The NHS White Paper *Equity and Excellence*

A submission from The LIFT Council

September 2010

The LIFT Council

The LIFT Council is the representative body for private sector investors in the Local Improvement Finance Trust (LIFT) programme. The Council currently comprises 11 organisations and represents more than 95% of the market.

Our role is to provide private sector investors in LIFT with a platform for debate and decision-making on all issues relating to LIFT. The organisation provides a mouthpiece for communication with Government and drives forward the development of this valuable delivery mechanism for primary healthcare. The LIFT Council was formed in March 2005 and has since built a major profile in the public policy arena.

The LIFT market is now very mature, having been in existence for seven years, delivering over 250 projects to the value of over £2 billion with a further £2 billion in the pipeline. LIFT is also an effective procurement vehicle for a wide range of infrastructure requirements including social care services, Children's Centres, libraries and public health facilities, enabling services to be co-located near to people's homes.

Summary of our response

- The LIFT Council welcomes the proposals set out in the NHS White Paper and look forward to working with the Government during the period of transition and full implementation of the new arrangements
- To deliver the best, most clinically and financially effective care to patients requires infrastructure that is fit for the purpose, most appropriately located and properly maintained. The best way of ensuring this is through a number of Public/Private Joint Venture Property companies such as existing LIFTCos
- Improving patient outcomes, promoting patient choice, improving the patient experience and levels of satisfaction, improving efficiency and productivity, increasing the numbers of co-located services and delivering overall improved utilisation are most likely to be secured if

clinical staff, commissioners and providers are freed from the burden and distraction of property management

- Commissioning freedom, whether at NHS Commissioning board level or GP Commissioning Consortia level, is enhanced by removing infrastructure issues from decisions about the delivery of clinical care
- Placing responsibility for providing suitable infrastructure in the right location at the right time in the hands of the property company JV will support the contestability of providers and secure the realisation of actual value from the existing NHS primary and community care estate
- For a variety of reasons we believe the acute sector estate can legitimately be owned and managed by providers but we firmly believe that the primary and community care estate must be owned by expert asset managers independent of providers with a joint venture vehicle being the most appropriate solution
- Should providers own and manage the primary and community care estate the Government's reforms will be frustrated. *Any Willing Provider* necessitates changing providers when service standards fall and the estate must not act as a barrier to contract flexibility
- LIFT represents the most effective way of managing the NHS estate through bringing in asset management expertise and capital along with an ability to integrate services along defined commissioning pathways that are in the best interests of the patient and with the advantage of a contractual framework that can overcome historic procurement and financial barriers to encourage integration of services

The overall vision

The LIFT Council welcomes the NHS White Paper *Equity and Excellence* along with its associated documents and looks forward to working with the Government to making safe and secure transition plans and implementing the vision laid out.

It is clear that the Government wishes to evolve the more radical proposals of the previous administration, most notably *Commissioning a Patient Led NHS* but also *Any Willing Provider* and the choice agenda, and is determined to introduce a greater emphasis on quality and a shift away from central diktat. This aligns well to the model that has been established by LIFT over the last decade, with the LIFT community working hard to ensure that facilities match local need and also that they are responsive to the inevitable demographic and clinical changes that happen over time.

As independent sector investors in the health service we believe in the primary principles that underpin much of the White Paper, particularly the drive to bring in greater competition through use of the independent sector. LIFT has already shown how by bringing in private sector investment and expertise standards can be improved and these reforms open the door to expand this.

We are also very pleased by the Government's stated intention of reducing bureaucracy and encouraging greater local determination. Whilst the focus for this has been on management and structures, we believe that LIFT can also be made more efficient by allowing the use of alternative lease structures rather than the centrally imposed 'one size fits all' structure which is currently the norm.

Patient engagement and consultation with frontline staff will become crucial and LIFTCos are ideally placed to support with this process having delivered partnering services to support the development of service strategies in several areas for a number of years. The LIFT Council is also supportive of the Government's clear focus on patient safety underpinning this vision, something that the LIFT community understands very well given our focus on modern, high quality facilities and equipment that meet all health and statutory compliance standards and requirements. This focus has seen rising levels of patient satisfaction and an overall improvement in service quality.

The thrust of the reforms is to give clinical leaders the opportunity to show that they understand not merely their patients' clinical needs but also that they can structure a system around those needs on a population level basis. With GP consortia entrusted with holding commissioning budgets at the local level and providers being brought in on a contract basis paid through tariff there will be further advances towards a market based system within the health service.

For these reforms to achieve their true potential there will need to be genuine competition between providers, an understanding between the NHS Commissioning Board and GP commissioning consortia and the involvement of Local Authority Public Health professionals to determine what clinical services are required and from where they should be provided. Facilities will also need to meet requisite standards including the Safety and Suitability of Premises which is Outcome 10 of the CQC's Regulations and outcomes document published in March 2010. We can also expect to experience a sea change in patient expectations away from being content with what they are given to demanding ever higher standards. To deliver these reforms against a backdrop of major financial uncertainty will require real focus and drive and also an NHS framework that can flex to support this evolution. Our view is that LIFT has a significant part to play during the transition phase and into the new system and it has the capacity to help manage the change process.

Removing barriers to progress

Delivering improvements in patient care whilst at the same time securing productivity improvements and financial savings is achievable. Indeed, it usually needs such a challenging environment in order to make profound service changes. It is, however, essential that perverse incentives and the unforeseen consequences of structural change are kept to an absolute minimum.

Ensuring there is a level playing field which will allow the proper testing of clinical providers and allow ease of entry for new providers is the principal reason why we believe that the primary and community care estate should not sit with providers of services but sit with expert asset managers that are able to react quickly to changing provider side arrangements. This situation may make sense in the acute environment where a facility is the focus for the service and is used by the same provider throughout the year but primary and community care is more fragmented and must be treated differently.

One of the major benefits of LIFT as it stands is that the local LIFTCo is obliged to develop a Strategic Services Development Plan (SSDP) from which it is possible to identify where the current infrastructure provision is constraining the delivery of improved services. Drawing on local population data the SSDP underpins the estate development and management plan and allows the local NHS to point to areas where investment is required or where shifts in service patterns may be needed.

From this infrastructure reform come new models of care and facilities that can often be used by a large number of providers including acute trusts. With a LIFTCo contractually obliged to work in a given locality for 25 years this means LIFT can play the long game and flex the system as required no matter what happens on the provider side.

Whilst the White Paper does not take a view on asset management The LIFT Council believes that a quick decision is required as to what will happen with residual PCT estate once PCTs cease to exist in 2013 and that the Government must not transfer assets to providers. A situation where providers control the asset means that the commissioning consortia or the NHS Commissioning Board can be held to ransom when questions arise over clinical quality or economic competence; frustrating just the market reforms that the White Paper seeks to introduce and restricting patient choice. It would also act as a barrier to entry for social enterprises, mutuals and smaller providers who may have clinical or healthcare expertise but lack the necessary capital to host Care Quality Commission compliant facilities.

The other options open to the Government over the transfer of residual estate are also flawed. Transfer to Local Authorities would mean that asset management would not be handled by health service experts and could also bring Local Authorities into conflict with the commissioning consortia. Similarly inappropriate would be any shift to acute trusts on the basis that acute trusts are primary and community care providers akin to independent and voluntary providers, subject to the principles of *Any Willing Provider* and therefore poorly positioned to own and manage the primary care estate.

It is vital that this issue is addressed speedily and properly and our proposals below set out how The LIFT Council believes that this can be achieved through existing Joint Venture vehicles.

Providing the infrastructure to support the vision

In the short-term, to assist with the need for both sensible transition arrangements and the critical need to protect existing Public sector asset value we believe that the Government needs to make three immediate decisions:

1. Where a PCT has a LIFTCo then that PCTs residual estate should transfer to the LIFTCo unless there are clear reasons why that should not be the case. We are happy to work with DH on ensuring a proper evaluation process of existing LIFTCo capability and capacity is undertaken
2. The Department of Health, through its ownership of Community Health Partnerships (CHP), should immediately have transferred to it all remaining residual estate where a locality does not enjoy the benefits of having a LIFTCo
3. The PCT's 20% shareholding in a LIFTCo should also be transferred over to CHP whilst consideration is given to future governance arrangements for existing LIFTCo estate

From this position the Government is able to have a better understanding of what estate it owns whilst also being confident that estate in LIFTCo areas is being owned and managed effectively by an expert asset management company. The alternative is that providers will simply cherry pick the best assets leaving the NHS to deal with those assets that have significant problems, such as inappropriate geographical location, low occupancy rates or high service costs due to their physical condition and inability to comply with statutory standards.

Once the existing estate has transferred either to LIFTCo or to CHP then further discussions will need to take place as to how best to drive maximum value from that estate. Areas without LIFTCos could consider entering into interim management service contracts with property management companies to ensure that value is protected during the transition. This will help mitigate against rising transition costs across the local NHS whilst also preparing the ground for a future PropCo to carry forward long-term estates management work.

Further consideration as to geographical scale will need to be considered in light of the abolition of PCTs and SHAs and may need to reflect the regional/local structures determined by the NHS Commissioning Board though must be small enough to ensure a detailed understanding of the local health economy is possible. JV structures on a significant scale, for example covering a population of anything more than 2 million patients, risks shifting away from local knowledge and understanding, thereby losing one of the major benefits of the LIFT model and a central coalition priority.

The LIFT Council believe that LIFTCos should be the joint venture of choice because:

1. The majority of LIFTCos and their private sector partners already possess the capability and capacity to operate as expert asset managers who are able to free commissioners from the

constraints of inadequate and/or poorly located infrastructure being a barrier to delivering health services changes

2. GP commissioning consortia will want to have one contact for estate development and management – essentially a 'Design, Build, Finance and Maintain' approach. LIFTCos offer this service across a given locality and can help free up clinicians to focus on patient care and not buildings
3. By freeing the NHS from current organisational constraints and bureaucracy LIFTCo is able to drive better value from the existing estate through improved utilisation and rationalisation of existing assets to ensure they are of the right standard and in the right geographical location
4. The NHS can realise financial value for the public sector by LIFTCo being the owner not just the manager of all 'appropriate' health and social care estate
5. LIFTCo can take a strategic view of estate requirements across a defined geography and match infrastructure to the public health agenda
6. LIFTCo can handle all statutory compliance matters
7. LIFTCos already build facilities to comply with HTM and HBN standards whereas if providers could build their own then the CQC or the Commissioning board or GP commissioning consortia would have to have a team of technical advisors assessing compliance. As a public/private body the joint venture could be put under a duty to ensure all facilities offered for use by providers met core standards
8. LIFTCo can ensure all premises meet the new regulatory frameworks e.g. carbon reductions and the Business Research Establishment Environmental Assessment Method (BREEAM) requirements for health
9. LIFTCo can proactively identify solutions that meet the integration and improved outcomes agendas across health and social care organisations
10. LIFTCos are expert contract managers already, have an extensive supply chain with regular market testing and enjoy access to a variety of funding sources
11. With many LIFTCos having a broad based portfolio they are able to provide flexible high quality infrastructure on variable lengths of tenure
12. LIFTCos already exist having been procured under a competitive public process so speedy implementation is possible ahead of the deadline for the abolition of PCTs and SHAs
13. LIFTCos are able to operate across organisational boundaries of both public bodies and also private companies e.g. it is possible for LIFTCo to own and run a facility but for it to have a multiplicity of different service providers on different contractual timescales as we have experience of this in LIFT buildings already
14. LIFTCos have proved themselves willing and able to secure private sector investment into areas of greatest deprivation which is something not before achieved under any financing arrangements
15. LIFTCos are ideally placed to support commissioning consortia with the delivery of *Quality, Innovation, Productivity and Prevention*

The LIFT Council is already working with its members to ensure that investors are equipped to harness an expanded supply chain including a wider range of support services and that the LIFT model can be scaled up quickly to meet the demands of the extensive residual estate. Aside from public ownership or provider led ownership, which as we have already described risks distorting competition and frustrating patient care and productivity improvements, we believe that this solution is the only meaningful option open to the Government to manage this transition.

Conclusion

The timetable for the Government's proposed reforms are relatively quick and with no explicit proposals for estate we feel that the Government needs to consider this matter urgently in order to ensure it is not unwittingly allowing estate to become a barrier to progress for its wider agenda. As established public private partnerships LIFTCos were always designed to play a major role in managing the NHS estate and after several years of working within the system are ideally placed to manage this process. The LIFT Council is positive about commencing dialogue with the Government to examine how best to bring this vision to reality.

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