NHS Property and Estates

Why the estate matters for patients

An independent report by Sir Robert Naylor
for the Secretary of State for Health

March 2017

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The supporting evidence for this review, the Kings Fund Evidence Review and the Analytical Report are available at:
https://www.gov.uk/government/publications/nhs-property-and-estates-naylor-review

1. Executive summary

The 1962 Hospital Plan for England created the hospital system we have today. This review presents the opportunity to rebuild NHS infrastructure to meet modern standards of service delivery for the future.

Without investment in the NHS estate the Five Year Forward View (5YFV) cannot be delivered, the NHS estate will remain unfit for purpose and will continue to deteriorate.

The form of the estate must follow the service strategies evolving through local Sustainability and Transformation Plans (STPs) – a process that needs acceleration and incentives.

My review set out to develop a new NHS estate strategy, which supports the delivery of specific Department of Health (DH) targets to release £2bn of assets for reinvestment and to deliver land for 26,000 new homes. As the Spending Review period has already started, and recognising that changes to the estate can take significant time to be realised, this review has also considered the opportunities presented in the medium term. This work suggests that the NHS can release £2bn of assets and deliver 26,000 homes and with an effective programme of interventions in high value propositions in London, this could significantly increase the property receipts to a figure exceeding £5bn in the longer term.

The general consensus is that the current NHS capital investment is insufficient to fund transformation and maintain the current estate. We estimate that STP capital requirements might total around £10bn, with a conservative estimate of backlog maintenance at £5bn and a similar sum likely to be required to deliver the 5YFV. This could be funded through property disposals, private capital (for primary care) and from HM Treasury. However, the NHS needs to develop a robust capital strategy to determine the final investment requirements through the STP plans.

This report therefore calls for the NHS, through the STP process to rapidly develop robust capital plans which are aligned with clinical strategies, maximise value for money (including land sales) and address backlog maintenance. Government should support these plans by providing capital, but only where a strong case has been made. The review recognises that STPs are at different points in their development so we do not expect all areas to progress and require funding on the same scale or at the same time. The allocation of additional public funds should be proportional to the amount received from property disposals.

There is no traditional business case to justify investment in backlog maintenance. In essence, it represents historical under-investment and the failure to fully commit capital allocations in the past. The business case for investment in the 5YFV will need to be agreed by the NHS through STPs.

This review was predicated on widely accepted assumptions that the NHS estate is not currently configured to maximise benefits for patients or taxpayers. It considered:

- the size of the opportunity – building on the Carter Report on efficiency;
- the mix of incentives and sanctions required for delivery;
- how to strengthen capacity and capability across the system.

The review commissioned detailed external analysis, which when combined with our own analysis identified gross risk-adjusted capital receipts of £2.7bn from inefficiently used land and property, perhaps substantially more with beneficial planning permissions. It also suggests significant service reconfigurations are required to maximise value, but these must be led by the relevant STPs. These disposals could deliver ongoing revenue savings exceeding £0.5bn per annum.

It is our view these targets will not be achieved without incentives for providers.

Swift action needs to be taken to accelerate change and build momentum in the system to capitalise on these opportunities. Opportunities exist in the short term to make running cost savings and to cut out waste through better utilisation of existing premises, even before rationalisation of the estate.

Despite the fact that gross proceeds will in many cases be subsumed in reprovision costs, this investment could dramatically reduce backlog maintenance and will produce a fit for purpose, more cost efficient estate, which enables better patient care.

We have developed recommendations for action based on extensive engagement with a wide range of key experts and stakeholders. In particular, I am extremely grateful for the input and wisdom provided to this report by the Advisory Group to the review (Appendix C). I am also grateful to all the trusts who responded to my call for evidence letter of 2nd August; they provided the review with excellent insight into the experiences and local perspectives on the challenges we are facing.

In addition, we considered an evidence review undertaken by The King's Fund and detailed modelling analysis undertaken by Deloitte. Both the evidence review and modelling analysis are published alongside this document.

2. Recommendations

Our recommendations fall into three categories. They set out how we can improve our capability and capacity, support action at a local level and develop a robust and sustainable strategy that enables the estate to support transformation in the NHS.

The Secretary of State for Health has already taken action to begin the design of a new NHS Property Board. The then minister, Lord Prior, started this process through his letter to DH arm's length body (ALB) chairs of 24th November 2016.

Improve capability and capacity to support national strategic planning and local delivery

1) Establish a powerful new NHS Property Board which provides leadership to the centre and expertise and delivery support to Sustainability and Transformation Plans (STPs). It should be a strategic organisation, at arms-length from the Department of Health and structured so that it empowers speedy executive action and professional credibility within the sector. To include a regional structure, which is aligned with NHS England (NHSE) & NHS Improvement (NHSI) and brings together functions of NHS Property Services (NHS PS), Community Health Partnerships (CHP) and other fragmented NHS property capabilities into a single organisation.

2) Establish the NHS Property Board in shadow form immediately (involving key staff from NHS PS and CHP) and substantively by April 2018. It should consider if the functions and residual assets it inherits from the abolition of Primary Care Trusts (PCTs) should be divested back to providers. In the interim NHS PS and CHP should focus on addressing their well-documented operational challenges.

3) The NHS Property Board should urgently bring together and expand the current strategic resources into a new national strategic planning and delivery unit to support local areas and strengthen capacity to deliver major projects.

4) The NHS Property Board should be the primary voice to the system on estate matters and should work with national bodies to ensure that the system receives clear and consistent messages about the importance of developing a modern fit for purpose estate, releasing land and addressing backlog maintenance.

5) The NHS Property Board should produce improved guidance on estates planning and disposals for the NHS, covering the scope of estates planning, accessing private sector expertise, models for affordable housing for NHS staff and partnerships with both housing associations and developers.

6) The NHS Property Board should produce improved guidance on building standards so they support the Five Year Forward View (5YFV) and deliver value for money. This should gather evidence on the most appropriate estate models through the vanguards programme and should prioritise new guidance on primary care facilities.

7) The NHS Property Board should improve transparency and intelligent use of data. This should include extending the minimum estates dataset to cover all NHS funded care, improving the quality of existing data collections and taking ownership for the future development of the benchmarking developed as part of this review.

8) The NHS Property Board, in partnership with other national bodies, should review processes to ensure they are proportionate and effective. It should particularly consider the business case process, which is often seen as cumbersome, and a block to estates development.

Encouraging and incentivising local action

9) STPs should develop affordable estates and infrastructure plans, with an associated capital strategy, to deliver the 5YFV and address backlog maintenance. These plans should be supported by robust business cases. The new NHS Property Board should support the development of these plans.

10) STP estates plans and their delivery should be assessed against targets informed by the benchmarks developed for this review. STPs and their providers, which fail to develop sufficiently stretching plans, should not be granted access to capital funding either through grants, loans or private finance until they have agreed plans to improve performance against benchmarks.

11) At a minimum, the Department of Health (DH) and HM Treasury (HMT) **should provide robust assurances to STPs that any sale receipts from locally owned assets will not be recovered centrally provided the disposal is in agreement with STP plans.** This report recommends that HMT should provide additional funding to incentivise land disposals through a “2 for 1 offer” in which public funds match disposal receipts.

12) NHSE and NHSI should provide guidance on the relative roles of providers and STPs with respect of estate matters.

13) NHSE and the NHS Property Board should ensure primary care facilities meet the vision of the 5YFV. This should consider linking payments to the quality of facilities and greater use of fit for purpose standards. The NHS Property Board should support GPs to meet these standards, taking advantage of private sector investment.

14) Land vacated by the NHS should be prioritised for the development of residential homes for NHS staff, where there is a need. The NHS Property Board should support this.

15) Urgent action should be taken to accelerate the delivery of a large number of small scale and low risk developments to deliver housing.

Funding and National Planning

16) All national bodies should work together, sharing intelligence, to develop a robust capital investment plan for the NHS by summer 2017. This should maximise value for money and make a strong case for securing both the public and private investment the NHS needs.

17) Substantial capital investment is needed to deliver service transformation in well evidenced STP plans. We envisage that the total capital required by these plans is likely to be around £10bn, in the medium term, which could be met by contributions from three sources; property disposals, private capital (for primary care) and from HMT.

3. Introduction

The NHS estate is one of the key enablers to change in the health system and directly contributes to the delivery of high quality healthcare to patients. It is also a significant source of untapped value.

This review has been tasked with considering the options open to the NHS to achieve best value, from NHS property, in alignment with the delivery of the vision set out in the 5YFV, and to support a small number of high value property transactions in London.

In this chapter, we consider what we can learn from the evolution of the NHS estate and the impact this has on the challenges we face today.

3.1 A brief history of the NHS estate

Since the foundation of the NHS, the size and location of most hospitals has been driven by what existed rather than rational planning. In 1948, the NHS was a patchwork of around 3,000 hospitals, run by local authorities and voluntary organisations. The estate was in poor condition, with decaying buildings providing out-of-date services, which needed reorganisation and an increase in capital and revenue expenditure.

3.1.1 Early reforms

In 1962, the Hospital Plan for England and Wales established the current network of district general hospitals and envisaged they would form the mainstay of hospital provision for the populations they served.[1] It was supported by an increase in funding for hospital building projects, and effectively created an estates plan for the NHS.

This 10-year programme, however, was new territory for the NHS and it soon became clear that the 1962 plan had underestimated the cost and time it would take to build the new network of hospitals. In addition, economic pressures in the 1970s meant that the hospital building programme was reduced and so many smaller general hospitals continued to operate.

The 1990 NHS Community Care Act[2] prompted the move to more autonomous local NHS organisations and reduced the scope for estates planning at a national scale.

3.1.2 The 21st century

The 2000 NHS Plan introduced the ‘100 new hospitals’ building programme, supported by £7bn of capital investment through an extended role for the Private Finance Initiative (PFI). The plan also saw the introduction of NHS Local Improvement Finance Trusts (LIFTs) intended to deliver increased investment in primary care premises. Both PFI and LIFT have delivered a number of modern hospitals and clinics, but at a considerable cost in

on-going financing and facilities payments.[3] Meanwhile under-investment at a local level has created a legacy of backlog maintenance at other sites.

More recently, the last decade has seen a series of initiatives which have been designed to restructure the system. Of note is High Quality Care For All – NHS Next Stage Review 2007 by Lord Darzi, which developed a coherent service plan backed up with a high-level vision for the healthcare estate required for delivery.[4]

Following the Health and Social Care Act 2012, the NHS underwent a fundamental restructure including the abolition of Strategic Health Authorities (which co-ordinated investment in health facilities at a regional level) and the replacement of Primary Care Trusts (PCTs) with Clinical Commissioning Groups (CCGs). Unlike PCTs, CCGs were not empowered to own property hence the creation of NHS Property Services (NHS PS) to own many of those premises previously owned by PCTs.

Those with long memories will recollect that the various estate functions, particularly building and engineering, were well represented at the senior levels of regional, area and district health authorities during much of the history of the NHS. Successive reorganisations of the NHS have seriously eroded these capabilities to the extent that they hardly exist today. This has resulted in substantial reliance on external advice and serious deficiencies in strategic estate planning.

Whilst these reforms were intended to simplify and streamline the organisation of the NHS, they removed the last elements of regional and national strategic estates planning as none of the resulting national bodies have this capability.

More recently there have been positive developments to address these challenges such as the work of the Carter review, which is working with trusts to reduce unwarranted variation in their estates efficiency and the hiring of Strategic Estates Advisors by NHS PS and CHP. In our recommendations discussed later in this report, we look to build upon and accelerate these developments.

3.2 Lessons for the review

The NHS estate has continuously evolved. Investment has been sporadic, with two major capital injections in the 1960s and 2000s. Both times this investment sat alongside a major service plan, however, only the 1962 plan created a strategic re-design of the estate to enable reform of service provision.

Continuous reform has eroded estates capabilities and increased reliance on the private sector, leaving the NHS with a lack of regional and national strategic estates planning capability.

4. The current NHS estate

The NHS estate is both large and varied, reflecting the wide range of services provided by the health system, but it is of variable quality.

In this chapter, we set out what we know about how the estate is currently configured, its legal status, form, size and state of repair.

4.1 Defining the NHS estate

This review defines the NHS estate as the estate used to deliver NHS-funded services, not simply the estate owned by the NHS. GPs as independent practitioners largely own the premises from which they deliver primary care, with charities, social enterprises and independent providers also playing an important role. For this reason, we have not included estate used to deliver social care or privately funded health care.

4.2 Legal status of the NHS estate

The NHS estate is occupied under a wide variety of legal arrangements, and the differences between these arrangements determine whether or not the NHS can direct how estate is used or vacated and also where the benefits from disposal of surplus property reside.

4.2.1 Estate owned by provider trusts

NHS foundation trusts and NHS trusts own the freehold to the majority of the land that they occupy, but lease some land and buildings.

With the exception of arrangements governing the former PCT estate and PFI contracts, NHS provider trusts generally retain all the beneficial rights of ownership to the freehold properties that they own.

4.2.2 Estate owned by other providers of NHS-funded care

Together general practice and independent providers, including charities and dentists, accounted for around a quarter of the NHS budget in 2015-16, but relatively little of the estate that these providers use to deliver services is owned by the NHS. Generally, they enter into their own arrangements to access the estate required.

In some cases, this estate is owned or controlled by an NHS body and leased to the providers. For example, NHS PS owns and then leases space to GPs, and CHP hold the head lease on LIFT buildings and then sub-let space to GPs. This accounts for fewer than 1,500 practices of the 7,600 GP practices in England. This means that significant areas of NHS-funded services are provided out of facilities over which the Government (NHS) has neither a freehold nor leasehold interest.

4.2.3 Contractual and regulatory requirements for providers of NHS-funded care

The major control of the quality of the estate used to deliver NHS-funded care is regulation by the Care Quality Commission (CQC). Providers, including hospitals and GPs are required to register with the CQC and are inspected to ensure they are delivering safe and effective care. Regulation 15, issued under the Health and Social Care Act 2008, states that all premises must be "suitable for the purpose for which they are being used, properly used, properly maintained, and appropriately located." Further detail on the suitability of premises is set out in the CQC provider handbooks, and inspection frameworks, which cite Hospital Building Notes (HBNs) as relevant professional standards.

Additionally within primary care, there are conditions within contracts, which require premises to be "suitable for the delivery of … services and sufficient to meet the reasonable needs of the patient."[5] Premises reimbursement for GMS contracts is also linked to achievement of both statutory standards and contractual conditions.[6] However, there is little evidence that these requirements are sufficient to drive the changes needed in the estate to develop new and improved models of care.

4.3 Survey of the NHS estate

4.3.1 Overview

Based on the analysis undertaken for the review, NHS provider trusts occupy:

- over 1,200 sites;
- 6,500 hectares of land;
- buildings with a gross internal area of 26 million square metres.[7]

In addition, there are:

- over 7,600 GP practices in England;
- over 100 licensed independent providers of NHS healthcare, many of which operate out of multiple sites.

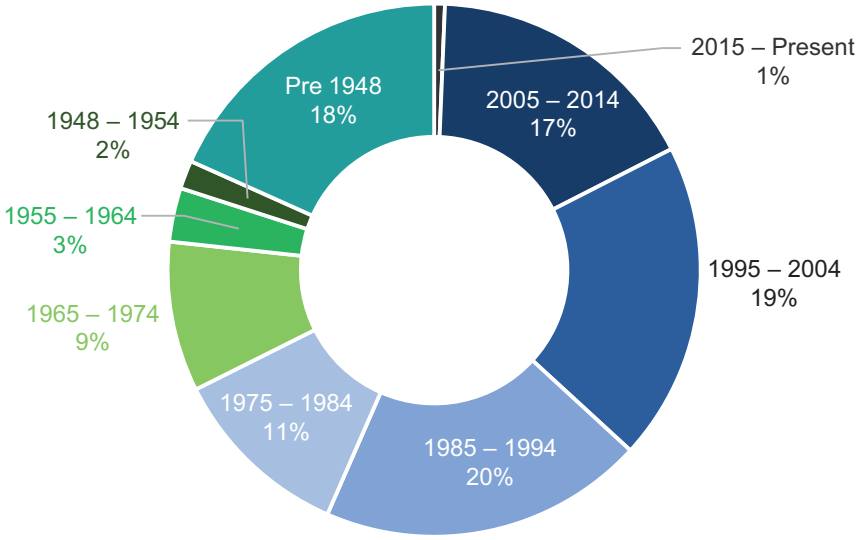
The NHS only collects comprehensive information on the estate owned by NHS provider trusts, via the Estates Return Information Collection (ERIC) return. This lack of data is a significant limitation in respect of national intelligence and strategic estate planning on the estate used to deliver primary and community care.

The estate covered by ERIC, which is the majority of the NHS estate by both land area and internal area is predominantly occupied by acute providers (54%), with mental health providers (34%) representing the next largest component. Analysed by internal area the picture is similar, but with an even greater preponderance of acute estate.

4.3.2 Condition of the estate

As outlined in Chapter 3, despite various hospital building programmes, NHS provider trusts still occupy significant estate that predates the formation of the NHS (18%) or is more than 30 years old (43%).

Figure 1 – Age of NHS Provider Estate



Naylor Review: Data Analysis Report - Based on 14/15 ERIC Data

While this is not always a problem, as some older buildings have been upgraded to meet modern standards of care, it is still too often the case that the NHS is operating in inadequate facilities.

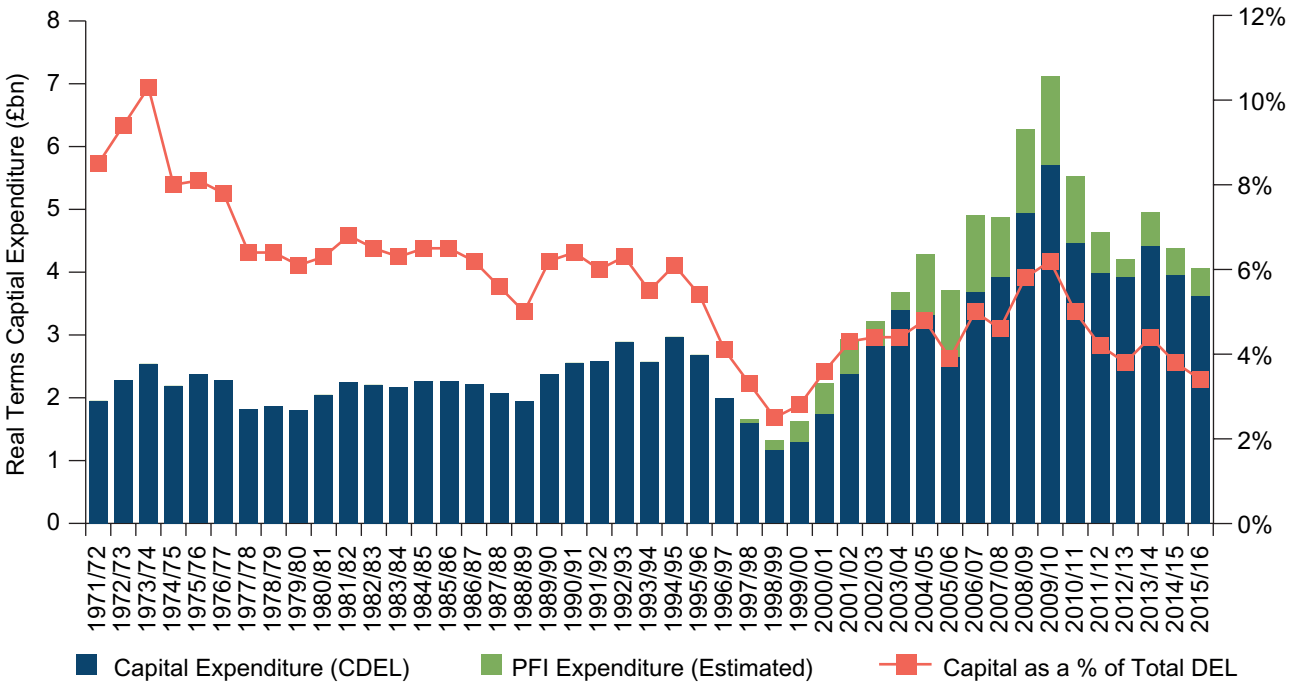
This is highlighted by the levels of backlog maintenance, which remain a significant problem across the NHS. The latest published figures suggest this has risen by over 9% between 2014/15 and 2015/16 to around £5bn, with £1.5bn of this in London. Furthermore, these figures suggest that the backlog maintenance of critical estate functions has risen faster than the overall average. Following discussions with NHS trusts, we believe these figures to be understated because there has been no real incentive to report the situation accurately.

No equivalent national data is collected on the maintenance of the primary care estate. Anecdotal evidence suggests the age and condition of the primary care estate is no better than that owned by NHS provider trusts. Certainly, the 30% of GP branches having a list size under 4,000 patients are unlikely to be large enough to meet the vision of person-centred care set out in the 5YFV.

4.3.3 Capital Investment in the Estate

The following table illustrates the historical trend in capital investment in the NHS.

Figure 2 – Historical trends in capital investment



Capital investment was around £4bn per year over the term of the last parliament, higher than the long-term average, but we have still witnessed rising backlog maintenance.

These recent investment figures would have been higher if the Department of Health had not transferred £950m from its capital to its revenue budget in 2015-16, which was partly facilitated by incentives on NHS providers to reduced local capital expenditure by £331m.[8] Continuation of these transfers will create significant challenges in maintaining high quality patient care and delivering the 5YFV.

This analysis excludes the primary care estate where the majority of patient contacts take place. NHS England has a small programme of capital grants to build or expand primary care premises, but this will be inadequate to facilitate the vision of the 5YFV.

4.4 Lessons for the review

While some broad knowledge of the NHS estate is captured within the current ERIC data collection, more granular detail of its size, type of properties, use, value and ownership is needed to make informed decisions about future strategic investment.

It is clear that there still is a driving need to modernise the estate. Dealing with the challenge of significant levels of backlog maintenance is a priority for the future estates strategy.

5. The future estate required to deliver the Five Year Forward View

The 5YFV sets out a vision for the NHS's future direction; improving public health, patient centred care and integration of services across health and social care. This vision is being developed by local STPs, backed up by national service strategies for key areas of change such as mental health, urgent and emergency care, maternity services and general practice.

In planning and building an estate, which is fit to meet both current and future needs, the NHS will need to consider not only the impact of the 5YFV but also the changing demand for care, driven by the aging population and the potential impact of new technologies. In this chapter, we deal with each of these factors in turn.

5.1 The implications of the Five Year Forward View ambitions

While there are few explicit references to the estate in the 5YFV, it does propose the development of new models of care. These models will have varying degrees of impact on the NHS estate, but given the emphasis on expanding and strengthening primary and out-of-hospital care, it will not be possible for the NHS to achieve its vision without changes in the estate.

Three of the national transformation strategies will have a high impact on estate planning, namely general practice, the Multi-Speciality Community Providers model and mental health. There is also likely to be impact from the 5YFV for maternity and the integrated Primary and Acute Systems (PACS) model.

For example, delivering improved mental health care in community settings requires community facilities for service users, which in most places simply are inadequate. Delivering more midwife led maternity care could imply different labour units in many hospitals and more standalone midwife led units. Most fundamentally, integrating care and improving the scale and consistency of primary care requires a transformation in out-of-hospital care and the estate used to deliver that care.

We know patient access to primary care is highly variable across the NHS and many single-handed practices, which might be appropriate in rural areas, remain in urban conurbations. This pattern of provision is unlikely to promote the vision of the 5YFV. The model preferred to meet the future vision of care by this review is the creation of a network of large primary care partnerships, particularly in urban areas. These networks would have a sufficient numbers of practitioners to ensure easier access for patients across the extended working day and on a 7-day per week basis. Community nursing services should be realigned with these larger practices.

The review has concluded that major investment is required to develop new models of primary care that will be capable of dealing with the growing numbers of older patients with chronic diseases and with the increasing problem of delayed transfers of care.

As these new models are developed, the NHS should consider the value for money implications and build up evidence on the best and most cost effective way to meet people's health and care needs. NHS England should ensure that the vanguards programme builds in the evaluation of different estate models to deliver new models of care, developing the case for new capital investment in the estate.

5.2 Changing demand for services

While the 5YFV will require improvements to the NHS estate, we also need to consider, in parallel, the underlying demand for care.

Current estimates show that by 2030, the population in England will reach 60.5 million, a rise of 6 million (9.92%) from 2015. Meanwhile over the same period, the number of people aged 75+ is expected to grow by more than 50%.[9]

Driven in part by these changes, the Nuffield Trust has estimated that without action healthcare activity would raise over the next decade by the equivalent of 22 new hospitals of 800 beds.[10] It is our view that such an expansion of hospital capacity would not be desirable or fit with the vision of the 5YFV.

The implication of this is that even when the new models are fully successful we are likely to need to maintain a similar level of hospital capacity (eg. in terms of bed numbers) as at present. While there will clearly be opportunities to redesign individual services, or co-locate smaller facilities to improve patient care and efficiency, the review finds no evidence to support a reduction in acute hospital capacity unless proposals meet the reconfiguration criteria set out by NHS England.

There would be significant benefit to the NHS from improved projections of healthcare demand, which would aid both clinical, and estates planning.

However, efficiencies within the acute sector can be achieved without reducing capacity. Historical trends are illuminating here and our exploratory analysis shows the number of NHS beds reducing over time, activity rising and a growing estate. This indicates that the NHS has been very effective at treating more patients with fewer beds, but has failed to make the same progress in reducing its overall estate. This again reinforces the significant opportunity for estate consolidation without reducing overall capacity.

5.3 The potential impact of technology

The impact of technology, medical and IT, has had a major influence on the NHS and its estate in the past and will continue to do so in the future.

Current emerging opportunities for technology to transform care, such as online doctor services, remain at an early stage with unknown estates implications. At present, there is little existing evidence that emerging IT schemes will reduce the need for buildings in the NHS, and the Department of Health is advised to commission a study to evaluate its future impact. The new care models and vanguards programmes should build the gathering of evidence on the estate required to deliver new technologies, into their ongoing evaluation processes.

Further consideration of the impact of technology is beyond the scope of this report, but one thing that is certain is that it will continue to influence the way in which healthcare is provided, and the future NHS estate needs will have to evolve to encompass these changes.

We know too that the NHS has a chequered history of delivering new IT solutions and changes are often delivered at a fairly slow pace, due to the scale and cost of deployment and the number of different providers of care and IT systems. The Wachter review[11] tells us that the way the NHS looks in future will depend on how both patients and the NHS embrace new technology. Given this uncertainty, it will be critical for the NHS to ensure that future estates are flexible and can take account of new opportunities. The NHS should also use the new models of care programme to evaluate the impact of new technology, including their implications for the NHS estate.

5.4 Lessons for the review

The review concludes that the priorities for the NHS investment should be:

- delivering the Five Year Forward View;
- addressing inadequate healthcare buildings and tackling backlog maintenance (as highlighted in the previous chapter).

The current public capital budget for the NHS is insufficient to meet these priorities.

The review cannot precisely quantify the gap for two reasons. Firstly, the cost of implementing the 5YFV is unknown and for the purposes of this report could be in the region of £5bn. Some commentators have informed us that this may be an underestimate and the figure could be between £8-10bn. Secondly, we believe that the backlog maintenance figure of £5bn is a substantial underestimate.

We conclude that the likely additional capital requirement to be around £10bn, in the medium term this could be met by a combination of three sources, property disposals, private investment and public funding. However, the precise investment requirements will need to be determined through the STP process.

Without adequate capital investment, the 5YFV cannot be delivered; backlog maintenance will continue to increase with the inevitable consequence of a deteriorating NHS estate increasingly unfit for purpose.

6. The opportunity to release value from the estate

Releasing land from the NHS estate which is no longer required to deliver health and care services, is a major opportunity for the NHS.

The review has investigated the opportunities presented by releasing inefficiently used or unused land for other purposes, in particular for residential development.

Building on Lord Carter's review, which identified where buildings in acute trusts are under-utilised or excessively used for non-clinical purposes, this review has gone further, looking at how much space NHS trusts use to deliver each unit of activity.[12]

This review commissioned a detailed analysis and benchmarking from Deloitte (available alongside this report), which identified a risk-adjusted opportunity of c. £1.8bn, which could be released from the acute estate alone. Combined with our own analysis of the estate outside the acute sector, we estimate that the NHS could release estate valued at a risk-adjusted figure of £2.7bn.

We conclude that this estimate could rise significantly if the NHS adopts a more commercial approach to obtaining planning consent, negotiating affordable housing quotas and maximising value from the highest value sites in London.

6.1 Previous estimates of opportunity

Previous estimates of the value which can be released from surplus NHS land differ widely, for example:

- in 2013 Monitor estimated the opportunity of land disposal at £7.5bn;
- in 2014 Savills estimated that 300,000 homes could potentially be built on surplus or under-utilised NHS land;
- in 2015 The King's Fund suggested that £0.7bn in capital could be released from land which had been already been declared surplus.[13]

We considered these reports and the assumptions on which they are based, and set out to evaluate the real scale of opportunity through a comprehensive detailed analysis.

6.2 Review methodology

We wanted to understand better the scale of the opportunity and its geographical distribution and commissioned Deloitte to carry out a detailed analysis of potential opportunities. A copy of Deloitte's work is available alongside this report, which provides more detail on their approach and the findings.

The analysis focused on identifying variation in the efficiency with which NHS organisations use their land and buildings and then quantifying the opportunity if relatively poor performers increased their efficiency up to the benchmarks.

The key measures the benchmarking examined were:

- building efficiency, which considers the amount of space used for delivering services, as well as the amount of non-clinical space and the amount of unutilised space; and
- land efficiency, using metrics to calculate building and facility footprint as a percentage of the total site area.

In the review we assessed the opportunity by seeing how much improvement would occur if NHS trusts below the upper quartile (in terms of performance) moved up to this benchmark. These benchmarks were set based on comparing similar sites i.e. for the land efficiency metric sites were split into three groups for London, urban and rural. Further detail is available in the Deloitte report.

Existing benchmarks for non-patient floor space (35%) and un-utilised buildings (2.5%) were used.

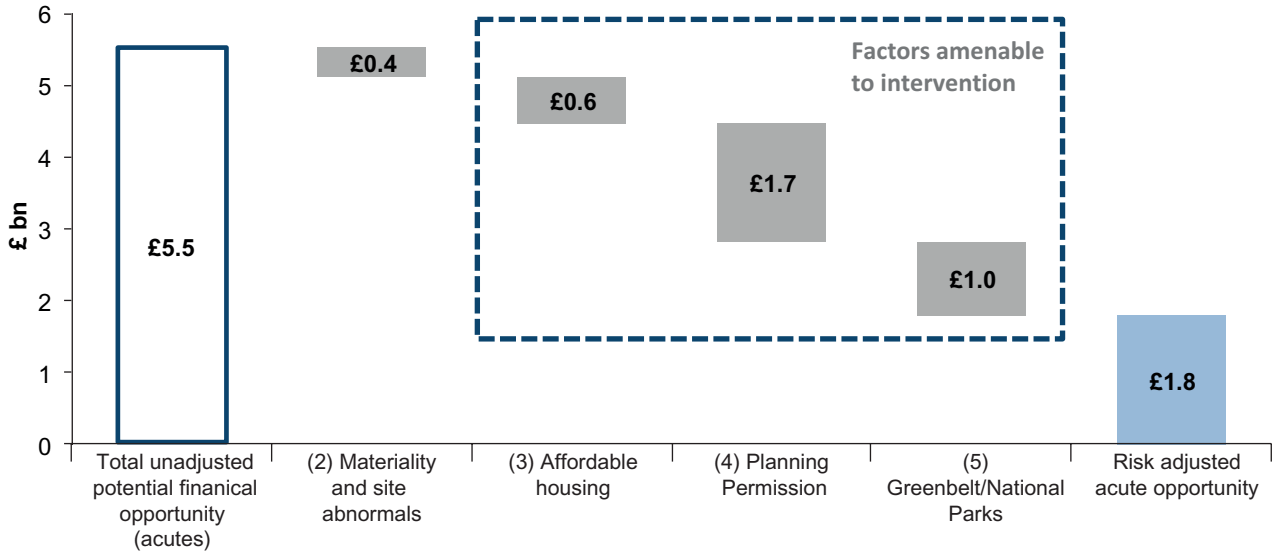
These benchmarks generated land opportunities which were valued using Department of Communities and Local Government (DCLG) benchmarks for residential development, adjusted for variations in price within local authorities. This opportunity was then adjusted for the risks that a site could not be developed to that potential. The valuation data is based on 2014/15 house prices, which may underestimate the current property markets. Similarly, the number of residential units that could be developed from this opportunity was estimated using benchmarks.

6.3 Review findings for the acute estate

From the analysis of the acute estate (54% of the total estate captured in ERIC in 2014/15), Deloitte conclude that the NHS could release land worth £1.8bn after risk adjustments for not achieving planning permission (£1.5bn), the provision of affordable housing (£0.6bn) and potential land within greenbelt or national parks (£1.0bn). This is lower than the £2.7bn set out earlier as it only relates to the acute estate.

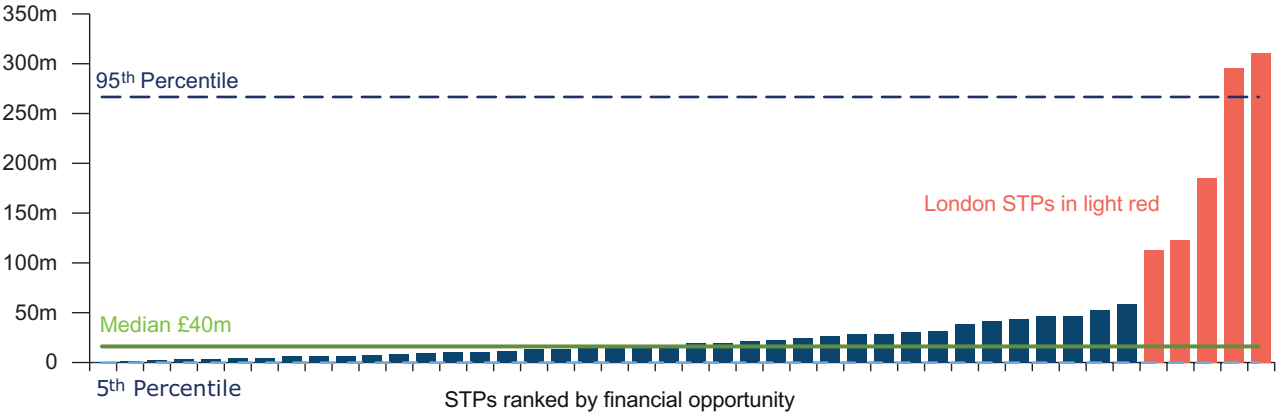
Although none of these risk adjustments can be entirely mitigated, the NHS could retain much of this value through a more commercial approach to estate management as outlined later in this report. This is illustrated in figure 3 below.

Figure 3 – Gross Risk Adjusted Potential Financial Opportunity (Acute sector only)



The distribution of this potential financial opportunity has been analysed by looking at individual sites and aggregating to STP level. The following Figure 4 illustrates the distribution by STP, which is heavily skewed towards London, which represents 57% of the total potential value.

Figure 4 – Gross Risk Adjusted Potential Financial Opportunity by STP (Acute sector only)



Source: Naylor Review: Data Analysis Report

Across all STPs, typically the majority of the opportunity comes from land efficiency rather than buildings efficiency. The detailed analysis for individual providers and STPs will be shared with the new shadow NHS Property Board, STPs and providers for validation and comment. We recommend that these benchmarks are used to inform targets for providers to improve efficiency and deliver property disposals.

6.4 Limitations of the findings

There are inherent limitations in estimating property values by top-down modelling and, based on the review's analysis of sites within London we think this approach underestimates the value of the estate.

For example, the modelling cannot capture opportunities represented by the most ambitious rationalisation plans. For instance, the consolidation of two inefficiently used sites within a trust is more likely to increase the opportunity compared to releasing a portion of each site.

None of the valuations take account of the impact of Brexit, and it is too early to make an assessment of this, as short term reactions are not a good guide to valuations over the medium term, which will be determined by the performance of the wider economy particularly in London.

The evidence we received suggests that the time period over which these opportunities can be released will be much longer than the current spending review period, particularly with schemes involving strategic rationalisation. Business cases for capital investment will need to take a long-term view, in most cases exceeding a decade.

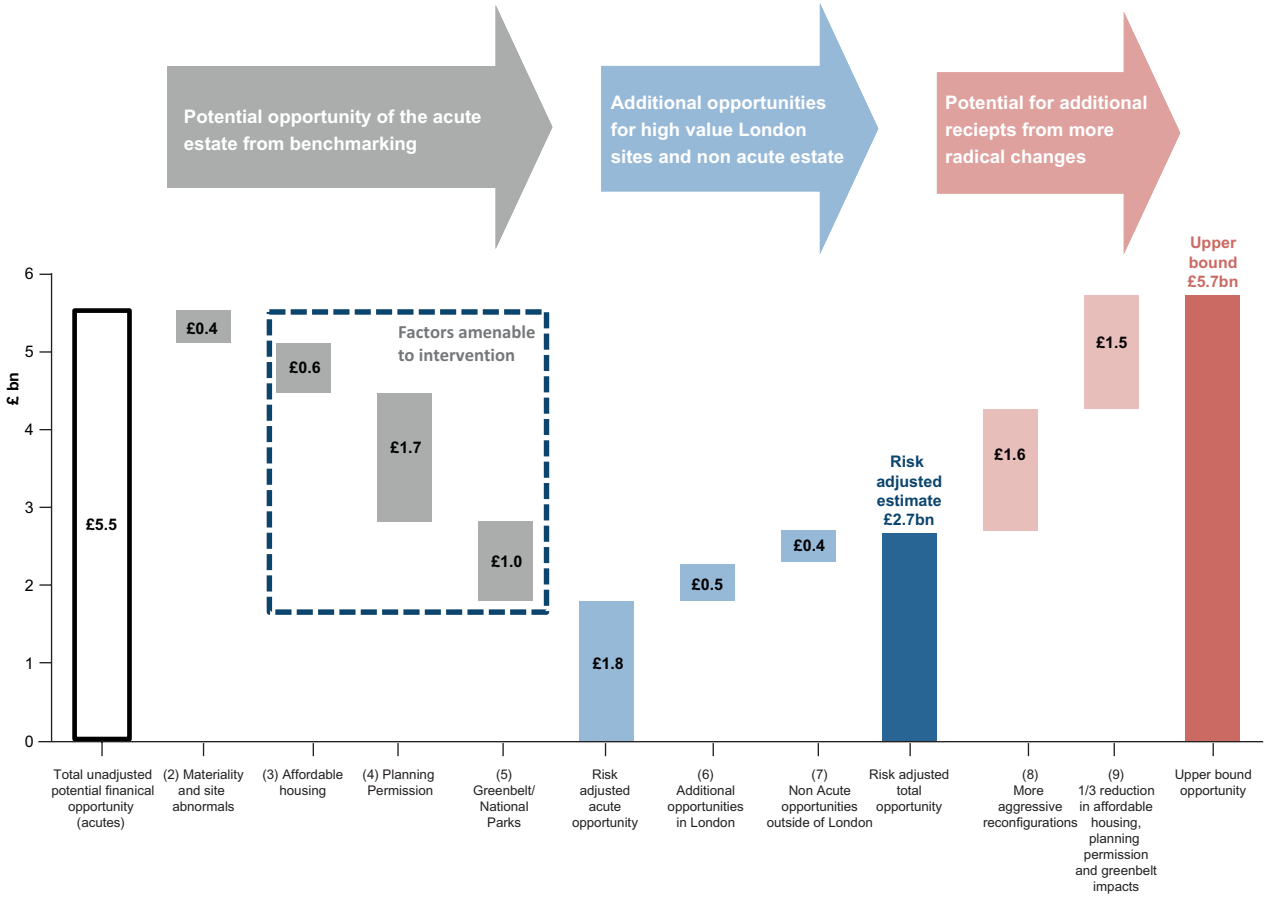
6.5 Review estimate for the total estate opportunity

The Deloitte analysis provides a solid basis for estimating the opportunity from the acute estate, but this represents just over half of the total NHS estate. Therefore, the review has undertaken its own analysis to estimate the additional opportunity from the mental health and community estate.

In addition, we have considered the impact of high value sites within London. This is based on a more detailed evaluation of the opportunities in London undertaken by the review.

This figure below gives our best estimate of the total opportunity.

Figure 5 – Estimate of total opportunity from land disposals



Source: Internal Naylor Review Analysis

Steps 1 to 5 are described in paragraph 6.3 above, based on the Deloitte analysis.

Steps 6 and 7 add the additional opportunity from the non-acute estate and additional opportunities in London (to reach a total of £2.7bn).

Steps 8 and 9 show how the estate could deliver significantly greater value if more radical reconfigurations were undertaken particularly within London, or if the risks associated with planning permission and affordable housing could be mitigated. This offers a potential upper bound opportunity of £5.7bn.

Delivering the more ambitious opportunities will be challenging and involve difficult trade-offs between objectives. For instance, reducing the planning permission risks might imply a reduction in open spaces, but could increase the potential number of new homes. This is a delicate balance, which the Government and the NHS will need to weigh and decide on how to prioritise.

Radical reconfigurations of services should not be undertake simply to release additional land but will need to be based on a full clinical case for change, both improving services and delivering better value for money. These proposals will need to be considered on a case-by-case basis taking account of local circumstance.

6.6 Revenue benefits from estate rationalisation

Rationalising the estate and releasing value as described above will also deliver revenue savings to the NHS. As noted in the Carter Report, moving to smaller buildings can deliver substantial savings for instance through reducing facilities management (FM) and heating costs.

The rationalisation described in this section could result in a reduction of NHS estate by around 5 million m^2. Applying the average FM costs to the acute estate findings leads to an estimated saving of £0.5bn per year from soft FM, rising to around £1bn per year if both hard and soft FM are included. These are necessarily high-level estimates and actual savings will depend on local factors.

The importance of achieving these savings should not be underestimated and could be used to support private capital investment or to improve patient care.

While these revenue savings overlap with those already set out in the Carter Report, they will only be fully delivered by moving to a smaller more efficient estate.

So far, the NHS has not focused sufficiently on estates rationalisation as a vehicle for moving to a more efficient, lower cost estate. Given the scale of opportunity identified above, the review considers that this approach should be revised. In future, plans for estate rationalisation should explicitly focus upon how they can reduce the running costs of the estate.

Furthermore as set out in Chapter 4, many clinical strategies to redesign local patient flows and treat people in more appropriate settings are reliant upon changes to the estate. Therefore, estates will continue to have a critical role in delivering the improvements in patient care and efficiency savings set out in the 5YFV.

7. Encouraging and incentivising local action

The analysis set out in previous chapters clearly establishes the opportunity for the NHS to realise additional value from its land, while also freeing up land for housing. This raises the question of why the NHS has not seized upon this opportunity to date. This review has identified two broad issues, which need to be addressed:

- the need to incentivise providers and STPs to take action and address backlog maintenance;
- the need to provide expertise to deliver on the opportunities outlined in this report.

In this chapter, we summarise how STPs and local providers should be encouraged to take action. In Chapter 9, we address the existing skills gap through the creation of an NHS Property Board.

7.1 The current incentives which influence behaviour

As discussed earlier, NHS providers have a high degree of independence over the management of their estates including investment, purchases and disposals. There is a need for central approvals for major investments and proposals requiring public funding, and in general, NHS trusts have a greater degree of central oversight than NHS foundation trusts.

NHS providers are not directed to dispose of surplus land or make particular investments. Instead, they are incentivised by the financial performance framework. The key influences are:

- a 3.5% annual cost of capital charged by the Department of Health on book values;
- allowing NHS foundation trusts to retain disposal proceeds and a de facto right of NHS trusts when proceeds are reinvested in new facilities;
- the provision of central capital or access to PFI to fund major investment projects;
- the inclusion of estate costs within the tariff for NHS services so if providers are able to provide care cost effectively they retain the difference.

In theory, the financial mechanisms described above should encourage providers to dispose of land where this releases value. However, this has not historically been the case, and providers have tended to hold on to land until they need funds to build new facilities. Additionally, the rapid rise of property prices has encouraged providers to hold onto assets as they appreciate.

7.2 How incentives could be strengthened

7.2.1 Centralised property ownership

The review considered the case for centralising the management of the NHS estate into a single property company, similar to many large private sector organisations. This could have significant benefits in supporting consistent planning across the NHS and deliver efficiency savings. However, this would require a massive structural re-organisation, requiring primary legislation, which is not desirable at this time, and would be contrary to the policy of devolution and local autonomy. It would also distance clinicians from seeing the estate as an enabler to the provision of high quality clinical care.

7.2.2 Tweaking existing incentives

We also considered options for changing the incentives trust face at a smaller, incremental level, for instance:

- increasing the capital charges from their current 3.5%;
- having greater charges on surplus land;
- having different charges for land and buildings.

These incentives can have positive effects and provide a helpful start to achieving change. However, alone, they are unlikely to have sufficient influence over behaviour given the scale of ambition set out in the 5YFV.

7.3 Our proposed framework

7.3.1 STPs as decision-making and planning units

In order to encourage the disposal of land, particularly to address backlog maintenance, the review concludes that we should explicitly link access to public capital with the achievement of property benchmark targets and strong engagement with STP service and estate plans.

In essence, if provider plans are not embedded in STP plans, which maximise disposals, address backlog maintenance, and deliver the 5YFV, then they would not be eligible to access public capital funding. Performance should be measured against hard-edged targets informed by the benchmarking developed as part of this review.

It is essential that local areas with agreed STP plans should retain receipts from locally owned property disposals. Greater clarity of this would provide reassurance and encourage further disposals either within STPs or aggregations of STPs.

This review calls for additional capital to address backlog maintenance and incentivise providers to dispose of property. This should take the form of a 2 for 1 offer in which providers are given additional capital to match their disposal proceeds. The allocation of

other national capital funding will need to take account of this offer to ensure that STPs which have lower opportunities for land sales are not disadvantaged.

This 2 for 1 offer should be time limited with a fixed funding pot and allocated on a “first come first served” basis. This will encourage STPs and providers to act quickly to take advantage of this opportunity and discourage them from holding on to land with the hope of taking advantage of this offer later. We envisage that this would initially be offered for a period of 5 years.

7.3.2 Devolution areas

This approach is complementary to the devolution discussion well advanced in Manchester and evolving elsewhere, such as in London. The review strongly supports this approach, which emphasises the need for engagement of local communities and the opportunities from working across the public sector. Within our framework, there is an opportunity for STPs to work together in aggregate if this fits better with local needs.

Estates have been a major focus of health and care devolution programmes in Greater Manchester and London. In both geographies, regionally-developed structures aim to enable collaborative decision making, leveraging the power planning and opportunities that local government can bring to bear. As my recommendations are implemented, consideration should be given to how governance and delivery can support the development of collaborative arrangements.

7.3.3 Conflicts of interest – STPs and providers

As already indicated, providers tend to hold on to property assets to fund their own interests when there might be a greater benefit in another part of the healthcare economy. The 5YFV and STP process is intended to address this problem, but it is unlikely that a provider would willingly give up property assets to support others with different statutory responsibilities.

In future providers need to be incentivised to support integration between primary, community and secondary care. This review is encouraged to see plans to develop accountable care, whereby an individual organisation becomes responsible for the health needs of a given population, rather than the fragmented system that currently exits.

The creation of accountable care organisations (ACOs) would overcome the conflict of interests that currently exist between the “advisory” role of STPs and the statutory responsibilities of NHS provider trusts. Primary care services could either be incorporated into ACOs or contracted to them via confederations of primary care providers.

The establishment of ACOs would incentivise acute providers to invest their property assets in primary, community and mental health services to enable more patients to be treated closer to home in line with the 5YFV.

We recognise that STPs will take time to evolve and indeed many organisations will retain their existing form or some other alternative. Consequently, it is recommended that NHSE and NHSI should provide guidance on the relative roles of providers and STPs with respect of estate matters.

It is vital that national bodies and the NHS Property Board send the system clear and consistent messages about the importance of developing a modern, fit for purpose estate, releasing land and addressing backlog maintenance. The review recommends that the NHS Property Board should be the primary voice to the system on estate matters.

7.3.4 Levers and incentives to support primary care

A key goal for estates planning in primary care is for the transformation of facilities to meet the vision of the 5YFV and support the co-location of services to support the health needs of the population.

Given the independence of the primary care sector which is largely already privately owned, active consideration should be given to how GP practices can be given incentives to move into new facilities, supported by substantial private sector investment. NHS commissioners and regulators have considerable latent authority to insist that premises be fit for purpose. These powers could be used far more explicitly to ensure that new investment is in line with the 5YFV and to force the pace of investment in or exit from inadequate premises.

There is also a case for changing the reimbursement payments of primary care practices for example by reducing payments for properties not meeting the future service strategy to encourage moves. Active engagement with the British Medical Association and Royal College of General Practitioners will be essential to driving real change on these issues, as the status quo will not deliver the change needed in this sector.

7.3.5 A continued focus on back office efficiencies

In line with the Carter Report recommendations, the NHS needs to exploit opportunities for consolidation and rationalisation of its back office estate.

Many public sector organisations have improved the efficiency and effectiveness of their office estates by bringing functions together, adopting industry standard space standards, embracing new ways of working, and active estate management. Cost reductions of 30% are often cited, and this should be a target for the NHS to achieve. By working with the wider public estate, and particularly the progressive work of the Government Property Unit around government hubs and one public estate, the scale of savings could potentially be much higher.

7.4 Recommendations

9) STPs should develop affordable estates and infrastructure plans, with an associated capital strategy, to deliver the 5YFV and address backlog maintenance. These plans should be supported by robust business cases. The new NHS Property Board will support the development of these plans.

10) STP estates plans and their delivery should be assessed against targets informed by the benchmarks developed for this review. STPs and their providers, which fail to develop sufficiently stretching plans, should not be granted access to capital funding either through grants, loans or private finance until they have agreed plans to improve performance against benchmarks.

11) At a minimum **DH and HMT should provide robust assurances to STPs that any sale receipts from locally owned assets will not be recovered centrally provided the disposal is in agreement with STP plans.** This report recommends that HMT should provide additional funding to incentivise land disposals through a "2 for 1 offer" in which public funds match disposal receipts.

12) NHSE and NHSI should provide guidance on the relative roles of providers and STP's with respect of estate matters.

13) NHSE and the NHS Property Board should ensure primary care facilities meet the vision of the 5YFV. This should consider linking payments to the quality of facilities and greater use of fit for purpose standards. The NHS Property Board should support GPs to meet these standards, taking advantage of private sector investment.

8. Creating more opportunities to build homes

There is a significant housing shortage in the UK, which is particularly acute in London and the south east. The NHS, as a significant holder of land needs to play its part in addressing this challenge.

Building more homes is the second key opportunity presented by unused or under-utilised NHS land and sits alongside the financial opportunity discussed earlier. In many cases, these two objectives can be delivered together.

This housing shortage has a significant impact upon the NHS. In terms of the health of patients, recent estimates suggest that poor quality housing is costing the NHS at around £4.3bn per year,[14] as well as the increasing evidence that the price of housing is creating recruitment and retention challenges, particularly in London and the south east.[15]

8.1 The current Department of Health surplus land programme

The Department of Health has been set a target to release land to build 26,000 homes by 31 March 2020. Its aim is to identify land for 33,000 homes, to mitigate the risk of slippage and to give the very best chance of meeting its target. While progress has been made, this target is challenging and there remains uncertainty about whether it can be delivered.

Given the short timescales remaining, urgent action should be taken to accelerate the delivery of a large number of small scale and low risk developments. For example, trusts with extensive car parks should consider developing multi-story facilities, thereby releasing land for additional housing. The NHS Property Board will need to build upon existing resources to speed up the process, driving forward progress with the disposal of sites that are already vacant or where limited capital investment is needed, in parallel with the longer-term recommendations of this report. There is a strong case for the NHS Property Board to have provision to support these schemes by providing streamlined access to loan funding.

8.2 Review analysis and findings

In line with Deloitte's analysis, the review has concluded that the NHS could, over time release land to build around 30,000 homes on the acute estate (after risk adjusting the opportunity for planning permission and greenbelt adjustments). We estimate that extending this to the whole of the estate would likely release land for an additional 10,000 homes, giving a total potential opportunity of 40,000 homes.

The review considers this number could increase significantly if action is taken to mitigate the risks, such as through enabling the NHS to take a more commercial approach to estate management.

The distribution of this potential housing opportunity has been analysed by looking at individual sites and aggregating to STP level. Figure 6 below illustrates the distribution, which is more evenly spread across the country than the financial opportunity, but is still substantially focused on London.

Figure 6 – Housing opportunity by STP (acute only)

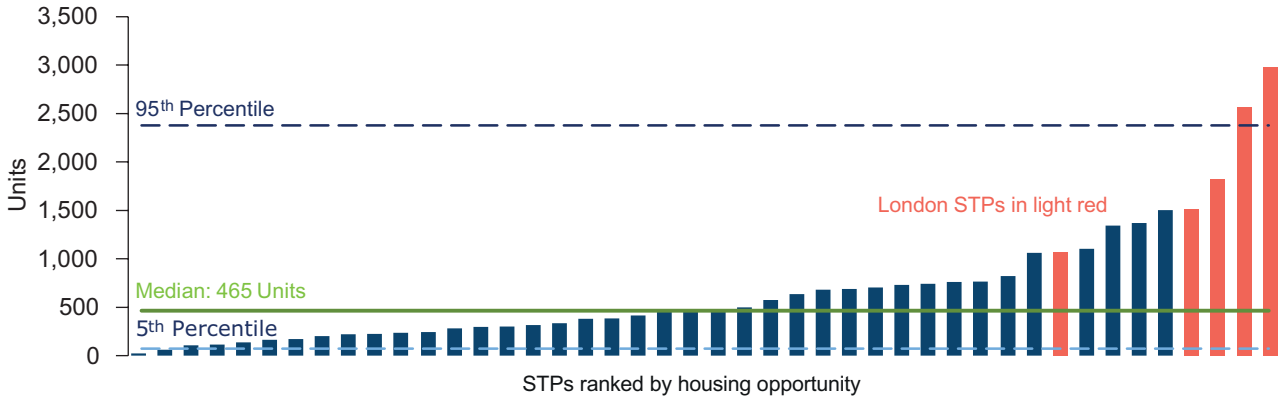


Table 2 below shows that while London has 57% of the opportunity in terms of value but this only equates to 33% of the housing units.

Table 1: Housing, Land and Financial Opportunity by region (acute only)

Region	Total Acute site area	Total Potential Surplus Land Opportunity	Risk Adjusted Total Potential Financial Opportunity	Total Potential Housing Capacity
	Ha	Ha	£ bn	#
All Regions	**3,548**	**1,322**	**1.8**	**29,922**
North	1,260 (36%)	470 (36%)	0.2 (12%)	8,343 (28%)
South	839 (24%)	321 (24%)	0.3 (18%)	5,302 (18%)
Midlands and East	1,051 (30%)	361 (27%)	0.2 (14%)	6,334 (21%)
London	398 (11%)	170 (13%)	1.0 (57%)	9,943 (33%)

Source: Naylor Review: Data Analysis Report

The same limitations apply to this top-down modelling as set out in Chapter 6 when we looked at the value the NHS can release. As before, there is the possibility for the NHS to significantly exceed these figures once the opportunities from other elements of the estate are taken into account and if the NHS is more successful at securing planning permission for development.

8.3 Homes for NHS Staff from surplus land

There is emerging evidence that high house prices, particularly in London, can make it more difficult to recruit staff, increasing reliance on expensive agency staff.

The NHS has historically provided a large number of staff residential units through nurses' homes and similar facilities. In recent times these facilities have become less well utilised as staff have chosen to buy their own homes.

However, there remains a substantial demand for affordable housing for less well-paid staff. Land sold by the NHS should be prioritised for the development of residential homes for NHS staff. This proposal has been discussed with a number of housing associations who have been asked to submit ideas on how this can be achieved. Alternatively, the NHS could create its own bespoke housing association.

Rather than simply renting these homes to staff, they could be leased for a period consistent with the duration of the employees' contract with the NHS. In this way, the employee could benefit from a share in any equity increase on their retirement and the property leased on to a new member of staff who could subsequently benefit in a similar way. It is recommended that this idea be progressed by the NHS Property Board. As part of this, the Board should develop a suite of models and guidance to support trusts in choosing the most appropriate option for their situation, recognising the importance of bringing together workforce planning and property planning.

8.4 Recommendations

14) Land vacated by the NHS should be prioritised for the development of residential homes for NHS staff, where there is a need. This should be supported by the NHS Property Board.

15) Urgent action should be taken to accelerate the delivery of a large number of small scale and low risk developments to deliver housing.

9. Capability and capacity to deliver

In this chapter, we explore the key principles that should be taken into account in the development of an estates strategy for the NHS and we recommend how to strengthen the capacity and capability across the system to support the system to deliver the 5YFV.

9.1 Developing an effective estates strategy for the NHS

We commissioned The King's Fund to undertake an evidence review on the current state of estates strategy in the NHS, and the key components of a comprehensive approach to strategic planning. The report from this work is available alongside this report and the broad conclusions are summarised in sections below.

9.1.1 Current state of estates strategy in NHS

- **there is currently no overarching estates strategy for the NHS; it is not clear where leadership for NHS estates strategy lies**. Different initiatives place responsibility with different parts of the system;
- **skills and capacity in estates strategy and management in the NHS largely reflects traditional skills, including technical knowledge and project management**. This will not be sufficient in developing a comprehensive estates strategy;
- **many local areas have established structures for place-based estates strategy and partnership working,** but the health sector has often been absent.

9.1.2 The features needed to create an effective estates strategy

In order to develop an estates strategy for the NHS, evidence suggests that the following features are needed:

- **a long-term vision for the NHS**, as the basis of an estates strategy and its delivery;
- **a clear understanding of the current NHS estate**, size, value and ownership;
- **clarity on leadership for estates strategy at different levels within the system**. To promote the vision for the NHS, and ensure that there are clear lines of accountability;
- **appropriate governance and decision-making processes across the system;**

- **access to the appropriate range of skills, to include technical and commercial skills, and in particular strategic estates skills**. It is important that strategic estates skills are developed within the NHS and embedded throughout the system;
- **capitalising on existing expertise.** A considerable body of expertise now resides within the public sector as well as within the existing NHS Property Companies;
- **a holistic approach, which considers the breadth of estates management.** Space use and environmental efficiency, as well as real estate, can provide increased opportunities to maximise outcomes;
- **partnership working.** This applies at all levels (locally and at central government level);
- **some degree of centralisation, particularly in terms of setting overall principles, objectives and standards** and **local autonomy responsive to local needs.**

Steps have recently been taken by DH and system partners to address some of these weaknesses, such as:

- aligning estates and clinical plans in the STP process;
- the recent provider engagement programme, which has been building a more robust understanding of the NHS estate;
- the creation of a group of strategic estates advisors from the two NHS property companies.

However, it is clear from the evidence that more action is needed to improve capability and capacity within the system to address the critical challenges of a lack of leadership, strategic direction, and to drive delivery.

The review recommends the creation of a powerful, new NHS Property Board to address these challenges. The Secretary of State for Health has already taken action to begin designing this body.

9.2 The new NHS Property Board

The NHS Property Board will provide a focus for the strategic development of the NHS estate and leadership across the system. Its key priorities should be to:

- provide leadership and support at all levels to support delivery of the 5YFV;
- develop and advise on commercial models to maximise value from the NHS, bringing in private investment and providing advice to the system;
- support the delivery of more homes for NHS staff (see Chapter 8);

- improve national and local intelligence on the estate. Creating the data infrastructure needed to support effective decisions;
- review and tackle inefficiencies in the system.

9.2.1 Provide leadership and embed strategic estates support at all levels of the system

The new NHS Property Board should bring together and strengthen existing capabilities and skills to ensure that the system's lack of strategic estates skills is addressed.

The focus should be on working with the NHS to support the development of the emerging estates strategies within STPs. The NHS Property Board should have a small central hub to support national functions but the majority of staff should be based in regional arms, aligned to the regional structures of NHSE and NHSI.

The NHS Property Board should consider how this strategic focus balances with asset management functions. In particular, it should consider if it continues to invest in property or, given the direction of travel for greater local ownership, it divests to providers the residual assets it has inherited from the abolition of PCTs. Similarly, it can be argued that the facilities management functions should be subject to competitive tendering with private sector providers.

9.2.2 Develop and advise on commercial models to maximise value

Private finance offers the opportunity to deliver facilities without short term recourse to public funds. Some providers have had mixed experiences of the cost and inflexibility of PFI and LIFT. However, the current low rates of return and the low risk profile of NHS investments means that there is likely to be no shortage of private capital finance available to the NHS.

It is vital that when developing their strategic estates plans, NHS providers have access to advice and support on the different commercial models available so they can consider how best to maximise value depending on their needs. The NHS Property Board should provide this support and develop a suite of tools to assist providers.

9.2.3 Improve national and local intelligence on the estate

There is a clear need to improve our data infrastructure to ensure we have accurate information that is aligned across systems. The Board should identify areas of inconsistency and improve the assurance of returns.

A revised core data collection on all estates used to deliver NHS services should be developed. This should include the key information about the property, specifically its location, size and internal area along with a unique site identifier so it can be linked to other NHS datasets.

The NHS Property Board should support publicly owned NHS providers to publish data on estates and upload this onto existing systems such as the Cabinet Office portal for public sector estates data.

The Board should build upon the benchmarking undertaken for this review, using data and information to drive decisions and develop an evidence-based estates strategy at both a national, regional and local level.

9.2.4 Reviewing and tackling inefficiencies in the system

Given the shortage of strategic estates capacity within the system we need to ensure that the capacity we have is used in the most efficient way to deliver the estate the NHS needs.

One aspect of the current system that has been repeatedly drawn to the reviews attention as an area of inefficiency is the development of business cases. While approvals are clearly necessary, the current process is cumbersome and seen to create additional work.

The review therefore recommends the NHS Property Board should consider how the process could be streamlined and improved. One improvement could be the development of a loan facility whereby the NHS Property Board has the authority to make loans, to meet up front development costs (where these support STP plans and cannot be immediately funded from internal or private resources).

The review considers that there is a strong case for linking this financing facility to some form of recyclable pot, possibly in the form of an NHS estates bond. This could allow providers selling land to bank capital receipts from the sales with the NHS Property Board, such a scheme is likely to be applicable to small scale investments which are justified on a clear value for money basis.

9.3 Recommendations

1) Establish a powerful new NHS Property Board which provides leadership to the centre and expertise and delivery support to STPs. It should be a strategic organisation, at arm's length from the Department of Health and structured so that it empowers speedy executive action and professional credibility within the sector. To include a regional structure which is aligned with NHSE & NHSI and brings together functions of NHS PS, CHP and other fragmented NHS property capabilities into a single organisation.

2) Establish this NHS Property Board in shadow form immediately (involving key staff from NHS PS and CHP) and substantively by April 2018. It should consider if the functions and residual assets it inherits from the abolition of PCTs should be divested back to providers. In the interim NHS PS and CHP should focus on addressing their well-documented operational challenges.

3) The NHS Property Board should urgently bring together and expand the current strategic resources into a new national strategic planning and delivery unit to support local areas and strengthen capacity to deliver major projects.

4) The NHS Property Board should be the primary voice to the system on estate matters and should work with national bodies to ensure that the system receives clear and consistent messages about the importance of developing a modern fit for purpose estate, releasing land and addressing backlog maintenance.

5) The NHS Property Board should produce improved guidance on estates planning and disposals for the NHS, covering the scope of estates planning, accessing private sector expertise, models for affordable housing for NHS staff and partnerships with both housing associations and developers.

6) The NHS Property Board should produce improved guidance on building standards so they support the 5YFV and deliver value for money. This should gather evidence on the most appropriate estate models through the vanguards programme and should prioritise new guidance on primary care facilities.

7) The NHS Property Board should improve transparency and intelligent use of data. This should include extending the minimum estates dataset to cover all NHS funded care, improving the quality of existing data collections and taking ownership for the future development of the benchmarking developed as part of this review.

8) The NHS Property Board, in partnership with other national bodies, should review processes to ensure they are proportionate and effective. It should particularly consider the business case process, which is often seen as cumbersome, and a block to estates development.

10. Funding and national planning

The local plan described in Chapter 7 and the capability and capacity covered in Chapter 9 must be complemented with a national investment plan and the funding required for delivery.

10.1 The existing Spending Review settlement for Capital

Any assessment of how we prioritise future NHS investment proposals must start by recognising the capital budget set in 2015 Spending Review (SR15) settlement. This held the DH Capital Departmental Expenditure Limit (CDEL) flat in cash terms, thereby implying a reduction in real terms over the course of the Parliament. However, this tight settlement is mitigated by the intended sale of £2bn of assets releasing land for 26,000 new homes and freeing up funds for investment.

In practice, it is difficult to estimate how much capital investment the NHS will receive from the published figures because:

- the NHS does not receive all of DH CDEL as funds are used for other health purposes. For example, the national genomics programme;
- there are commitments to PFI funded projects that are not included in these figures;
- capital to revenue switches (which totalled £950m in 2015/16) are likely to continue with CDEL being used to support current services.

10.2 The absence of an overarching national picture of capital need

One consequence of the most recent changes to the structure of the NHS is that there is currently no single overarching picture of the capital investment need. This means there is no national visibility of the totality of investment plans in primary and secondary care in the future, affecting our ability to make a robust case for future investment. Whilst the recent STP submissions begin to create this picture the capital ‘ask’ within the plans are not realistic.

We recommend that there is a sharing of current intelligence amongst national organisations and the new NHS Property Board, to enable a better understanding of the capital investment decisions to prioritise public capital.

10.3 The need for investment

This report concludes that there is an urgent need for additional capital to address backlog maintenance and deliver the 5YFV. As a first step there should be a discontinuation of the practice of using NHS capital budgets to support current activity.

The precise investment required needs to be determined locally as part of the STP process. These STP plans need to take account of the estate required to deliver modern healthcare services and address backlog maintenance. However, there is likely to be an additional requirement of around £10bn. We suggest that this could be funded from land disposals, private finance and public finances.

We recognise the tight fiscal constraints and the need to ensure that this investment delivers value for money. STPs need to build the case for this investment, which is critical to delivering the 5YFV and correcting the historical underspending on backlog maintenance. Given the critical need for this investment, it will be vital to move quickly to develop, assess and fund these plans.

The quicker these funds can be made available the sooner benefits will start to be realised in terms of service transformation, patient care and land disposals. However, it will be critical that this investment is linked to the increase in capability to undertake strategic estates planning. Providing funding to STPs which do not demonstrate they can use it well would risk poor investment decisions leaving the NHS with an estate which doesn't meet its own and patients' future needs. Therefore as stated in Section 7 access to capital will need to be linked to the quality of STP plans including alignment with clinical strategies value for money and land disposals.

In order to achieve this provision of funds to STPs should take account of the following criteria:

- STPs must have strong local leadership and bring together all the key players in the local health economy;
- Estates strategy must align with robust clinical plans which deliver the vision of the 5YFV and improve patient care;
- STPs should make use of the resources already available to them including maximising their income from land disposals and taking advantage of appropriate private finance opportunities. To encourage this public funding should be linked to land disposals through a 2 for 1 offer;
- Estates strategies should be sustainable addressing backlog maintenance and maximising value for money;

10.4 Building the case for investment and a national plan

However, we recognise that the NHS needs to make a credible case for this investment. The gaps in skills and the lack of a national estates plan have often meant that local investment proposals lacked diversity.

The requirement for additional capital is broadly split between backlog maintenance and funding to support the 5YFV, but the case for each is quite different. The estimated £5bn of backlog maintenance is largely due to historical underfunding and failure to commit expenditure for this purpose. There is no credible business case for this investment, but without it the NHS estate will continue to deteriorate.

To address this, action is required at both a national and local level, STPs will need to work to develop credible plans, which maximises value for money, and make the case for investment. Any new investment should be made after evidencing that existing modern facilities in the local area are being efficiently used. However, at a national level DH and HMT will need to continue to send clear signals that funds will be made available for investment where this is backed up by evidence.

The review recognises that funds will remain constrained and therefore national bodies will need to bring together these STP plans to develop a coherent national plan. This will allow the development of estimates of overall capital need, the likely timing of investment and support strategic planning at a national level.

This national picture will also enable trade-offs to be made between different schemes to ensure that investment is focused where it will deliver the most benefit to patients. However, to build this strategic approach it will be critical that the system is provided with clarity about the funding available. Continuation of recent capital to revenue switches is both unsustainable in terms of overall funding and creates significant confusion within the NHS about the funds available. Going forwards greater clarity will support the delivery of the estate that the NHS needs.

10.5 The March 2017 Budget announcement on capital investment

The recent Budget announcements on capital investment[16] present a very positive step forward and will address some of the challenges outlined in this report. In particular, we would like to note two provisions in the budget;

- £325m of capital over 3 years to support local proposals for capital investment where there is the strongest case to deliver real improvements for patients and to ensure a sustainable financial position for the health service.
- In the autumn, a further round of STP proposals will be considered, subject to the same rigorous value for money tests. Investment decisions will also consider whether the local NHS area is playing its part in raising proceeds from unused land, to reinvest in the health service

A strong signal from government that high quality plans will be supported with capital is a vital step to building momentum at a local level. The challenge, as set out above, is now for the NHS supported by the new NHS Property Board to produce these high quality STP plans, which maximise the release of surplus land.

10.6 Recommendations

16) All national bodies should work together, sharing intelligence, to develop a robust capital investment plan for the NHS by summer 2017. This should maximise value for money and make a strong case for securing both the public and private investment the NHS needs.

17) Substantial capital investment is needed to deliver service transformation in well evidenced STP plans. We envisage that the total capital required by these plans is likely to be around £10bn, in the medium term, which could be met by contributions from three sources; property disposals, private capital (for primary care) and from HMT.

11. Appendices

Appendix A

Abbreviations

Accountable Care Organisations (ACO)
Clinical Commissioning Groups (CCGs)
Capital Departmental Expenditure Limit (CDEL)
Care Quality Commission (CQC)
Community Health Partnerships (CHP)
Department for Communities and Local Government (DCLG)
District General Hospital (DGH)
Department of Health (DH)
Estates and Technology Transformation Fund (ETTF)
Estates Return Information Collection (ERIC)
Facilities Management (FM)
Five Year Forward View (5YFV)
General Practice Forward View (GPFV)
Gross Internal Area (GIA)
Hospital Building Note (HBN)
HM Treasury (HMT)
Local Improvement Finance Trust (LIFT)
Multispecialty Community Providers (MCPs)
NHS England (NHSE)
NHS Improvement (NHSI)
NHS Property Services (NHS PS)
Primary Care Trust (PCT)
Private Finance Initiative (PFI)
Provider Engagement Programme (PEP)
Public Dividend Capital (PDC)
Revenue Departmental Expenditure Limit (RDEL)
Strategic Estates Adviser (SEA)
Spending Review 2015 (SR15)
Sustainability and Transformation Plans (STPs)

Appendix B

List of Tables and Charts

Appendix C

The review's Advisory Board consists of the following members:

John Bacon, Chair Community Health Partnerships

Lord Patrick Carter, Chair Review of Operational Productivity in NHS Providers

Ian Ellis, Chair NHS Property Services

Sir Sam Everington, Chair NHS Tower Hamlets Clinical Commissioning Group

Sir Malcolm Grant, Chair NHS England

Lord Robert Kerslake, Chair Kings College Hospital Foundation Trust

Bruce Mann, Former Executive Director Government Property Unit

Francis Salway, Chairman TfL's non-executive property advisory group

David Williams, Director General Finance and Chief Operating Officer, Department of Health

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2 National Health Service and Community Care Act (1990), HMSO

3 House of Commons – Committee of Public Accounts (2007) The Provision of Out-of-Hours Care in England Sixteenth Report of Session 2006-07

4 Department of Health (2007) NHS Next Stage Review: High Quality Care For All, Cmnd 7432

5 Documentation on GP contacts availibe at: https://www.england.nhs.uk/gp/gpfv/investment/gp-contract/2016-2017/ GMS contract, clause 7.1. PMS contract, clause 7.7, APMS contract, clause 6.2

6 National Health Service (General Medical Services – Premises Costs) Directions 2019 clause 10 and schedule 1

7 Naylor Review: Data Analysis Report available at: https://www.gov.uk/government/publications/nhs-property-and-estates-naylor-review

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9 ONS (2017) 2014 based Subnational Population Projections

10 Nuffield Trust (2014) NHS hospitals under pressure: trends in acute activity up to 2022

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Savills (2014). Public Land: unearthing potential. 2014. P3
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15 http://www.bbc.co.uk/news/uk-england-london-36151927

16 HMT (2017) Budget Report – March 2017, HC 1025, HMSO
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