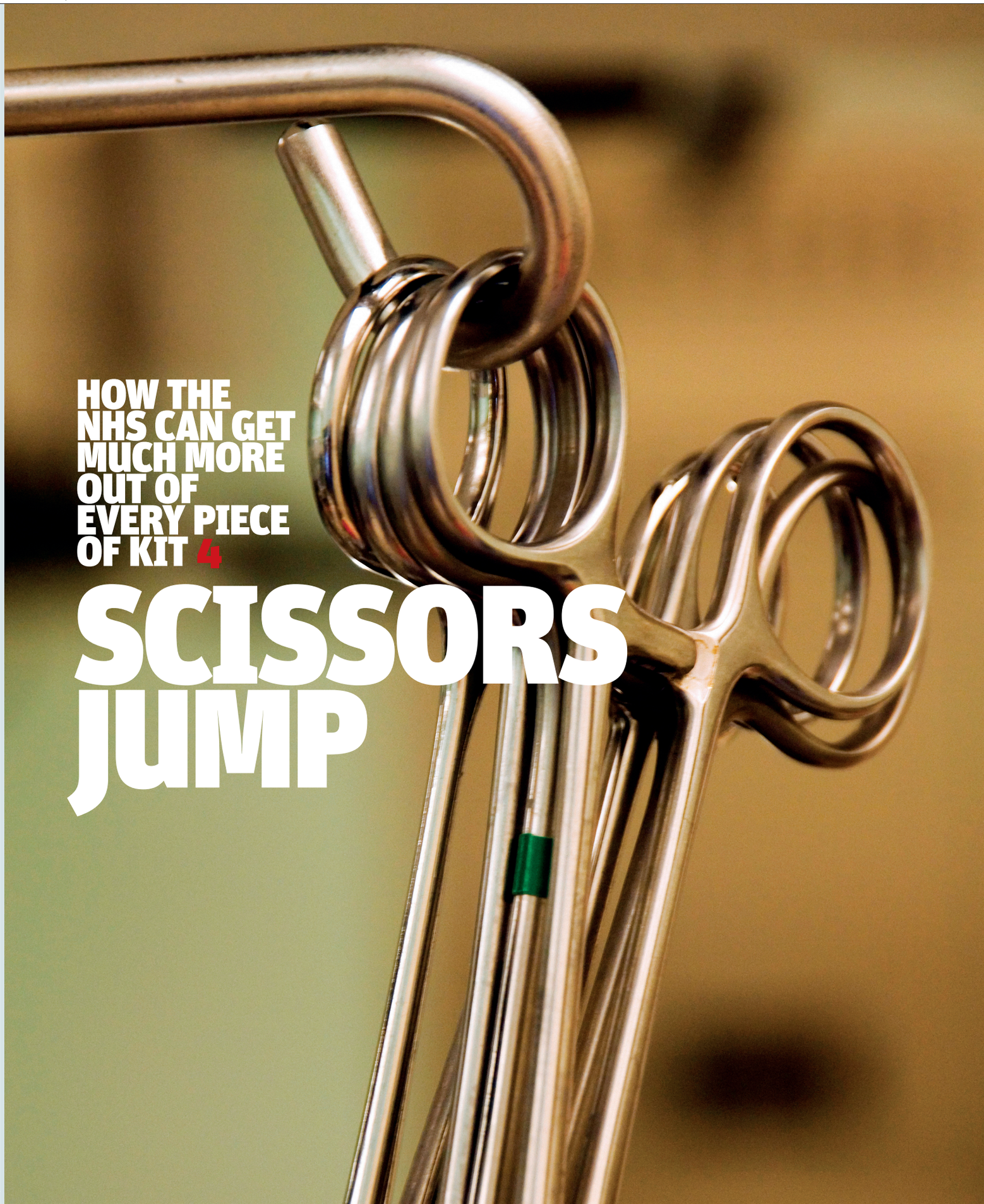
FOR HEALTHCARE LEADERS
HSJ

FUNDING THE FUTURE

AN HSJ SUPPLEMENT/28 MARCH 2013



HOW THE NHS CAN GET MUCH MORE OUT OF EVERY PIECE OF KIT 4

SCISSORS JUMP

CONTENTS

INSIDE

Supplement editor
Claire Read

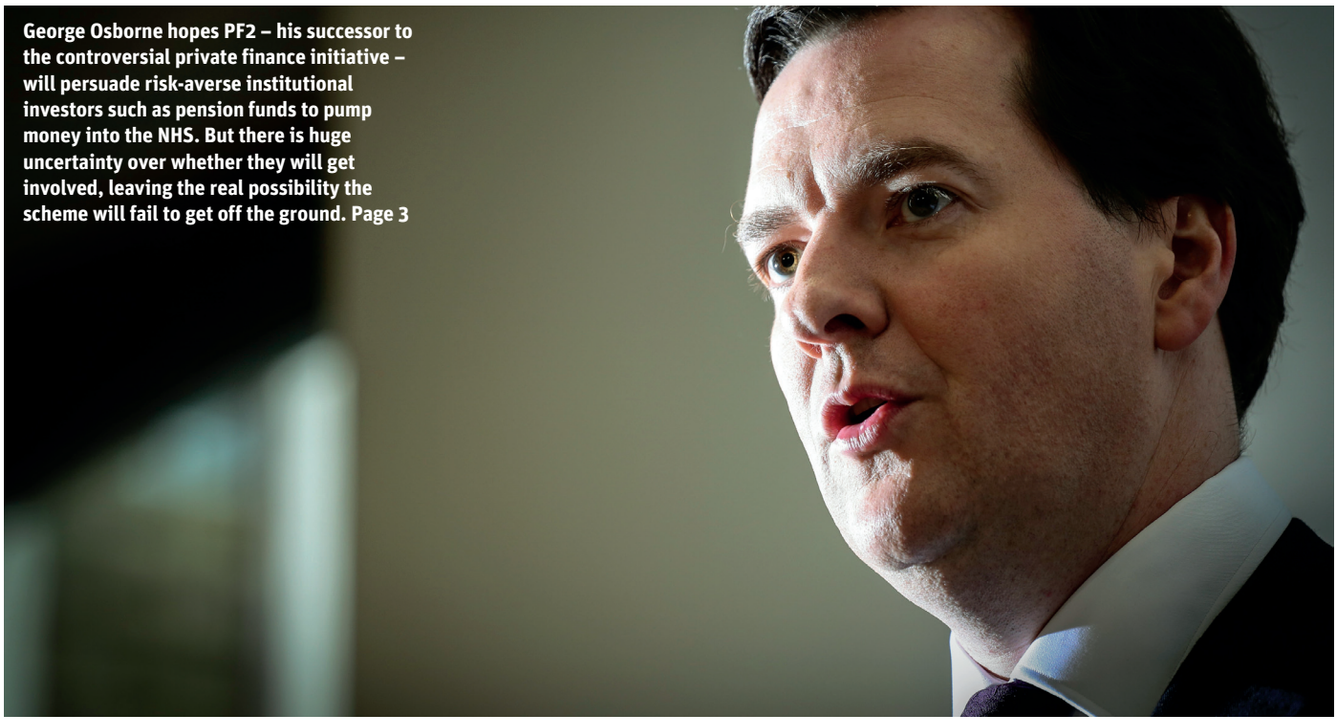
ASSET MANAGEMENT

The typical district general hospital uses 10,000 pieces of medical equipment – and the NHS has in the past failed to get the best value out of all this kit. But the pressing need to cut costs should finally prompt action. One option for trusts is to follow police and fire services among others and contract out asset management. Page 4

INFRASTRUCTURE

Investment in new NHS building has nearly come to a standstill. Reforms of the NHS, the uncertain impact of NHS Propco and investors' worries about the future foundation trust failure regime are all reasons cited for the dearth of new projects. But a more fundamental reason may be the move of care into the community, which may mean the future NHS will not need so many new buildings. Page 8

FINANCE



George Osborne hopes PF2 – his successor to the controversial private finance initiative – will persuade risk-averse institutional investors such as pension funds to pump money into the NHS. But there is huge uncertainty over whether they will get involved, leaving the real possibility the scheme will fail to get off the ground. Page 3

PFI: THE SEQUEL

Chancellor George Osborne was determined to 'do something' about PFI but there are huge uncertainties over his proposed successor to it, explains Mark Hellowell

How can NHS and foundation trusts get hold of affordable, long term finance as public capital budgets fall and the bank lending squeeze intensifies?

In PF2 – launched by George Osborne at the end of last year as the successor to the controversial private finance initiative (PFI) – the coalition government believes it has an answer.

And no doubt many NHS organisations – such as the Sandwell and West Birmingham Hospitals Trust, whose £400m scheme was placed in doubt last year when it was deleted from the Treasury-endorsed PFI programme – will welcome the creation of a financing model that, unlike the PFI, has the unambiguous support of the Chancellor.

Yet the outlook for PF2 is very uncertain.

Almost five years since the collapse of Lehman Brothers in September 2008, the project finance market remains in a poor state.

Many banks remain concerned about the quality of the assets they hold, and are nervous about forthcoming regulations (Basel III) that will make long term infrastructure investments expensive in capital adequacy terms.

In response, they are simply not lending. Even in the rare cases where debt finance is available for capital projects, it tends to be short term and expensive, adding to the affordability and value for money concerns that have long been associated with PFI.

This is the fundamental problem that PF2 is designed to address (along with the political requirement to "do something" about a model that the Chancellor himself attacked when in opposition).

The Treasury has made clear that it no longer regards bank finance as a sustainable source of debt capital for public sector projects.

Instead, officials want capital to come from institutional investors – pension funds and insurance companies, in particular. And PF2 has clearly been structured with a view to achieving that objective.

The big move is to increase the proportion of the capital expenditure requirement that is financed by equity, as opposed to debt.

'The success of PF2 is mostly out of the government's hands'

Traditionally, privately financed projects have had debt to equity ratios of 90/10. Now, the Treasury wants to increase the equity component to 25 per cent.

The hope is that this shift will do two things. First, the entry of new blood into the market will help to bring equity returns down to a more reasonable – and politically defensible – level than the 15 per cent-plus that has been the norm in the past.

Second, and more importantly in terms of the economics of the model, the lower gearing will persuade risk-averse institutional investors to lend into projects and even take on the construction risk – the logic being that the increased amount of equity will provide a comforting buffer of risk capital.

The government believes this will free up new sources of capital, liberating PF2 from reliance on the banks, and thereby leading to lower prices and less restrictive terms.

So will it work?

In the short term at least, the result of lower gearing will be to increase the cost of capital – and the ultimate cost of the deals for the NHS organisations involved.

And, even if NHS and foundation trusts can make the financial case for PF2 work with these higher costs, there is no guarantee that institutional investors will want to get involved.

Insurance companies, for example, face regulatory challenges under the European Union's Solvency II protocol, which will raise reserve requirements for long term assets and limit the attractiveness of infrastructure investment. Similar regulations are likely to be introduced for pension funds in the medium term.

Even without such constraints, these institutions have never invested in the due diligence capacity required for transactions like this, and it is not clear they will do so now for the sake of a £1.75bn programme – relatively small fry for them.

Because of this, the success or failure of PF2 is mostly out of the government's hands. It will be determined by the response of the debt and equity markets.

We still have no real idea whether they will respond to the government's overture.

If they don't, PF2 will never get off the ground – and NHS and foundation trust access to affordable, long term finance will continue to be minimal. ●

Dr Mark Hellowell is a lecturer in global public health in the school of social and political science at the University of Edinburgh and adviser to the House of Commons Treasury Select Committee's private finance inquiries

Dash for cash: George Osborne hopes to attract new investors with PF2

PA

EVE HOLDING ON ASSETS

IN ASSOCIATION WITH BABCOCK

babcock
trusted to deliver™

Babcock International Group is a proven partner to the UK public sector, delivering critical services for police forces, fire and rescue services, ambulance services and local authorities, as well as servicing key organisations within the education and defence sectors.

All these organisations rely on Babcock to deliver support services critical to their long term success. A valued and trusted partner, Babcock has enabled its clients to realise significant savings and so demonstrate effective use of public funds.

The UK health sector has many similarities to these sectors. With a flexible approach, Babcock responds to the specific challenge facing NHS trusts: the underlying need to continually improve clinical care and keep patient outcomes at the heart of all they do.

As a support partner, Babcock is often the unseen provider of critical services, releasing its clients to make best use of their specialist resources. It is this approach which will allow NHS clients to focus on delivering exceptional clinical care while Babcock ensures the smooth running of support services.

The assets of the NHS are diverse – the health service must continually invest in its people, equipment and estates – and require bespoke attention. Drawing on its understanding of the UK public sector, Babcock brings to the NHS a joined-up approach to asset management.

'A partnership approach can enable innovative financial models'

Many public bodies have benefited from Babcock's strategic, organisation-wide solution to asset management and optimisation. This has delivered financial savings, allowing clients to reach stringent economic targets. A partnership approach can enable innovative financial models which could deliver whole life asset management of all medical equipment across an entire trust, going far beyond managed equipment service-type contracts.

Babcock is able to bring a level of sophistication around commercial capability, as well as an ability to transfer risk around delivery and capital replacement. With in-house medical equipment expertise, Babcock is able to offer independent advice on equipment selection to meet clinical needs; guide and support procurement; and commission, maintain and manage assets through life. This capability includes equipment repair and replacement programmes for existing assets, and disposal of equipment at end of life for the benefit of an NHS partner.

Eve Holding is director of health services at Babcock International
Email: health@babcockinternational.com
www.babcockinternational.com/health

ASSET MANAGEMENT

DON'T FORGET YOUR KIT

For years the NHS has got poor value from equipment. Is that finally about to change? Claire Read reports

The National Audit Office was far from complimentary when it examined acute trusts' management of medical equipment.

The resulting report made clear that most organisations were a long way from getting the best value for money out of the procurement, maintenance and use of equipment used to deliver patient care. Clear responsibility needed to be allocated for medical equipment at board level, it argued. Trusts should have a clear picture of kit inventory and use that in decision making, it urged. Procurement needed to be addressed, it suggested, with technical staff closely involved and potential economies of scale investigated.

That was in June 1999. In 2011, these recommendations were repeated more or less verbatim in another NAO report.

An investigation into the management of high value capital equipment found an NHS still failing to make the most of its kit, still without a coordinated approach to asset management, and still missing out on significant cost and efficiency savings as a result. Why so little progress in the course of more than a decade?

"Equipment and asset management tends to be in the 'too difficult to do pile'," reflects Eve Holding, director of health services at the engineering support services company Babcock International Group. "It's often on the back burner."

Consider the scale of the issue, and that "too difficult" classification starts to make sense. An average district general hospital uses 10,000 pieces of medical equipment to deliver patient care. That kit is often being procured and managed by some 30 departments, generally in an uncoordinated way and with little strategic control.

"Typically these differing parts of the organisation are contacting more than 35 major suppliers to negotiate maintenance agreements, medical equipment replacement, and even consumables," explains Ruth Strickland, co-founder and director of Managed Technology Services, a company providing health equipment consultancy and procurement.

At some trusts, clinical staff find themselves getting involved in equipment management. "One of the main issues with equipment in the NHS is that clinically trained staff are involved in contract administration," reports Caroline Finlay, Ms Strickland's co-founder and director at MTS. "While clinical input into the selection of equipment is of paramount importance, the requirement for them to be involved administratively is not the best use of resources."

It is a status quo which those working in the field believe can no longer continue. With the pressing need for cost savings, and a greater focus than ever on the delivery of high quality care, the time may finally be right for change.

"The assets within a trust are an enormous proportion of their cost and so have a direct impact on income," points out Ms Strickland. "At the same time, there's a greater focus and demand on chief executives and finance directors to adhere to, uphold and deliver high quality of care. So I think the time is right to look at equipment, the support function – actually in some instances, it's not the support function, it's the critical function to deliver cutting edge healthcare in the NHS."

It is a view shared by Costi Karayannis, director of corporate development at Babcock. "The general principle in my mind is that trusts have to do something about equipment, both because of the financial imperative and the clinical imperative to improve services," he says.

"Some trusts are high performing and will

CASE STUDIES OVERLEAF ▶

be able to build up their own capability but some will have to look at alternative options.”

After years of providing equipment and asset support services to public sector organisations including fire brigades, the Metropolitan police and the Ministry of Defence, FTSE100 firm Babcock is entering the health sector. “We are taking our proven ‘whole life’ asset management services and now offering them to the NHS,” says Ms Holding.

That means support of complex and critical equipment “from cradle to grave”. Babcock helps procure equipment, manages it on the organisation’s behalf, repairs it, advises when it needs replacing, and arranges disposal and replacement. It also seeks to support trusts in developing a more strategic approach to the whole area.

“For me, one of the biggest potential benefits of a trust entering into a partnership with Babcock is the ability to take a long term view of their equipment investment requirements,” says Mr Karayannis.

“So moving away from the annual budgeting cycle and towards a strategic and well planned, long term investment programme.”

Such a programme should lead to significant cost savings. Ms Holding points out that better management of equipment will extend the life of that equipment. More than that, savings and efficiencies could be driven through better use of clinical staff’s time, better data on what the hospital has and how it is being used, and better negotiation with equipment manufacturers.

“I think there’s an opportunity for a vendor-neutral partner of scale who can work with trusts on a far more strategic level,” says Mr Karayannis. “That doesn’t just mean how many MRI machines do you need this year – it’s where do you want to spend your resources across your entire equipment portfolio, starting from what the clinical priorities are.”

“A strategic focus on equipment procurement, usage, location and management would undoubtedly realise savings,” agrees Ruth Strickland. “It would provide more control and ensure trusts could plan ahead for equipment to lead and support the clinical delivery by staff to patients.”

“This isn’t going to stop the NHS working tomorrow,” acknowledges Ms Holding. “Trusts are still going to be open tomorrow whether they address asset management or not.

“But I think in such pressing economic times, and certainly with the inevitable upheaval of NHS reorganisation, it would be very easy to overlook equipment and asset management and then look back and say: why didn’t we just keep our finger lightly on the pulse?” ●

ASSET MANAGEMENT: CASE STUDIES

READY FOR A NATIONAL EMERGENCY

How the NHS can learn from the system that manages the 650 vehicles and 175,000 items of stock that could be used to respond to a terrorist or nuclear attack

MOD ASSET MANAGEMENT

The NHS often sees improving its performance on asset management to be a case of bringing in experts on procurement. As the experience of another big public sector player has shown, however, having a partner to develop a wider asset strategy can lead to even greater savings.

The Ministry of Defence has taken just such an approach to the management of its construction and non-combat vehicles. Since the mid-2000s, it has handed over full responsibility for these fleets to Babcock.

"Effectively what we do with our full service is lifetime management," explains Sam White, director of land equipment support at the firm.

"We're the customer's procurement agency, so we go out and help them define their requirements. Then we go out and acquire these vehicles, run the competitions and so on. We then manage those vehicles once they're on fleet – if there is a problem, the customer calls us rather than the manufacturer.

"For the construction vehicles, we also deploy the kit to wherever it's needed in the world, train people to use it, and then take it back at the end of its lifetime. We effectively take the whole thing away from them, and they come to us as a one stop shop."

It means significant cost savings: Babcock is committed to save £43.6m over the latest four year non-combat vehicles contract, which began in September 2011. By improving performance at each stage of the asset management process, the firm fully expects to meet that target.

A big part of that is ensuring the best possible use of resources. Historically, each Ministry of Defence unit would have had its own collection of cars, vans and lorries and often failed to share resources usefully.

"What we've done is to consolidate the fleet to create an overall pool," explains Mr White. "So rather than having 10 coaches sitting at one barracks with nothing to do, and another unit hiring in 10 coaches for a special event, they now book through a system and have access to a national fleet."

That system is based on what Babcock terms 'request to requirement'. "We challenge the customer's thinking," says Mr White. "Our booking systems and management information systems don't book by request but by requirement. People tend to ask for a specific item, but we ask about the activity you're using that kit for.

"What is the requirement, and is it satisfied by something that is more cost effective and cheaper to support during its life? And then we align this requirement with other people who are looking to buy similar things at the same time, driving savings through economies of scale."

Mr White is confident that NHS organisations would see similar results were they to adopt this sort of system.

"Our customers are not in the business of asset management, and nor should they be. We strip out a huge amount of effort and time that's involved in managing multiple suppliers, running competitions, testing equipment, chasing repairs.

"It's not unusual for us to deliver 10 to 15 per cent savings," he reports.

TECHNICIAN TRAINING

If a piece of electronic equipment fails in an NHS hospital, it tends to mean a call to clinical engineering and then perhaps one to the manufacturer. For healthcare professionals in the army, Royal Navy and RAF that is rarely an option. The forces' dental and medical technicians therefore play a crucial role. It is they who are responsible for making sure that the kit needed to treat injured servicemen and women is working correctly.

Since January 1999, the Ministry of Defence has outsourced the training of these technicians to Babcock.

According to contract manager Mike Gordon, it is another way in which the organisation's total focus on equipment – and its comprehensive knowledge of it – offers benefits for clients.

"All our trainers are ex-medical and dental technicians from the military or come from non-military engineering backgrounds," explains Mr Gordon. "So it's not just people who understand the MOD perspective, but people who understand engineering from a much wider perspective.

"And since we have direct links to the manufacturers, we can facilitate training on the specific equipment being used out in the field."

This kit is varied. The technicians have to be trained in the maintenance of everything from the devices used to monitor vital signs to infusion pumps, X-ray equipment, ventilators and anaesthetic equipment.

Mr Gordon says that the initial decision to bring in an external firm to run this training was driven by the desire to save costs. That has happened, but other benefits have been seen too – not least a continuity of provision which was not present before.

"Trainers from the army, RAF and navy come in for maybe two, three, four years as a

Moving out: police and fire services are among those public organisations that now contract out asset management

posting and then move on again," he explains. "When that happens, you need to train somebody else and upskill them before they're able and competent to deliver training. Whereas we've got people who have been here for many years. We provide a level of continuity and consistency for the MOD."

The course is rated highly by both those who have completed it and by the Ministry of Defence, and it reflects what Babcock director of health services Eve Holding argues is the firm's integrated approach to asset management. "We view assets as being all assets, and that includes people," she explains. "Any organisation should invest in its people just as it does in any other asset."

NEW DIMENSION CONTRACT

The 10,000 pieces of kit that an average district general hospital needs to deliver its services seems almost small when compared to the equipment required for national fire and rescue capability.

Some 650 vehicles and 175,000 stock items of equipment are needed by the New Dimension programme, set up following the September 11 attacks.

The programme ensures that Britain's fire and rescue services are able to cope with major emergencies on a national scale – such as chemical, biological, radiological, nuclear and conventional terrorist incidents – as well as dealing with large scale incident support.

Just as in the NHS, there is no central store for this kit – it is held by the country's 46 individual fire and rescue services. But unlike the NHS, there is central management of the equipment. Since 2008, there has been a unique partnership between Babcock and the Chief Fire Officers Association National Resilience Assurance Team (NRAT). This team's capability officers manage the equipment itself, as well as the continual replacement and procurement process.

'What is the requirement, and is it satisfied by something that is more cost effective?'

Babcock and NRAT work together to ensure the equipment is always where it is needed, and maintain a central record of its location and when it has been serviced, repaired and replaced. This enables NRAT to ensure fleet availability and to monitor and track equipment to meet legal requirements.

"This is critical to our operation – knowing that we have a full view, at any point in time, of exactly the equipment that's there and the cost across the whole organisation," says Brian Ward, national resilience officer for NRAT. "This contract is very much a partnership, working together to anticipate the level and specification of equipment we need to meet immediate and future requirements."

Valued too is the consistency that having an external support partner brings when equipment is held across 46 services nationwide. For example, when a vehicle or equipment is brought into Babcock's central facility, everything is taken out in the same way, laid out in the same way, and reviewed in the same way to the same checklist. It is not necessary to pull staff from frontline duties for this work. Instead Babcock's dedicated contracts team ensures – on behalf of NRAT – that each piece of equipment is managed and maintained to a high standard.

In delivering the service, Babcock through NRAT remains fully accountable to the Department for Communities and Local Government. Key performance indicators are agreed and regular review meetings held. This combines with the complete view of available equipment to ensure a consistently good overview of the situation. It also offers the opportunity to improve the service and identify areas in which Babcock can add value.

Trusting equipment management and maintenance to an external partner allows the fire and rescue service to focus fully on its core operations – dealing with incidents and providing resilience at all times. ●

BRICKS AND TORPOR

Uncertainty over reform is not the only thing stopping new NHS buildings, says Daloni Carlisle. Moving care closer to home may mean they will never be needed

The prospects for local dignitaries attending topping out ceremonies for any new NHS buildings in the near future are slim – and it's not just because of the economy, stupid.

Despite the announcement late last year that PF2 was set to replace PFI (see page 3), movement to invest in NHS infrastructure is all but at a standstill, says Richard Darch, director of Ashley House, specialists in developing healthcare estates.

"Very little is happening and the market has been very quiet for the last couple of years," he says. "I do not think the problem is financial because there is money out there to invest and developers are looking for something to develop.

"But with all the changes in the NHS, it is no longer clear who either investors or developers should be signing contracts with. When there is a lack of clarity and a lack of process, nothing happens."

He is not the only one. "Inevitably with the level of change taking place in the NHS, with the CCGs settling in, the pressure on budgets which will have restricted capital, [and] the impact of NHS Propco – unknown at this stage – there is some drag in the system," agrees Christopher Calkin, director of policy for the Healthcare Financial Management Association.

"I can understand the reluctance to make investments and the frustration on the suppliers' side."

But the problem is not just the PCT to clinical commissioning group shift, says Mr Darch. Another source of blight is the foundation trust failure regime, with questions about the extent to which the public purse will pick up the tab for PFI projects outstanding. "What happens when a foundation trust that has signed a contract for 25 to 30 years moves into the failure regime?" he asks. "The Department of Health does not want to give an absolute obligation, in which case investors face a greater risk and costs of capital will be greater."

PF2, he argues, is designed to meet the needs of big projects of a few hundred million pounds. But the strategy for the future is to move away from care delivered in hospitals to care closer to home.

"Community hospitals, diagnostic centres, urgent care centres – this is what is in acute hospitals' strategies. The ticket size is £15m to £50m."

Site unseen: where are the new NHS building sites?

'With all the changes in the NHS, it is no longer clear who either investors or developers should be signing contracts with'

Not everyone would agree, though, that new buildings are needed. Mr Calkin points out that in future, care may be delivered in people's homes. And, as he points out, it is doctors and nurses who make people better, not buildings.

"We need to spend money on staff, not bricks and mortar," he says. "The strategy needs to be one of making better use of the estate we... have. It might not be perfect and it might not always be in exactly the right place but there is spare potential."

David Hare, director of strategy for the Lift Council, which represents Local Improvement Finance Trusts, agrees. The slowdown recently also reflects recent the scale of investment.

"You do not need to build a community hospital twice in a decade," he says. LIFT partners have begun to focus more on helping health communities to make the best of existing estates rather than create new buildings, he adds. Part of this involves lobbying for better strategic representation of estates and facilities.

"It is not just buildings and making better use of them but also disposal of surplus estate. If you do not have the estates from which to deliver your service reconfiguration, you will find yourself hampered," says Mr Hare.

"We are encouraging the NHS Commissioning Board to create local estates boards to bring together the key players so that rather than having a meeting where 55 minutes is on strategy and five minutes is on estates, we can have proper planning."

Where Mr Hare is hopeful, saying this is falling on fertile ground – albeit against a backdrop of massive competing priorities – Mr Darch is pessimistic. "We need clarity and we need processes," he says. "This is a job for the NHS Commissioning Board and the Department of Health. The view I hear from ministers is that this will be sorted and it has not been. To me it feels as though infrastructure has been forgotten." ●