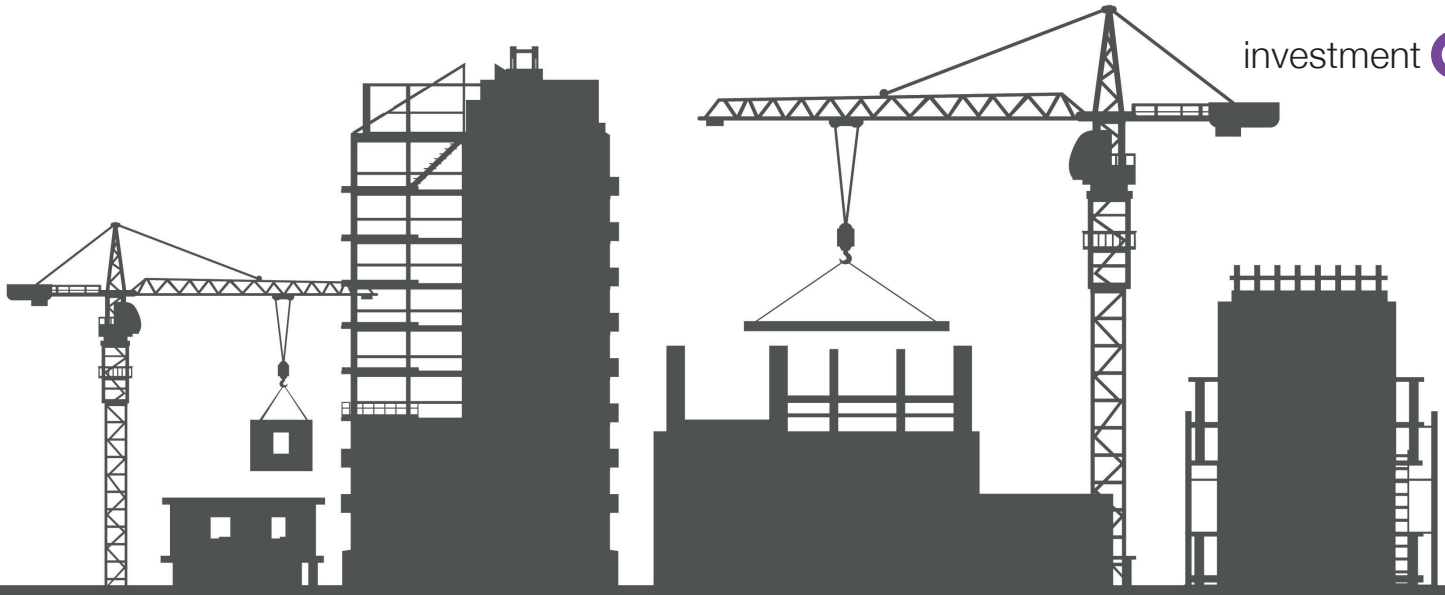


Capital challenge

The health service must modernise its estate if it is to realise the ambitions of the *NHS long-term plan*. That means new buildings in some places, while addressing significant levels of backlog maintenance. A recent HFMA roundtable discussed the challenges ahead. Steve Brown reports

HFMA ROUND TABLE

It was a big summer for capital investment in the NHS. First, instructions for all providers to cut capital plans by 20% were dropped when £1bn was added to this year's capital spending limit. This was then followed up with news that numerous hospital rebuilds would be funded, culminating in the unveiling of further funding as part of a new long-term, rolling programme of capital investment.

But the capital challenge facing the NHS is far from over. The vision set out in the *NHS long-term plan* will need a transformation of the NHS estate. Existing facilities will need to have the capacity and quality to meet current and future demands, and new infrastructure – including digital infrastructure – will be essential to support integrated models of care.

More funding is needed as a minimum – a point that was recognised in some of the party manifestos published ahead of December's general election. The Conservatives made no new specific pledges on capital as part of their campaign, sticking to pre-election commitments to build 40 hospitals. However, only £2.7bn has so far been awarded for six projects, and some estimates suggest the total cost of the rebuilding programme could be over £20bn.

While addressing some very specific needs for new facilities, this in no way covers the service's wider capital needs. With the election out of the way, the service will now be looking to next year's long-term spending review to deliver a multi-year capital settlement for the NHS.

But changes are also needed to the current processes used to prioritise and approve projects for investment. In November, the HFMA – supported by health and care property development company Prime – brought together finance leaders and capital project experts to explore the current capital challenges and discuss possible solutions.

'While the summer announcements are welcome and the release of funds is helpful, there still remains a significant amount of uncertainty and there is a lot to do to implement the long-term plan,' said Ian Moston, chief finance officer of Northern Care Alliance NHS Group and chair for the roundtable discussion. 'All of us are living with huge backlog maintenance issues. At a national level, the latest figure is £6.5bn and it is growing quicker than we can erode the issue. On top of this, private finance [or at least the private finance initiative] is no longer an option.'

He added that lead times for major capital

Jane Cole

Ian Moston

Tim Morgan

projects were long – wave two beneficiaries of the recently announced Health Infrastructure Plan (HIP) would be unlikely to see any funds until 2025. For those trusts not yet prioritised as part of HIP, understanding how to take forward schemes was paramount. And even for trusts in the HIP fold – with seed funding to explore capital development further – there were other assets and sites that somehow needed to be made operational without, as yet, any promise of further funding.

The added dimension in the last few years has been the need to ensure capital is deployed to further system plans, not just to meet the needs of individual organisations. And this was where the roundtable started its discussions – exploring how system capital plans were developing to meet the requirements of the long-term plan.

'What is the system? That has to be the first question,' said Rob Forster, director of finance and deputy chief executive of Wrightington, Wigan and Leigh NHS Foundation Trust. The trust has a £14m capital programme – about 'one third the size of legitimate demand' – which it is funding from internally generated resources. 'A lot of this is backlog maintenance, but we are also stretching the economic useful lives of our assets too, which masks the issue.'

And although he recognises the need to take a system view to meeting the needs of patients, he thinks organisational requirements also have to be factored in. 'It is helpful to have the sustainability and transformation partnership (STP) plan, but the best place to start may be with the locality,' he said. 'We should ensure [locality plans] meet the needs of the STP rather than starting with the STP and trying to wedge localities in.'

Cross-border flows

Geography can also provide challenges to taking a system-wide view. Nicky Lloyd is chief finance officer at Royal Berkshire NHS Foundation Trust, one of the HIP2 organisations and part of the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System.

Julia McLarty

Gerard Hanratty

"Good relationships across the STP, including agreeing on capital priorities, are the key to developing the ICS"
Gerard Hanratty, Browne Jacobson

'Patient flows won't always fit into a single ICS,' she said, suggesting cross-border trading may be necessary to deliver convenient capacity for issues such as diagnostics. 'Just over the border from Oxfordshire may be better for some patients rather than centralising somewhere in our own patch,' she said. 'So, we need to look at different configurations.'

This point was underlined by Jane Cole, director of finance for the Hampshire and Isle of Wight Partnership of Clinical Commissioning Groups. While some systems appear to be self-contained from a geographical viewpoint, in reality there will always be a requirement to work in partnership with other providers. And the use of digital solutions to streamline future service models will be key.

Mr Moston said there were other examples of how current controls around capital did not fit with a system approach. 'We are operating as a single organisation at the Northern Care Alliance, but while we are still two separate statutory bodies (Salford Royal NHS Foundation Trust and The Pennine Acute Hospitals NHS Trust), we can't move capital between the two.'

Gerard Hanratty, head of health at law firm Browne Jacobson, suggested there may be some reshaping of STP boundaries as ICSs develop. But in the meantime, he encouraged all systems to be completely clear about their capital plans as an STP/ICS. 'If you are competing within your STP, you won't get anywhere [with national funding],' he said. 'Good relationships across the STP, including agreeing on capital priorities, are the key to developing the ICS.'

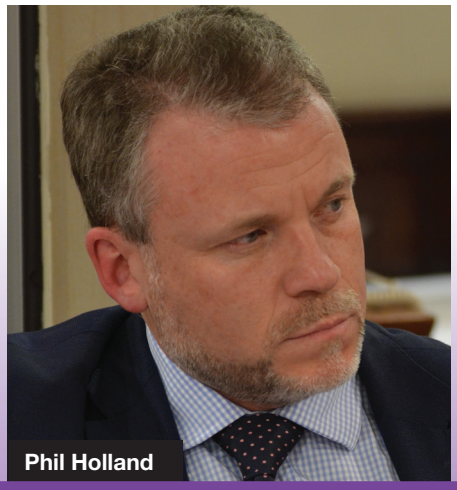
There were other issues raised about the lack of flexibility. 'We put in a case and it was approved,' said Nick Thomas, deputy chief executive and director of planning and site services at the University Hospitals Plymouth NHS Trust. 'But when we got into the detail, we wanted to develop a better scheme and push the financial envelope. Even though it was a better scheme, delivering more value for the public purse, it was very clear that the envelope is the envelope. The answer was "no" and we had to use a lot of imagination to get the figure back down.'

The Northern Care Alliance had a similar issue because of the time taken by the approval process – with inflationary drift massively increasing the cost of a planned project. 'You can't change without going back to the start. We couldn't get our cost back down and we had to make the difference back up with a pot we'd created to address a diagnostic deficit,' said Mr Moston. 'That has now gone and so we have still got ageing diagnostic machines.'

Tameside and Glossop Integrated Care NHS Foundation Trust does not have this option. It was awarded £16.3m to create an urgent care village as part of 20 hospital upgrades given the go-ahead in August. However, the project had originally been worked up over a year earlier for funding as part of the wave 4 STP capital programme. Costs are likely to have risen since, and will rise further in the time it takes to secure full business case approval.

'We have an offer of £16.3m, which is almost five times our annual capital programme and we have no cash available to supplement that,' said Sam Simpson, the trust's director of finance. 'So, the overall cost cannot exceed the external funding available and we will need to manage expectations. We will also need to fund the development of the business case from our own resources.'

Roundtable participants also called for greater clarity around what they had to do to get projects approved. They said it was clear that the formal business case approval process was different to the process used for applying for STP capital



Phil Holland

funding in the four waves that have been run to date. But better understanding of the detail of the process would be helpful – especially given that the HIP document talks about streamlining the business case process moving forward.

And with some trusts being awarded capital funds as part of the first wave of STP capital still waiting to see any cash more than two years later, the service needed to be given a better idea of timescales. In particular, this might help manage staff, clinician and local population expectations.

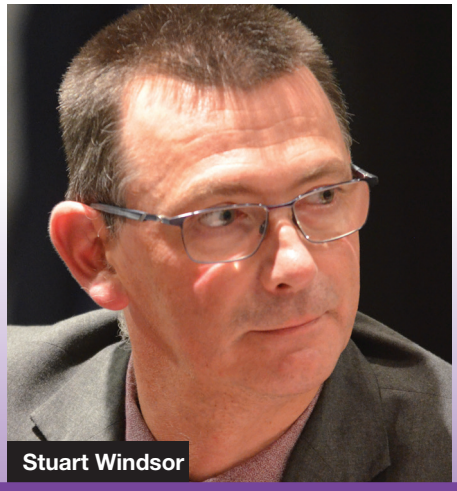
Detailed technical guidance on the 2020/21 capital system was promised before the end of the year – although this was before the announcement of a December general election.

However, Ms Lloyd said that recent conference calls with the Department of Health and Social Care and the Treasury since the announcement of HIP2 funding had been encouraging. 'Colleagues have been very helpful and they stressed they want to make [the process] very straightforward,' she said. 'So far it feels like there is a real commitment to simplify processes and help us to fast-track our application– I'm sensing a real commitment to get schemes delivered.'

Concerns were also raised about the potential skills gap. Julia McLarty, head of redevelopment finance at the Royal National Orthopaedic Hospital NHS Trust, suggested that the lack of major capital projects in recent years meant many trusts would not have the necessary experience of navigating the external systems and processes to get cases approved. Again, she said that guidance would be helpful.

'Sometimes the in-house team does not have the capacity or full capability to complete business cases to the standard required,' she said, highlighting technical accounting support as a good example. While there was some informal support from other practitioners across the system, this was piecemeal and far from comprehensive – the onus was on organisations to make their own arrangements, often at cost.

Mrs Cole agreed. 'With significant capital sums being awarded, teams will not have been exposed to producing outline and full business cases at such scale,' she said. 'These cases require the right skills and expertise appropriate to this size of capital challenge.'


Stuart Windsor


Sam Simpson

Mr Moston added that this could be an issue for the whole service. 'There is only a finite level of expertise in the system to support business case development,' he said. 'With the cascade of announcements, will there be a gap in the support available as schemes progress?'

Sorting priorities

The roundtable also discussed how priorities were being identified and evaluated. Stuart Windsor, director of estates and facilities at Plymouth, said the Devon STP had revised its approach to prioritising projects and bidding for STP capital funding as the waves have progressed. 'Last time we went through the STP prioritisation process – essentially we had competing bids. All organisations were involved and the STP ended up with a ranked list. But this time, rather than filter out the noise at the end, we started to brigade things together at the system level.'

It was a bottom-up approach, with projects identified provider by provider. The aim is then to effectively submit these under a single theme to align with the long-term plan.

The trust has been successful in the STP capital funding waves and is one of the 21 trusts named in HIP2. Mr Thomas said this was partly thanks to having an up-to-date site development plan that was refreshed every year and having projects 'ready to go.'

Ms Lloyd agreed that organisations needed to 'broaden the scope' of their prioritisation processes. 'For our capital programme, we are building in a whole matrix of considerations to help identify priorities. For example, we are looking at the prevalence of incident reporting and single points of failure, what demand and capacity modelling has shown us and what could be spade-ready if money became available at short notice,' she said.

HFMA ROUND TABLE

This contrasted with previous approaches where work often waited until there was money available to bid for.

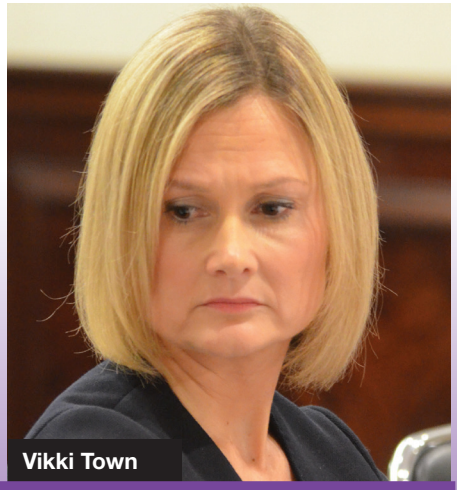
Mrs Cole said there was a real challenge for the NHS in ensuring it met the capital needs of the non-acute sector. 'It is not all about shiny new hospitals. How do we bring in primary care networks and integrated care trusts too,' she said.

There was general agreement with this, with participants acknowledging that it was difficult to understand primary care needs, especially given the complication of different ownership arrangements from GP practice to GP practice. Mr Forster added that while investment in out-of-hospital services including social care would enhance direct patient care, it could also have knock on benefits for the acute sector. 'If we can improve some of these facilities – as well as some of the services outside the traditional health arena – it could have a major impact on acute demand,' he said.

Mrs Simpson said that Tameside and Glossop had some advantages in progressing this agenda. The trust is an integrated care organisation, working with a single strategic commissioning function across the CCG and local authority. And there is a mental health trust with wave 4 funding on site. 'This means we can get into discussion about one public estate as all our health and social care staff are co-located across the system in five neighbourhoods,' she said. 'Where we can, we try to ensure that the whole estate is used to best effect, whoever owns it.'

Other participants suggested that collaborative work with local authorities and other bodies was also developing – albeit not as advanced as in Greater Manchester in most cases.

Mr Hanratty called on trusts not to overlook their unused estate. 'That is the big asset that the NHS has,' he said. It was a source of capital that meant you may not be competing for central


Vikki Town

funding and that should improve the ability to take forward system capital priorities by reducing the permissions needed. 'How you use this is key to unlocking some of the money you are in control of,' he added.

Mr Forster agreed. 'We need to look at utilisation as well,' he said. 'Some parts of the estate particularly the hospital – are really well utilised,' he said. 'But other parts are not well used – some community facilities for example – and could be consolidated.'

Ms Lloyd went further and said that some services were currently run out of high-cost parts of the estate. Changes to the model of care delivery – or where services are delivered from – could free-up existing space and avoid the need for increased capacity. 'We've been looking at outpatient transformation and what actually needs to be on our main hospital site,' she said. 'Acute facilities are very over-specified for some interactions that don't need that cost around them. We need to consider what sort of outpatient environment is needed for the interactions that are being undertaken and stratify where services are delivered from rather than necessarily have very large bespoke departments that do everything under one roof.'

Funding and permission

Funding for capital investment was the final area covered by the roundtable. Mr Moston pointed out that the NHS was unique in attempting to run itself around its income and expenditure, when businesses typically ran themselves through the balance sheet. This change of approach would protect against the NHS running down its facilities and reaching a position where its capital estate was in need of heroic levels of investment.

The roundtable discussed the lack of a level playing field for different types of provider. NHS trusts have capital resource limits to restrict spending so that the NHS overall stays within the capital departmental spending limit. Foundation trusts not in financial distress are in theory free to spend on capital, although their decision to do so impacts on the availability of capital funds for the rest of the service. However, if they need public borrowing to support this investment, they also require central approval to move forward.

HFMA ROUND TABLE

'For the Royal National Orthopaedic Hospital – as a non-foundation trust – our hands are tied,' said Ms McLarty. 'Everything that we might want to do has to go through the regulators – so there is no level playing field.' She welcomed the introduction of the HIP, providing a long-term approach to capital investment. But she said that, as a specialist non-foundation trust, that was currently outside the HIP programme, the question was how did it get 'on the inside'.

A number of alternatives have been suggested in recent years as alternative sources of funding to government borrowing. Tom Morgan, head of health at real estate services firm CBRE, said that, if you put aside the issue of CDEL, there were a number of possible funding options waiting in the wings. 'Where we are seeing greatest interest now is from endowment funds, pension funds and insurance providers,' he said. 'It is not a question of "if there is money", it is a case of how to get access to that capital.

Historically, buildings have often been funded by NHS organisations taking long-term leases. But he sensed a different environment was emerging with a change in attitude towards risk.

'[Funds] are looking at investment timescales of 30, 40 or 50 years and they want safe and secure, while also being interested in social impact,' he said.

> **"It feels like there is a real commitment to simplify processes and help us to fast-track our application"**
>
> **Nicky Lloyd, Royal Berkshire NHSFT**

However, the overall limit on capital spending currently discourages trusts from exploring private sector funding routes. 'The calculation of CDEL is the biggest preventer to making further progress,' said Vikki Town, group finance director at Prime. 'Any new money brought in counts against the limit and this has to change to do some of the things we've talked about.'

She added that there should also be a distinction between clinical and non-clinical schemes, such as car parking or key worker accommodation. 'It is currently the same process even though a development may have an income stream that means it pays for itself,' she said.

Phil Holland, Prime's chief investment officer, encouraged the service to be more aware of its brand and the value for organisations of working with or being close to the NHS. He said there were opportunities for branding and sponsorship or from capturing a revenue stream based on the footfall though the estate.

And he stressed the importance of specialisms when deciding whether public or private capital is used. 'You aren't car park operators or accommodation providers, but there are expert organisations out there that can provide these things for you and allow you to concentrate on your estate providing key services,' he said.

All eyes now turn to the promised detailed guidance on next year's capital system. And beyond that the focus is clearly on the 2020 spending review, when details should be announced of a multi-year capital settlement for the NHS. The overall pot made available for this settlement will go a long way to deciding how quickly the long-term plan's vision of a transformed NHS to meet the demands of a modern health service can be realised.

In the meantime, finance and estates professionals must ensure they are well-equipped to deliver current capital programmes, while also preparing for the likely expansion of their activities.


Nick Thomas


Nicky Lloyd


Rob Forster