Department of Health

Health Building Note 00-08 Part A: Strategic framework for the efficient management of healthcare estates and facilities

October 2014

Health Building Note 00-08
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Preface

About Health Building Notes

Health Building Notes give best practice guidance on the design and planning of new healthcare buildings and on the adaptation/ extension of existing facilities.

They provide information to support the briefing and design processes for individual projects in the NHS building programme.

The Health Building Note suite

Healthcare delivery is constantly changing, and so too are the boundaries between primary, secondary and tertiary care. The focus now is on delivering healthcare closer to people's homes.

The Health Building Note framework (see next page) is based on the patient's experience across the spectrum of care from home to healthcare setting and back.

Health Building Note structure

The Health Building Notes have been organised into a suite of 17 core subjects.

Care-group-based Health Building Notes provide information about a specific care group or pathway but cross-refer to Health Building Notes on **generic (clinical) activities or support systems** as appropriate.

Core subjects are subdivided into specific topics and classified by a two-digit suffix (-01, -02 etc), and may be further subdivided into Supplements A, B etc.

All Health Building Notes are supported by the overarching Health Building Note 00-01 in which the key areas of design and building are dealt with.

Example

The Health Building Note on accommodation for adult in-patients is represented as follows:

"Health Building Note 04-01: Adult in-patient facilities"

The supplement to Health Building Note 04-01 on isolation facilities is represented as follows:

"Health Building Note 04-01: Supplement 1 – Isolation facilities for infectious patients in acute settings"

Health Building Note number and series title	Type of Health Building Note
Health Building Note 00 – Core elements	Support-system-based
Health Building Note 01 – Cardiac care	Care-group-based
Health Building Note 02 – Cancer care	Care-group-based
Health Building Note 03 – Mental health	Care-group-based
Health Building Note 04 – In-patient care	Generic-activity-based
Health Building Note 05 – Older people	Care-group-based
Health Building Note 06 – Diagnostics	Generic-activity-based
Health Building Note 07 – Renal care	Care-group-based
Health Building Note 08 – Long-term conditions/long-stay care	Care-group-based
Health Building Note 09 – Children, young people and maternity services	Care-group-based
Health Building Note 10 – Surgery	Generic-activity-based
Health Building Note 11 – Community care	Generic-activity-based
Health Building Note 12 – Out-patient care	Generic-activity-based
Health Building Note 13 – Decontamination	Support-system-based
Health Building Note 14 – Medicines management	Support-system-based
Health Building Note 15 – Emergency care	Care-group-based
Health Building Note 16 – Pathology	Support-system-based

Other resources in the DH Estates and Facilities knowledge series

Health Technical Memoranda

Health Technical Memoranda give comprehensive advice and guidance on the design, installation and operation of specialised building and engineering technology used in the delivery of healthcare (for example medical gas pipeline systems, and ventilation systems).

They are applicable to new and existing sites, and are for use at various stages during the inception, design, construction, refurbishment and maintenance of a building.

All Health Building Notes should be read in conjunction with the relevant parts of the Health Technical Memorandum series.

NHS Premises Assurance Model (NHS PAM)

The NHS PAM is a tool that allows NHS organisations to better understand the efficiency, effectiveness and level of safety with which they manage their estate and how that links to patient experience. The NHS PAM has two distinct but complementary parts:

- Self-assessment questions: supporting quality and safety compliance;
- Metrics: supporting efficiency of the estate and facilities.

For further information, visit the NHS PAM website.

How to obtain publications

Health Building Notes are available from the UK Goverment's website at:

https://www.gov.uk/government/collections/health-building-notes-core-elements

Health Technical Memoranda are available from the same site at:

https://www.gov.uk/government/collections/health-technical-memorandum-disinfection-and-sterilization

Executive summary

The National Health Service (NHS) has a corporate responsibility to account for the stewardship of its publicly funded assets. This includes the provision, management and operation of an efficient, safe estate that supports clinical services and strategy.

This corporate responsibility is carried by all accountable officers, directors with responsibility for estates & facilities and their equivalents, chairs, chief executive officers and non-executive board members. Together they have a responsibility to enact the principles set out in this framework document, provide leadership and work together to implement the necessary changes to provide a safe, efficient high quality healthcare estate.

This document is principally directed at land and buildings owned by NHS Foundation Trusts and NHS Trusts (FTs and Trusts) given the size, operating costs and capital value of this estate. Its direct cost is in the region of £7 billion per annum (DH, 2014a), which makes it the third largest cost after staff costs and drugs. The book value of this estate is about £33 billion[1].

This estate has important contributions to make in delivering savings and reducing running costs. These must be undertaken to meet the challenges of funding the NHS in the future and will form part of the government's drive to increase the efficiency of the public sector estate. Accordingly, a significant step change in the way this estate is managed has to be achieved.

The opportunities to achieve efficiency savings and reduced running costs in the estate are considerable. These efficiencies need to be driven by:

- more efficient plus effective running and use of the estate;
- improved efficiency, including value for money, in capital procurement and construction;
- adherence to best practice in land management, ensuring the optimum solutions are implemented which includes the identification and disposal of surplus land.

"Business as usual" is simply not an option as it does not support the future of a sustainable NHS.

However, efficiencies cannot be driven at the expense of safety and compliance: in the NHS Constitution the NHS commits to ensure that services are provided in a clean and safe environment that is fit for purpose; in turn, the Care Quality Commission (CQC) will assess whether services are meeting fundamental standards of quality and safety.

The above represents an important challenge for FTs and Trusts, which will involve using the right skill mix and expertise to deliver solutions. This document has been designed to set the strategic framework and assist them in identifying examples of best practice that should be considered as part of good estate and facilities management.

Even though the focus of this document is on the acute and mental health estate, the three

[1] Based on information contained in NHS Foundation Trust and NHS Trust financial accounts 2012/13.

above-mentioned bullet points relating to efficiencies also apply to the community estate owned and managed by NHS Property Services (NHS PS) and Community Health Partnerships (CHP). These are managed by these organisations to facilitate the delivery of NHS services sought by commissioners. Similar savings and reduced running costs can be delivered by these organisations.

Inevitably, commissioning decisions will have an impact on the estate used for NHS services. Commissioners, namely the NHS Commissioning Board (operating as NHS England) and clinical commissioning groups (CCGs), should ensure their clinical service requirements can be matched by service providers, which include FTs and Trusts. They will have to work with these Trusts as well as NHS PS and CHP to ensure changes in demand for NHS services applicable to the estate owned by these organisations can be met through further investment in existing or new facilities or disinvestment in existing facilities.

Furthermore, commissioners should ensure that different FTs and Trusts cooperate for the benefit of the local health economy. Examples of such cooperation include the provision of joint services, the reuse of surplus land and buildings by other FTs or Trusts, and shared initiatives to deliver required efficiencies within the NHS estate.

FTs, Trusts, NHS PS and CHP should be aware that there is an increasing trend and demand to improve the transparency of data and information across the NHS. Consequently, their estates and facilities data will be an integral part of this process. Therefore, these organisations should ensure the quality of their data will be to the required standard needed for publication or analysis, as in the future, data is likely to be more prominent and available in the public domain.

It is expected that FTs and Trusts will use this document to give assurance that their property assets are being used efficiently, savings are being achieved and surplus estate where identified is sold for reinvestment. Equally this will apply to assets owned and managed for NHS services by NHS PS and CHP.

This document is split into two parts. Part A outlines how efficiencies in the running of land and property can be achieved.

Part B provides more detailed advice about the active management of land and buildings used for healthcare services. Many of the topics covered here will help to achieve the efficiencies outlined in Part A. It includes advice on:

- general management of property including commercial opportunities for the benefit of patients, visitors and staff, and town planning;
- the selling of surplus property and where required the buying of additional property.

Contents

1.0 Overview

Introduction

1.1 The Department of Health (DH) considers that as part of the drive to improve the efficiency of properties owned by FTs and Trusts (the estate), it can be improved through three areas while still maintaining patient safety and quality outcomes:

- improved efficiency in the running of the estate;
- improved efficiency in capital procurement and construction;
- ensuring optimum solutions for land management are implemented including identifying and disposing of surplus land.

1.2 All three areas should reduce the running costs of the estate. Figure 1 highlights how this could be achieved.

1.3 The rest of this chapter looks at:

- the policy context – sets the background of existing national policy;
- guidance and powers – considers the regulatory framework around estates compliance;
- the strategic context and key drivers/ objectives – examines the drivers for change and key objectives; and
- the target audience – explains who should read and take action on the contents of this document.

The policy context

1.4 The Health and Social Care Act 2012 is a crucial part of the government's vision to empower patients, put clinicians at the centre of commissioning, free up providers to innovate and give a new focus to public health.

1.5 The 2012 Act inserted provisions into the National Health Service Act 2006 placing a duty on commissioners to exercise their functions with a view to ensuring that:

- health services are provided in an integrated way; and
- the provision of health services are integrated with the provision of social care services, where this will improve service quality and/or reduce inequalities.

To achieve this, a fit-for-purpose, properly located and efficiently operated estate is essential.

1.6 Commissioners are drivers of change in their local health economy. They should be taking a strategic overview of the planning of the existing estate in consultation with various stakeholders and setting the future direction of the estate. In addition, commissioners should liaise with FTs and Trusts on how improvements in patient services can be achieved through improved efficiencies in the running of the estate.

1.7 Commissioners should also actively engage with local planning authorities to achieve the maximum benefits from the planning system for the NHS. Furthermore, they should ensure that different providers cooperate for the benefit of

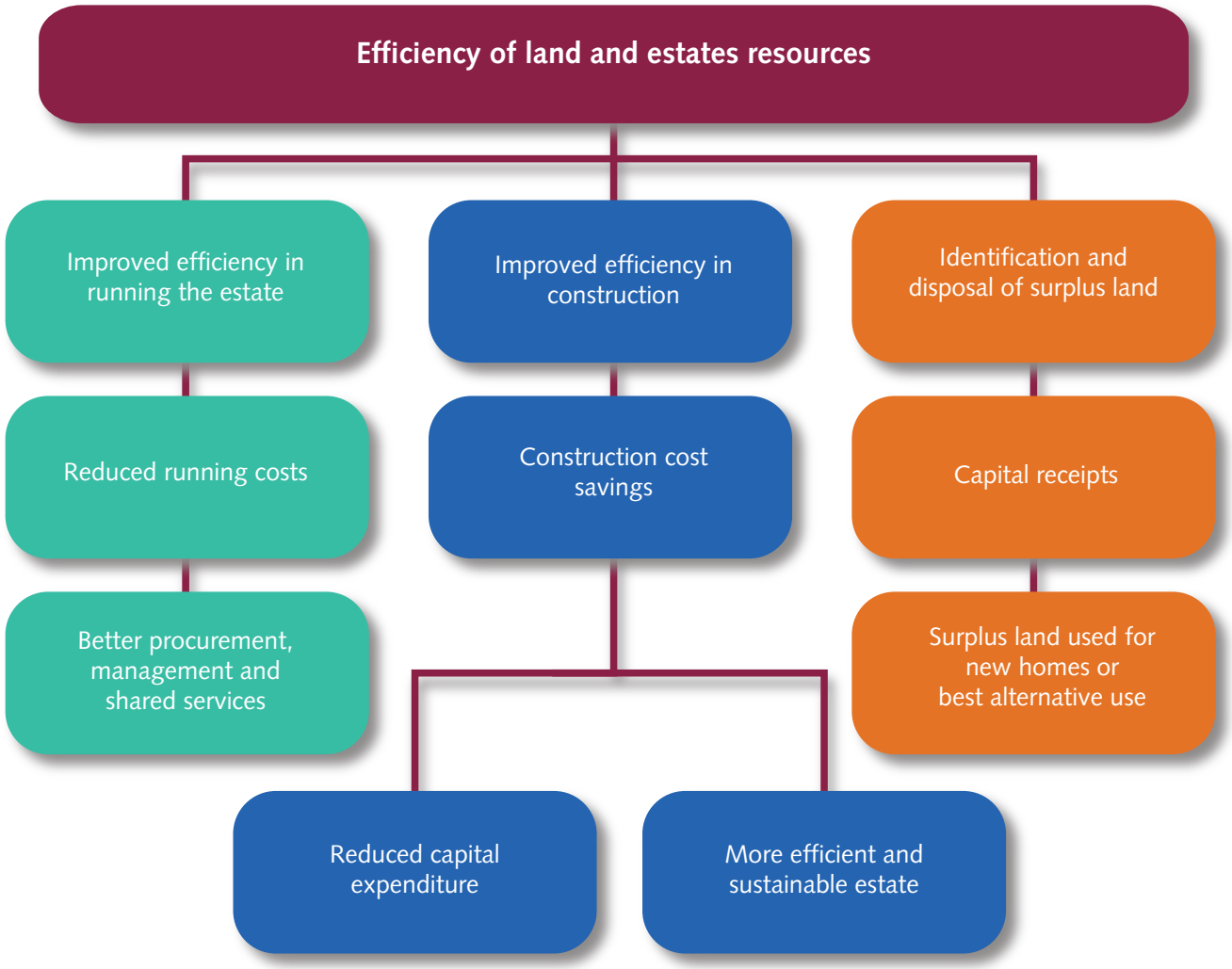


Figure 1 The three strands of efficiency measures

local health economies. Examples of such cooperation include the provision of joint services, the reuse of surplus land and buildings by other providers of NHS healthcare services, and shared initiatives to deliver required efficiencies within the NHS estate.

1.8 NHS Property Services (NHS PS) and Community Health Partnerships (CHP) as stakeholders own and manage the majority of community property occupied by the NHS and other providers. Commissioners, in conjunction with providers of NHS services (where applicable), should liaise with these companies when considering how this community property is planned, developed, used and rationalised.

1.9 FTs and Trusts will need to:

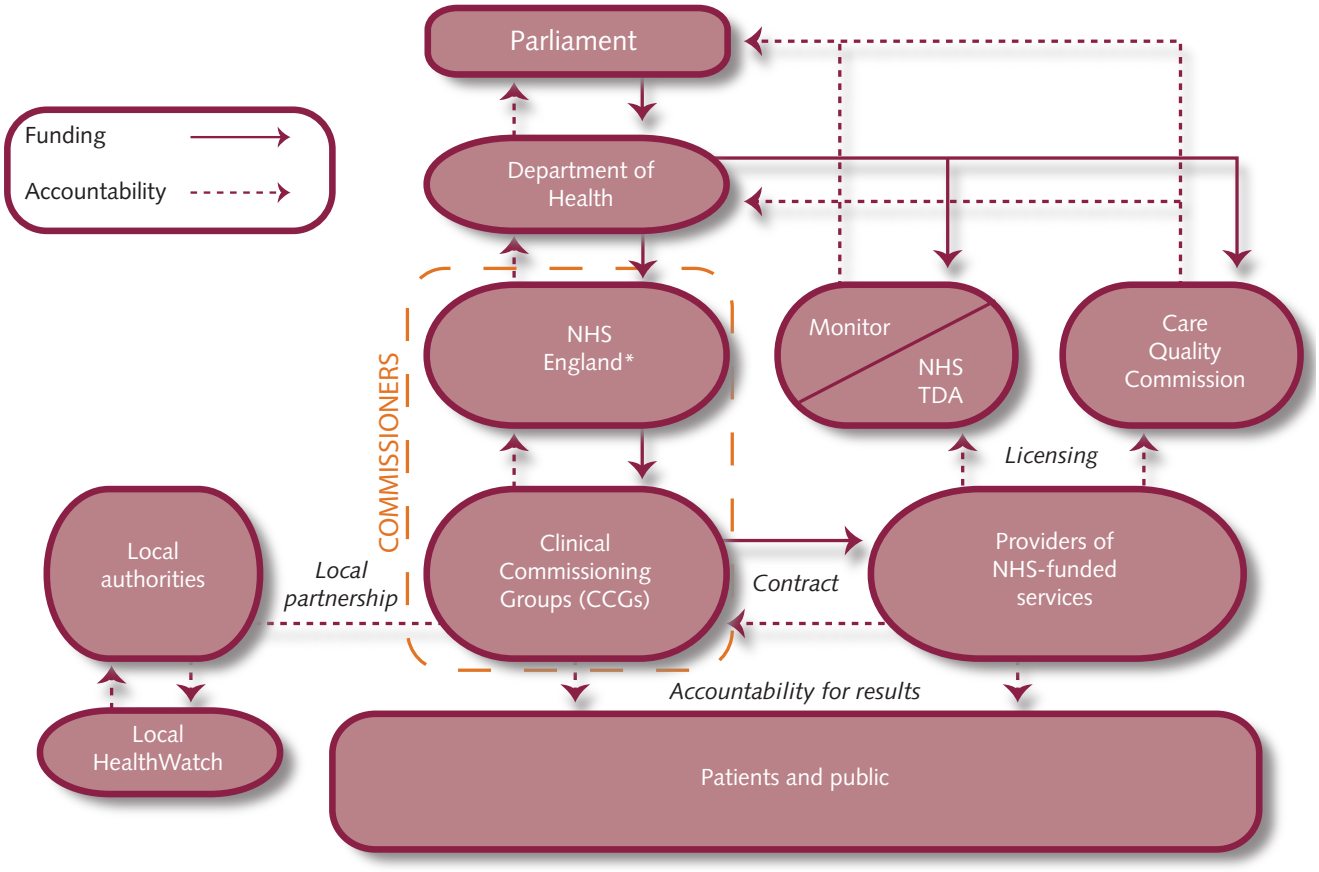
- ensure that land and property are used effectively to support commissioners' clinical strategies and patient needs;
- provide and maintain an appropriate level of affordable NHS healthcare facilities in the right locations, which are fit for purpose, safe and compliant with legislation and best practice guidance;
- achieve continuous improvements and better efficiencies from the performance of their estate;
- improve efficiencies in the cost of construction;
- identify and release surplus land for disposal.

1.10 When addressing estate matters, it is important for these organisations to reduce the environmental impact of their operations (both existing property and when undertaking new builds/refurbishments).

1.11 The delivery of services and demands for care are subject to continuous change. FTs and Trusts should be aware of the policies and other drivers in their localities that will affect the estate (this will include commissioning policies/drivers as outlined in paragraph 1.5).

Guidance and powers

1.12 Changes within the NHS structure and the constitution of its organisations are not uncommon. Therefore every NHS organisation will have varying governance and powers to operate. It is important that relevant personnel understand the structure, governance and associated operating frameworks for their respective organisations in the health and social care system (see Figure 2). These will affect an organisation's ability to enter into various legal arrangements (such as joint ventures or setting up separate property/operational companies). They will also impact on the delegated limits and authorities of a Trust to carry out the estate management function (such as capital development approvals and disposals). Relevant personnel should be aware of the organisation's standing financial instructions, standing orders and other relevant governance and approvals procedures including the rules and regulations set by DH, Monitor, the Care Quality Commission (CQC), NHS England and the NHS Trust Development Authority (NHS TDA).



Note:
*NHS England is the operating name of the NHS Commissioning Board

Figure 2 The health and care system

Compliance of the estate

1.13 Assurance of estates and facilities is assessed against a set of legal requirements and standards. Principally, these relate to:

- Regulations 12 and 15 of the **Health and Social Care Act 2008 (Regulated Activities) Regulations 2010** on the safety and suitability of premises;
- the registration requirements in the **CQC's standards**;
- the legal duty to have regard to the pledge on a clean, safe environment as outlined in the **NHS Constitution**.

Note

The list above is not exhaustive. There are numerous other statutes and legal requirements that NHS organisations, supporting professionals, contractors and suppliers must comply with. These are covered in the respective Health Building Notes (HBNs), Health Technical Memoranda (HTMs) and the NHS Premises Assurance Model (NHS PAM) (see the Preface).

Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

1.14 Regulation 12 decrees that registered providers must ensure that:

- services users;
- persons employed for the purpose of the carrying on of the regulated activity; and
- others who may be at risk of exposure to a health care associated infection arising from the carrying on of the regulated activity;

are protected against identifiable risks of acquiring such an infection.

Appropriate standards of cleanliness and hygiene should be maintained in premises used for the regulated activity. DH (2010) issued 'The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance' (the HCAI Code of Practice), which contains statutory guidance about compliance with regulation 12.

1.15 Regulation 15 of the Act states that patients must be "protected against the risks associated with unsafe and unsuitable premises, by means of . . . suitable design and layout . . . adequate maintenance and . . . the proper operation of the premises".

Regulator requirements

1.16 The CQC independently regulates all providers of regulated health and adult social care activities in England. The CQC's role is to monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety.

1.17 The registration requirements for providers are set out in the Care Quality Commission (Registration) Regulations 2009 (CQC Regulations) and include requirements relating to:

- safety and suitability of premises;
- safety, availability and suitability of equipment; and
- cleanliness and infection control.

1.18 The CQC is responsible for assessing whether providers are meeting the registration requirements (see the CQC's 'Guidance about compliance' (2010)). Failure to comply with the CQC Regulations is an offence and, under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, CQC has a wide range of enforcement powers that it can use if a provider is not compliant. These include the issue of a warning notice that requires improvement within a specified time, prosecution, and the power to cancel a provider's registration, removing its ability to provide regulated activities.

Note on amendment to the CQC Regulations

New regulations are due to come into effect from April 2015 and will apply to all providers of health and social care that are required to register with the CQC.

NHS Constitution

1.19 The NHS Constitution "sets out rights to which patients, public and staff are entitled". It also outlines "the pledges which the NHS is committed to achieve, together with responsibilities that the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively". It states:

> The Secretary of State for Health, all NHS bodies, private and voluntary sector providers supplying NHS services, and local authorities in the exercise of their public health functions are required by law to take account of the Constitution in their decisions and actions.

1.20 It commits the NHS to ensuring "that services are provided in a clean and safe environment that is fit for purpose, based on national best practice (pledge)". In order to deliver on this pledge, the NHS should take account of:

- the NHS Premises Assurance Model (NHS PAM) – the NHS PAM identifies where the NHS Constitution needs to be considered and where assurance is required;
- national best practice guidance for the design and operation of NHS healthcare facilities (such as HBNs and HTMs).

1.21 Figure 3 illustrates how DH estates and facilities best practice guidance (such as the NHS PAM and HBNs) aligns with the statutory and policy framework. This guidance is fundamental to ensuring that FTs and Trusts are able to deliver on their commitments under the NHS Constitution and to comply with the CQC's registration requirements and standards.

Strategic context and key drivers/ objectives

1.22 The financial challenge facing the NHS resulting from rising public expectations and demand means that significant efficiencies must be delivered now and in the future to ensure sustainability of services in the longer term. The NHS-owned estate and facilities services have important contributions to make in achieving savings by reducing operating costs. This supports a sustainable NHS and forms part of meeting wider government policies.

1.23 In addition, the NHS-owned estate will need to respond to changes in the way care is delivered as a result of:

- demographic trends (in particular, an ageing population and the projected prevalence of dementia, obesity and other long-term chronic conditions);
- increasing specialisation and centralisation of certain aspects of acute care;
- the integration of health and social care and providing care closer to home;
- shorter lengths of stay;
- an increase in ambulatory care and surgery via community settings; and
- technological advances (for example, in surgical techniques, telehealth, telemedicine, mobile working and diagnostic imaging).

1.24 In order to meet these changes, FTs and Trusts need to continuously improve but at the same time have to maintain compliance. The key drivers and objectives are:

- Reconfigure services in line with commissioners' plans.
- Align estate priorities with the business strategy.
- Drive out inefficiencies in the system through rationalising of the estate while

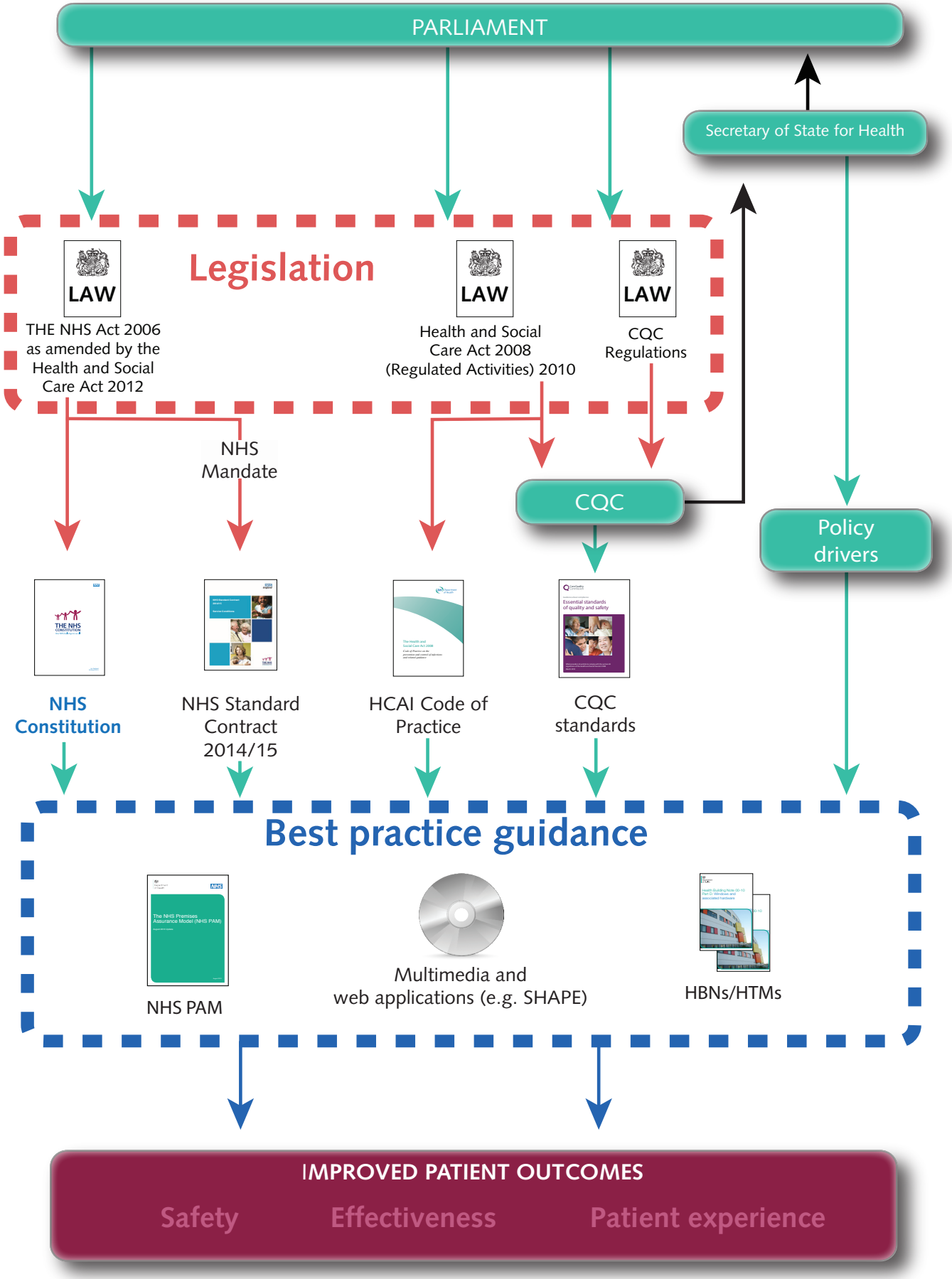


Figure 3 How best practice guidance on the safety and quality of healthcare estates and facilities fits in with the legislative and policy framework.
(The statutes and mandatory requirements shown in this figure are not exhaustive. See Note after paragraph 1.13.)

promoting and facilitating operational and clinical efficiency.

- Support and adopt more effective working practices that align with changes in the way services are delivered.
- Minimise high and significant risk backlog maintenance.
- Develop maximum flexibility within the estate to address future priorities.
- Use the opportunity to improve or develop patient, visitor and staff facilities through income-generation strategies.
- Develop estate solutions that help diversify risk and promote strategic partnering opportunities, notably in areas that support the organisation's core missions and values.
- Explore innovative solutions for new construction and refurbishment of the estate.
- Explore innovative procurement solutions for the delivery of goods and services in relation to estates and facilities services.

1.25 FTs and Trusts should align their estate strategies (see Figure 4) with clinical strategies and commissioners' clinical objectives and priorities. This should be carried out in partnership with other healthcare, social care and (where appropriate) public sector organisations (see Figure 4). This approach emphasises the need to engage at board level when developing estate strategies (see paragraph 3.6) and to liaise with all those responsible for clinical decision-making and the planning of care.

1.26 One of the major challenges is to reconfigure services and sites to operate at a lower cost base without detriment to the safety or the quality of care.

1.27 Further savings may be achieved through the reconfiguration of the estate to reduce underutilisation and/or poor-performing accommodation and buildings. This may identify surplus land and buildings that could then be sold, making the estate more efficient and potentially providing income for reinvestment.

1.28 The above issues are discussed further in Chapters 2 to 4.

1.29 Estates planning will be a fundamental part of enabling and facilitating health and social care service delivery. Innovative and creative building solutions are to be encouraged in driving the optimum future use of the estate. Any refurbished or new premises have to be better designed to deliver more flexible, efficient and sustainable buildings that cost less to construct, run and maintain.

1.30 Estates teams should ensure they have ready access to the required skill mix – if not directly, then indirectly with the use of:

- shared services;
- joint ventures with one or more independent estate and facilities management (EFM) service providers; or
- EFM service providers chosen from established frameworks.

1.31 Estate planning in community property should be carried out by commissioners, providers of NHS services, NHS PS and CHP through the use of estate strategies or strategic infrastructure plans (SIPs). These will ensure that the service objectives are appropriately matched to the available estate.

1.32 Where relevant, estate management best practices in other industries should be used in conjunction with this document to ensure optimum use of the estate to enable the delivery of safe and effective healthcare services.

1.33 The provision of suitable estate for NHS services should fully exploit the benefits of integration and colocation with other relevant organisations. Engagement with local authorities and other public sector organisations could lead to joint rationalisations of assets and associated services. This could achieve savings in capital and revenue from jointly used premises as well as savings from identifying surplus NHS estate.

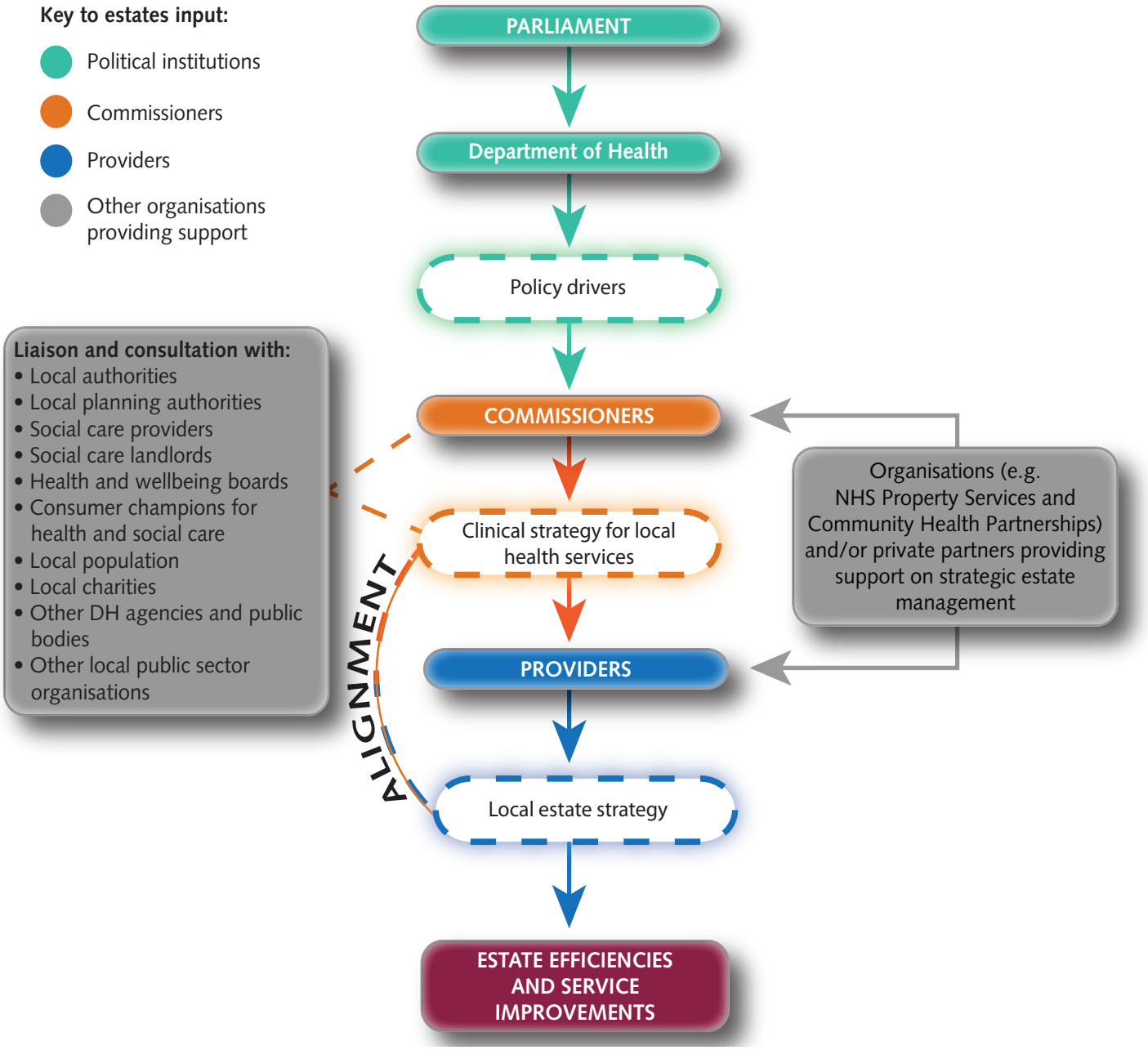


Figure 4 Estate priorities and strategies should be carried out in consultation and/or partnership with various stakeholders and should be aligned to commissioners' clinical strategies

Target audience

1.34 This document is for:

- personnel at any level in FTs and Trusts responsible for overall control, strategic development or day-to-day decision-making regarding the use of land and property and for the provision of a safe healthcare estate;
- commissioners;
- NHS PS;
- CHP.

1.35 Using this document, NHS England and clinical commissioning groups (CCGs) should be able to actively work together with FTs and Trusts, NHS PS and CHP to realise the most beneficial and sustainable property solutions in the delivery of health and social care services.

1.36 It is important for all chairs, accountable officers, CEOs, finance directors and other board members (including non-executive members) to fully understand the policy context described in this document.

2.0 Performance of the estate

Introduction

2.1 It is essential that all NHS organisations should continue to meet new challenges and improve overall performance. For FTs and Trusts, a key element of this will be establishing the baseline assessment of the performance of their estate which should be benchmarked against local and national organisations of a similar size and clinical case mix. This approach is fundamental when planning how to move forward and make improvements.

2.2 Data capture and analysis are key to proactive estate performance management and will be required for many business activities associated with an NHS organisation. However, to be meaningful, data on current performance needs to be interpreted in the context of organisations with a similar profile and size.

2.3 FTs and Trusts should maintain a comprehensive record of hard and soft estate facilities management (EFM) maintenance contracts (including LIFT and PFI), asbestos registers and other statutory maintenance registers.

2.4 Estates and facilities costs should be proportionate to the income of FTs and Trusts and within an appropriate level of performance. This information should be used for benchmarking an organisation's current performance and for setting key improvement targets in annual business plans and five-year estate strategies (see paragraphs 3.6–3.11).

2.5 Fundamental to this is an up-to-date and accurate electronic database of all the land and buildings owned, occupied, let or shared by the NHS organisation plus legal title documents, deeds (including Establishment Orders and Transfer Orders), and documentation relating to any leases, licences or other types of occupation by a third party.

2.6 The costs of holding land and buildings should be known, updated and assessed annually including costs of maintenance, cleaning, energy, insurance, service charges (where leased accommodation), business rates and utility costs.

2.7 The gross internal area and net internal area of buildings should be accurately known and where possible accompanied by plans and other data that can be easily accessed and updated regularly. This will help in interpreting accommodation costs per occupier and per service when developing cost improvement plans. This will also assist the organisation to improve its environmental performance by helping to reduce its carbon emissions and thereby allaying its costs associated with the Carbon Reduction Commitment (CRC) Energy Efficiency Scheme (see paragraphs 3.31–3.33).

2.8 Information held should be in a format that is easily transferable to the government's e-PIMS system.

Resources used to analyse performance

2.9 Primarily these resources include the FT's and Trusts's own costs database, NHS PAM, use of Estates Return Information Collection

(ERIC) benchmarking data and the Patient-Led Assessments of the Care Environment (PLACE) programme. The latter three resources are discussed in more detail in the following sections below. Use of these resources will enable an FT or Trust to take an informed view of overall estate performance.

2.10 Other tools and data that can be used include:

- Public Health England's Strategic Health Asset Planning and Evaluation (SHAPE) tool;
- assessments of high and significant risk backlog maintenance;
- lifecycle costs;
- BREEAM assessments;
- six-facet surveys;
- space utilisations; and
- energy performance standards (or other similar benchmark assessment systems).

NHS Premises Assurance Model (NHS PAM)

2.11 The NHS PAM is a management tool designed to provide assurance and a nationally consistent approach to evaluating NHS premises and facilities performance against a set of common self-assessment questions (SAQs) and established metrics. Commissioners may require providers to demonstrate active management of the NHS PAM as part of clinical service contracts.

2.12 The use of the NHS PAM alongside the land and property appraisal (six-facet surveys) and a risk-based methodology for establishing and managing assets provides a sound basis to prioritise and plan future capital investment and management of the estate.

2.13 The NHS PAM metrics allow comparisons across a range of Trust types on aspects of asset management using ERIC, PLACE and in-patient surveys. FTs and Trusts can therefore compare performance levels and understand how efficiencies can be improved. Analysis of Hospital Episode Statistics data also assists in the comparison of the spatial efficiency of clinical activity.

2.14 The NHS PAM measures performance against five domains. Figure 5 illustrates the distribution of self-assessment question ratings within each of the domains. The NHS PAM also identifies any capital investment required to achieve compliance, which can then be used in conjunction with the NHS PAM metrics to inform action plans for future investment and improvements in the efficient use of the estate.

Estates Return Information Collection (ERIC)

2.15 ERIC data enables the analysis of estates and facilities information from FTs and Trusts in England. It is a mandatory requirement that returns are submitted, which in turn becomes part of the national statistics.

2.16 Statistics taken from the organisation's annual ERIC returns are a good basis for assessment and can be used to indicate its performance relative to its peers. Most importantly, ERIC should be treated as the standard first step when analysing estates data.

2.17 It is important that accurate figures to address critical infrastructure and longer term risks are presented at local and national level via ERIC in order to monitor the condition of estate assets.

Patient-Led Assessments of the Care Environment (PLACE)

2.18 NHS England's PLACE assessment programme offers a non-technical view of the building and non-clinical services across all hospitals providing NHS-funded care.

2.19 The PLACE results are shared with the CQC, which uses the information in discharging its responsibilities for monitoring and reporting on a hospital's performance.

2.20 NHS England has developed a spreadsheet tool to display PLACE data

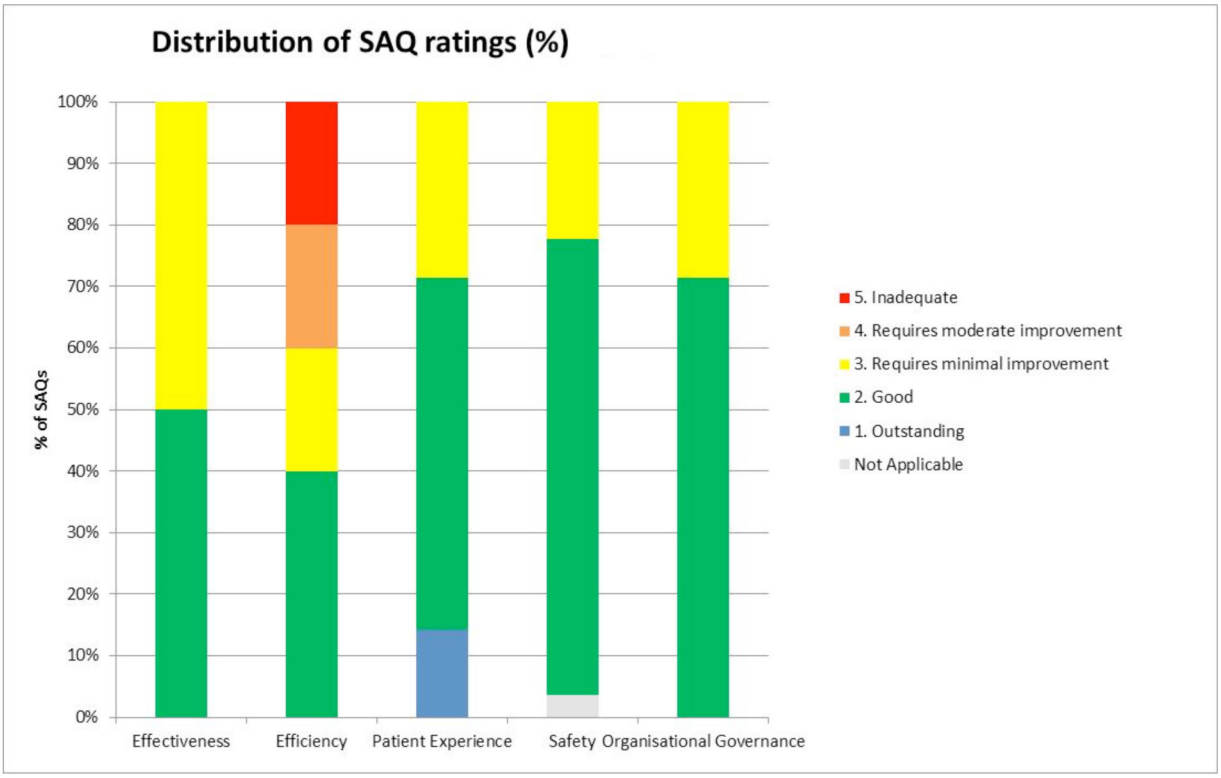


Figure 5 Example of distribution of self-assessment question (SAQ) ratings (%)

alongside ERIC data. Users can choose to contrast any of the PLACE domains against any domain within the ERIC data, and display the data by region, area team and CCG. Additionally PLACE data is used to support an organisation's overall NHS PAM assessment and assurance against compliance.

Benchmarking against similar NHS organisations

2.21 FTs and Trusts should peer-review their estate costs against organisations of similar size, type and specialism. This can be done through local estate forums or other established networks.

2.22 Exemplars of efficient practice elsewhere in the NHS should be used to raise standards and produce savings through reduced running costs. These should be expanded to include better and innovative procurement of all types of services (for example, maintenance and advisers) and service contracts. This could involve using established service-provider frameworks.

2.23 All this information should be used for benchmarking the current position and for setting improvement targets.

3.0 Improved efficiency and effectiveness in running the estate

Introduction

3.1 FTs and Trusts spend in the region of £7 billion per annum on management of their estate, which makes this the third largest cost for the NHS after staff costs and drugs (DH, 2014a). To address the financial challenges identified in paragraph 1.22, there needs to be a step change in the management of the estate to achieve savings and reduce running costs; however, this should not compromise patient, visitor and staff safety.

3.2 FTs and Trusts will need to work with commissioners and other stakeholders to be able to deliver the required efficiencies.

3.3 National data (for example, ERIC) analysis and benchmarking (see paragraphs 2.21–2.23) should be used to assist in producing more accurate, timely and comprehensive management information and evidence to support the delivery of savings which will be achieved by, for example:

- reduction in property costs relative to income from activity and expenditure;
- reduction in high and significant risk backlog maintenance (see DH (2004) 'A risk-based methodology for establishing and managing backlog');
- optimisation of the estate – (for example, increase in room utilisation, reduction in void costs and rationalisation);
- efficiency in back-office functions (for example, achieving savings by consolidating IT and human resource departments into one centralised location);
- creation of opportunities to develop existing and additional income;
- partnership working;
- effective use of new technologies;
- achieving value for money from existing PFI and LIFT contracts.

3.4 These points are expanded upon in the rest of this chapter.

3.5 FTs and Trusts will need to review the skill mix of their estates and facilities workforce, encouraging business and commercial skills and acumen to support the reduction of costs. They will also need to identify the support required to achieve their goals and objectives. How this information is acquired will be a matter for the option and financial appraisals (for example, in-house, short-term consultancy, outsource, contract arrangements and strategic estates partnerships).

Business planning

3.6 A key element in improving efficiency is through a rigorous system of business planning and regular review. The annual business plan should be centred on improving efficiency and effectiveness, enabling FTs and Trusts to deliver core clinical, business and sustainability objectives.

3.7 These objectives should be aligned to the organisation's and commissioners' local clinical strategies (see paragraph 1.25) and should be continuously reviewed. The aims are:

- to ensure that the estates and facilities management (EFM) service design and delivery is both clinically and business-led and supports the needs of front-line services; and
- to enhance the organisation's overall performance.

3.8 The plan should therefore be responsive, patient-focused and easy to access. It also needs to ensure the existing service standards are maintained or improved.

3.9 The business plan should provide an overview of the activity that the organisation will undertake during the forthcoming financial year. Targets for continuous improvements for estate performance should be set with a view to reducing costs now and in the future. This will depend on the current performance of the particular organisation, which is evaluated using ERIC benchmarking data and submitted to the organisation's board for review (see paragraphs 2.21–2.23).

3.10 FTs and Trusts will need to engage with commissioners to understand the local population, disease prevalence and existing and future demands for services. They will need to assess what impact these issues will have on their estate.

3.11 An integral part of the business plan will be an estate strategy that will identify opportunities for optimising the estate. When developing the estate strategy, FTs and Trusts should be realistic in their assessment of the commercial potential of their land and property.

Estate optimisation

3.12 The configuration of the NHS-owned estate is changing with increasing opportunities to lease and share facilities. FTs and Trusts should explore the possibility of optimising their estate by colocation or joint use of premises to maximise service benefits, together with a strategy to rationalise the use of both clinical and administrative estate, thereby improving efficiencies and reducing costs.

3.13 The above can be achieved through the introduction of more effective working practices, providing a workplace that enables greater productivity and collaboration across teams and acting as a catalyst for cultural change across the organisation.

3.14 Initial investment is likely to be required to provide workplace solutions that meet the needs of the organisation. A programme should be developed in order that more effective working becomes "business as usual".

Space utilisation

3.15 FTs and Trusts should have a regularly updated asset management system that allows estates managers to identify unused or under-used space on a room-by-room level. This is essential to the improvement of space utilisation.

3.16 Any information/data reported from the system can be used to inform rationalisation strategies and support more effective working through reconfiguration of underutilised space. However, it must be noted that any rationalisation/consolidation should be service-led.

3.17 See also paragraph 4.18 on 'Flexibility and future-proofing'.

Maximising benefits from commercial opportunities from land and property to enhance the experience of patients, staff and visitors

3.18 FTs and Trusts should develop the full potential of their estates for the benefit of front-line patient care, staff and visitors. This should be assessed with clear governance and rigour

throughout the process to ensure they are aligned to DH and Public Health England policies together with National Institute for Health and Care Excellence (NICE) guidance. The objectives for engaging in commercial activities should be clear from the start.

3.19 Typical examples where these benefits can be achieved include:

- welcoming front entrances with retailing;
- car-parking;
- energy.

3.20 Professional advice should be sought from those who have specialist knowledge and experience in dealing with commercial contracts and service operators. This is necessary to ensure that the correct terms are included in any agreement in order that the policies/ requirements of an FT or Trust will be implemented by the operator of a retail outlet. In addition, an FT or Trust must be assured that the proper returns are being received whether this is purely financial or for other specific benefits or a combination of these options. Failure to negotiate the best deal will result in losing out on potential income and/or benefits.

Welcoming front entrances with retailing

3.21 The way a building looks, inside and out, has a profound effect on what people think about the organisation it houses and how they relate to it. A high quality point of entry gives users confidence in the organisation and should reflect its values.

3.22 Main entrances would normally be expected to offer amenities for patients and visitors such as welcome desk/reception, digital check-in, good wayfinding, hospital security and access to health information. However, many hospital concourses are also able to offer a variety of retail outlets. Creating a meeting point or hub can help reduce bottlenecks in other parts of the hospital and can offer a welcome distraction for those patients fit enough to leave the ward. It can also support staff to manage their day-to-day activities (for instance, by providing such amenities as ATMs, dry-cleaning services and hairdressing).

3.23 Food outlets and/or vending machines can be good sources of income. However, it is important that operators support the main business of the NHS – promoting and maintaining health as well as dealing with ill-health. To ensure retailing contributes to the welcoming environment, the amount of space it occupies should not be overwhelming and its design and display should not conflict or compete with those of the healthcare facility.

3.24 FTs and Trusts should work with retailers and vending machine operators to increase the range and visibility of healthy food options for customers and reduce the availability of more unhealthy options.

3.25 The Hospital Food Standards Panel recommends that all NHS hospitals should develop and maintain an organisation-wide food and drink strategy. This should include attention to the food and drink provision in shops and vending machines. For further information, see 'The Hospital Food Standards Panel's report on standards for food and drink in NHS hospitals' (DH, 2014b).

Car-parking

3.26 Car-parking charges and their enforcement is a sensitive topic. Decisions on the provision of parking spaces and the level of charges should be retained by individual providers and allow them to reflect local circumstances. Charges should be reasonable for the area.

3.27 To protect frequent users of NHS services, concessions should be offered. Details of charges, concessions and penalties should be well publicised including at car park entrances, wherever payment is made and inside the hospital. FTs and Trusts should consider installing "pay on exit" or similar schemes so that drivers pay only for the time that they have used.

3.28 Car-parking schemes in partnership with developers and operators should be considered with professional advice giving due regard to DH policy, the benefits, risks, terms of the proposal and the anticipated return on investment.

3.29 FTs and Trusts should consider imposing a requirement for contractors to be members of the British Parking Association and the Independent Parking Committee. Decisions should be supported by an analysis of access to facilities by patients, visitors and staff. Option appraisals and business cases with robust financial analysis will also be required. Ultimately, FTs and Trusts need to cover their costs so that they can eliminate or minimise the need for funding to be diverted from other budgets.

Further guidance on car-parking principles for patients, visitors and staff is available on the government's website.

3.30 In parallel to the above, as part of green travel plans, FTs and Trusts should also consider alternatives to cars and car-parking such as shuttle buses, working with local authorities on park-and-ride schemes, car-sharing and the facilitation of cycling racks (see DH (2006) Health Technical Memorandum 07-03 – 'Transport management and car-parking').

Energy

3.31 Energy costs account for approximately 9% of the overall NHS estate costs (£636 million in 2013/14)[2]. The procurement and efficient use of energy has an important part to play in reducing estate running costs. Innovative frameworks exist for the competitive procurement of energy, be it gas, electricity, steam or forms of solid fuel, and their suitability for an organisation's specific needs should be explored.

3.32 Reducing energy consumption or moving to renewable energy sources have the added benefit of reducing an organisation's financial charges under the CRC Energy Efficiency Scheme.

3.33 The Crown Commercial Service (CCS) provides an income generation opportunity for the public sector estate via its Demand Side Response Framework. Typical current revenue streams quoted by CCS are £14,000 per MW. More information is provided in HBN 00-08 Part B.

Partnership working

3.34 As outlined in Chapter 1, reconfiguring the NHS estate to improve patient care while driving efficiencies is challenging. Where appropriate and where powers are available, collaboration with other organisations (for example, shared services partnerships) or partnership with third parties (for example, joint ventures) may be considered as possible solutions to achieve efficiencies and deliver better value for money.

Shared services partnerships (SSPs)

3.35 SSPs can be beneficial for FTs and Trusts that share a centralised team to undertake estate and facilities management activities. This form of collaborative working and procurement can help with efficiencies, pool expertise, improve productivity, provide resilience and reduce carbon emissions from the activities provided. The colocation of back-office services also allows organisations to benefit from economies of scale and deliver financial savings.

3.36 SSPs are appropriate for those organisations that wish to keep EFM services within their control and feel they can grow and develop the services collectively.

3.37 There are many mechanisms for establishing SSPs under various structures including:

- one organisation takes the lead in providing EFM services for the group;
- a separate operating company;

[2] Source: Estates Returns Information Collection 2013/14. This total figure is based on information collected from FTs and Trusts in respect of their annual cost of energy consumed, including electricity, gas, oil and coal.

- a partnership with a commercial sector company;
- outsourcing.

3.38 The options available should be appraised and should operate within organisational guidance and delegated authorities. Fundamental to an SSP will be a robust operating framework for ensuring the compliance and safety of buildings and a lower operating cost base from the activity.

3.39 Other key benefits will include:

- a greater focus on patients' needs and clinical requirements;
- improved service quality with defined service level agreements;
- increased efficiency of operational staff;
- cost reduction and reinvestment;
- more development opportunities for the staff involved;
- much improved capability to measure performance;
- the pooling of scarce and expensive skills and expertise.

Joint ventures (JVs) in estates management

3.40 JVs are appropriate for FTs and Trusts that consider that the private sector can help them improve their in-house business expertise and skills to deliver more efficient and effective estate and facilities management services.

Seeking professional and legal advice

3.41 It is important that professional and legal advice is sought when considering any JV. A robust framework for cooperation should be established alongside clearly defined key performance indicators. The mechanism for terminations, payment of services, level of liability and degree of risk-sharing should all be clearly understood before entering into any agreement.

3.42 Paragraphs 3.43–3.47 give examples of types of joint venture.

Local asset-based vehicles (LABVs)

3.43 In an LABV, the NHS partner organisation provides its surplus land and property to the joint venture, and the private sector matches the value of the land with a capital contribution. LABVs allow FTs and Trusts to work in partnership with the private sector in order to achieve a better financial return from the proposed investment.

Strategic estates partnerships (SEPs)

3.44 In an SEP, the NHS partner organisation seeks to improve service provision by using private sector investment and innovations for the delivery of estate objectives, including estate and facilities management, estate transformation, asset disposal and estate development.

Contractual joint ventures

3.45 Contractual joint ventures are relatively quick and simple to establish and provide straightforward access to the wide range of resources and services that can be provided from the chosen partner.

Subsidiary companies

3.46 Only FTs can choose to incorporate a trading subsidiary company to undertake certain trading activities. This mechanism can help to drive operational efficiencies and allow FTs to focus on their core clinical service responsibilities.

3.47 FTs can also choose to implement separate EFM companies in partnership with others to own and manage developments and to undertake future property investment and management activities. This can lead to increased flexibility in the use of the estate and improved management of costs.

New technologies

3.48 Changes in healthcare delivery, together with increasing use of technology, are likely to see the number of facilities providing NHS services reducing over time. Telemedicine, self-monitoring and medication, wireless access and mobile working will all contribute to a reduction in the use of and need for space. The potential impact of technologies should be recognised in business plans and estates strategies.

3.49 The role of estates professionals will need to adapt so that they become more creative in their understanding of the potential of technology in order to promote innovative property solutions that will make a real difference to patient care.

Achieving value for money from existing PFI and LIFT contracts

PFI contracts

3.50 It is essential that value for money is consistently derived from existing PFI contracts. This means ensuring that contractors perform to the agreed standard – that is, ensuring that FTs or Trusts are getting what they are paying for and that the PFI project is delivering the value that was targeted.

3.51 An HM Treasury review concluded that savings of at least £1.5 billion were possible over the remaining life of the operational PFI contracts as a result of, for example, effective contract management or more intensive use of the asset (HM Treasury, 2013). In particular, it advocated that savings on annual unitary charges for PFI projects are realistically achievable. In the main these savings come from the effective application of existing contract provisions such as:

- payment mechanisms;
- benchmarking/market-testing processes;
- service-level standards.

3.52 This would include, for example, service failures to be properly logged and any appropriate deductions made. However, commitment to adequate and suitably skilled contract management resources will be required to realise such savings.

LIFT contracts

3.53 NHS PS and CHP should work together with commissioners to ensure that the LIFT estate is being used efficiently and effectively. Maximising occupation of LIFT premises should enable NHS PS to vacate and sell surplus community buildings and land, thereby generating capital receipts and reducing overall estate costs for the benefit of the NHS. It will also contribute to the government policy of disposing of surplus NHS land for new housing.

4.0 Improved efficiencies in capital procurement, refurbishments and land management

4.1 In responding to clinical needs, FTs and Trusts should give careful consideration to the capacity of their existing buildings and individual sites including, where relevant, properties owned by NHS PS and CHP. The resulting master plan (see paragraph 4.19) should show how much of the current clinical use should remain, where suitable capacity exists and the extent of any new construction that may be required.

4.2 Options will usually involve:

- relocating or reassigning functions within the existing fabric of the building, with minimal building work;
- refurbishing existing buildings;
- new developments (including the decommissioning and demolition of existing buildings);
- sale of surplus land or buildings.

Capital procurement and refurbishments

4.3 Any capital procurement and refurbishment projects are to be taken forward in line with local standing orders and financial instructions and in accordance with relevant HM Treasury and DH guidance.

4.4 DH is working with the Cabinet Office to deliver cost-efficiency savings to meet the government's target to reduce the cost of public sector construction on an ongoing basis. It is using benchmarking analysis of new schemes measured against those completed to ensure continuous improvements in value for money.

4.5 For publicly-funded capital projects, the options in terms of capital procurement methods are:

- locally managed (through OJEU, if required);
- ProCure21+ National Framework.

4.6 For those schemes with an element of private finance then PFI, PF2 and NHS LIFT can be considered.

4.7 There are also existing frameworks for the procurement of professional services (such as the NHS London Procurement Partnership and NHS Shared Business Services).

ProCure21+ National Framework

4.8 This is the recommended procurement method for publicly-funded capital projects over £1 million. The framework operates in line with best practice as set out by HM Treasury and the Cabinet Office.

4.9 ProCure21+ monitors efficiencies in construction procurement. FTs and Trusts should try to apply the same level of efficiencies to any alternative procurement process they are using locally before making the final decision.

4.10 The use of benchmarking as a means of measuring and improving efficiencies delivered by the framework has demonstrated that projects are delivered on time, within budget and have good, high quality standards. Information relating to performance on completed schemes is published on an annual basis.

4.11 DH is benchmarking ProCure21+ construction costs in terms of cost per square metre across a number of NHS healthcare facilities against completed schemes. The framework partners are driving through cost efficiencies to produce facilities more economically. DH reports back regularly to the Cabinet Office on such savings. This enables the NHS to have access to benchmarking data on construction costs to help them drive down the cost of their capital projects.

4.12 As part of this, sustainable NHS buildings should incorporate design solutions that provide quality at the optimum value. They should ensure high levels of efficiency in terms of energy usage. The floor area should be utilised to provide the most efficient use of the clinical activity. Key to this is also the need to consider operational costs throughout the planning, design and construction phases to ensure that running the facility is sustainable and cost-effective.

4.13 An additional benefit of the framework is that DH has introduced standardised/ repeatable rooms and materials and components for acute and mental health facilities. There is no need to design facilities from scratch as these standard designs, materials and components are already proven and help to drive through continuing cost-efficiency savings for the NHS.

4.14 For more information visit the ProCure21+ website. See also the Government Construction Strategy website for guidance on sustainable buildings.

Building information modelling (BIM)

4.15 BIM is a process used by the construction industry that enables the assimilation of all the digital data for any capital project. This data can then be used to:

- produce 3D models of the proposed and subsequently built capital project;
- manage the maintenance of the capital project;
- manage the operation of the capital project and monitor/manage delivery of services within it as well as its performance;
- provide information for the future upgrading and development of the facility.

4.16 During the design and construction phase of a capital project's lifecycle, the information produced by using BIM can assist with:

- reducing on-site problems (clash detection);
- buildability;
- reducing design and construction time;
- providing improved assurance of design;
- improving cost certainty.

4.17 BIM is identified as one of the recommendations in the Government Construction Strategy that will support the delivery of achieving savings of up to 20% in construction costs.

Flexibility and future-proofing

4.18 Buildings and space should be flexible to support different levels of acuity, function and/or technology. Healthcare planning should ensure efficient patient flows to minimise delays and waiting times. Ideas and innovation should also be encouraged such as the use of step-up or step-down facilities, premises that accommodate integrated health and social care services, multifunctional rooms and easily adaptable rooms for future-proofing.

Land management

4.19 Master planning of the whole portfolio (or on a site-by-site basis) can be an important part of effective land management which is often developed as part of the FT's or Trust's board-approved estate strategy. It can also assist in maximising the benefit of a strategic disposal programme including benefits to be gained from the planning system.

4.20 An estate strategy should assist in determining the most appropriate means of managing the residual estate with a view to ultimately identifying surplus land and buildings. Land should not be left vacant without a substantive reason.

Identification and disposal of surplus land

4.21 Identification and disposal of surplus land by FTs and Trusts is a win/win for both the NHS and the public. It will provide income for reinvestment in healthcare services. The public and local economy benefit from new development on surplus land through:

- new housing or commercial development; and
- increased employment in the construction industry.

4.22 Improved returns may be obtained by combining an FT or Trust's surplus land with the disposal of an adjoining landowner and/or other public sector organisations.

Abbreviations and definitions

Abbreviations

BIM: building information modelling

BREEAM: Building Research Establishment environmental assessment methodology

CCG: clinical commissioning group

CCS: Crown Commercial Service

CQC: Care Quality Commission

DH: Department of Health

EFM: estates and facilities management

e-PIMS: electronic property information mapping service

ERIC: Estates Return Information Collection

HBN: Health Building Note

HTM: Health Technical Memorandum

LABV: local asset-based vehicle

LIFT: local improvement finance trust

NHS PAM: NHS Premises Assurance Model

NHS TDA: NHS Trust Development Authority

FT: NHS Foundation Trust

JV: joint venture

PF2: private finance 2

PFI: private finance initiative

PLACE: Patient-Led Assessments of the Care Environment

SAQ: self-assessment question

SEP: strategic estates partnership

SSP: shared services partnership

Definitions

Benchmarking: the process of comparing performance against similar organisations, with a view to identifying areas for potential improvement.

Commissioners: in the context of this document, this will be the NHS Commissioning Board, operating as NHS England, and CCGs unless otherwise stated.

Community property: property for use by community care services.

NHS organisation: this term means any of the following – a Trust, an FT, NHS England and a CCG.

PF2: the government's successor policy to the PFI for the delivery of infrastructure and services through public–private partnerships.

Providers: organisations that provide or intend to provide healthcare services for the purposes of the NHS.

Strategic estates partnership: a long-term joint venture where a private sector partner is engaged to provide an estates strategy to assist an NHS organisation with estates rationalisation and planning its capital programme. The SEP private partner would be expected to plan, develop, arrange finance for and deliver the capital programme which typically involves delivering new facilities, refurbishing existing facilities and seeking to maximise the value of the estate.

Trust: NHS Trust.

References

Acts and regulations

Care Quality Commission (Registration) Regulations 2009.

See Note after paragraph 1.18.

Health and Social Care Act 2012.

Health and Social Care Act 2008 (Regulated Activities) 2010. SI 2010 No. 781. HMSO, 2010.

National Health Service Act 2006.

DH guidance

DH (2004). A risk-based methodology for establishing and managing backlog.

DH (2006). Health Technical Memorandum 07-03. Transport management and car-parking.

Note: this guidance is to be updated in 2015.

DH (2010). The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance.

DH (2014a). Hospital Estates and Facilities Statistics 2013-14.

DH (2014b). The Hospital Food Standards Panel's report on standards for food and drink in NHS hospitals.

(The) NHS Constitution. The NHS belongs to us all.

NHS Premises Assurance Model (NHS PAM).

HM Treasury guidance

HM Treasury (2013). Savings from operational PFI contracts.

Care Quality Commission guidance

Guidance about compliance: essential standards of quality and safety. 2010