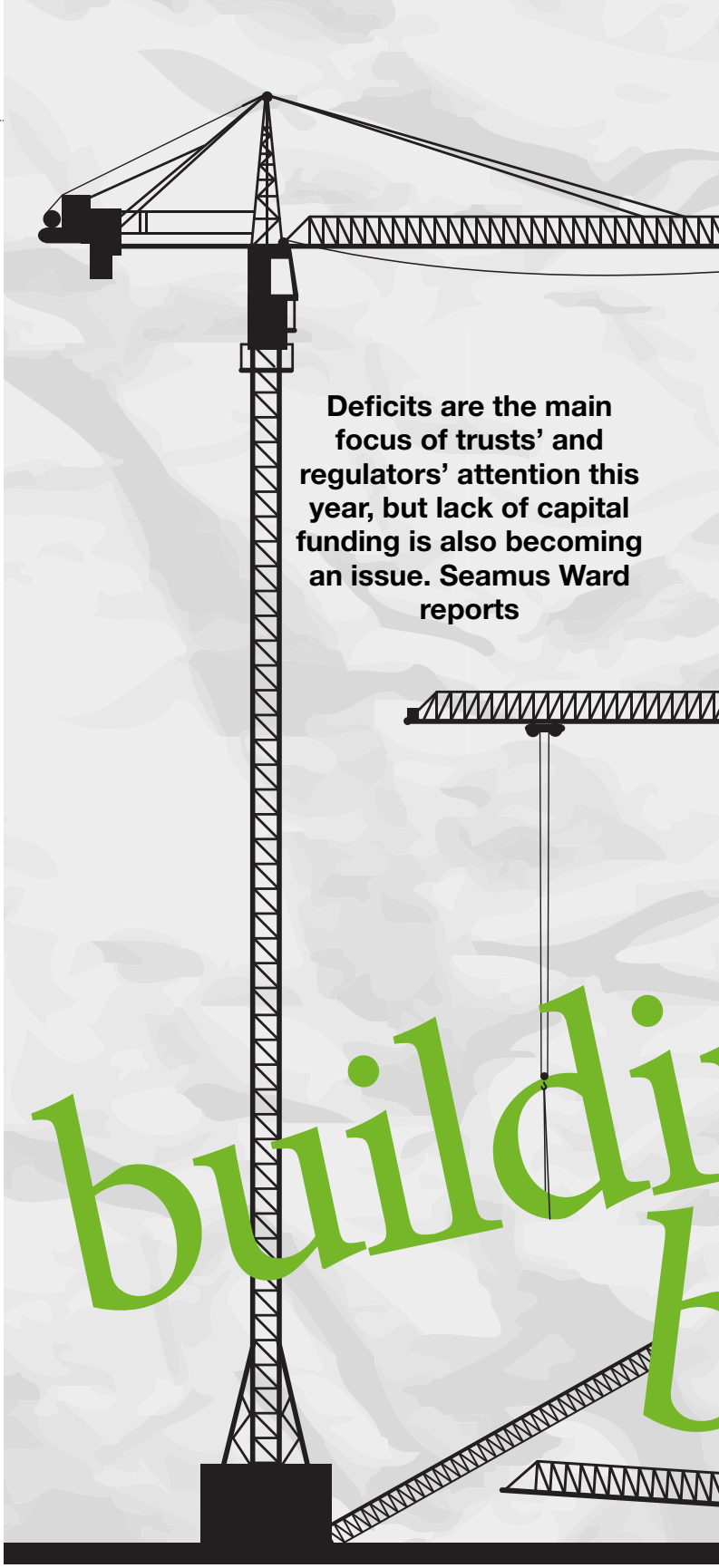

Deficits are the main focus of trusts' and regulators' attention this year, but lack of capital funding is also becoming an issue. Seamus Ward reports

In recent months, the focus for NHS finance in England has been on reducing the forecast revenue deficit in providers, particularly in acute trusts. A number of measures have been taken, including local and national capital to revenue transfers. And in 2016/17 capital allocations have been reduced to transfer funds to support revenue budgets. The message is clear from the centre (NHS Improvement and its predecessors): capital is being restricted as efforts to get the NHS provider revenue budget back into balance takes precedence.

But can the service afford to reduce the availability of capital funding? The spending review allocated £4.8bn to NHS capital budgets in each year of the five-year period, although for 2016/17 this appears to have been reduced by about £1bn in the March Budget.

The Department of Health promised £500m of the original sum would be spent on building new hospitals. The Department also hopes the NHS will generate £2bn from the sale of surplus estate over the course of the parliament. Internally generated funding such as from asset sales and depreciation will be vital – NHS Improvement is clear that loans will only be made in a rapidly reducing number of exceptional cases.

Cost of transformation

But there is growing concern. Service transformation could be particularly capital-hungry as care is moved out of hospitals, perhaps to new or refurbished units in the community. One finance director says each of the 44 sustainability and transformation plan footprint areas will have its own capital needs. And, while surplus land and building sales will help, he doubts they will raise enough to meet their requirements.

There will also be significant need for new IT and diagnostic and imaging equipment must be refreshed regularly. Meanwhile, the Department says backlog maintenance exceeds £4bn, including £1.5bn needed to address maintenance classed as high or significant risk.

So how are trusts coping? In general, there is a feeling that capital for transformation may be needed further down the line – next year possibly. But capital is still needed this year as trusts begin to address Carter efficiency measures (implementing step-down facilities to reduce delayed transfers of care, for example) and beef up electronic patient records, as well as procuring new equipment and carrying out vital maintenance. It's not difficult to find building or refurbishment projects that have been postponed, and trusts are sweating assets beyond their planned life cycles.

Finance directors say trust capital funding and cash positions cannot be seen in isolation. Surrey and Sussex Healthcare NHS Trust chief finance officer Paul Simpson says restrictive cash controls are being applied to encourage trusts to manage their financial positions and deliver NHS Improvement's priorities, such as control totals and agency spending reductions. It is tougher to access working capital.

His trust had a £6.6m deficit in 2015/16, with a £12.5m working capital facility. Going into 2016/17 with the restrictions outlined above, its senior leaders have thought carefully about how it will manage cash.

One of the steps the trust has taken is to discuss how it will spend its capital funds with its chiefs of service – consultants who lead service directorates such as cancer, surgery and women and children's services.

Surrey and Sussex Healthcare NHST has spent £14m on theatres

Mr Simpson says: 'With the agreement of chiefs of services, executive committee (of which chiefs are part) and board, we've set our capital programme £3m lower than our capital resource limit is expected to be. We have done this at the start of the year so that later in the year we can take the decision to spend it or keep it if we need it for cash flexibility.'

Nick Gerrard, East Kent Hospitals University NHS Foundation Trust director of finance, says the position is getting tougher. 'When I got to the trust last May, cash was a serious issue so we took a decision to

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cut £5m from the capital programme and put in train another £5m of asset sales. To take the £5m off the capital programme meant we had to delay some refurbishment, procurement of equipment and backlog maintenance to safeguard our cash position.'

The move worked, but compromises had to be made – the purchase of a CT scanner was postponed until the new financial year, though the building work to house the scanner was completed. The refurbishment of surgical assessment and fracture units was also delayed.

Mr Gerrard says his trust has a balance sheet of £320m and an ageing estate. Last year, after the reduction in the capital budget, it spent about £12.5m on capital and plans to spend around £14m this year. 'Compared with our needs, it's a drop in the ocean,' he says. 'It's an emerging risk for all trusts. There's insufficient money to replace equipment so assets are running well beyond their standard lives in pathology and radiology, for example – all the big-ticket items. The cath labs that were bought nationally 10 or 12 years ago are all coming to the end of their lives too.'

"We recognised that restricting the capital programme would be problematic; hence the discussions with the service chiefs. We are now taking a breath so we can consider how we move forward"
Paul Simpson, Surrey and Sussex Healthcare NHST

There are other signs of a slowdown in capital spending. Mr Gerrard sits on the NHS Supply Chain customer board for the south of England, leading work on the co-ordination of capital projects to maximise the health service bulk buying power. Near the year end there is usually a marked increase in deals as trusts look to spend their available capital.

But he says: 'There was hardly anything at the end of 2015/16, as people were safeguarding their cash and some had given up capital in exchange for revenue.'

Mr Simpson acknowledges that the restriction on capital will be tough for his trust. A capital investment programme over the past five years has been a vital part of rebuilding its reputation for clinical quality. The Care Quality Commission rated the trust as 'good' in 2014. 'We have spent £14m on new theatres, got a new A&E department and main entrance – we have been doing a range of things linked to changing how we work. We recognised that restricting the capital programme will be problematic; hence the discussions with the service chiefs.

'We are now taking a breath so we can consider how we move forward with the key things we need.'

Making a difference

The current capital programme may sound mundane, but will make a difference, Mr Simpson says. The completion of an on-site medical records unit will include areas for consultants and others to work, freeing up space for patients elsewhere in the hospital; the emergency department will get its own CT scanner, ending the need to move its patients around the hospital; and the trust will be spending significantly on basic ward refurbishment.

He adds that the trust is aware that clinicians identify needs for capital expenditure during the year, after plans have been made. 'Our flexibility is considerably reduced, but if there is an absolutely essential need we will do something about it. However, we have found that this process has resulted in chiefs of service managing this and that will help us be clear about anything we urgently need to do while being fair. Their input, rather than just our capital group doing it, is a notable shift in terms of the management of the hospital.'

The Surrey and Sussex trust will need extra capital and intends to lodge a business case with NHS Improvement for a loan to further develop its electronic patient record. 'This would bring revenue benefits [in 2017/18], reducing lengths of stay by providing better information to clinicians, quicker and in the right format,' Mr Simpson says.

There are potential alternative sources of capital funds. Some trusts

Capital focus

While the NHS in England has cut capital spending in 2016/17 and transferred capital funding into revenue budgets, Scotland appears to be bucking the trend.

It has a recent history of publicly funded hospital projects, including the £842m Queen Elizabeth University Hospital in Glasgow (pictured), which opened just over a year ago.

This year, capital investment will increase by £292m to £495m. Most of this (£352m) will be held centrally to support a number of building projects, such as the new Edinburgh Royal Hospital for Sick Children and the Dumfries and Galloway Royal Infirmary.

While the Edinburgh and Dumfries developments are being funded through the non-profit distributing model – the Scottish government's replacement for traditional private finance initiative projects – public funds have been set aside for items such as enabling works and equipment.

A recent agreement on the balance sheet treatment of NPD has opened the door for the model to be used more widely, according to law firm Blake Morgan. Partner Simon McCann said: 'I'd expect this development will now kick-start the adoption of NPD projects across the UK. As long as the projects are properly structured, there is no reason why they cannot become the "new PFI".'

The territorial health boards will receive a total capital allocation of £133m while special health boards will receive around £9m.

The funding includes £23.5m to begin work on a network of diagnostic and elective treatment centres.

Though organisations in England are transferring capital to revenue budgets to minimise deficits, in Scotland territorial health boards have been sending funds the other way – from resource budgets to capital. The Scottish government has recognised this and in 2016/17 has included £53m of additional capital in boards' allocations to remove the need for resource to capital transfers.

are exploring the possibility of using partnerships with local authorities and other public sector bodies to gain access to non-NHS capital.

Mr Gerrard says some central funding for specific uses is available, highlighting the Department's technology fund for IT infrastructure. However, the £1bn fund announced in the spending review is spread over five years and will primarily support the move of care out of hospital and the integration of health and social care records.

Technology demands

Demand for new IT is rising – from the likes of new pharmacy, procurement and costing systems, while joining up systems to share data will be crucial to the Carter process. Lack of capital could have as much impact on IT schemes as on traditional capital projects, such as buildings and equipment. A Department review of NHS IT, including electronic health records and the paperless NHS, is due to report in June.

'We have been talking about a business case to replace a lot of our paper medical records,' Mr Gerrard says. We are looking at £5m in capital over the next five years and £3.5m in revenue in transition and implementation costs. At the minute, it's hard to see where that could come from. Trusts will have to take harder and harder decisions – do you replace an ultrasound or choose an IT project instead?'

While the watchwords will be 'make do and mend' in some cases, in others it will be about other ways of procuring equipment, such as leasing and managed equipment services (MES).

Some finance directors see them as too complex and expensive, but trusts are looking to sign deals with the private sector. Just last month, Asteral signed a five-year managed maintenance contract with Royal Berkshire NHS Foundation Trust, covering its diagnostic imaging equipment, including MRIs and CT scanners.

Nancy West, Siemens Healthcare head of business development, healthcare enterprise solutions, says that while NHS trusts' appetite for purchasing new equipment has not declined, financial pressures sometimes lead to projects slipping. She adds there is a 'healthy interest' in MES with more routes to procure these deals.

With MES paid from revenue, she accepts that they could add to the pressure on a trust's revenue budget, but believes that the benefits outweigh these costs. MES contracts add value by offering the opportunity to forge a partnership that can lead to further efficiencies and access to new technologies.

'MES contracts typically offer price certainty and assured equipment

refresh during the concession term. These long-term contracts typically include finance and performance risk transfer. MES contracts have usually also enjoyed favourable VAT treatment as they are delivered as a service, with assets typically owned by the MES provider.'

Her colleague Chris Wilkinson, head of sales for healthcare and public sector for Siemens Financial Services in the UK, adds that leasing and other asset finance techniques remain important for the NHS. As well as allowing the cost to be spread over an agreed period, trusts can expect to benefit from improved operational efficiency and patient care, he says.

'The equipment can be paid for from the trust's revenue budget over its working life, thereby removing the need for a large initial outlay,' says Mr Wilkinson. 'Recent research from Siemens Financial Services shows that a majority of healthcare organisations regard access to such flexible financing techniques as an important prerequisite to meet the common challenges the sector faces.'

Surrey and Sussex is also looking at newer and innovative sources of funding. When granting planning permission, local authorities can levy funding from developers. This community infrastructure levy (CIL) can be earmarked for a number of public sector projects, including in health. Sums raised vary, though perhaps the most significant CIL is helping fund London's £14.8bn Crossrail project – in just under four years to date, the mayor's CIL had raised about £200m.

Outside the capital, the amounts raised by CIL will be less, but the Surrey and Sussex trust is keen to tap into this potential source of funding. Mr Simpson says the trust has written to around 20 local authorities in its area and received responses from all.

'CIL used to be restricted to things like GP surgeries, but as emergency activity grows – we had 6% growth across the trust last year – it is acknowledged there is an issue with infrastructure in hospitals,' he says. 'One of the district councils has already invited us to submit a bid. Working with councils on this has also helped joint working and planning in a more co-ordinated way.'

"A majority of healthcare organisations regard access to flexible financing techniques as an important prerequisite to meet the common challenges the sector faces"
Chris Wilkinson, Siemens Financial Services

The trust and councils are working more closely with local clinical commissioning groups, he adds, with growing recognition that increases in population have an impact on hospitals, as well as primary care.

The trust is working with East Surrey Clinical Commissioning Group and Surrey County Council to reduce the number of delayed transfers of care in patients who are medically ready to be discharged from hospital. In January, they opened an integrated reablement unit run by social care staff, with the building funded by £900,000 from each of the three organisations. Mr Simpson says trusts will increasingly be looking at this model. Indeed, the trust is working on a similar project for frail patients.

Other partnerships are important. It opened a cancer information centre with Macmillan Cancer Support, funded with £400,000 from the trust and the balance of £1.2m from the charity. It is also working with Brighton and Sussex University Hospitals NHS Trust on a pathology joint venture that will require a new microbiology laboratory to centralise services and a substantial joint managed lab service contract.

With traditional funding constrained, it is clear trusts will have to be innovative as they look to provide new facilities, maintain existing ones and procure the latest diagnostic equipment.