Shaping healthcare finance...

Discussion Document

The Future of Planning and Funding Capital Investment in the NHS

February 2013

Purpose

The HFMA's Financial Management and Research Committee has discussed the future of capital planning and funding in the NHS. The first version of this discussion document was drafted in the autumn of 2012 to highlight the issues raised and posed a series of questions reflecting the uncertainties surrounding capital in the NHS. Having sought the views of members and practitioners to help inform the debate in this area, the document has now been updated to reflect the comments received and wider changes since it was first drafted.

Introduction

As the new landscape of the NHS continues to take shape, the HFMA has been considering the future of planning and funding capital investment. This has always been an area that only a few know about or deal with but is very important as the NHS estate in its widest sense (which encompasses not only land and buildings but also IT and medical equipment) dictates to an extent how efficient the service can be and how it can develop over time. Although the estate also needs replacement, on-going renewal and maintenance to remain fit for purpose is also vital.

Given the need for public sector spending restraint and the continued drive for on-going savings to sustain the service, previous sources of capital for major investments are unlikely to be available to the NHS in the future. This document summarises the issues and challenges that have been identified focusing on capital for major investments. It also poses a number of questions on which members' views are welcome.

Challenges in the immediate future

The following represent significant areas of challenge:

- Reduction in the Department of Health (DH) capital limit: a reduction in capital monies was announced in the 2010 spending review – there will have been a 17% cut in the capital budget by 2013/14
- Ownership of primary care estate: NHS Property Services Limited is in the process of taking over the residual primary care trust and strategic health authority estate (approximately 3,700 properties and the associated staff). NHS bodies using NHS Property Services Limited premises will pay a revenue charge but not incur capital expenditure or depreciation. A commercial solution to the estate and NHS Property Services Limited is likely to be developed by 2016
- Surplus primary care estate: the most suitable option will depend on the asset in question and the wider economic conditions at the time. For assets owned by the NHS, the options to be considered here are disposal; lease or re-development
- Temporary lending programme: HM Treasury's temporary lending programme will initially run until July 2013, providing a government loan alongside private sector investment to 'kick start' public private partnerships if certain criteria are met.

Financing

In its recent Fair Playing Field review, Monitor highlighted the access to and cost of capital as key issues preventing all organisations (both public and private sector) having comparable access to competing for and delivering healthcare services. Although a truly fair playing field may be unattainable, a number of significant issues have been identified in relation to financing capital investment now and in the future.

Confidence over income

The current mechanism for reimbursing many healthcare providers (Payment by Results) reimburses providers for average costs i.e. the average level of capital expenditure. Uncertainty of future funding streams is exacerbated by the inherent time delay in producing the current tariff and annual changes to the tariff itself.

At its simplest, the tariff could be adjusted by a capital weighting to recognise organisations with a higher cost of capital. Regular review and recalculation would be essential to reflect changes in the relative position of organisations as investments aged and new ones came on stream. However, a degree of long term stability would be required to enable prospective investments to be properly modeled and assessed.

This is best supported by accurate, granular costing with all organisations involved in the cost collection process using a more detailed approach to costing. Private and independent providers are unlikely to have the same level of infrastructure costs as NHS providers

supporting emergency and non-elective healthcare services and this must be appropriately reflected. This is also the case where NHS organisations already have significant major investments particularly existing private finance initiative (PFI) schemes. As a result, the costs for some providers are inherently higher than for others which need to be reflected in the tariff and any adjustment for the cost of capital.

However, it is unlikely that funding through prices alone would be sufficient to encourage cooperation between a group of smaller organisations to support a major capital investment and another solution would be required.

Affordability of existing schemes

High infrastructure costs must be subsidised from within an organisation's existing income often alongside additional reductions in operating costs: the higher the cost of capital the greater the focus on securing savings from clinical services and the greater the potential impact on safety and the quality of care.

Public/ private partnerships

Public private partnerships have been under intense scrutiny by both HM Treasury and the DH. The new approach which will replace the private finance initiative was announced alongside the autumn statement on 5 December 2012. The government is committed to the continuation of private sector involvement in public sector infrastructure projects and proposes a new long term contractual arrangement know as 'Private Finance 2' or PF2. Under this approach, the government will act as a minority equity co-investor with investments managed by a commercially focused central unit located within HM Treasury. Recognising the importance of greater transparency, information will be published in relation to the progress of individual projects as well as the private sector returns generated. Individual organisations will no longer undertake the procurement process for themselves; rather an NHS central procurement unit will undertake this role. However, the responsibility for asset design, construction, maintenance and renewal will continue to be reflected in the award of a single contract to the preferred bidder. Greater flexibility will be introduced by excluding soft facilities management services for example, catering and cleaning from service contracts – a feature of a number of existing PFI agreements.

Since the economic downturn of 2008, public private partnerships have been significantly affected by economic conditions and there are now fewer lenders to support this type of investment. It has been increasingly difficult to raise debt finance from the private sector and at the same time, the cost of borrowing has increased alongside a reduction in the availability

of long term debt. As a result, the PF2 approach requires '…bidders to develop a long-term financing solution where bank debt does not provide the majority of the financing requirement.'[1]

Financial track record

For borrowing to be affordable, organisations need a good financial track record. This is particularly pertinent for newly established healthcare social enterprises/ community interest companies created as a result of the Transforming Community Services project. With a limited asset base and less than two years in operation, these organisations face a significant risk premium for any capital secured.

Questions to consider

What needs to be done to the tariff to make capital investment affordable in the longer term?

Which form of public private partnership is best suited to the NHS? How can this be supported with the NHS capital regime?

How can newly established NHS organisations gain access to affordable borrowing with a limited financial track record?

Availability and source of funds

The worsened economic climate has reduced the availability of traditional sources of public expenditure available to the NHS. In the future, sources of funds may be limited to the following:

- Borrowing: it is important for individual organisations to consider the value for money of different sources of borrowing. However, if options here are severely constrained then commercial borrowing might be the only means to fund capital investment in the future
- Pooling resources: it may be helpful for the DH to consider whether capital receipts could be pooled to create a fund to support redevelopment in areas with inherently low land and property prices where asset sales are likely to be more challenging or to

[1] *A new approach to public private partnerships,* HM Treasury, December 2012

support smaller providers who do not have the income stream or critical mass for major capital schemes. This could be devolved to geographical areas to encourage local coordination

- Social impact bonds: a longer term approach to investment where private sector money is invested in a public sector project to deliver improved outcomes. As outcomes improve, both the initial investment and a return are paid to the private investor
- Pension funds: there may be increasing scope for investment to come from large pension funds which are able to diversify their investments and therefore the associated risks
- Partnership with a private or public sector organisation for example, with a local authority which may be able to borrow at rates far below commercial rates. A partnership also creates the possibility of enhancing joint planning and reducing overall costs through sharing common services.

In response to the initial discussion document, it was suggested that better access to capital could be facilitated by the underwriting of a scheme by or a risk share agreement with the NHS Commissioning Board to encourage private sector capital investment. This would enable a small organisation to benefit from a major capital scheme on the basis of a robust business case.

Questions to consider

Can the NHS make use of HM Treasury's temporary lending programme (currently available until July 2013)?

Should a public sector source of borrowing continue to be available for public sector organisations?

Should this be made more affordable than private sector equivalents?

Could social impact bonds and/ or pension funds be viable sources of financing capital expenditure in the NHS?

Planning

Approach

The need for a consistent approach across the NHS and a greater degree of certainty were identified as critical factors for planning capital investment. In particular it was noted that planning by individual organisations can be undermined by annual or ad hoc changes.

However, recognising that all organisations must manage uncertainty, it has been suggested that a standard business case assessment process would support capital expenditure in the most appropriate areas irrespective of organisation or NHS sector. This would need to be sufficiently flexible to deal with large and small capital schemes while being 'user-friendly' to all and meeting HM Treasury requirements.

Timing

For all NHS organisations, planning well is vital to ensure that the right thing is done at the right time within the overall strategic intention of delivering better patient care. This includes capital projects and managing their financial impact.

Flexibility

Flexibility in asset use and the way in which capital assets are financed may provide a workable solution to make better use of existing assets. For example, this may be through a 'multi-part' approach to redevelopment whereby a site is split into component parts with a different approach taken to financing each element.

It is also worth considering that as public sector holdings in PFI or LIFT companies are 'fixed' and are subject to guaranteed payment under contract, any rationalisation of the NHS estate must accommodate these 'fixed points', whether or not the estate itself remains suitable.

Financial duties

Although well established within the financial regime of the NHS, it has been suggested that a review of capital resource limits and external financing limits for non foundation trusts is now timely. The separation of revenue and capital for the achievement of financial duties is specific to NHS trusts; foundation trusts operate without such limits and can manage their financial position as a whole while remaining within an overall borrowing limit. As NHS trusts move towards foundation status they could be required to ensure that expenditure adequately caters for the replacement and maintenance of an organisation's assets while supporting strategic plans.

Questions to consider

How are the NHS reforms combined with the economic climate going to affect capital spending, planning and financing in the coming years?

What is the best mechanism for driving efficiencies in the use of capital assets?

How can a level playing field be created within the NHS?

What would be the best long term solution for the properties transferred to NHS Property Services Ltd?

How could the NHS make best use of the surplus primary care assets?

Could the NHS share assets with other public or private sector organisations?

Summary

The future of major capital projects in the NHS depends on the availability and affordability of funds to support long term projects. The NHS must also seek to achieve a 'balance' within each local health economy. Therefore, a wider focus on 'whole health economy' projects may offer a way forward to better meet local health needs, share risk and improve affordability.