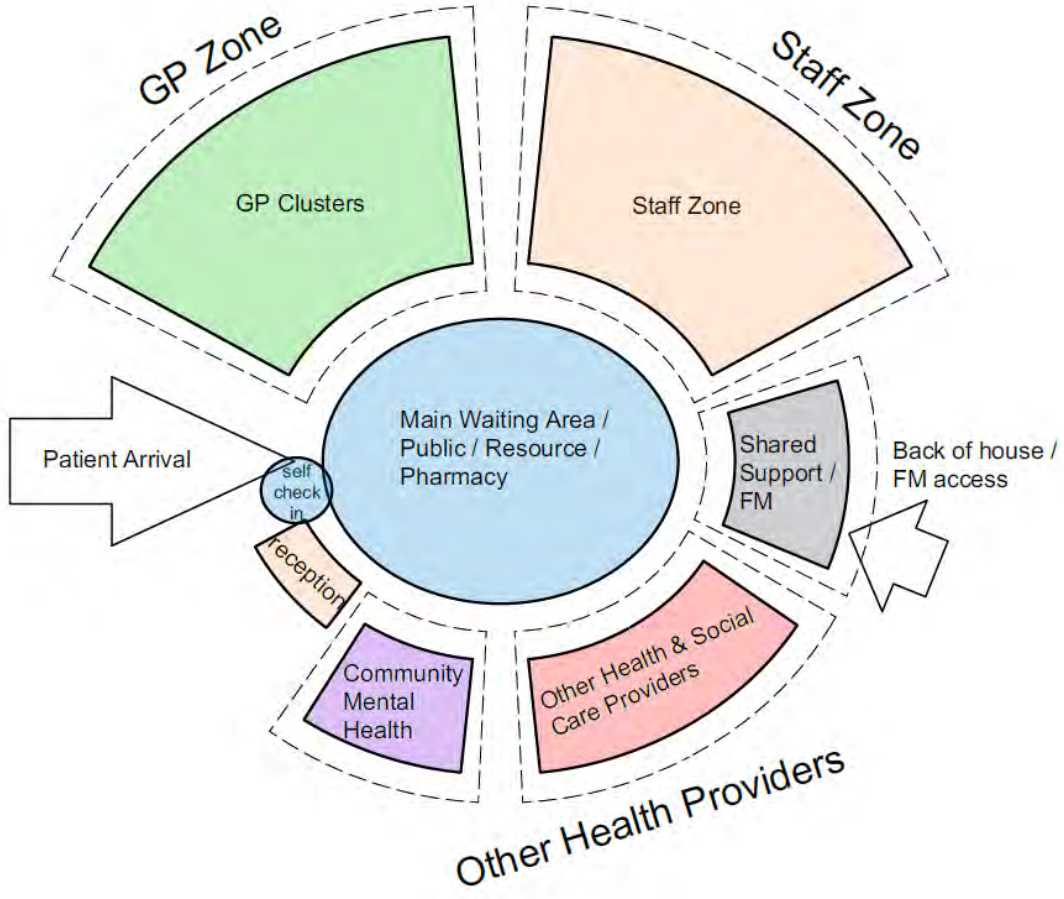
4 Level 3

Total Population catchment	12,000
Travel time (upper limit)	30min
Fixed clinical consultation spaces	8 rooms
Wider clinical rooms	12 rooms
Estimated Gross Internal Area	1900m2 (830 Core GMS Space)

Urban / rural location	Mostly Urban
Current no. comparable facilities in Wales	TBC
No. practices with sufficient reported GIA to deliver this model	TBC

Level 3 Exemplar Layout Illustration

The Level 3 facility example is a single storey concept, based on patients and visitors arriving at a central public core, providing reception, waiting and commercial facilities. Accommodation is then split into discreet 'zones' that are accessed from the central core, including clinical, staff and support zones. The clinical zones include GPs and other health and social care providers. The clinical zones can be further split into clusters of clinical rooms. Separate access is provided to the FM area for deliveries etc.



Area	Room	No.
Public Zone		
	Entrance Foyer and way finding	1
	Clinical area signposting and self-checking space	1
	Reception Area (Public/Shared)	2
	Waiting Room	1
	WC: semi-ambulant	4
	WC: independent wheelchair	2
	Nappy changing room	2
	Infant feeding room	2
	Push Chair/Loan Wheelchair Parking bay	2
GP Zone		
	Consult / Exam	7
	Consult / Treatment/ Minor surgery	3
	Digital consultation pods	4
	Near Patient Testing Capacity	1
	Training Room(s)	2
	Large training room	1
	Large Therapies Gym/group rooms	1
	Therapies storage	1
Other Health & Social Care Provider Zone		
	Counselling Room- Social care and IAPT	2
	Therapies/OPD Clinical Room/Private consultation rooms "drop in space"	4
	Phlebotomy room/Measurements	2
	Health and Wellbeing Advisor Space	2
	Health Visitor/ Community teams drop in office	1
	Third sector open plan Hub/Wellbeing advice Hub	1
Community Mental health		
	Community mental health/CAMHS[1] consultation rooms	2
	Sub waiting area	1
	waiting area toilets(wheelchair)	1
Commercial and Community Interactive Spaces		
	Resource centre with digital enablement suite (6 PCS and 4 consultation PODs)	1
	Pharmacy	1

[1] child and adolescent mental health services

Area	Room	No.
Staff Zone		
	Multi-disciplinary team meeting / Learning and Development VR Training room	2
	Toilets, Changing area, showers and staff room	1
	Staff rest/ beverage bay	2
	Staff Kitchens	2
	Administrative hot desk spaces	15
	Facility Manager office	1
	Building Security office	1
Facilities Management Space		
	Storage and records management desk(48m2)	1
	Clean utility	3
	Cleaner's store	2

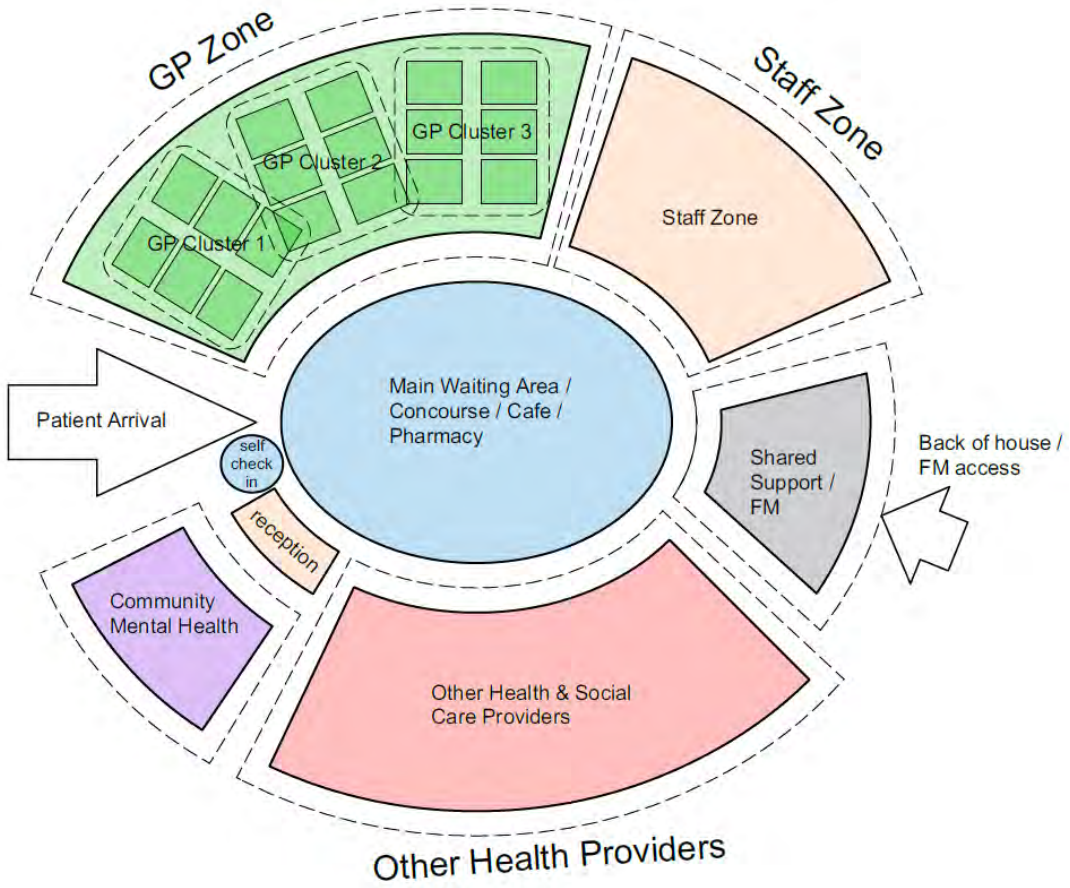
5 Level 4

Total Population catchment	24,000
Travel time (upper limit)	30
Fixed clinical consultation spaces	20 rooms
Wider clinical rooms	15-20 rooms
Estimated Gross Internal Area	1200-1500m^2

Urban / rural location	Predominantly suburban with tactical rural hubs
Current no. comparable facilities in Wales	TBC
No. practices with sufficient reported GIA to deliver this model	TBC

Level 4 Exemplar Layout Illustration

The Level 4 facility example is a single storey concept, based on patients and visitors arriving at a central public core, providing reception, waiting and commercial facilities. Accommodation is then split into discreet 'zones' that are accessed from the central core, including clinical, staff and support zones. The clinical zones include GPs and other health and social care providers. The clinical zones can be further split into clusters of clinical rooms. Separate access is provided to the FM area for deliveries etc.



Area	Room	No.
Public Zone		
	Entrance Foyer and way finding	1
	Clinical area signposting and self-checking space	1
	Reception Area (Public/Shared)	2
	Waiting Room	1
	WC: semi-ambulant	6
	WC: independent wheelchair	3
	Nappy changing room	2
	Infant feeding room	2
	Push Chair/Loan Wheelchair Parking bay	3
GP Zone		
	Consult / Exam	13
	Consult / Treatment/ Minor surgery	6
	Near Patient Testing Capacity	2
	Digital consultation pods	2
	Training Room(s)	2
	Large training room	2
	Large Therapies Gym/group rooms	1
	Therapies storage	1
Other Health & Social Care Provider Zone		
	Clinic reception drop in desk	1
	Sub-waiting area	1
	Sub-wait Accessible toilets	1
	Counselling Room- Social care and IAPT	4
	OPD Clinical Room/Private consultation rooms "drop in space"	10
	Minor Surgery Enhanced procedure room	2
	Ambulatory care trolley assessment space/CPR space	1
	Phlebotomy room/Measurements	2
	Health and Wellbeing Advisor Space	2
	Health Visitor/ Community teams drop in office	1
	Third sector open plan Hub/Wellbeing advice Hub	1
Community Mental health		
	Community mental health consultation rooms	2
	Sub waiting area	1
	waiting area toilets(wheelchair)	1

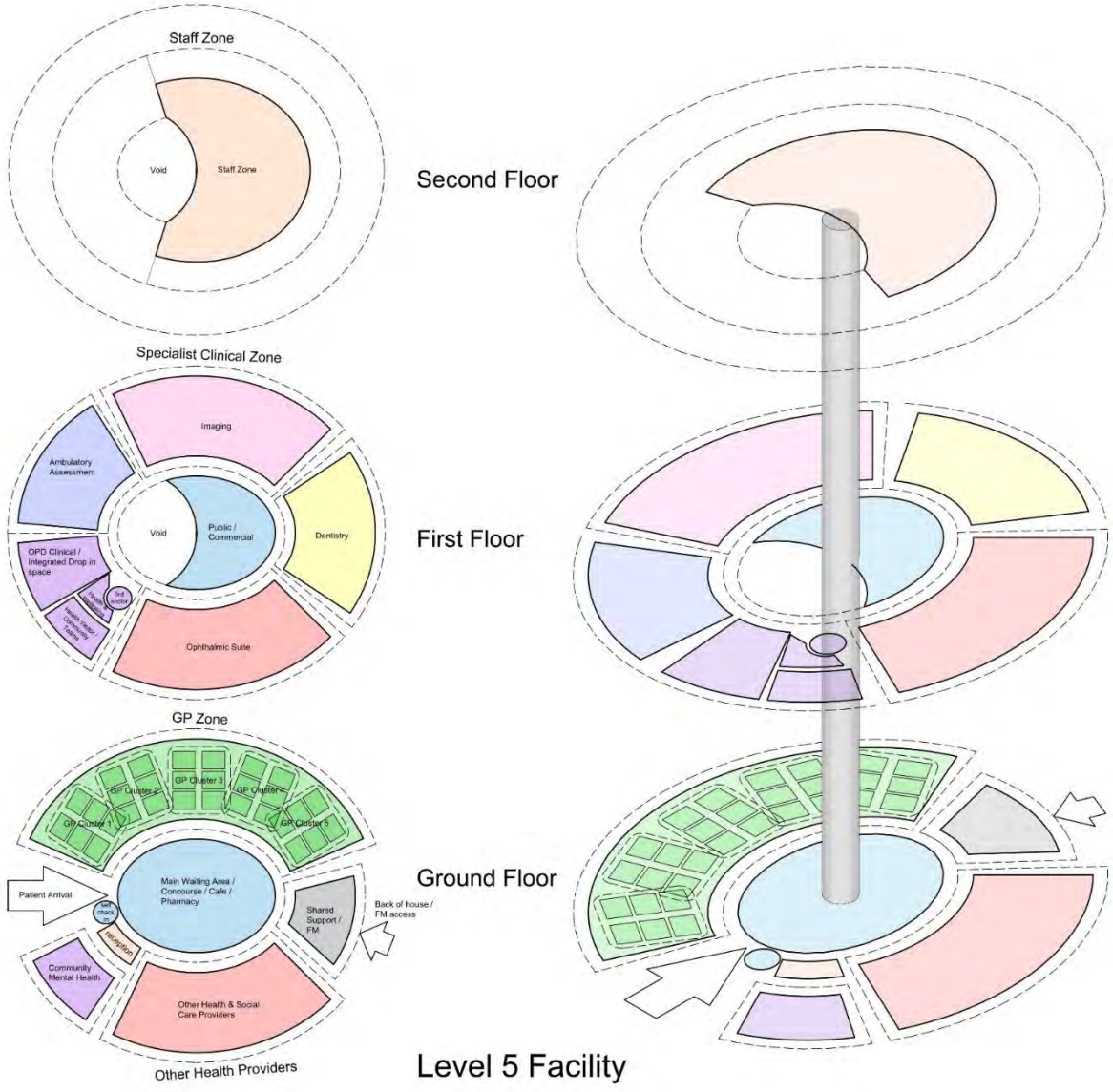
Area	Room	No.
Commercial and Community Interactive Spaces		
	Resource centre with Digital enablement suite (10 computers and 6 consultation PODs)	1
	Group Meeting Space	2
	Youth Recreational Space	1
	Self-contained creche space	1
	Visiting Advisory Services	6
	Community Kitchen/Café	1
	Pharmacy	1
Staff Zone		
	multi-disciplinary team Meeting / Learning and Development VR Training room	4
	Toilets, Changing area, showers and staff room	1
	Staff rest/ beverage bay	4
	Staff Kitchens	3
	Administrative hot desk spaces	30
	Facility Manager office	1
	Building Security office	1
Facilities Management Space		
	Storage and records management desk (48m2)	3
	Clean utility	2
	Dirty Utility	2
	Cleaners' store	2

6 Level 5

Total Population catchment	35-50000
Travel time (upper limit)	45 mins
Fixed clinical consultation spaces	40 cons. / procedure rooms
Wider clinical rooms	30 rooms/ diagnostic zones
Estimated Gross Internal Area	6500-7000m^2

Urban / rural location	Urban only *
Current no. comparable facilities in Wales	None at present
No. practices with sufficient reported GIA to deliver this model	1-2 Health & Wellbeing Centres planned

Level 5 Exemplar Layout Illustration



The Level 5 facility example is split into 3 storeys with clinical accommodation on the ground floor and first floor, and Staff spaces on the second floor. The concept is based on patients and visitors arriving at a central public core, providing reception, waiting and commercial facilities. Clinical accommodation is then split into discreet 'zones' that are accessed from the central core, and can be further split into clusters of clinical rooms. The ground floor includes GP accommodation, other health and social care providers, community mental health, and associated FM support. Specialist clinical areas are contained on the first floor and are split into specialities. Separate access is provided to the FM area for deliveries etc.

Area	Room	No.
Public Zone		
	Entrance Foyer and way finding	1
	Clinical area signposting and self-checking space	1
	Reception Area (Public/Shared)	4
	Waiting Room	2
	WC: semi-ambulant	8
	WC: independent wheelchair	3
	Nappy changing room	2
	Infant feeding room	2
	Push Chair/Loan Wheelchair Parking bay	4
GP Zone		
	Consult / Exam	30
	Consult / Treatment/ Minor surgery	12
	Near Patient Testing Capacity	4
	Digital consultation pods	8
	Training Room(s)	6
	Large training room	4
	Large Therapies Gym/group rooms	2
	Phlebotomy room/Measurements	4
	Therapies storage	2
Other Health & Social Care Provider Zone		
	Clinic reception drop in desk	4
	Sub waiting area	1
	Sub-wait Accessible toilets	2
	Counselling Room- Social care and IAPT	6
	OPD Clinical Room/Private consultation rooms "drop in space"	14
	Minor Surgery/Enhanced procedure room	4

Area	Room	No.
Specialist Clinical Facilities		
	Ambulatory Assessment Area (cubicles and Sub-wait)	1
	Imaging hub	1
	Dentistry (5 rooms, clinical support spaces and Sub-wait)	1
	Ophthalmic Suite (2 Diagnostic, 2 consult, 1 Theatre, 2 recovery pods)	1
	OPD Clinical Room/integrated consultation rooms "drop in space"	12
	Health and Wellbeing Advisor Space	6
	Health Visitor/ Community teams drop in office	1
	Third sector open plan Hub/Wellbeing advice Hub	1
Community Mental health		
	Community mental health consultation rooms	4
	Sub waiting area	1
	waiting area toilets(wheelchair)	2
Commercial and Community Interactive Spaces		
	Resource centre with Digital enablement suite (10 computers and 6 consultation PODs)	1
	Group Meeting Space	2
	Youth Recreational Space	1
	Self-contained Creche space	1
	Visiting Advisory Services	6
	Community Kitchen/Café	1
	Pharmacy (including retail)	1
Staff Zone		
	multi-disciplinary team Meeting/Learning and Development VR Training room	6
	Toilets, Changing area, showers and staff room	1
	Staff rest/ beverage bay	6
	Staff Kitchens	4
	Administrative hot desk spaces	30
	Facility Manager office	2
	Building Security office	2
Facilities Management Space		
	Storage and records management desk(48m2)	4
	Clean utility	4
	Dirty Utility	4
	Cleaner's store	4

7 Summary of facilities at level provision

Area	Room	1a	1b	2	3	4	5
Public Zone							
	Entrance Foyer and way finding	1	1	1	1	1	1
	Clinical area signposting and self-checking space			1	1	1	1
	Reception Area (Public/Shared)	1	1	1	2	2	4
	Waiting Room			1	1	1	2
	WC: semi-ambulant	2	2	2	4	6	8
	WC: independent wheelchair	1	1	1	2	3	3
	Baby changing room	1	1	1	2	2	2
	Infant feeding room	1	1	1	2	2	2
	Large meeting room	1	1				
	Large Therapies Gym/Group Rooms		1				
	Push Chair/Loan Wheelchair Parking bay		1	1	2	3	4
	Resource storage	1	1				
GP Zone							
	Consult / Exam			4	7	13	30
	Consult / Treatment/ Minor surgery			2	3	6	12
	Near Patient Testing Capacity			1	1	2	4
	Digital consultation pods			2	4	2	8
	Training Room(s)			1	2	2	6
	Large training room				1	2	4
	Large Therapies Gym/group rooms			1	1	1	2
	Phlebotomy room/Measurements			1	2	2	4
	Therapies storage			1	1	1	2
Other Health & Social Care Provider Zone							
	Consult/Exam		2				
	Consult/Treatment or Minor surgery		1				
	Advice Resources Lobby and Digital Library (4 computers + displays)	1	1				
	Visiting Advisor desk	1	1				
	Digital Consultations PODs (one bookable / one drop in)	2	2				
	Small Meeting / Counselling Room- Social care and IAPT	2	2				
	Mini Kitchens	1	1				
	Administrative hot -desk spaces	1	1				
	Facility Manager office	1	1				
	Clinic reception drop in desk					1	4
	Sub waiting area					1	1
	Sub-wait Accessible toilets					1	2

Area	Room	1a	1b	2	3	4	5
	Counselling Room- Social care and IAPT			2	2	4	6
	OPD Clinical Room/Private consultation rooms "drop in space"			2	4	10	14
	Minor Surgery/Enhanced procedure room					2	4
	Specialist Clinical Facilities						
	Ambulatory Assessment Area (cubicles and Sub-wait)					1	1
	Imaging hub						1
	Dentistry (5 rooms, clinical support spaces and Sub-wait)						1
	Ophthalmic Suite (2 Diagnostic, 2 consult, 1 Theatre, 2 recovery pods)						1
	OPD Clinical Room/integrated consultation rooms "drop in space"						12
	Health and Wellbeing Advisor Space			1	2	2	6
	Health Visitor/ Community teams drop in office			2	1	1	1
	Third sector open plan Hub/Wellbeing advice Hub			1	1	1	1
	Community Mental health						
	Community mental/CAHMS[7] health consultation rooms				2	2	4
	Sub waiting area				1	1	1
	waiting area toilets(wheelchair)				1	1	2
	Commercial and Community Interactive Spaces						
	Resource centre with Digital enablement suite (10 computers and 6 consultation PODs)			1	1	1	1
	Group Meeting Space					2	2
	Youth Recreational Space					1	1
	Self-contained Creche space					1	1
	Visiting Advisory Services					6	6
	Community Kitchen/Café					1	1
	Pharmacy				1	1	
	Pharmacy (including retail)						1
	Staff Zone						
	Multi-disciplinary team meeting/Learning & Development VR Training room			1	2	4	6
	Toilets, Changing area, showers and staff room			1	1	1	1
	Staff rest/ beverage bay			1	2	4	6
	Staff Kitchens			1	2	3	4
	Administrative hot desk spaces			5	15	30	30
	Facility Manager office			1	1	1	2
	Building Security office				1	1	2
	Facilities Management Space						
	Storage and records management desk(48m2)			1	1	3	4
	Clean utility			1	3	2	4
	Dirty Utility					2	4
	Cleaner's store	1	1	1	2	2	4

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