Using NHS land to drive integration

I. Introduction

The NHS is being encouraged to use its surplus sites to provide the land necessary for new homes. NHS organisations have well established ways of disposing of surplus land that for the most part require that land is sold to those who bid the most for it. However, it is worth asking how they could best generate value, provide new homes and ensure that the public continue to receive the services they want. This will involve a new operational model, a new cost model and, crucially, new responses to what the end user of services wants. In this paper we will explore:

- How the NHS makes decisions about its surplus estate;
- How housing and support organisations make work with NHS providers to redesign care pathways;
- How the NHS can use its estate to deliver housing and support for older people, people with mental health problems, complex needs and learning difficulties.

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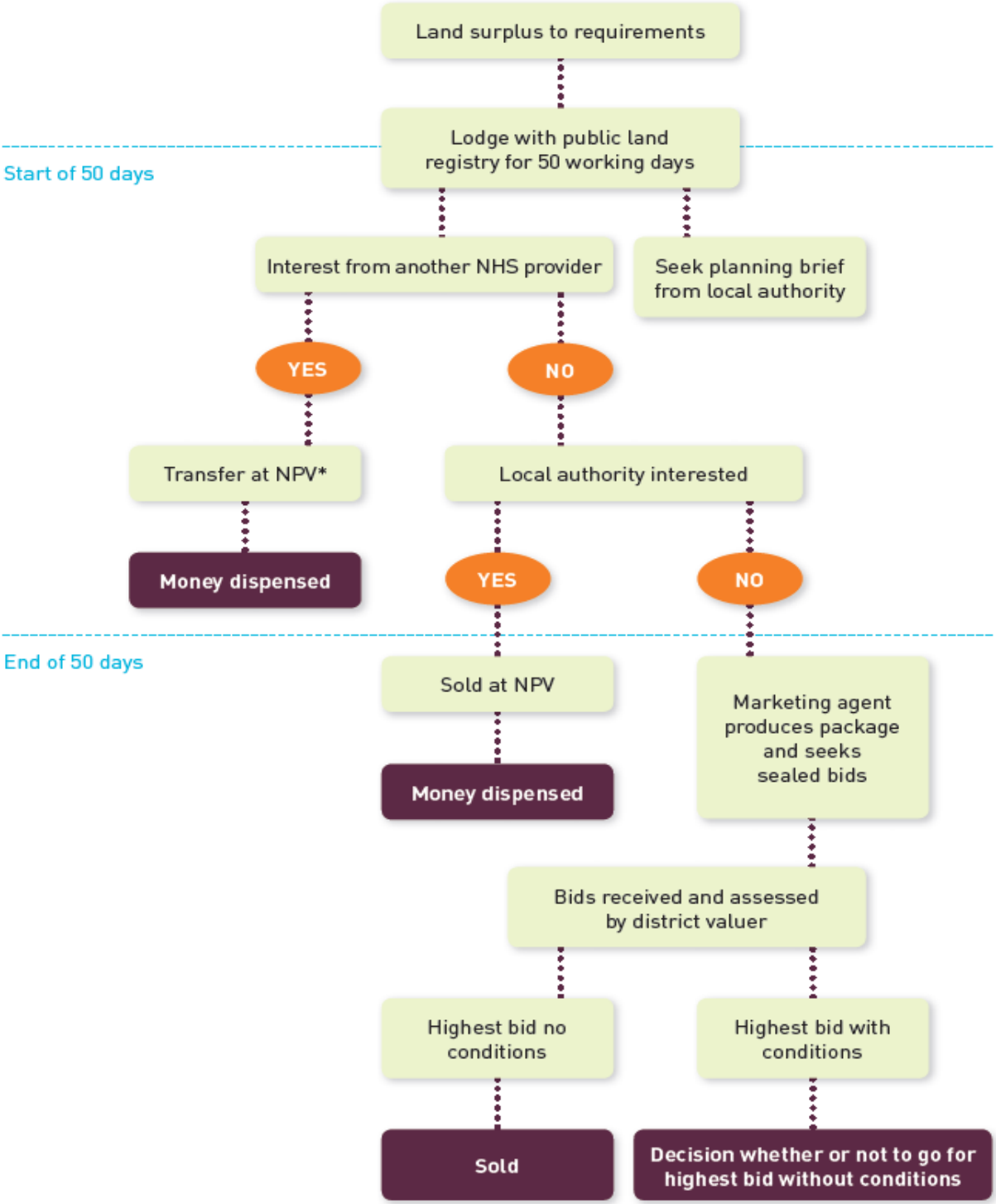
II. How the NHS declares land surplus

Figure 1: NHS Land Disposal Process



* Net Present Value

When an NHS organisation decides that it has land or building that it no longer needs to provide its own services it declares it to be "surplus to requirements". Once an organisation has declared a site surplus it is lodged with the Public Land Registry. After it has been lodged there are 50 working days during which another public body can express an interest in the site. In most circumstances this will be another NHS provider who wishes to use the estate to deliver health care services or a local authority[1].

If another NHS Trust expresses an interest in the site it is transferred at Net Present Value (NPV). If the local authority expresses an interest then it is sold to them at NPV. The Local Authority may express an interest to, say, provide a school or together with a strategic partner such as a housing association with a view to seeing the provision of an extra care scheme. The 50 day period also provides an opportunity for the disposing Trust to approach the local planning authority for a Planning Brief.

On the 51st day the Trust's marketing agent puts together a marketing package. Sealed bids are returned and assessed independently by the District Valuer as the guardian of the public purse and an independent assessor. In almost all circumstances the highest bid would be accepted. If the highest bid was conditional on a successful application for planning for a particular number of units and there was an unconditional offer that was deemed to be at an appropriate level then the unconditional offer might be accepted even though it was lower.

If the Trust is a Foundation Trust (FT) then it owns its own assets and it reinvests the income from the sale. The Trust would need to comply with Monitor's Risk Assessment Framework. An NHS Foundation Trust does not require approval from Monitor's (the regulator of Foundation Trusts). However, the Trust would need to follow the process set out in the Risk Assessment Framework. The Risk Assessment Framework process will lead to the ratings for the FT being revised. The Board and Governors will be mindful of this when making the decision as to whether not to proceed with the transaction.

Under the Foundation Trust's license conditions Monitor's consent is required if an asset being disposed of is part of the Trust's assets that are needed to provide the services required by Commissioners – these are called Commissioner Requested Services. It is also possible that the proposed transaction falls within the terms of a significant or major change then it may also require approval from the Council of Governors.

NHS Trusts (i.e. those that are not Foundation Trusts) are entitled to retain and reinvest land sale proceeds of up to £5 million from a disposal transaction, (except where an NHS Trust goes into financial deficit in which case the NHS Trust Development Authority (TDA) has the discretion to reduce the limit). NHS Trusts have delegated authority to approve business cases for capital investment with a financial value for the proposed capital investment (or property transaction) up to a value of £5million or 3% of turnover, whichever is the lower.

The retention of receipts above this £5 million limit requires the approval of the TDA. The TDA has powers to approve capital business cases up to a £50 million limit. Any business cases over £50million that show that the proceeds are needed for reinvestment require a further stage of

[1] For a more detail refer to Health Building Note 00-08 : Estate Code 2007.

approval by the Department of Health before submission to the Treasury. However, where an NHS Trust goes into financial deficit the TDA has the discretion to reduce the limit. Any proposal over £10m requires a Strategic Outline Case, Outline Business case and a Full Business case and there can be up to a year between each of these stages.

There are not currently any instances where the TDA have retained land sale proceeds. In the past the DH has retained land sale proceeds where the DH had not agreed in advance that the Trust could keep the monies[2].

In the next section we will look at housing and support organisations can contribute to service transformation programmes and care pathway redesign.

III. How housing organisations can contribute towards service redesign

There are a number of ways in which housing and housing-related support services have contributed to improved health outcomes. For older people, people with mental health problems and those with complex needs this has meant a focus on :-

- prevention and early intervention that reduces admission to in-patient facilities;
- facilities that enable step-down to recovery;
- repatriation of out of area treatments and
- avoidance of institutional forms of care.

Health and housing providers are increasingly developing supply chains that deliver the desired solutions across the whole of a particular pathway or an overall package of care, which include housing providers and providers of care and support from other parts of the not for profit sector[3]. With the advent of Multi-specialty Community Providers signalled in the Five Year Forward View[4] there are new opportunities for integration. For this to work a number of things need to be present:

- A desire to improve quality through innovation to increase productivity and prevent need for care;
- Work with agencies that service users and local people trust, allowing them to mange their own health;
- Clarity on how reductions in cost will be released and measured;
- Clarity around desired outcomes for all commissioners;
- Development of new ways of providing services.

Releasing NHS estate is not only a useful way for the NHS to invest in service models that reduce unplanned admissions and support recovery in the community. Adopting more revenue based approaches to land release will also provide much needed income streams to the NHS. By offering their land to developers at no upfront cost on a lease-back arrangement, the NHS could receive a

[2] NHS Property Services has been set up by the Department of Health to manage all the ex-Primary Care Trust estate not transferred to providers.
[3] http://www.onehousinggroup.co.uk/sites/default/files/THExecsummaryweb.pdf
[4] www.england.nhs.uk/ourwork/futurenhs/5yrfv-ch3/

guaranteed annual return and retain ownership of the land. Alternatively the NHS could take an equity stake in a development in lieu of a one-off capital receipt for the land. Under this approach the NHS would take a share of the revenue from a scheme and/or sell its stake to an institutional investor at a later date to benefit from the uplift in value.

IV. Creating value from the NHS estate

Although NHS Foundation Trusts have considerable freedoms when it comes to owning property and sub-contracting to third parties they are still subject to the same requirement to deliver best value from their assets. In parts of the country where the market is over-heating there is a strong imperative to achieve this through a straightforward sale.

Much of the public sector land that has currently been identified for disposal will be released for housing development[5]. The priority for Government is to create new homes on sites previously owned by NHS Trusts and investment and technical support is being provided to them to help facilitate disposals of surplus land[6]. It is worth asking whether there is more value that could be created either by developing the accommodation necessary to provide for an ageing population, accommodation to support speedy discharge and step-down to recovery, accommodation for those with support needs or to deliver a revenue stream that can be routed back into service delivery.

In areas of high land value, Trusts may decide to go for a straight forward disposal. However, many NHS Trusts now recognise that they can invest the land in a joint venture that delivers both a developer's return and develops the accommodation necessary to help provide the necessary finance and supply of accommodation to help with care pathway redesign and deliver their cost improvement programmes. This is even more the case in areas of low land value. Here there may be no market for the land and developing housing designated as being for older people or people with mental health problems may be the only realistic way of realising any value from the land. It may also help to reduce health inequalities and support the management of long-term conditions and the prevention agenda[7].

Some Trusts are forming joint ventures with housing developers, including housing associations, to support capital input to re-provision and refurbishment. This way they can develop their supply-chains to deliver new facilities, create public assets that strengthen the balance sheet and contribute to deficit reduction, and deliver a model that uses the public estate in both a more commercial and creative way[8].

NHS Foundation Trusts recognise that housing associations buy land in the same market as do private housing companies. In contrast to private investors where profits go to deliver shareholder value, housing associations are likely to have discussions with local authorities about providing a

[5] http://www.monitor.gov.uk/regulating-health-care-providers-commissioners/information-nhs-foundation-trusts/correspondence-foundation-trusts
[6] http://www.homesandcommunities.co.uk/ourwork/brownfield-and-public-land
[7] http://www.onehousinggroup.co.uk/sites/default/files/One%20Housing%20Group_Roundtable%20Report.pdf
[8] http://www.housing.org.uk/policy/health-care-and-housing/health-hub/building-partnerships/unblocking-care-pathways/

proportion of the development at an affordable rent. Housing associations can offer to provide the same high value housing scheme but would put all profits into the scheme. This would increase the social benefit of schemes with all profits going back to support, say, the transfer of care from institutional settings.

By creating a third party vehicle any NHS land is invested rather than disposed of. A housing association puts in an equal amount of equity. The NHS has 50% of the seats on the Board and can determine what return it wants and what form of accommodation will create the most value.

A site could used for housing for sale and housing with support. The housing for sale provides the funding to cross subsidise the supported housing and so "replaces" the grant funding. The NHS gets a return due to it from investing its' land. Provided that this can be structured correctly many housing associations can deliver an accelerated process by making use of scheme specific development finance with no call on the public purse.

If we are going to change thinking and consider land disposal as a lever in delivering service transformation, this needs to be built in from the outset. At the point of conception there needs to be a clear service plan that delivers the necessary service changes and includes some clarity about who will deliver what and where – whether that is a care provider, a support provider or an advice provider. There also needs to be the willingness to sell the idea to the public pre-planning and some thinking on not just how to dispose of land, but also how to use it.

V. Conclusion

The disposal of land and of buildings is highly political and often highly emotive for the communities concerned. There will be strong views held on all sides of a proposition and this makes decision-making difficult. In a fast changing health and social care landscape it is often the buildings that provide a sense of continuity and hence take on far greater importance than is perhaps justified. Any disposal requires a broad range of stakeholders with a broad range of interests to agree and a considerable amount of time and effort.

So there is no simple step by step approach to the issues. However, there are a number of ways in which health care and housing organisations could work together to create value for organisations and communities :-

- Ensure that there is a clear service offer that is measurable, marketable and tradeable based upon a sense of 'common cause' amongst partners.

- Ensure that there is an understanding of what the NHS Trust(s) are seeking to deliver through their service transformation programmes and cost improvement programmes. Then identify how housing and related support services could help the Trust to deliver these programmes and ensure that the right care is delivered in the right place at the right time.

- Establish requirements of the local authority – especially for specialist or designated housing for older people – and work up a proposal that can be used to declare an interest in the site in the 50 day window.

- Housing organisations should ensure that their quality standards and assurance processes are fit for purpose and meet the changing requirements of the Homes and Communities Agency and the Care Quality Commission. This will involve being able to demonstrate that they can assure themselves and others about the quality of their services and that they have the necessary systems in place to allow for safe transfers of care and support across organisational boundaries.

What is being proposed here is not easy to achieve. However, there is definitely a business case to be made to the Boards of NHS Trust that allows them to create value for the long-term. It achieves the goal of ensuring that people are enabled to look after their own health, that health care is delivered in the right place, supports pathway redesign and helps to deliver the required cost improvements.

VI. Acknowledgements

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