DAC BEACHCROFT

NHS ESTATES

Innovation and a sustainable future

Healthadviser

DAC Beachcroft's Health Adviser publications seek to provide insight, foresight and thought-provoking features and articles that provide practical solutions for the issues of the day, for health and social care professionals.

FOREWORD

It is widely accepted that there is a £6 billion maintenance backlog for our NHS estates, £3 billion of which is safety critical. This backlog arises as a result of years of austerity; whereby £4.3 billion of capital funding, together with receipts from the sale of NHS assets, have been diverted to keep day-to-day NHS spending in balance.

The primary care and community estates are in particularly poor order, with aged and decaying buildings, many of which are contaminated with asbestos, that are wholly unsuitable for hub working, new technology or the housing of multi-disciplinary teams. All of these are key elements of the NHS Long Term Plan (LTP).

Capital spending to address these issues has seen a 7% real-terms decline from £5.8 billion in 2011 to £5.3 billion last year, according to a Health Foundation report.[1] To compound this list of problems, the report's authors calculate that capital to revenue budget transfers have led to the capital budget falling as a share of the total departmental health budget from 5% in 2011, to less than 4% in 2015/16.

Private finance initiative (PFI) schemes have also fallen out of favour. These build-and-maintenance deals with private sector partners, that built over 125 replacement or upgraded hospitals, have kept NHS capital spending off Treasury balance sheets for the last two decades. HM Treasury's recent Infrastructure Finance Review Consultation[2], which closed in June 2019, makes it clear that the Government supports and is exploring new ways to attract private finance, but not schemes that share the same characteristics as PFI and PF2.

And yet, any alternative scheme needs to address the impact on The Capital Departmental Expenditure Limit (CDEL) limits; while there is no apparent shortage of willing investors in NHS property, borrowing which counts against DHSC CDEL can mean it is difficult, or even impossible, to get an otherwise compelling scheme approved.

Then there is the matter of NHS Property Services (NHSPS), the commercial company wholly owned by the Secretary of State which acts as landlord to a sprawling and diverse primary care and community estate. NHSPS provides estates management, support and facilities management services to some 3,000 properties – accounting for 10% of the NHS estate, and worth £3 billion.

Dogged by criticism since it was established in 2012 to take on and manage assets of the former Primary Care Trusts, the original intent – to find a joint venture private sector partner to invest in the NHS estate – was quickly shelved. Critics question the rationale for the management of NHS estate assets on a national basis, when the LTP appears to promote more localised Sustainability and Transformation Plan (STP)-driven solutions.

Many trusts are now keen to acquire and potentially develop these assets in line with STP planning, but progress in transferring assets from NHSPS has been slow.

In autumn 2019 the NHS was cheered by two injections totalling over £4 billion worth of government capital investment for new-builds and vital repairs, while £100 million was allocated to 21 other trusts to develop business cases for rebuilding.

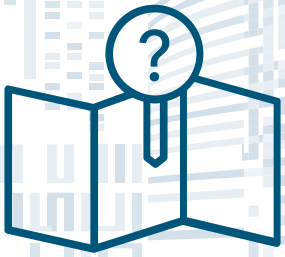
While the British Medical Association (BMA) and the NHS Confederation say new funding is welcome, what is required is a consistent, planned approach to maintaining and renewing the NHS estate.

In this report we examine these challenges, considering the views of experts who call for new freedoms to innovate and form relationships with private and public sector partners. New ideas are coming to fruition, demonstrating how the NHS estate can potentially derive more sustainable income for trusts and help deliver the LTP's aims. Here our experts share their thoughts on how to create a world-class NHS estate for patients and staff.

We would like to take this opportunity to thank our experts: Sir Robert Naylor (former Chief Executive at University College London Hospitals NHS Foundation Trust), Nigel Edwards (Chief Executive at the Nuffield Trust), Paul Price (Head of Commercial at Northumbria Healthcare NHS Foundation Trust), Richard Darch (Chief Executive at Archus), Tony Spotswood (Director of Health and Community Development at Affordable Housing & Healthcare Group) and Mark Bagnall (former Director of Estates, Facilities and Capital at University Hospital Southampton NHS Foundation Trust).

Anne Crofts
Partner at
DAC Beachcroft

[1] Failing to capitalise: Capital spending in the NHS https://www.health.org.uk/publications/reports/failing-to-capitalise
[2] https://www.gov.uk/government/consultations/infrastructure-finance-review



CHAPTER 1.

WHERE ARE WE NOW?

The NHS estate is in a parlous state. Years of austerity, selling off assets and diverting capital funding to balance day-to-day spending has created a £6 billion maintenance backlog.

At the end of September 2019, Health Secretary Matt Hancock allocated £2.7 billion of new money to enable six NHS trusts to undertake major rebuilding work. Some 21 other schemes will also share £100 million seed funding to develop business cases for rebuilding schemes.

Seven weeks prior to this, Prime Minister Boris Johnson announced a £1.8 billion investment, including £850 million to upgrade 20 hospitals across England and a £110 million investment in primary care premises. However, Paul Price, Head of Commercial at Northumbria Healthcare NHS Foundation Trust, was quick to point out that much of the latter announcement was not new money – rather, trusts were being allowed access to capital funds that were limited under Capital Departmental Expenditure Limits (CDEL).

Mark Bagnall, former Director of Estates, Facilities and Capital at University Hospital Southampton NHS Foundation Trust, welcomed the new investment. He says NHS Improvement (NHSI) is "very aware" of the challenges trusts face and has been "lobbying hard at a senior level to raise the profile of the needs of the NHS estate."

"The £6 billion backlog estimate is a large amount," he continues, "but despite the extra funding going in, it may be even higher as we come to a better understanding of the real extent of the issues we are facing."

Sir Robert Naylor, the influential former Chief Executive of University College London Hospitals NHS Foundation Trust, said that allowing trusts to spend on local maintenance or other priorities does address immediate problems. But he feels it does not address the £6 billion backlog, which he says stems from "a lack of capital investment from the last two decades, no PFI start-ups in the last five years, and an absence of cross-party political consensus – each blames the other for no progress."

His figures show that NHS capital spend has plummeted since 2007 from nearly 7% to around 3% of total healthcare expenditure. Average spend in Organisation for Economic Co-operation and Development (OECD) countries, by comparison, has

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> **Nigel Edwards, Chief Executive, Nuffield Trust**

maintained a relatively steady rate of 4-5% since 2000.

Lack of autonomy stifles innovation

The purpose of creating Foundation Trusts, according to Price, was to give them autonomy in order to be answerable to their local community and deliver healthcare appropriate to their locale. But over the past five or six years "there has been a systematic clawing back of control to the centre," he says.

NHSI now requires any investment in a new corporate entity, including a joint venture company, regardless of the amount of investment, to be subject to their approvals process. Any change to existing arrangements or new "material" risks are also required to be reported, even by Foundation Trusts with an established track record in setting up and managing subsidiary entities.

Price says: "If we want to make an investment in a joint venture, say with a private company, and set up a new entity, we have to go through a whole raft of processes. Even by taking a 1% stake in that new entity, we are creating a subsidiary company that needs NHS Improvement vetting and approval."

Tony Spotswood was Chief Executive of the Royal Bournemouth and Christchurch Hospitals NHS Trust for 19 years. Earlier this year he became the Director of Health and Community Development at the Affordable Housing & Healthcare Group (AHH), which works with NHS and local authorities to provide affordable homes for key workers, first-time buyers and last-time buyers.

Spotswood feels that the current CDEL "discourages innovation and the potential to partner with outside organisations – particularly where trusts would be concerned that they could secure capital and then not be able to use it, so their efforts are not rewarded."

And he wants less bureaucracy: "Provided that trusts are developing their cases and satisfying their boards that the relevant arrangements are put in place to spend money effectively, boards should be vested with the authority to agree those schemes without the whole process having to go back to the Treasury."

In 2016 Sir Robert produced an independent report which called for the NHS to consider how it could utilise its unwanted and unused capital assets, with many in the community entering into joint ventures with investors and developers. Echoing AHH he advocates building affordable, conveniently located accommodation for key workers. The report generated much interest at the time and the Government's response to it appeared to encourage such innovation. And although there are some interesting initiatives that have emerged, particularly on redevelopment for retirement housing, there seem to be fewer schemes for key worker accommodation.

Capital asset sell-offs

Sadly, many trusts are using capital receipts for running costs, or to meet spending targets. According to the same Health Foundation report cited above, sales of NHS capital assets have risen significantly since 2015/16, with over £400 million in sales in 2017/18 (compared with £175 million in 2010/11). Nigel Edwards, the Nuffield Trust's Chief Executive, comments: "I am concerned by the way that land sales are not being used as strategically as they might. Where possible you should be turning land and property into revenue streams."

Rebuilding the crumbling primary care estate should be easier, says Edwards, because there are fewer constraints on borrowing money. "There are lots of private investors who like to lend here. But the government is not prepared to underwrite the borrowing, which means the rates they can get are not so attractive.

Significantly, Edwards says GP practices themselves cannot afford to service the capital debt. "There is the capital available, but it's the revenue consequences of that capital spend that are the issue – capital assets cause a capital charge and depreciation costs, so there may not necessarily be the revenue to support these added charges and costs."

Guidance was produced in 2019 to enable trusts to request transfer of local assets, transferred to NHSPS in 2012, back into their control. Some trusts see this as a real opportunity to develop community assets in a way that can help deliver the changes necessary to meet the aims of the Long Term Plan. In essence, the guidance envisages

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Richard Darch, Chief Executive, Archus

properties transferring back to NHS trusts on much the same basis as historic NHS statutory transfers; in other words, the property is acquired with responsibility for all historic rental arrears or backlog maintenance transferring to the acquiring trusts. This can be off-putting for some potential acquirers.

Richard Darch, Chief Executive at Archus, an advisory, investment and development company specialising in health and social care, says a few trusts are making the case to take properties on. "Much of the NHSPS estate is poor quality and not in great areas. As many properties do not have leases or licences in place, then any buyer would discount the property heavily and it is unlikely that the NHS will get value whether sold outright, or sold and leased back."

However, for those trusts with the appetite to manage the legacy issues, and to find the right development opportunities and partners, this new approach may enable some STPs to use these assets in a more agile way.

CHAPTER 2.

MAKING ESTATES WORK

There are trusts developing innovative schemes, such as joint ventures and Limited Liability Partnerships, to raise funds for capital projects.

For all the apparently bad news, there is evidence of innovation. Sir Robert points to his old workplace: "The nearly £300 million phase 4 development currently under construction at UCLH – cancer, day surgery and proton beam therapy – is funded partially by the Treasury, trust cash, the UCLH Charity and a long-term lease for two private floors to the private sector."

University Hospital Southampton NHS Foundation Trust has a three-year capital plan which will draw on some £75 million from surpluses, plus £50 million from sources including Department of Health projects, the National Institute for Health Research, Southampton University, the hospital's own charity and the Murray Parish Trust which raises money for children's emergency services across the south of England.

Bagnall is proud of his work to date. He says the trust has built a new radiotherapy linear accelerator bunker, set in motion a £15 million replacement programme for ageing linear accelerators, and built a new cancer immunotherapy research centre which is playing a role in the recent breakthrough in the treatment of melanoma. The trust has almost finished building a new urology day unit and a general intensive care unit with 32 beds – up from the current 25 beds.

In 2013 the trust formed a strategic estates partnership joint venture with Prime PLC which has resulted in a new front entrance for the hospital. The trust receives rental income from the retail units, but much of the income is used to offset the building costs.

"The old entrance from the '80s looked very tired and not fit for purpose," says Bagnall. "Now there is plenty of space, plenty of facilities, a Marks & Spencer, WH Smith, Costa, Subway etc. It's a way of realising a commercial interest, but it's also important for patients and visitors: they can sit down, relax and not worry about where they can get a sandwich. It's also enabled us to build a new 800-space multi-storey car park, so there is now adequate space for patients, visitors and staff."

> "We share dividends and profits on a 50:50 basis. We orientate it towards what the trust feels will be most effective for them."
>
> **Tony Spotswood, Director of Health and Community Development, Affordable Housing & Healthcare Group**

Reducing financial risk

Spotswood is another advocate of joint ventures, where the NHS does not carry significant financial risk: "Five years ago my (then) organisation had some surplus land and we were approached by AHH to form a joint venture vehicle, in which AHH would guarantee the trust a return equivalent to the open market value of that land, but with potential for a far higher return.

"AHH built an 80-bed nursing home and a range of assisted living accommodation which it then sold. It did all of that at its cost. The trust put in no capital or other finance. The end-product was that the trust received a 50% share of the profits."

Summing up one AHH model, he says "There is no risk to the trust. It continues to own its land, it puts it into a joint venture vehicle and we fund the design, planning, construction and sale of the properties and share dividends and profits on a 50:50 basis. It can be either a revenue stream or a capital receipt – we orientate it towards what the trust feels will be most effective for them."

AHH also offers shared ownership schemes to last-time buyers where purchasers buy 50% and rent the other 50% at a government set interest rate of 3%. "We take that interest stream and sell it on to a major institution, such as a pension fund, which generates a further significant tranche of income, which again we split 50:50 with trusts, so they gain in a number of ways."

AHH is working with NHSPS to create value from some of the more moribund elements of the community estate: "In purchasing sites directly from NHSPS we have sought to develop principally for older persons' shared ownership. For other sites we have sought an NHS partner to work with, for example key worker housing. This is in the early stages," Spotswood says.

> "In buying out the PFI, we have more than demonstrated that we have saved money, plus some."
>
> **Paul Price, Head of Commercial, Northumbria Healthcare NHS Foundation Trust**

For many investors the possibility of also leveraging an NHS covenant over a, say, 30-40-year period is attractive. Although adding NHS facilities to a development can add complexities from a procurement law perspective, Spotswood believes it can help to maximise the investment potential.

Freedom and flexibility

According to Price, trusts like his own with outstanding Care Quality Commission ratings have more bargaining power with NHSI. Famously the trust went to Northumberland County Council to raise funds to buy out the PFI at Hexham Hospital. "When we did the PFI buy-out we went through all sorts of hurdles, as the centre had concerns about the fact that we had obtained cash from outside the 'NHS family' – which is what Foundation Trust status allowed us to do. In buying out the PFI, we have more than demonstrated that we have saved money, plus some."

The trust has created Northumbria Healthcare Facilities Management Limited (NHFML), a wholly-owned subsidiary that delivers estates facilities and infrastructure across the trust. The subsidiary vehicle also built the pioneering emergency care hospital at Cramlington to the same 'PFI' spec, says Price. "Using this model enables all 'new' estates to be fully life-cycled, so we can maintain that standard in a long-term, ring-fenced budget."

As a separate vehicle, NHFML provides the ability "to deliver a PFI standard contract without the ball and chain of the PFI debt, because we are not charging the interest rate of a PFI," says Price. "The only shareholder NHFML is answerable to is the trust, and it knocks out the whole process of paying dividends to a separate investor entity – the dividends come back to the trust and into frontline healthcare."

Price also advocates joint working with local authorities including sharing back office services. His trust's procurement team sits within Northumberland County Council and all the capital works that are put out to tender are managed through a joint team. "The council's chief executive is an executive director of the trust," he adds. "That helps us to work on common projects. It ticks a lot of boxes in the locality with the council, GPs and the community."

NHFML is also working with partners further afield, setting up a limited liability partnership (LLP) with both North Tees & Hartlepool NHS FT and York Teaching Hospitals NHS FT, where the LLPs provide a full range of estates and facilities services together with project management for capital investments.

Of course, since NHFML was established, the new guidance from NHSI requires the business case or proposal to be submitted to NHSI before it can start to operate. This was following concerns that some trusts were seeking to utilise wholly-owned subsidiaries primarily as a means of recovering VAT, rather than achieving the

wider commercial benefits which Price describes. The fact that all proposals for new corporate structures and changes to existing ones are now subject to NHSI scrutiny, needs to be factored into the timescales for any new proposal and causes concern to some that it will lead to significant delays for even relatively minor schemes. The original 2018 Guidance did say that NHSI would review it after 12 months (in November 2019) to see if it is still "appropriate and proportionate".

The bar remains even higher for non-Foundation Trusts who do not share the same "freedoms" as Foundation Trusts. Non-Foundation Trusts can only participate in subsidiary companies for income generation purposes, meaning generating additional income from non-NHS activities. While this could include income derived from estates projects, any such scheme requires the consent of the Secretary of State.

The regulatory hurdles which NHS Trusts must navigate have increased since Robert Naylor's 2016 report. But for those trusts, especially Foundation Trusts, who have already enjoyed or can see the potential returns of a successful JV partnership, utilising the established mechanism of a limited liability company or partnership remains an attractive option.

CHAPTER 3.

WHAT NEXT?

NHS leaders and partners say that capital funding must come from a range of sources that provide efficient and flexible ways to maintain estates and plan for the future.

NHS leaders say that they want to play a significant role in developing a new capital and estates strategy for the NHS. Importantly, they say it needs to be a system in which the bane of most PFI schemes – that the NHS bears the crippling cost of underwriting private sector partners' risk – is eliminated.

Richard Darch, Chief Executive at Archus, an advisory, investment and development company specialising in health and social care, is one of a number of NHS opinion formers who wants the NHS to be allowed to raise money from 'Health muni-bonds'. These are an adaptation of local authority muni-bonds which were launched in 2017. "Working with local authorities it appears perfectly possible that a health muni-bond could be raised," Darch says, "taking advantage of the expertise and structures that exist within the UK Municipal Bond Agency (which oversees local authority muni-bonds).

"Such an approach creates a financial discipline and engenders local ownership with constituent organisations in an STP geography, including local authorities, being jointly responsible for managing the repayments. Service transformation is easier to sell locally if people have visibility of the new developments that are required in their communities to support new service models, as well as some clarity on how they are to be funded."

He calls for an end to the sale of NHS assets, so the land can be leveraged to generate regular income. "The Crown Estate has land and building assets of some £6 billion and generates a contribution to the exchequer of around £400 million a year. Of the £40 billion NHS estate, there is certainly a significant amount of surplus that could deliver an ongoing return if co-developed, rather than sold.

"Bond and leverage options could work in tandem," he adds. "If you have an income stream being generated through

> "If you have an income stream being generated through land, that stream can help to capitalise a fund, or a bond, for other developments."
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> **Richard Darch, Chief Executive, Archus**

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Sir Robert Naylor, former Chief Executive, University College London Hospitals NHS Foundation Trust

land, that stream can help to capitalise a fund, or a bond, for other developments. If you look at how a lot of the large infrastructure funds operate, they will generate income from their assets which helps to capitalise other investments."

Prioritisation

All contributors call for better strategic planning and horizon scanning at a local level, to ensure the right projects get priority, in line with the aims of the local STP and the wider NHS plan.

"Major projects will need to be prioritised as part of a national process," says Darch, "and projects also prioritised locally within emerging Integrated Care Systems. This will create the visibility of a pipeline, and it is only when you have determined 'what' needs to be delivered that can you move on to the 'how' and the 'who'."

To put that prioritisation into context, Sir Robert gives the example of the minimum five-year timescale for building a new hospital: from planning, public consultation and design, to construction.

"There are 168 acute hospitals in the NHS. Assuming a lifespan of 50 years, we need at least three new starts each year, with more in the early years to catch up with the backlog. The historical annual allocation of £3.3 billion is less than half of what will be needed in the future if we are to keep up with international comparisons. Of course, it's not just acute hospitals that need investment, we also have to redesign primary care and community services to meet the NHS LTP."

Sir Robert also advocates a £10 billion capital budget to be funded with a third each from public funds, land sales and private finance. "Obviously the private third is now in question. I have argued that this could be found from pension funds and Lord Prior (the former Chair of NHS England) has suggested a £50 billion bond. These options need to be explored further."

The capital settlement must be long term, he says, with regions being allocated indicative capital budgets. He also calls for an end to capital-to-revenue transfers, putting emphasis on aligning STP and estates strategies to match the goals of the LTP.

More freedom

While he agrees there are "major bureaucratic barriers that trusts have to overcome to get their proposals considered and then executed", Sir Robert says that on the other hand, "the centre criticises the poor quality of business cases prepared by trusts.

"I have argued that capital allocations should be regionalised with much greater devolution, but again the capacity and capability of trusts to develop these schemes has to be improved."

Price says that where appropriate trusts should set up estates management vehicles. He feels that Foundation Trusts must be allowed more freedom to "borrow, spend and deliver in line with what they have in their own financial envelope".

He adds: "Allowing them to come back to the centre and say 'our estate is crumbling around us and here is the investment we need to make, here is the business case that says why you should allow us to do that'."

There is certainly the case to be made that some trusts with the capability and appetite to manage estates and developments across STP areas should be encouraged to do so.

However, Edwards cautions that the public accounting system doesn't allow for total autonomy, as trusts are state-owned entities whose spending is part of the Public Sector Borrowing Requirement. He calls for the strategic view to deal with the massive geographical variation in the value of receipts from sales – a sale in central London, for example, would generate significantly more than a trust in north-east England. "There is a question of how far that profit should fall back to that one organisation."

Spotswood is adamant that sources for NHS capital should come from public funds and joint ventures. "Organisations like AHH can generate between £5 million and £50 million for trusts, depending on how the land is used. This approach offers the public much better value and offers assurances to boards that organisations are not selling off the crown jewels. If we can combine the two, we can start to make some serious

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Sir Robert's suggestion in his 2016 report that a third of the required capital should come from private investment has seen little progress in the intervening years. The barrier to such investment appears to be the models that are used in letting land for NHS services.

Most clinical services leases are granted for 3-5 year terms with a break linked to the related service contract, to allow the service provider certainty that they will not have to pay the rent if they are not being paid to provide the service. As NHSPS have found, there will be little interest from investors in property with this kind of rental income stream. If the commissioner or the land-owning trust could guarantee the rent for 20 to 25 years, then this might open the door for more investment into clinical space.

We need to develop models that provide this kind of certainty to investors and allow NHS bodies to benefit from their covenant strength.

IN SUMMARY

This report shares some novel and exciting ideas for raising capital, and locally effective and accountable ways of using it, that take into account future, as well as present, need. Here we highlight a number of important points from the report.

The NHS is asset-rich in terms of land and property, so it should emulate the successful property empires such as the Duke of Westminster's Grosvenor Estate or even the Crown Estate, to leverage steady and significant revenue streams, rather than simply selling off the family silver. Estate management and other joint ventures can help leverage revenue and provide cheaper and efficient alternatives to PFI managed estates.

A larger capital allocation – perhaps as much as £10 billion per year – is needed to match European averages. This could be derived from a range of sources, including bonds, the Treasury, leveraging NHS property and private partnerships.

There is evidence of innovation, but it requires a commitment from all sides and needs local joint working and planning, free from too much centralised control with an emphasis on taking into account future need. A steely approach to project prioritisation could provide greater clarity and focus.

There needs to be more and better training for NHS staff in capital and estate development and management, and less bureaucracy. This will enable the NHS to enter into novel partnerships with private sector investors, local authority partners and even housing providers in schemes that will provide a fitting environment in which to provide a world-class 21st century health service.

There need to be longer-term rental streams on NHSPS properties once they transfer to local NHS control. If NHS commissioners or trusts could guarantee rent for 20-25 years, this could provide an opening for more investment in clinical space.

And finally, **doing nothing is not an option** if we are to achieve a fit-for-purpose NHS estate and deliver on the Long Term Plan. Access to capital has to be prioritised to ensure delivery of what is needed: the key to this is change, not a continuation of the status quo.

If you would like to discuss any of the issues in this report, please contact Anne Crofts on +44 (0)20 7894 6531 / acrofts@dacbeachcroft.com

CONTRIBUTORS

Mark Bagnall
Former Director of Estates, Facilities and Capital at University Hospital Southampton NHS Foundation Trust

Sir Robert Naylor
former Chief Executive at University College London Hospitals NHS Foundation Trust

Anne Crofts
Partner at DAC Beachcroft

Richard Darch
Chief Executive at Archus

Paul Price
Head of Commercial at Northumbria Healthcare NHS Foundation Trust

Nigel Edwards
Chief Executive at the Nuffield Trust

Tony Spotswood
Director of Health and Community Development at Affordable Housing & Healthcare Group

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