Why this area is important
Estates and facilities could not be more important to the delivery of an integrated health system. When we talk about health services, we talk about the buildings: we refer to the ‘hospital’, the ‘surgery’, the ‘clinic’. A physical environment is almost always required for healthcare provision, and the two are intrinsically interlinked.

Key issues
The estate needs to be available for the delivery of these integrated services. Currently, there are real tensions over land powers which bring into question where the ownership of the NHS estate really lies. To take one example, CCGs are tasked with delivering estates strategies but they have no direct legal powers to require trusts to make their land available. This can be problematic where a commissioner wishes to commission primary care or community services in an acute setting where there is a need to ensure all services are available to patients ‘under one roof’.

Co-operation between the parties is essential to allow the integration of the services in the estate, but this can be hampered and creates tensions where a third party is seen to exercise control over an asset that has previously been viewed as solely within a trust’s legal ownership, particularly where trusts come under political pressure to give up their estate to allow the service to be delivered from their estate by the most capable provider. Additional tensions arise where trusts are ‘babysitting’ properties and have no real long-term interest in them – if they are liable to lose ownership essentially at the commissioners’ behest it leaves them unwilling to invest in what may be critical healthcare facilities.

With new models of care, commissioners are looking to ensure more services are provided within the community, with a big push to get patients out of hospital beds. PACS and MCP models mean more integration of primary and secondary care, and hospital trusts will find themselves needing to provide new capital facilities off their main sites comprising this accommodation. These might take the form of health villages, where there is real collaboration and partnership between the local authority, GPs and trusts. There is a knock-on effect in that trusts will also need to reconfigure services within their existing estate, enabling them to identify land which can be developed or reused.

Potential solutions
Full integration of healthcare services will take a long time to develop to maturity but in the short term there is an acute need for savings. Some efficiencies can be delivered through the restructuring of the delivery of estates and facilities services within trusts.

“We are already advising a number of trusts who are setting up structures to enable them to drive efficiencies in this area – these structures can be used in the future to enable trusts to work collaboratively to drive further efficiency savings,” highlights DAC Beachcroft Associate Andrea Proudlock. However, she warns that there needs to be a unified approach to restructuring these services if this collaboration and integration is to work across trusts.

In a perfect world, there would be legislative solutions to afford more clarity on the powers of bodies such as CCGs in the development of estates.
A unified approach to the delivery of estates and facilities services is essential to enable organisations in health - and more widely - to collaborate and deliver these services in an integrated way.

In the imperfect real world, however, constituent parts of the NHS that may once have been part of the same organisation, now find themselves on opposite sides of the fence and are working hard to rebuild and improve, in order to deliver truly integrated healthcare. Structural integration of the estate can be achieved through any one of many models. Key to this is to put the estate - and estates professionals - at the heart of decision making so that commissioning intentions can be supported by the healthcare environment, rather than the estate sometimes appearing to be hindering those intentions.

More information
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