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Developing robust estates strategies

Challenges and opportunities

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The NHS has recognised that the development of integrated care systems (ICSs)*, presaged in the Five Year Forward View, requires a significant change to the way planning and resourcing estates has been undertaken. Rather than the conventional institution-based approach, planning and managing assets has to be managed on a collective basis across a wider area involving several partner organisations, including local authorities.

In late 2017 and early 2018, the Nuffield Trust and the Realisation Collaborative brought teams from five local health systems together to consider some of the practical challenges to developing and implementing estates strategies in today's NHS. It was clear from the outset that the challenges experienced by these teams were far from unique, and insights about what would help resolve them had much wider relevance. It is those challenges and insights that form the basis of this report. We have also drawn on **background papers** prepared by Nuffield Trust and other contributors as resources for programme participants, and conversations during and following the three workshops between ourselves, the participating teams and expert advisors.

* ICSs are partnerships of NHS organisations and local authority partners at STP or sub-STP level, which agree to collectively manage resources and population health in order to deliver more integrated care.

The report does not record what was said by whom, and neither does it describe the specific issues facing each of the five health systems in any great detail. Instead it provides an overview of the challenges facing most health and care systems in developing integrated estates strategies, and practical suggestions for national bodies, local systems and third party advisors to address these challenges and enable local systems to deliver a health and care infrastructure that is sustainable and fit for the future.

The Nuffield Trust and the Realisation Collaborative would like to express our appreciation to all workshop participants, expert advisors and report authors for their contribution to this report. For a full list of teams and participants, please see **page 29**.

Who this report is for

What is in this report for local system leaders

We hope that local system leaders will find much that resonates with them, and that together with the associated **compendium of papers** it provides a set of resources on which they can draw, as they continue to develop their estates strategies following the initial submissions made to NHS England and NHS Improvement.

What is in this report for national bodies

We have made a number of recommendations for national bodies, many of which we understand are now being addressed. The common theme running through almost all our recommendations to the centre is a request for clarity – for example, to be clear on the roles of the various national bodies, to be clear about approval processes, to be clear on governance requirements.

What is in this report for third party advisors and funders

We have also made recommendations for third party advisors and funders working with local systems – the input we had from such advisors in our workshops was invaluable. They bring a fresh perspective and a wide range of expertise. But they can also find the NHS a frustrating sector to engage with, and this is sometimes (not always) a result of a failure to understand the complexities of the environment within which their NHS partners operate. Taking time to build local relationships, and understand the pressures under which NHS colleagues operate, can help third party advisors think carefully about how to offer solutions that really address the underlying challenges in a local system.

You can read the full recommendations for all the above in boxed sections throughout the report.

A successful estates strategy must revolve around people

Perhaps the most important message from the work, which applies at both a national and local level, is that people must be at the heart of every estates strategy. An effective organisation ensures through its estates strategy that people with the right skills and experience work in an environment that makes it easier for them to do their job properly. An effective system sees the efficient use of their combined estate and other infrastructure, such as IT, as a significant enabler to health and care staff working in partnership. And the whole point of organisations working in partnership in systems is to improve the experience of and outcomes for patients.

An estates strategy that focuses entirely on the technical aspects of the location, size and funding of buildings, which seeks to fit an off-the-shelf solution to a complex local problem, is doomed to failure. A strategy with a much greater chance of success will be one developed by system leaders who truly connect with the needs and potential of the population they serve and the staff they employ, who have a deep understanding of the benefits that can be realised through partnerships with local authorities and industry, and who are able to work with advisors that bring creative solutions to well understood challenges.

Estates and infrastructure development: challenges for local systems

Most health systems have come to recognise that their buildings and infrastructure are essential 'enablers' to the delivery of the better care for patients to which the NHS aspires, and to making the efficiencies required for its long-term financial sustainability. But whether it is at the level of sustainability and transformation partnerships (STPs), or at that of the 'place-based' local systems that often have smaller footprints, this shift from institutional to collaborative working is easy to understand in principle, but rather more difficult to realise in practice.

We have organised the challenges faced by local systems under nine themes. For each theme, we have identified recommendations for local system leaders and, where relevant, for national bodies and for third party advisors.

The nine challenges for local systems

- Creating the environment to craft effective estates strategies
- Future proofing
- Demand is growing faster than the resources available
- Capital funding
- Governance
- Primary care
- Improving what we already have
- Approvals
- The public engagement and consultation challenge

Throughout the report we have used the term 'estate' to refer to the facilities in which health and care is provided, because that is the term most frequently used in the NHS. However, as programme participants rightly pointed out, the NHS is one of the few sectors to use the term 'estates' in preference to the broader and more dynamic 'infrastructure'. A shift to the term 'infrastructure' would bring into clearer focus matters such as the efficient and sustainable energy and water systems, information and communications technology and developments in medical equipment – all of which can have a profound impact on the design, location and accessibility of health and care facilities.

Creating the environment to craft effective estates strategies

Place in the planning process

Effective estates strategies are not developed in isolation. The first challenge, which applies at both national and local level, is to create an environment where creative thinking and strong partnerships can flourish.

Effective estates planning is a pivotal requirement of delivering integrated care and financial sustainability. It needs to be positioned 'centre stage', along with financial and workforce planning, if the goal of integrated care is to be achieved. While the interdependencies between estates and finance are obvious, the relationship between estates and workforce are perhaps less so. Yet the location and design of facilities – especially technology – can help resolve some of the workforce pressure points being experienced by providers, just as shifts in the shape and functionality of the workforce can have a powerful and positive influence on the infrastructure required. Estates and workforce considerations share a common trait in requiring planning over a longer timeframe than one or two years, so early conversations and investment in modelling in changing assumptions (for example, about working practices and space requirements) would be worthwhile.

Commissioners – CCGs, NHS England and local authorities – have to be prepared to take (and make explicit) a long-term view of their commissioning intentions to support local systems in reshaping the health and care estate. No matter how flexible the design, buildings have a working life measured in decades. If commissioners lack vision, the level of risk to investors and developers will be higher and the costs of capital will rise. Equally important is for CCGs to come together as appropriate to establish what Restate participants called a 'strategic commissioner function', in order to align multiple and potentially contradictory commissioning intentions across wider footprints.

It is also important to recognise that the health and care sector form part of a wider economic development movement. STP estates strategies should both inform and be informed by wider place-based estates and infrastructure strategies led by metropolitan mayors, local authorities and local enterprise partnerships. This is particularly relevant in the context of links to new transport, connectivity and housing plans, as well as offering the potential for alternative financing routes.

A common issue identified by participants is that estates requirements have not been considered sufficiently early in the planning process. The planning, approvals, financing and implementation arrangements for most infrastructure developments mean that they have long lead times. Yet too often these projects are seen as matters that can only be considered after the clinical workstreams have completed their redesign work. While improving efficiency/utilisation of assets is a key driver in STP and local system estates strategies, an equally important driver is to ensure that there is the appropriate estate in which to deliver new care models. The challenge for estates specialists is that the clinical models being developed are either not sufficiently detailed or geographically focused enough to translate into specific requirements for buildings, information systems and equipment.

There is a need for an element of pragmatism here. Clinical strategies may need to evolve and mature in parallel to the development of estates strategies, if STPs and local systems are to have a chance of accessing the scarce capital available within the timescale envisaged for service transformation. In addition, as explored further below, buildings and other infrastructure will need to be planned with flexible use in mind, not least because clinical models may evolve over short timespans than building lives.

Both national bodies and local STP leaders can signal the importance of estates strategies by according them the necessary prioritisation and attention in meeting cycles, sharing good or interesting practice from across STP areas and beyond, and facilitating better networking and collaboration between people who can help each other to tackle some of the inevitable blockages in strategy development and implementation.

Complexity of environment

A significant issue, which we experienced at first hand while establishing the Restate programme, is the multiplicity of organisations operating at a national level that have some role to play in setting the environment within which local systems operate, and in supporting those systems. Players include (and are not limited to): the Government Property Agency, Government Property Unit, One Public Estate, the NHS Property Board, NHS Property Services, Community Health Partnerships, NHS England (NHSE), NHS Improvement (NHSI) and Homes England. That degree of complexity would be hard to navigate at the best of times, but it was clear that, at least during the period of the programme, local systems did not understand the differing roles and responsibilities of those different bodies and the value they added individually and collectively.

This impacted on their ability to make best use of the considerable resource that could be available to them.

The geographical areas of STPs are, in many cases, far too broad or diverse to serve as a focus for planning meaningful and implementable estates strategies. The number of organisations and the range of interests involved in STPs can make it difficult to reach agreement or prioritise developments in a sufficiently concrete way to allow the redevelopment of estates. As one of the participants commented, "we find ourselves focusing on what it is possible for us to agree, rather than the most important things to be done".

STPs – and indeed NHSE and NHSI – need to recognise that, notwithstanding the coordinating function of STPs, in many cases it is likely that strategic estates plans will have to be developed in an integrated and inclusive way at a more local level. It is at local community levels where there will be the right level of detailed understanding of population needs, and the most productive opportunities to align the political, civic, institutional, professional and personal interests involved.

Although sub-STP local systems may experience similar challenges, they typically have the benefit of having a recognised social geography in which the benefits of coordinated or integrated care will be experienced. In most cases they will have had a longer tradition of collaborative work between NHS providers and with local authority partners. It is at this local, place-based, community level that it can be easier to negotiate agreement and make faster progress. The most effective STP estates strategies therefore are likely to be 'bottom up' – based on an aggregation of local system plans, but with a framework that provides a degree of consistency and a means to agree cross-STP priorities, and a focus on those opportunities where there are benefits to working at scale – for example, when dealing with facilities for the centralisation of specialist acute services. STPs have a role to play in supporting plans developed at local system level.

STPs can, for example, encourage imaginative approaches to NHS infrastructure that deliver broader value than simply being a place for the delivery of health and care services. This could mean, for example, encouraging local systems to take account of economic multipliers, sharing insights about innovative approaches to delivering environmental sustainability or facilitating links with technology suppliers or developers. It also means testing the robustness of assumptions on which local system plans

are built (for example, around long-term trends in demand for care as well as assumptions about workforce availability or technology shifts).

Priorities

Notwithstanding the need to focus on local, place-based strategies, there is a need for STPs to establish 'priorities of priorities' – i.e. to identify those capital developments that are most urgent and most important across the whole STP area. This process needs to be open and clear. Whereas it is relatively easy to prioritise schemes that deliver either essential safety improvements or much needed revenue savings, Restate participants argued that STPs should be cautious about dismissing capital developments whose primary purpose is to improve the quality of care or the care environment. While these sorts of schemes may be less of a priority for publicly-funded capital investment, STPs could support local systems in developing their understanding of the risks and benefits of alternative sources of capital and potentially brokering relationships with third party developers.

It is not surprising that those involved in strategic estates planning are looking for precision about the design and implications of new models of care and other outputs from clinical workstreams. Yet it would be a mistake to wait until this detail is forthcoming. There is value in early and ongoing conversations between clinical leaders and infrastructure leads to explore objectives and assumptions about new ways of working, not least because of the estate utilisation improvements that local systems will need to deliver, and the potential for developments in estates to act as a catalyst for change. Quantitative and qualitative modelling can also be used to explore and test alternative options both to inform plans and risk mitigation.

Although there is an understandable tendency for service planners to develop 'horizontal' patient pathways either for particular age/care groups or conditions, from an estates planning perspective these pathways need to be considered alongside each other, in order to understand the interface between the various services that might be accommodated in a facility or in a building. This is particularly the case for primary and community services, for which there is an expectation of significant service redesign through the creation of integrated primary and community teams and primary care 'homes' or 'care hotels'.

Skills and development

Local systems need to ensure that they marshal the right range of skills and experience to complement the technical estates elements of planning if they are to ensure that the benefits of schemes are deliverable. There is a risk that leaders in both STPs and local systems see their estates strategy development as a largely technical exercise that can only be completed by people with 'capital', 'estates' and 'finance' in their job titles. Many estates developments involve changes that are controversial – whether it is for staff, for patients for the public or for the local and national politicians that represent them. These 'softer' issues are easy to ignore – until attempts are made to implement plans.

The benefit and costs built into estates business cases may require major changes for the organisations involved, for the staff who work in them and even for the behaviour of the people who use the services. To be effective, estates planning, procurement and delivery therefore requires a much broader range of skills. Communications and engagement, organisation development, employee relations, financial planning, governance – all have their place in gaining the necessary public, patient, political and staff support for change and in ensuring that the facilities are utilised in the way envisaged in the formal business case.

The NHS is able to marshal a significant amount of expertise both from its own staff and through third party advisors. One of the biggest challenges for local systems is having insight into the full range of skills that they will need to be successful in developing and implementing their strategies, and having the ability to commission third party experts effectively. The Strategic Estates Planning function trailed in the **Government response to the Naylor report** will be critical to this.

Key recommendations

National bodies

- The Department of Health and Social Care should clarify the respective roles and responsibilities of the Government Property Unit, One Public Estate, the NHS Property Board, NHS Property Services, Community Health Partnerships, NHSE, NHSI, Homes England and STPs in overseeing and guiding capital planning for health and social care. They should also be clear about how those organisations align with each other to create consistency for local systems, particularly in relation to the timescales that they each set for different aspects of estates plans.

Local systems

- STPs should determine the 'places' within their footprints that are appropriate for developing local estates strategies, and also be clear on the issues where there are benefits to working at scale, for example when dealing with facilities for the centralisation of specialist acute services, and those capital developments that are most urgent and important across the whole STP area.
- STPs should encourage imaginative approaches to infrastructure that deliver broader value than simply being a place to deliver health and care services.
- STPs should position estates planning 'centre stage' along with financial and workforce planning.
- Local systems need to ensure that they marshal the right range of skills and experience to complement the technical estates elements of planning if they are to ensure that the benefits of schemes are deliverable.
- Commissioners must explicitly take a long-term view of their commissioning intentions to support local systems in reshaping the health and care estate, and in doing so ensure that health and local government commissioning intentions are aligned across the 'place'.

Third party advisors and funders

- Third party developers and advisors must understand the complex environment within which NHS partners are operating, including the tension for leaders at all levels between addressing day-to-day pressures and delivering strategic and transformational change.

Future proofing

It is easy to see that new technologies will have a marked impact on the design and delivery of services over the coming decade. Wider adoption of smartphone technology to manage health and consult with specialists, personalised therapies, and miniaturised diagnostics available locally already have the potential to transform the way people access services and, therefore, our requirements for the design, configuration and location of health infrastructure. Technological solutions can, for example, reduce the need for face-to-face consultations, better equip patients to self-manage and enable remote and mobile working – all reducing the amount of space required for delivering patient care.

We can anticipate the general trend, yet the scale and pace of change can be notoriously difficult to quantify. Not least is the problem of anticipating the uptake of technology solutions. Historically the UK has been the driving force behind many significant health advances and is considered a world leader in life sciences (pharmaceuticals, medical biotechnology and medical technology).

Notwithstanding that reputation, the NHS has a less positive record of adopting innovation at pace and scale, despite numerous reports, structures and processes to encourage diffusion. Addressing the challenge of adoption of innovation is largely outside the scope of this report. However, estates redesign is one way in which adoption cannot only be enabled, it can be driven. Strategic estates advice to local systems should encompass technology trends, the expected impact on the way health and care will be delivered to individuals and communities, and the implications of this for the health and care workforce and estate, as well as more readily available information about innovations in building design, construction, refurbishment and repurposing of public or even redundant retail buildings to help local systems reduce costs and improve services.

Flexible design will be critical, and there are a number of well-established approaches to this. Internationally there is a growing trend away from whole new hospital builds and towards campus-style developments that can be adapted over time as care models change. There are opportunities to engage with technology and equipment suppliers in new ways. Local systems may wish to consider engaging such companies in providing the building so they

can wrap their technology solutions around it – allowing the health care organisation to enter into a fully serviced lease.

Flexibility can be built into building design to allow for changing models of health care delivery. Many new builds now adopt a modular or template construction approach that allows for new builds to begin on a small scale but with scope for expansion – repurposing older buildings while further plans are refined. Building design features to be considered include:

- moveable and demountable walls with wide grids and pillars at external walls
- space for additional engineering services to be added at a later date
- flood wiring
- soft space around high-tech departments
- shell space
- open ended corridors
- interstitial floors.

In general terms, clinical space should be separated from administrative offices, support and engineering services, to reflect different building lives, while still considering how best to enable strong connections between administrative and clinical services.

We comment further below on the trade-offs between land sales with a current financial benefit and the potential need for additional facilities in the future. Where surplus land currently exists, but there is a potential for future need, local systems may benefit from working with partners in the wider economy, to make best use of such sites in the short to medium term while maintaining the ability to return to health care provision use in the future.

Key recommendations

National bodies

- NHSE and NHSI should collate or commission futures research to clarify technology trends, the expected impact on the way health and care will be delivered to individuals and communities and the implications of this for the health and care workforce and estate.
- Strategic estates advice to local systems should encompass technology trends, the expected impact on the way health and care will be delivered to individuals and communities and the implications of this for the

health and care workforce and estate. This is as well as more readily available information about innovations in building design, construction, refurbishment and repurposing of public or even redundant retail buildings to help local systems reduce costs and improve services.

Local systems

- STPs should test the robustness of assumptions made in local system plans on how future technologies may impact on models of care and estates needs, and ensure building design is appropriately flexible.
- Local systems should invest in the OD support required to enable best use of technology and flexible building spaces through changes in working practices.

Third party advisors and funders

- Third party developers should find ways to share their wealth of experience more effectively. For example, details about the conditions that financiers expect (e.g. commissioning assurances), innovative and flexible building designs and their comparative costs can be set out in principle.
- Linked to this, third party developers and property services organisations should consider developing the equivalent of a 'pattern book' of cost-effective, sustainable and flexible designs and construction techniques for primary and community health premises.
- Similarly developers should identify ways of making information about innovations in building design, construction, refurbishment and repurposing of public or even redundant retail buildings more readily available to STPs.
- Given the fluidity of plans for the delivery of primary and community services and uncertainty about the impact of technology, both third party developers and existing landlords need to show willingness to offer leases with the flexibility to accommodate changes of use or even tenants. This is in order to help local systems manage the risks of facilities or parts of them being 'stranded' without proper utilisation.

Demand is growing faster than the resources available

There is widespread acknowledgement that the resources currently available to the NHS will be insufficient to meet future need. The Nuffield Trust has examined the underlying financial position of the NHS in some detail over a number of years, such as in **Sally Gainsbury's commentary** on the additional funding provided in the 2018/19 budget. The NHS is seeing an upward trend in demand from an increasingly elderly population, more patients with long-term diseases, more costly interventions and an increasingly demanding patient population, and a financial settlement trend that means resources are diminishing in relative terms.

Even with the recent indications that a more generous settlement may be agreed for the NHS in future, it remains important that the NHS delivers efficiencies and makes better use of assets. There are rising costs too: on the estates front, backlog maintenance adds to the pressures to release funds simply to make buildings safe.

The **Naylor report** estimated that in 2016 NHS backlog maintenance was over £5 billion, and that at least an equivalent sum needed to be invested to deliver the Five Year Forward View. Naylor's recommendations to address the NHS's collective estates challenges suggested that there should be more effort and incentives to dispose of surplus land or property, releasing resources to reinvest in capital schemes, or return to the Treasury and freeing up land for much needed housing developments. His recommendations that STPs agree 'stretching local targets' for disposals or face funding withdrawals was accepted by the Department of Health and Social Care in their response to the review.

There are two risks to consider here. The first is in seeing NHS buildings as costs and liabilities, rather than assets that can generate value. The NHS undoubtedly needs access to the receipts from the sale of some surplus property, where appropriate. But it is important to bear in mind that rarely does a receipt generate sufficient cash injection to fund new facilities at any scale. The sale of NHS land and buildings has historically leaked value – the tendency has been for the developers who acquire the property, obtain planning permission or a change of use, and build new homes or facilities to **secure the profit**, although the NHS has improved on this in recent years. There may be other creative ways of using the property portfolio so that it generates income, providing the NHS with property at low cost, subsidised by income such as from rental on mixed use developments or from keyworker

or general needs housing. It is important to consider not only footprint but airspace – mixed developments may enable the NHS to generate a revenue stream from housing or office accommodation built above clinical facilities.

A second risk is that, notwithstanding changing models of care and use of technology as discussed elsewhere, as health care demands rise (including demand for beds), precious assets that we are anxious to liquidate today may still be needed in a few years' time. There is pressure on STPs and local systems to secure immediate estates disposals and generate capital receipts. NHSE/I should ensure that these requirements are appropriately applied across the country, taking due account of the longer-term trends in need and demand and potential for revenue streams that may argue against immediate disposals.

Key recommendations

National bodies

- NHSE/I should ensure that the requirements for estates disposals and capital receipts are appropriately applied across the country, taking due account of the longer-term trends in need and demand, and potential for revenue streams that may argue against immediate disposals.
- NHSE/I should also support inward investment opportunities, including working with social landlords.

Local systems

- Estates strategies and clinical strategies should be developed in parallel through an iterative process that allows each to shape the other appropriately. Quantitative and qualitative modelling over a range of time horizons should also be used to explore and test alternative options, both to inform plans and risk mitigation.
- Local systems should explore opportunities to work in partnership with other sectors to make best shared use of available sites. This may include the short- to medium-term use of NHS owned space for non-health purposes, if a health need is likely to exist in the longer term.

Third party advisors and funders

- Advisors will wish to consider how best to enable the NHS and local partners to maximise the value of assets, whether that is through their sale value or through ongoing ownership with creative development.

Capital funding

This combination of rising costs and limited revenue funding is challenging enough, but the problem is compounded by the lack of public sector capital currently available. This has been exacerbated by the NHS's practice of **raiding capital budgets** to mitigate revenue shortfalls. The ability of NHS providers to generate resources internally has also come under pressure in recent years. NHS providers who run deficits, for example, are having to borrow simply to pay for day-to-day running costs. The recent trend of falling asset evaluations and assessments of longer asset lives reduces the capital resource generated through depreciation charges.

Notwithstanding the availability of cash to spend on capital developments, the most significant constraint on capital expenditure is the Department of Health and Social Care's overall 'capital departmental expenditure limit' (CDEL) that is essentially a cap on the total amount of capital spending by all NHS bodies in England. Borrowing money to spend on NHS estate therefore is not a solution if the expenditure results in the overall CDEL being breached. In 2010/11, the CDEL stood at £5.7 billion: in 2016/17 the limit had fallen to £4.6 billion and, although some increases are projected in the next three years, these are not likely to be sufficient to meet the need.

For all these reasons, NHS bodies are looking for alternative ways to finance capital projects, without incurring capital expenditure – these include various forms of PFI and the primary care equivalent, the Local Improvement Finance Trust initiative (LIFT), and funding tied to local authority planning approvals and infrastructure developments. The potential sources of funding for capital investments vary by the type of NHS body, but for NHS providers the key sources are:

- internally generated resources (retained surpluses, depreciation and proceeds from sale of surplus assets)
- borrowing from the market in the case of foundation trusts or from the Department of Health and Social Care
- access to Section 106 funds and other local authority funding mechanisms
- working with social landlords partners to access capital from Homes England to develop general needs or **specialist housing**
- public private partnerships of various types
- leases
- donations and grants.

There was considerable interest in the workshops we ran in the experience of one participating hospital, South Warwickshire NHS Foundation Trust, which over time had developed a protocol with their local authority for access to Section 106 and Community Infrastructure funding levied from local developers. This type of experience could be disseminated more widely.

This range of sources presents opportunities, but the challenge for STPs and local systems, and indeed individual organisations, is that each of these sources requires a different set of evidence, different process for prioritising and accessing the funding and their own distinctive costs and benefits. Deciding the most appropriate and affordable vehicle in each circumstance is complex. If local systems are fortunate enough to secure capital funding to transform services, they then have to find the associated revenue resources to service the debt and meet the running costs. This was a very significant issue for those teams with a health economy-wide net deficit. It is perhaps not surprising that NHSE have stated that they expect that any capital funding bids approved by STPs will need to show they can generate recurrent revenue savings.

Key recommendations

National bodies

- NHSE/I (in conjunction with CHP and/or NHS Property Services) should offer general advice on the benefits, risks and downsides of different sources of capital for a range of circumstances. At an early stage in the planning of capital developments, STPs/local systems must have independent advice to enable them to identify the most appropriate source of capital for each scheme (including the new Project Phoenix).
- NHSE/I should identify areas of innovative local practice and share them more widely.

Local systems

- STPs should ensure that their local authorities are fully engaged with estates planning, moving beyond social care partnerships to engage with colleagues in the planning and economic development functions, with the explicit objectives of maximising the sources of capital funding available to deliver the strategy and of ensuring consistency between STP and LEP plans.

- When prioritising capital investment, STPs should be cautious about dismissing capital developments whose primary purpose is to improve the quality of care or the care environment, and which do not deliver a direct revenue saving. Where such schemes meet the priorities of the STPs, local systems should work in partnership with their strategic estates advisor, who may be able to broker appropriate relationships with third party developers.

Third party advisors and funders

- Funders will wish to understand the capital financing regime, and its revenue consequences for local systems fully, in order to support local systems in identifying appropriate funding vehicles.

Governance

While individual trusts may have a track record of developing/managing their own assets, the focus on local systems (including establishing ICSs) requires the development of mature partnerships, capable of managing resources collectively within legal frameworks and making shared business decisions about improving health and care services. Even if there are positive and trusting relationships between the various NHS providers and their local government counterparts, it is not uncommon to find that there is a degree of confusion about how decisions are made in STPs or local systems, and how to balance the different priorities and interests of the partner organisations. If the decision-making process is not in line with the statutory framework, then decisions are unlawful and are capable of being challenged. The statutory framework still exists and, even if parties are collaborating, then that collaboration must be **done within the law**.

Notwithstanding the move to ICSs, the law remains clear that in the case of NHS providers only the individual provider – the legal entity – can make decisions about their own assets. It is not something that can be shared with other parties. Clinical commissioning groups have a little more leeway in making shared decisions with other commissioners, but these bodies are not the ones that own the NHS estate. These legal requirements about decision-making not only relate to the management and disposal of assets, but also to access to loans and other sources of capital funding.

In some instances, local systems are considering capital disposals from one trust to fund investments in the wider system. At present the law makes it difficult for providers to 'pool' asset values and risks, or move or redeploy resources released from sales on a system-wide basis.

In an attempt to circumvent these challenges, most local systems are exploring either structures or processes that will strengthen their ability to work collaboratively. These range from loose agreements to memoranda of understanding to committees in common, and even special purpose vehicles such as hospital chains or joint ventures.

Agreements drafted by lawyers may appear to offer a degree of reassurance, but in practice they can be easily ignored. The best partnerships are based on trust and where the points of tension are named, understood and worked through in discussion rather than summarised in a legal contract. Notwithstanding that, it is likely that local systems will need to find establish more formal and explicit governance arrangements if they are to be able to resolve issues about risk management, asset deployment and disposal. To do this, they need to have a shared understanding of the relative merits and risks of models such as special purpose vehicles, wholly-owned subsidiaries and community interest companies – especially in relation to VAT liability. It is worth noting that collaborations between NHS bodies and local government around estates matters have a specific set of challenges, in addition to those noted above, due to their differing duties and decision-making processes.

Particular considerations in working with local authorities

As well as developing clear frameworks for decision-making within the NHS, there is a need to build better understanding within the NHS around the policy direction of localisation of finance and decision-making in the local authority sector. For example, the move to retain business rates locally will once again create a direct link between business rates and the financing of local public service provision. This is likely to be a significant influence on future local authority estates planning.

Restate participants were clear that health and care estates planning has to involve their local authorities, not only as principal partners but as sources of considerable expertise, and with the levers to secure funding as well as the necessary planning permissions. Aside from being commissioners (and in some cases providers) of social care, housing and public health,

local authorities' wider interests include economic development and wider infrastructure planning.

As planning bodies, local authorities can ensure that developers contribute to the public good through Section 106 requirements and community interest levies – yet to be fully exploited by the NHS. Moreover many local authorities are adept at creating organisational entities to handle financing large-scale public infrastructure or regeneration projects from the market, with the recent moves to greater devolution and the growing roles of Local Enterprise Partnerships giving them increasingly powerful levers to influence the way that communities evolve.

Key recommendations

National bodies

- NHSE/I should provide practical guidance to local systems about whether and how the current governance arrangements of NHS trusts, foundation trusts, local authorities and other relevant bodies can be adapted to enable the collective management of assets, including use of the proceeds of estates disposals across the wider system.
- If the current legal arrangements preclude this then Department of Health and Social Care need to consider changes to legislation, or to identify special delivery entities that would be acceptable to the Treasury and provide information on the tax implications of these models.

Local systems

- Local systems should establish formal and explicit governance arrangements appropriate to their circumstances that are able to resolve issues about risk management, asset deployment and disposal.
- Governance arrangements should take account of the move to localise finance and decision-making in the local authority sector.

Primary care

All 44 STPs have developed transformation plans that envisage a more significant role for primary and community services, both in promoting better health and in providing a larger volume of treatment outside hospital. Central to this is the expectation that GPs will work in primary care or community hubs alongside other health and social care professionals. While there is a recognition that larger and more modern facilities will be required that are capable of providing a base for these enhanced and integrated services, what is not clear is how these facilities will be funded. NHSE have established a Estates and Technology Transformation Fund (the ETTF) specifically aimed at GP facilities and technology for the period from 2015 to 2020, but it has been heavily oversubscribed with bids from both GP practices and CCGs for refurbishments (as well as new-build premises), and this has resulted in a funding cap being applied that has resulted in some projects being put on hold.

From an estates perspective, the assets used for the delivery of these essential and important services are those with the most complex arrangements around ownership, funding and leases. In many cases, the assets are privately owned by the GPs themselves – others are leased from Community Health Partners, NHS Property Services or third party developers. While many GPs continue to support the continued arrangements for GP-owned property, this presents commissioners and local systems with great uncertainty, even vulnerability. For example, there is the risk that assets may be lost when GPs retire and other partners cannot be found to take over the practice.

Where CCGs are encouraging practices to move into new premises, it can be difficult to secure the type of long-term commitment that future landlords or developers expect – either because GPs want the flexibility to decide on retirement, or because of concerns they will not be able to secure reimbursement for their rent and service costs. This risk should be easily mitigated by CCGs having close links with local practices, so they understand their future plans and make appropriate provisions, yet it is not uncommon even within practices for the plans of GP partners to be fluid or opaque. Moreover, some local systems have experienced difficulties in engaging GPs in both clinical and estate strategies.

Local systems have very limited scope for manoeuvre in bringing GP-owned/leased properties into their plans for the whole health and care estate, and

the delivery of primary and community services at greater scale. Whether GPs own their premises or lease them, the GP contract reimburses them for the costs of the premises (notional rent or borrowing costs for GP-owned premises and lease reimbursement for rental).

GP practices have long held that the principle of full reimbursement of the cost of their accommodation is a fundamental element of their contract. When a facility is patently unsuitable as a place for delivering the transformed primary and community services required by the local system, neither the CCG nor the system have much leverage in aligning plans for clinical services with the existing primary care premises. This is because the terms and conditions for premises and GP contracts are nationally negotiated and with premises reimbursement largely guaranteed.

Restate participants noted that it is not just GP-owned premises that present them with difficulties. Local systems can find it difficult to exit facilities owned by NHS Property Services without incurring ongoing costs. The message here is that local systems expect NHS Property Services to work more collaboratively with local health and care systems – listening to their priorities for service change. Taking a longer-term perspective, NHS Property Services need to consider finding alternative tenants or subletting their buildings, rather than expecting the costs of voids to be absorbed by the health and care system. The **Vacant Space Handback** policy published by NHS Property Services in August 2017 does not seem to be widely understood.

Engaging GPs

Traditionally, primary care premises have not been included in the NHS's capital planning framework. Given their centrality to the realisation of new integrated models of care, STPs and local systems, this presents particular challenges to the development of effective, comprehensive estates strategies.

A pragmatic approach to the engagement process for GPs is required. In some situations, CCGs may be best placed to develop a better understanding of practices' own plans, expectations and appetite for risk and make the necessary connections with the emerging service and estates strategies and plans. In other situations, it may be that emerging GP federations or local medical committees are better placed to play that role. It is becoming clearer that the ETTF will not be sufficient to meet all of the planned primary care developments that are required, so local systems need to identify and potentially broker alternative financing options.

Key recommendations

National bodies

- The Department of Health and Social Care should consider whether there is a case for changes in national policy, including premises directions or GP contracts, that would give GPs greater incentive to collaborate and commissioners of primary care more leverage to help realise their local plans.

Local systems

- STPs and local systems should agree locally appropriate mechanisms to ensure GPs are involved in service and estates planning, both from the broad strategic perspective and more directly in relation to planned developments in primary care.
- STPs should identify a range of alternative sources of funding where the ETTF will be insufficient, and broker relationships with third party funders as required.

Third party advisors and funders

- NHS Property Services and other large landlords should work collaboratively with local health and care systems, and offer proactive solutions to the constraints that may be caused by current lease arrangements, including finding alternative tenants or subletting their buildings rather than simply expecting the costs of voids to be absorbed by the health and care system.

Improving what we already have

Sir Robert Naylor's report on NHS estates highlighted that around 18% of health service properties pre-date the NHS's introduction in 1948. However, there has been perhaps too much focus on building new rather than improving the way we use existing assets – for example, focusing on better efficiency, imaginative repurposing/refitting both of NHS and other buildings. The Five Year Forward View highlighted the goal of making the estate more efficient, saving money and also refurbishing buildings so that they are more suitable for delivering new models of care.

One key area where this is being applied is in the sharing of back office functions, providing not only the opportunity for organisations to share

non-clinical support services, but also to consolidate their use of space in line with the targets suggested by Lord Carter.

With the ongoing requirement to demonstrate good value for money in order to secure business case approvals, it may be that the NHS will redouble its efforts to look at imaginative ways of refitting and refurbishing existing buildings, and pursue initiatives that encourage sharing of public buildings such as the One Public Estate (OPE) programme. Aside from generating efficiencies and opening access to other funding sources, there are two further benefits that the OPE programme is designed to achieve – the delivery of integrated services and the creation of economic growth.

Key recommendations

Local systems

- With particular reference to community-based facilities, STPs should apply imaginative thinking to the flexible use and repurposing of existing publicly-owned space and former retail space.
- Local systems should consider the opportunities that consolidation of back office functions may create for better use of estate, and vice versa.

Third party advisors and funders

- Funders may wish to consider how their business models can support the repurposing of existing estate as well as the provision of new facilities.

Approvals

There has been a significant increase in the complexity of business case requirements, in part because of NHSE and NHSI's approval process for any investment over £15 million. In parallel with this, there has been a reduction in strategic estates planning expertise inside the NHS.

These changes, combined with the difficulty of sourcing capital, may make NHS providers become less able to invest the necessary time and skills to complete estates strategies and business cases properly and/or to opt for sub-optimal cheaper schemes that stay under the approvals limit. This was a point underlined by NHSE and NHSI – in their view the business case process and requirements are clearly specified: the challenge is that providers can

lack appropriate competence or experience in developing their submissions, adding to the timescale for capital bids to be reviewed. For their part, local systems have noted that approval of capital schemes is not simply a matter for NHSE – the Treasury also has a part to play and it is their expectations that can be difficult for local systems to read.

A second challenge here is that the approvals processes and limits set by NHS regulators and the Treasury are not always compatible with those in other sectors or even other government departments – a particular challenge for capital schemes involved in multi-sector partnerships such as combined authorities with their devolved powers – or the timescales to which third party investors work.

The shortage of publicly available capital may be difficult to change in the short to medium term, although some positive indications have been made by the Department of Health and Social Care. However, it should be possible to create greater clarity and expertise around the approvals process.

Key recommendations

National bodies

- NHSE/I should share their insights about the Treasury's requirements and expectations so that STPs and local systems make realistic assessments of their chances of accessing central capital funding and can shape their business cases appropriately.
- NHSE/I should consider how their approvals processes interface with those in other sectors, and in particular should liaise with Ministry of Housing, Communities & Local Government on the relationship with local authority processes.
- NHSE/I should provide greater clarity about the criteria and weighting used in evaluating capital bids, and share learning from both successful and unsuccessful bids to enable local systems to learn how to improve future business cases.

Local systems

- Local systems should assess carefully the skills and capacity required to see business cases through to completion, and where there are shortfalls locally should ensure that they are filled with appropriately contracted staff, ideally independent of scheme funders.

Third party advisors and funders

- Advisors and funders will want to ensure that they are familiar with approvals processes in all relevant sectors, and able to support local systems in navigation through them, in particular where multiple approvals are required.

The public engagement and consultation challenge

Public service buildings, especially those housing NHS services, can have a special, almost totemic place in the hearts and minds of the public. While there is evidence from the 2014 British Social Attitudes Survey that over 86% of the survey respondents would be willing to **travel further away** for better specialist and complex care, and that there is majority support for more services shifting from hospital to community settings, it is also the case that the public can be deeply opposed to attempts to change NHS services, particularly if it is seen to threaten the much-loved buildings in which they are provided. The reasons for this are complex as Andy Cowper, Editor of Health Policy Insight, explores in his **background paper** for the Restate programme. They include:

- a lack of understanding about how the NHS works
- different attitudes to risk and safety to those held by clinicians
- a distrust of the new
- prior experience of mishandled decisions on changes to services or facilities
- mixed messages presented by the various commissioner and provider organisations involved.

A failure to engage politicians and crucially to provide them with a positive narrative to tell – in order to secure their support for NHS changes – is a further and all-too-frequent problem.

Critically important to the effective implementation of estates strategies is the creation of a positive and receptive public engagement and involvement 'climate'. There are plenty of lessons from history that shows that the way the NHS approaches public engagement does not work in persuading 'hearts and minds', as Cowper's article makes clear. Restate participants believed this to be one of the most important functions for an STP – the development

of a common communications programme explaining service and estates changes.

These messages needed to avoid platitudes and principles, begin at an early stage before any decisions are made, and provide specific details about the context for change and what the public should expect. This would also help in the development of an STP-wide 'political umbrella' for estate development that is likely to be more cost effective than having each organisation or local system mounting its own campaign.

Key recommendations

National bodies

- NHSE/I must support a high-level national narrative and dialogue with politicians and other opinion formers on the 'case for change'.
- NHSE/I should recognise and ensure that processes allow for the time required for truly effective engagement with the public, service users and staff, both on overarching strategies and on specific changes.

Local systems

- STPs and local systems must develop communications programmes in which all partners engage consistently to enable members of the public, patients and staff to participate in the design and implementation of service and estates changes.

Conclusion

In conclusion, there are many issues that need to be addressed – at national level and in local systems – before the NHS will truly be able to develop robust and creative estates plans. Our experience suggests that the expertise the NHS needs to be able to do this does exist, whether in local NHS bodies, in other partner organisations, at a national level or vested in third party advisors. The greatest challenge local systems face lies in corralling that expertise, and creating the time and space needed to work with people across the system. These include not only system leaders, but importantly members of staff, service users and the wider public – to develop plans that are both affordable in the present and sustainable into the future.

Although there are many technical questions to be addressed, the greatest challenges in changing the NHS estate are cultural – developing the partnerships that will be needed across the wider public sector and with business, ensuring that staff are supported in working differently, and most importantly developing the right relationship with members of the public on whose behalf the assets are owned.

Annex 1

The Restate programme was designed by the Nuffield Trust and the Realisation Collaborative to explore how best local leaders might undertake this new collaborative approach to strategic estates planning, and who might need to do what to enable and support them.

The programme – supported and sponsored by a number of specialist organisations – brought together representatives from five evolving place-based teams: South East London, St Helens, West Cheshire, South Warwickshire and Bristol and North Somerset, with advisors with expertise in estates planning and delivery, third party investment, primary care developments, medical technology, governance, One Public Estate, housing, communications and engagement and public and patient involvement, plus input from NHSE, NHSI, the Department for Health and Social Care, Community Health Partners and the Local Government Association.

They worked together for three day-long events over a period of three months.

Name	Institution
Teams	
Ant Burn	Community Health Partnerships
Tricia Down	North Bristol NHS Trust
Mark Halligan	Bristol City Council
Laurie Stroud	Avon and Wiltshire Mental Health Partnership
Graham Wilson	NHS Bristol Clinical Commissioning Group
Andrew Windsor	NHS Property Services
Julie Ashurst	St Helens Clinical Commissioning Group
Jill Baker	West Cheshire Clinical Commissioning Group
Sarah Bullock	St Helens Council
Simon Holden	Countess of Chester Hospital NHS Foundation Trust
Laura Marsh	West Cheshire Clinical Commissioning Group

Name	Institution
Andy Muir	Community Health Partnerships
Sarah O'Brien	St Helens Clinical Commissioning Group
Justin Pidcock	Cheshire and Wirral Partnership Trust
Graham Pink	Cheshire West and Chester Council
Samantha Simpson	Cheshire and Merseyside STP
Jane Bond	King's College Hospital NHS Foundation Trust
Tim Borrie	Essentia at Guys and St Thomas' NHS Foundation Trust
Rachel Evans	Oxleas NHS Foundation Trust
Gus Heafield	South East London STP
Liz Luxton	Community Health Partnerships
Jacqui Malone	One Public Estate
Lillian Nsomi-Campbell	South London and Maudsley NHS Foundation Trust
Paul White	Our Healthier South East London
Anna Hargrave	South Warwickshire Clinical Commissioning Group
Jayne Blacklay	South Warwickshire NHS Foundation Trust
Guy Collier	Warwick District Council
Anne Coyle	South Warwickshire NHS Foundation Trust
Linda Frost	South Warwickshire NHS Foundation Trust
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Emma Knowles	HFMA
Sue O'Connell	Community Health Partnerships
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Catherine Davies	Department of Health
Mel Dunn	Q5 Partners
Craig Egglestone	Local Government Association
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Sharon Lamb	McDermott Will and Emery
Nick Mathew	Q5 Partners
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David Pencheon	NHS Sustainable Development Unit
Andy Stephens	Royal Free London NHS Foundation Trust
Michael Wood	NHS Confederation
Restate team	
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Nigel Edwards	Nuffield Trust
Maddy Farnworth	Nuffield Trust
Louis Vine	Nuffield Trust
Sarah Harvey	Realisation Collaborative
Laurie McMahon	Realisation Collaborative

Nuffield Trust is an independent health charity. We aim to improve the quality of health care in the UK by providing evidence-based research and policy analysis and informing and generating debate.

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