WHITEHALL LECTURES

Professor Sir Malcolm Grant CBE
Chairman NHS England

'The extraordinary challenges of future healthcare and the estates implications for the NHS'

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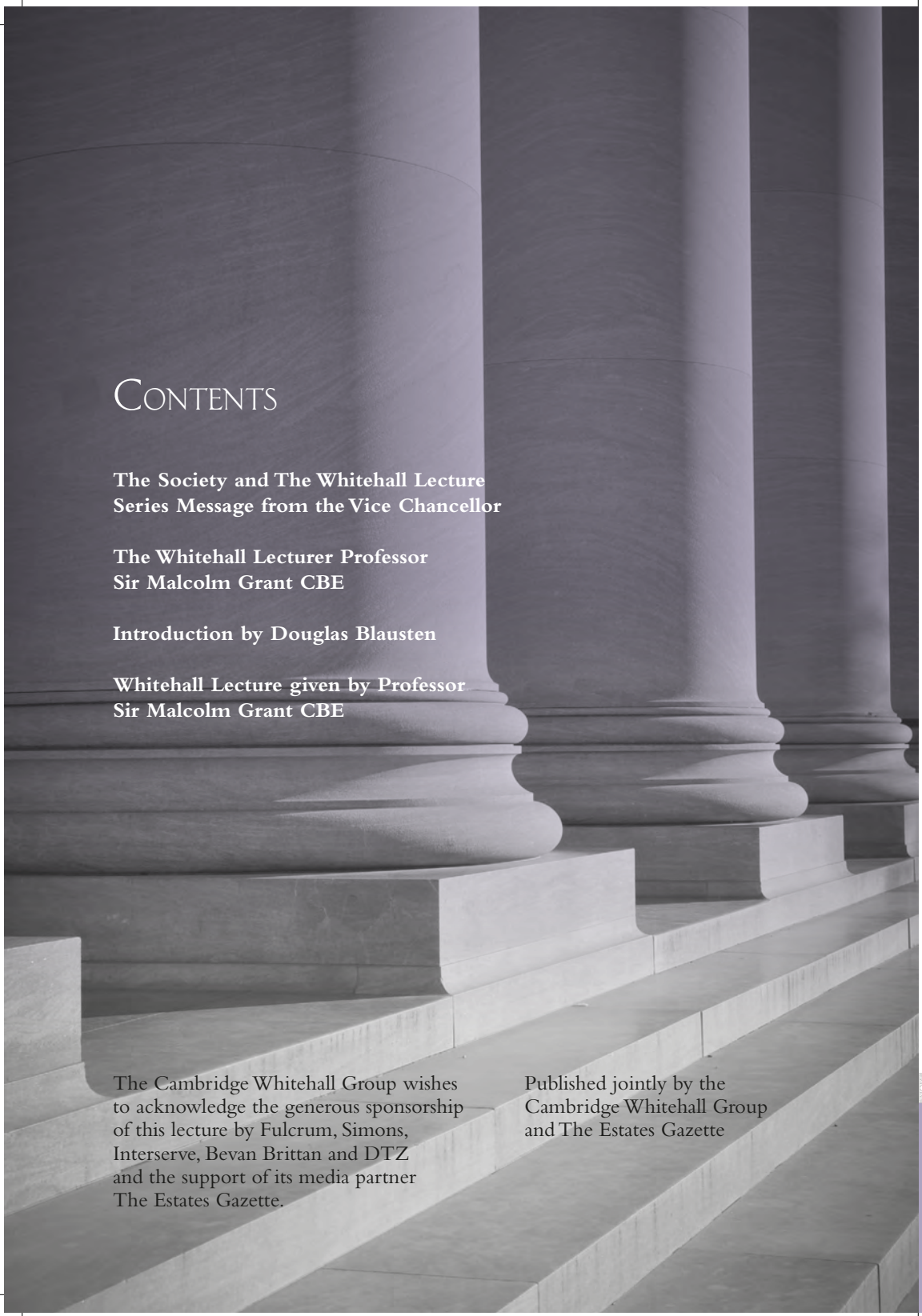
Cambridge University Land Society
ALUMNI



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The Cambridge University Land Society (CULS) through its Cambridge Whitehall Group forum, is launching this important series of lectures in recognition of the part its members play in contributing to public policy issues. Society members are mainly alumni of the Department of Land Economy, but also from many other academic disciplines in the University of Cambridge. Many play important, often distinguished, roles in many aspects of public policy that are covered by the work of the Department.

The Cambridge Whitehall Group is a member of CULS and is a high level influential policy discussion group of well-connected Cambridge alumni, who are mainly members of CULS. In addition to its member events it also runs this distinguished series of policy lectures of which this lecture by Professor Sir Malcolm Grant is the inaugural one.

The lectures will discuss major aspects of public policy that in one way or another touch on the disciplines of policy, economics and the application of land use.

It is intended that the lectures are published as occasional papers.

www.cambridgewhitehallgroup.com

The Society and the Whitehall Lectures - Message from the Vice Chancellor of the University of Cambridge

The Cambridge University Land Society is an exemplary society at Cambridge – for its longevity and for its level of engagement with a wide range of sectors and contemporary issues.

Over the last 50 years, the Society has built a membership base of nearly 1,000 alumni, spanning those who graduated from Cambridge in the 1950's who now hold senior positions in their fields, to current students and recent graduates of the Department of Land Economy.

The number of disciplines and interests represented in the Society's membership – as well as the broad range of issues discussed at business and social events held by the Society each year – highlight what Cambridge does so well. We recognised that the challenges we face today are increasingly complex, multi-faceted and global in nature, and that they cannot be overcome with the expertise of just one area. This is why it is so valuable that the Land Society continues to bring together fresh and diverse perspectives from those studying and working in economics, land, planning, governance, finance, environmental resources and beyond on critical public and private issues.

The Whitehall Lecture series represents a good opportunity to take this debate forward – and to build the Land Society's critical mass of expertise – and I wish it every success.

Professor Sir Leszek Borysiewiez, Vice-Chancellor, University of Cambridge.

Whitehall Lecture Series, Douglas Blausten, Chairman, Cambridge Whitehall Group

Douglas Blausten is Senior Partner of Cyril Leonard, Property Consultants, where he is responsible for Corporate Strategic Real Estate Consultancy Services, as well as for their offices in Munich and affiliate office in Paris. He is Vice Chairman of NHS Property Services Limited and Chairman of its Audit and Investment Committee, a Centre Fellow of the Cambridge Centre of Climate Change Mitigation Research and a member of the Cambridge Land Economy Advisory Board. He has held a number of executive and non-executive directorships in public and private companies.

He is the Chairman and Trustee of a number of Charitable Trusts and Funds, including the Mental Health Foundation and is a Past President of the Cambridge University Land Society.

The Whitehall Lecturer
Professor Sir Malcolm Grant CBE

Professor Sir Malcolm Grant was the Professor of Land Economy at Cambridge from 1991-2003, and is a Life Fellow of Clare College. He became Pro-Vice Chancellor of Cambridge from 2002-2003. In 2003 he took up appointment as President and Provost of UCL (University of College London) and recently completed a 10 year term of office. He was appointed CBE in 2003 for services to planning law and local government and was knighted in 2013 for services to higher education.

He is now Chairman of NHS England, the independent body charged with holding and investing the NHS budget strategically so as to secure significant long term improvements to healthcare and health outcomes for the population of England. Sir Malcolm has served as Chair of the Local Government Commission for England, of the Agriculture and Environmental Biotechnology Commission and the Russell Group. He is currently a board member of the Higher Education Funding Council for England and of the University Grants Committee of Hong Kong; and he serves as a UK Business Ambassador.

He is a barrister, a Bencher of Middle Temple, and an honorary member of both the Royal Institution of Chartered Surveyors and the Royal Town Planning Institute. He is the author of several books, including Urban Planning Law, and he was 25 years the Editor of the Encyclopaedia of Planning Law and Practice.

Introduction By Douglas Blausten, Chairman, The Cambridge Whitehall Group

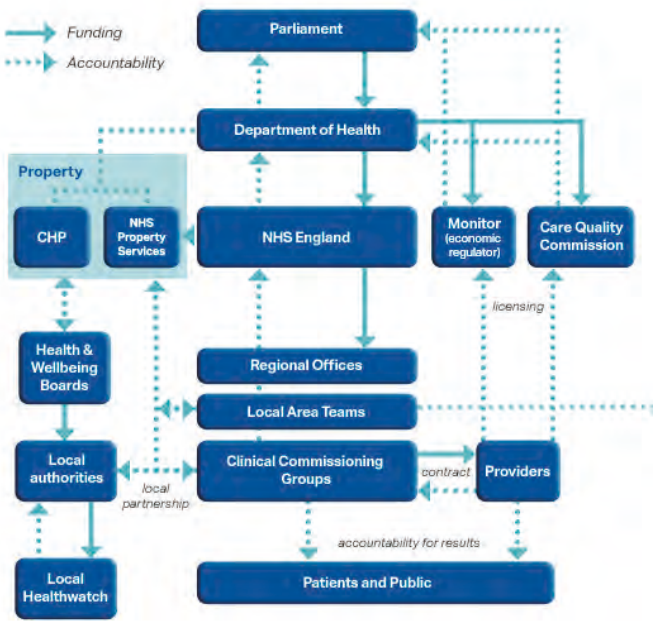
The subject of this important inaugural policy lecture is a continuation of the Society's interest in the Government estate and in particular the NHS estate.

On 1st April 2013, the Secretary of State for Health brought into being a property company through the merger of 161 Primary Care Trusts, perhaps the largest M & A transaction in Europe for decades, creating a portfolio of about 10% of the NHS estate – but still bigger in volume than Land Securities. Its portfolio has 2.7 million square metres of space in 3,800 properties with a spend of £ 800 million and a value of around £ 3 billion.

In November 2013 the Cambridge University Land Society held a conference at the Royal Academy of Engineering jointly with NHS Property Services to explore 'Developing a roadmap to cultural change; the stewardship of the NHS's property portfolio'. The idea for this lecture resulted from the Conference and the thought leadership process those in NHS Property Services have embarked upon in seeking to identify a roadmap that will distinguish the company from an NHS business to a property company providing commercially based services to the NHS to ensure, develop and maintain excellence of clinical care facilities.

The Company sits within a property industry group that has a policy of 'stewardship' and generally a single shareholder. Those companies include the London Landed estates, the Crown Estate, the Corporation of London, and the BBC. This group of asset holders have developed efficient, innovative and profitable ways of managing major assets, the profit element being interpreted as investing for the very long term as well as providing cash receipts for their shareholders. In his lecture, Sir Malcolm postulates that "....in some ways [NHS Prop Co] is a model for what is needed for better use of the NHS estate...."

Professor Sir Malcolm Grant's lecture sets the context for the enormous challenges the NHS faces, the changes being brought about and the role of real estate in the process – a vital role that can in many ways be a catalyst to bring about the changes needed. Above all he sets out the importance of the need for cultural change in how all stakeholders need to view the role of real estate in the process. It will be self-evident to the reader from the diagram below as to just how complex the NHS estate is at the moment:



I studied Land Economy long before Sir Malcolm became the Cambridge Professor of Land Economy but true to the principles of the subject he taught, he is one of the few thoroughbred academics who has actually put into practice what he taught to his students. He did this as president and Provost of UCL where he has been responsible over a period of 8 years in starting to transform the physical estate of one of the world's great Universities into one of the best teaching environments in Europe. He delivered and there is no better person to lead NHS England and to deliver this lecture.

The Whitehall Lecture Given At The Royal Institution Of Great Britain By Professor Sir Malcolm Grant CBE

For the whole of my professional life I have been involved in different aspects of the use of land and property, from the perspective of the common law and also from the increasingly complex framework of regulation, across land-use planning, environmental regulation and energy; through to a university leadership role which included property development, exacting greater value from the estate, remodelling it to the needs of teaching and research in a world-class competitive institution in a changing digital environment based in Grade I listed buildings, searching for more estate to accommodate a rapidly growing institution, and land-use planning from a user perspective (very different experience).

And now, with the NHS, I find we are facing all of these issues on a scale that is extraordinary both for its size and for its complexity.

I thought that I knew the rules well – 12 years as the Professor of Land Economy and almost 25 years as the Editor of the Encyclopaedia of Planning Law and Practice had taught me a little of such things – but the practice exists in almost a parallel universe, haunted by the ghosts of times past, and resistant to any simple rules of human and physical organisation.

Wokingham Medical Centre (Barbara Weiss Architects)

Much has been analysed and written about the NHS estate over many years, most especially in specialist reports, conferences and professional journals. But the audience to which those publications are primarily directed simply isn't enough, for two

reasons. One, the estate is too important to be left to estates professionals: estates issues are core to the business of any organisation, however large or small, yet are too often ignored in the boardroom. Two, the demography of England, the way we care for patients and the country's financial circumstances have all been changing rapidly. The estate of the NHS is potentially a huge asset, but only so far as it is adaptable to these changing demands. Without change it risks acting as a constraint upon rational operation.

We face in England a crisis that is common across all developed economies, which is that, varied as our healthcare systems are, not one of them is sustainable in its present form over the next decade. There is growing consensus that how modern societies must care for the health of their population calls for a transformation of the conventional approach. The provision of health care in the 21st-century remains a cottage industry across the globe. It has not adapted sufficiently to the changing patterns of ill health, including the shift from communicable to non-communicable disease, and towards an increasingly elderly population many of whom are living with chronic disease; it remains fragmented, and it tends to be dominated by the providers of healthcare rather than those to and for whom it is provided. Other industries faced with such challenges have either transformed themselves or died.

WHAT DOES THE NHS DO?

I need to start by outlining the service that the NHS provides. Every year, there are 438m visits to community pharmacy; 340m GP consultations (the NHS has around 1 million contacts with patients every day); 24m calls to NHS urgent and emergency care phone lines; 7m emergency ambulance journeys; 21.7m attendances at A&E departments, minor injury units and urgent care centres and 5.2m emergency admissions to England's hospitals. And the NHS does not act in isolation. Much of

Care Centre, Peterborough

what it does is in partnership with others: with the charitable sector and with local government. This volume of activity is reflected in the number of people involved in the enterprise: it is commonly estimated that the NHS employs 1.3 million people in England, alongside a further 1.5 million employed in adult social services, and an estimated 17,000 organisations involved in providing or organising adult social care at 39,000 establishments. On top of this, there are over 5.8 million people providing unpaid care to family and loved ones: of these, 3.7 million are providing free care for between one and 19 hours a week, with 1.4 million caring for more than 50 hours a week.

It has been estimated that for every hour of NHS contact, patients engage in almost 5,000 hours of self-care. That should give us pause for thought as we contemplate how healthcare may need to be transformed in the future and the role of NHS estate.

At one level, none of the estates challenges of the NHS differ from those of any large industrial organisation – and healthcare is above all a service industry. Witness the transformation in the way in which modern banking is now undertaken. Most of its activity is now virtual, with clients acting as their own bank tellers, and their former high street premises sold on to become restaurants and boutiques. Or with retail, where online shopping is starting to overtake high street provision in major sectors of activity, even with such major and trusted brands as John Lewis. Or with travel, where online advisory services, reservations, payments and check-in have rendered the high street travel agent almost completely redundant. Digital provision has empowered citizens as consumers and brought about radical changes in the way our needs are met. All the evidence is that we prefer it this way – it allows us to buy exactly the services we need.

WHAT IS THE EXTENT OF THE NHS ESTATE?

Estimates vary widely. A recent report from the King's Fund, a leading health think tank, maintains that the land owned by the NHS in England totals almost 7,000,000 ha. That is highly improbable, given that the total amount of land in England is only a little over 13,000,000 ha. More likely is the estimate that the total floor space is 28.4 million m². Both of these estimates exclude primary care premises.

The estates assets of the NHS in England estimated to be worth some £44 billion at net book value, and would cost £83 billion to replace. Annual expenditure on the estate exceeds £7.7 billion and the cost of clearing the total backlog of necessary maintenance exceeds £4 billion. A study presently underway suggests that 66% of primary care estate is not fit for purpose, and that it may cost between £1.5 billion and £3 billion to remedy this. Although there has been a significant reduction in the proportion of unused space in the four years up to 2012 – some 53% reduction – the wasted space across the NHS estate is reputed to be still greater than the size of London's Hyde Park (or, if you prefer, the entire Tesco estate in the UK). It has been argued that the adoption of broader new thinking to the use of the estate could yield up £2.3 billion revenue for reinvestment in the NHS.

The scale is vast, but many of the problems of managing a large and varied estate are common across all large organisations. Many large companies have struggled to manage their property portfolios, have struggled to ensure that estates strategy is properly considered at main board level and competently led, have struggled to ensure that the shape and quality of the estate keeps pace with the fast changing technology-driven environment that it serves, and have struggled with deeply embedded cultural issues, such as their relations with tenants, business partners and local communities. Indeed, it was this very realisation that led my predecessor, Prof Donald Denman, to establish the Department of Land Economy at Cambridge as an applied area of political economy. His mission, and that of the Department to this day, has been to deploy the tools of modern analysis to better understand the place of property in the contemporary economy.

So there is nothing unique or even unusual about these challenges in the NHS. What actually is unique is that the NHS is not an organisation nor a company, but a service. It is not, as is sometimes assumed, like a large hospital, centrally run and with clear internal lines of accountability. In fact, the service is fragmented between thousands of different organisations, and different rules govern their ability to own, develop and dispose of their estate.

THE COMMISSIONER- PROVIDER SPLIT

Since 1991 there has been a structural split between organisations responsible for commissioning healthcare, and those who they commission to provide it, whether

other NHS bodies, from the voluntary sector, independent sector or elsewhere. This has been an area of frequent reorganisation, most recently under the Health and Social Care Act 2012 which brought about the abolition of the 161 former commissioners – the strategic health authorities (10) and primary care trusts (151). Of their two major assets, property was transferred to the NHS Property Services Company (of which more later) and the 50,000 staff had the opportunity to be appointed to some of the new organisations, although there were also some 15,500 jobs lost in the reforms.

Cranleigh Health Centre, Cranleigh

In place of those former bodies, there is now a single national body, NHS England, and 211 local commissioning organisations. NHS England holds the budget for healthcare services in England, approaching £100 billion a year. It is the first time that the NHS has had a formal Board of Directors, established by primary legislation, and NHS England shares with the Secretary of State for Health a statutory duty for promoting a comprehensive healthcare service in England, plus a duty to deliver on health outcomes for the population of England as specified in a formal Mandate, renewable annually by the Government, and laid before Parliament.

NHS England commissions around £30 billion of healthcare directly, including primary care (general practice, dentistry, community pharmacy and optometry) and specialised services (where the rarity of the condition or the degree of specialisation of treatment require that it be conducted in tertiary institutions). But the bulk of the budget, around £67 billion, is allocated by us to the new clinical commissioning groups (CCGs). Although these have a statutory basis, they are locally formed member associations. Every GP is required to be a member of a CCG, and the outcome of their exercise of local choice has been the establishment of 211 CCG's of greatly varying size, serving populations ranging from 60,000 through to 900,000. Their responsibility is to commission the range of health care that is appropriate to

Kirkley Mill Health Centre, Suffolk

their populations. It is a clinically led system of commissioning, and although it is still in its early days, there are signs of outstanding innovation and radical new approaches in many of the CCG's.

In NHS language, a trust is a statutory unit of organisation through which health services are provided through hospitals and in community and mental health. Some 150 trusts have earned the status of foundation trust which, while subject to economic regulation by Monitor, confers significant freedoms for self-determination, borrowing and estates development; the remaining 99 are on that journey. Foundation trusts own their own estate and have autonomy in its development and disposal. The other trusts do not.

GPs are the other major actors. It is a fundamental tenet of the NHS that GPs are not employees. They are independent contractors, who provide a service to patients registered with them, and are remunerated mainly on the basis of a capitation payment, with some supplementation for items of service. This is unlike the hospital trusts, whose payment comes through a national tariff applied to activity undertaken by them. There are in England some 20,000 GPs operating in 8000 practices, which are small businesses. The conditions under which they work are determined in part through the GP contract, which is renegotiated annually and in part through our commissioning arrangements. As has been widely reported in the press recently, the proportion of the NHS budget going into general practice has been falling over recent years by comparison with the proportion going into the acute and mental health sector.

Property ownership within general practice is mixed. Practitioners are reimbursed their operating expenses, and have the option to own or rent their premises. For those who own, the capital value of the premises is often seen as part of a pension pot.

Alongside provision from GPs is a range of other institutions, including hospices (which are only part funded by the NHS); voluntary sector organisations such as Marie Curie and Macmillan Cancer Support; and the independent sector.

THE NEEDS OF PATIENTS IN THE 21ST CENTURY

There are two principal drivers for change in the NHS: the first is the changing burden of disease with an ageing population; the second is the financial crisis.

The health and longevity of the population of England has been transformed over the 65 year life of the NHS. The population is steadily ageing. The number of people in Britain over 85 increased from 416,000 in 1971 to over 1.1 million in 2009, and is expected to reach 2.6 million by 2032. People are not only living longer, but are living in a more healthy state. However, the length of a healthy life has not increased as much as total length of life. Hence the increased pressure on NHS services. The average age of people in hospital is now over 80. People aged over 65 consult GPs five times more frequently than the average population; they account for 62% of total bed days in hospital, and 68% of emergency bed days. In place of early death, our ageing population now live with chronic disease. One third of the population of England has at least one long-term condition and most people in that group have more than one. A third of them also have a mental health problem. One of the commonest long-term conditions associated with enhanced longevity is dementia: the number of people with this condition presently stands at around 800,000 in the UK, and we expect it to rise above 1 million by 2021. Patients with chronic disease currently consume 70% of NHS spend and their numbers are projected to rise from 1.9m people to 2.9m by 2018. Hospital provision currently lies at the heart of their healthcare support, because around 48% of health expenditure goes to acute and mental provision, most delivered in hospital.

The needs of patients have changed much faster than our health care system has been able to adapt. The gap between the two is well illustrated in this example from the recent Oldham report:

"Mrs P is widowed and lives on her own a few miles away from her daughter. She is 85, has breathing problems, high blood pressure and diabetes. In a good

month (without any emergency visits), she will see 10 different professionals from the health and social care world – each of whom has a specific task. Most of her days are spent waiting for someone to come and carry out some care. . . . Last year Mrs P went to A&E 5 times, and on two occasions she had to be admitted to hospital for breathing trouble. Both her periods in hospital came about because the various elements of care did not help to identify early deterioration. In total she spent 30 days in hospital in emergency beds. This is what happens to millions of people as a result of our fragmented system of care. It would be better for Mrs P if she saw fewer people who were better coordinated and better informed about her care and health."

THE CALL TO ACTION

It is clear to all observers that the NHS cannot continue to provide high quality service for much longer within the current funding environment. In every year since its foundation in 1948, funding has gone up by around 4% above inflation, well above the growth of GDP over that time. This has been in recognition of continually rising demand of the same order. But since 2009, although the NHS has been ring fenced, it has received little above flat real, and analysis by the Institute of Fiscal Studies suggests that, given the squeeze on other public services, there is little room for significant supplementation before 2021 without a significant upturn in GDP or increase in general taxation.

We therefore foresee a funding gap of £30bn by 2020; we believe that as much as 30-40% might be closed by traditional efficiencies (pay restraint, reduce length of stay, better procurement etc); but the rest must come from transformation. I should stress that this is not just about economics. Even if we succeeded in closing the funding gap through further efficiencies – and no other health economy in the world has ever managed transformation on this scale – we would be left with a health service poorly equipped to meet the needs of the 21st century.

Over the past year we have embarked upon a widespread consultation programme, the Call to Action. Through a series of stakeholder events, and the engagement of professional and patient organisations, we have advanced what we believe to be the six essential characteristics of a sustainable healthcare system in England

that will need to evolve over the coming five years. I must stress that all six are interdependent: this is not a pick and choose menu; nor is there any longer scope for eclectic, headline catching initiatives that fall outside these characteristics.

(1) a completely new approach to ensuring that citizens are fully included in all aspects of service change, and that patients are fully empowered in their own care. There are many aspects to this, most importantly co-production of new models of care with patients. And new technology lies at the heart of many of them. We expect all people with long-term conditions to have a personalised care plan which is accessible, available electronically, which links to their GP health record, and that conforms to the best practice standards of the world. There will be much more use of tele-health and tele-care in supporting people with long-term conditions to manage their own health and care out of hospital. Much care has already moved out of hospital settings, for example in diabetes and kidney disease. Informed patients will often know more about their condition than their GP. We can anticipate also that technological advancement, in miniaturisation of previously bulky diagnostic and therapeutic equipment and in data analytics, will continue to drive this approach. So will enhanced transparency: uniquely in the world, we have now agreed upon the publication of consultant level activity in clinical outcomes data for 10 surgical specialties, and we plan to extend this in a way that will provide new insight for both patients and healthcare professionals about the care that is provided.

The NHS is information rich and intelligence poor, hence our proposal for care. data to join up data from primary care sources with that already held from hospitals, to provide much richer data on the state of health across England, on local and regional variations in patterns of disease, and on the consequences of interventions and their implications for commissioning healthcare for the future. Without this data the NHS is effectively flying blind. As part of this program patients will have access to their own health records. Many general practices already provide patients with the ability to book appointments, order repeat prescriptions and access their medical notes on line: this will become a universal practice.

(2) Wider primary care, provided at scale: this involves access to a broader range of services in primary care, provided in patients own homes and in their

communities and with an expanded role for general practice to coordinate and deliver comprehensive care in collaboration with community services and experts clinicians. There is a growing appetite across England for new models of primary care that are more proactive, holistic and provide a more responsive service particularly for frail older people and those with complex health needs. There is huge variety in the scale of general practice: in London for example over 20% of practice is a single-handed, and 40% have only two GPs; yet there are also some practices with over 100 doctors. New models of merger, federation, alliance and cooperation are evolving all the time.

(3) a modern model of integrated care: as the example of Mrs P demonstrates, the current model of care is highly fragmented as between general practice and hospital. Delivering care in a way which is integrated around the individual patient, with a partnership between health and social care and across different elements of NHS care is an essential first step. We need also to shift our focus from treating the consequences of poor care to the causes of poor health. From 2015/16 some £3.8 billion is being transferred into the better care fund, aimed at supporting the integration of health and social care. Of that sum, £2 billion comes from internal NHS transfer, and will need to be found from the budgets of the acute and mental health trusts. The need to plan well in advance for this means that there is already a powerful catalyst to change. Significant changes in the commissioning of integrated care are now coming forward, notably in Cambridgeshire and in Oxfordshire.

(4) access to the highest quality urgent and emergency care: this follows the review undertaken by our medical director, Sir Bruce Keogh, of how we could deliver NHS services in a way that complements modern-day lifestyles and preferences, focusing on the treatment of patients as close to home as possible and establishing networks between A&E services to allow major specialised services to be offered in between 40 and 70 major emergency centres, supported by other emergency centres and urgent care facilities.

(5) a step change in the productivity of elective care: we need a new approach to the design of services managed from start to finish to remove error, maximise quality and achieve a major step change in productivity. We anticipate that this will be through centres that can deliver high-quality treatment, treating adequate numbers of patients to ensure the highest level of expertise, and with the most

modern equipment available. International comparisons suggest that there are significant productivity gains to be made if we change our model of delivering elective care.

(6) specialised services concentrated in areas of excellence: specialised services are currently being delivered out of too many sites, with too much variety and quality and at too high a cost. Nobody should any longer assume that any hospital can provide world-class outcomes across the whole range of human disease. Modern medicine is much more successful and much more dangerous than ever before. We will be looking to reduce significantly the number of centres providing NHS specialised services, and we will require standards of care to be applied consistently across England and to maximise synergy from research and learning. We can foresee a concentration of expertise in some 15 to 30 centres for most aspects of specialised care currently provided in over 300 centres.

HOW CAN CHANGE ON THIS SCALE BE BROUGHT ABOUT?

Effecting change throughout the modern NHS is difficult. The provision of health and social care is highly fragmented, and it is no longer – despite occasional reversions to past practice - a top-down system. Most organisations that employ talented people know that they get best results by liberating that talent to allow it to flourish, rather than trying to direct it (universities are a good example).

The recent reforms of the commissioning side of the NHS are focused upon liberating clinical leadership. For that reason, the 211 new clinical commissioning groups are autonomous organisations: they are not controlled by us at NHS England. We fund them, we review their plans in the context of our own planning guidance, we support them and facilitate them, and we have powers to intervene if things should go wrong. And they operate, as do hospitals and other providers of healthcare, within a national framework that includes the NHS Constitution , which establishes patient entitlements such as maximum waiting times for treatment. But top-down targets focused on process can perversely distort performance, as the instances of shockingly bad care at mid Staffordshire Hospital has demonstrated. When managers are compelled to meet targets or face the sack – and incidentally,

the average time in post of NHS chief executive is just 700 days – they tend to lose sight of their main purpose, which is to attend to the holistic needs of patients for all-round compassionate care.

And so the starting point in reform is through the high quality clinical leadership that is already in evidence with the leading CCG's. The next stage will be to secure the replication of best practice across the whole of England, adapted as appropriate to local circumstances of each CCG. As care comes increasingly to be provided out-of-hospital, so the future of hospitals themselves becomes a critical issue. Hospital trusts have extensive investment in bricks and mortar, and in staff; the introduction of the Better Care Fund from 2015 instils an urgency in the transfer of resources from these institutions that cannot readily be accommodated without threatening their financial viability, unless we have new ways of approaching ownership and use of valuable NHS estate.

WHAT ARE THE OBSTACLES?

(1) That estate tends to be tied to healthcare delivery in silos, particularly as between hospital, general practice and social care. That has been the historical model, but it need not be the case for the future. There is increasing boundary-hopping in practice: there are now many examples of GPs employing hospital consultants alongside or within their practice, particularly with multidisciplinary teams reviewing complex cases of long-term conditions; equally, we see GP surgeries co-located with hospitals, for example providing a triaging facility for patients attending A&E.

(2) Inflexibility: even buildings that have been procured relatively recently are difficult to adapt to the rapidly changing demands of modern health care. They tend to be over specified, lack of flexibility for growth or decline in particular services and to provide facilities that are used infrequently.

(3) localism: the hospital is widely regarded as a vital asset for local people, rather than as an institution which provides only that care which by reason of its degree of specialisation, or the severity of the patient's condition, cannot be provided elsewhere. That is, a hospital is a concept rather than a physical structure. But it is difficult to allay public concern about reconfiguration of hospital services or the closure of hospitals: we all associate them in our minds with the staging posts of

life, of births, of accidents, medical emergencies and death. For many, they represent community centres. And if clinicians should oppose changes to the functions of a hospital, often with the claim that lives will be put at risk, reorganisation that seems clinically and financially rational becomes practically impossible. All things being equal, people will prefer to be treated locally. Yet, at the same time, people will travel hundreds of miles to secure the highest quality healthcare with the demonstrably best outcomes: the Mayo Clinic in the Cleveland clinic in the USA are de facto national hospitals, not just local providers. Locational sensitivity means in many cases that the future of hospitals depends upon their being able to adapt to providing health care in innovative ways, and taking advantage of the new opportunities for mixed health and community use, including social care and education.

(4) vested interests: the dominant model of healthcare remains focused on providers more than on patients, and this is reinforced by our own funding models. People's jobs and self-esteem can be threatened by proposals for change.

(5) culture: the King's fund report claims that "as a client for new buildings and PFI, and as a joint-venture partner, the NHS has a reputation for being indecisive, adversarial, overly controlling and risk averse. This reduces the opportunity for innovation and increases the cost of these challenges which are factored into the price by suppliers." This culture is not uncommon in the public sector, especially in areas that are acutely exposed to political and media scrutiny. But it also reflects a lack of priority for using the estate proactively to achieve improved returns for patients.

All of this complexity requires leadership that is focused predominantly on understanding the needs of patients. There is general consensus around the need to reduce the pressure both on hospitals (and especially A&E) and on GPs, and the way forward is for healthcare to shift to the home and to the community close to home. The old ways of looking at the NHS estate are now increasingly redundant.

To achieve this requires a different understanding of priorities and assets. I'm very taken by the approach in Christchurch New Zealand, where, following the earthquake two years ago there was a need to cope quickly with a reduction in hospital beds. The leaders of their new system resolved that the most important asset was not the provision of new facilities, or additional staffing, but the time of

the patient. That starting question compels a completely different approach. Many other questions then follow: why is the concept of a waiting room so predominant in the provision of healthcare? Why do hospitals have beds, and why is their size and capacity commonly measured by the number of beds they have? Why are those who receive healthcare called patients, a title that implies dependency and need always to be patient? Why do so many providers in the 21st-century continue to perpetuate a service based on five days a week?

Much more can be done in the home, supported by a wide range of diagnostic capability in the hands of GPs, working together in modern well-equipped premises, with highly trained staff and state-of-the-art technology; also making better use of other community assets including pharmacists.

All the survey evidence tells us that most patients would prefer to remain in their home environment for as long as possible, and indeed in due course to die at home and not in hospital. If the home is to be the centre of the new healthcare estate, then the challenge is to facilitate adaptation using appropriate technologies for supporting independent living for as long as possible, and also in both adaptation and in the design of new housing, to bear in mind the growing incidence of dementia. Experience elsewhere in the world suggests that a unified approach to an expanded model of primary care arguably needs a population of around 100,000 to make it effective. Social service provision in England currently use this number for their planning, and the Netherlands have invested in 120 primary care centres with 24 hour access for patients. As a consequence, their hospital admission rate has been reduced, allowing for a reduction to 75% bed occupancy and lower levels of hospital infection.

NHS PROPCO

Property is illiquid. Transactions are lumpy: all of them carry risk, and all are time-consuming. This is a major obstacle to transformational change. To counter it, there is a need for significant cultural change: to ensure that estates are properly considered as a major strategic asset of the NHS, no matter where they are held; to widen the perspective beyond the routine tasks of maintenance and disposal of surplus estate to look at new and mixed uses, including for the models of integrated care that I have outlined above. Property has to become a catalyst for change.

The NHS estate in England is not a model of clarity. Ownership is widely dispersed, and the problems have been compounded by regular top-down reorganisations of the service during which assets of institutions being abolished have been legislatively transferred to new institutions, often without comprehensive and accurate records and with the loss of personal corporate memory. A recent example has been the establishment of NHS Property Services Ltd to take over the responsibilities previously held by the 161 strategic health authorities and primary care trusts in respect of the day-to-day management of NHS estate.

Records had been kept by the 161 on widely varying bases, and in many cases remain incomplete and inaccurate. We do know that NHS Propco holds over 4,000 properties, amounting to around 20% of the total NHS estate. Much of the property is vacant, or underused. The company took on over 3,000 staff, and has a focus on modernising and improving NHS facilities for patients and staff, and ensuring that the costs associated with managing and running the estate are fully recovered, working closely with partner organisations in the reformed NHS. They also have the responsibility of disposing of facilities that are no longer required or no longer fit for purpose.

The buildings that they hold include administrative estate, GP practice buildings, community hospitals, some NHS foundation trust and NHS trust properties, pharmacies, health centres and walk-in centres and dental practices. All proceeds from sales are to be reinvested for the benefit of patients. It works with NHS England, the CCGs and the other NHS organisations to ensure the efficient and effective running of NHS Estates. The total value of the business is approximately £3 billion.

NHS property services is one of the biggest property companies in Europe, yet it is still in transition from a start-up. Europe's other property companies have developed over time; NHS Propco has had its property thrust upon it. It has experienced serious cash flow problems, and needed an injection of further transitional funding from the Department of Health. An enquiry by the National Audit Office is expected to report shortly.

Yet in some ways it is a model for what is needed for better use of the NHS estate, if only in the sense that it has brought into single ownership an unusually fragmented

estate. Ownership within silos is inimical to the radical reforms that are needed, and will have a dead hand effect on local innovation. Many trusts are too small to have the flexibility for estates reform that will be necessary.

THE FUTURE

I conclude with some thoughts about possible models for the future, and how fragmentation may be turned to the advantage of patients.

First, there needs to be a review of all property holdings across each local health economy and the compilation and publication of a comprehensive asset register. Evidence suggests that there is considerable room for improvement in behaviours to overcome the wide variation in performance between NHS trusts: whilst the best trusts have been active in pursuing high levels of utilisation, senior staff in other trusts often don't know their own metrics for area, condition and costs by estate type.

Second: mergers. There will continue to be a number of mergers as part of the consolidation of the NHS, implicit in the understanding that not all trusts will become foundation trusts. But mergers tend to be high risk and time-consuming – they may even be challenged under European competition law by the new Competition and Markets Authority on the basis that they are anti-competitive by reducing patient choice, even although the intention is to concentrate provision in such a way as to improve outcomes for patients. Mergers do not necessarily offer the flexibility that will be needed.

Third, the pooling of real estate assets through such means as a special purpose vehicle, and establishing a separation of ownership from operations. If so created, as a not-for-profit entity, across a local health economy, and with partnership with other branches of government, including local government, and a mandate to use the collective real estate strategically in the interests of enhancing out of hospital care, an SPV could be a major driver for change in an environment where the estate threatens otherwise to be an obstruction rather than an enabler. It could facilitate partnership between different NHS organisations, including trusts and CCG's, and local government. To be successful it would need to include all the relevant interests and provide adequate consideration, probably through equity shares, to the

organisations pooling their estates interests. Such a model is now under development for the London Mayor's Healthcare Commission, in a city which has the paradox of some of the world's best hospitals and some of the world's worst health outcomes.

An alternative model for pooling of estates would be by creating a chain of management for a group of hospitals and other providers, tied to local health economies or ranging further afield. This model, now widely deployed in Germany, has the advantage of an industrially efficient approach to the provision of back office services, and a more efficient use of the estate. It could also be a driver of a more integrated model of care.

Fourth, considerable efficiency gains are possible by providing NHS services in a range of non-NHS buildings, such as nursing homes, schools, retail premises and pharmacies. Equally, NHS facilities can more readily be made available for use by other related community users. Monitor, the NHS economic regulator, has calculated that £4.2 billion to £6.4 billion of estate value could be realised if acute trusts improved their asset utilisation.

Fifth, imaginative redevelopment, including for providing much-needed new housing. The King's fund report highlights the experience of Townlands Community

St Ann's Valley Centre

Hospital, at Henley-on-Thames. The whole of the existing site was split into three sections: the site of the original hospital was sold freehold, the listed buildings refurbished, and the additional development designated as a private older People's Housing scheme. The second section was sold on a long lease to the Order of St John to build a care home, which included facilities for patients with Alzheimer's disease. The income from those two transactions was used as a prepayment on a lease to a developer to build and maintain a new community hospital, the tenants of which include a community services foundation trust, an acute foundation trust and a national hospice operator. But it took 15 years to achieve. We need urgently to facilitate joint development occupation schemes with local authorities to give effect to the Better Care Fund, and an expedited planning process that places a higher priority on the health of the nation.

Sixth, lessons can be learnt from the transfer of mental health functions in the 1980s from the old asylums into new models of community services. This was facilitated by a banking function which allowed organisations to borrow, and also to restructure their operational and business models. Capital investment, through a rolling fund, will be critical to freeing up the processes, together with expedited Treasury approval where that is required, approached within the framework of the overall strategy rather than as a series of one-offs.

Seventh, whatever the mechanics, a guarantee that all return from disposal, development or redevelopment of the NHS estate must accrue to the benefit of patients in the local health economy. It's all about patients, not about property development for its own sake. Every part of a new strategy has to serve the interests of patients in a rapidly changing ecosystem.

CONCLUSION

For the NHS estate to serve the needs of the patients and public of the future, we have a duty to unlock the presumptions of the past. The starting point is to conceive of the NHS estate as a single huge asset, with the potential – through transformational leadership – to deliver the facilities necessary for a modern model of health and social care, and to return both capital and revenue into the NHS to support continuous improvements in the quality of care for patients.

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