# Primary Care Estate Strategy:

# East Dunbartonshire HSCP

# FINAL REPORT

**26 October 2022**
**Version 1.5**

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**EXECUTIVE SUMMARY**

In response to the agreed need to develop a primary care property strategy for the NHS Greater Glasgow & Clyde area, East Dunbartonshire became the fourth Health & Social Care Partnership (HSCP) area formally reviewed, through a project that commenced in February 2022.

The project, which was delivered with the support of hub West Scotland, sought the often-complex answers to four simple questions that are at the heart of any strategic estate plan:

- What do we want?
- What do we have?
- What do we need?
- What is therefore required? (What are our options?)

Overall, as with previous project elements, the work undertaken to date has been extensive and featured: the review and analysis of historical and new data; structured visits to all key sites; and extensive dialogue with a number of stakeholder groups including GP's, service providers, local management teams, estates staff, the third sector and local authority representation. It has identified the main core elements of a future primary care property strategy for the East Dunbartonshire HSCP area in the short and medium to long term.

This developing East Dunbartonshire component of an NHS Greater Glasgow & Clyde Property Strategy is consistent with the needs of the local and wider organisation whilst supporting delivery of the facilities element of Moving Forward Together, NHS Greater Glasgow & Clyde's blueprint for health and social care services. It is also consistent with the early phases of "place-based decision making" as advocated by the Scottish Government through informing the estate element of local vision and strategy. In summary it recommends that East Dunbartonshire HSCP should:

**In the short-term (0-3 years)**

- Review the data, assumptions and scenarios presented within this report to ensure they are valid and amend or update as appropriate.
- Support operational re-alignment of existing services/staff where feasible to make better use of existing available property resources based on the data collected and reviewed.
- Seek formal support from the Capital Planning & Premises Team to undertake project support and development activities.
- Review and re-present the augmented argument for a new "West Locality Health & Care Complex", supported by an amended Schedule of Accommodation (S of A), intended primarily to address those issues identified in the original "Milngavie Health and Care Centre" paper (presented as a component of the previous NHSGG&C prioritisation process) but with an added understanding of the substantial risk associated with existing premises in the area and space requirements as highlighted by this review.
- Finalise work already underway relating to the alternative means of delivering "shared satellite space" across the HSCP area to physically increase capacity available to support the delivery of clinical services and support short-term contractual and policy obligations whilst mitigating those risks identified associated with GP owned/leased premises in the area.

- Secure the funding required to implement those preferred solutions identified as essential in the short-term.
- Seek the inclusion of the preferred strategic option(s) identified in local HSCP plans within the next appropriate NHSGG&C capital prioritisation process to understand the actual timetable for development and/or any remedial actions required.
- Continue to review emerging proposals in the context of the "Place Based Approach" advocated by the Scottish Govt. that has been at the heart of the process followed to date.

**In the short to medium-term term (0 – 10 years)**

- Seek appropriate local and Board-wide agreement to develop the required business case(s) in support of capital investment or an alternative to this.
- Develop the business case(s) agreed as being required to support infrastructure developments in response to the findings of the option appraisal conducted and in the context of the relevant NHSGG&C Capital Planning & Prioritisation process/project programme.
- Develop the detailed briefing documentation required to support the development of detailed designs for any capital projects approved, ensuring that these can deliver the required range of services for the required planning period (including more detailed assumptions relating to changing demand and capacity requirements)
- Implement any remedial actions required in reflection of projected differences between strategic capital investment programmes and local demand/facilities (if required).

**In the medium to long-term (3 – 10 years plus)**

- Use "otherwise essential investment" and new monies secured through the capital business case process to maintain, develop, refurbish and/or construct the physical infrastructure associated with approved business cases in line with the overarching NHSGG&C Primary Care Estate Strategy and place-based investment approach. This is likely to include, most notably:
    - The replacement of Milngavie Clinic, +/- local GP Practices, (The proposed "West Locality Health & Care Complex" or "hub").
    - The provision of HSCP "shared satellite space" in the Bishopbriggs/Auchinairn area or an alternative to this agreed through an option appraisal process.

Overall, work across the East Dunbartonshire HSCP area has been well received, with lessons learned continuing to be incorporated into the developing review methodology ultimately intended to develop an NHSGG&C-wide primary care property strategy.

Such a strategy will support the practical implementation of Moving Forward Together, whilst enabling the Board to review and prioritise future facility developments across Primary Care, further ensuring that the right investment decisions are being taken at the right time and for the right reasons as components of an over-arching integrated services and property strategy.

## 1. INTRODUCTION

In reflection of a broad range of historic primary care property-related challenges but growing clarity on the developing future vision for health and social care services, hub West Scotland (hWS) were asked by NHS Greater Glasgow & Clyde (NHSGG&C) to provide operational support to its development of a Primary Care Estate Strategy (PCES).

Based on a series of preliminary meetings and dialogue with representatives of NHSGG&C, a methodology was agreed relating to how this work should be progressed, initially as a pilot within the Renfrewshire Health & Social Care Partnership (HSCP) area.

Following the successful completion of the Renfrewshire HSCP pilot, the project has been expanded across the Board area, with this report addressing relevant strategic property considerations across East Dunbartonshire HSCP. It has three primary objectives:

1) To provide a significantly abbreviated summary of the extensive property review process undertaken to date.
2) To identify the emerging core elements and apparent "direction of travel" of the East Dunbartonshire component of a developing Primary Care Estate Strategy and;
3) To present a brief series of recommendations relating to specific activities the review team believe are now worthy of further consideration.

## 2. BACKGROUND

In response to a number of defined property challenges across primary care areas, NHSGG&C identified a requirement to develop a primary care property strategy. This was intended to step back from the day-to-day operational premises challenges currently being experienced across primary care to ensure that even short-term solutions and investments were ultimately contributing to a medium-longer term vision.

Recognising the challenging nature of this activity, especially given significant short-term pressures, the work was conceived as an independently facilitated "conversation" that sought engagement and commentary from all stakeholders before developing evidence-based proposals relating to the required longer-term property strategy. These proposals were to reflect the wants and needs of all affected internal stakeholders along with data relating to the current condition, capacity, and functional suitability of the existing property portfolio. In so doing they would also support the development of an appropriate investment strategy and ensure that best use was made of any new and otherwise essential investment.

## 3. THE PROJECT TEAM

This project has been delivered by an extensive project team that represents:

- NHS Greater Glasgow & Clyde
- East Dunbartonshire Health & Social Care Partnership
- East Dunbartonshire Council
- Hub West Scotland

The core team supporting the project are indebted to a wide range of staff and supporters from within these teams; other planning partners; and GP practices across East Dunbartonshire without whom this activity could not have been completed effectively.

### 3.1 NHS Greater Glasgow & Clyde

Greater Glasgow and Clyde Health Board commissioned the Primary Care Property Strategy Pilot and supported the selection and scheduling of relevant HSCP areas for participation. Jeanette Hawthorn, Service Manager Property, led this work on behalf of the Board supported by colleagues from Property and Capital Planning.

### 3.2 East Dunbartonshire HSCP

East Dunbartonshire Health & Social Care Partnership (HSCP) deliver all adult, children's, and criminal justice social care services as well as community health services for adults and children in the East Dunbartonshire area. East Dunbartonshire HSCP leadership of the pilot was provided by Jean Campbell, Chief Finance & Resources Officer with extensive support from Vandrew McLean, Business Manager and the HSCP senior management team.

### 3.3 East Dunbartonshire Council

East Dunbartonshire Council is the relevant local authority and covers the same geographical area as East Dunbartonshire HSCP. The Review Team are indebted to a range of Council staff who supported this review process in recognition of the role they play in delivering a range of facilities from which HSCP staff operate and HSCP-led services are delivered.

### 3.4 hub West Scotland

Established in April 2012, hub West Scotland (hWS) is the joint-venture development company appointed to work in partnership with public bodies in the Greater Glasgow and Clyde area, also known as the West Territory. The pilot study and subsequent reviews have been delivered through hWS's Strategic Support Partnering Services with the support of Higher Ground Health & Care Planning Ltd (HGHCP), a specialist healthcare and master planning consultancy selected by NHSGG&C from hWS's pre-qualified list of suitably experienced suppliers. The hWS team supporting the project was led by Angeline Robertson, hWS Partnership Director, with core support from Gary Smithson, hWS Senior Project Development Manager and Billy Murray hWS Supply Chain Manager. HGHCP support for the project was primarily delivered by Norman Sutherland, HGHCP's Director (Health).

## 4. THE PROCESS

As with previous review activity, the project was progressed through an amended version of HGHCP's established Strategic Estate Review (SER) process. This process recognises that optimal investment/dis-investment decisions can only be achieved through realising the optimum balance between fixed assets and service delivery models and is in line with established estate and asset management methodologies. In summary, it seeks the (complex) answers to four simple questions:

- What do we want?
- What do we have?
- What do we need?
- What therefore is required?

This process is shown graphically in Diag. 1. (Overleaf).

### 4.1 Phase 1: "What Do We Want?"

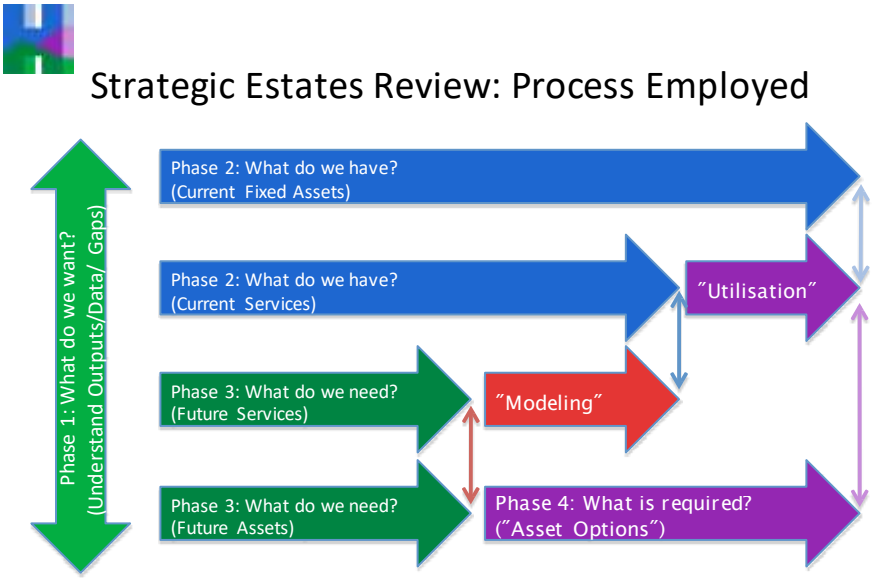
It is essential to identify and document the desired operational outputs of any project or process to understand and be able to explore the alternative means of achieving these. This project phase therefore involves seeking agreement on the proposed methodology, programme, and activity schedule; supporting initial interactions with the NHS client; and attempting to understand stakeholder "wants", as well as recognising where differences of opinion may exist.

### 4.2 Phase 2: "What Do We Have?"

Establishing the range of existing services along with the resources and assets available to support them is essential to the identification of a baseline against which future service developments and the assets required to support them can be measured. This project phase is therefore primarily about baseline data collection and specifically about relating people, services and activity to places and fixed assets (facilities).

### 4.3 Phase 3: "What Do We Need?"

Phase 3 relates to delivering robust clinical, operational, asset/building-specific, and strategic challenge. Specifically, it is about understanding the real emergent issues and challenges – which are often different to those previously identified; supporting the development of the evidence base for current and future capacity requirements; presenting alternative means of achieving the same output goals; and understanding the actual service and associated site development/consolidation implications of any alternative options emerging.




**Diag. 1. The HGHCP Strategic Estate Review Process**

### 4.4 Phase 4: "What is Required?

Phase 4 of the process involves identifying how existing services and facilities could change in future in response to baseline opportunities for improvement and anticipated strategic challenges agreed. This includes:

- The generation of primary options relating to a more appropriate distribution of services and utilisation of facilities in key geographical locations.
- The identification of apparent priority investment/dis-investment opportunities across the area for further consideration/review and business case development as appropriate.
- A developing vision for the property portfolio and clear sense of "strategic direction of travel".

## 5. WHAT DO WE WANT?

The methodology employed in the first phase of the project involved two separate but linked elements:

- Workshops with local stakeholders to help understand and discuss local services and property issues.
- A review of wider local and national policy and context.

### 5.1 Stakeholder Workshops: What Do We Want?

A series of stakeholder workshops were held that were designed to explore the first key question posed by the process: "What do we want?" and importantly, to test if everyone who participated "wanted the same thing". These workshops, which were all held virtually, used a semi-structured format but adopted a safe, conversational style. Appendix A presents a summary of the people and organisations who participated in these sessions.

The workshops, which were independently facilitated, used a series of trigger questions to break down the main question "what do we want?" into a series of more manageable discussions.

In the event, the workshops were well attended (despite significant pressures); constructive; and characterised by extensive positive discussion and widespread agreement on the key issues. Collated feedback, which is presented in Appendix B, summarised a desire on behalf of those who participated for:

- Openness, honesty & inclusiveness.
- Recognition that some challenges can't wait for a strategic resolution.
- Equity of access to all services across all areas and over an extended day where appropriate.
- A strategy that sees "the bigger picture" … even where this is at odds with individual aspirations and presents the basis for securing structured investment.
- Clear proposals or options about the way forward that are linked to local and national strategy.
- Support (and investment) for developments that take us towards the preferred strategic direction of travel.
- Facilities that are able to support delivery of the GP contract and offer a "soft landing" for GP's who are affected by any changes proposed .
- The ability to deliver the Primary Care Improvement Plan (PCIP).
- Agreement on how we will be working in a "post COVID" world that retains the positive elements of recent rapid change.
- An understanding of what this will mean for services and the premises required to support them.

- An understanding of defined local communities and how they must influence strategy.
- More flexibility, more sustainability (buildings and services).
- Fit for purpose spaces, where people of all ages want to be – and can be safely.
- A new Milngavie Health & care Hub in response to what was seen as a collection of HSCP and GP facilities in this area that are no longer fit for purpose. (This had also been presented in a feasibility study that had been considered by a previous prioritisation panel but failed to secure the required funding)

The workshops provided an important insight into local thinking and specific concerns but also broadly reflected the issues, challenges and objectives reflected in the formal documents and strategies subsequently reviewed.

In overview, feedback demonstrated a need for equity of access to flexible accommodation that can respond to increasingly challenging policy initiatives; service requirements; and demands whilst maximising opportunities for more integrated working.

**5.2 Wider Policy Context: What Do We Want?**

As well as seeking the views of individual local stakeholders and groups, the process also sought to answer the question "what do we want?" at a corporate and national level by considering it in the wider policy and guidance context as this relates to either buildings and/or services. Whilst this involved a very broad review, key issues, documents and agreed strategies identified that are deemed worthy of specific note include:

- NHS GG&C Property Asset Management Strategy (PAMS)
- East Dunbartonshire HSCP Property Strategy
- East Dunbartonshire HSCP Strategic Plan (2022 – 2025)
- East Dunbartonshire Prioritisation Report (Milngavie Health & Care Centre Feasibility Study)
- COVID-19 response
- NHS Scotland Property Appraisal Manual and associated Estate Asset Management (EAMs) alongside wider premises guidance
- The new GP Contract and GP Premises National Code of Conduct
- Moving Forward Together, NHSGG&C's vision for health and social care services

**5.2.1 East Dunbartonshire HSCP Property Strategy**

The East Dunbartonshire HSCP Property Strategy identifies that national planning guidance states:

"The Chief Officer of the Integration Joint Board is recommended to consult with the Local Authority and Health Board partners to make best use of existing resources and develop capital programmes. The Integration Joint Board should identify the asset requirements to support the Strategic Plan. This will enable the Chief Officer to identify capital investment projects, or business cases to submit to the Health Board and Local Authority for consideration as part of the capital planning processes, recognising that partnership discussion would be required at an early stage if a project was jointly funded."

It identifies that East Dunbartonshire Health and Social Care Partnership (HSCP) collectively make use of property across both East and West localities where health and social care functions are carried out. It also recognises that there is "an opportunity and clear need to":

- Review the approach taken to strategic planning and utilisation of the estate available to the Partnership.
- Support the aims of integration and delivery of effective, efficient health and social care services in East Dunbartonshire.
- Utilise an agreed Property Strategy for the HSCP to inform a specific property strategy group and the Council's Transformation Programme Board.

Key objectives of the property strategy identified are:

- To gain best value from our use of property.
- To ensure that health and social care services are provided in and from fit-for-purpose, modern buildings.
- To enhance provision of health and social care services in local communities.
- To rationalise our estate to reinvest savings into frontline services.

Stated principles are:

1. Designing and delivering accessible services to meet the needs of individuals, carers, and communities.
2. Being open and showing that we are fair when allocating resources.
3. Delivering services to people in their local communities.
4. Making best use of the assets available to us.

A range of "key strategic issues for East Dunbartonshire HSCP" are also identified within the Property Strategy. These include:

- The development of an integrated health and social care centre proposal in the West locality to provide further integration of health and care along with GP and third sector services in line with the national policy direction.
- The need to identify space for the Older Peoples Mental Health service within the West locality.
- Additional plans for remodelling existing space in and around KHCC.
- Implementation of the older people's day care strategy and learning disability review.
- Consolidation of HSCP accommodation within the East locality.

**5.2.2 Milngavie Health & Care Centre Proposal**

East Dunbartonshire HSCP have previously identified a significant challenge associated with premises and service delivery in the West locality and consequently developed a proposal for a new strategic hub facility to address these. This proposal, which was included in the NHSGG&C capital prioritisation process but did not receive funding support, states that the provision of Milngavie Health & Care Centre is integral to the vision of East Dunbartonshire Health & Social Care Partnership (HSCP) vision for the transformation of health and social care services within the locality and to improving access to services, tackling inequalities, and delivering better outcomes for local people.

The proposal identifies that existing facilities in the area are unable to accommodate the expanding GP practice population or the developments in services and new ways of working brought about by the current GP contract. It also notes that the proposed new build facility would enable the HSCP to provide a range of other services currently unavailable within the West Locality (including Milngavie, Bearsden, and local villages) and, by bringing together a few practices into a single facility, have future sustainability benefits and economies of scale. Existing facilities to be consolidated within the new facility as proposed are:

- Milngavie Clinic (HSCP Hub facility with no GP services at present)
- Ashfield Medical Practice (GP)
- Denbridge Surgery (GP)
- Kersland House Surgery (GP)
- Kessington Medical Centre (GP)
- The Terrace Medical Practice (GP)

Collectively, these facilities support a local practice population of just under 40,000 people or 36% of the East Dunbartonshire population. Services that it is proposed would be delivered from this new facility include all existing HSCP and GP services/clinics, although it would also act as the base for a wider number of defined teams. The early schedule of accommodation for the proposed facility identifies a Gross Internal Floor Area (GIFA) of circa. 7,500m2, including:

- 1,300m2 of GP area
- 1,700m2 HSCP area
- 752 m2 of agile working area including 120 desks
- 210m2 of Community space
- 100 consulting, treatment, or interview rooms
- 20 group/meeting rooms (Baseline for all East Duns is 37 rooms)

For comparison purposes:

- The total area associated with the existing GP practice facilities it is proposed to replace is 1,830m2 – although this includes circulation space (corridors, stairs, etc) plus walls and structure that are listed separately in the proposed S of A. The Project Team's assessment is that the current proposal probably represents a similar overall area for the GP practice element.
- The total area associated with the existing Milngavie Clinic is 576m2 - although again, this includes circulation space (corridors, stairs, etc) plus walls and structure that are listed separately in the proposed S of A. The Project Team's assessment is that the current proposal probably represents an increase of around 400% for the HSCP component of the facility taking the current Milngavie Clinic as the baseline.
- Existing facilities include 71 consulting, treatment, or interview rooms (9 in Milngavie Clinic, 62 across the five GP practices included)
- Existing facilities have no group/meeting rooms identified within the data gathered in support of the review but the baseline number of group/meeting rooms identified across East Dunbartonshire is 37 rooms. This includes 24 small meeting rooms; 9 medium meeting rooms; and 4 large meeting rooms including 18 in KHCC; 8 in Southbank; and 4 in Lennoxtown Hub.

Work undertaken on the Primary Care Premises Strategy for East Dunbartonshire is ultimately supportive of this proposed hub development, having identified a broader range of factors

and risks that need to be included within the case for investment that are explored further in later sections of this report.

### 5.2.3 Other Key Policy Context

Other, developing project-wide policy context information can be found in Appendix C. This includes information on a range of issues including:

- COVID-19
- NHS Scotland Property Appraisal Manual and associated Estate Asset Management (EAMs) alongside wider premises guidance
- The new GP Contract and GP Premises National Code of Conduct
- Moving Forward Together (MFT), NHSGG&C's vision for health and social care services

### 5.3 Summary: What Do We Want?

In consideration of the issues raised in Phase 1 as well as those identified through the wider process to date, it can be concluded that a Primary Care Property Strategy for East Dunbartonshire – in line with programme-wide developing thinking - should in summary:

- Be open, inclusiveness and engaging – with no surprises.
- Consider longer-term, strategic property needs.
- Reflect on short-term risks and opportunities where feasible.
- Deliver a better quality, more functionally suitable estate that meets all standards.
- Deliver fair and equitable access to services.
- Help to better match demand and supply in property terms.
- Support sustainability in property, service, and financial terms – including the further consolidation of facilities where appropriate.
- Inform all future property decisions (Including as they relate to GP practice premises).
- Reflect on and support the delivery of local and national strategy, including MFT.
- Develop a vision and agreed "direction of travel" for all Primary Care premises.
- Remain flexible – especially over the medium to long-term.
- Consider the relative merits of those existing capital proposals developed, most notably the proposal for a new Milngavie Health & Care Centre.

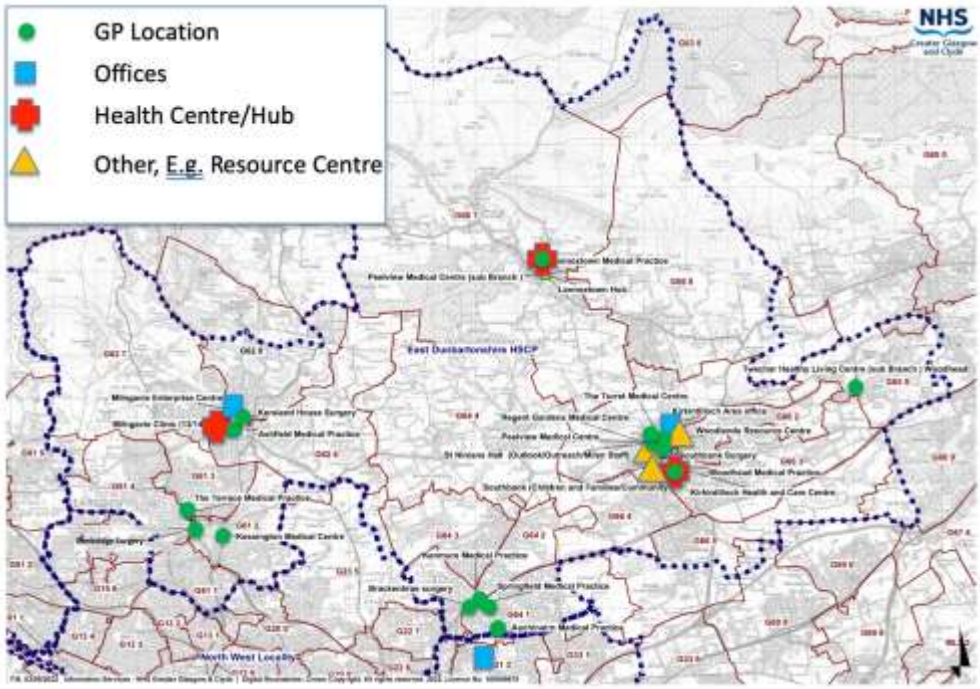
## 6. WHAT DO WE HAVE?

In order to understand and record "what we have" in terms of the existing Primary Care estate and those services currently delivered from it, this project phase involved:

- The identification of all premises/part thereof to be included in the review process.
- The robust collection and review of baseline clinical and service data, to understand the relationship between current services and the facilities reviewed.
- Visits to key NHS/Local Authority owned/leased sites identified by members of the project team to supplement our shared understanding of existing accommodation, its condition, current clinical functionality, strengths, weaknesses, opportunities, and threats.
- A desktop review of GP owned facilities based on current EAMS building condition and functional content data entries.

- The development of appropriate assumptions, based on experience and learning from historical project activity, where no or only minimal data is available.
- The cross-referencing of data by service and physical accommodation to determine current global utilisation, indicative capacity available and options for strategic consolidation that may release space for alternative use.
- The geo-referencing of properties to determine their relative strategic importance and overall level of risk based on geographical location.
- The generation of a Strategic Infrastructure Database (SID) that pulls all collated services and facilities data together into a single master document to aid evidence-based planning.

An overview of those facilities included in the review process is shown in Diag. 2., below.




**Diag. 2. East Dunbartonshire HSCP: All Premises Reviewed by Type**

### 6.1 The Strategic Infrastructure Database (SID): Overview

The Strategic Infrastructure Database (SID) is the programme's means of collating all relevant data collected in response to the question "what do we have?".

The SID is an expansive spreadsheet used for data analysis and planning purposes that relates existing services to the facilities/locations they are being delivered from. Its main objective is to provide a single repository for all relevant information/data and ultimately to inform a developing property strategy that is derived from the best data currently available. An overview of the detailed contents of the SID is presented in Appendix D, with Appendix E outlining the implications of space and room types recorded in the SID on the analysis undertaken. The SID itself is presented in Appendix F. As a database with nearly 7,000 individual data cells, the full SID is not reproduced in paper copies of this report.

Much of the historic property data analysed during the pilot project was extrapolated from the HSCP's existing and comprehensive EAMS database, although this was supplemented by extensive site visits and additional data collection/review by various members of the Property

and Capital Planning Team including the Board's Project Director, Property Asset Manager, Senior Property Manager, GP Premises Development Manager, Project Support staff and Asset Senior General Manager.

Services data used in the SID was all as provided by East Dunbartonshire HSCP and reviewed/agreed with them prior to and throughout analysis.

### 6.2 The Strategic Infrastructure Database (SID): Detail

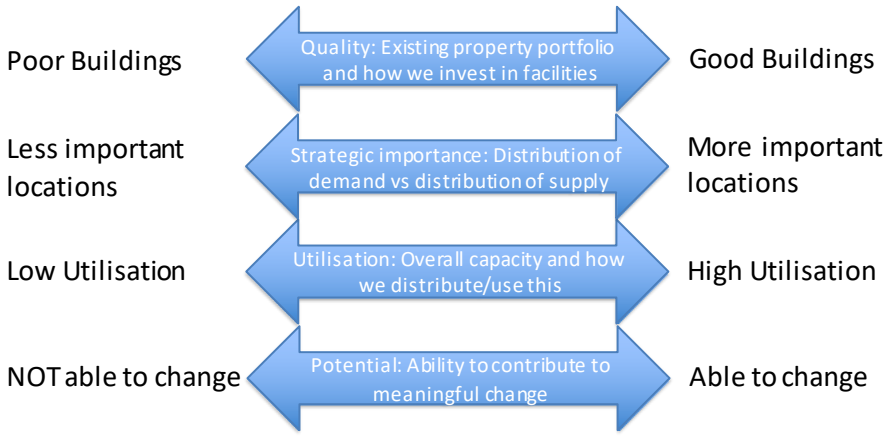
To aid decision making at a strategic level around what, if any, role existing assets may play in a future strategic estate model, the SID ultimately attempts to consolidate all available information into 4 summary criteria that reflect:

- The overall quality/fitness for purpose of existing buildings.
- Their baseline utilisation.
- Their strategic significance as a service delivery location.
- Their potential to support future change/deliver service needs.

In the context of a developing property strategy this supports strategic analysis by allowing individual premises to be plotted graphically on a range of different charts according to how they score against each criterion to allow ready visual comparison and analysis. The relevance of these criteria is shown in Diag. 3. (Below)

### 6.3 Buildings Assessment & Backlog Maintenance Reporting

One criteria used as a proxy for the relative "quality" of a building is "backlog maintenance". Backlog maintenance is expressed as a cost (£), but it is important to recognise that there is currently no single accepted descriptor of this across the public sector which makes any kind of direct comparison impossible.




**Diag. 3. The Relevance of Consolidated Criteria Used to Summarise Existing Properties**

To ensure that the project was able to merge NHS and Local Authority facilities assessments and make reasonable over-arching comparisons, a workshop was held between relevant estates professionals from both organisations to better understand the pertinent issues.

### 6.3.1 NHS GG&C Buildings Assessment & Backlog Maintenance Reporting

NHS GG&C undertake cyclical condition surveys of its property portfolio to report into NHS Scotland's Estate and Asset Management System (EAMS). The survey categorises condition based upon surveys by independent survey partners that is subsequently verified by local Estates teams. It also generates an overall assessment regarding the standard and suitability of the building, classifying these as follows:

A = Excellent/as new condition (Generally less than 2 years old)
B = Satisfactory condition with evidence of only minor deterioration
C = Poor condition with evidence of major defects
D = Unacceptable condition, reached the end of its useful life
X = Supplementary rating added to D only to indicate cases where it is impossible to improve the building without replacement

The aim of NHS backlog maintenance appraisal is to assess the cost and risk level of any works required to return the estate to a physical condition "B" (satisfactory condition with evidence of only minor deterioration) and statutory compliance. They do this by assessing the lifecycle period and lifecycle replacement cost for each asset. Overall, all items with a grade C or D, or within Year 0 and 1 (NHS)/Year 1 and 2 (LA) should be classed as backlog.

It is important to recognise that backlog maintenance costs are expressed as works costs (i.e., the base costs to undertake works) and that consequently a wide range of additional costs are excluded. These include:

- Professional fees
- VAT
- Contingencies
- Inflation
- Risk
- De-cant costs
- Temporary services to other areas
- Overtime/out of hours working
- Disruption
- Etc

As a result of these additional considerations –which incur a real cost – NHS Scotland now widely recognises a three times multiplier to generate a more accurate reflection of true "investment cost" to address identified backlog maintenance as recorded. It is normal practice to assume that the actual costs to undertake background backlog maintenance is around three times the reported backlog maintenance costs.

### 6.4 Core Space (Room) Types

For the purposes of this strategic exercise, the review team worked on the principal that all facilities have 3 core types of accommodation in scheduled planning terms. These were defined as:

- Primary delivery areas (PDA's)
- Desk & administrative areas (Desks)
- Secondary support spaces

### 6.4.1 Primary Delivery Areas (PDA's)

"Primary delivery areas" or sometimes "primary clinical delivery areas" (PCDA's) depending on context, are those key rooms/spaces that deliver core client-facing service functions. In the context of this Primary Care strategy work they primarily include:

- consulting rooms
- treatment rooms
- interview rooms; and
- other specifically defined/identified clinical/service delivery spaces/rooms. E.g., Gyms

It should be noted that simplifying room types for the purposes of analysis can lead to specific challenges/errors in some, especially smaller properties, but that it is seen as an appropriate means of simplifying data and analysis in the context of a 15 – 20-year strategic property strategy involving multiple individual premises such as this. It is also noted that the SID includes a more detailed breakdown of rooms and key spaces should further investigation or analysis be required.

All the data relating to room numbers and types recorded in the SID has been provided or verified by relevant Capital Planning and HSCP staff, with more detail on the nature of all the spaces recorded and their implications in the context of the developing property strategy to be found in Appendix E.

### 6.5 GP Owned/Leased Premises & Activity Data in the SID

Although extensive property survey data is available to the Board and HSCP, the data available relating to GP owned/leased premises is still considerably less informed/detailed than that available for NHS owned/leased premises. As a result, the information/data relating to GP owned/leased premises has been supplemented by structured discussions with over-arching GP premises/contract staff who know the buildings and published practice population information in support of this review.

The initial assessment of individual GP facilities should therefore be taken as indicative only at this time and intended to support a general assessment of the overall GP premises strategic property challenge rather than to inform specific practice by practice investment decisions.

In terms of GP activity data, practice population has been used as a simplified proxy for relative activity levels. (See Appendix G) Whilst acceptable for a high-level, strategic exercise such as this it is acknowledged that many factors affect the relationship between practice population and actual appointments that will have to be considered in any detailed plans subsequently developed. These include, but are not limited to:

- Variation in local services offered.
- Local need/demand.
- Demography.
- Uptake.
- Accessibility.
- Deprivation.

Consequently, this data has only been used to highlight a general apparent view of PDA's available by GP practice and cluster to determine where the most acute space issues may be and where further, more detailed analysis and immediate action may be required.

It is also important to underline that this information will need to be discussed in detail with individual GP practices before it is used to inform any specific changes or investment decisions and that future decisions around what GP practices choose to do with their premises lies solely with them as the premises owners/lease holders.

**6.6 Summary: What do we have?**

In summary, the East Dunbartonshire SID (Appendix F) identifies a wide range of data in support of property strategy development. This includes:

- A practice population of circa. 110,000 people.
- GP/HSCP managed services that are delivered from 23 physically separate premises and 26 different delivery locations (further sub-divisions of space).
- A total of 10 NHS/Local Authority owned/leased premises.
- A total of 13 GP owned/leased premises.
- Around 153,000 appointments being delivered from HSCP owned/leased premises
- Clinical services being delivered overall through circa. 218 individual PDA's (rooms) across all premises – not including administrative or support spaces.
- A total of 15 GP practices arranged across 3 defined but relatively isolated GP clusters broadly related to the existing urban conurbations.
- Only 2 GP practices that operate from NHS owned/leased premises and account for 9% of the local GP practice population (Although one further practice has a sub-branch with two clinical rooms within an NHS health centre facility)
- 13 GP practices that operate from GP owned/leased premises and account for 91% of the local GP practice population.
- Properties that range from less than 10 years old (Lennoxtown Hub) to over 50 years old (E.g., Milngavie Clinic).
- Within the NHS/Local Authority owned/leased component of the estate circa. 846 wte staff and 555 desks.
- Two facilities that include a total of 372 desks; representing 72% of the available total desk/administrative capacity. (KHCC and Southbank)
- A total backlog maintenance figure of circa. £3.1m across all properties that reduces to £2.1m when the significant component associated with the shared offices at Stobhill Hospital is removed. This figure is positively affected by the high number of Council facilities in use where zero backlog maintenance is reported and includes:
    - £222k associated with the nine HSCP occupied facilities (excluding the NE sector offices at Stobhill)
    - £1.8m backlog associated with the thirteen GP owned/leased facilities in East Dunbartonshire

## 7. WHAT DO WE NEED?

To answer the question "what do we need?", phase 3 of the process involved interrogating the data collated within the SID and identifying core options/opportunities for improvement/advantageous change that were aligned to the preferred direction of travel defined previously as "what do we want?". Specifically, it sought to confirm:

- Current and future service requirements in terms of client-facing capacity and functionality, e.g., the broad volume of client-facing and administrative capacity required now, and in the future, based on agreed future capacity modelling data by geographical locality.
- How this relates to those assets currently available based on previously assessed criteria including:
    - The overall quality/fitness for purpose of existing buildings
    - Their baseline utilisation
    - Their strategic significance as a service delivery location
    - Their potential to support future change/deliver those services identified as being required
- Those geographical areas/localities/facilities that represent the greatest challenge/highest priorities for service review and property investment/consolidation.

**7.1 What do we need now?**

Assessments of baseline space utilisation were derived using the provided property and activity data in combination with conservative but appropriate and evidence-based assumptions regarding key metrics. These included:

- PDA numbers available
- Numbers of appointments annually
- Assumed or calculated clients/PDA/day
- Session utilisation
- wte staff numbers by facility and role
- Desks required by wte and role

Overall, the project team sought to understand the difference between spaces available and required based on appropriate optimal utilisation as agreed through discussion with wider stakeholder participants.

The review team recognise that historic assessments of space utilisation within consultation areas are frequently based on "session utilisation", that is to say, the number of rooms available to support activity booked by clinic. This has historically shown very high levels of utilisation in some areas and a lack of rooms available for those services who wish to expand their service/physical footprint. The strategic primary care property review has instead considered "in-session utilisation", i.e. How well individual rooms are likely to be used daily based on the number of clients recorded as accessing them. It has done this, in line with the wider review process, by attempting to align historical activity with the space available to support it.

The review team note that all the metrics and assumptions we have used are clearly documented within the SID and can be altered to present alternative perspectives/scenarios to determine the impact of any proposed changes on space required. E.g., The impact of assuming fewer desks/wte/role

Overall, the review of client-facing (PDA) space available vs required has identified:

- A total of 218 PDA's available to the HSCP across all facilities (HSCP and GP owned/leased) to support the local health and social care needs care needs of the 110,000 local practice population
- This equates to an overall average of 2.0 PDA's/1,000 practice population across East Dunbartonshire (Renfrewshire, the pilot area, by contrast had a ratio of 1.75 PDA's/1,000 practice population and Inverclyde 2.4)
- That circa. 153,000 appointments are currently being delivered each year within the public sector owned/leased component of the estate (10 properties and 59 PDA's).
- For services within HSCP owned/leased facilities this represents a range of between 2.4 and 19.4 clients/PCDA/day.
- Overall GP activity is being delivered from 15 different locations and 170 PCDA's.
- This represents a range of between 0.9 and 2.5 rooms/1,000 population.

This appears to reflect a property portfolio that is overall well-utilised from a client-facing activity perspective, albeit with understandable/explainable variances in baseline capacity utilisation that is explored further in subsequent sections of this report.

With respect to administrative areas, the available data has identified:

- Within the NHS/Local Authority owned/leased component of the estate circa. 934 wte staff and 519 desks against a total estimated requirement for 736 desks at 80% utilisation based on current project assumptions and metrics. (A substantial under provision)
- Four facilities that include a total of 443 desks; representing 85% of the available total desk/administrative capacity and 79% of the identified wte desk requirements based on the agreed baseline metrics used relating to desks/wte and utilisation. (KHCC, Southbank, Milngavie Clinic & Woodlands) NB Milngavie Enterprise Clinic has also been included in admin planning tables as it is a new facility that is not yet in use that represents additional capacity that will come online in the near future.
- These facilities can be seen as the main "administration" areas with large numbers of desks where additional analysis of desk utilisation may be appropriate.

| Site Name | DESK COUNT | MEDICAL | NURSING | AHP | SOCIAL WORK | CLINICAL/SERVICE SUPPORT | NON-CLINICAL/SERVICE SUPPORT | TOTAL ADMIN | TOTAL (wte) | Desk utilisation (%) |
|---|---|---|---|---|---|---|---|---|---|---|
| | Desks | Staff | | | | | | | | Space Utilisation |
| HSCP ASSOCIATED PREMISES | | | | | | | | | | |
| KHCC | 300 | 14.15 | 86.1 | 41.7 | 302 | 55.35 | 4.6 | 80.34 | **584.24** | 124% |
| Southbank* | 72 | 0 | 0 | 0 | 92 | 0 | 0 | 0 | **92** | 77% |
| Milngavie Clinic | 42 | 0 | 51.92 | 7.7 | | 11.9 | 0.6 | 3.88 | **76** | 110% |
| Woodlands Resource Centre | 29 | 14.2 | 15 | 2 | 2 | 6.6 | 0.3 | 8 | **48.1** | 108% |
| Milngavie Enterprise Centre | 28 | | | | | | | | | |
| | | | | | | | | | 800.34 | |

* Southbank staff numbers may be headcount

**Diag. 4. Baseline Desk Utilisation in Key Facilities with Extensive Administrative Areas (Based on agreed project metrics and assumptions)**

Diag. 4. (Above) presents an overview of the current desk count within the five primary facilities with large administrative areas along with data relating to wte staff numbers by professional grouping. It also includes an overall assessment of baseline desk utilisation based on agreed project metrics relating to desks/wte/staffing group.

The table shows a consistently higher utilisation of space than may be expected across three of the four areas currently in use that the project team hypothesis is a consequence of on-going "blended working" and may be indicative of the possibility to reduce baseline metrics in reflection of this.

Diag. 5. (Below) presents an alternative view of the same data but now calculating the difference between desks available and required at a baseline utilisation of 80% to indicate the net excess/(deficit) in desk numbers by facility.

| Site Name | DESK COUNT | TOTAL (wte) | DESKS REQUIRED @80% UTILISATION | DESK EXCESS/(DEFICIT) @ 80% OCCUPATION | Desk utilisation (%) |
|---|---|---|---|---|---|
| | Desks | | | Desk Excess/(Deficit) | Space Utilisation |
| HSCP ASSOCIATED PREMISES | | | | | |
| KHCC | 300 | **584.24** | 464 | (164) | 124% |
| Southbank* | 72 | **92** | 69 | 3 | 77% |
| Milngavie Clinic | 42 | **76** | 58 | (16) | 110% |
| Woodlands Resource Centre | 29 | **48.1** | 39 | (10) | 108% |
| Milngavie Enterprise Centre | 28 | | | | |
| | | 800.34 | | | |

* Southbank staff numbers may be headcount

**Diag. 5. Baseline Desk Excess/(Deficit) in Key Facilities with Extensive Administrative Areas (Based on agreed project metrics and assumptions)**

Diag. 5. identifies a number of areas where existing baseline demand for desks may be exceeding supply when utilising the metrics agreed – a situation that could result in desks not being available when required. Overall, there is a uniformly higher level of desk utilisation than baseline metrics indicate may be appropriate which the project team hypothesise may indicate either:

- A lack of available administrative space in KHCC, Milngavie Clinic; and Woodlands Resource Centres, or
- The on-going medium-long-term impact of changes in working practices originally developed in response to COVID that have reduced overall desk requirements and should result in desk planning metrics being amended moving forward.

The HSCP Team also note that there has been a significant increase in staffing levels because of Scottish Government investment across a number of policy initiatives that has had a consequential impact on desk utilisation. This includes the Primary Care Implementation Plan (PCIP); Alcohol & Drug Support Teams; The National Mental Health Strategy; Winter planning funding; Medication Assisted Treatment (MAT) standards; etc. All these investment

programmes have resulted in the need to find space for additional staff within existing facilities, at least in the short-term, with a consequential increase in utilisation.

It is important that this situation is reviewed and addressed if necessary either through:

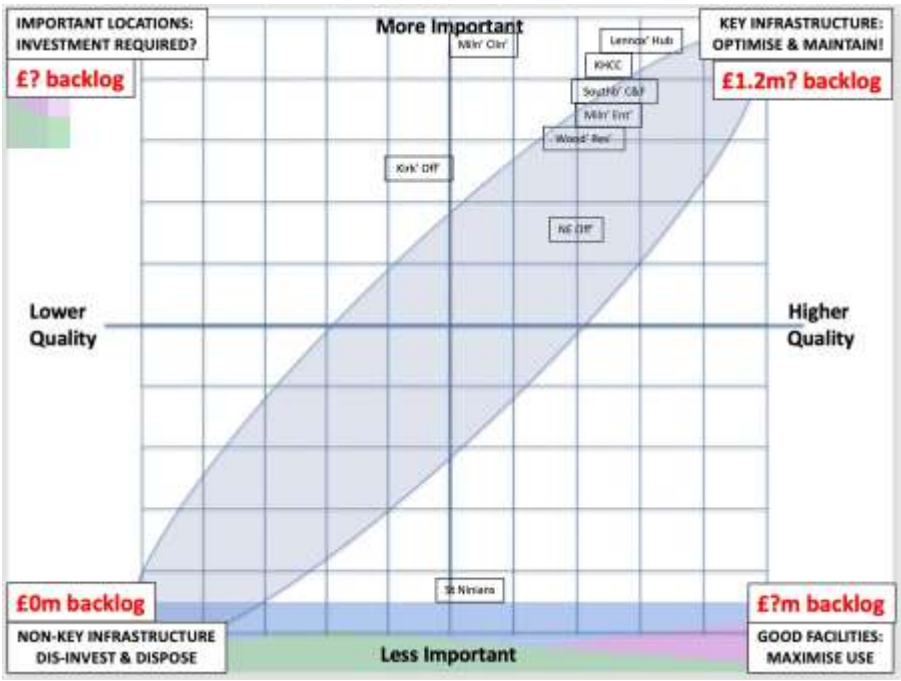
1) The re-alignment/expansion of teams/desks between facilities to ensure enough space is available, and/or
2) The adjustment of project metrics (desks/wte/professional grouping) to reflect less desks being required on an on-going basis in reflection of permanent changes to the amount of time staff will be expected, E.g. To undertake "hybrid working", including from home.

The project team also note that the limited opportunity to re-distribute baseline capacity (if required) using the apparent space available at Southbank and the new capacity likely to come online at Milngavie Enterprise Centre which is included within the SID but not yet occupied. They also note that the space available at Southbank may be underestimated if, as noted, staffing numbers are indeed a head count rather than whole time equivalent (wte) number.

### 7.2 What are the key property challenges and opportunities?

#### 7.2.1 The East Dunbartonshire HSCP Occupied Estate

Diag. 6. (Below) graphically presents SID data relating to the overall review team's assessment of existing key primary care infrastructure used by East Dunbartonshire HSCP. This shows "building quality" (x axis) mapped against "strategic importance" (y axis) on the agreed "strategic property assessment framework".




**Diag. 6. Quality of Primary Care Buildings vs Strategic Importance**

This framework also identifies the core elements and objectives of a property strategy as they relate to the quadrants formed and properties within them. These are:

- The high quality/strategically important quadrant: “Key infrastructure’, important properties whose use needs to be optimised and that should be maintained accordingly.
- The high quality/strategically less important quadrant: good facilities whose use needs to be optimised – potentially in support of services where delivery location is less important/relevant.
- The low quality/strategically important quadrant: Delivery locations whose strategic importance are not reflected in the poor-quality facilities available – potential investment in new facilities may be required.
- The low quality/strategically less important quadrant: non-key infrastructure where the primary property objective should be to dis-invest and dispose as soon as alternative options are available.

It is important to note that:

Building Quality scores (x axis) are based on extensive local reporting data along with structured on-going facility assessments, supplemented by the capital planning teams additional assessments and site visits. These have been generated by local estates staff from both the NHS and East Dunbartonshire Council in conjunction with the Capital Planning Team before being discussed and verified by the HSCP strategic management team to ensure continuity and robustness. Components of the assessments include:

- Physical condition
- Statutory compliance
- Environmental management
- Functional suitability

Strategic Importance scores (Y axis) are based on the HSCP’s assessment of the strategic significance of the facilities/sites assessed based on an initial assessment undertaken by the Capital Planning Team to ensure continuity and robustness. Components of the assessments include:

- Overall strategic importance of the location from an NHSGG&C/HSCP-wide perspective.
- Accessibility of the facility/site as a strategic delivery location.
- Proximity to other relevant locations.
- Proximity/relationship to public/service needs.
- Whether there is any duplication or replication of the relevant facilities/services locally.

The distribution of premises across the framework is broadly as might be expected, primarily along an axis running between the low quality/less important to high quality/more important quadrants. This is probably indicative of an effective historical estates management strategy that has concentrated available funding on the most important facilities in combination with a capital planning strategy that has sought to maximise the value of new investment. A number of properties lie outside this axis and do appear to be worthy of note however, in so far as their strategic importance seems at odds with the baseline quality assessment of their buildings. These are:

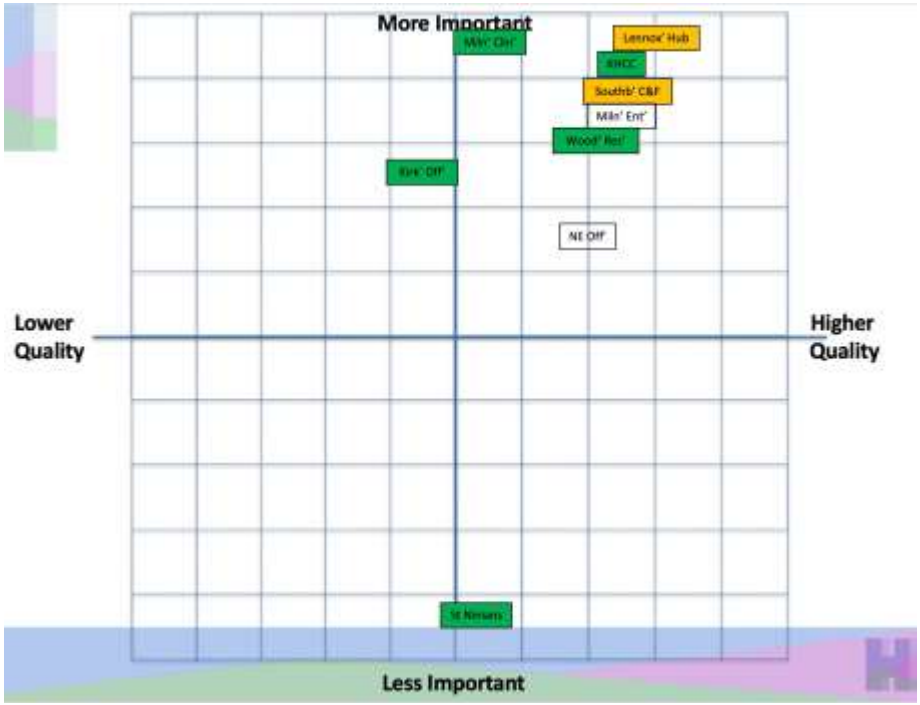
- Milngavie Clinic (Strategic significance 10/10, Building Quality 6/10)

- Kirkintilloch Area Office (Kilsyth Road), Criminal Justice Services (Strategic significance 8/10, Building Quality 4/10)
- St Ninian's Hall (Strategic significance 1/10, Building Quality 5.4/10)

Diag. 7. (Below) presents the same assessment of premises but with the additional inclusion of assessed utilisation. This is conveyed through the simplified use of colour that represents a range of assessments – developed from SID data - as summarised in Diag.8. (overleaf) where:

- Qualitative assessments range from "Could hardly be better, Perfection, A" to "Could hardly be worse, D-"
- GP space utilisation activity (in reflection of the absence of detailed patient appointment numbers) is measured in PDA's (rooms)/1,000 Practice Population and ranges from <0.5 to >2
- HSCP utilisation activity is measured in Appointments/PDA/Day and ranges from 0 to >20 appointments/PDA/day
- Desk utilisation is based on the difference between the number of desks available and the number of desks assessed as being required utilising agreed desk ratio metrics and ranges from <30% to >85%
- Utilising a simple red/amber/green annotation, a score of between 1 and 3 is categorised as "red"; 4 and 6 is "amber"; and 7 and 10 is "green"

For clarity, it is noted that, in buildings where both HSCP and GP services are co-located (Lennoxtown Hub and KHCC) this assessment reflects HSCP activity only. Where buildings include a mixed client-facing/administrative element, scores are based on an overall "blended" assessment that is apportioned to baseline areas.

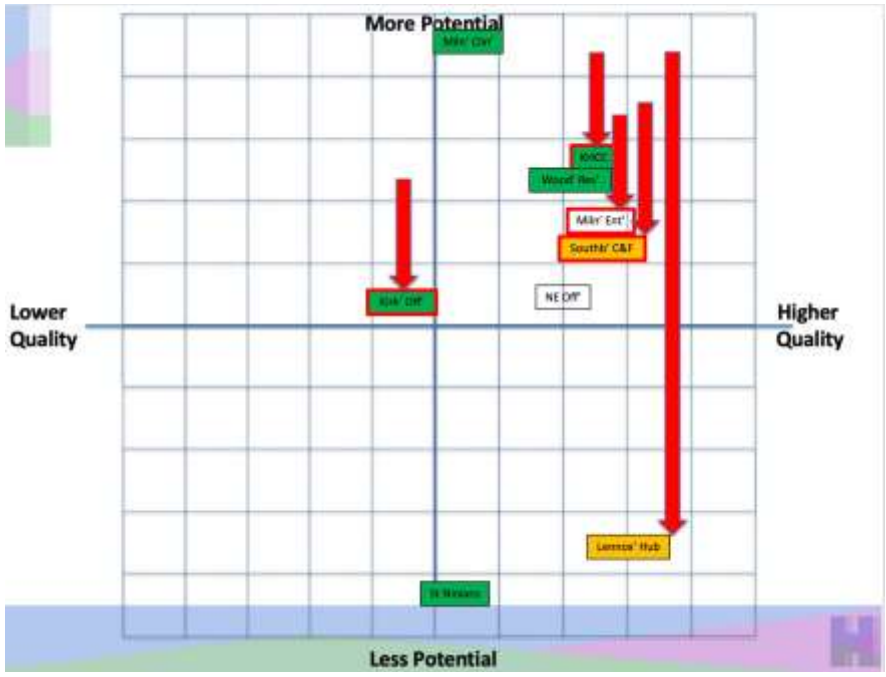



**Diag. 7. Quality of Primary Care Buildings vs Strategic Importance vs Utilisation**

| ASSESSMENT | GP ACTIVITY | HSCP ACTIVITY | DESK UTLISATION | SCORE |
|---|---|---|---|---|
| Descriptor | PDA's/1,000 Prac' Pop | Appts/PDA/Day | Desk Utilisation | (1 - 10) |
| Could hardly be better, perfection (A) | 2.0+ | 20+ | 85% and over | 10 |
| Excellent, almost perfect (A-) | 1.8 - 2.0 | 18-20 | 80-85% | 9 |
| Very good (B+) | 1.6 - 1.8 | 16-18 | 75-80% | 8 |
| Good (B) | 1.4 - 1.6 | 14-16 | 70-75% | 7 |
| Quite good (B-) | 1.2 - 1.4 | 12-14 | 65-70% | 6 |
| Adequate (C) | 1.0 - 1.2 | 10-12 | 60-65% | 5 |
| Less good (C-) | 0.8 - 1.0 | 8-10 | 50-60% | 4 |
| Poor (D+) | 0.6 - 0.8 | 6-8 | 40-50% | 3 |
| Very poor (D) | 0.5 - 0.6 | 4-6 | 30-40% | 2 |
| Could hardly be w orse (D-) | Less than 0.5 | 0-4 | Less than 30% | 1 |

**Diag. 8. Overall Utilisation Assessment Criteria**

Diag. 9. (Below) presents an alternative graphical representation of the SID data relating to the overall review team's assessment of existing key primary care infrastructure owned/leased by East Dunbartonshire HSCP. This continues to show "building quality" (x axis) but now mapped against "potential".




**Diag. 9. Quality of Primary Care Buildings vs Strategic Potential vs Utilisation**

"Potential" scores (Y axis) are based on the collective Project Team's overall strategic assessment of the potential for each facility/site to change based on an initial assessment undertaken by the Capital Planning Team to ensure continuity and robustness. Components of the assessment include:

- Ownership. Whether the site/facilities are owned or leased, etc.
- Willingness of the owners/relevant stakeholders to support change.
- The presence of options to support change of existing facilities (Modify, extend, vacate, alter use, etc).
- The availability of options to make additional/alternative use of the site.
- Value, saleability, transferability, income generation potential, other financial considerations, etc.

The key differences highlighted here reflect how the additional consideration of site/facility "potential" affects analysis with, most notably:

- Milngavie Clinic being identified as a poorer quality but well-utilised and strategically important facility that may have the potential to be developed/replaced in its current location. (Need to invest in or otherwise secure a long-term alternative?)
- Kirkintilloch Area Office being identified as a poorer quality but well utilised facility with limited potential and very limited options for change. (Need to find an alternative location for the existing 9 desks and 2 rooms?)
- Lennoxtown Hub being identified as a high-quality, strategically important facility with limited opportunity for further development, but available consulting room capacity based on the activity data provided. (Opportunity to make better use of consulting space?)
- St Ninian's Hall being identified as a small but well-used facility that is poorer quality, has no potential for change and is of no strategic significance. (Requiring the re-provision of at least the baseline 13 desks currently provided)

### 7.2.2 The East Dunbartonshire GP Owned/Leased Estate

As noted previously, although survey data is now available related to GP premises that includes room numbers and backlog maintenance assessments, less is still known in relation to these privately owned/leased facilities. It is also important to recognise that, unlike for HSCP owned premises, meetings have not taken place with all GP stakeholders to agree an overall detailed assessment (scores) for individual properties against the criteria assessed. (Other than capacity based on rooms/1,000 practice population where scores are allocated based on actual data provided)

Notwithstanding this, a desktop review did take place involving representatives of the project team and NHSGG&C Primary Care commissioning team with knowledge of the facilities in question. This identified that of the thirteen facilities reviewed:

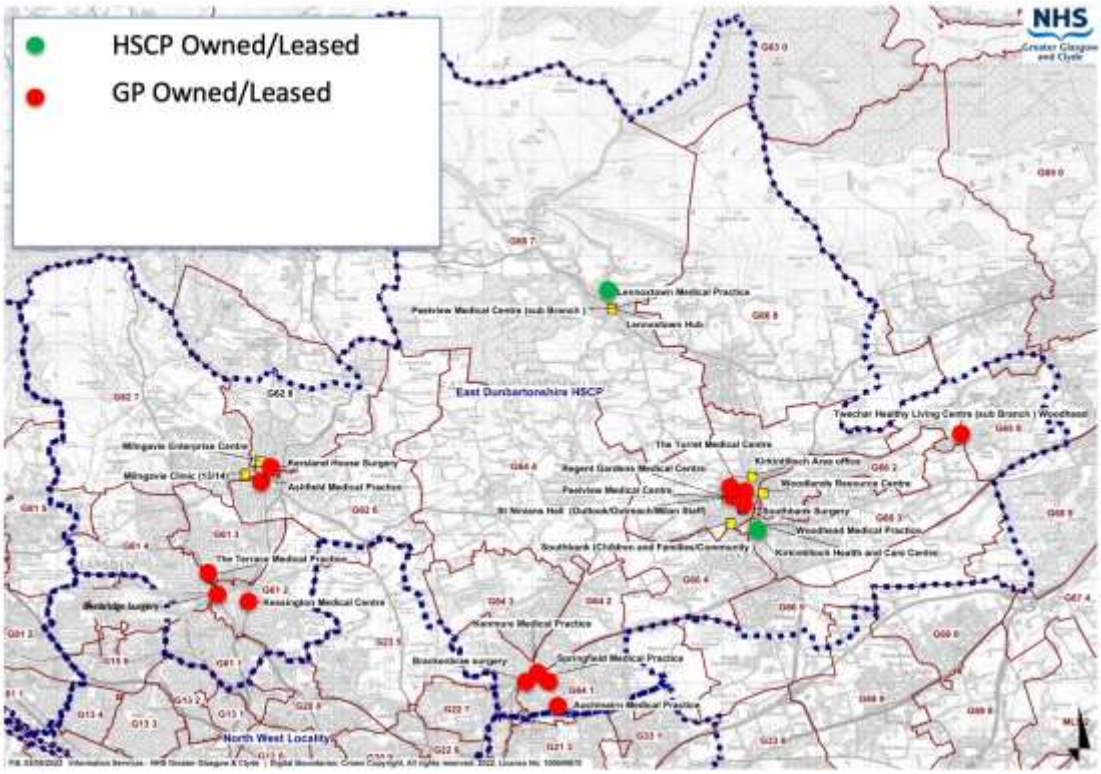
- Six were purpose built as GP facilities whilst the remainder have been converted for this use.
- Eleven are owned by GP's and two are leased (One from a private landlord, one from a third party).
- There is a substantial difference in the likely suitability of these facilities for the short-medium term delivery of GP/Primary Care services based on their current location, configuration, status, etc.
- Five GP owned/leased practice buildings appear to have an effective long-term future as healthcare delivery locations; two appear suitable for the medium to long-term delivery of GP services; and six that are highly unlikely to be fit for purpose in medium-long-term.
- Collectively, they account for just over £1.8m of backlog maintenance.

- Utilising the nationally recognised multiplier (3x) indicates a likely cost to address backlog issues across the GP owned/leased estate of around £5-6m.

In terms of utilisation, available data identified two practices with 1 or less than 1 room available/1,000 practice population that may represent an early physical capacity challenge. These were:

- The Terrace Medical Practice (0.9 PCDA/1,000 practice population)
- Woodhead Medical Practice – located within the Local Authority owned KHCC facility (0.9 PCDA's/1,000 practice population)

The Project Team note that, whilst the overall quality and utilisation of the GP owned/leased estate in East Dunbartonshire is broadly similar to that seen in other parts of the NHSGG&C Board area reviewed thus far, East Dunbartonshire is unique in terms of the very high volume of GP services delivered from GP owned/leased premises. Specifically, it is noted that only 2 GP practices in East Dunbartonshire operate from NHS owned/leased premises, accounting for only 9% of the local GP practice population whilst the remaining 13 operate from GP owned/leased premises and account for 91% of the local GP practice population. (Diag. 10)

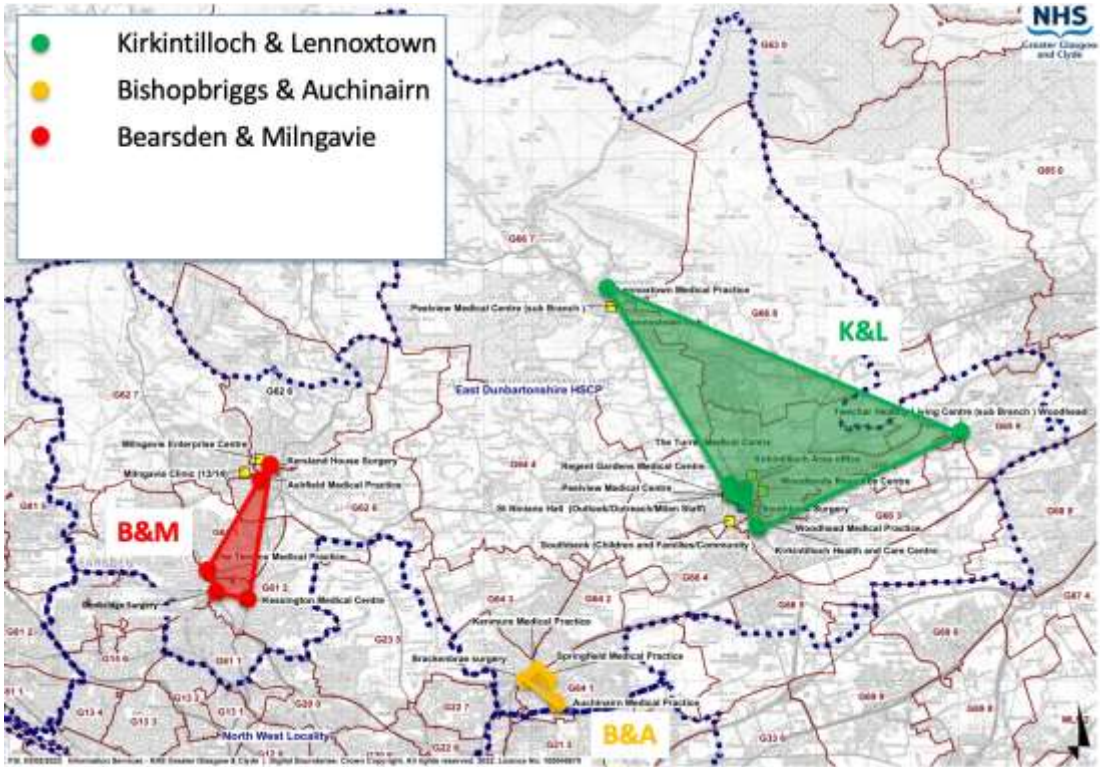



**Diag. 10. GP Premises by Ownership/Lease Responsibility**

This is clearly a risk in terms of the current GP contract (See Appendix C) which seeks a shift, over 25 years, to a new sustainable model in which GPs will no longer be expected to provide their own premises. The risk is considerably more than just contractual however, as analysis and detailed discussions have also identified that:

1) East Dunbartonshire is serviced by relatively isolated clusters of GPs that serve the existing urban conurbations as identified in Diag. 11.

2) Those facilities identified as potentially not suitable for the medium to long-term delivery of health services, based on the assessments undertaken thus far, are concentrated in the Bearsden/Milngavie area.
3) Whilst potentially not suitable for the long-term delivery of primary healthcare services, these facilities are in highly desirable residential areas and therefore likely to command strong values if marketed and to sell easily. (Unlike existing facilities reviewed in other parts of the NHS board area)
4) This potentially means that the owners (partners) are less likely to be dependent upon NHSGG&C to realise a sale as they might be in other parts of the Board area and that this COULD lead to the loss of physical premises without a sufficient lead time to develop replacement capacity should existing partners decide to retire and sell their premises on the open market without reference to the Board.




**Diag. 11. GP Clusters in East Dunbartonshire**

Collectively, these factors should be seen as a unique and substantial risk in terms of the delivery of GP capacity across East Dunbartonshire but specifically in the Bearsden & Milngavie and Bishopbriggs & Auchinairn areas.

### 7.2.3 What Do We Need Now: In Summary?

Overall, with respect to the existing owned/leased estate, it is possible to conclude that East Dunbartonshire benefits from a majority of good/very good buildings, in strategically important delivery locations across the area that appear to have an important medium/long-term role (economic considerations such as lease costs aside). These include:

- Lennoxtown Hub
- Kirkintilloch Health & Care Centre (KHCC)
- Southbank Children & Families/Community Centre

- Woodlands Resource Centre
- Milngavie Enterprise Centre

Whilst these facilities are primarily well used, the opportunity may exist in the short-term to re-align some services to make better/optimal use of the space available and address potential "over-crowding" when (if?) desk utilisation returns to pre-COVID levels. It is recognised however, as noted previously, that such opportunities will be further constrained by the substantial investment in additional staff to support a wide range of relevant policy initiatives.

East Dunbartonshire also features a smaller number of poorer/less appropriate facilities, that are also strategically important but appear to have a strategic significance that exceeds their baseline quality. These are:

- Milngavie Clinic
- Kirkintilloch Area Office

Of these, Milngavie Clinic is clearly the most significant as it is difficult to see any strategic solution to this challenge that does not involve substantial capital investment.

This requirement to consider a substantial capital investment in the Milngavie/Bearsden area is only exacerbated by wider detailed consideration of the existing GP owned estate. This is because the Project Team believe, as detailed previously, that:

1) existing GP capacity in the Bearsden/Milngavie area is already not the most suitable for the medium to long-term delivery of healthcare
2) the existing five practices in the Bearsden/Milngavie area currently account for £768k in backlog maintenance costs and are all owned by the practices using them
3) all this capacity could be lost to the NHS with minimal notice – and certainly not sufficient lead time to develop a built solution – if practices decided to vacate current premises for whatever reason
4) if this happened – even in part – the additional demand would fall on Milngavie Clinic as the only existing HSCP owned/leased clinical facility in the area
5) Milngavie clinic is already a well utilised but poor-quality facility. As such it would not be able to cope with the additional demand, possibly resulting in a substantial failure of the local service.

This must be seen as a unique and substantial challenge.

With regards to the balance of the estate, it is also important to recognise that within the Bishopbriggs and Auchinairn area, whilst existing GP owned/leased facilities are more fit for purpose in the medium-long term:

1) There is no existing HSCP facility capacity.
2) (This makes the delivery of PCIP and CTAC commitments impossible)
3) All GP practice capacity is again owned/leased by General Practitioners.
4) A level of risk relating to ownership of premises similar to that highlighted in Bearsden/Milngavie is evident that needs to be considered and mitigated.

St Ninian's Hall must also be considered, with available data and HSCP's assessments highlighting it as a facility that is neither strategically important or functionally suitable, where

the preferred strategy is likely to be to vacate by transferring the existing small number of staff and services – which are not geographically relevant – to an alternative facility. These assessments are considered further in phase 4 of the process: what is required?

### 7.3 What may we need in future?

Whilst considering the difference between what we "have" and what we "need" now is a relatively clear (if complex) task, understanding what we may need in the future is considerably more challenging. The project has however identified a range of factors that need to be considered during detailed future facility planning including:

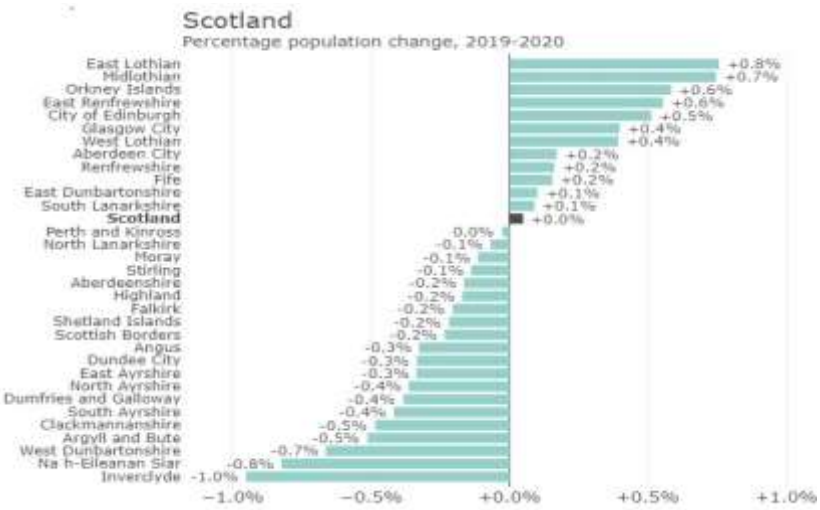
- Overall population change and demographics.
- Population shift, including the creation of new/different population centres.
- Addressing inequalities.
- The impact of improved facility utilisation and flexibility.
- Changes in the kind of spaces needed as delivery models change and other factors.
- The impact of shifting the balance of care and MFT.

Whilst the impact of COVID, MFT and improved utilisation is considered elsewhere in this report – and across the entire PCES programme - it is necessary to reflect on broader demographic and inequality considerations here to understand the impact they are likely to have on facility planning moving forward.

#### 7.3.1 Overall Population Change and Demographics

Latest National Records Scotland (NRS) Mid 2020 Population Estimates published by NRS on 25th June 2021 record that East Dunbartonshire's estimated population as of 30 June 2020 was 108,750.

Data also indicates that East Dunbartonshire has experienced a very slight increase in population in recent years but that this is broadly in line with the Scottish average at around 0.1% between 2019 and 2020 as highlighted in Diag. 12. (Below)




**Diag. 12. Scotland % Population Change 2019 - 2020**

Diag. 13. (Below) highlights the population breakdown of East Dunbartonshire by age and sex in 2018 and is taken from NRS population data sets used to project population change for the next 25 years from then. Full details of NRS population breakdowns and projections can be found here:

**https://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/population/population-projections/sub-national-population-projections/2018-based/detailed-datasets**

| East Duns by Age | Total | Males | Females |
|---|---|---|---|
| 0-14 | 18,225 | 9,384 | 8,841 |
| 15-29 | 17,012 | 9,156 | 7,856 |
| 30-44 | 17,475 | 8,433 | 9,042 |
| 45-59 | 23,607 | 11,104 | 12,503 |
| 60-74 | 20,639 | 9,717 | 10,922 |
| 75+ | 11,792 | 4,890 | 6,902 |
| Total | 108,750 | 52,684 | 56,066 |

**Diag. 13. NRS mid-year population estimates for East Dunbartonshire in 2020**

Diag 14 highlights anticipated changes to this baseline population of East Dunbartonshire by age and sex for the next 25 years based on 2018 baseline data published by NRS. Although data is available by year on the NRS website, only summary information has been included here relating to 10, 20 and 25 years after the baseline. (2018)

As can be seen, current NRS population projections indicate a likely increase in the population of East Dunbartonshire of around 8,000 people or circa. 7% over the next 25 years if current trends continue.

| Age Group | 2018 | | 2028 | | 2038 | | 2043 | |
|---|---|---|---|---|---|---|---|---|
| | Number | % | Number | % | Number | % | Number | % |
| 0-15 | 19,224 | 18% | 20,088 | 18% | 19,841 | 17% | 20,016 | 17% |
| 16-29 | 16,196 | 15% | 15,115 | 13% | 16,187 | 14% | 16,021 | 14% |
| 30-44 | 16,998 | 16% | 20,249 | 18% | 18,998 | 16% | 18,764 | 16% |
| 45-59 | 24,478 | 23% | 20,554 | 18% | 23,094 | 20% | 24,163 | 21% |
| 60-74 | 20,022 | 18% | 22,028 | 19% | 19,642 | 17% | 18,562 | 16% |
| 75+ | 11,412 | 11% | 14,365 | 13% | 17,645 | 15% | 19,010 | 16% |
| Total | **108,330** | | **112,399** | | **115,407** | | **116,536** | |

**Diag. 14. NRS Population Projections for East Dunbartonshire to 2043**

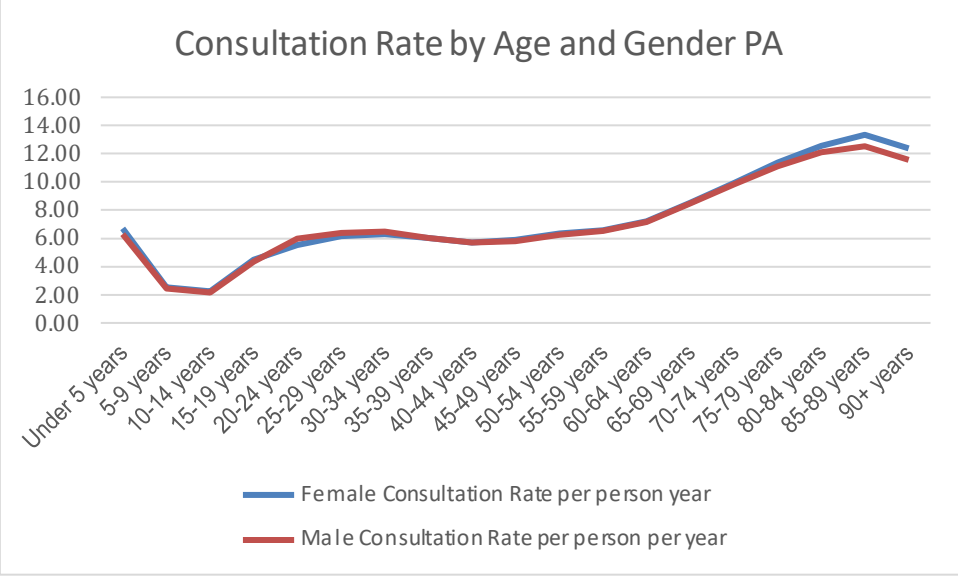
(NB Breakdown % shown to nearest whole number so totals do not always equal 100)

As well as a general increase in population over time, NRS projections also indicate a significant increase in the average age of the population over the next 25 years, including a substantial increase in the share of the overall population represented by those aged 75 years and over.

This is highly relevant, as these are the age groups who are statistically most likely to require higher levels of health and social care support due to increased frailty, co morbidity and complexity of need.

Whilst it is difficult to definitively estimate the potential impact the ageing population will have on Primary Care capacity required and not appropriate in terms of this strategic property planning exercise, historic QR RESEARCH data collated by the Office for National Statistics (ONS) on behalf of NHS in England that ceased to be reported on after 2008 identified, at this time, the relationship between age and gender on consultation rate per year. Elements of the 2008 data are reproduced in Diag 12 (Overleaf) to provide a (historic) indication of the growth in appointment activity that might be expected based on an ageing population.

As can be seen, historically at least, those aged 75 or over were likely to require more than three times as many appointments per annum as those aged 40-45 with a broadly similar pattern for men and women.




**Diag.15. Historic ONS QR RESEARCH Data From 2008 Showing the Relationship Between Age and Consultation Rate Per Year by Sex**

### 7.3.2 Population shift, including the creation of new/different population centres

As a 15–20-year strategy, it is essential to consider the difference between current and future population centres and distribution to understand the impact on existing and future infrastructure. The Project Team have considered this through the review of a range of relevant documentation that indicates how the population may change and grow through planned housing developments.

#### 7.3.2.1 The East Dunbartonshire Local Housing Strategy and Strategic Housing Investment Plan

The East Dunbartonshire Local Housing Strategy 2017 – 2022 sets out the strategic policy approach to the Local Authority and its partners to deliver high quality housing and housing related services across all tenures to meet identified need in East Dunbartonshire.

The East Dunbartonshire LHS identified 5 priority outcomes:

1. Enable a suitable, efficient, affordable supply of housing
2. Enhance the role of housing options in preventing homelessness
3. Encourage independent living
4. Address housing condition, fuel poverty, regeneration
5. Improving service delivery, quality, and value for money

All Scottish local authorities are required to prepare and update a Strategic Housing Investment Plan (SHIP) annually. The SHIP is supplementary to The East Dunbartonshire Local Housing Strategy (LHS) which has the core purpose of meeting the varying housing requirements of residents across East Dunbartonshire. The current East Dunbartonshire SHIP sets out how investment in affordable housing will be targeted over the five-year period 2021/22 to 2025/26, and outlines how the Council and its partners will deliver these priorities.

The East Dunbartonshire LHS identifies housing need and demands across the council area using the Scottish Govt's HNDA tool. The Tool collates evidence relating to key criteria such as demographic projections and economic indicators, to estimate future levels of housing need and demand.

The HNDA Tool calculation combines the number of existing households who require additional housing with an assessment of the number of new households that will form each year and produce a total annual housing requirement. This requirement is then broken down by housing tenure by assessing the ability of households to meet housing costs.

https://www.eastdunbarton.gov.uk/filedepot_download/35878/1828

https://www.eastdunbarton.gov.uk/filedepot_download/301631/3458

#### 7.3.2.2 East Dunbartonshire Local Development Plan (2017)

East Dunbartonshire Council are currently preparing a new Local Development Plan (LDP) that will guide the future use of land in East Dunbartonshire. By setting out planning policies and identifying sites for development and protection. As a result of this on-going process the current (existing) plan was published in 2017. Full copies of the relevant documents can be found here:

https://www.eastdunbarton.gov.uk/filedepot_download/26637/1760

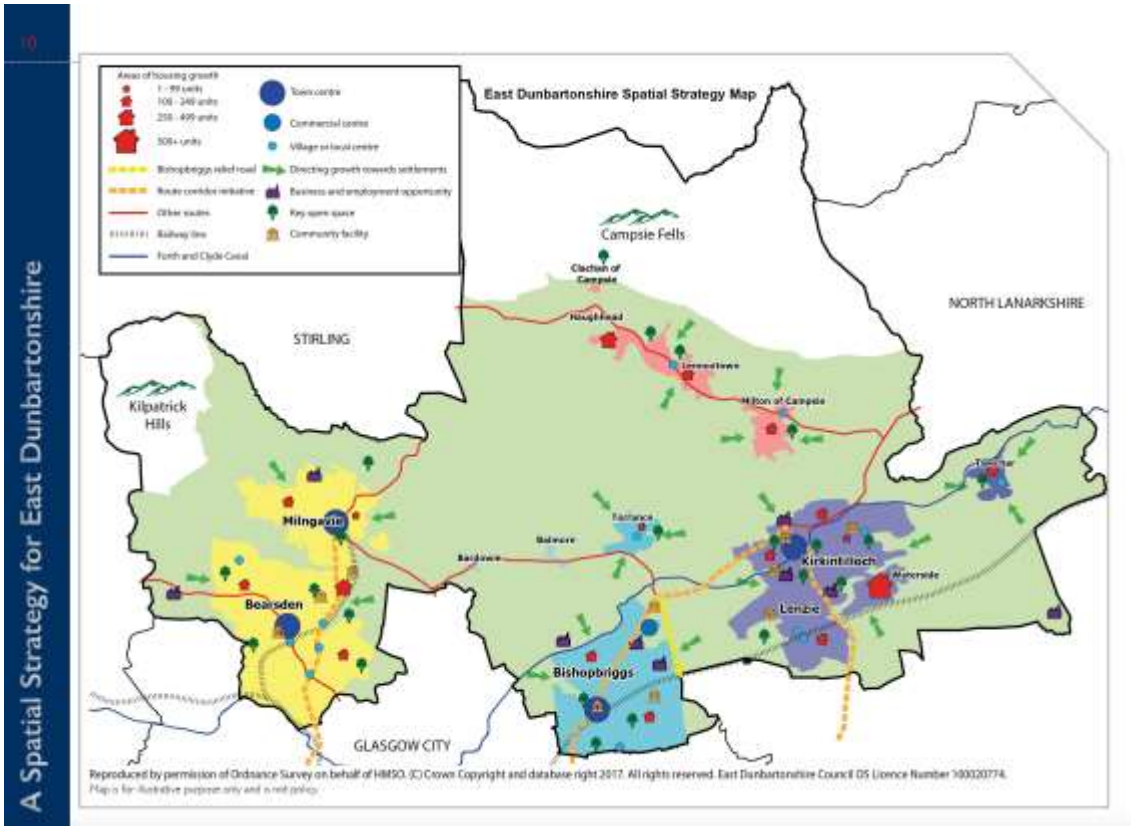
The Local Development Plan sets out a land-use strategy for East Dunbartonshire to deliver the Community Planning Partnership's Local Outcome Improvement Plan. The planning policies in this document are intended to improve the quality of East Dunbartonshire as a place to live, work and visit. The Plan reflects the Council's desire to create high-quality places for residents to live, facilitate sustainable economic growth and the development of our town centres, maximise our tourism and business potential, and protect and enhance the quality of our local historic, natural and water environment. It also ensures that essential infrastructure for energy, broadband, minerals, and waste is provided.

The plan also includes a summary of "Housing Development Opportunity Sites" that identify where future replacement or additional housing provision could be developed that is likely to be directly relevant to the developing Primary Care Estate Strategy.

### 7.3.2.3 Local Population Shift & Housing Developments

As well as the additional capacity required to address any overall increase in the size of the health needs of the patient population across East Dunbartonshire (if not population numbers) and address existing inequality, there is also a requirement to consider new housing developments and population moves that have the potential to place significant strains on local health services if not planned for appropriately.

The Local Development Plan identifies all sites currently zoned for housing as well as the indicative number of units planned for each. Whilst there is no clear timetable for these developments – in recognition of the wide number of factors out with the Council's control that may impact upon this – it is reasonable to assume that all are likely to have an impact on health and social care service delivery within the lifespan of assets considered within this strategy.




**Diag. 16. A Spatial Strategy for East Dunbartonshire (Extract from the Local Plan)**

Diag. 17 (Overleaf) presents a simplified overview of existing facilities being considered by this review with the approximate locations of the main areas of potential housing development identified to outline the likely relationship between the two.

As can be seen, the main sites currently identified (100 units or more) include:

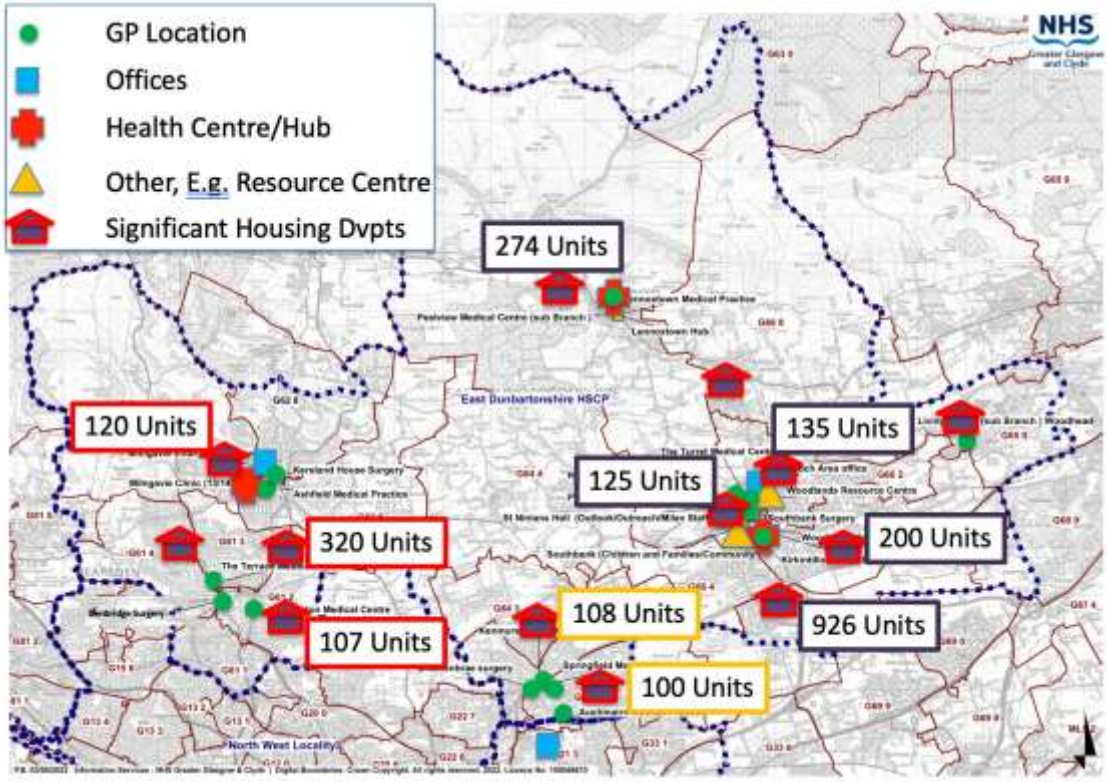
- Within Bearsden & Milngavie

- Craigton Road, Milngavie (120 units)
- Kilmardinny, Bearsden/Milngavie (320 units)
- Former St Andrews College, Bearsden (107 units)

- Within Bishopbriggs, Torrance, Balmore & Bardowie
  - Bishopbriggs East (194 units, 99 remaining)
  - Former Cadder Sewage Works, Meadowburn West & Jellyhill Nursery, Bishopbriggs (108 units)

- Within Kirkintilloch, Lenzie, Waterside & Twechar
  - Braes O' Yetts, Kirkintilloch (200 units)
  - Broomhill Hospital, Kirkintilloch (135 units)
  - Fauldhead, Kirkintilloch (125 units)
  - Woodlea Hospital, Lenzie (926 units, 561 remaining)

- Within Lennoxtown, Milton of Campsie, etc
  - Lennox Castle, Lennoxtown (274 units)




**Diag.17. The Relationship Between Key Housing Development Sites in East Dunbartonshire and Existing Primary Care Infrastructure**

In addition to these larger development sites however, a substantial number of additional units are planned on a range of smaller sites across the area. These include:

- Within Bearsden & Milngavie, a further 318 units planned across 11 additional sites
- Within Bishopbriggs, Torrance, Balmore & Bardowie, a further 326 units planned across 13 additional sites

- Within Kirkintilloch, Lenzie, Waterside & Twechar a further 637 units planned across 16 additional sites
- Within Lennoxtown, Milton of Campsie, etc a further 322 units planned across 13 additional sites

It is important to contextualise all these potential developments to understand the impact they could have on local health and social care services and the Primary Care Estate required to support this. To this end, several variables are relevant that need to be considered for each development to support modelling. These include:

- The number of units planned.
- The size/nature of these units (Number of bedrooms, etc).
- Their location relative to existing health and social care provision.
- The anticipated occupancy per unit (Impact on population shift).
- An assessment of how many of these people are moving to the area as compared to moving within it, i.e. Do they represent additional or new demand or simply a geographical shift in the locus of this? (Impact on overall population)
- An assessment of their local health and social care needs and where these are likely to be met, E.g. The impact on local specified GP practice population sizes and;
- Consequently (in the context of this strategic primary care property strategy development) their likely impact on specific existing delivery locations or;
- Their requirement to develop completely new/additional local capacity.

Whilst the size of the units identified in the LDP is currently not known and likely to continue to change as planning approvals are developed, it is possible to estimate a range for required variables based on recent similar developments and more detailed analysis undertaken in support of these. One example of this used previously in the PCES programme is Dargavel Village, Bishopton, a relatively remote/self-contained new housing development in Renfrewshire where:

- The anticipated occupancy per unit was modelled at between 2 and 4 persons per unit based on actual occupations.
- Up to 100% of new occupations were deemed to be "additional population" based on the close correlation between known occupations and the local GP population.
- The impact of this additional population on existing local GP premises was modelled to determine the likely impact on space requirements over and above any baseline currently available.

Diagrams 18-21 present one potential scenario modelled and the potential impact on space requirements associated with these developments as they relate to each of the four planning areas identified in the LDP. In this scenario, which reflects the final variables agreed in the Bishopton/Dargavel example:

- Estimated units are as identified in the East Dunbartonshire LDP
- Assumed persons/unit is set at 2.7 (based on recent Dargavel modelling)
- Assumed impact is set at 75%, i.e. It is assumed that 75% of people establishing themselves in these new developments will be new to the area and therefore represent additional demand.
- Assumed rooms required are set at 1.2/1,000 practice population.
- The total number of rooms (PDA's) likely to be required is in the order of 9-10 (against a total baseline GP number of rooms available of 170).

The diagrams also show the breakdown of room requirements by practice/housing development based on the assumptions documented – which also include:

- The estimated new population associated with larger developments (100 units or more) apportioned to individual practices based on first principles. I.e., Visual assessment based on geographical proximity only; and
- The balance of the estimated population associated with smaller developments apportioned evenly across all practices within the relevant GP clusters.

The Project Team acknowledge that in infinite number of alternative scenarios exist and would encourage the local teams to review and refine these to understand the detailed impact they are likely to have on local service requirements as well as the sensitivity associated with modifying all variables. Notwithstanding this, this baseline scenario has been used to support all further analysis in the context of this strategic planning exercise.

| Scenario: Bearsden & Milngavie "For Strategic Planning" | | | | | |
|---|---|---|---|---|---|
| Site | Craigton Rd Milngavie | Kilmadinny Bear/Miln | St Andrews Bearsden | Additional Dispersed | Total |
| Estimated Units (Total) | 120 | 320 | 107 | 318 | |
| Assumed Ave Persons/Unit | 2.7 | 2.7 | 2.7 | 2.7 | |
| Est local population change (Units ave persons/unit) | 324 | 864 | 288.9 | 858.6 | |
| Assumed impact of pop change on GP Provision (%) | 75% | 75% | 75% | 75% | |
| Assumed impact of pop change on GP Provision (Pop) | 243 | 648 | 217 | 644 | |
| Assumed additional rooms required/1,000 practice population | 1.2 | 1.2 | 1.2 | 1.2 | |
| Assumed gross additional rooms required (Number) | 0.3 | 0.8 | 0.3 | 0.8 | 2.1 |
| Assumed % Impact: Kessington MC | 0% | 20.0% | 33.0% | 20.0% | |
| Est Population Impact (Numbers) Kessington MC | 0 | 130 | 72 | 129 | 330 |
| Assumed % Impact: Denbridge Surgery | 0% | 20.0% | 33.0% | 20.0% | |
| Est Population Impact (Numbers) Denbridge Surgery | 0.00 | 130 | 72 | 129 | 330 |
| Assumed % Impact: The Terrace | 0% | 20.0% | 33.0% | 20.0% | |
| Est Population Impact (Numbers) The Terrace | 0 | 130 | 72 | 129 | 330 |
| Assumed % Impact: Ashfield MP | 50% | 20.0% | 0.0% | 20.0% | |
| Est Population Impact (Numbers) Ashfield MP | 122 | 130 | 0 | 129 | 380 |
| Assumed % Impact: Kersland House | 50% | 20.0% | 0.0% | 20.0% | |
| Est Population Impact (Numbers) Kersland House | 122 | 130 | 0 | 129 | 380 |

**Diag.18. The Potential Impact of Key Housing Development Sites in Bearsden & Milngavie on Room Requirements (A potential scenario)**

| Scenario: Bishopbriggs, Torrance, Balmore & Bardowie "For Strategic Planning" | | | | |
|---|---|---|---|---|
| Site | Bishop' East | Cad, Mead' & Jelly' (Bish') | Additional Dispersed | Total |
| Estimated Units (Total) | 100 | 108 | 326 | |
| Assumed Ave Persons/Unit | 2.7 | 2.7 | 2.7 | |
| Est local population change (Units ave persons/unit) | 270 | 291.6 | 880.2 | |
| Assumed impact of pop change on GP Provision (%) | 75% | 75% | 75% | |
| Assumed impact of pop change on GP Provision (Pop) | 203 | 219 | 660 | |
| Assumed additional rooms required/1,000 practice population | 1.2 | 1.2 | 1.2 | |
| Assumed gross additional rooms required (Number) | 0.2 | 0.3 | 0.8 | 1.3 |
| Assumed % Impact: Kenmure MC | 25% | 25% | 25% | |
| Est Population Impact (Numbers) Kenmure MC | 51 | 55 | 165 | 270 |
| Assumed % Impact: Springfield MP | 25% | 25% | 25% | |
| Est Population Impact (Numbers) Springfield MP | 51 | 55 | 165 | 270 |
| Assumed % Impact: Auchinairn MP | 25% | 25% | 25% | |
| Est Population Impact (Numbers) Auchinairn MP | 51 | 55 | 165 | 270 |
| Assumed % Impact: Brackenbrae Surgery | 25% | 25% | 25% | |
| Est Population Impact (Numbers) Brackenbrae Surgery | 51 | 55 | 165 | 270 |

**Diag.19. The Potential Impact of Key Housing Development Sites in Bishopbriggs, Torrance, Balmore & Bardowie on Room Requirements (A potential scenario)**

| Scenario: Kirkintilloch, Lenzie, Waterside & Twechar "For Strategic Planning" | | | | | | |
|---|---|---|---|---|---|---|
| Site | Braes O Yett Kirkintilloch | Broomhill Kirkintilloch | Fauldhead Kirkintilloch | Woodlea Lenzie | Additional Dispersed | Total |
| Estimated Units (Total) | 200 | 135 | 125 | 926 | 637 | |
| Assumed Ave Persons/Unit | 2.7 | 2.7 | 2.7 | 2.7 | 2.7 | |
| Est local population change (Units ave persons/unit) | 540 | 364.5 | 337.5 | 2500.2 | 1719.9 | |
| Assumed impact of pop change on GP Provision (%) | 75% | 75% | 75% | 75% | 75% | |
| Assumed impact of pop change on GP Provision (Pop) | 405 | 273 | 253 | 1875 | 1290 | |
| Assumed additional rooms required/1,000 practice population | 1.2 | 1.2 | 1.2 | 1.2 | 1.2 | |
| Assumed gross additional rooms required (Number) | 0.5 | 0.3 | 0.3 | 2.3 | 1.5 | 4.9 |
| Assumed % Impact: Lennoxtown MP | 0% | 0% | 0% | 0% | 16% | |
| Est Population Impact (Numbers) Lennoxtown MP | 0 | 0 | 0 | 0 | 206 | 206 |
| Assumed % Impact: Woodhead MP | 20% | 20% | 20% | 20.0% | 16% | |
| Est Population Impact (Numbers) Woodhead MP | 81 | 55 | 51 | 375 | 206 | 768 |
| Assumed % Impact: Regent Gardens MC | 20% | 20% | 20% | 20% | 16% | |
| Est Population Impact (Numbers) Regent Gardens MC | 81 | 55 | 51 | 375 | 206 | 768 |
| Assumed % Impact: The Turret MC | 20% | 20% | 20% | 20.0% | 16% | |
| Est Population Impact (Numbers) The Turret MC | 81 | 55 | 51 | 375 | 206 | 768 |
| Assumed % Impact: Southbank Surgery | 20% | 20% | 20% | 20% | 16% | |
| Est Population Impact (Numbers) Southbanks Surgery | 81 | 55 | 51 | 375 | 206 | 768 |
| Assumed % Impact: Peelview MC | 20% | 20% | 20% | 20% | 16% | |
| Est Population Impact (Numbers) Peelview MC | 81 | 55 | 51 | 375 | 206 | 768 |

**Diag.20. The Potential Impact of Key Housing Development Sites in Kirkintilloch, Lenzie, Waterside & Twechar on Room Requirements (A potential scenario)**

| Scenario: Lennoxtown, Milton of Campsie, Etc "For Strategic Planning" | | | |
|---|---|---|---|
| Site | Lennox Cas' Lennoxtown | Additional Dispersed | Total |
| Estimated Units (Total) | 274 | 322 | |
| Assumed Ave Persons/Unit | 2.7 | 2.7 | |
| Est local population change (Units ave persons/unit) | 739.8 | 869.4 | |
| Assumed impact of pop change on GP Provision (%) | 75% | 75% | |
| Assumed impact of pop change on GP Provision (Pop) | 555 | 652 | |
| Assumed additional rooms required/1,000 practice population | 1.2 | 1.2 | |
| Assumed gross additional rooms required (Number) | 0.7 | 0.8 | 1.4 |
| Assumed % Impact: Lennoxtown MP | 100% | 16% | |
| Est Population Impact (Numbers) Lennoxtown MP | 555 | 104 | 659 |
| Assumed % Impact: Woodhead MP | 0% | 16% | |
| Est Population Impact (Numbers) Woodhead MP | 0 | 104 | 104 |
| Assumed % Impact: Regent Gardens MC | 0% | 16% | |
| Est Population Impact (Numbers) Regent Gardens MC | 0 | 104 | 104 |
| Assumed % Impact: The Turret MC | 0% | 16% | |
| Est Population Impact (Numbers) The Turret MC | 0 | 104 | 104 |
| Assumed % Impact: Southbank Surgery | 0% | 16% | |
| Est Population Impact (Numbers) Southbanks Surgery | 0 | 104 | 104 |
| Assumed % Impact: Peelview MC | 0% | 16% | |
| Est Population Impact (Numbers) Peelview MC | 0 | 104 | 104 |

**Diag.21. The Potential Impact of Key Housing Development Sites in Lennoxtown Milton of Campsie, etc on Room Requirements (A potential scenario)**

| GP Cluster | Practice | Baseline PCDA's | Baseline List Size | Est' Impact of New Housing | Projected List Size | Baseline PCDA's/1,000 | Projected PCDA/1,000 | Baseline PCDA's/1,000 | Projected PCDA/1,000 |
|---|---|---|---|---|---|---|---|---|---|
| Bearsden & Milngavie | [redacted] | 17 | 7389 | 330 | 7719 | 2.30 | 2.2 | | |
| Bearsden & Milngavie | [redacted] | 13 | 9261 | 330 | 9591 | 1.40 | 1.36 | | |
| Bearsden & Milngavie | [redacted] | 7 | 7673 | 330 | 8003 | 0.91 | 0.87 | 1.6 | 1.5 |
| Bearsden & Milngavie | [redacted] | 10 | 7642 | 380 | 8022 | 1.31 | 1.25 | | |
| Bearsden & Milngavie | [redacted] | 15 | 7671 | 380 | 8051 | 1.96 | 1.86 | | |
| Bishopbriggs & Auchinairn | Kenmure Medical Practice | 14 | 7897 | 270 | 8167 | 1.77 | 1.71 | | |
| Bishopbriggs & Auchinairn | Springfield MP | 13 | 9296 | 270 | 9566 | 1.40 | 1.36 | 1.5 | 1.4 |
| Bishopbriggs & Auchinairn | Auchinairn MP | 9 | 7142 | 270 | 7412 | 1.26 | 1.21 | | |
| Bishopbriggs & Auchinairn | Brackenbrae Surgery | 3 | 1697 | 270 | 1967 | 1.77 | 1.53 | | |
| Kirkintilloch & Lennoxtown | Lennoxtown MP | 5 | 3,353 | 866 | 4219 | 1.49 | 1.19 | | |
| Kirkintilloch & Lennoxtown | Woodhead MP | 6 | 6,785 | 872 | 7657 | 0.88 | 0.78 | | |
| Kirkintilloch & Lennoxtown | Regent Gardens MC | 19 | 10331 | 872 | 11203 | 1.84 | 1.70 | 1.6 | 1.4 |
| Kirkintilloch & Lennoxtown | The Turret Medical Centre | 16 | 6389 | 872 | 7261 | 2.50 | 2.20 | | |
| Kirkintilloch & Lennoxtown | Southbank Surgery | 10 | 7241 | 872 | 8113 | 1.38 | 1.23 | | |
| Kirkintilloch & Lennoxtown | Peelview MC | 13 | 10396 | 872 | 11268 | 1.25 | 1.15 | | |

**Diag.22. The Potential Global Impact of Housing Development Sites in East Dunbartonshire on Room Requirements by Practice and Cluster (A potential scenario)**

Diag. 22 summarises the global potential impact associated with housing development across East Dunbartonshire by individual GP practice and GP cluster based on the preferred scenario developed for planning purposes. This scenario, which is seen as "pessimistic" indicates that, were no additional capacity created – and in the absence of any other changes:

- All practices are likely to be impacted negatively in space terms by potential future housing developments based on identified sites and unit numbers.
- A number of individual practices may increasingly struggle to cope with the additional physical capacity requirements suggested.
- Three of the practices (Denbridge Surgery, Springfield Medical Practice and Lennoxtown Medical Practice) are likely to go from being green ("good") in relative capacity terms based on current project assumptions to (amber) "reasonable" due to a drop in rooms/1,000 practice population available (although these assessments are relatively arbitrary)
- Woodhead Medical Practice – which appears already seriously compromised in relative capacity terms becomes even more challenged, moving from (amber) "reasonable" to red; however,
- when considering existing services on a "cluster" basis – even although existing clusters do not have any "shared" responsibility for local service delivery - all housing development associated demand appear to be "collectively" manageable; and,
- none of the developments planned appear to pre-empt the requirement for completely new GP facilities where none exist at present, although they will place further pressure on PCIP and CTAC implementation, especially in Bishopbriggs & Auchinairn, where no shared HSCP capacity currently exists.

Overall, it is possible to conclude that, whilst these proposed developments will affect space requirements locally, it is highly likely that they will be manageable within existing collective capacity. They will however inevitably challenge the ageing infrastructure already identified, most notably associated with local GP premises in the Bearsden/Milngavie area and Milngavie Clinic, further underpinning the case for investment in these facilities. They will also further expose the lack of shared HSCP capacity in Bishopbriggs and Auchinairn and exacerbate the impact this is likely to have on the development of these important programmes – potentially underlining the requirement for additional shared support space in this area.

#### 7.3.2.4 Addressing Inequality

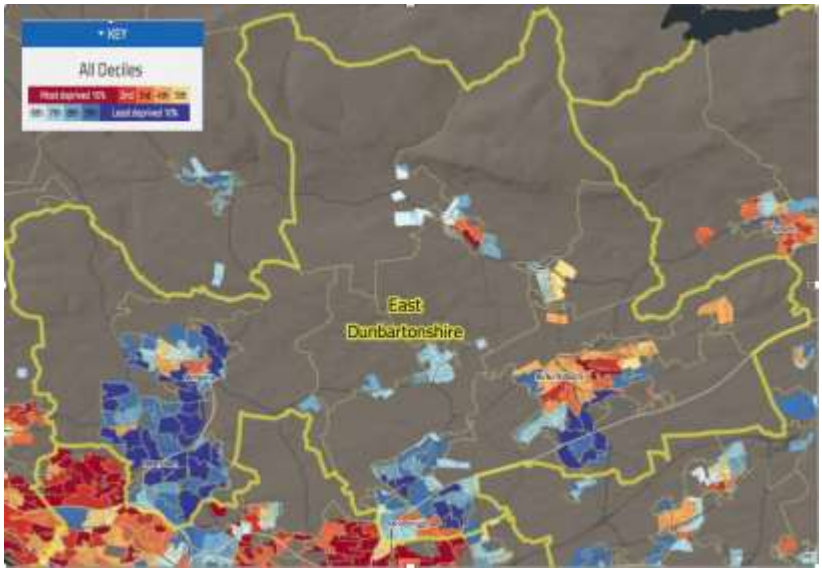
The Scottish Index of Multiple Deprivation (SIMD) is a relative measure of deprivation across 6,976 small areas (called data zones) that cover the whole of Scotland. If an area is identified as 'deprived', this can relate to people having a low income, but it can also mean fewer resources or opportunities. SIMD looks at the extent to which an area is deprived across seven domains, income, employment, education, health, access to services, crime, and housing.

SIMD is the Scottish Government's standard approach to identify areas of multiple deprivation in Scotland. It can help improve understanding about the outcomes and circumstances of people living in the most deprived areas in Scotland. It can also allow effective targeting of policies and funding where the aim is to wholly or partly tackle or take account of area concentrations of multiple deprivation.

SIMD ranks data zones from most deprived (ranked 1) to least deprived (ranked 6,976). People using SIMD will often focus on the data zones below a certain rank, for example, the 5%, 10%, 15% or 20% most deprived data zones in Scotland.

SIMD is an area-based measure of relative deprivation: not every person in a highly deprived area will themselves be experiencing high levels of deprivation.

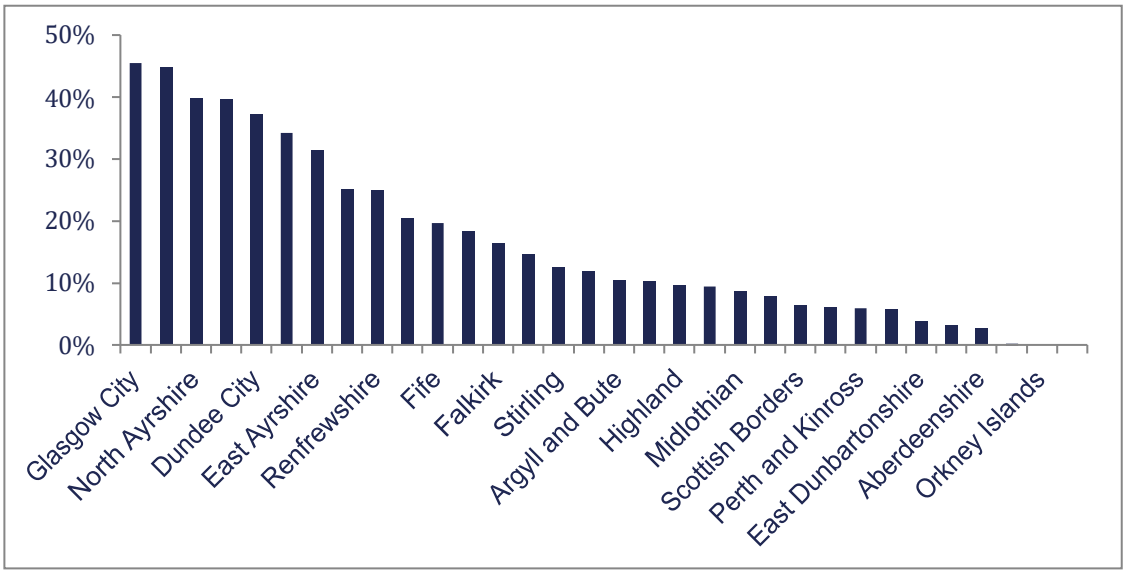
Data zones in rural areas tend to cover a large land area and reflect a more mixed picture of people experiencing different levels of deprivation. This means that SIMD is less helpful at identifying the smaller pockets of deprivation found in more rural areas, compared to the larger pockets found in urban areas. SIMD domain indicators can still be useful in rural areas if analysed separately from urban data zones or combined with other data.




**Diag.22. SIMD 2020 Index Breakdown Graphic (Source SIMD, 2020 v2)**

An interactive map showing all SIMD data can be found here:

https://simd.scot/#/simd2020/BTTTFTT/10.853333333333328/-4.8531/55.8736/




**Diag.23. SIMD 2020 Local Authority Analysis (Source SIMD, 2020v2)**

In property terms, simplistically, deprivation is likely to translate into more space being required/head of population in more deprived areas in reflection of the direct relationship between local demand for services and the space required to support their delivery. (More and/or longer responses plus more pro-active interventions)

This is unlikely to be a significant factor in East Dunbartonshire as, whilst it features isolated pockets, overall, the area does not suffer from significant deprivation.

It is currently anticipated that the impact of addressing inequality from a property perspective will be considered on a programme-wide basis.

## 8. WHAT IS REQUIRED?

Phase 4 of the process involves identifying how existing services and facilities should change in future in response to baseline opportunities for improvement and anticipated strategic challenges agreed. This includes:

- The generation of primary options relating to a more appropriate distribution of services and utilisation of facilities in key geographical locations.
- The identification of apparent priority investment/dis-investment opportunities across the area for further consideration/review and business case development as appropriate.
- A developing vision for the property portfolio and clear sense of "strategic direction of travel".

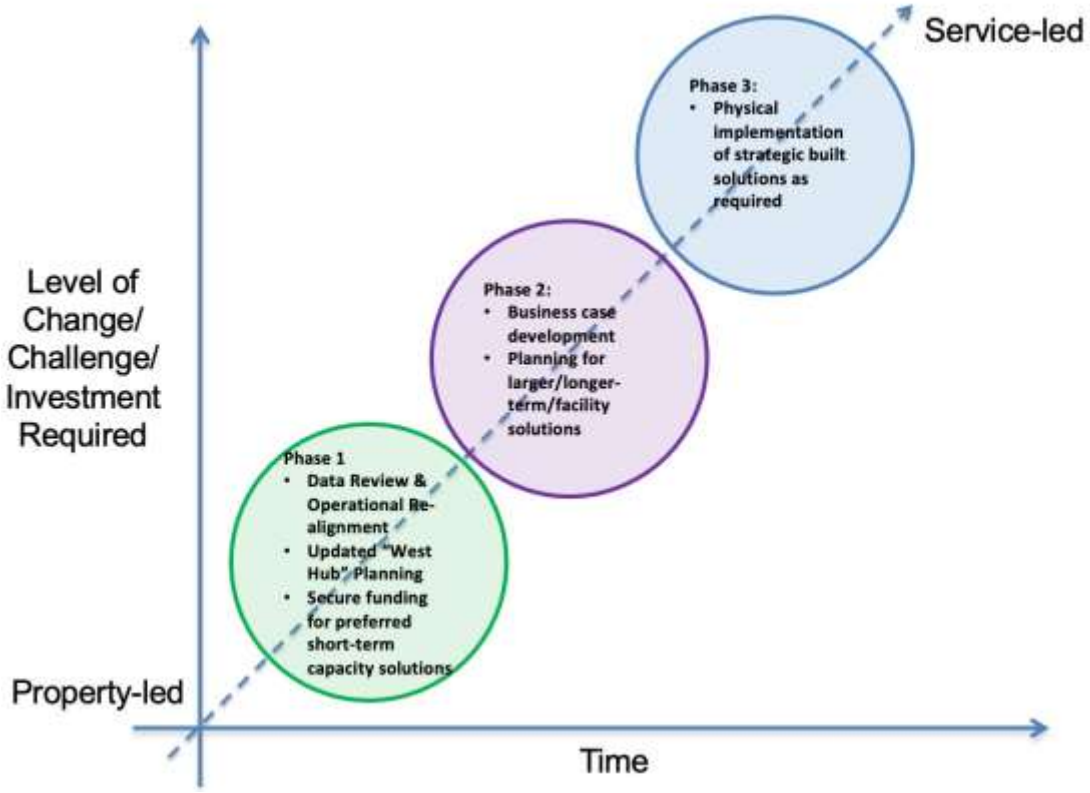
### 8.1 The Options Framework

The developing options strategy is presented on a continuum that is broadly representative of key stages in the strategic estate development process, i.e. What may be appropriate in the short (0-3 years), medium (3-10 years) and longer-term (10+ years). The rationale for this is:

- In line with the original intended purpose, it presents the long-term vision required from a Primary Care Premises Strategy.
- In reflection of the comments received from local stakeholders, it references a series of more practical, shorter-term options/solutions/actions to help address those capacity/premises related challenges that cannot/should not wait for a longer-term strategy to implement and/or the detail required to help develop the same.
- It presents a sense of an evolving strategy in which even short-term changes/investments/dis-investment decisions are wholly contributory and taking the whole Primary Care estate in a preferred "direction of travel".

In reflection of the desire to address immediate challenges, the options framework acknowledges that short-term options are inevitably more "property-led", i.e., primarily responding to or addressing property-related challenges or opportunities. Over time however, the goal of the developing strategy and the options generated in support of it is for the strategy to be increasingly service-driven.

The framework also recognises the relationship between time and level of investment required, with larger investment decisions inevitably taking longer to develop, support and fund through the national capital business case process. (Diag. 24)




**Diag.24. A Continuum for the Development of Primary Care Property Strategy Options**

**8.2 Property Strategy Phases**

The three phases of the developing Primary Care Property Strategy for East Dunbartonshire (as proposed) might currently be seen as:

- Phase 1 (Short-term): Data review and operational re-alignment (as appropriate); undertaking updated planning for a new "West Locality Hub" in the Bearsden/Milngavie area; progressing work already underway relating to the alternative means of delivering "shared HSCP capacity" or "shared satellite space" across the HSCP area to support short-term contractual requirements; and securing the necessary funding to deliver these preferred solutions in the short-term.
- Phase 2 (Short – medium-term): Additional business case development & facility planning relating to larger/longer-term/more permanent premises solutions.
- Phase 3 (Medium - long-term): Physical implementation of these more substantial built solutions – that will inevitably require proportionately more preparation and business case development work - as agreed.

**8.2.1 Phase 1 (Short-term): Data review and operational re-alignment (as appropriate); undertaking updated planning for a new "West Locality Hub" in the Bearsden/Milngavie area; finalise work already underway relating to the alternative means of delivering "shared HSCP capacity" or "shared satellite space" across the HSCP area to support short-term contractual requirements; and securing the necessary funding to deliver these preferred solutions in the short-term.**

Phase 1 of the developing strategy is seen as being deliverable within the short-term, identified as a period of between 0 and 3 years. During this time, the strategy proposes an opportunity to:

- Review the data, assumptions and scenarios presented within this report to ensure they are valid or to amend and update as appropriate.
- Support operational re-alignment to make best use of existing available property resources based on data collected and reviewed. (If possible)
- Review and re-present the augmented argument for a new "West Locality Health & Care Complex" (or "hub"), intended primarily to address those issues identified in the original "Milngavie Health and Care Centre" paper presented by East Dunbartonshire HSCP as a component of the NHSGG&C prioritisation process but with an added understanding of the substantial risk associated with existing premises in the area as highlighted within this review.
- Finalise work already underway relating to the alternative means of delivering "shared HSCP capacity" or "shared satellite space" across the HSCP area to physically increase capacity available to support the delivery of clinical services and support short-term contractual and policy obligations whilst mitigating those risks identified associated with GP owned/leased premises in the area.
- Secure the funding required to implement those preferred solutions identified as essential in the short-term.

The rationale for reviewing data, assumptions and scenarios presented within this report is that:

- A huge volume of data has been collected and reviewed in support of this project.
- All this data has been supplied by the HSCP, NHSGG&C or other national sources as referenced however, it is important however that the local HSCP Team recognise this data, are comfortable with the way it has been used and can agree with those conclusions drawn.
- This is particularly true where assumptions have had to be developed in the absence of detail to understand the potential future picture, E.g., Relating to housing developments and the impact on future service delivery.
- It is also important that they have the opportunity to use it to support more detailed local planning that falls out with the scope of this strategic exercise.
- (The Project Team note that all original data and planning documentation will be made available to the local HSCP Team in order that they can review all identified variables and amend these as required to present alternative scenarios for detailed planning purposes.

The rationale for operational re-alignment in the short-term is that:

- Whilst most facilities are well/very well utilised, data analysis based on agreed assumptions indicates variance and a mismatch between some areas available and required on a site-by-site basis with both over and under provision indicated.
- There may be an opportunity to better align these services and facilities promptly.
- One example of this relates to KHCC, where there is an apparent mismatch between the space available within the HSCP area of the facility and the GP element. Specifically, Woodhead Medical Practice has the lowest rate of rooms/1,000 practice population of any GP facility in the locality (0.9 based on six rooms and 6,800 people),

whilst the HSCP element includes 19 rooms seeing an average of 12 appointments/room/day?

The rationale for reviewing and re-presenting an augmented argument for a new, potentially re-branded "West Locality Health & Care Complex" is that:

- Although the original proposal for a Milngavie Health & Care Centre, intended to replace the existing Milngavie Clinic and a number of existing GP practices in the area, as presented for consideration by the NHSGG&C capital prioritisation process, remains valid;
- data collected appears to have presented an opportunity to review, re-align and potentially reduce the spaces proposed in some areas substantially; and
- a wide range of additional factors have been identified through this review process that add significant weight to the argument for investment in the area in response to a major assessed risk.

These additional factors include:

- The perception of Bearsden and Milngavie as an affluent area, with a healthy albeit ageing population to the detriment of the alternative arguments for investment in the area.
- The poor functional suitability of the existing GP estate in the Bearsden/Milngavie area that is not suitable for the medium to long-term delivery of primary healthcare.
- The relatively high backlog maintenance costs associated with Milngavie Clinic but especially practice-owned accommodation in the area.
- The fact that all GP practice premises in the Bearsden/Milngavie area are owned by the practices, placing a substantial and concentrated risk to the Board with respect to the premises element of the current GP contract.
- That all these premises are likely to be "high-value" in property terms, with a ready private buyer's market and therefore probably less dependence on the Board with respect to any future disposals.
- As a consequence, the reality that all local GP capacity could be lost to the NHS with minimal notice – and certainly not sufficient lead time to develop a built solution – if practices decided to vacate current premises for whatever reason without reference to the Board.
- The poor state, high utilisation, and strategic significance of the existing Milngavie Clinic, the only existing HSCP owned/leased clinical facility in the area, that would be unable to meet any of this additional demand.
- The consequential potential rapid loss of some or all local GP consulting capacity in an area that is affluent but has a significant ageing population with little or no warning.
- The need to see this situation as a unique and substantial risk that must be considered alongside more traditional prioritisation arguments.

The rationale for finalising work already underway relating to the alternative means of delivering "shared HSCP capacity" or "shared satellite space" across the HSCP area is that:

- A physical increase in capacity is required to support the delivery of clinical services, national policy implementation and contractual obligations in the short-term based on the data reviewed.

- The exposure to risks associated with the premises element of the GP contract is broadly similar across the area and immediate, in so far as a majority of GP practices operate from facilities that are owned by the practices.
- It is noted however, that - unlike in Milngavie - there is currently no existing HSCP capacity in either Bearsden or Auchinairn, making PCIP, CTAC and other commitments associated with the GP contract virtually impossible to implement.
- The complete lack of HSCP owned/leased capacity in these areas also means that there are currently no mitigation options available with respect to any continuity or assuredness of supply from a premises perspective.
- In recognition of these concerns, East Dunbartonshire HSCP has already evaluated a range of alternative options to deliver the additional capacity they have assessed as required in the short-term across the area and the potential alternative means of procuring/otherwise funding these. This includes a range of local property solutions such as business premises and shop fronts.
- It may be possible to identify at least one option where satellite capacity is generated as a new build, with the space created the first phase of the suggested "Western Health & Care Complex".

The rationale for securing the funding required to implement those preferred solutions identified as essential in the short-term is that:

- Any essential expansion of capacity will have an associated cost.
- It may not be possible to meet these essential short-term costs within existing budgets/funding streams.
- Even schemes/options that seem modest from an NHS Board-wide perspective may be prohibitively expensive in East Dunbartonshire and require additional funding.

#### 8.2.1.1 Shared Satellite Space (SSS or "S3")

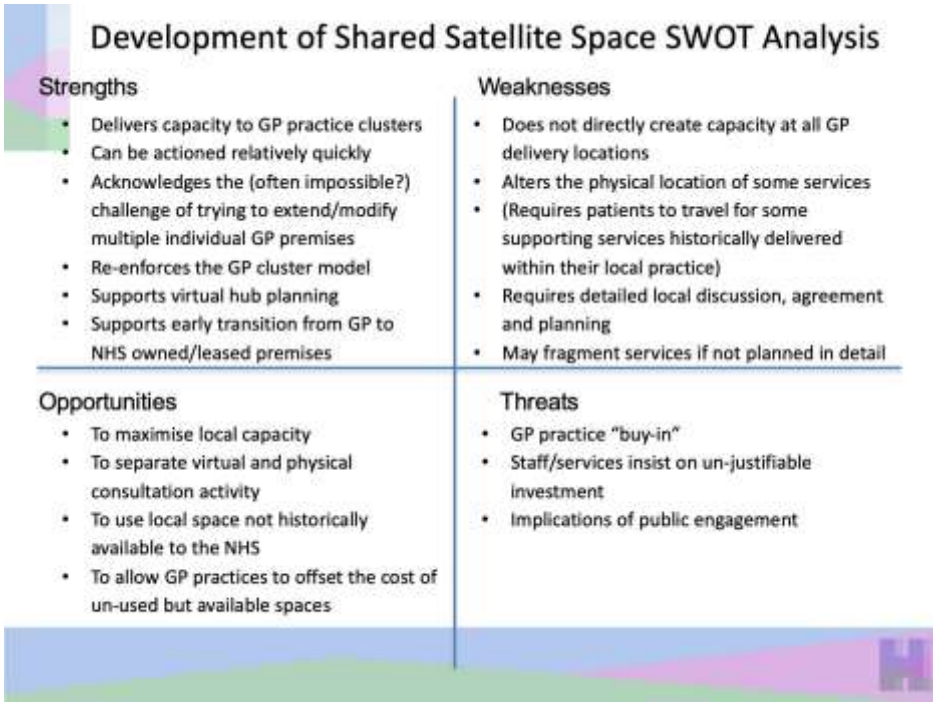
"Shared satellite space" is a concept developed as a result of property strategy work undertaken throughout the review process to date as a means of addressing short-term capacity needs – particularly within or between GP premises - through the re-distribution or creation of additional collective space by GP cluster.

- "Shared" because the space does not belong – in operation at least - to any one single practice.
- "Satellite" because whilst in the same geography/GP cluster area, it is not necessarily physically attached to any of the GP practices it is supporting.
- "Space" because its core aim is to deliver physical space (rooms) to ease pressure on practices and support local service delivery.

Shared satellite space may be able to ease immediate capacity concerns and deliver local solutions to what is a complex, time-consuming and often impossible challenge to address at individual practice premises level. Depending on the local situation it may be:

- In defined cleared/currently vacant areas within virtual hub premises, or;
- in defined cleared/currently vacant areas within existing GP practice premises, or;
- in defined cleared/currently vacant areas within the wider public sector property portfolio – subject to further discussions.
- Used to free up space at practice level to optimise local care delivery and successful implementation of the practice-based model or augment existing HSCP capacity.

- A first, important step in the transition of GP premises space from GP partner ownership/lease to NHS Board ownership/lease.




**Diag. 25. Development of Shared Satellite Space SWOT Analysis**

The concept appears relevant in East Dunbartonshire:

- Due to the lack of HSCP capacity in the Bishopbriggs/Auchinairn area – and consequential inability to support implementation of the GP contract, CTAC and PCIP.
- Due to the potential loss of wider capacity in the Milngavie/Bearsden and Bishopbriggs/Auchinairn areas.
- To support the growing capacity needs of all GP clusters in the face of increasing demands across the HSCP area.

In addition, the availability of land adjacent to the existing Milngavie Clinic – a potential site for a replacement facility – may present the opportunity for the creation of new build shared satellite space as the first phase of the suggested "West Lcality Health & Care Complex". This has the potential to:

- Secure the required funding sooner than may be possible for a full replacement facility.
- Negate the requirement for "sunk costs" or short-term solutions.
- Further consolidate capacity in the area.
- Mitigate a number of the risks identified by the review process.
- Instigate a masterplan for the development site and potential phased construction programme.
- Present a credible and affordable programme moving forward.

**8.2.2 Phase 2 (Short – medium-term): Business Case Development & Facility Planning Relating to Larger/Longer-term/More Permanent Premises Solutions**

Phase 2 of the developing strategy is seen as being deliverable within the short – medium-term, with the medium term notionally being identified a period of between 0 and 10 years. During this time, the strategy proposes a requirement to:

- Seek appropriate local and Board-wide agreement to develop the required business case(s) in support of substantial capital investment or as an alternative to this.
- Develop the business case(s) agreed as being required to support major infrastructure developments in response to the findings of the option appraisals conducted and in the context of the relevant NHSGG&C Capital Planning & Prioritisation process/project programme.
- Develop the detailed briefing documentation required to support the development of detailed designs for any capital projects approved, ensuring that these are able to deliver the required range of services for the required planning period (including more detailed assumptions relating to changing demand and capacity requirements)
- Implement any "shared satellite space" solutions identified as required.

**8.2.3 Phase 3 (Medium – long-term): Physical Implementation of These More Substantial Built Solutions – That Will Inevitably Require Proportionately More Preparation and Business Case Development Work - As Agreed.**

Phase 3 of the developing strategy is seen as being deliverable within the medium to long-term, notionally identified as a period of between 3 and 10+ years. During this time, the strategy proposes an opportunity to:

- Deliver those physical construction/re-furbishment projects associated with approved business cases in line with the overarching NHSGG&C Primary Care Estate Strategy and place-based investment approach.

## 6 SUMMARY & RECOMMENDATIONS

Overall, in summary, the East Dunbartonshire project has:

1) Identified the emerging core strategic elements and apparent "direction of travel" and vision of the strategic East Dunbartonshire component of a developing Primary Care Estate Strategy for NHSGG&C.
2) Followed a clear, transparent, and agreed process that responded to the key questions: What do we want? What do we have? What do we need? And what is required? In pursuit of this objective.
3) Engaged with a large number of stakeholders and stakeholder groups in the process.
4) Continued to add to accrued learning so that the review process and methodology used can continue to be modified and simplified for on-going application across the NHSGG&C Board area.

In recognition of all the data reviewed and work undertaken to date, the review team have also developed a number of strategic recommendations. These include that NHSGG&C and East Dunbartonshire HSCP, with the support of wider stakeholders as appropriate, should:

- Consider and provide formal comment on the developing Primary Care Estate Strategy for East Dunbartonshire to ensure that the developing options have the widespread support required before they are used to inform discussions with planning partners and the wider community.

- Review and amend as appropriate any data and assumptions presented in the SID or text of this report before considering the impact such changes may have on the analysis conducted and recommendations made.
- Complete an evaluation of the activity undertaken with a view to continuous improvement of the developing process as it seeks to ultimately create a Board-wide Primary Care Property Strategy. Thereafter, use this strategy as a key tool:
    - to support the practical implementation of Moving Forward Together from a property perspective
    - to enable the Board to review and prioritise future facility developments (including GP practice requirements) across Primary Care, further ensuring that the right investment decisions are being taken at the right time and for the right reasons as components of an over-arching integrated services and property strategy.
    - Review and consider those options presented relating to the future strategic development of the Primary Care estate in East Dunbartonshire in an area, regional, national, and service-specific planning context before finalising the Primary Care Estate Strategy for East Dunbartonshire. Currently, core elements of the proposed strategy are:

**In the short-term (0-3 years)**

- Review the data, assumptions and scenarios presented within this report to ensure they are valid and amend or update as appropriate.
- Support operational re-alignment of existing services/staff where feasible to make better use of existing available property resources based on the data collected and reviewed.
- Seek formal support from the Capital Planning & Premises Team to undertake project support and development activities.
- Review and re-present the augmented argument for a new "West Locality Health & Care Complex", supported by an amended Schedule of Accommodation (S of A), intended primarily to address those issues identified in the original "Milngavie Health and Care Centre" paper (presented as a component of the previous NHSGG&C prioritisation process) but with an added understanding of the substantial risk associated with existing premises in the area and space requirements as highlighted by this review.
- Finalise work already underway relating to the alternative means of delivering "shared satellite space" across the HSCP area to physically increase capacity available to support the delivery of clinical services and support short-term contractual and policy obligations whilst mitigating those risks identified associated with GP owned/leased premises in the area.
- Secure the funding required to implement those preferred solutions identified as essential in the short-term.
- Seek the inclusion of the preferred strategic option(s) identified in local HSCP plans within the next appropriate NHSGG&C capital prioritisation process to understand the actual timetable for development and/or any remedial actions required.
- Continue to review emerging proposals in the context of the "Place Based Approach" advocated by the Scottish Govt. that has been at the heart of the process followed to date.

**In the short to medium-term term (0 – 10 years)**

- Seek appropriate local and Board-wide agreement to develop the required business case(s) in support of capital investment or an alternative to this.
- Develop the business case(s) agreed as being required to support infrastructure developments in response to the findings of the option appraisal conducted and in the context of the relevant NHSGG&C Capital Planning & Prioritisation process/project programme.
- Develop the detailed briefing documentation required to support the development of detailed designs for any capital projects approved, ensuring that these can deliver the required range of services for the required planning period (including more detailed assumptions relating to changing demand and capacity requirements)
- Implement any remedial actions required in reflection of projected differences between strategic capital investment programmes and local demand/facilities (if required).

**In the medium to long-term (3 – 10 years plus)**

- Use "otherwise essential investment" and new monies secured through the capital business case process to maintain, develop, refurbish and/or construct the physical infrastructure associated with approved business cases in line with the overarching NHSGG&C Primary Care Estate Strategy and place-based investment approach. This is likely to include, most notably:
    - The replacement of Milngavie Clinic, +/- local GP Practices, (The proposed "West Locality Health & Care Complex" or "hub").
    - The provision of HSCP "shared satellite space" in the Bishopbriggs/Auchinairn area or an alternative to this agreed through an option appraisal process.

The review team respectfully commend these strategic recommendations to East Dunbartonshire HSCP and NHS Greater Glasgow & Clyde for their further consideration and feedback at this time.

**Norman Sutherland**

Director (Health)
For and on behalf of
Higher Ground Health + Care Planning Ltd
(hub South Supply Chain Member)

**1st September 2022**

**APPENDIX A**

**What Do We Want? Workshop Participants**

**Workshop 1: HSCP Management Team, Operational Managers & Third Sector (24/2/22)**

Chris Bancroft, Podiatry Lead
Jean Campbell, Chief Finance & Resources Officer
Claire Carthy, Criminal Justice
Leanne Connell, Interim Chief Nurse
Gordon Cox, Volunteer Service User Representative
Lorraine Currie, Service Manager Mental Health & Learning Disability
Carolyn Fitzpatrick, Clinical Pharmacists
Susan Frew, Interim General manager, Oral Health
Caroline Galloway, MSK Team Lead
Suzanne Greig, C & F Fieldwork service manager
Kathleen Halpin, Interim Senior Nurse, ANS
Jeanette Hawthorne, Service Manager, Property
Angus Hunter, Project Support Officer, Capital Planning
Vandrew McLean, Business Manager
Jillian Mitchell, Service Manager, Children's Services
Richard Murphy, Registered Services Manager, East Dunbartonshire Council
Derek Pearce, HSCP Head of Service, Community Care and Health
David Radford, Health Improvement
Diane Rice, Primary Care Development Officer
Norman Sutherland, Healthcare Planner, HGHCP (Facilitator)

**Workshop 2: HSCP Management Team and GP's (3/3/22)**

Jean Campbell, Chief Finance & Resources Officer
Pamela Doran, Practice Manager, Kenmure Medical Practice
Jeanette Hawthorne, Service Manager, Property
Angus Hunter, Project Support Officer, Capital Planning
James Johnstone, Practice manager, Turret Medical Centre
Vandrew McLean, Business Manager
Ainsley McGroarty, GP, Kirkintilloch/Lennoxtown and Cluster Lead
Derek Pearce, HSCP Head of Service, Community Care and Health
Diane Rice, Primary Care Development Officer
Tracey Secrett, GP, Bearsden
Norman Sutherland, Healthcare Planner, HGHCP (Facilitator)
Alastair Taylor, GP, Bearsden and PCIP Lead
Paul Treon, Clinical Director
Christine Wilson, GP, Bishopbriggs & Auchinairn

**APPENDIX B**

**What Do We Want? (Summarised Cumulative Responses/Workshop Feedback)**

A Summary of responses received to date at two scheduled workshops with participants as identified in Appendix A including representatives of:

- the HSCP Management Team;
- Local GP's;
- service managers;
- professional leads;
- the local authority;
- third sector organisations

**In the short-term?**

- recognition and acknowledgement of those problems/challenges that are time critical and can't wait for a long-term strategy E.g., Vaccinations
- Agreement on how to work best post COVID – probably a combination of digital and face to face
- to be able to continue to work (and consult) from home where this is appropriate (Including the ability to issue prescriptions)
- to retain the positive elements of recent rapid change including virtual appointments and home working – where these work
- to return to more face-to-face consultations/interactions where this is essential/virtual is not a suitable alternative
- to be kept up to date with the developing strategy

**From the process?**

- openness, honesty & inclusiveness
- a clear proposal or options about the way forward
- to understand what effects our property needs
- to include learning from COVID
- investment decisions that are based on effective prioritisation
- realism and pragmatism
- a property strategy that is fit for purpose, able to support our service needs and supported by a broad consensus
- to feel involved and valued
- to address our critical property needs

**From the Strategy?**

- clear proposals or options about the way forward that are linked to local and national strategy
- a strategy that reflects the inter-dependency of many different services and the impact of changing any single service
- a strategy that provides equity of access to all services across all parts of the area
- more flexibility, more sustainability (buildings and services), more joined-up planning/working.

- A strategy that sees "the bigger picture" … even where this is at odds with individual aspirations and presents the basis for securing structured investment
- a strategy that can provide context and support for any required business cases
- a strategy that is strongly linked to wider HSCP, NHS Board and national strategies
- agreement on how we will be working in a "post COVID" world that retains the positive elements of recent rapid change
- (an understanding of what this will mean for services and the premises required to support them)
- to optimise the use of those high-quality, functionally suitable buildings we do have whilst developing proposals for addressing the challenges associated with the balance
- health to be able to respond better, more quickly and in a more informed way to wider developments, E.g., New schools, housing, infrastructure, etc
- to be able to address the needs of the wider teams and the relationships between them
- to support delivery of the GP contract
- to allow GPs to move from GP owned/leased facilities to NHS/HSCP owned/leased buildings where they want this
- ("Buying into practice premises and managing the challenges associated with them is an increasing barrier to GP recruitment")
- a "soft landing" for GP's who are affected by any changes proposed
- support (and investment) for developments that take us towards the preferred strategic direction of travel
- recognition that some challenges can't wait for a strategic resolution
- support for a Milngavie Health & Care Centre

**From our facilities?**

- equity of access to all services across all areas and over an extended day where appropriate
- an estate that works for the community and all stakeholders
- fit for purpose spaces and facilities, where people of all ages want to be – and can be safely
- locations that are easy to get to – and buildings that are easy to move around in
- places people can walk to or cycle to, along with the infrastructure to support this (Showers, cycle parking, etc)
- age-appropriate accommodation
- sufficient, appropriate car parking
- to be together with our colleagues – at least on a regular basis
- space to support the full complement of the local enhanced team – and room to allow this to expand
- to deliver capacity where it is needed now and in the future – rather than where it has historically been/was needed in the past
- the ability to deliver the Primary Care Improvement Plan (PCIP).
- spaces where the public can access IT to support remote digital consultation, etc. (Existing inequalities are affecting disadvantaged populations disproportionately)
- to support personal interaction, with our patients and our colleagues
- access to outdoor spaces – for staff and the public!
- the capacity and space we need to deliver services appropriately
- "future proofed" facilities
- to get rid of buildings that are not fit for purpose

- possibly less buildings overall – but with a wider range of services
- potentially, multi-practice multi-agency facilities that include health and social care
- fewer, better quality, more consolidated delivery locations
- facilities that are flexible
- more shared space, less names on doors, less different room types
- potentially different kinds of spaces – including those designed to deliver virtual clinic activity
- greatly increased strategic and operational flexibility
- an effective and sustainable IT infrastructure that works across the whole system – separate LA and NHS systems are a huge frustration at present!
- multi-purpose spaces
- A new Milngavie/Bearsden Health & Care Hub

**What are the risks we need to be aware of?**

- recruitment of staff is still the biggest challenge!
- the availability of finance/affordability
- increasing demographic demands and population shifts
- managing expectations
- an inability to address short-term challenges quickly enough?
- A lack of space within GP premises to support local service delivery/enlarged teams?
- The poor quality of some existing premises
- Practices folding because they fear the financial impact on their business?
- Key stakeholders not engaging?
- How long it will take to deliver strategic solutions vs how long some of the existing facilities will be able to operate!

**APPENDIX C**

**What Do We Want: Strategic/Policy Context**

**COVID-19 Learning**

The launch of Strategic Estate Review pilot activity in 2020 corresponded almost exactly with the developing COVID-19 situation across the UK. Consequently the virus had an immediate impact on programme and project outturns.

The NHS GG&C re-mobilisation plan was produced collaboratively across the health and care system led by the Recovery Tactical Group. This presents a COVID re-mobilisation based on a number of shared principles. These include:

- Flexibility, in order to respond to future COVID waves.
- Social distancing will shape the way we deliver services in future.
- Embracing new ways of working.
- Continued cross system working, which has been successful in the COVID response.
- Maximising the opportunities to use digital tools to enable and sustain recovery.
- Supporting staff health and well-being.

Overall, although the exact impact of COVID on services – especially over the medium to long-term - is still unknown, it still seems appropriate to conclude that:

- COVID has reduced face to face clinical activity substantially since March 2020.
- Whilst many services will increase traditional consultations as and when the current emergency subsides, this will vary by service and specific needs.
- Traditional consultation activity will not return to pre-COVID levels, with the Board's aim that 70% of activity in future with remain virtual.
- Whilst the number of interactions required may not change substantially, the way this activity is conducted and the nature of spaces required to support it may be different.
- In the longer-term, some activities may continue to be delivered virtually/in a different way where this has been found to be advantageous and appropriate.

In terms of staff areas, it may also be reasonable to assume that:

- The huge increase in home working is likely to be maintained to some extent with a consequential reduction in the number of permanent desk spaces required.
- It is highly likely that traditional office-based working will not return to pre-COVID levels for the foreseeable future with home working taking up the difference.
- Whilst the volume of administrative support required will not change substantially, the way this activity is conducted and the nature of spaces required to support it, will.
- This is likely to mean fewer desks but with more space around them and in support areas to facilitate social distancing.

**NHS Scotland Estate Asset Management (EAMs)**

The Estate Asset Management Project (EAMs) is being delivered by Health Facilities Scotland (HFS) to improve the management of the NHSScotland estate by ensuring that an accurate, consistent and meaningful database of asset information is put in place and maintained. This is intended to assist with the development of Property and Asset Management Strategies

(PAMS), as well as with the management and risk based prioritisation of backlog maintenance. The data is also used by Scottish Government Health and Social Care Directorates (SGHSCD) to compile a Property Performance report on an annual basis.

The Scottish Government policy document 'A Policy for Property and Asset Management in NHSScotland' requires that all NHSScotland bodies must have a current Property and Asset Management Strategy (PAMS) which reflects the following policy aims:

- to ensure that NHSScotland assets are used efficiently, coherently and strategically to support Scottish Government's plans and priorities and identified clinical strategies and models of care;
- to provide, maintain and develop a high quality, sustainable asset base that supports and facilitates the provision of high quality health care and better health outcomes;
- to ensure that the operational performance of assets is appropriately recorded, monitored, reported and reviewed and, where appropriate improved;
- to ensure an effective asset planning and management with other public sector organisations.

PAMS have generally only covered premises which were owned or occupied by the Health Board and have not historically included premises which were owned by GPs or leased by them from private landlords. However, in reflection of changes associated with the GP Premises National Code of Conduct, all Health Boards must now include GP owned/leased premises in their Property and Asset Management Strategies.

**GP Premises National Code of Conduct**

The Scottish Government and BMA Scottish GP committee (SGPC) have agreed a national code of practice for GP premises that sets out how the Scottish Government will support a shift, over 25 years, to a new sustainable model in which GPs will no longer be expected to provide their own premises. This includes a provision for interest free sustainability loans and a planned transition to health boards leasing these premises rather than GP contractors.

It is planned that NHS boards will gradually take on the responsibility from GP contractors for negotiating and entering into leases with private landlords and the subsequent obligations for maintaining premises. Principles for all participants, as outlined in the code are that Health Boards and HSCPs should:

- have regard to their statutory duty to provide or secure the provision of primary medical services in their area;
- have regard to the needs of the population in their areas;
- have regard to their budgets;
- consider whether assistance is an efficient and effective use of their resources;
- have regard to their HSCP's plans for primary care;
- share their plans with practices through the local consultative bodies; and
- have regard to the level of co-operation and information they receive from GP contractors.

The National Code of Practice for GP Premises also recognises that:

- Health Boards, in conjunction with HSCPs, must take an active approach to the management of the whole of their GP estate.

- HSCPs and Health Boards must work together to identify their priorities for investment in primary care premises. Their priorities for investment must support HSCPs' primary care improvement plans.
- HSCPs must take into account the needs of their population, the need to sustain general practice and, working with Health Boards, address the need to provide fit for purpose premises for the provision of primary medical services when they identify their priorities for investment in primary care premises.

Historically it was extremely difficult for NHS Boards and HSCP's to plan for required investment in GP premises due to the independent nature of the contractors involved and consequential limited data on premises condition and capacity available. In support of the changing environment however, the Scottish Government commissioned surveys of all GP premises, whether owned by Health Boards, GPs or third parties, so as to better understand the GP estate and to help plan for the future. They have also acknowledged that the GP estate will now need to be surveyed at regular intervals in future in line with existing obligations on Health Boards such as that of CEL 35(2010).

Health Boards and GP contractors are required to co-operate with survey work, in the understanding that such inspections are necessary to assist GPs to manage their premises and to allow Health Boards to manage the primary care estate better. Other specific considerations include that:

- HSCPs and Health Boards should consider the potential benefits to GP sustainability of making space available in existing Health Centres for GP contractors which are not currently in publicly owned facilities.
- GP contractors who are offered the opportunity to relocate to existing Health Centres should consider the benefits to their long-term sustainability of doing so.
- The HSCP, together with its Health Board, must consider how best to use any GP premises purchased or leased by the Health Board.
- The HSCP and Health Board should also consider whether the premises should be used for any other health and social care purposes in addition to GP services.

The full national code of practice for GP premises can be found here:

https://www.gov.scot/publications/national-code-practice-gp-premises/

**Moving Forward Together**

The NHSGGC Board approved the Moving Forward Together (MFT) Vision for Health and Social Care services as the blueprint for the development of future models of care On 24 June 2018. MFT is aligned to Scottish Government, national and West of Scotland regional strategies as well as the projected needs of the GGC population. The aim of the Moving Forward Together Programme is:

"To develop and deliver a transformational change programme, aligned to national and regional policies and strategies, that describes GGC's delivery plan to provide safe, effective, person centred, accessible and sustainable care to meet the current and future needs of our population".

MFT adopts a tiered network approach across health and social care spanning a local and community-based element which can then escalate care as required into specialist or hospital-

based care. This tiered network of care delivery seeks to provide access as locally as possible with access to increasingly specialist care provided for a geographical sector or indeed for the whole of GGC or sometimes for the West of Scotland.

Central to the MFT tiered approach is the list based system of primary care, where people are registered with a GP practice. This provides a foundation for the delivery of a full range of preventative and treatment services, as well as a network of locations for the delivery of care. This also provides an opportunity for coordinated care within a defined geographical area, with a wide network of services. MFT also highlights that each HSCP will need to balance local accessibility with colocation to meet need and provide safe and effective delivery of services. In each HSCP and locality therein, the vision suggests that services will come together in a virtual network or in some places there will be a single physical hub from which services reach out. This will require a clear strategy for the development of community-based premises and accommodation to ensure that premises are fit-for-purpose and support the new models of working at practice, cluster, health and care centre or community network levels.

Discussion with representatives from the MFT team have identified that any future Primary Care property strategy must respond to the objectives of MFT but also act as a key property enabler for it, recognising that buildings – especially in local communities - will have a major impact on enabling the shift required in the balance of care proposed.

Full details on Moving Forward Together can be found here:

https://www.movingforwardtogetherggc.org

**APPENDIX D**

**The Strategic Infrastructure Database (SID): Core Elements**

Within the SID, individual properties/part there-off are presented in rows whilst data collected/calculated/otherwise assessed as it relates to each property is presented in columns.

Main property (row) sub-sections are:

- HSCP owned/leased premises
- GP owned/leased premises

Main data (column) sub-sections are:

- Buildings information:
    - Property location and classification.
    - Build year.
    - Gross internal area (GIA)
    - Historic 6 facet estate classification (Building, engineering, functional suitability, space, quality and physical condition).
    - Backlog maintenance costs and breakdown by building element and risk level.
    - Tenure/lease information where relevant.
    - Block name (To identify accommodation at a departmental/practice level).
    - List of core rooms, service delivery and support spaces by type (Consulting rooms, interview rooms, office desks, meeting rooms, etc).
- Staff information:
    - Numbers of staff located within the facility by professional group and role.
    - Desk/wte assumptions by professional group and role (to assess number of desks required).
    - Desks required (Calculated based on staff numbers and assumptions regarding desks required/wte/role).
- Activity information:
    - Practice population information (For GP practice locations – used as a proxy for actual appointment activity where no detailed information is available).
    - Actual activity appointment numbers (including attendances and DNA's by sub-specialty as reported).
    - Operational activity assumptions to support high-level capacity analysis including: assumed working days PA; calculated appointments/day; assumptions re: optimal appointment numbers/day; assumptions re: optimal session utilisation; and rooms potentially available for alternative/enhanced use based on these assumptions.
- An assessment of refreshed property and activity data plus consideration of "strategic significance" and "potential" to support the development of strategic estate recommendations (utilising agreed scoring criteria) including:
    - Property actual physical condition (Scored /10).
    - Property actual statutory compliance (Scored /10).
    - Property environmental management (Scored /10).
    - Property space utilisation (Scored /10).
    - Functional suitability (Scored /10).
    - Quality (Scored /10).

- Strategic significance (Scored /10).
- Strategic potential (Scored/10).

"Strategic significance" and "strategic potential" are additional assessed elements recorded in the SID that are over and above conventional 6 facet survey information. They are intended to ensure that the developing property strategy considers each building/block in a broader, more strategic context, as 6 facet surveys only assess individual building blocks in isolation.

"Strategic significance" is about understanding how important a facility/site/block is in the context of an existing services/facilities strategy and whether or not it is consequently seen as having a longer-term role. Key prompts used to generate a score in this regard were:

- Strategic importance of the location (How important a site appears to be from an overall service delivery perspective in overview).
- External accessibility (How easy it is to access/get to from across the area being reviewed).
- Proximity to other relevant locations (Including whether or not it is important because it is close to other facilities/services).
- Proximity/relationship to public/service needs (Including whether or not it is close to current demand/future need/demand).
- Duplication/replication locally (Including whether or not a facility is important because the services it delivers are not replicated locally).

"Strategic potential" is about understanding the potential role a facility/site has in the context of a developing future services/facilities strategy and whether or not it has the ability to respond appropriately to changing needs. Key prompts used to generate a score here were:

- Ownership (Is the property owned or leased and how this might affect its ability to change/develop in support of a future strategy).
- Willingness/preparedness of the owners and other relevant stakeholders to support change (irrespective of who owns the building, whether there is likely to be a willingness to support its change/re-modelling if required).
- Availability of facility options? (Whether options exist to change, extend, modify, re-model or re-use existing facilities as required).
- Availability of site options? (Whether options exist to re-use the existing site alternatively as required).
- Proximity/relationship to changing public/service needs (Including whether or not it is close to future demand/need, E.g. Based on population change, housing projections, etc).
- Ability to support the "what we want?" element of the process to date.

In order to aid decision making at a strategic level around what, if any, role existing assets may play in a future strategic estate model, the SID then attempts to consolidate all of the available data and evidence-based assessments into 4 summary criteria that reflect:

- The overall quality/fitness for purpose of existing buildings.
- Their baseline utilisation.
- Their strategic significance as a service delivery location.
- Their potential to support future change/deliver service needs.

**APPENDIX E**

**The Strategic Infrastructure Database (SID): Core Space (Room) Types**

The SID includes a detailed summary of all of the rooms by type and function identified within the buildings reviewed. For strategic analysis purposes however the planning team have worked on the principal that these facilities feature 3 core types of accommodation in scheduled planning terms. We have defined these as:

- Primary delivery areas (PDA's)
- Desk & Administrative areas (Desks)
- Secondary support spaces

**Primary Delivery Areas (PDA's)**

"Primary delivery areas" or sometimes "primary clinical delivery areas" (PCDA's) depending on the context, are those key rooms/spaces that deliver core client-facing service functions. In the context of this Primary Care strategy work they primarily include:

- consulting rooms
- treatment rooms
- interview rooms; and
- other specifically defined/identified clinical/service delivery spaces/rooms for client-facing activity. E.g. Gyms, group rooms, etc.

It should be noted that simplifying room types for the purposes of analysis can lead to specific challenges/errors in some, especially smaller properties, but that it is seen as an appropriate means of simplifying data and analysis in the context of a 15 year strategic property strategy involving multiple individual premises such as this. It is also noted that the SID includes a more detailed breakdown of rooms and key spaces should further investigation or analysis be required.

All of the data relating to room numbers and types recorded in the SID has been provided or verified by relevant Capital Planning and HSCP staff.

**Desk and Administrative Areas**

Desk and administrative areas represent a significant percentage of the overall property portfolio reviewed and deliver an important and growing role in health and social care delivery. As well as acting as a base for permanent administrative staff, they also provide important areas for other staff with a primarily client-facing role to undertake essential administrative functions, meaning that specialist areas such as consulting rooms can be used to optimal effect.

As a consequence of COVID, the on-going role of administrative areas in delivering direct client support "virtually" has also been accelerated, although this has been significantly offset – in the short-term at least – by increased "working from home".

Within the SID, desks are primarily defined as:

- Desks within offices

- Reception desks

It should be noted that properties reviewed fall into three broad types with respect to desks and administrative accommodation. These are:

- Administrative buildings whose main purpose is to deliver desk/administrative space with little or no client-facing PDA type spaces. (Almost entirely "desk based" resources)
- Mixed client facing/clinical buildings with a combination of PDA rooms, support spaces and separate administrative areas. (A mix of "client-facing" and "desk based" resources)
- Client-facing buildings whose main purpose is to deliver face to face client interaction with desks only provided in support of this activity. (Almost entirely "client-facing" resources)

Whilst it is possible to determine desk requirements in defined administrative areas based on agreed metrics and known wte staff numbers, E.g. "A 6 to 10 desk ratio for Social Workers", it is considerably more challenging to do this in mixed facilities or where the primary role is client facing due to the higher range of relevant factors and variance. These include but are not limited to:

- The variable impact of visiting staff
- The complexity of scheduling "client-facing" and administrative sessions
- The generally smaller numbers of people and desks involved
- The impact of un-scheduled/drop-in activity
- Etc

As a consequence, administrative area utilisation data should be treated with more caution where desks represent a relatively small component of a larger client-facing facility than it can be when presenting a picture of the difference between desks available and potentially required in larger, defined administrative areas/facilities.

All of the data relating to desk numbers recorded in the SID has been provided or verified by relevant Capital Planning and HSCP staff.

**Secondary Support Spaces**

Secondary support spaces represent the balance of rooms/accommodation supplied which can, depending on facility purpose, represent a significant percentage of the "Gross Internal Floor Space" (GIFA) of a building. They include things such as:

- Clinical support spaces
- Facilities Management (FM) support spaces
- Whole facility support spaces
- Staff support areas
- Etc

Despite the substantial amount of floor area they represent, these areas are not reported upon in detail in the SID because of the strategic nature of the review process and the fact that their actual required number and size can broadly be determined/understood from the other core data collected relating to activity, staffing, facility size, function, etc. They may

however be seen to have an impact upon the overall “quality score” a facility receives based on the detailed assessment given in defined scoring areas such as:

- Statutory compliance
- Environmental Management
- Functional suitability
- Etc

**APPENDIX F**

**The East Dunbartonshire Primary Care Strategic Infrastructure Database (SID)**

NB This document is an extremely large database with nearly 8,000 individual data elements. It is not therefore reproduced in paper copies of this report. It can however be accessed electronically here:

Link to be inserted to the East Dunbartonshire Primary Care SID

**APPENDIX G**

**Estimating GP Practice Room (PCDA) Requirements**

Scottish Health Planning Note (SHPN) 36, Part 1, General Medical Premises in Scotland does not provide any specific guidance on calculating room numbers required in GP practice premises. Health Building Note HBN 11-01: Facilities for Primary & Community Care Services (The English equivalent) however, recommends a capacity model that considers a range of factors that are relevant here. These are:

- Catchment population
- Access rate
- Opening times
- Appt duration
- Assumed room utilisation

In an NHS Greater Glasgow & Clyde context, based on the reasonable assumption that each patient on a practice list attends for 3 appointments PA on average (which is broadly consistent with local data for those practices where both practice population and actual attendance is known); that practices are open 250 days PA; appointments last on average 20 minutes (room occupied time); and a room occupancy of 60% is expected (as indicated in HBN 11-01) it is reasonable to assume in general terms – and for the purposes of a strategic property review such as this - per 1,000 practice population:

- 3,000 appts PA in total
- 12 appts/working day
- 240 minutes consultation time required/day
- 360 minutes available/room/day (Based on 2 x 3 hour consulting sessions being available)
- 400 minutes of "room time"/day required at 60% occupancy or
- 1.1 rooms/1,000 practice population as a minimum (Before the addition of additional services traditionally delivered in other areas)

Although no nationally published data is available to test this high-level assumption, HGHCP's experience, based on work completed in other parts of Scotland, is also that less than 1 rooms/1,000 population begins to be highly problematic. This can vary however and is affected by issues such as:

- diseconomies of scale (less flexibility in smaller premises)
- room flexibility
- room functionality
- room access
- space "ownership" issues
- consulting models
- service delivery models (Partners and other health professionals)
- local operating procedures

The measure of PCDA's/1,000 practice population is intended to present a broad indicative comparison between capacity in different GP premises only; to identify those specific practices where space may be more of a problem; and where more detailed analysis may be required.