

# Developing an estate strategy

For information only:  
All NHS trusts,  
including primary care trusts  
and foundation trusts

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# Developing an estate strategy

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# Executive summary

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A well thought-out estate strategy is essential to the provision of safe, secure, high-quality healthcare buildings capable of supporting current and future service needs. An estate strategy cannot be developed in isolation. Rather, it is an integral part of service planning.

This guidance gives best practice advice on developing a robust estate strategy. It includes example strategies in the form of case studies.

This document is directed primarily at senior managers in all NHS trusts, including primary care trusts (PCTs) and foundation trusts, and those involved in private finance initiative (PFI), public-private partnership (PPP) and local investment finance trust (LIFT) schemes.

'Developing an estate strategy' complements two other key documents: 'Estatecode', which includes a section on property appraisal for assessing the state of the existing asset base, and the 'Capital Investment Manual', which sets out the process for procuring new capital assets. This document should therefore be read in the context of the other two.



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# 1 Introduction

## What is an estate strategy?

An estate strategy is a plan for the current and future development/management of your estate. It is recommended that it should cover 5–10 years and should culminate in the production of a high-level, written document.

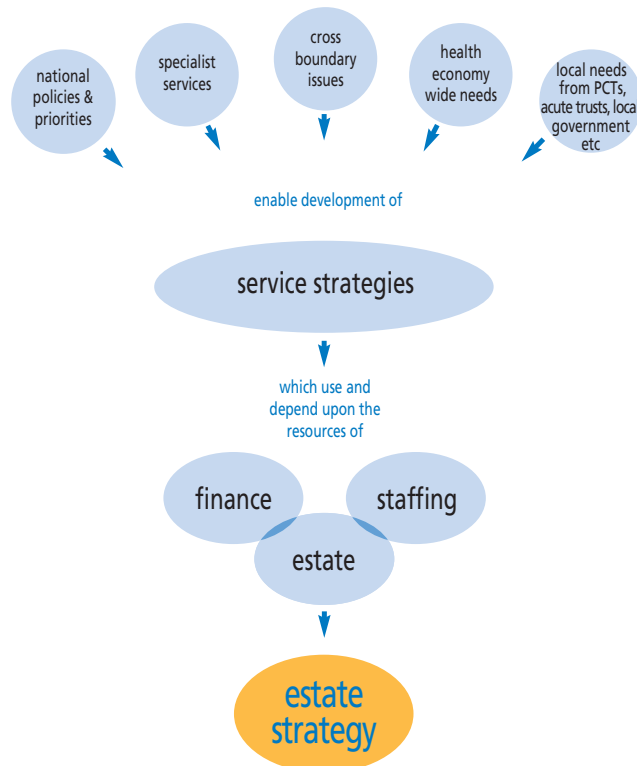
All NHS trusts, including primary care trusts (PCTs) and foundation trusts, are advised to have an estate strategy.

The starting point for developing an estate strategy is to identify the current and future healthcare service needs of your local population and the current condition of your healthcare estate. An estate strategy cannot, therefore, be developed in isolation. Rather, it is an integral part of service planning.

Strategic health authorities (SHAs) are tasked with setting the overall service and estate framework within which trusts develop their individual strategies. This should identify service-led changes to the estate over a 10-year period and define high-level estate performance requirements.

PCTs are advised to develop strategic service development plans (SSDPs). Any local service plans should take account of plans for the wider healthcare community.

Figure 1 The strategic planning process





The development of an estate strategy should lead to the production of a strategic outline case (SOC) or outline business case (OBC) for each investment scheme under consideration. In other words, an estate strategy is an essential precursor to the allocation of capital.

## What are the benefits of an estate strategy?

An estate strategy provides the following benefits:

- premises developments that support service/capacity requirements and national/SHA commitments;
- the provision of safe, secure and appropriate buildings;
- the provision of high-quality healthcare environments, which may aid staff retention/morale and patient outcomes/satisfaction levels;
- a plan for change that enables progress towards goals to be measured;
- a clear commitment to complying with sustainable development and environmental requirements/initiatives;
- a means of targeting investments to minimise the risks associated with the built environment;
- an opportunity to dispose of surplus and/or poorly-used assets and reinvest released resources;
- an opportunity to optimise occupancy costs.

## Who is responsible for the estate strategy?

Trust chief executives should ensure that responsibility for the production of their estate strategy is clearly assigned to a senior manager, usually the estates and facilities director.

It is important that the strategy is considered and approved by the whole of the trust board. It is recommended that it is reviewed, at least annually, by a senior manager.

Estate strategies should be monitored on an ongoing basis by your local SHA strategic adviser to ensure a fit with strategic asset management.

## Purpose and scope of this guidance

This guidance gives best practice advice on developing a robust estate strategy. It includes example strategies in the form of case studies.

It is directed primarily at senior managers in all NHS trusts, including PCTs and foundation trusts, and those involved in private finance initiative (PFI), public-private partnership (PPP) and local investment finance trust (LIFT) schemes.

## 2 The context within the NHS

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### Introduction

The NHS estate has a current use value of about £24bn and a significantly greater replacement value. The overall aim of the Department of Health (DH) is that at least 40% of the total value of the NHS estate should be less than 15 years old by 2010.

Approximately 20% of a trust's annual income is spent on its infrastructure. This is a significant financial commitment that needs to be managed effectively.

Patients' first impressions of healthcare services are formed by the appearance of healthcare buildings and facilities. Services should therefore be delivered in well-designed environments.

Patients and staff need to feel safe, secure and comfortable. Healthcare buildings should ensure good functionality, meet expectations in terms of privacy and dignity, provide good access for all, reduce infection and minimise accidents.

*"Care is provided in environments that promote patient and staff well-being and respect for patients' needs and preferences in that they are designed for the effective and safe delivery of treatment, provide as much privacy as possible, are well maintained and are cleaned to optimise health outcomes for patients."*

Source: 'National Standards, Local Action: Health and Social Care Standards and Planning Framework 2005/6–2007/8'. DH, 2004.

Estate strategies should be developed within the context of public expectations and Government initiatives for delivery of healthcare services.

### The drive for increased choice and quality

'Building on the best: Choice, responsiveness and equity in the NHS' (DH, 2003) sets out new policies for giving people real choice in how they access and use healthcare services.

From the point of view of estate planning, the report emphasises the importance of offering a choice of provider for selected surgical procedures, the need to build capacity for people with long-term conditions, and encourages innovative new providers for a wider range of services in primary care.

'Improvement, Expansion and Reform: The Next 3 Years: Priorities and Planning Framework 2003–2006' (DH, 2002) describes requirements for

improvements to GP premises and the establishment of one-stop primary care centres and treatment centres.

## **Payment by results**

The introduction of the national tariff and its use in contracting healthcare procedures over the next four years will introduce fresh incentives for trusts to manage their costs efficiently.

The largest element of a trust's overhead costs is its estate overheads, which can only be changed by careful forward planning linked to targeted investment. Your estate strategy should examine how fixed overheads can be reduced.

## **The need for comprehensive planning**

Initiatives to modernise the NHS, including shifting services from secondary to primary care, have given renewed emphasis to the importance of coherent service planning across the wider health community. This requires close partnership working between SHAs, PCTs and local NHS trusts.

The "long-term conditions" initiative, in particular, is facilitating more community- and home-based services.

The estate strategy for each trust should not be developed in isolation but needs to take account of service changes across the wider area. The interaction between health and social care also requires that account be taken of local authorities' strategies.

## **Capital procurement**

An estate strategy provides an essential framework within which procurement proposals can be developed and evaluated. The strategy should therefore be recognised as an integral part of the procurement process.

For major capital schemes, it will form one component of the SOC. With current pressures on the allocation of capital, it is unlikely that investment proposals will be approved in the absence of a comprehensive and up-to-date estate strategy.

Successful procurement demands an emphasis on outputs. In other words, it requires a clear specification of what any capital investment will achieve in terms of service delivery, environmental and maintenance specifications. An estate strategy provides an accepted baseline of performance criteria for the estate that can be used to inform the development of schemes.

Capital investment schemes are increasingly being targeted to achieve specific improvements in the NHS estate, for example improved quality, increased compliance with statutory safety legislation and mandatory fire safety requirements, and meeting the requirements of the Disability Discrimination Act 1995. The estate strategy should demonstrate the priority given to these requirements.

## 3 A framework for an estate strategy document

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### Introduction

Your estate strategy document should describe the overall use of the estate, occupancy costs, service and organisational constraints, and capital investment decisions.

It should demonstrate how the current supply of capital assets meets current service needs and the needs of the community, and how assets will change through investment, acquisition or disposal to meet future needs. It should also show how it is intended that value for money will be achieved.

The following framework – based on asking three questions – may be used to produce an estate strategy document:

- Where are we now?
- Where do we want to be?
- How do we get there?

Differing local circumstances will be reflected in an estate strategy document, therefore no two documents will be exactly the same. The detail of individual documents may be adapted from this framework.

### Where are we now?

*One of the most important duties of estate professionals is to ensure that relevant information about the estate is made available in a timely manner to enable the estate strategy to be developed by the nominated in-house team.*

Answering this question involves a comprehensive analysis of the current position and performance of your trust in relation to the estate that it uses. The key objective of this stage is to establish a baseline against which estate development planning can take place.

It is recommended that you collate the following information:

- the current service profile;
- the current property schedule;
- the current estate value, including relevant outputs from the district valuer's reports;
- a breakdown of estate occupancy costs;
- a short history of your estate;
- an analysis of current estate performance and utilisation using the land and property appraisal as described in 'Estatecode' (see Chapter 4 of 'Estatecode' for details);
- an analysis of your environmental impact assessments (see box on [page 7](#) for details);
- the findings of patient perception surveys;

- a breakdown of backlog maintenance costs and risks;
- a prioritised risk register;
- a summary of the priorities to be addressed.

Where your estate includes historic buildings, you are advised to prepare a conservation brief for each building and adhere to 'Historic buildings and the NHS' guidance in relation to investments or disposals. Any plans for historic buildings should be referred to in your estate strategy document.

Your current property schedule and estate occupancy costs may be presented in tabular form (see [Tables 1 and 2](#) in Appendix 2 for example tables).

Information from your land and property appraisal may be presented in a series of pie charts and histograms. Your analysis may be usefully supplemented by an aerial photograph if available.

### Environmental impact assessments

The "NHS Environmental Assessment Tool" (NEAT) should be used to conduct an environmental impact assessment on your existing estate. It will allow you to appraise your estate across a range of issues, such as energy performance, water consumption, and waste

and transport management. NEAT is based on a score weighted approach in order to identify opportunities for improvement. For further information go to <http://www.nhsestates.gov.uk>

Guidance on establishing and managing backlog is available as a separate document. The document provides best practice advice on undertaking a detailed survey for the purpose of establishing backlog maintenance costs, and introduces a model for measuring risk in relation to sub-standard assets in order to prioritise investments. It also includes recommendations for the presentation of findings.

### The patient journey

It may be appropriate in some patient areas to measure patients' perceptions of the facilities provided. A quality assurance model for the patient journey has been developed, which helps to assess the quality of the patient environment. It can be used as a tool for the planning, targeting and confirmation of improvements.

For further information go to <http://www.nhsestates.gov.uk>

A summary of your findings should be prepared. This should draw specific conclusions in terms of:

- high-risk areas that need urgent attention, including environmental problems;
- opportunities for rationalisation and disposal;
- opportunities for improving value for money.

## Where do we want to be?

It is recommended that you:

- obtain a summary of the long-term strategies for providing local healthcare services;
- develop an environmental strategy covering energy, water, waste and transport management;
- establish estate performance criteria based on performance indicators (PIs), benchmarks and 'Estatecode' guidance.

Whilst healthcare service strategies may not be comprehensive, or several options may be under consideration, this should not prevent you developing an estate strategy provided that proposals for investment or divestment are clearly contingent upon the ultimately agreed service strategy.

### Establishing estate performance criteria

An essential component of this section of the document will be the establishment of criteria for monitoring estate performance.

Appropriate criteria include:

- improvements in the quality of the operational estate over time (which can be measured through reductions in backlog maintenance costs/risks and using annual patient perception surveys);
- improvements in statutory compliance and reduction in risk (which can be measured through reductions in non-compliance with statutory legislation and incident rates);
- improvements in energy performance (in line with mandatory targets for NHS organisations in England to reduce the level of primary energy consumption by 15% or 0.15 million tonnes of carbon from March 2000 to March 2010 and for existing premises to achieve energy efficiency levels (delivered energy) of 55–65 GJ/100 m<sup>3</sup> by 2010), water consumption, and waste and transport management (all of which can be measured using NEAT – see [page 7](#) for details);
- reductions in the revenue cost of the operational estate over time (which can be measured by mapping trends in overall maintenance costs, utilities costs and your income-to-asset value ratio);
- improvements in the use of the estate over time, that is, eliminating under-used and surplus assets (which can be measured by comparing your building floor area with total site area and by your income-to-asset value ratio);
- improvements in the quality of the environment for patients (which can be achieved using the patient journey model).

The ratio of building floor area (footprint) to total site area provides a guide to site density. Comparing your ratio with the ratios of similar trusts may provide an indication of whether your site is being used efficiently.

Too high a ratio may indicate a cramped site with inadequate access and parking space; too low a ratio may imply a site capable of rationalisation, the opportunity to dispose of parcels of land, and revenue costs tied up in site maintenance.

In terms of income-to-asset ratios, anything less than a 1:1 ratio usually indicates that you need to increase your income or reduce your asset base.

A series of other PIs for the estate has been developed, from which a trust may benchmark its estate performance and monitor improvements. These are outlined in [Chapter 4](#) (under acute trust case study) and in [Appendix 1](#).

## How do we get there?

The final section of the document will use the information and objectives of the preceding stages to develop a realistic and feasible option(s) for the future estate. It should describe in a concise way the practical steps to be taken.

It is important to involve several creative and design-based thinkers who can envisage the “big picture” and provide illustrations of changes to current site and building configurations.

It is essential to involve financial, general and business managers from across the trust, as well as clinicians whose services are affected and stakeholders from the SHA. This approach should help to generate a broader understanding of the importance of the estate in strategic service planning.

It is recommended that you:

- assess the implications of the service strategy for the estate, that is, procurement, accessibility issues, design issues, functional suitability, space utilisation and disposals;
- develop strategic options (where relevant) for estate change based on a whole-life costing approach;
- assess the implications of local authority development strategies;
- devise a capital investment programme for major and minor schemes;
- identify in outline the revenue impact of the capital investment programme;
- collate a summary of site and building disposals and anticipated sale proceeds;
- compile site-based development control strategies;
- forecast the effect of the estate strategy on estate performance and risk reduction;
- forecast the effect of the environmental strategy on improving energy, water, waste and transport management in partnership with the local authority.

The following questions may be asked in order to ascertain the implications for the estate of the service strategy:

- Are new site acquisitions required?
- What are the anticipated town planning issues?
- Would whole-site disposals maximise revenue savings?

- Is it possible to use existing sites more intensively through new builds, adaptations, link corridors etc?
- What are the key functional relationships (for example X-ray next to A&E facilities)?
- Can services be co-located using new models of service delivery (for example primary care one-stop centre for the provision of GP services alongside dentistry services)?
- Will transfer of services out of acute hospital settings require more highly engineered local sites, including information technology (IT) links?

It is recommended that site-based development control strategies indicate, in diagrammatic form, the major changes that are planned by the trust.

Any potential development should involve an environmental impact assessment using NEAT (see box on [page 7](#) for details). New builds should achieve a NEAT score rating of “excellent”, whilst refurbishments should achieve a score of “very good”.

As part of the mandatory targets for NHS organisations in England, new-builds and major refurbishments must achieve energy efficiency levels (delivered energy) of 35–55 GJ/100 m<sup>3</sup>. Environmental impact assessments should ensure this is the case.

### Capital investment programme

A capital investment programme should be prepared and incorporated into this section of the document (see [Table 3](#) in Appendix 2). This should show the total capital cost and timing of the schemes required to implement the service strategy.

All costs should be shown in £ thousands and should include equipment, fees (according to the cost headings in the OB1 form in the ‘Capital Investment Manual’) and VAT, irrespective of the financing mechanism chosen for the investment.

The timing of known or anticipated land and property disposals or acquisitions should be set out in the format illustrated in [Table 4](#) of Appendix 2.

Depending on the approach agreed locally towards the use of capital receipts, it may be useful to indicate forecast disposal receipts netted off against cumulative capital expenditure.

Programmes for major planned maintenance and reducing backlog maintenance costs should provide further details on the areas covered and the priority order: for example compliance with statutory safety legislation and mandatory fire safety requirements, renewal of major engineering plant, and the achievement of improved physical condition of buildings.

### Monitoring improvements in estate performance

Targeted improvements in the chosen estate PIs which will result from the implementation of the estate strategy should be clearly set out. Progress against these indicators should be regularly monitored.



### **Risk management**

The estate strategy should assess and document the risks the trust would face if the proposed developments did not go ahead. Proposals for mitigating or managing risks should be produced.

### **Conclusion**

A meaningful estate strategy is based on good-quality information about current and future service needs, and the condition and performance of the existing estate. This should be used as the basis for future improvements in the quality/functionality of the estate in the context of future service plans; and those improvements should be measurable.

The strategy should seek to reduce risk not only through improved compliance with statutory legislation but also through a reduction in incidents. It is important to understand the revenue costs associated with the estate and how they compare with the best in class. Strategies should recognise the need to demonstrate best value.

It is critical to ensure that space is fully used, in both density of occupation and frequency of use; driving out facilities that are duplicated, over-provided or no longer necessary in the delivery of effective healthcare.

Recurring savings drawn from the asset base can either be invested in new capital assets or be diverted to enhance patient care.

## 4 Case studies

These case studies are selected extracts from estate strategy documents. They are designed to show the main elements of an estate strategy document, namely an overview of the existing estate and proposed changes to the estate.

The case studies give examples of strategies for an acute trust, mental health trust, ambulance trust and PCT.

### An acute trust

#### The existing estate

The trust currently has an estate comprising one main site, an acute general hospital, with a total land area of 32.5 acres, and buildings with a total floor area of 27,500 m<sup>2</sup>. Its value in existing use is £30m, and the open market value is estimated at £21m. See block layout plan on [page 13](#).

**TABLE 4.1 CURRENT PROPERTY SCHEDULE**

Property	Use/function	Size m <sup>2</sup>	Tenure	Physical condition	Functional suitability	Space utilisation	Quality	Mandatory fire safety/statutory requirements	Environmental management
Name of site	Acute general hospital	27,500	Freehold	B and C	Mainly B and C	F and U	B and C	B and C	B and C

A large part of the trust's estate (51%) is more than 40 years old, and this is reflected in the high backlog maintenance costs.

A range of key PIs for the estate is shown in Table 4.2. The trust's profile is compared to those of trusts with a similar service and estate profile (benchmark group).

**TABLE 4.2 PERFORMANCE ANALYSIS**

Performance indicator	Trust performance	Average	Benchmark group	
			20 percentile	10 percentile
a. income/asset value ratio	0.9	0.95	1.1	1.2
b. expenditure on premises as % total expenditure	6.7%	6.6%	5.4%	4.9%
c. building floor area (footprint) to site area	2385 m <sup>2</sup> per hectare	2494 m <sup>2</sup> per hectare	2705 m <sup>2</sup> per hectare	3220 m <sup>2</sup> per hectare
d. annual expenditure on maintenance per m <sup>2</sup> floor area	£16 per m <sup>2</sup>	£16 per m <sup>2</sup>	£14 per m <sup>2</sup>	£12 per m <sup>2</sup>

## BLOCK LAYOUT PLAN



## Key

- |                           |                       |
|---------------------------|-----------------------|
| 1. Boilerhouse            | 46. Nurse home        |
| 2. Incinerator            | 47. Store             |
| 3. Store 3                | 48. Plantroom ducts   |
| 4. Store 2                | 49. Operating theatre |
| 5. Store 1                | 50. Sterile services  |
| 6. Estates offices        | 51. A&E               |
| 7. Mortuary               | 52. X-ray             |
| 8. Linen                  | 53. ICU               |
| 9. Maternity ground floor | 54. Day unit          |
| 10. Maternity first floor | 55. Ward 5            |
| 11. Maternity 2nd floor   | 56. Ward 6            |
| 12. Maternity 3rd floor   | 57. Rehabilitation    |
| 13. Midwifery school      | 58. Pathology         |
| 14. Stores                | 59. Medical physics   |
| 15. Main kitchen          | 60. Pharmacy          |
| 16. Dining room           | 61. Out-patients      |
| 17. Jackson ward          | 62. OPD boilerhouse   |
| 18. Library               | 63. Fracture clinic   |
| 19. Ward 3                | 65. Gas meter         |
| 20. Anaesthetics          | 66. Garages           |
| 21. Ward 2                | 67. House 1-7         |
| 22. Computer centre       | 68. D-residence       |
| 23. Ward 1                | 69. Social club       |
| 24. Switchroom            | 70. Plantroom         |
| 25. Ward 8                | 71. C-residence       |
| 26. Boardroom             | 72. Gardeners         |
| 27. Ward 10               | 73. Gardeners         |
| 28. Ward 11               | 74. Houses 6-9        |
| 29. Admin/personnel       | 75. B-residence       |
| 30. Old hospital          | 76. E-residence       |
| 31. Diabetics centre      | 77. Garages           |
| 34. Finance department    | 78. A-residence       |
| 38. Ward 7                | 79. Plantroom         |
| 39. Day unit              | 80. Education centre  |
| 40. Gen hv intake         | 81. Gas meter         |
| 43. Safe haven            | 82. Radio room        |
| 44. Patient info          | 83. Chapel            |
| 45. Conference            |                       |

### *Notes on the trust's performance analysis*

- a. anything less than a 1:1 ratio usually indicates that the trust should examine how to increase its income or reduce its asset base;
- b. the value of this indicator depends on the size and age of the estate. There is no absolute measure of what is an appropriate spend on the estate, although the NHS in Wales attempted to define a benchmark figure of 8%;
- c. this is a guide to site density. Too great a density may indicate a cramped site with inadequate access and parking space; too low a ratio may imply a site capable of rationalisation, the opportunity to dispose of parcels of land, and revenue costs tied up in site maintenance;
- d. this is a similar measure to (b) and should correlate to the age of the building, how heavily engineered the building is, and the quality of the technical services and visual environment.

### **Proposed changes to the estate**

#### *Service changes*

Local service and business strategies envisage a significant shift from secondary to primary care over the next decade. The main elements of these strategies that will have implications for the estate are:

- a. a reduction in the size of the acute general hospital from 550 in-patient beds to 450 in-patient beds;
- b. a 20% reduction in the number of out-patient sessions held on the acute general hospital site;
- c. the development of a new dedicated day surgery unit on the acute general hospital site;
- d. the development of a new chemotherapy suite on the acute general hospital site;
- e. the expansion of local health centres to accommodate increased out-patient sessions and primary care services;
- f. a reduction in residential accommodation provided for staff to include only essential staff groups and on-call facilities within the hospital.

#### *Key estate performance criteria*

In addition to the implications for the estate of the service changes outlined above, the trust has established key performance criteria in relation to the estate:

- a. the elimination of all backlog maintenance costs;
- b. to improve the utilisation of space to 90% of floor area in condition F (see 'Estatecode' for details on space utilisation);
- c. to improve the functional suitability of the estate to 90% of floor area being in conditions A and B (see 'Estatecode' for details on functional suitability);
- d. to improve the trust's overall energy performance to 60 GJ/100 m<sup>3</sup>;
- e. to improve the trust's income-to-asset value ratio to 1:1.2.

### *Estate development control plan*

The estate development control plan shows in diagrammatic form the major changes taking place on the site (see [page 16](#)).

It can be seen that the downsizing of the acute general hospital resulting from reduced in-patient beds, fewer out-patient sessions and more day surgery, creates a significant opportunity to rationalise the estate.

This will enable two sites (zones one and two on the plan on [page 16](#)) with valuable road frontage to be declared surplus to requirements and sold on the open market. The whole of the trust's requirements can be met by the 16.5 acre site (shown as zone three on the plan). This has the major advantage of concentrating the trust's use of floor space into buildings that are currently in the best condition, requiring least expenditure on backlog maintenance.

### **Capital investment programme**

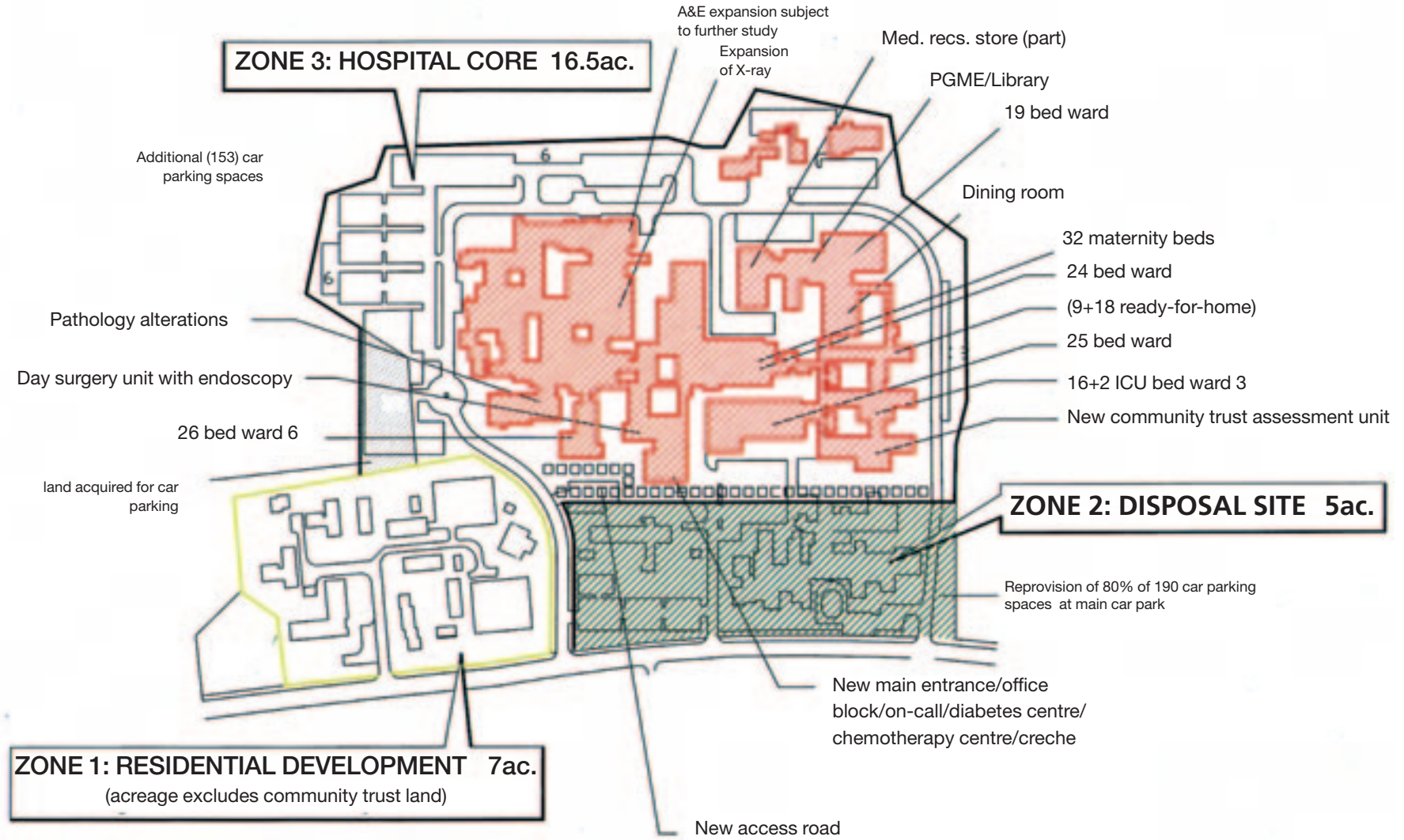
Table 4.3 shows the total capital cost and timing of the various schemes required to implement the estate strategy. It can be seen that these equate to a total of £17.28m over the decade.

*All costs in £millions inclusive of fees and VAT*

**TABLE 4.3 CAPITAL INVESTMENT PROGRAMME**

Scheme	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Total
Refurbishment of ward 2	0.25										0.25
New-build day surgery unit		0.4	0.45								0.85
Relocation of central stores			0.2								0.2
Refurbishment of kitchen		0.1	0.2								0.3
Extension to ward 5				0.2							0.2
New-build chemotherapy unit					1.0						1.0
Installation of CHP plant					0.4						0.4
Extension to rehab centre						0.3					0.3
Car park reversion							0.2				0.2
Backlog maintenance	0.5	0.5	0.47	0.5	0.5	0.5	1.0	3.0	3.97	1.14	12.8
Medical equipment replacement	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.2	1.5
<b>Total</b>	<b>0.85</b>	<b>1.1</b>	<b>1.42</b>	<b>0.8</b>	<b>2.0</b>	<b>1.0</b>	<b>1.4</b>	<b>3.2</b>	<b>4.17</b>	<b>1.34</b>	<b>17.28</b>

The table shows the investment for eradicating backlog maintenance costs. The initial investment will concentrate on ensuring compliance with statutory legislation such as COSHH Regulations 2002, Electricity at Work Regulations, Disability Discrimination Act and the Health and Safety at Work



DEVELOPMENT CONTROL PLAN

etc Act 1974. This will ensure full compliance with statutory legislation by year three of the strategy.

The overall investment to eradicate backlog is significantly less as a result of rationalising the estate and disposing of buildings with high backlog maintenance costs.

### Land and property disposal and acquisition programme

Table 4.4 shows the timing of land and property acquisitions and disposals required to implement the estate strategy. It can be seen that these result in estimated net receipts to the trust of £5.2m. Further work on analysis around timing and value would need to be undertaken.

**TABLE 4.4 LAND AND PROPERTY DISPOSAL AND ACQUISITION PROGRAMME**

Property	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Total
Disposal of DGH – Zone 1 site			-2.8								-2.8
Disposal of DGH – Zone 2 site									-2.5		-2.5
Acquisition of car park land				0.1							0.1
Total	0	0	-2.8	0.1	0	0	0	0	-2.5	0	-5.2

## A mental health trust

### The existing estate

The trust provides mental health and learning disability services to a population of 500,000 in a mixed urban and rural area covering 140 square miles. The trust delivers these services from five hospitals, 18 resource centres and eight other main premises, and in addition uses seven buildings as offices and stores.

The property is a mix of freehold and leasehold property; 28% is under 15 years old, 17% is between 15 and 80 years old, and 55% is over 80 years old.

There are four clinical directorates in the trust:

1. adult mental health;
2. older people's mental health;
3. child and adolescent mental health;
4. learning disabilities.

The largest occupier of floor area is the adult mental health service, which also occupies many of the oldest buildings.

Site densities are low, with 23 properties being below the average site density for comparable trusts.

All these sites have been reviewed; four have been earmarked for disposal while six have development potential. The remaining 13 properties are on sites with limited or no scope for development.

Disability Discrimination Act site audits have been undertaken, and a four-year investment strategy has been implemented covering both owned and leased sites.

Environmental impact assessments have been carried out in phases across the trust over a period of three years using the “NHS environmental assessment tool” (NEAT). Following this, actions have been agreed against each of the five component parts of NEAT (energy, waste, water, transport and procurement).

### **Service strategy**

The service strategy for acute adult mental health services includes the following main components:

- provision of a new acute in-patient unit on the main acute hospital site;
- construction of a new forensic in-patient facility to provide integrated premises for low-security, long-term and rehabilitation facilities. The existing buildings are incapable of accommodating the required service model;
- development of new bases for community mental health teams, including improved crisis resolution provision.

The service strategy for child and adolescent mental health services is to develop and upgrade the two existing resource centres and expand activities in health centres and acute hospitals managed by other trusts.

The service strategy for the older people’s mental health service is to retain two hospital sites and modernise the in-patient accommodation to improve its appearance and poor functional suitability, to build an extension to in-patient facilities in order to meet Mental Health Act Commission recommendations, and to relocate the community mental health teams to locality-based accommodation.

The service strategy for learning disability services involves construction of an acute assessment and treatment unit, refurbishment of five resource centres, a major reorganisation of day services with closure of some facilities, and the reprovision of a number of community teams into more local centres.

### **Performance management**

The performance of the estate has been assessed through a comprehensive property appraisal exercise, carried out both on NHS-owned premises and on property leased from the local authority.

Most property is in condition B in terms of physical condition and compliance with statutory safety legislation/mandatory fire safety requirements. Where property has been assessed as below condition B in terms of space utilisation and functional suitability, it is being addressed through an investment strategy.



Some sites have sub-standard energy performance, in particular leasehold property in the learning disabilities directorate and both leasehold and freehold property in the adult mental health directorate.

The estate strategy also incorporates trust-wide estate performance criteria (see [Table 4.6](#)).

### Investment strategy

The estate strategy brings together a very detailed list of schemes in order to address deficits in the service provided or in the current condition of the estate. The capital investment programme covers a period of five years and includes both confirmed and funded schemes and those that are only at feasibility stage.

An extract of the capital investment programme is set out in [Table 4.5](#).

**TABLE 4.5 CAPITAL INVESTMENT PROGRAMME**

ADULT MENTAL HEALTH DIRECTORATE					CAPITAL CASH FLOW					
Ref	Service	Proposal	Status/ next steps	Anticipated cost	Year 1 (2004/05)	Year 2 (2005/06)	Year 3 (2006/07)	Year 4 (2007/08)	Year 5 (2008/09)	Anticipated completion
In-patient services										
AMH 1	Forensic and learning disabilities services	Development of 36-bed and 18-bed units	Construction commenced June 2004	£5m	£2m	£3m		–	–	Feb-05
AMH 2	Adult mental health: acute wards 4 and 11	Construction of a 38-bed AMH unit comprising male and female acute facilities	£9m awarded from SHA for reprovion of wards. OBC/ FC approval planned for June 2004	2004–05 £2m 2005–06 £6m 2006–07 £1m	£2m	£6m	£1m		–	Dec-06
Community mental health teams										
AMH 3A	Crisis resolution service: north sector	Accommodation for 6 new WTE staff	Commenced December 2004	–	£58,000	–	–	–	–	Jan-05
AMH 3B	Adult community mental health team: north sector									
Option 1	Refurbishment/extension of Spring House	Refurbishment of existing premises	Subject to feasibility, functional content and affordability. Business case to prepare	To establish	–	–	–	–	–	–
Option 2	Co-locate service with other North PCT services at new primary care facility	Co-locate with other North PCT services at new facility		To establish	–	–	–	–	–	–
Option 3	Relocate service to new facility	Relocate to new stand-alone facility		To establish	–	–	–	–	–	–
AMH 4	Adult community mental health team: south-west sector	Reprovion of ACMHT into a single facility to provide integrated mental health and social care services. Approximately 30 WTE and growing	£4m awarded from SHA for reprovion of south-west team. OBC/FBC approval planned for December 2004. Construction to commence February 2005	2004–05 £1m 2005–06 £3m	£1m	£3m	–	–	–	Mar-06
AMH 5	Adult community mental health team: south sector	Reprovion of ACMHT into a single facility to provide integrated mental health and social care services	Subject to feasibility and affordability	To establish	–	–	–	–	–	–
AMH 6	ACMHT facilities at Mill Centre	Reprovion of ACMHT into newly-constructed single, modern facility to provide integrated mental health and social care services. Mill Centre is overcrowded and functionally unsuitable	Requirement for new premises by October 2005. Reprovion will be dependent on review of F Hospital and funding from North PCT regarding integrated services	To establish	–	–	–	–	–	Oct-05

**TABLE 4.6 TRUST-WIDE ESTATE PERFORMANCE CRITERIA**

To complete a board-approved environmental strategy
Reduce backlog maintenance overhead by 25% from 1/4/03 to 30/04/05
Reduce primary energy consumption by 15% or 15 MIC from 2000 to 2010
Plan for at least 40% of total value of the estate to be less than 15 years old by 2010
FIRECODE: Annual certification of compliance to DH standards
To be fully compliant with the provision and use of Work Equipment Regulations
Workforce accommodation: Contribute to the increases in staff accommodation of 1500 new staff accommodation units nationally
Nursery facilities: Contribute to improved childcare provision including developing new nurseries
To achieve a board-approved Green Transport Plan

## An ambulance trust

### The existing estate

The trust operates from 19 ambulance stations and from one centre where the control centre, management headquarters and central logistics depot are sited.

It has suffered from a lack of investment and a low operational maintenance budget for some time. There are concerns over health and safety issues at some of the stations, and many are overcrowded because of increased staffing levels and the integration of the patient transport service into the stations.

A recent land and property appraisal exercise indicated widespread problems. The overall rating put six stations in condition C and seven in condition D.

Problem areas included roofs which were leaking or at the end of their economic life; lack of emergency and security lighting; inadequate toilet facilities; garage floors that were breaking up; and vehicle workshops that did not meet requirements.

### Service strategy

The drivers for change have been:

- the need to meet ever more stringent ambulance response times;
- development of existing and new services, for example an unscheduled care service to assist with out-of-hours provision;
- growth in professionalism of ambulance staff, which requires more and better training facilities;
- the fact that ambulance crews spend much more time on the road and in their vehicles than in the past, and consequently less time in the ambulance station.

It is recognised that some of the existing ambulance stations are in the wrong place to maximise response times. In addition, staff rosters are based on individual stations, which make them inflexible. The service is divided into three divisions on which the future operation of the service will

be based, and the rosters will migrate to a divisional basis over time. This will also help to control staff costs.

There are plans to introduce new technology to help deliver telemedicine and clinical assessment capabilities.

### **Matching the estate to the service strategy**

The estate implications of the strategic service model were considered and agreed as follows:

- the development of modern bases, which will provide the full range of facilities;
- the capacity to support increasing numbers of staff and vehicles;
- the introduction of a hub-and-spoke model for each division, based on a single large ambulance station at the hub, and spokes consisting of serviced and unserved ambulance points. These will be roadside points or locations at primary care sites, community hospitals, fire and police stations and even McDonald's food outlets;
- facilities for enhanced training both for in-house requirements and for external income-generating opportunities;
- a modern, well-maintained estate that allows estate maintenance costs to be controlled and avoids the need to invest significantly in backlog.

Specific estate criteria have been set that will deal with substandard physical condition, statutory safety legislation and mandatory fire safety requirements, and environmental management by defined dates over the five-year period of the strategy.

Implementation of the strategy will involve the following steps:

- identification and acquisition of three "hub" sites in a phased process. These will either be converted leased buildings on existing industrial sites or will involve site acquisition and new build. An investment appraisal will be undertaken as part of each business case;
- marketing and disposal of all existing ambulance station sites on a phased division-by-division basis;
- short-term investment in existing "black spot" ambulance stations to deal with problems that cannot wait;
- an online investment strategy has been put together that matches the investment needed with the likely capital returns from the site sales. Many of the sites have strong development potential and, with advance liaison with local authority planners and effective marketing, will contribute well over two-thirds of the estimated capital requirement.

## A primary care trust

### The existing estate

The PCT has inherited over 20 health centres and clinics that are in a very poor state. Many are over 40 years old and were not designed to accommodate the growing range of services now delivered in a primary care setting. In addition, the trust faces the following facts:

- 59% of its buildings are in a condition where replacement is urgently needed;
- GP accommodation is cramped;
- the access needs of patients with disabilities cannot be met;
- restricted accommodation is inhibiting the transfer of out-patient clinics to the community;
- lack of space is likely to hinder the introduction of enhanced services under the new general medical services (GMS) contract;
- over £3m would be needed to improve the condition of buildings worth only £5m.

There is an opportunity to look at the local estate in terms of a whole system approach. Primary care, community and social services currently operate from over 60 delivery points within the urban setting in which the trust is situated. The new range of services needed for the future, which will require increased multidisciplinary working practices, cannot be delivered from this number of sites.

### The service strategy

The PCT's aim is to:

- enable GPs to develop innovative ways of delivering services;
- provide facilities where whole teams of healthcare professionals can be based and work together;
- create opportunities for other public-sector services such as pension advice, social care, housing advice and library services to be offered from the same location;
- allow further hospital-based clinics and diagnostic services to transfer to community settings.

This will be achieved by creating two different levels of primary care facility: one-stop centres and primary care resource centres.

The one-stop centres will be a mix of new purpose-built centres and existing GP owned premises that are suitable for further expansion and development. Their functional content will include rooms for the GP and primary health team, rooms for health promotion, counselling, therapists, dental and voluntary services, pharmacy and social services.

The primary care resource centres will offer a wider range of services for a larger population to include specialist out-patient clinics, walk-in and minor illness services, extended child health and sexual health services, as well as information and advice suites.

### **Matching the estate to the service strategy**

The PCT assessed eight different configurations of centres and sites, based on population centres, neighbourhoods, age, sex and illness profiles, and transport access. The eventual configuration provided three primary care resource centres, 11 one-stop centres, and 12 GP-owned premises, which would be retained and developed.

A 10-year plan was developed to move from the current 60 sites to 26, based on three phases of construction and transfer of services. The whole scheme will be managed under a local NHS LIFT, in which the ownership of the existing properties will be checked, outline planning permission sought, and sites transferred to LIFT Co in three phases. In this arrangement LIFT Co will maintain the properties with a continuing life on a planned preventive maintenance basis throughout the term of the lease, ensuring that they remain in condition B.

# Appendix 1 – Estate strategy performance indicators

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A series of 15 PIs has been developed to allow informed judgement on the efficiency and condition of the estate. All are expressed as ratios of building and land area.

The information needed to generate the PIs is currently gathered on an annual basis through the “estates returns information collection” (ERIC) and other mandatory returns of estate performance.

Software entitled “Trust high-level performance indicators” provides PI data for all trusts in England; it enables individual trusts to compare their PIs with PIs of similar trusts, and uses a traffic-light classification system to indicate whether the trust’s PIs are acceptable, where:

- green indicates no or very limited problems;
- amber indicates some problems;
- red indicates serious concerns.

The traffic-light classification system is based on grouping trusts into three roughly equal clusters.

The software also groups the PIs into batches of four in such a way as to create a series of radar charts indicating space efficiency, asset productivity, asset deployment, estate quality and cost of occupancy.

In addition to enabling local performance review, PI data has other uses including:

- supporting the “performance assessment framework” (PAF) and star performance rating process;
- assisting the Healthcare Commission to fulfil its auditing and inspection role;
- informing business case analysis and capital investment decisions;
- providing answers to parliamentary questions and contributing to ministerial reports.

The current PI data, which is solely estates-related, will become part of a broader set of key PIs currently being developed to provide a “balanced scorecard” of the whole estates and facilities management area. It will provide information for both operational and strategic management purposes.

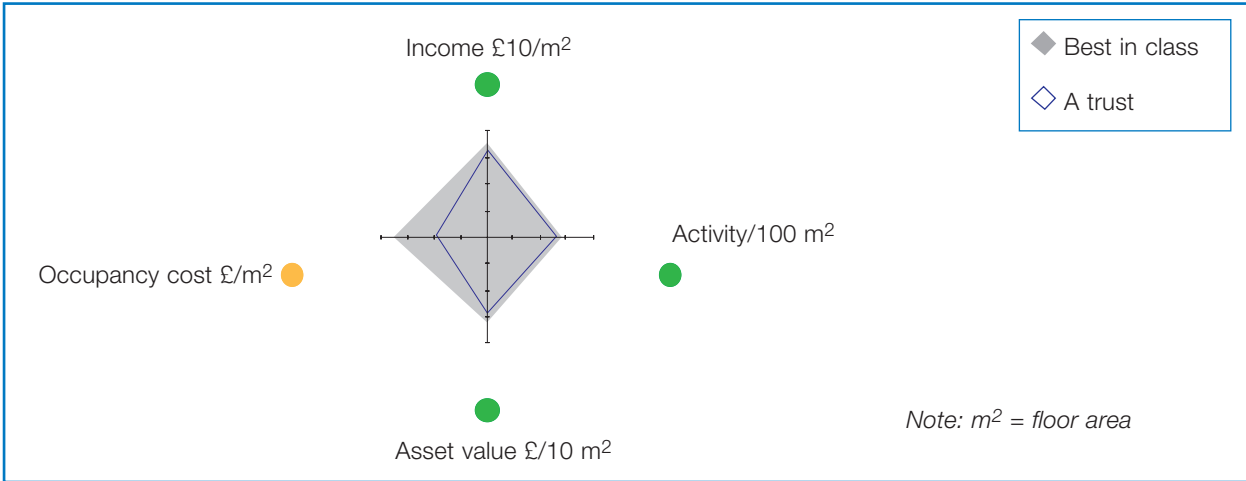
The PIs illustrated in [Table 1](#) are based upon an anonymous trust and are for information purposes.

TABLE 1 – TRUST PERFORMANCE

PI summary	Trust PI	Grouping PI (percentile bands)		
		33%	34%	33%
<b>Space efficiency</b>				
Income £10/m <sup>2</sup>	119	Below 89	89 to 107	Above 107
Activity/100 m <sup>2</sup>	99	Below 61	61 to 74	Above 74
Asset value £10/m <sup>2</sup>	105	Below 77	77 to 91	Above 91
Occupancy cost £/m <sup>2</sup>	70	Below 115	115 to 131	Above 131
<b>Asset productivity</b>				
Asset value £10/m <sup>2</sup>	105	Below 77	77 to 91	Above 91
Capital charges £/m <sup>2</sup>	39	Below 82	82 to 95	Above 95
Total backlog £/m <sup>2</sup>	200	Below 47	47 to 129	Above 129
Rent and rates £/10 m <sup>2</sup>	73	Below 86	86 to 115	Above 115
<b>Asset deployment</b>				
Land £/m <sup>2</sup>	100	Below 70	70 to 122	Above 122
Building £10/m <sup>2</sup>	85	Below 60	60 to 72	Above 72
Equipment £/m <sup>2</sup>	99	Below 61	61 to 88	Above 88
Capital charges £/m <sup>2</sup>	39	Below 82	82 to 95	Above 95
<b>Estate quality</b>				
Asset value £10/m <sup>2</sup>	105	Below 77	77 to 91	Above 91
Depreciation £/m <sup>2</sup>	11	Below 36	36 to 43	Above 43
Capital investment £/m <sup>2</sup>	9	Below 10	10 to 35	Above 35
Risk-adjusted backlog £/10 m <sup>2</sup>	140	Below 75	75 to 227	Above 227
<b>Cost of occupancy</b>				
Rent and rates £/10 m <sup>2</sup>	73	Below 86	86 to 115	Above 115
Energy/utility costs £/m <sup>2</sup>	6	Below 7	7 to 9	Above 9
Maintenance costs £/m <sup>2</sup>	14	Below 14	14 to 16	Above 16
Capital charges £/m <sup>2</sup>	39	Below 82	82 to 95	Above 95
Note: m <sup>2</sup> = floor area				

### Space efficiency

**Aim: to relate the estate and its annual occupancy cost to the output of the trust**

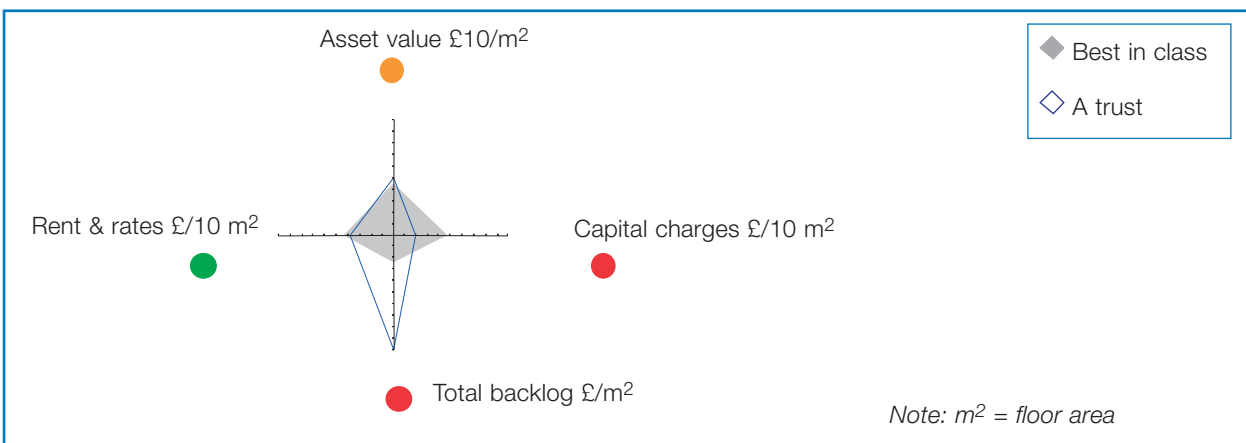


These PIs indicate that the trust is generally using floor space efficiently, because its income, activity levels and asset values are all good, relative to the gross internal floor area, when compared with similar trusts.

There is, however, a concern that the trust is not investing sufficiently in occupancy costs, which, if not reviewed, may lead to increasing financial pressures in future years (for example from backlog maintenance expenditure requirements or lack of capital for reinvestment from capital charges).

### Asset productivity

**Aim: to demonstrate the actual cost of owning/renting assets**



The trust needs to improve its performance with respect to capital charges and backlog. It should aim to increase spending on capital by heavy investment and rationalising its estate to achieve a more modern and functionally suitable estate.

Similarly, its backlog PI, which is relatively high, suggests an estate that may be near the end of its designed life, with an increasing number of backlog failure and replacement pressures.

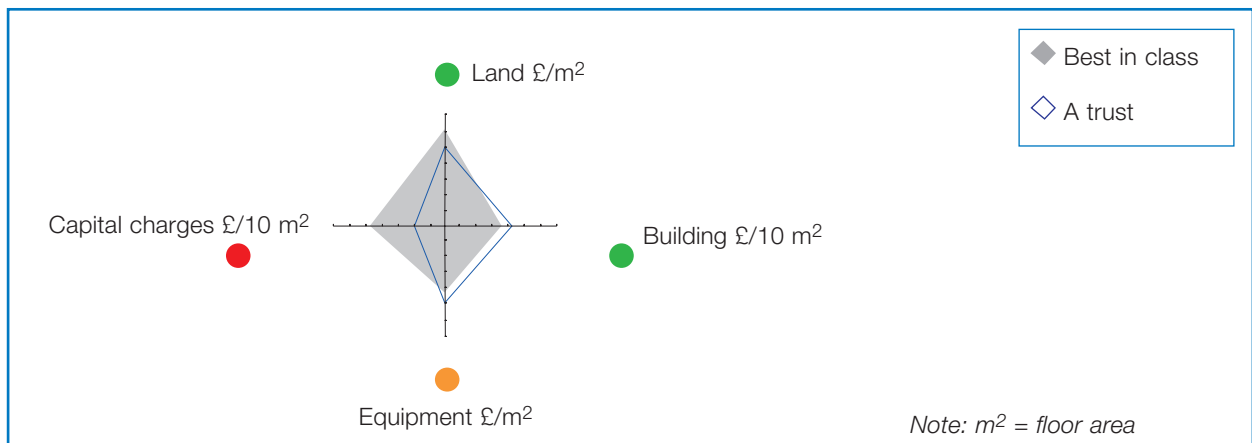


Whilst the rent and rates figures are relatively low, this could also be a reflection of an older estate, which may be less appropriate for the provision of modern healthcare.

Despite the comments noted above, there is also a suggestion in these PIs that the value of the trust's assets is high when compared with the rest of the cluster group, suggesting an oversized estate in poor condition.

## Asset deployment

**Aim: to compare the makeup of the asset base**

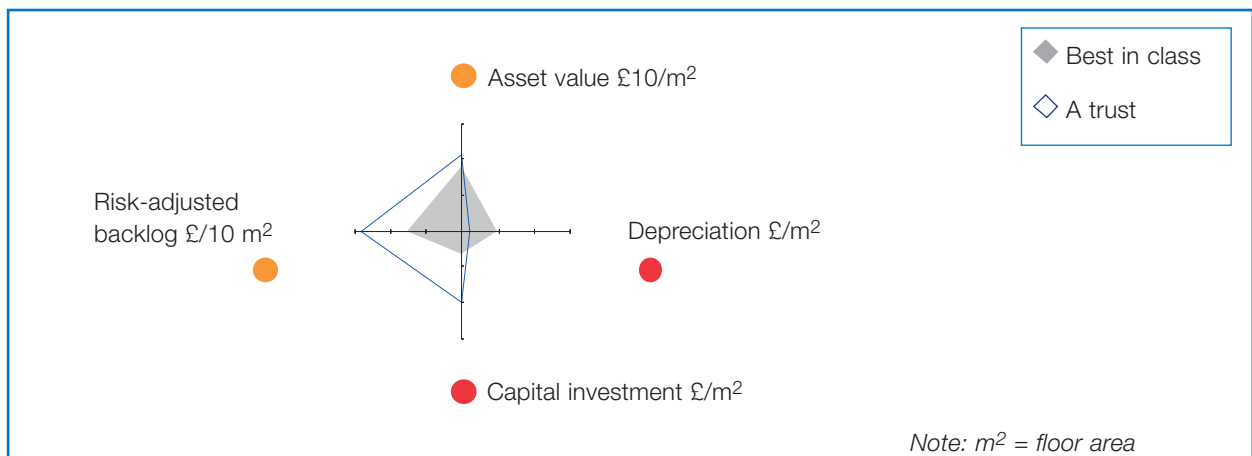


These PIs suggest that the trust uses a “normal” quantity of land for its needs, but the value of its buildings and equipment is generally higher than the cluster group. The reason for this is not immediately clear and requires local knowledge and interpretation. However, the PIs suggest an oversized estate in poor condition.

As noted above, the capital charges PI suggests that the trust needs to improve its performance. Again, this PI suggests that the trust should aim to increase spending on capital.

## Estate quality

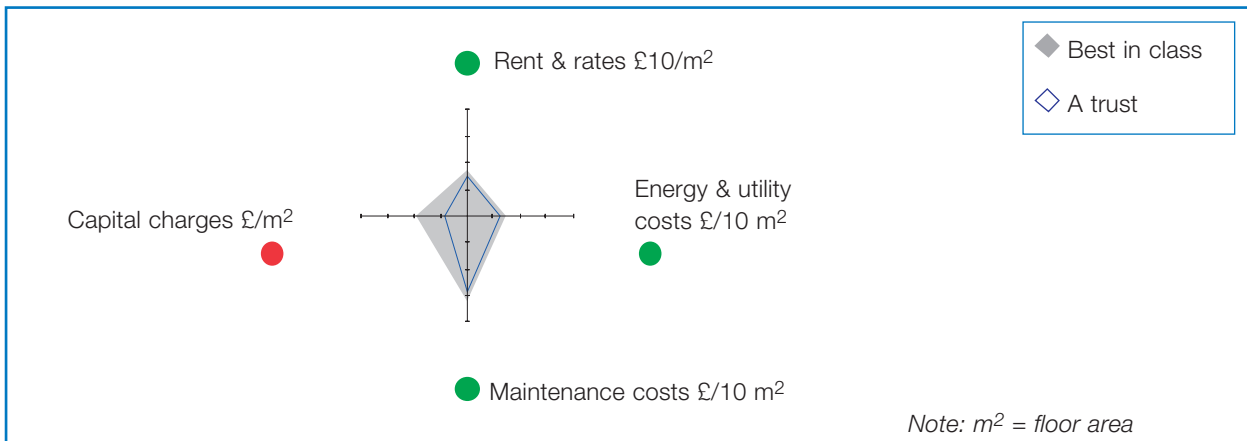
**Aim: to give a balanced view of the overall condition of the estate relative to value and age**



All four of the estate quality PIs fall short of comparable PIs in the cluster group, suggesting that the estate quality is below an acceptable level. There should be particular concern about the trust's depreciation and capital investment situation.

## Cost of occupancy

**Aim: to identify the profile of occupancy costs (revenue)**



The PIs for maintenance, energy and utilities suggest that the trust is performing well. However, if the trust's spending on maintenance drops at all, the backlog maintenance will be unacceptably high in future years.

## Summary

The trust is generally using floor space efficiently, because its income, activity levels and asset values are all good.

However, the PIs suggest an asset base that may be near the end of its designed life and possibly in need of investment and rationalisation to achieve a more modern and functionally suitable estate. There are also strong indications that the quality of this estate is generally below an acceptable level.

## Second level performance indicators

Trusts should also include second level indicators in their estate strategy. These will normally be presented in graphical form as in the following example. They may be supported by spreadsheets giving greater detail, and may be used to usefully compare current performance with future targets.

## Definition of terms

<b>Income</b>	Total income for the trust
<b>Activity</b>	Finished consultant episodes (FCE)
<b>Capital charges</b>	Capital charges for the trust
<b>Rent and rates</b>	Rent and rates for the trust
<b>Maintenance costs</b>	Engineering, building and ground works costs
<b>Energy and utility costs</b>	Energy and utility costs (including water and sewage)
<b>Occupancy costs</b>	Capital charges + rent and rates + maintenance costs + energy and utility costs
<b>Capital investment</b>	Total capital invested on the estate
<b>Total backlog</b>	Total of high, significant, moderate and low risk backlog
<b>Risk-adjusted backlog</b>	As described in the document 'A risk-based methodology for establishing and managing backlog'
<b>Land value</b>	Land asset value
<b>Building value</b>	Building asset value
<b>Equipment value</b>	Equipment asset value
<b>Asset value</b>	Total land, building and equipment asset value

# Appendix 2 – Examples of tables

**TABLE 1 CURRENT PROPERTY SCHEDULE**

PROPERTY	USE/FUNCTION	SIZE OF BUILDINGS (sq m)	SITE AREA (hectares)	TENURE	PHYSICAL CONDITION	FUNCTIONAL SUITABILITY	SPACE UTILISATION	QUALITY	FIRE & SAFETY REQUIREMENTS	ENVIRONMENTAL MANAGEMENT	ESTATES COMMENT
Site				Freehold/leasehold	A,B,C, D,X	A,B,C, D,X	E,U,F,O	A,B,C, D,X	A,B,C, D,X	A,B,C, D,X	
Disaggregated by block											
Disaggregated by portion											

**TABLE 2 ESTATE OCCUPANCY COSTS**

PROPERTY	RATES	UTILITIES	MAINTENANCE (as defined in ERIC)	CAPITAL CHARGE/ RENT	INCOME (from leases etc)	TOTAL	CAPITAL VALUE (EUV)
Site name							
TOTAL							

**TABLE 3 CAPITAL INVESTMENT PROGRAMME (AT CURRENT COST)**

SCHEME	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	TOTAL
A	XXXXX	XXXX				
B		XXX	XXXX			
C		XX	XXXXXXXX	XXXXXXXX		
D		XXXX	XXXXXXXX			
E			XXXXXXXX	XXXXXXXX	XXXXX	
F			XXXXXXXX	XXXXXXXX	XX	
G			XXXX	XXX		
Backlog maintenance eradication not dealt with through disposals of the above schemes	XXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXX	
TOTAL						

**TABLE 4 LAND AND PROPERTY DISPOSAL AND ACQUISITION PROGRAMME**

PROPERTY	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	TOTAL
Disposal site A						
Disposal site B		-£	-£			
Disposal zone 2 site C						
Acquisition car park			+£		-£	
Acquisition land			+£			
Acquisition 2 houses				+£	+£	
etc						
TOTAL						

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