

# NHS buildings: obstacle or opportunity?

**Author:** Nigel Edwards

Our Time to Think Differently programme aims to stimulate debate about the changes needed for the NHS and the social care system to meet the challenges of the future. By promoting discussion and debate, we hope to generate new thinking about innovative ways of delivering high-quality care and to support health and social care leaders in their decision-making.

As part of the process, we hope to challenge assumptions about how health and social care is delivered, who delivers it and where it takes place. Our starting point for this debate is that the pressures for change, although significant, are not insurmountable but require new thinking and fresh ideas.

This is the first in a series of four papers that aim to crystallise ideas for change in areas where, we believe, new thinking is required. Subsequent papers will focus on the health and social care workforce; use of technology; and role of patients and service users. The papers draw on ideas generated by seminars, discussions with experts and feedback from the Time to Think Differently programme.

## Introduction

The NHS estate in England has a floor area that would cover the City of London ten times over. The land it owns totals 6.9 million hectares while the total floor space of trust and primary care trust buildings is estimated at 28.4 million square metres (both figures exclude primary care premises) (NHS Information Centre 2013). There has been little real attention given to how this huge resource could help to improve efficiency, move more care out of hospitals and exploit new technologies. Models of care are still designed around buildings, but could re-thinking the way that the NHS uses its estate catalyse change?

## The current issues

The NHS has many under-utilised properties, and a significant amount of its estate is in poor condition or not fit for its current purpose. The NHS Information Centre latest data shows that the cost of clearing the total backlog of maintenance required is more than £4 billion. There appear to have been a number of property sales over the past few years that have reduced the unoccupied floor area of NHS organisations to 1.5 million square metres.<sup>1</sup>

<sup>1</sup> This calculation is based on subtracting the occupied floor area of all NHS organisations from the gross internal floor area (see [www.hefs.ic.nhs.uk/DataFiles.asp](http://www.hefs.ic.nhs.uk/DataFiles.asp), 2011/12 data).

Unfortunately, some of the newer estate, developed to deal with the previous maintenance backlog and as part of service developments in the past decade, has created new problems. There has been investment in buildings that are in the wrong place, and others that now appear to be surplus to requirement, or are rapidly becoming out of date as treatments and care change. Many of these buildings are over-specified and inflexible, which makes them expensive to operate and to reconfigure. This also means that they often have a low residual or alternative value compared with their initial costs, which makes them relatively expensive to finance and difficult to dispose of. The use of the private finance initiative (PFI) to procure these buildings exacerbates the problems because of inflexible contracts in which the costs of adaptation and change often lie with the NHS. This is a problem with planning and commissioning services rather than just an issue with procurement.

The NHS estates management function has been largely concerned with the maintenance and operation of buildings; there has been little development of more entrepreneurial property management skills. Building utilisation is often not actively managed. There is very limited property expertise within the organisation, with the result that the NHS has been severely criticised in the past for failing to achieve an appropriate return on land sales and other property transactions.

Some of the financing deals underpinning both PFI and other NHS property transactions have been distinctly unfavourable, including upward-only rent reviews and in some cases PFI contracts with uplifts of the unitary payment that outstrip inflation. There has been criticism of the short-termism and the poor commercial acumen shown in a number of these deals (McKee *et al* 2006). As a client for new buildings and PFI, and as a joint-venture partner, the NHS has a reputation for being indecisive, adversarial, overly controlling and risk-averse. This reduces the opportunity for innovation and increases the cost as these challenges are factored into the price by suppliers.

The way that the NHS accounts for land and buildings is somewhat opaque. While the national tariff does contain a component for capital charges and depreciation, this only constitutes just over half of providers' income. Also, given that this component is based on the average book value of the estate, it is unlikely that providers receive enough payment to set up reserves. The specificity of design of many health buildings also means there are few alternative uses that will create sufficient income to cover costs, and the arrangements for provider insolvency makes it difficult to borrow large sums for investment secured against providers' assets.

The rapid pace of change in medicine means that it is very difficult to future-proof large-scale investments in estate and, once built, there are very few mechanisms for these assets to be changed. Many hospitals are still planned in ways that perpetuate practices that may be inefficient or out of date. A significant amount of the NHS estate houses back-office functions and services that could be provided in much lower cost buildings. High-cost buildings and equipment are, in general, substantially underused.

NHS-owned primary and community care estate suffers from many of the same problems, including inappropriate buildings; wasted space; inadequate space for expanded services; over-specified rooms; and facilities that are unused for large parts of the week. For example, there is no clear economic logic in having procedure rooms and minor theatres that are used only one afternoon a week.

Both national and local government also have a large portfolio of underutilised land and buildings. Currently there are few examples in which the potential for combining public sector buildings has been properly exploited – this is partly related to the challenges in aligning different funding and governance arrangements.

The NHS is not unique in experiencing these problems. Many other industries find estates and property difficult to manage, and this task is increasingly being outsourced. While all of this means that there are unexploited opportunities for improving value for money, perhaps the most important concern is that opportunities for new models of care are not being maximised and that existing estate is an obstacle to innovation.

## **What should be done?**

There needs to be more ambition in the way the NHS estate is used. The current model of ownership and operation needs to be challenged and new methods of financing need to be developed that avoid the very significant downsides of PFI, in particular, the associated intergenerational transfer of debt.

The objective of any change needs to be to support and encourage new or improved models of delivery that bring health care, social care, housing, private sector provision of long-term care and other related services together in a more integrated way and create more value for the wider community. These models may need to separate service provision from building ownership. Providers can change more rapidly and be more imaginative about models of delivery if they are not tied to a particular location.

Innovative approaches to the estate could help to break down the barriers between primary and secondary care, mental health, and social care. There is a case for creating multi-purpose, flexible facilities for extended primary care teams, integrated community and social care staff, diagnostics and specialist consultation. While the polyclinic model proposed in Lord Darzi's *NHS Next Stage Review* (Darzi 2008) was not sold well and was poorly implemented, the idea is sound and needs to be developed. Creating campus developments that have mixed use and ownership offers opportunities for much more flexible space and the ability to ensure a high level of utilisation. An example of an innovative whole-system approach in Warrington, Cheshire, is shown in the box below. The case study from Henley-on-Thames shows the potential for different types of private sector involvement.

There is also potential for mental health providers and housing and employment services to explore a more integrated approach to the estate to open up new opportunities for supporting service users and to help unlock issues around discharge from hospital.

The piecemeal development of primary care premises should cease and instead primary care development should be part of a wider strategy to develop networked integrated services. Incentives to develop these new approaches are required.

### *Orford Jubilee Neighbourhood Hub, Warrington*

Opened in May 2012, the Orford Jubilee Neighbourhood Hub brings together leisure, library, and lifestyle services, which transferred from Warrington Borough Council into a non-profit community interest company called LiveWire (LiveWire 2013). Leisure, NHS and library staff work under one roof, providing a wide range of services for the local community, including stop smoking and healthy weight services, a crèche, swimming lessons and reading groups. The development, which is the only 2012 Olympic legacy facility built outside London, is the result of a £32 million regeneration initiative and a successful partnership between Warrington Borough Council and Warrington Primary Care Trust. In total, more than 20 organisations were involved in the project – all with different funding and governance arrangements (Fulcrum 2013).

Providers need to be more willing to use non-NHS buildings to provide care. This would make services more flexible and accessible, and money saved on running premises could be invested in staff and technology. Providers could use space in a variety of locations – hospitals operated by other organisations, residential and nursing homes, primary care premises, schools, retail premises or the patient’s own home. The Royal College of Paediatrics and Child Health is advocating more use of school premises for providing child health services. Using technology to allow more care to be delivered by phone or web is a key part of US health care provider Kaiser Permanente’s strategy and to date has been under-exploited in the United Kingdom.

A different approach to the design of health buildings is required. There needs to be an end to the tendency to over-specify a large numbers of different rooms, to provide facilities that are duplicated or underused, and to build administrative and other space at nearly the same cost as areas used for clinical work.

A new approach that looks across the whole system and tries to bring services together has the potential to improve the experience for patients and provide opportunities for service co-ordination and collaboration.

In addition, there is potential to:

- reduce the overall cost of the estate and improve the efficiency with which it is used
- improve the appropriateness and quality of the environment for patients and staff
- develop much more environmentally sustainable buildings and services
- create collateral for new sources of finance
- generate income from property rather than create one-off windfalls from sales – particularly when the property market is flat.

At the very least the contribution the estate can make to ‘social value’ in local communities should be a more important consideration.

## **Facilitating change**

### *Improving management*

The key issue is not the quality of operational estates management but rather the need for a strategic property management function. There is a strong case for NHS organisations to develop much better expertise in this area. For most organisations this will mean buying in advice rather than developing it in-house. Boards need to develop a more strategic approach to the estate and to think much more creatively about how it is used.

This may relate to a more general problem about the need for much more robust long-term strategies led by clinical and population health considerations. The regular disruption of the commissioning function has not helped with this. The track record of strategic planning is not encouraging, and if local area teams are to take on this function, the quality and robustness of the analysis needs to improve significantly.

### *Townlands Community Hospital, Henley-on-Thames*

Proposals for a new community hospital to replace a dilapidated health facility on the Townlands site in Henley-on-Thames have been through various iterations for more than 15 years. Townlands Hospital sits on a 6.5 acre site of prime land value, close to Henley town centre. The original hospital site included listed buildings that had to be retained. Successive business cases were not able to progress for financial reasons, and at one point the hospital was identified for closure. However, in 2010 Oxfordshire Primary Care Trust sought commercial advice on how to secure the investment required for a new modern and safe health care facility. This led to an innovative solution that delivered significant value for money to the NHS.

The whole site was split into three sections. The first section, the site of the original hospital, was sold freehold. The listed buildings were refurbished, and the additional development around them was designated as private older people's housing, including extra-care. The second section was sold on a long lease to Order of St John to build a care home, which included facilities for patients with Alzheimer's disease.

The income from these two transactions was used as a pre-payment on a lease to a developer to build and maintain a new community hospital. The tenants of the new hospital include a community services foundation trust, an acute foundation trust and a national hospice operator.

The commercial transaction made innovative use of the intrinsic value of surplus land in order to modernise the estate. The commercial approach to designing the site generated significantly greater income than the original value of the dilapidated buildings.

### *Investment decisions*

More attention needs to be given to the total value a building generates over its life. This includes the quality of the environment, the benefits of adaptability and wider impacts such as environmental sustainability. The incentives in capital funding have tended to lead to designs that are less adaptable and often house functions that could be provided in cheaper buildings.

### *Options for ownership and financing*

The ownership model, payment methods and incentives in the current system are likely to make it difficult for all but the largest organisations with a substantial portfolio of spare assets or access to reserves or charitable funding to make major changes to their estate. Hospital trusts with one or two sites are constrained by their relatively small scale and lack of flexibility. Mental health and community trusts with large portfolios of small and often unsuitable properties lack the collateral to raise money for major change and have the challenge of managing a very complex portfolio, often including properties with complex legal covenants and restrictions. The primary care estate lacks the scale needed to support future service models, and new facilities often replicate the fragmentation of the old system.

At the seminar we ran on the future of the NHS estate, participants agreed that a much more radical and strategic approach is required. Some of the participants thought that it was unfortunate that some trusts have benefited from windfall gains by inheriting large and valuable estate that is potentially surplus to their requirements, while others, in desperate

need of change, upgrading, or complete reconfiguration, had very little access to capital or useful legacy assets.

A number of ideas for new approaches to ownership and financing were suggested at the seminar and in conversations with experts, as explored below.

### *Splitting ownership from operation*

The NHS should consider creating one or more not-for-profit property management companies to hold assets for small and medium-sized hospitals. These companies could incorporate the community assets taken over by NHS Property Services – a company set up by the Department of Health to develop and manage estate, property and facilities transferred from primary care trusts and strategic health authorities. They could also hold assets for local government and other parts of the public sector where the use of the estate could be rationalised across the wider system. For example, schools and libraries are often appropriate venues for many types of health services.

While in this scenario the property would still belong to the state, it would be managed by a professional property management company. The company would be paid on results, including its use of assets to improve social value in communities and to maximise both the income available for services now and the flexibility for investment in new services in future.

#### *Department for Work and Pensions estates and facilities management*

The Department for Work and Pensions (DWP) occupies almost 1,000 properties across the United Kingdom for job centres and other services. The vast majority of these are occupied under the Private Sector Resource Initiative for Management of the Estate (PRIME) contract, which is held by Telereal Trillium and took effect in 1998 to run for 20 years. Under the contract, DWP transferred almost all its property portfolio to Telereal Trillium, which provides a full facilities-management service, including maintenance and refurbishment, cleaning, catering and portering (DWP 2013).

The advantage of using large property management companies is that they have a portfolio that can be used to smooth the flow of capital, where previously a hospital may have had to sell land or buildings to fund a development. Depending on the status of these companies they could issue bonds to create lower cost and more flexible sources of finance that would not carry the same inflexibilities as PFI.

A more commercial version of this approach is the creation of a real estate investment trust (REIT), which allows shareholders to invest in a wide portfolio of property. REITs are exempt from corporation tax and the returns can be redistributed to the shareholders. They may also be listed on the Stock Exchange. With appropriate partners, foundation trusts could invest in this type of model, which would allow them to raise money on investment markets.

### *Changing incentives*

NHS trusts are required to pay dividends to the Department of Health on the assets (buildings, equipment, etc) transferred to them on their formation (Public Dividend Capital). For those NHS providers that retain their estate, the return they pay could be increased to reflect more accurately the true costs of capital. This could provide an incentive to think about more innovative approaches to how their property is used. Previous reviews of this issue

suggest that this may not be a powerful enough approach to create the desired effect – there are so many other incentives and issues that finance directors have to balance.

Alternatively, there is an argument for splitting the tariff for some services into a fixed sum to reflect fixed and semi-variable costs, such as land and buildings, contracted over a long period and variable costs contracted over the short to medium term. This would allow time for the costs of capital to be adjusted.

### *Bonds backed by local community engagement*

An alternative approach could be to unlock some of the surplus assets in the system and support the financing of new schemes by making property-backed bonds available to the local public. These could be operated regionally and could be a focus for philanthropic investors. An important advantage of this approach is that it avoids the sale of assets and retains the ability to create funding streams for future investment. The trust as 'issuer' could source the funding and issue the bonds backed by the portfolio of assets; they could then use the income to pay the government a proportion of the initial transferred value of the portfolio and also to raise a development fund for new schemes.

### *Banking*

The absence of any sort of banking function in the NHS is a major obstacle to change. Organisations need to be able to borrow not just for buildings and equipment, but also to restructure their operational and business models. The best UK example of this model to date was regional health authorities' long-term financial support to allow the closure of asylums and the development of community services in the 1980s. A banking function could use bonds or the property fund model described above to create working capital.

### *Multiple occupancy of buildings*

The multiple use of buildings should be encouraged. It might be worth reconsidering whether regulators or commissioners could insist that a provider makes its facilities available to other providers. This proposal was dropped from the Health and Social Care Bill and there are some significant practical difficulties to be overcome, but it could be a useful lever for providing new and innovative solutions where market entry is difficult. Careful planning and piloting would be required before widely adopting this approach.

## **Conclusions**

There are some lessons from the past that providers should heed when thinking about new assets.

- Where possible, try to use buildings and assets that belong to other bodies.
- Where this is not possible, build in a way that allows much more flexible use of the building.
- Avoid creating highly specialist facilities that will be under-used and avoid adopting very specific designs, room types, etc.
- Check that the specifications for new buildings are not replicating models suited to current users or based on practice that may already be changing.

Beyond this there are more general policy lessons.

- Providers need to develop joint ventures and alliances with organisations that understand property management.

- Investment in large numbers of individual primary care schemes that are not linked to a wider strategy should be avoided.
- Great care is required before any further major hospital investment is made.
- Governments and regional authorities currently lack the necessary property management expertise and are too distant from where the decisions need to be made. This needs to be addressed.

A new approach to the design and operation of the estate and new partnerships with other parts of the public, private and voluntary sector are now required to release money and creativity and allow the development of some very different models. The expertise and vision to do this across whole systems, while currently in short supply, is crucial to unlocking innovation.

To comment on these ideas and continue the debate, go to [www.kingsfund.org.uk](http://www.kingsfund.org.uk) or [#kfthink](https://twitter.com/kfthink)

## References

Darzi A (2008). *High Quality Care for All: NHS Next Stage Review final report*. CM 7432. London: The Stationery Office. Available at: <http://www.official-documents.gov.uk/document/cm74/7432/7432.pdf> (accessed on 14 May 2013).

Department for Work and Pensions (2013). 'Estates and Facilities Management'. Department for Work and Pensions website. Available at: [www.dwp.gov.uk/supplying-dwp/what-we-buy/estates-and-facilities](http://www.dwp.gov.uk/supplying-dwp/what-we-buy/estates-and-facilities) (accessed on 7 May 2013).

Fulcrum (2013). 'Orford: Together delivering community services' [online]. Case study. Fulcrum website. Available at: [www.fulcrumgroup.co.uk/case-studies/orford/](http://www.fulcrumgroup.co.uk/case-studies/orford/) (accessed 23 May 2013).

LiveWire (2013). 'About Us – Lifestyles' [online]. LiveWire website. Available at: [www.livewirewarrington.co.uk/about-us-lifestyles](http://www.livewirewarrington.co.uk/about-us-lifestyles) (accessed on 7 May 2013).

McKee M, Edwards N, Atun R (2006). 'Public-private partnerships for hospitals'. *Bulletin of the World Health Organisation*, November, vol 84, no 1). Available at: [www.ncbi.nlm.nih.gov/pmc/articles/PMC2627548/pdf/17143463.pdf](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2627548/pdf/17143463.pdf) (accessed on 9 July 2013).

NHS Information Centre (2013). 'Hospital Estates and Facilities Statistics' [online]. NHS Information Centre website. Available at: [www.hefs.ic.nhs.uk/ReportFilter.asp](http://www.hefs.ic.nhs.uk/ReportFilter.asp) (accessed on 24 May 2013).

The King's Fund is an independent charity working to improve health and health care in England. We help to shape policy and practice through research and analysis; develop individuals, teams and organisations; promote understanding of the health and social care system; and bring people together to learn, share knowledge and debate. Our vision is that the best possible care is available to all.

[www.kingsfund.org.uk/think](http://www.kingsfund.org.uk/think)  
[#kfthink](https://twitter.com/kfthink)

The King's Fund  
 11-13 Cavendish Square  
 London W1G 0AN  
 Tel 020 7307 2400

Registered charity: 1126980  
[www.kingsfund.org.uk](http://www.kingsfund.org.uk)