ADDLESHAW GODDARD

HOW CAN GREATER DEVOLUTION TRANSFORM THE NHS?

The Big Question Series

How can greater devolution transform the NHS?

Partnerships Bulletin

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ADDLESHAW GODDARD

Local Solutions

PAUL JARVIS
MANAGING EDITOR

Devolution was once the 'big idea' under previous Prime Minister David Cameron. Despite the obvious merits of giving greater power to those at a local level, the concept has never fully taken flight, and has fallen down the political agenda over recent years, particularly as Brexit has dominated both central government and local providers' time and energy.

However, the NHS has moved further down the devolution road than many and there remains a belief that giving greater responsibility to those at the sharp end of delivery will help to unlock benefits and improvements that are currently caught up in a sclerotic bureaucracy. When it comes to the NHS estate, that is especially true, with local providers best placed to make decisions on what services are needed and what the best forms of buildings are to provide those services.

Over the course of two roundtable sessions, experts from across the NHS came together to discuss these issues and try to build a more effective consensus on how to develop and deliver the estate that is needed for a modern health service.

While all agreed that the concept of devolution remains an important target to deliver progress, it was also clear that many barriers remain.

The events were held in London and Manchester, and alongside a number of common themes, the two destinations threw up some significant differences in the priorities discussed by practitioners. Of particular note was the way in which Manchester's combined authority is taking a more central role in the delivery of healthcare services. Its interaction with the local NHS providers, on both the public and private sides, is still in its relative infancy, but offers signs of how local authorities can work with the health sector to deliver a holistic solution to a region's needs.

At a higher level, however, there are frustrations that were common to both debates, perhaps most notably regarding the need for leadership. One overarching concern that clearly influenced both events is the suspicion that central government has been willing to give responsibility for outcomes to local organisations, but without providing the clear pathways for decisions to be taken – and who should be taking them. As a result, some organisations find progress increasingly difficult, with no-one empowered to make the bold decisions that are necessary.

Another key consideration is utilisation. Although central government, through various initiatives, has long urged better utilisation of the existing estate, the clear feeling from practitioners is that this is still not happening enough. In primary care, there is a growing frustration around the lack of incentives for better utilisation of the estate and both the public and private sectors acknowledge that this is an area that must be improved before any decisions are made on what 'new' buildings are needed.

For devolution to truly work, there needs to be consistency of funding and responsibilities passed down to the relevant organisations so that they can deliver what is being asked of them.

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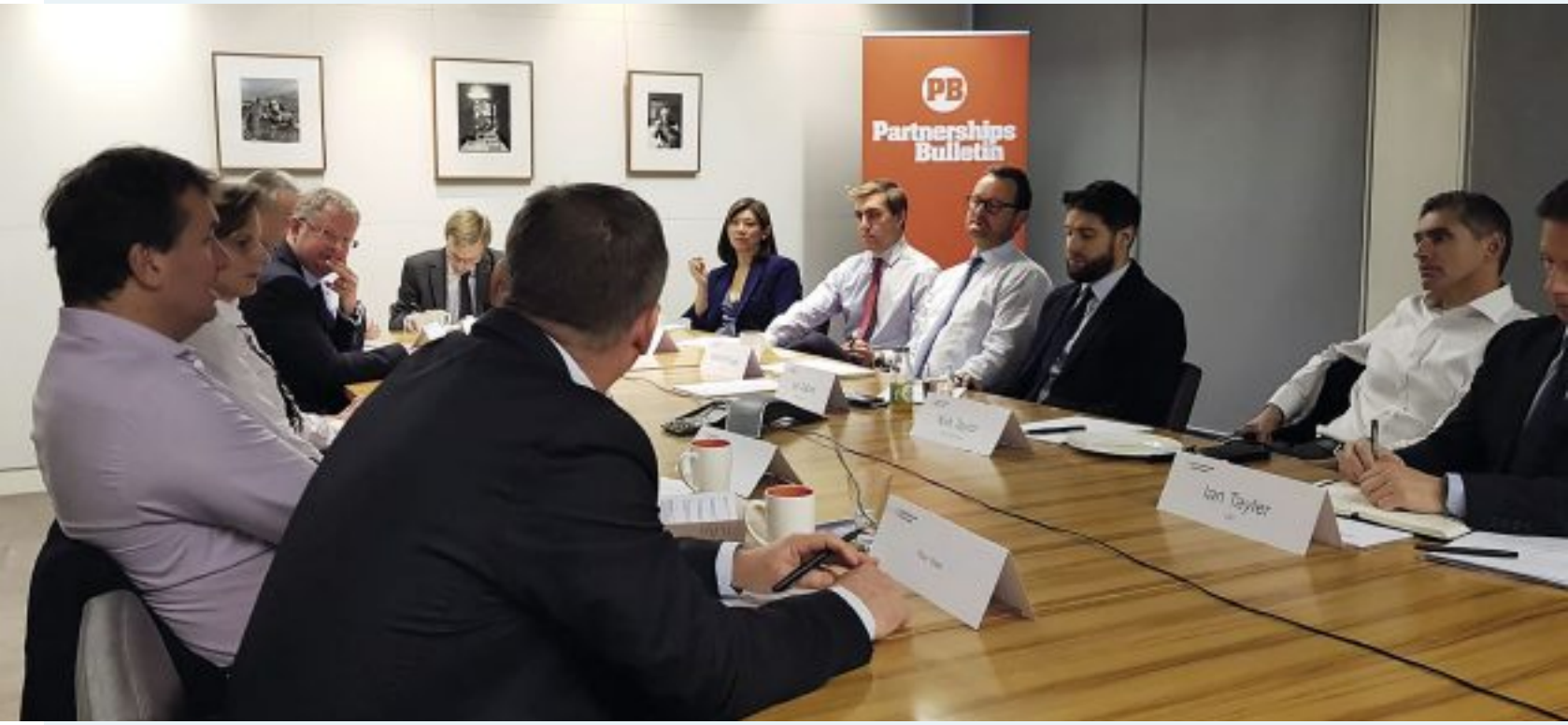
Roundtable: London



Attendees

Chair: Paul Jarvis, Managing Editor – Partnerships Bulletin
Elaine Siew, Managing Director – gbpartnerships
Matthew Newing, Partner – Addleshaw Goddard
Edward Clough, Business Development Director – Octopus Healthcare
Sean Cook, Head of Infrastructure Origination, London – Nord LB
Alastair Gourlay, Director – Cityheart Partnerships
Diane MacDonald, Estates Lead – North Central London STP
Adrian Powell, Head of Property Development – NHS Property Services
Ian Tayler, Director – BBGI
Kirk Taylor, Head of Development – Kajima Partnerships
Malcolm Twite, Chief Commercial Officer – Community Health Partnerships
Peter Ward, Director of Real Estate Development – King's Health Partners

"The concept of greater devolution is great," said Matthew Newing as the roundtable got underway. "Experts who have looked at how to make the NHS more efficient have usually suggested devolution as part of the solution.

"The issue is that, as it is set up at the moment, I don't think it will achieve those aims."

Newing and others expressed a disconnect in the way that London devolution has been established as a prime example of the problem. For while there may be a Memorandum of Understanding between various London health bodies, Newing pointed out that none of the acute or foundation trusts are signed up to it – despite being the organisations holding the majority of NHS land in the capital.

This led to a discussion around a wider point,

Under discussion: Experts get together at Addleshaw Goddard's London office to consider the issues

raised by many of the participants, over the question of what 'devolution' actually means for the health sector. While all agreed that the concept should mean the passing down of control, authority and – crucially – the money to deliver the necessary change, in essence many in the room argued that devolution has often meant simply passing around responsibility.

"We see plenty of good ideas," said Kirk Taylor, "but we are not seeing a lot of delivery coming through from it."

"Let's empower people to take decisions and support them in this rather than focus on the consequences for them if things don't turn out perfectly," added Newing.

With so many disparate structures within the NHS framework, the challenge is to bring them all together and provide a clear vision and direction, with incentives for all sides to get on board. In part, this is what the Sustainability and Transformation Plans (STPs) and the programmes that they have spawned are meant to achieve.

However, as Diane MacDonald pointed out, these are not legal entities and as a result, each organisation within the STP still has its own agenda and there is no power to force them into line with the rest of the STP area. "Organisations are used to ring-fencing their own budgets," she added.

"[The NHS] doesn't have structures that allocate leadership," lamented one participant. "It is not clear who is taking the lead on a project."

"Getting that bit right is the thing that will really help in speeding up delivery," added Elaine Siew.

Some in the room suggested that, while devolution to the clinical commissioning groups (CCGs) is not necessarily a problem in itself, there are questions over whether those organisations are being supported properly from the centre so that they can work effectively and efficiently.

Simplifying structures within the NHS, such as ending the "merry-go-round" of the way in which some services are paid for, was described as one approach to tackle this problem.

As some participants pointed out, it is still early in the process of the STPs deciding what exactly it is that they want to do with their estate, therefore questioning the ability to deliver may be a little premature.

As Taylor pointed out, there remains a problem at present over where the money will come from to deliver projects. "Ultimately it is a funding issue," he argued.

This brought the debate back to the central question of how much devolution really exists in the health system, as Newing said: "On the one hand there is supposed to be devolution, but you have a chancellor who with one sweeping statement [on abolishing PFI and PF2] has thrown into doubt an obvious financing route."

All acknowledged the limitations on the NHS while the future of private finance remains in limbo, but one suggested that the politics associated with the health service will never go away and as such the industry "needs to recognise the reality of that and work within that".

> **"Let's empower people to take decisions and support them in this rather than focus on the consequences for them if things don't turn out perfectly"**

One of the biggest frustrations for the private sector participants around the table has been the lack of pace in the delivery of projects in the health sector in England and Wales over the past few years. Whether this is through a lack of clear plans from CCGs, or the failure of programmes such as the regional health infrastructure companies (RHICs, formerly known as Project Phoenix) to get off the ground, there was a feeling that more needs to be done to start creating a pipeline.

"The central NHS should set out clear timing requirements for the delivery of new schemes (both at an individual level and aggregate targets) to generate some much needed pace," said Ed Clough.

Part of the reticence here is a fear that as technology and trends change, buildings commissioned today will be obsolete by the time they are built. "We ought to have the courage of our convictions and go ahead and do these projects, because significant time spent perfecting business cases results in inflationary cost increase that erodes any value improvement," said Peter Ward. He and others pointed out that this was particularly true for London, where land values and population increases mean a trust is unlikely to end up with something it either does not need or cannot sell at a profit.

The key here, however, is to ensure that what is being built is flexible. "There is a history of designing healthcare buildings for current service use, and paying a high price to adapt them," Ward continued. "That needs to change to a culture where we deliver flexible buildings that can adapt cost-effectively to changing services."

Such flexibility is being designed into the way many in the health sector are now working, which can feed into developing new buildings that accommodate flexible working. "The commissioning strategy could move towards a flexible working strategy," suggested one participant.

Whatever the difficulties within the delivery of new buildings, however, Malcolm Twite was eager to urge improved utilisation of existing buildings.

"Utilisation is the bit we can deal with now," he said. "We should be making our buildings work harder. We need to look at how we get more services and more people through the doors, including changing the way people in the NHS work."

There are, however, some positive examples of how projects can be developed and delivered. Clough argued that NHS bodies and commercial parties should focus on delivering the 'no brainer' schemes first – those where there is a clear need and delivery will be relatively easy – rather than trying to deliver estates strategies simultaneously, with single, overly complicated procurement exercises. "Getting individual schemes across the line will help build relationships and trust, and again bring much needed momentum and pace," he said.

Sean Cook highlighted his experience in Scotland as an example that the rest of the UK could learn from. "The Hub model has been successful in delivering community health facilities, allowing projects to reach financial close in 18 months," he said.

An important ingredient in the Scottish approach has been the role played by the centre – even though it remains a properly devolved model of government. "The Scottish Futures Trust plays a pivotal role in this delivery mechanism," said Cook.

"Scotland has a good devolution model," added another participant. "It is organised in a way that enables things to get done."

However, others pointed out that while lessons could clearly be learnt, the London picture is more complex than Scotland. That means there are more layers to be unpicked and resolved before a programme of investment such as that seen over recent years in Scotland can be replicated south of the border.

"The NHS is fragmented and complicated," concluded Alastair Gourlay. "I hope devolution leads to faster, better and more joined-up decision-making."

Twite suggested this could well be within reach. "Many of the solutions are not complicated, but implementing them will be the issue."

Key takeaways:

- There needs to be more leadership within NHS authorities, so that individuals are empowered to make bold decisions on the estate
- Such empowerment can speed up decision-making, which has long held the NHS back
- Buildings should be flexible enough that they can be built today and withstand whatever the future holds, thereby reducing concerns over utilisation
- Private finance will remain an important part of the solution for the estate
- There are lessons to be learnt from the Hub model in Scotland

Roundtable: Manchester

Attendees

Chair: Paul Jarvis, Managing Editor – Partnerships Bulletin

Elaine Siew, Managing Director – gbpartnerships

Stephanie Townley, Legal Director – Addleshaw Goddard

Eamonn Boylan, Chief Executive – Greater Manchester Combined Authority

Alan Campbell, Director – MAST Liftco

Mark Day, Chief Operating Officer & Deputy Chief Executive – Community Health Partnerships

Paul Patterson, Executive Director Business Growth and Infrastructure – Bury Council

Adrian Powell, Head of Property Development – NHS Property Services

Dave Sweeney, Executive Implementation Lead – Cheshire and Merseyside Health and Care Partnership

Christine Winstanley, Health & Care Managing Director – Eric Wright Group

Alex Woods, Director – Aviva

Devolution may appear something of a buzzword for the health sector of late, but in the North West there are promising signs that transferring powers to the relevant local organisations can have a significant positive impact on the way services are provided.

Eamonn Boylan gave participants an insight into the powers that the Greater Manchester authority has around the health and social care agenda, explaining that his organisation sees it as an opportunity to tackle some of the inequalities within the region, rather than simply focusing on providing clinical services.

"We have stopped talking about 'the system' and now talk about 'the place'," he explained. "The emphasis is about moving out of acute hospitals and into the proactive wellbeing sector. We want our places to be health and wellbeing centres, not simply about reactive treatment."

In response, Christine Winstanley highlighted some of the work that her team has been doing, acquiring properties at the firm's own risk and then developing them in conjunction with the local health sector in a way that provides a more flexible option for the public sector.

Dave Sweeney also highlighted examples in the North West where projects had focused on the idea of making 'place' a central part of the wellbeing agenda, with sites that offered a wide range of services beyond a traditional GP surgery.

In this sense, the region is perhaps ahead of the game, with several sites that are now delivering services that can be considered as core functions for the heart of the community, thanks to co-working between different public and private sector parties.

This was underlined by Paul Patterson from Bury Council, who highlighted the work that his council has been doing to integrate the health and wellbeing agenda. As many in the room agreed, there is the potential for the primary health estate to play an important role in the communities that they serve, acting as a hub.

This is especially true in a world that is changing rapidly due to technology. Whether that is through the increasing options being afforded by digital technology, or the improvement in treatment approaches that mean a growing number of treatments can be provided outside of the acute hospital setting, technology is having a major impact on the way in which the public interacts with the NHS and wider public sector.

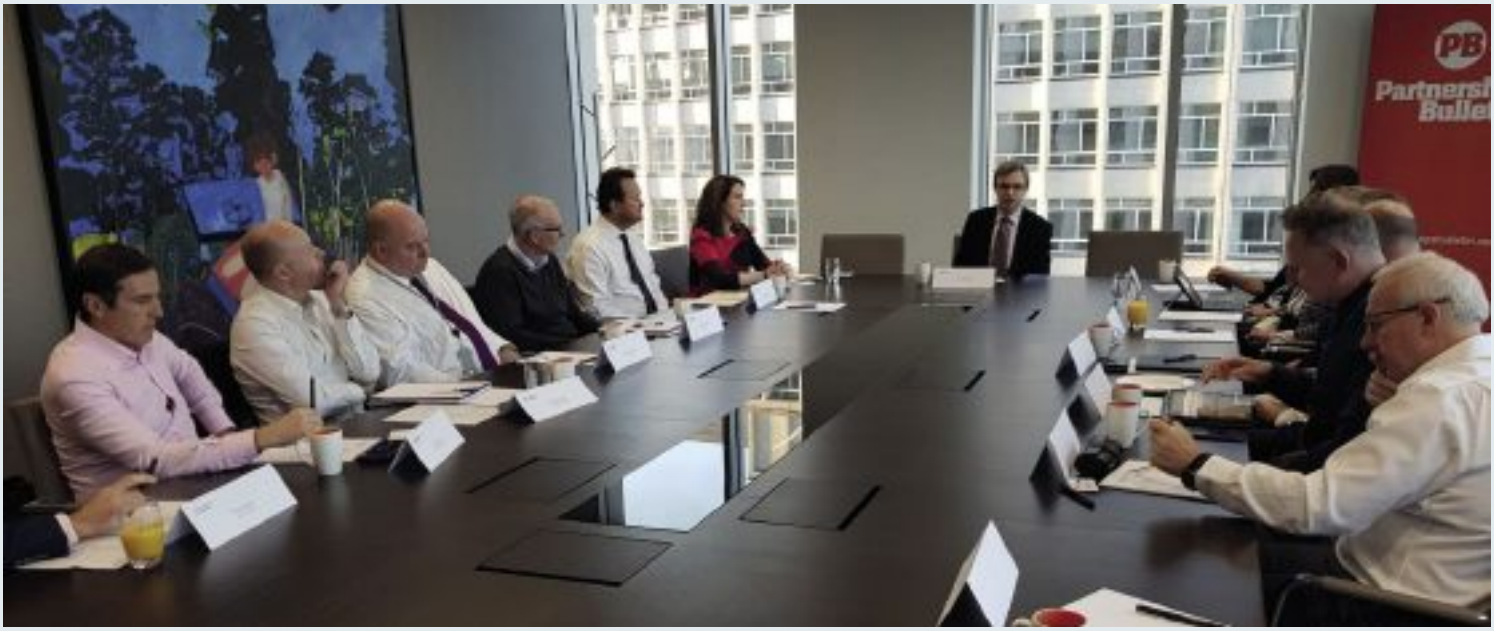
As Elaine Siew asked: "Are we in danger of discussing facilities for a generation that is not going to be there? Are we effectively answering the wrong question? It may be that we need to be re-imagining what facilities are required not for the next 10 years, but in 20 or 30 years' time when the way people interact with those facilities will be quite different."

"This is where devolution is important, in changing the relationship between the public and the public sector authorities," added Boylan. "The government is starting to get this."

Indeed, Health Secretary Matt Hancock is renowned for his love of the opportunities that digital developments can offer, which potentially puts the health estate in a strong position to capitalise on the developments in technology.

"As the private partner, we could look at how we can bring digital developments to the fore in our buildings," added Winstanley.

Alan Campbell suggested that things need to go much further, with a shift in focus at a national level. "Outpatients is 100 years out of date," he said. "The whole principle needs re-imagining so that it is only necessary to queue up in an outpatients facility for very specific cases. That



outpatients estate needs to come out of major hospitals and be significantly scaled back."

However, while devolution can play an important role in this area, those around the table agreed that the focus should not simply be on developing and delivering new buildings. "The biggest challenge is getting existing buildings used more effectively," said Mark Day.

The participants suggested that Lift buildings and similar projects could fill this space by enabling simple reconfigurations of their space to provide the services that are required, instead of having rooms always being designated for a specific purpose, meaning they are unavailable when not being used for that particular purpose.

"Lift buildings sit in the heart of their communities," said Winstanley. "We have looked at what we can do with existing buildings so that if they are empty, we could consider consolidating them and put some capital into those buildings to do something different with them."

Improving utilisation is something that all agreed needs to be a focus for any national vision for the NHS, with Sweeney suggesting it needs to be a core part of the proposed 10-Year Plan. At present, it has been suggested that new buildings may not be approved unless a certain threshold is met in terms of the utilisation of existing buildings.

"That would help because it means you can say to a board or different boards, 'As per the 10-Year Plan, we believe the following needs to happen'," said Sweeney.

He also argued that, alongside the stick from central government, there needs to be a more local element that will encourage GPs to move into new facilities, where they can see the benefits through being able to refer those with social needs quickly and easily within the same building. Such an approach can significantly reduce a GP's workload as well as provide a better service to patients.

"The tools are there, but the question is how do we free up GPs and move them from the old traditional surgery in town houses?" asked Campbell. The issue here is how to build critical mass among GPs to offer a wider range of 'out of hospital services' focused in state-of-the-art buildings, rather than fragmented across multiple converted dwellings.

This points to how the centre and localities can work together. However, Boylan warned that on the key area of funding, central government is still holding back the devolution agenda. He highlighted Treasury rules that will often see local government efforts to invest in new infrastructure counted on the health department's capital budget, thereby making a scheme potentially unviable – despite it being what all in a locality agree is necessary.

"The money is there but the way we are forced to account for it is the problem," he said. "You need a place-based approach but that will require change at a national level. We are not there yet, although those discussions are ongoing."

Paul Deverill, however, suggested that the funding challenge could provide an opportunity for local organisations to carry out more place-based efforts. "It means there is a need to collaborate."

This is where the private sector can support the public sector organisations providing healthcare, whether it be local authorities, CCGs or health trusts. Some in the room suggested that this should be something that the private sector considers and works with the public sector to see how they can provide the places that are needed.

Boylan agreed with this and urged the private sector players in the room to support the Greater Manchester authority.

On a practical level, there was enthusiasm in the room to work on a number of small place-based programmes to demonstrate the concept, with Patterson among those being prepared to develop or act as test cases for greater partnership working on specific places to improve outcomes.

"How do you create a new approach to town centres?" asked Patterson. "Creating a wellbeing place is something that we are looking at in Bury to try to increase footfall into the centre. We need to increase the leisure opportunities as retail is being reduced. It has to be based on a wellbeing principle with community health as a part of that."

"That sort of approach does exist," concluded Stephanie Townley. "And because the space can be configured in a variety of ways, it creates lots of activity. It needs to be all connected in the right place for the people who are going to use it. It is about making it a 'destination'."

Key takeaways

- One of the biggest frustrations remains getting decisions made
- Utilisation of existing buildings needs to be a key focus
- Rules around how money is accounted for needs to be changed to liberate local public sector organisations to be able to fund new projects
- Technology is going to change the way people interact with health services and there is a need to reflect that with more flexible buildings that act as community hubs

> The question is what does 'devolution' mean and how much is devolved that will facilitate the transformation that we need to see? It is good to do things at a local level, but there needs to be a central policy and incentives that work in tandem

Elaine Siew
Managing Director, gbpartnerships

People at the centre are telling their local colleagues to get on with the job, but there are rules that the NHS is bound by that actively discourage that approach. Until that is dealt with, it is difficult to achieve what is being proposed in the timescales that are envisioned.

The centre needs to be more directive-driven. At the moment, there are blockers that prevent progress.

Currently people are not making decisions. Partly, that has always been the case to an extent in the NHS. But this is also now down to the fact that it is not clear what people are empowered to do. The responsibility matrix in the NHS is out of kilter.

What we have seen is that there is a fragmented system in primary care, where there is no single person or point of contact who is responsible for a project. There needs to be a senior responsible officer for each project. Devolution has not addressed that yet.

As an industry, we were hoping that devolution would cut out the central approvals process to an extent, to allow it to be done at a local level. In an ideal world, all a system's money would be pooled in one place and the decision would then be for that one system to consider how to use that money in accordance with local needs. At the moment, each system is, at best, in shadow form and still has to go back to various boards to get approval.

Part of the problem is that the centre, perhaps understandably, doesn't want to transfer responsibility until the local bodies have proved themselves. But it is not yet clear how a local body can prove it has earned its stripes to take decisions at a local level without central oversight.

Our roundtables also showed that the definition of devolution can change in different places. In London, the debate was centred around the health organisations. But in Manchester, it was clear that the local authority has a big say and is an important part of the decision-making process.

Private support

How do we collaborate with the public sector if not through PFI/PF2?

One of the things that we see is that trusts and other health providers often do not know or realise what options they have. So we have to go to people to tell them what they could use us for. I think there needs to be more education from government over who can be those partners, for example whether that's through Lift, or Procure 21, Procure 22, etc. Lift is a pre-procured PPP and Liftcos are already in place to collaborate with its public sector stakeholders now.

For example, CCGs are building up estate teams and trusts are considering strategic estate

partnerships when the expertise and experience may already be available to them through these pre-procured partners and frameworks.

So many investors want to put their money into health projects, but at the moment the approvals process is getting in the way. People will find other things to do if projects aren't happening in health. Investors may look elsewhere if they find these projects are becoming more effort than they are worth.

One question coming from the Naylor Review is: how can we be sure that the government will put enough revenue aside to support the proposed private capital investment? Sir Robert Naylor's report recommended that a third of capital investment in the health estate should come from the private sector, but it seems likely that there will need to be public sector revenue available to support that. This has not yet been addressed.

The public sector also needs to consider which projects are most suitable for private financing and which are better for public investment. We have seen examples of discreet projects that would be most appropriate for private finance being given capital allocations, while other projects that would be unlikely to be taken on by private investors have not received capital allocations. So the way resources are allocated needs to be more thought through with the private sector's ability in mind.

The private sector can work with visionary people in the public sector to push forward new ideas and make them work.

Utilisation

At the ground level, there needs to be a better understanding of what 'occupation' and 'utilisation' mean. For example, in Lift, the occupation rate is high. But because there may be clients who may not be using certain rooms for much of the week, the utilisation rate is far lower than it should be.

Properties need to be managed by an individual buildings manager who is in charge day-to-day. Whether that is someone from the provider trust or the private partner, the key is that they will be able to know whether a space is being properly utilised and can be incentivised to improve utilisation within their building. This approach needs to be facilitated by the correct funds flow and financial incentive for tenants to encourage the right behaviours and decisions that result in maximum utilisation of fit-for-purpose estate.

One of the blockers of increased utilisation at a higher level is that it can be hard to do even a small variation without incurring big costs, because we are bound by the legal regulations of the initial Lift contract. We are trying to work with all parties to address this issue.

One of the things we are doing is creating a product where the implementation plan now has to be part of any utilisation study. This forces people to think about how they are going to make changes, rather than simply surveying the existing situation.

> **We do not have all the right people signed up to the process. Devolution of responsibility is good, but devolution of authority needs to go with it**

Matthew Newing
Partner, Addleshaw Goddard

For me, there are two things that came out clearly from the discussions: one is that we do not have all the right people signed up to the process – it needs to be expanded to include acute and foundation trusts.

Secondly, devolution of responsibility is good, but devolution of authority needs to go with it.

The concept behind devolution is right. Local and regional devolution, at its core, is a way to transform the estate into an enabler for better service provision and wider change within the NHS. No government has ever managed to create an NHS estate that effectively enables services.

It can be easy for us working in the estate sector to focus solely on that, but the truth is we need fit-for-purpose buildings to deliver what the NHS needs.

Estate planning in the NHS to date has never really been implemented on a coordinated regional basis, with those organisations being given real authority to implement decisions and change. Bringing regional bodies together to plan estate delivery will help to develop what is right for that area. Each area and region can learn from what has been done well in other places. The relevant organisations can then use their estate as one of the enablers of excellent service delivery.

It is all about aligning the requirements and interests of the acute, foundation and mental health trusts with the community and long-term social care providers. Empower these organisations locally, allow them to plan and deliver estate solutions. At that level, devolved power can work.

Currently devolution passes down responsibility but no real authority to go with it. This came through clearly in the debates. If everything has to come back to the centre for sign-off and approval, how are we really devolving power?

The problem is that, if every project has to go back to the centre for approval, a region can come up with a solution that works for it, but which can be scuppered by one approval body somewhere along the line objecting to just one or two schemes within the programme.

The centre needs to be prepared (at least within certain delegated limits) to give up control and trust the local organisations and make sure all the relevant organisations are involved. There has to be political will for that to happen. That is the next big challenge for the sector.

London is a good example of this, which was touched on in the roundtable. The current memorandum does not have the acute trusts and foundation trusts signed up to it, and yet they hold most of the estate. So they need to be involved in planning the community estate within their region. You have to get all the right people in the room.

Organisations like the Greater London Authority are directly accountable to their constituents, so they should be empowered to take decisions and be accountable for those decisions and be supported by the other local organisations and trusts in doing so.

Healthcare is always an emotive subject, but within delegated limits the government should be able to give responsibility and authority to local organisations to implement change. Then, if it is not done properly, those local organisations can have no excuses and have to accept responsibility for their decisions.

Devolution is sensible because it allows for local decisions. For instance healthcare planning may be different for London than for Manchester, with different requirements and needs. Who better than the local organisations and councils to inform and take those decisions? Hopefully that way, local and regional authorities and local NHS organisations will deliver what is required and in theory what is best for their regions. What is important and a priority for Manchester may not be important for London, and vice versa. The needs will be different, so a national response does not work. That does not mean the department and central government has no role; it will always have a role (as a coordinator if nothing else) but in order for devolution to work much greater authority needs to be ceded to local organisations.

There is also an acceptance I believe that financial limits would have to be imposed on delegated authority. Provided these were set at appropriate levels (depending on the region), I do not think it would detract from the positive impact proper devolution could have.

There is a sense of frustration, particularly in the private sector, that to date the government has talked a good game, with some good ideas coming forward, but there is a reluctance from the centre to release authority.

Private sector help

The obvious thing that the private sector brings is that it can provide finance at a moment when the country doesn't have the capital available for social infrastructure.

People in the private sector who are looking to invest in health, are people who care about the health service and want to see positive change in it. Many organisations could invest in lots of other things that would make them more money.

As well as finance, they can bring a wealth of experience, expertise and discipline.

The concept of placing delivery risk and performance risk on the private sector to incentivise them is fundamentally right. While we need to learn the lessons of PFI and change what was bad, we can bring forward new models that still transfer those risks.

There is a frustration in the private sector because many in the market are willing to look at appropriate sharing of risk and return, but there seems to be no real political will for this to be looked at in government. Positive messages are issued and statements made but very little real progress is ever seen.

For more information on this survey or to find out about partnering on a future report, please contact:

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