CAPITAL EMERGENCY

The NHS is in urgent need of capital funding. But a recent HFMA roundtable, supported financially by a sponsorship by Baxter Healthcare Ltd, agreed that changes were also needed to reduce the bureaucracy around bidding and the timeliness of allocations

HFMA ROUND TABLE

NHS capital financing has hit the headlines recently, with the government recommitting to build 40 new hospitals by 2030 supported by a total investment of £20bn.

But this showcase announcement masks significant concerns about the wider NHS estate. The service's capital requirements stretch much further than the 40-hospital programme, with some trusts in urgent need of investment and no obvious way to access the required funding.

With the move to system working, integrated care boards (ICBs) have a big role to play in prioritising how system capital funds are allocated across their areas.

But how do you compare bricks-and-mortar projects – in some cases, hospitals literally need to fix leaking roofs – with digital programmes to modernise service delivery? How do you evaluate the needs of the mental health and community sectors against those of big acute hospitals, which are still viewed as being at the forefront of the elective recovery drive? And how does the current capital allocation system support the most effective use of scarce funds?

A recent HFMA roundtable, supported financially by a sponsorship by Baxter Healthcare Ltd, set out to explore how to get the best value out of capital resources in the NHS. It highlighted many of the current frustrations and, in the absence of a significant increase in the capital budget, looked to highlight opportunities to improve the current financial regime.

Missing out

Mike Woodhead, director of finance and estates at Bradford District Care NHS Foundation Trust, explained that the mental health and community service provider had no additional capital other than its fair share operational capital allocation. It did have a scheme that it had put forward for the government's new hospital programme (NHP) but it missed out, despite strong local and regional support, and excellent feedback on the strength of the bid.

'It's a rebuild of a mental health hospital – much cheaper than your average district general hospital, so a relatively modest scheme of £90m,' he said. 'But being a small trust, our share of operational capital every year is about £7m. We have no chance of building a £90m hospital.'

He acknowledged that everybody was short of capital funding. But he suggested that the emergence of hospitals built using reinforced

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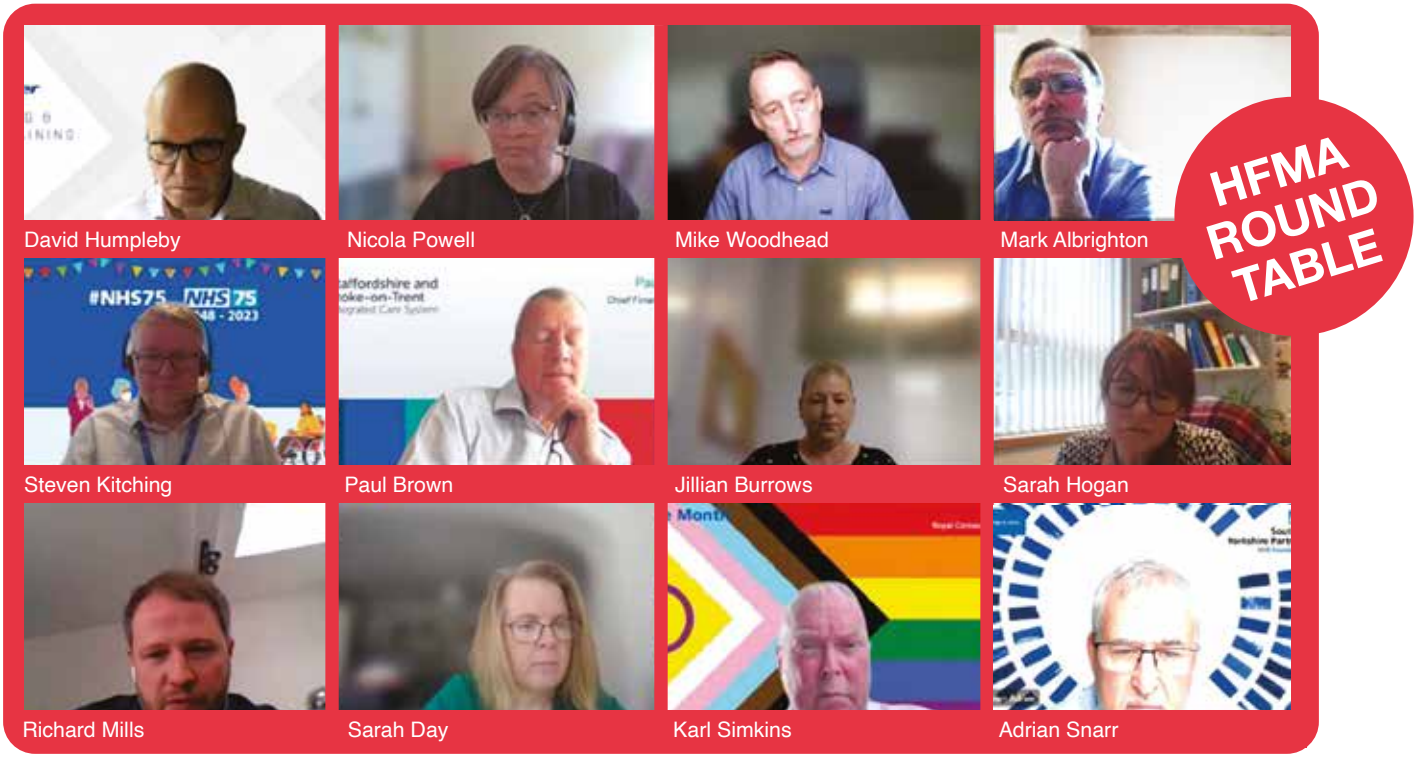

autoclaved aerated concrete (RAAC), which need to be replaced urgently, had restricted access to funding for other schemes. This might be particularly the case for those in the same systems as RAAC hospitals. 'How do you compare the need to fund a hospital that might fall down on people's heads any minute to the issues we face?' he asked.

However, the trust's issues are very real. It has poorly arranged spaces for modern healthcare, contributing to some of the longest lengths of stay in the country and forcing the trust to spend about £10m a year on out-of-area placements. And it has major drain problems, with spillages into ward areas requiring frequent call-outs – on average two per day in the last 12 months.

'We are throwing literally millions per year down the drain unnecessarily, just patching things up with short-term solutions,' he said.

While the ideal solution has to be a bigger overall capital pot, Mr Woodhead said he was encouraging finance directors in the integrated care system to start doing something different with operational capital, other than allocating it out on a 'fair share' basis.

'When the money is really tight, it is even more important you target it effectively,' he said. 'The danger is that, instead, we all revert back to organisational self-interest, or the status quo (because that's the path of least resistance). It has been really hard progressing this conversation so far. But we have to – as system finance leaders, we need to do what is in the best interests of the overall system, our service users and our tax-paying public.'

His idea would be for organisations in the system to make proposals for how to use operational capital across the system in a more targeted and strategic way. For example, he said that while the £90m hospital rebuild was a non-starter, the trust could do something worthwhile for £45m. The trust could find some £16m of this (over multiple years) but would then need support from other organisations' operational capital.

'It might only need 3% to 4% of ICB capital for three or four years,' he said. 'But it would get the project built and it would reduce our trust's requirement for capital in future years, as well as significantly improving revenue pressures for the trust and therefore the whole system.'

Mr Woodhead said the conversation would be an opportunity for all organisations to make their own case for some access to the wider system operational capital pot.

The system could explore the risks of not taking forward the strategic scheme with the risks of slightly reduced operational capital budgets for other organisations. Every organisation would have a chance to argue their own case based on needs and risks.

He said realism was needed. A district general hospital was never going to be built from system operational capital. But it could be useful for the £20m to £40m smaller projects that often get overlooked when strategic capital is handed out.

Participants

- Mark Albrighton, University Hospitals of Derby and Burton NHS Foundation Trust
- Paul Brown, Staffordshire and Stoke Integrated Care Board
- Jillian Burrows, Wirral University Hospital NHS Foundation Trust
- Sarah Day, Dorset Healthcare University NHS Foundation Trust
- Sarah Hogan, York and Scarborough Teaching Hospitals NHS Foundation Trust
- David Humpleby, Baxter Healthcare Ltd
- Steve Kitching, York and Scarborough Teaching Hospitals NHS Foundation Trust
- Richard Mills, Sherwood Forest Hospitals NHS Foundation Trust
- Nicola Powell, Welsh government Health and Social Services Group
- Karl Simkins, Royal Cornwall Hospitals NHS Trust
- Adrian Snarr (chair), South West Yorkshire Partnership NHS Foundation Trust
- Mike Woodhead, Bradford District Care NHS Foundation Trust

Funding allocation

Paul Brown, chief finance officer at Staffordshire and Stoke Integrated Care Board, said capital funding was 'one of the most frustrating parts of my job'. 'It is the ICB's job to facilitate the system to come to decisions on priorities,' he said. 'But it is almost impossible.'

It boiled down to taking money off one organisation that didn't have enough capital to give it to another organisation that didn't have

enough either. 'And it is exacerbated because the allocation is broken down into so many small bits that you have to spend on,' said Mr Brown. 'So you have to spend the digital allocation on digital and so on, until you don't have anything left for strategic decisions.'

For example, an organisation might prioritise fixing the roof over investing in digital systems, but the money it has is for digital. 'And at the system level, it is hard to prioritise when you've got all those constraints of not enough money and lots of small ringfenced pots,' he said.

One possibility would be to remove, or relax, some of the capital ringfencing and give systems the full capital resource to spend on its local priorities.

Ringfencing issues

However, there was also recognition that ringfencing served a useful purpose. Because of the scarcity of capital funding in general, and the size of the backlog maintenance, ringfencing at least forced the NHS to invest in areas such as digital. Given complete freedom on how monies were spent might see everything soaked up into bricks-and-mortar estates programmes.

Richard Mills, chief finance officer of Sherwood Forest Hospitals NHS Foundation Trust, said from the centre's point of view, ringfencing was perhaps the only way of ensuring organisations deliver some level of minimum standards in terms of equipment and facilities.

The range of digital maturity across the NHS was evidence of different local priorities in terms of capital spend as well as differential access to capital funding. Better defined minimum standards might help systems to prioritise limited capital funds.

However, Mr Mills also raised concerns about the way operational capital was shared out. He said trusts with private finance initiative hospitals had particular problems with the methodology because of the deduction of PFI financing costs.

'It reduces our share of the allocation to less than £1m, which wouldn't even fund the replacement of our IT kit,' he said. 'For us, the starting point is just negotiating up to get a level of depreciation cover that just keeps us running, rather than any strategic capital.'

The limited capital availability has led to discussions about how to weigh up investment in digital – for example, against backlog maintenance. 'It is really difficult without a common set of metrics,' he said.

He added that the bidding process for the different funding pots was also difficult

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Hospital rebuilds

Trusts in the government's new hospital programme (NHP) may feel lucky to have been prioritised for significant capital investment. Karl Simkins acknowledged that Royal Cornwall Hospitals NHS Trust appreciated seeing its £291m new women and children's hospital NHP cohort two scheme progressing, but the process had been highly challenging, involving multiple reviews and significant bureaucracy.

He said a high level of scrutiny was understandable, but the process needed refinement and simplification because it had resulted in significant and cost-increasing delays to the project. In particular, he said, 'changing evaluation criteria' during the process added complications to the completion of the outline business case.

In addition, the steer, as part of the recent NHP announcements suggested the Cornwall scheme would now proceed in line with the full standardised design elements included in the new hospital 2.0 design and build approach.

Mr Simkins said this had created late concerns given the stage of the project. The project had already been pushed back to a 2028 estimated completion, but this was now potentially at risk if further redevelopment of the scheme was required.

Positively, though, he said the trust had learnt a lot about the financial evaluations that are needed for the business case fundamental criteria reviews and comprehensive investment appraisal model. There were opportunities for other schemes to learn from this and he was very happy to share the experience.

Dorset Healthcare's Sarah Day agreed with concerns about the bureaucracy of the NHP. But she said Dorset as a county was fortunate to have three NHP projects on the go. 'These are all working to different timescales, but because we have all got those programmes going on and we are dealing with the political process and trying to manage the bureaucracy, it feels as though the day-to-day capital is being overlooked as a system,' she said. And yet, while the new hospitals were a major step forward, they only sorted out individual sites among a wide estate.

Wirral University Teaching Hospital NHS Foundation Trust has a new build that was first announced in 2018. Jillian Burrows, the trust's assistant director of finance, financial services, echoed the concerns around bureaucracy with the approval process and involvement of multiple parts of the Department of Health and Social Care. 'The mechanisms that you go through are so time-intensive and the amount of investment we've made before a spade has been put in the ground is phenomenal,' she said. 'I think this is often overlooked. Certainly, when you do your business case, you just assume this is a sunk cost and you can afford it. But that isn't necessarily the case and we've seen the guaranteed maximum price rise significantly.'

Negotiations started in 2020 and concluded early this year and the trust has seen a £10m increase in costs that will have to be found from its CDEL. 'And as we progress through the programme, costs are likely to increase further and that will have a significant impact on our "business as usual", which is already under pressure.'

Delegates discussed the fact that projects change over time and this would have an impact on the value assessment made at the start of the project. But is this ever revisited? Roundtable chair Adrian Snarr said there was a learning point for NHS projects in general.

'We should perhaps be retrospectively reviewing how we have deployed our capital over the past three-to-five years. There should be some post-project evaluation to assess what was done, would you do it the same way and did it deliver the benefits we were targeting?'

The Welsh government's Nicola Powell agreed. 'For example, you can have a strategic outline case with very high-level costings and then you see the outline business case come in and the cost envelope has increased,' she said.

'And at full business case (FBC), even taking inflation out of the equation, we often see movement again. From a value-for-money perspective, would you have made the same decision on day one if you knew the full financial implications at the FBC stage?'

She added: 'It is very difficult to push back when cases have been in the system for some time, but, because of the limited funding, we have to ask these questions.'

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and time-consuming, especially for smaller organisations, which might not have as much expertise in making such submissions. 'The quality of the written submission is bound to have an impact on allocation decisions,' he said. Local discussions about adopting specific metrics have not progressed very far, but Mr Mills said there was a much better common understanding of where the different organisations' relative risks lay and the system was beginning to see this as a system risk, rather than a collection of organisational risks.

'But it is very difficult,' he said. 'Our allocation in Nottinghamshire, although relatively good compared with some systems, is less than half of the critical infrastructure risk of one of our providers.'

Mark Albrighton, lead capital accountant at University Hospitals Derby and Burton NHS Foundation Trust, underlined Mr Mills' concerns about the costs of the bidding process. 'Just the sheer cost of pulling some of these bids together is difficult, but with delays you have to keep rewarming them and you can end up committing quite a lot of capital to just try to access some of the national pots,' he said.

'And though some of that is valid and useful for the build project, other aspects such as the bid writing and associated processes aren't actually that useful. So there is a concern that we are spending money just to access capital money – and that isn't that productive overall.'

It was pointed out there were 128 bids for a final eight places on the NHP. These new schemes were eventually not added but will have collectively taken up significant time and resource in pulling together.

Karl Simkins, chief finance officer at Royal Cornwall Hospitals NHS Trust, said the secondary care system faced major capital challenges – his own organisation could spend its operational capital 'three times over' to tackle significant infrastructure issues, including an ageing estate.

The trust also has a significant scheme in cohort two of NHP to replace one of the oldest blocks within the main hospital site, which will help, but not resolve, a much wider multimillion-pound capital requirement.

He added that it was challenging for systems to prioritise operational capital resource allocations across organisations.

'Prioritising on the basis of risk, urgency but then also more strategic capital investments within a trust is difficult enough, but doing that across a system with multiple providers, it perhaps becomes unworkable,' he said.

'However, we have to ensure the highest priority requirements are progressed in a system and a standardised risk assessment may be a partial solution to elements of the operational capital resource.

"The allocation is broken down into so many small bits you have to spend on – you have to spend the digital allocation on digital and so on – until you don't have anything left for strategic decisions"

Paul Brown, Staffordshire and Stoke ICB

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'We must also consider primary care capital investment when we think about how system capital resource should be prioritised.'

He acknowledged that taking anything out of an organisation's fair share of operational capital would have a major impact on maintaining facilities and infrastructure.

But he said there could be an argument for creating a top-up fund to support some of the smaller strategic infrastructure schemes that have a benefit across the system. 'I know that is top-slicing, but it is perhaps an option at an appropriate and proportionate level,' he said.

Mr Simkins also called for streamlining the current capital application and approval process. 'At the moment there remain significant constraints in being able to respond to requests for capital funding bids with relatively short bidding times, followed by extended timelines in receiving responses, and then delivering schemes within that financial year,' he said.

'The inflexibility of capital resource movements across financial years is a major problem for organisations often having very limited time to deploy funding.'

He added that there needs to be more clarity and a faster turnaround on the whole bidding process for national strategic capital funds.

Bureaucracy and timing

Concerns about the timeliness and bureaucracy of the process around bidding for national capital funds were echoed around the table. Sarah Hogan, head of corporate finance at York and Scarborough Teaching Hospitals NHS Foundation Trust, said the restricted time allowed for spending the funds could force trusts into sub-optimum procurement processes.

'You can end up doing single tender actions,' she said. 'And I don't know that you always get better value for money then because you've made those decisions based on the timeline you have got.'

She said she was not opposed to ringfencing, although fewer 'more generalised' pots would be an improvement, but the funding needed to come with a longer timeline.

'So if you put a bid in during the summer and you get it back in December, but it's for spending in the next financial year,' she said. 'That would give more time to plan and make the right decisions, rather than taking snap decisions based on what can be spent quickly.'

Sarah Day, director of operational finance at Dorset Healthcare University NHS Foundation Trust, raised the issue of trusts having available cash to fund capital programmes, but not being able to use it because of an insufficient capital departmental expenditure limit (CDEL).

'Our CDEL is about £9.5m for this year,' she said. 'Our backlog maintenance is about £20m. We could do it all if we could spend the cash that we've got.

'But as it stands, we can only do the high-risk and the critical-risk items, which means everything else that we could do to prevent things getting worse has to wait until it actually gets worse before we can mend it.'

She concluded with a plea. 'If we could access some of the cash that we've got to do what we need to do, then we would not be wasting the money now on things that then end up costing more because we've had to wait so long for something to happen,' she said.

Adrian Snarr, roundtable chair and director of finance at South West Yorkshire Partnerships NHS Foundation Trust, reinforced this point.

'We have an organisation in our patch that has been saving up its cash with the sole intent of buying out its private finance initiative at the expiry of the contract,' he said.

'They've been planning this for years, but they can't enact it because, although they have the cash, they don't have the CDEL cover to do it. And they are competing for the same resources that other trusts are trying to get to rebuild hospitals.'

Steven Kitching, deputy finance director at York and Scarborough Teaching Hospitals NHS Foundation Trust, said there was limited discussion in the trust's ICS about the use of strategic capital. Trusts' allocations were based on depreciation. This was insufficient to cover the Yorkshire trust's two big risks – which relate to its theatre block ventilation and renal facilities. 'So we are building up speculative

cases in the background hoping that there will be some national funding that comes along,' Mr Kitching said.

He added that the trust had a rigorous internal prioritisation programme to decide how to spend its roughly £16m operational capital – which tends to generate bids worth close to a combined £70m.

But mostly, he said, it was backlog maintenance that was funded rather than anything more strategic as that was what made the biggest difference to the frontline in the shortest space of time.

He also highlighted that capital spending had revenue implications. His trust had received funding during Covid to build a new intensive care unit and to extend its emergency department. However, the current financial position meant it could hardly afford to staff the new facilities.

He said capital was so scarce that organisations would not turn down the chance to gain more funds, but the revenue implications are often very significant.

Mr Kitching added that the scarcity of capital funds also meant schemes that would lead to revenue savings were not getting taken up. 'There are schemes in our ICS that have really significant revenue benefits – such as clinical waste incineration or laundry as an ICS,' he said. 'But they will never reach the top in terms of getting CDEL cover because of clinical risk.'

'There needs to be something around some of this development stuff that can shave millions of pounds off revenue, which is where our other real pressures are.'

Leasing frustrations

There was general agreement that finance directors, supported by the HFMA, needed to continue to make the case for increased capital funding. But even within the current level of funding, more flexibility could help – particularly around leasing. There was some frustration among participants that IFRS 16 rules mean that leasing options count against capital limits.

'When I came into post at the trust, I thought that if we couldn't get national funding for the new hospital I could sell the land and buildings to our local authority, who have said they'd be happy to finance a new build and make a little bit of profit on charging as a lease for the next 30 years,' said Mr Woodhead.

'But you can't do anything innovative like that any more because of IFRS 16. The link between CDEL and the IFRS 16 leasing standard is a massive problem, which could be solved by the Treasury. I'm not advocating for PFIs, but there are other models we could pursue with public sector partners.'

"The mechanisms are so time-intensive and the amount of investment made before a spade has been put in the ground is phenomenal"

Jillian Burrows, Wirral University Teaching Hospital NHSFT

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But he stressed that in the absence of national solutions, which are likely to take their time to come through anyway, the focus needed to be on prioritisation of programmes across systems, informed by a better understanding of different organisations' risks.

Although he dismissed the idea of overly simplistic metrics and a scoring system, Mr Woodhead said prioritisation should be based on intelligent debate. And this should involve a common approach to measuring financial and quality risks.

Nicola Powell, deputy head of capital, estates and facilities for the health and social services group in the Welsh government, provided an insight into how Wales was attempting to inform prioritisation across the country.

'We have asked NHS Wales Shared Services' specialist estates services – our adviser – to develop heat maps across the estate to map the key infrastructure risks,' she said.

'It is still a work in progress, but this will assist in investment decisions for compliance issues, for example.'

However, she said after discretionary capital was allocated to organisations, the remaining capital was constrained, with demands outstripping available resources in the same way as in England.

Wales also has ringfenced pots of funding targeted at certain programmes such as digital, although there is flexibility to move resources between funding lines to take account of slippages and increased demands.

She said an infrastructure investment board made all the business case recommendations to the health and social services minister for NHS Wales and there were plans to develop an investment framework to support prioritisation.

It was still very early days in development, she added. 'And while supporting investment decisions, I don't think it will wholly resolve the problem of trying to weigh backlog maintenance up against the other infrastructure asks to provide a fit-for-purpose estate and deliver digital transformation.'

Mr Brown said there were opportunities to get better value out of previous capital spending. The shared care record roll-out, for example, had been really successful.

'But the problem is we are not using the data properly,' he said. 'We've got really powerful data now that joins together the patient record across primary, secondary, tertiary and social care and we hardly use it. That's a big opportunity to start to make real progress with population health.'

He added that rationalisation of the estate also offered significant potential. The pandemic had shown the potential for more home working and for more patient support in their own homes.

'But how many buildings have we disposed of as a result of that change in behaviour?' he asked. 'If we put some money into rationalising the estate – and having fewer buildings – then we can release a lot of capital.'

Mr Woodhead agreed with the potential to reduce organisations' footprints. But he said the biggest potential could be in looking at how assets are used across broader public services. Again, he said the ability to do something more innovative, such as renting space from a local authority and co-locating some services, could be undermined by IFRS 16 and the need to find CDEL cover.

In summary, Mr Snarr said the limited capital resources for the NHS were an obstacle to improved service delivery, better efficiency and transformation. Finance directors – together with the HFMA – should continue to make this point. Delivering high-quality sustainable services could only be delivered with improved infrastructure.

But he said there were other avenues to be explored in parallel to lobbying for an overall bigger pot. IFRS 16 has effectively removed the potential flexibility provided by leasing. The bidding process for capital needs to be overhauled, reducing the bureaucracy and making the approval and release of funds much more timely – reducing the time lags that led to cost increases and allowing enough time to plan and spend resources efficiently and effectively.

And thought should be given to how operational capital could start to be used strategically across whole systems, informed by a better understanding of the relative opportunities and risks of spending in one area rather than another.