pump priming

STPs need capital, but there is little public funding available, forcing the NHS to rethink how it can find the money, says Seamus Ward

In the NHS, capital funding can sometimes feel less important than revenue spending. Capital budgets are often underspent, while in recent years capital funds have been transferred to revenue budgets to shore up providers' financial positions. However, the health service across the UK is integrating and transforming, moving more care out of hospital – and this will require capital to fund new or upgraded buildings and equipment. A change in attitude towards capital funding, as well as a plan for how to find the money, is needed.

Acknowledging the funding need, England's sustainability and transformation plan (STP) areas have been asked to assess their capital requirements. A British Medical Association freedom of information request – to which 36 of the 44 STPs responded – put the total requirement at £9.5bn. The recent Naylor review of NHS estates put the figure at £10bn, a figure that seems to have been accepted by NHS Improvement. But with access to capital constricted, where will the funds come from?

In England, the spending review settlement set NHS capital spending at £4.8bn a year until 2020/21. In this year's Budget the capital allocation has been revised upwards to around £6bn a year between 2017/18 and 2019/20. The Treasury says this is due to the additional funding for A&E and STPs announced in the Budget and the reclassification of research and development spending as capital. But the value of capital budgets has been eroded by capital to revenue transfers, which have been needed to reduce provider deficits and keep the NHS in overall financial balance. In 2016/17 this amounted to £950m – £640m in 2015/16.

Other parts of the UK have seen a reduction in capital budgets – in

Scotland, for example, revenue spending increased by 8.6% between 2008/09 and 2015/16. But over the same period capital spending fell by almost 65%, according to Audit Scotland. Even so, NHS Scotland's capital budget more than doubled to around £500m in 2016/17, mostly to fund four new facilities.

With growing calls for increased capital funding in England, chancellor Philip Hammond relaxed his grip, albeit in a small way. In the March Budget, he announced £325m over three years for STPs sufficiently advanced in planning, and promised further sums for all STPs would be allocated in his autumn Budget. He also allocated £100m to allow hospitals to build facilities to extend the use of GP triage in emergency departments.

Golden opportunity

It seems unlikely that all of STPs' capital requirements will be funded directly by the Exchequer. Certainly, this is a view taken by NHS Improvement chief executive Jim Mackey, who has held discussions with private financiers. He told *Healthcare Finance* that even though public finances are tight, historically low interest rates offer the NHS a golden opportunity to access the capital it needs.

NHS Improvement believes an increase in the capital available to the NHS could secure better A&E performance by building extra hospital capacity and modernising facilities, and technological innovations could be scaled up to increase efficiency and productivity. Overall, an injection of capital could provide greater stability for NHS finances, it adds.

Mr Mackey says radical new ways of raising funds for STP capital plans is needed. 'We have to be realistic because we aren't going to get a £10bn cheque to pay for all the transformation under way and the massive maintenance backlog, so we need to think long and hard about another way of doing things,' he says.

'Historically low interest rates are a golden opportunity for the NHS but we are constrained by rigid rules around borrowing that prevent us from taking action. An NHS Fund could power the improvement needed to sort out problems at our hospitals and to drive the change required to get the NHS ready for future challenges. If we are open to new ideas then we could really be in business.'

NHS Improvement also wants NHS bodies and local authorities to work together to secure investment that stays off the NHS balance sheet.

Healthcare Finance spoke to one trust in advanced talks with its local authority over a loan for a retail development that would benefit patients and visitors and aid recruitment and retention. But it was halted by NHS Improvement over concerns that the liability would end up on the public sector balance sheet. The trust is nonplussed – the deal would have delivered a higher rate of return than a privately financed alternative – but is exploring other avenues.

CIPFA and the HFMA are working to bring local authorities and health organisations together. Jane Payling, CIPFA's head of health and integration, says clear themes emerged from a recent roundtable, chaired by CIPFA director of local government and policing Sean Nolan and attended by county and district councils, NHS provider bodies, NHS Improvement, the Department of Health and the HFMA.

'The key message was that, whatever we do, if it results in an asset that's on the NHS balance sheet then we are not solving the problem,' she says. 'Capital is constrained at a national level in the NHS, and creation of any further NHS assets, however funded, is likely to count against the CDEL [capital departmental expenditure limit].'

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Jane Payling, CIPFA

Some councils have reserves potentially available for investment, and all have the ability to borrow within the guidelines of CIPFA's prudential code. Local authority capital could be invested in the NHS for tactical reasons – for example, rates of return may be better than the amounts available on the markets – or to meet strategic goals such as improving services for older people. A scheme to help the local NHS could be a vote winner, it could generate a commercial return, or council services such as social care could benefit from co-location with NHS services.

There are opportunities for local authorities and the NHS to work together, she insists, but those putting together the projects must be careful about where an asset sits.

Joint ventures between councils and the NHS – potentially with private funding – could sit on the local government or joint venture balance sheet rather than in the NHS. Such an approach might work for an intermediate care facility, which would allow trusts to discharge patients medically fit to leave hospital but who do not have the family support or care availability they need to live at home.

The NHS and local authorities could work together to identify land for joint use or to sell off housing, for example – particularly when they can bundle packages of land together to provide more attractive sites for developers. The value of this land could be much higher with planning permissions in place, a system governed largely by local authorities.

The planning system, with its potential for contributions from developers through section 106 agreements and the community infrastructure levy (CIL), could also offer the NHS an alternative source of capital. *Healthcare Finance* knows of at least one trust that has explored the potential of CIL with its local authorities.

There are opportunities to be brought about by closer working on capital between the NHS and local authorities; and where working relations are strong and incentives are shared there is potential for successful ventures, Ms Payling says.

Local authorities, on the other hand, have a wide range of competing calls on their cash, Mr Nolan adds. So, any projects must first meet the council's commercial or policy agenda. Once this is met, a combination of good relationships and local political backing will be required to navigate obstacles such as the constraints of the NHS CDEL, he says.

Property review

The sale of surplus NHS estate and its potential to raise large amounts of capital, are central elements of the recent review of property and estates by Department of Health property adviser Sir Robert Naylor.

The review says the NHS needed capital. Provider trusts are on 1,200 sites and cover 6,500 hectares, but despite significant hospital building programmes over the past 15 years, 18% of the provider estate predates the formation of the NHS and 43% is more than 30 years old. While the report acknowledges that refurbishment programmes mean this is not always a problem, it insists too much of the NHS still has inadequate facilities – as the maintenance backlog proves. This was put at £5bn in 2015/16, but the report believes this to be an underestimate as there is no incentive for trusts to report their situation accurately.

Sir Robert does not see an argument for reducing hospital bed numbers, except where NHS England reconfiguration criteria are met. Indeed, even if new models of care are successful, demand fed by the growing and ageing population will mean current bed numbers will have to be more or less maintained, he says.

However, his report argues that the acute sector can make efficiencies without reducing bed numbers. Over time, it has treated more patients

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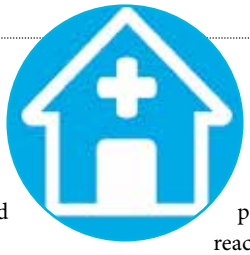

with fewer beds, though at the same time the size of its estate has grown – so there must be surplus estate. External analysis of the acute estate and research by the Naylor team on non-acute property identified potential gross risk-adjusted capital receipts of £2.7bn from disposing of inefficiently used land and property – more with planning permission. This includes £1.8bn from the acute sector. Though service reconfiguration was needed to maximise value, the disposals could lead to revenue savings of £0.5bn a year.

Chris Hopson, the chief executive of NHS Providers, believes the targets for trusts to raise money from the sale of assets for reinvestment and to deliver land for new homes are stretching. 'Trust leaders recognise their important responsibilities in this area but, as the report points out, trusts currently lack the leadership bandwidth and expertise to deliver this target. We will want to consider, with members, whether these targets are realistic and deliverable given the constraints,' he adds.

In 2015/16 and 2016/17, there have been significant capital to revenue transfers and the Naylor report says the NHS will face significant challenges in maintaining patient care and delivering the *Five-year forward view* if the transfers continue. It estimates the need for significant capital investment of about £10bn, funded through property sales, private capital for primary care developments and exchequer funds. Primary care capital grant funding is small and will not be sufficient to deliver the forward view vision of more out-of-hospital care.

BMA council chair Mark Porter says the £10bn capital requirement is even higher than the figure in its analysis earlier this year. 'The NHS simply doesn't have this kind of money available and these plans are fast becoming unworkable. The figures are especially concerning given that everyone can see that the NHS is at breaking point. We urgently need an honest look at the pressures facing the NHS and how to give the investment needed to match the promises made.'

While the disposal of surplus estate could recover £2.7bn, the Naylor report says business cases will have to take a long-term view – in most cases, more than a decade – as the time period over which the receipts from sales can be realised will be longer than the current spending review period. Sir Robert insists providers must be given incentives if these figures are to be reached. Providers have tended to hold onto land until they need funds to build facilities – encouraged by the rapid property price rises.

The report says that, at a minimum, the Department should allow STPs to keep receipts from the sale of locally owned assets, provided the disposal is in agreement with the STP plan. But it adds that the Treasury should offer incentives to dispose of land through a '2 for 1' offer, with public funds matching sales receipts, given in addition to those receipts. This should be offered, initially for a five-year period, on a first come, first served basis, to encourage STPs and providers to act quickly.

The allocation of other national capital funds should take the '2 for 1' incentive into account so STPs with lower potential sales values are not disadvantaged.

Sir Robert considers incentivising disposal of surplus land by increasing capital charges from the current 3.5%, introducing higher charges for surplus land, or having different charges for land and buildings. While he believes these would have positive effects, alone they would not sufficiently influence behaviour to meet the forward view's ambitions. Land should be prioritised for residential homes for NHS staff, where needed, either in partnership with housing associations or through a national NHS housing association. Urgent action should be taken to deliver a large number of small-scale and low-risk housing developments, the report adds.

The report produced 17 recommendations (see box), including the creation of a national property board to improve capability and capacity in estates and support action at a local level.

Overall, it suggests all national bodies should work together to produce a capital investment plan by this summer, which maximises value for money and makes a strong case for securing public and private funding. With STPs also developing their estates plans, capital funding – and where it can be sourced – will be a key issue for the NHS.

Estates expertise

Eight of the Naylor recommendations relate to establishing a new arm's length NHS Property Board, bringing together some of the functions of NHS Property Services (NHS PS) and Community Health Partnerships (CHP).

While both invest in new properties, NHS PS provides estates management and facilities support for properties inherited from primary care trusts and strategic health authorities. CHP oversees the 49 LIFT companies – joint ventures with private partners to develop integrated health and social care centres.

Naylor recommends the new organisation be set up immediately in shadow form, substantively from April 2018. The new NHS Property Board should consider divesting back to providers the functions and residual assets given to NHS PS following the abolition of PCTs and SHAs.

With many primary care surgeries not set up for the expansion of services envisaged by the *Five-year forward view*, the report suggests GPs should be incentivised to move to more appropriate premises by linking reimbursements for estates to the quality of facilities.

A financing facility – possibly funded from sales receipts – could lend up-front development costs where no other sources of finance could be secured.

The new property board should support STPs to develop affordable estates and infrastructure plans, to deliver the forward view and address backlog maintenance.

Benchmarks developed for the review should be used to assess these STP estates plans and access to capital – through grants, private finance or loans – should be denied if plans do not meet quality standards. Plans should align with clinical strategies, provide value for money and include land disposals.

In a joint statement to *Healthcare Finance*, NHS PS chief executive Elaine Hewitt and CHP chief executive Sue O'Connell backed the creation of a national property organisation. They are already working to support STPs.

'Our collective expertise and success in reducing costs and developing new facilities for healthcare will form a strong foundation for the new organisation. Our work releasing surplus land is not only generating valuable cash for the NHS, it is also supporting government housing targets,' they say.

NHS Property Services says it has generated nearly £200m for reinvestment in the NHS through sales of surplus assets since 2014/15 and invested £60m in capital developments in 2016/17. More than 3,000 new homes have been built since 2014/15 through the release of surplus land.