CIPFA

# Exploring challenges and solutions for the NHS estate

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# Executive summary

This report builds on a roundtable hosted by CIPFA, which brought together finance and estates professionals from the NHS and those with experience of partnering with the NHS to explore the challenges involved in NHS infrastructure planning and delivery. The discussion identified some potential solutions that the new Labour government could explore to support their mission to **build an NHS fit for the future** and contribute to the **secretary of state's commitment** to focus on the role of the NHS as an anchor institution to boost local and national economic growth.

## Summary of key points

Capital availability is a key challenge. Affordability and the current state of the estate can limit ambition, driving a tendency to focus on maintaining services rather than taking a more strategic, transformative approach.

- Overall levels of capital in the NHS should be considered and better aligned with policy priorities at local and national level. This should be reflected in how capital is allocated.
- Long-term strategic infrastructure planning needs to be matched with a multi-year capital settlement.
- Additional flexibilities to shift capital funding across time/partners should be explored.

Collaboration is key to maximising the NHS and wider public sector estate. Yet the NHS is often not perceived as a credible partner.

- Reliance on 'traditional' capital funding is unrealistic; new models of investment should be explored including those involving public and private sector partners.
- Rationalisation and optimisation of the existing estate is crucial, both within the NHS and across the wider public sector.
- Learning and experience from other NHS bodies, government departments, devolved nations and international examples should be harnessed to enable broader sharing of best practice.

Elements of the NHS capital regime have not kept pace with changes in structures, standards or policy and are obstructing infrastructure planning, delivery and collaboration.

- An end-to-end review of the capital regime is required to ensure it is streamlined and fit-for-purpose to support the desired outcomes. This should incorporate a review of the support, resource and skills required by NHS organisations

# The state of the NHS estate

## "Public services that have for years been creaking are now crumbling."

Performance Tracker 2023, the CIPFA/Institute for Government analysis of public services, showed that public service performance has been weakened by historic capital underinvestment. The UK has consistently under-invested in health-related capital in comparison to many other OECD countries, and evidence of this can be seen across the NHS estate:

- In hospitals, the estate maintenance backlog is at its highest ever level: £11.6bn in 2022/23.
- The New Hospitals Programme (NHP) has been repeatedly delayed and its future is uncertain, with the National Audit Office (NAO) raising doubts on whether it can deliver.
- The Fuller Stocktake suggested that the primary care estate is not fit for multi-disciplinary teams and needs to develop 'neighbourhood hubs' to co-locate integrated services.
- Capital constraints are impacting on the need for decisions to be made on the future of many NHS LIFT schemes.

Tight budgets and increasing demand pressures have meant transformation work is often delayed, or capital funding diverted. Between 2014/15 and 2018/19, £4.3bn of capital was transferred to cover revenue spending, with similar transfers being made to cover revenue pressures of £0.4bn in 2022/23 and £0.9bn in 2023/24. Even though capital budgets are tight they are often underspent at national level, and as highlighted by the NAO, "capital investment does not always achieve the level of infrastructure originally planned". The long-term consequences of all of this are clear in the decline of the NHS estate, which is in turn hindering productivity, as recognised in a recent NHS England board report.

Like many others, CIPFA have called for a long-term capital programme to address this historic underinvestment and support an NHS estate that is fit for purpose and aligned with the policy agenda around the closer integration of services, with an emphasis on prevention to improve outcomes for citizens and ensure vital services are financially resilient and sustainable.

# Developing local NHS infrastructure strategies

Integrated care boards (ICBs) are developing ten-year infrastructure strategies to improve health and care services across their area and prioritise their share of capital funding. These plans are also serving a number of other, perhaps competing, purposes at national level:

- aligning with national NHS objectives, including sustainability and net zero goals
- informing the development of national infrastructure priorities by NHS England, to demonstrate to government how and where capital investment is required
- focusing on "how the NHS estate's cost-effectiveness, productivity and efficiency can be increased and long-term running costs reduced", as highlighted in a recent NHS England board paper.

While all participants were supportive of a more strategic, long-term, locally led approach to planning, our discussion identified some challenges that may constrain truly strategic infrastructure planning.

## Availability and timing of capital funding

The elephant in the room is how much capital funding is actually available. In many areas, capital allocations have not kept pace with existing challenge of population growth, rising demand for services, and condition and compliance issues in the existing estate.

> The capital departmental expenditure limit (CDEL) for 2024/25 is £12.6bn. Recently, The Health Foundation estimated the need for future CDEL based on two scenarios:
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> For 'minimal change' (ie funding rising to just meet demand) capital allocations would need to increase to £15.8bn over the five years to 2029/20, and to £17.3bn over the ten years to 2034/25, meaning real terms annual growth of 3.2% over ten years.
>
> For 'sustained improvement' (ie increasing funding to include service improvement and clear the backlog, with a shift towards prevention and out of hospital care) capital allocations would need to increase to £20.5bn over the five years to 2029/30, and to £26.7bn over the ten years to 2034/25, meaning real terms annual growth of 7.8% over ten years.

Our discussion included examples of service failures occurring as a result of this. Such incidents can be caused by disrepair in NHS buildings, others are due to the inability to replace reinforced autoclaved aerated concrete (RAAC) in NHS buildings. This issue of service failures 'happening day in, day out' was recognised in evidence from the NHS England CFO to the Public Accounts Committee.

Where capital funding is available, it is often ringfenced for specific national priorities (eg diagnostics or digital). Where NHS bodies do have funds available for use, there are tensions regarding how this can be used, given the constraints of the capital regime and the need to remain within the overall CDEL envelope.[1]

1 Further detail on the NHS capital regime can be found in HFMA, Introductory guide to NHS Finance, Chapter 14: capital funding, planning and accounting (April 2024) and NHS England, Capital guidance update 2024/25 (May 2024).

A particular challenge is the mismatch between the ten-year infrastructure planning horizon and the lack of a multi-year capital settlement, giving NHS bodies little certainty of their capital allocations. Capital allocations are often time-constrained and must be used within the financial year, which can result in a 'frantic' rush at year-end, capital being used sub-optimally and underspent at national level.

> "There are so many longer-term things we could be doing, which would be more in line with strategy...but you almost end up pushing them to one side, because of the lack of a multi-year capital settlement. We've pressed the department on this a number of times, but they keep coming back with one-year spend, and then you hear that capital is underspent at national level. Surely this is just the mechanics of the system..."

These frustrations around the level and pace of capital spending are also complicated by external factors, including rising building costs, higher financing costs, capacity of the construction industry and impact of the recent period of increased inflation, all of which make the delivery of capital projects extremely difficult.

Long-term strategic infrastructure planning needs to be matched with the long-term certainty of a multi-year capital settlement. The Labour government's commitment to set three-year allocations in future spending reviews goes some way to addressing this. However, the current system of single-year time-constrained capital allocations is hindering a more strategic consideration of the NHS estate and collaborative opportunities.

## Tensions of competing priorities and affordability

Given the limited capital funding available and the state of the estate, there is a risk that infrastructure plans are primarily driven by affordability and focused on 'keeping the rain off'.

It was felt that the NHS has a tendency to replace existing assets as they fall into disrepair, to preserve current delivery models in the short/medium term and avoid issues around public perception of 'closing' existing facilities. Taking a more ambitious and transformative approach often seems unrealistic, as reliance on NHS capital allocations alone is not a viable mechanism of funding this.

> "...we wait a long time to be told capital [funding] is available, and when it is then some of those burning platform estates issues drive service reconfiguration where services just have to be replaced."

Transformation and shifting models of care rely on additional resource elsewhere. For example: replacing outpatient consulting rooms with virtual appointments needs support for virtual outpatients; reducing the number of elective beds needs community assets to support the reduced bed base; diagnostics on the high street requires capital cover to enter into leases. But experience of seeing capital bids fail, or funding being downscaled, creates reticence, due to the risk of whether both the acute and community elements of business cases would be approved, and funded, simultaneously.

There is some dichotomy in NHS policy which can create tensions in infrastructure planning. For example, where an NHS hospital may be failing and needs to be decommissioned, an ambitious strategy may consolidate acute services across other providers in the area and deliver an alternative infrastructure. However, one framing of NHS policy states that more general and acute beds are needed to provide for the future, while in contrast the NHP started out by reducing bed numbers.

At national level, there is perhaps the hope that the NHP will somehow "come to the rescue of failing hospital sites", but participants felt that it would need to move a lot quicker, include more sites and so require more funding. This seems unlikely given the NAO's concerns over the existing programme and whether it can deliver as planned. There are already sites where NHP bids have been unsuccessful and backlog maintenance has worsened, meaning the "capital programme is prioritised to ensure the estate continues to run in a safe and operational manner for our patients and staff and to avoid, wherever possible, any disruption to services".

Overall, there was concern that continuing to simply replace existing infrastructure does nothing to advance service transformation and improve outcomes, nor to grasp opportunities to unlock greater economic value through proper estates planning within the NHS, or across the wider public sector estate.

> "...trying to fund the same thing over and over again, with a smaller pot of money and growing demand, seems to me to be not particularly likely to be a successful strategy...we need a different plan."

A different form of strategy is required, with clarity on levels of available funding over appropriate timescales. Rather than being constrained by inputs such as increasing demand, condition and availability of funding, it should be focused on the outcomes to be achieved: a revised operating model, community collaboration, improved population health and wellbeing and wider economic benefits.

## Is the NHS capital regime 'frustrating' capital delivery?

Infrastructure planning should be driven by clinical, or broader health and wellbeing, strategy. Given that this has been clear for many years, participants discussed why the NHS still doesn't seem to have cracked it. It was felt this is partly due to the fact that the NHS capital regime is almost designed to frustrate capital delivery.

There is a perception of only 'one way of doing things' in relying on available capital allocations. It was suggested that this could actually be at odds with HM Treasury's Green Book, which encourages exploring a range of models.

> "...the capital regime encourages NHS organisations not to be masters of our own destiny in setting out a clear estates strategy."

Even where there is 'political' support for specific priorities, the mechanics of the regime are not designed to support delivery. The systems of capital allocation and control are still rooted in the internal market system, which has now largely been abolished, yet the capital regime has not been updated to reflect this.

Elements of allocative inefficiency are built into the system. The NHS tends to focus on specific diseases/conditions, and accessing various pots of capital funding depends on guessing what the next 'political' priority will be, while Green Book guidance is quite focused on projects rather than being geared towards strategic estates planning. Such factors frame thinking, rather than considering what is required to achieve system priorities and deliver a more sustainable model of care.

There was recognition that there is a tendency in the NHS to complain about the regime, and in HM Treasury to complain that the "NHS doesn't do capital well", and there may be elements of truth on

both sides. Our discussion compared approaches in the NHS and other government departments. In the NHS, individual trusts will develop business cases, which then need to pass various levels of approval before reaching NHS England/the Department of Health and Social Care (DHSC), slowing the process. When it arrives at HM Treasury they wonder why it's taken so long and question the contents. Other departments often have dedicated teams, with input from HM Treasury, to build the business case, which may be approved within the same department. The extensive process of approval in the NHS also acts a source of frustration for potential partners.

It was recognised that the NHS struggles to articulate benefits in business cases, but that this may be due to wider factors. When bidding for capital funding is determined by 'political' priorities then it may be a case of "a solution seeking a problem, rather than problems driving solutions", which contributes to this. There was also reflection on the dual nature of business cases in the NHS, reflecting the two types of strategy outlined above – justifying investment to maintain service levels, or more ambitious, transformative plans – and the recognition that the NHS may not be particularly skilled in differentiating between these. Further challenges related to the capital regime are discussed in later sections.

## Learning from experience of delivery – integrated care hubs

As highlighted in CIPFA's Integrating care: policy, principles and practice for places report there is significant variation among systems, including the nature of their relationships and history of collaboration. However, there are some good examples of infrastructure collaborations, for example around polyclinics or 'health hubs' involving multi-agency partnerships (as recommended in the Fuller Stocktake), from which lessons could be learned and shared.

Participants shared their experience of co-locating services and cautioned against the danger of designing hubs around a 'wish list' rather than robust strategy with a laser-like focus on the clinical and community benefits to be delivered. A clear vision of the outcomes, watertight governance and legal processes in such arrangements are essential, as well as clarity on what the actual accommodation requirement for the facility is and how it will be used.

There is a need for the business case to be managed across the life of the asset with clear communication across the system. This was highlighted by the issue of void space that has arisen in some Community Health Partnerships (CHP) LIFT schemes. While robust business cases were in place at time of investment, over time tenants have withdrawn without consideration of the wider impact and unintended consequences across the system.

While a centralised 'national blueprint' may address some of these issues, it was felt to be more important that local determination of need should be the driver for such facilities and the services they provide. However, it was agreed that it would be helpful to have a means of sharing best practice and experience more widely across the NHS from those who have embarked upon such projects.

# Multi-agency collaboration – one public estate?

A strategic approach to developing an infrastructure plan focused on improving health and wellbeing across each system calls for a truly collaborative approach. This is recognised in the guidance from NHS England which outlines that strategies should set out:

- an understanding of resources required at system level and how the system collaborates with partners including local government and the voluntary, community and social enterprise (VCSE) sector
- how they align with a number of national drivers, including One Public Estate
- how resource will be efficiently used to promote effective investment decisions, including through local government collaboration.

The discussion turned to why such multi-agency collaboration on estates is so challenging – particularly given that the One Public Estate programme has been around for many years.

## Optimising the existing public estate

The NHS estate is complex, with a number of differentiated asset ownership models: GPs, integrated hubs, NHS Property Services, Community Health Partnerships and over 240 NHS trusts. This adds to the fragmentation of the estate and complexity of managing multiple stakeholders in collaborative approaches. Yet this should not act as a barrier to collaboration within the NHS itself, or with other agencies, to optimise possibilities and rationalise the wider estate in the spirit of One Public Estate.

With limited capital available, most ICBs are realising the need to maximise the existing estate. Again, there are examples of repurposing or rationalisation from which learning could be shared. For instance, clinical facilities that are no longer fit for purpose can be modified to support other more administrative functions, or social prescribing, mental health, preventative or wellbeing appointments can be co-located in civic spaces such as churches, mosques or Citizens Advice Bureaus.[2] Each system's estates plans should include a regular review of how facilities are being used, to ensure that all space is being optimised, or how it may be repurposed to best effect.

Short-termism should not drive decisions on estates. It was suggested that some of the dwindling utilisation of CHP or NHS Property Services facilities is driven by the perception that they are more expensive. However, this does not take on board whole life operational and maintenance costs, and so is not comparing like with like. Similarly, providers may be trapped in facilities which are not fit for purpose because they cannot afford dilapidations liabilities to exit private leases. Given the current climate it is understandable that short-term decisions may have to be taken to remain within budget, but ultimately this causes future problems.

Collaboration with local government is a huge opportunity. Many councils have properties/accommodation that they are seeking to rationalise/consolidate, and have shared incentives around integrating care and improving outcomes for the population and wider economy. Such community assets

2 For example: Exploring co-located public mental health interventions in community spaces and impacts on health inequalities: a realist evaluation (NIHR, 2022).

present an opportunity to co-locate services and shift care closer to the community, providing health on the high street. It was recognised that such partnerships provide huge opportunities for the community, particularly around housing and the NHS acting as an anchor institution for the wider economy.

Again the NHS capital regime presents challenges, requiring capital cover for lease arrangements, as well as the revenue impact at a time when the NHS is "in the most constrained revenue position it has ever experienced". Such 'mechanical' issues should not act as a barrier, rather a finessing of the capital regime is in order to support a one public estate approach (discussed further under 'Collaboration is complicated by the capital regime' below).

There appears to be a tendency towards the 'illusion of control' in the NHS, ie the belief that to control a facility you must own/build it. Lessons could be learned from the shift in ownership seen in other central government departments, such as the Home Office and Defra sharing the Marsham Street development.

## Is the NHS a credible partner?

Faced with the NHS backlog maintenance and the fact that the NHP is unlikely to deliver any time soon, the discussion turned to the need for the new government to consider alternative investment strategies, as reliance on the use of 'traditional' NHS capital is no longer viable. Collaboration presents an opportunity, whether that be with local government in relation to making use of existing community assets and the potential to harness prudential borrowing flexibilities, or with the private sector in some form of public private partnership (PPP). Participants considered how attractive the NHS is as potential partner.

One ICB finance director set out their experience of a primary care estates programme. As the ICB cannot hold assets, this involves negotiating an agreement with the local government partner, while also negotiating a contract with GPs for the cost of the building. Simultaneously each individual project is going through the business case approval process, with a time-bound capital funding allocation, during a period of fluctuating building costs and inflation rates. The process should be streamlined to improve this operating environment and enable a more credible conversation with potential partners.

> "I just can't quite envisage how I could be a trusted or preferred partner with the existing NHS capital regime. People would look at me and just ask, 'you've got to do what to get this project off the ground?'"

Private sector partners emphasised the main challenge of working with the NHS compared to other agencies is around business cases and approvals (discussed above). Added to this are issues of limited, time-constrained capital funding and competition among NHS trusts. It was suggested that many private sector partners would 'run a mile' from NHS projects as the system is 'completely constipated'.

Contract management was suggested as something NHS partners could improve upon. There is a tendency to focus on new projects, rather than on the quality implementation and delivery of those approved. The business case is intended to be a living document to be managed over the life of the project, but teams and resources must be in place to support this, secure outcomes and ensure value for money. Updates to the Green Book have sought to address this, requiring the costs of contract management teams to be included. Examples were discussed of other organisations from whom lessons could be learned on contract management, such as Network Rail and Highways England.

Uncertainty and timing constraints around capital are also a challenge to multi-agency partnerships. Local government participants with experience in partnering with the NHS discussed examples where plans for integrated community-based facilities were well underway and the **NHS capital contribution was delayed** due to pressures at national level. Where partners have invested a significant amount of work and commitment to these projects this leaves them in a difficult position and perhaps reticent to enter into such partnerships in future.

Another participant shared experience of working with an NHS partner on a housing regeneration project incorporating a health hub, where the council were providing both the land and building. They described frustrations over changing specifications, and the difference in risk appetite, with NHS partners being extremely risk averse. If the expectation is for one partner to carry all the risk, this is hardly the basis for the robust relationships required for a successful partnership to secure the desired outcomes.

Despite current financial constraints, many councils do still have resources for the right community projects, and genuinely see the benefits of partnering with the NHS around aligned incentives to integrate care and boost the local economy. But these and other obstacles, such as issues around leases and IFRS 16 (see below) and the differential VAT regimes involved, often make it too difficult.

> "If the opportunities and outcomes are right, then local government has the risk appetite to deliver. We know the strength of our borrowing power, we should be a cheaper partner than the private sector, but the NHS has got to be a savvy client. So the desire is there but how we achieve it in a way that is equitable to both parties is the challenge."

## Collaboration is complicated by the capital regime

Aspects of the capital regime have been touched on already, but one particular aspect which was felt to hinder collaboration is the ability to enter into lease arrangements following the application of IFRS 16. This requires multi-year leases to have capital cover (and score against CDEL), rather than annual lease costs scoring as revenue. In the 2021 spending review, HM Treasury provided DHSC with **additional annual CDEL of £1.4bn** for IFRS 16 lease reclassification. Despite this, there is evidence that this is constraining investment decisions, with NHS bodies becoming more reticent to enter into operating leases.[3]

Although participants appreciate the intention to provide 'substance over form' accounting, there were concerns that IFRS 16 creates the situation where both landlord and tenant 'own' the asset. The question was raised as to whether this was appropriate in the context of One Public Estate – if one part of the public sector owns a building and leases it to another public sector body, should this create a call on capital?

There was also concern that finding workarounds may drive some 'odd behaviours', such as short-term leases or changing the risk profile. Again this raises questions around whether these are really the optimum solutions in terms of value for money, and whether accounting rules should be driving infrastructure/commercial decisions.

3 For further information, see **Delivering a general practice estate that is fit for purpose** (Institute for Government, June 2024), **Capital spending in public services**: Fixing how the government invests in the NHS, schools and prisons (Institute for Government/Grant Thornton, June 2024) and **'Inadequate' action on cap-ex changes leading to 'suboptimal' decisions** (HSJ, February 2024).

One obvious way to address this would be to ensure that adequate capital is provided at the next spending review to cover the impact of IFRS 16. Yet similar issues have not arisen in other countries that have adopted IFRS 16, which suggests that the accounting standard itself is not the problem, but rather it is the wider capital regime, including budgeting and accounting rules, which require revisiting.

As discussed earlier, there are other ways in which participants felt that the capital regime complicates collaboration. There is a danger that the more organisations involved in a proposition, the more it tends to be delayed as consensus takes time to obtain. Combined with the timing issues of business case approvals this can add to pressures and even risk the project, given the time-constrained nature of capital funding.

The discussion turned towards mechanisms that may be explored to ease these tensions, including:

- the possibility of passing capital funding to local government partners as grant allocations, who then have greater flexibility to take this forward to delivery
- models adopted by some infrastructure delivery bodies (eg National Highways) which have been granted multi-year flexibility on capital allocations; it was suggested that similar flexibilities could be granted to NHS Property Services, CHP or a newly created NHS infrastructure body
- local or national mechanisms for prioritising schemes, so if one is delayed another approved scheme can be brought forward. The national example of **independent sector treatment centres** under the Blair government, which was essentially forced through local NHS bodies in "a triumph of political capital over system resistance", was discussed as one way of achieving nationally led programmes, but involved huge costs and created a lot of ill-will across the sector. An alternative example was seen with the private finance initiative (PFI), where a central scheme oversaw and provided guidance to a series of local teams, who developed projects, pushing them through to enable locally led change.

# Capital availability and future of capital in NHS

Given the limited availability of capital in the NHS, most participants agreed that it was likely that the new government will need to consider alternative mechanisms for investment, and that some form of PPP could be revisited. Many others have recently echoed this.[4] While there was an understanding of the reluctance to bring back PFI in its traditional form, there was also frustration around the current refusal of HM Treasury to discuss private finance at all, particularly given concerns around the **future of the NHS LIFT estate**.

> "...unless we seek alternatives, then we are going to be perpetually looking at projects that have a high return on investment, but with no way to deliver them."

4 For example: **Reimagining estates funding** (NHS Confederation, July 2024), **The mythbuster: is bringing back PFI a necessary evil?** (HSJ, July 2024) and **NHS leader calls for partnership with private sector to build new hospitals** (The Guardian, July 2024).

However, they were keen to stress that this is not just about raising private finance, given that the era of 'cheap' finance has gone. So a new version of PPP should be focused on exploring new models of delivery, bringing the benefits of a consortium approach and expertise from the private sector. The old design, build, finance, manage and operate (DBFMO) models, had a tendency to get drawn into 'all or nothing' deals in terms of delivery. A more nuanced approach to PPP could be developed, which enables better understanding, management and evaluation of projects, and to address some of the wider challenges of infrastructure schemes identified above.

Risk transfer is an essential element. In the old models of PFI, where things went wrong, it was often relatively easy for the private sector partner to walk away. A key element of a new PPP model would be the need to ensure that all partners have 'skin in the game' on a long-term basis. Private sector partners need to carry a share of the risk, which may be challenging in the NHS context, and would need careful consideration of what the private sector could control. However, there are international examples of where private sector partners have carried demand risk, such as transport projects utilising dynamic pricing for toll roads. Similarly, public sector partners need to be more than just the client and need to be involved for the long-term rather than leaving all delivery to the private sector partner.

Sustainability and net zero commitments are looming on the horizon, with a lack of clarity on how this will be funded. While there have been some initiatives and pots of grant funding for infrastructure, the capital investment required to reach net zero, conduct decarbonisation and adaptation works in the NHS alone is likely to be huge. It was also recognised that sustainability and net zero concerns should also be shaping potential models for developing infrastructure, in terms of moving away from DBFMO models and more towards rationalising and refurbishment of the existing estate.

Examples were discussed from which lessons could be learned on what a new model of PPP could look like, including:

- various rail related developments, where Network Rail invited private sector partners to bid in the form of an HM Treasury-compliant business case
- examples from the LIFT portfolio where effective risk sharing has been achieved with private sector partners carrying risk that the public sector could not bear, such as housing developments where funding has been raised to incorporate health centres
- central government department deals incorporating elements of rationalisation, including the DWP, HMRC and MoD examples where the private sector was given the opportunity to consolidate the estate and re-purpose existing sites
- private sector deals such as the Santander contract with GE Lighting, which are beneficial not because of the finance aspect, but rather the project delivery and commercial incentives
- on an international level there are many examples of innovative models, and closer to home there is the **mutual investment model** in Wales and the **non-profit distribution model** in Scotland.

# Challenges and potential solutions

This rich discussion identified many challenges in relation to NHS infrastructure planning. However it clearly demonstrated a willingness and enthusiasm to move towards a truly strategic approach to NHS

estates planning, focused on transformation and improving outcomes for people, communities and the wider economy. It also identified some potential solutions to address the challenges involved.

## Challenge: Availability of capital funding

The greatest challenge in terms of NHS infrastructure strategies is the availability of capital funding. Development of local strategies is constrained by affordability, driving a tendency towards maintaining existing services, rather than a more ambitious and transformative approach focused on achieving outcomes to meet local need and national priorities. While more capital funding is clearly the ideal solution, in the current climate this is perhaps unrealistic.

- The government should consider levels of CDEL for the NHS at the next spending review, and re-balance spending to address historic under-investment and better align available capital funding with policy priorities, at both national and local levels. This should also be reflected in how the capital is apportioned and allocated at all levels.
- Long-term strategic infrastructure planning needs to be matched with the certainty of a multi-year capital settlement. The current system of single-year time-constrained capital allocations is hindering a more strategic consideration of the NHS estate and collaborative opportunities.
- Additional flexibilities for NHS bodies should be explored, such as the ability to shift capital across financial years, or pass it to partners who have greater flexibilities, in the form of capital grants.
- Regardless of the source of finance used for investment, a different form of infrastructure strategy is required at both local and national levels. One which is less influenced by the constraints of inputs and completely focused on the outcomes to be achieved, such as a revised operating model for a health and wellbeing service, community collaboration, improved population health and harnessing wider economic benefits. This will necessitate clear and coherent policy at national level, which must recognise the current challenges and not stymie nor compete with the ability for local levels to develop infrastructure strategy based on local circumstances and need.

## Challenge: Credible collaboration

Collaboration is key when it comes to infrastructure planning, both within the NHS itself and with wider partners. Yet often the NHS is not perceived as a credible partner.

- Given the current state of the NHS estate, rising demand and the ambition for transformation, reliance on the 'traditional' NHS capital funding alone is unrealistic. Other models and mechanisms for investment should be considered, in line with Green Book guidance. This should include other public sector partners on a One Public Estate basis, but also the possibility to explore new models of working with the private sector.
- Such collaborative approaches do not necessarily mean building new facilities. Rationalisation and optimisation of the existing estate is also a crucial element of estates planning, both within the NHS itself and across wider public sector partners to ensure that the public estate is used to its maximum potential and to better align with sustainability and net zero ambitions.
- At local level, infrastructure strategies should be regularly reviewed to ensure that the available NHS estate is being optimised, and possibilities should be explored, particularly with local government partners, around rationalisation of the public estate to harness wider opportunities and benefits.

- There are many systems with experience of different approaches to estates rationalisation and working in collaboration with local government partners to provide community-based facilities. Similarly there are lessons that can be learned from the experience of other departments/agencies, devolved nations and international examples of working with the private sector. This experience should be harnessed by central bodies such as NHS England, DHSC or dedicated infrastructure bodies, to raise awareness and enable broader sharing of lessons learned and best practice.

## Challenge: NHS capital regime

A recurring theme throughout our discussion was the many challenges presented by the mechanics of the NHS capital regime itself. Challenges identified included controls on capital spending, prioritisation of infrastructure schemes, business case approval, contract management through to capital accounting rules.

While individual elements of the capital rules and regime are all there for good reason, overall there is the perception that it may no longer support the desired outcomes and may in fact 'frustrate' capital delivery. This may in part be due to how it has developed over time and not been updated to reflect broader changes such as the removal of the internal market and the introduction of additional accounting standards.

- The government should take the opportunity to conduct an end-to-end review of the NHS capital regime, stripping out complexity, unnecessary layers of approval and aspects that may have unintended consequences, to ensure that the entire system and how it operates is lean, streamlined and fit for purpose, focused on supporting and driving the desired outcomes. This should be done in consultation with HM Treasury, DHSC, NHS bodies and wider partners.
- This should also incorporate a review of the support, resources and skills required in NHS organisations to ensure they are suitably equipped to support infrastructure planning and delivery.

# Moving forward

The new Labour government have shown early promise with their mission to build an NHS fit for the future and the secretary of state's commitment to focus on the NHS's role as an anchor institution to boost local and national economic growth. We hope that the challenges, opportunities and solutions outlined will aid consideration of how to address historic underinvestment and support the creation of an NHS estate which is fit-for-purpose and aligned with the policy agenda around closer integration of services, with an emphasis on prevention, to improve outcomes for citizens and ensure our vital public services are financially resilient and sustainable.

> "We are understandably focused on projects to fix the failing estate. But wouldn't it be nice to get that sorted so we could start to talk about the projects we could and should do in order to incentivise growth in life sciences, to create a world class centre to attract world-leading researchers? Health is 10% of the economy, the biggest employer in most places, and enables huge onward investment. We shouldn't have it on life support, we should be building the economy around it."

CIPFA is in a unique position to support and empower health and local government partners in their integrating care journey. Find out more about more about our work on Integrating Care: making it count, and the support and training we offer on property and commercial skills.

77 Mansell Street, London E1 8AN
+44 (0)20 7543 5600



cipfa.org

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