

Greater Manchester Health and Social Care Strategic Partnership Board

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Date: 28 April 2017

Subject: Greater Manchester Estates Strategy

Report of: Steve Wilson, Executive Lead: Finance & Investment, GMHSC Partnership

SUMMARY OF REPORT:

The aim of this report is to update the Strategic Partnership Board on the work being undertaken on the estates programme within theme 5.

The report contains details of the key ongoing estates work streams and focusses on the potential for financing any prioritised capital investment requirements.

KEY MESSAGES:

The purpose of the report is to bring the SPB up to date with the work that has been undertaken on estates since the formation of the GM HSCP, outline the emerging Estates Strategy, action plan and focus on some of the key work streams including:

- Development & prioritisation of the GM Capital Estates Pipeline
- Capital financing strategy
- Utilisation Strategy
- Neighbourhood Asset Review Process
- Master planning Process

RECOMMENDATIONS:

The Strategic Partnership Board Executive is asked to note the progress of the estates programme and to support further work to:

- Develop a commissioning map to link into the estates pipeline and investment “ask” – to ensure that capital proposals support delivery of the GM Strategic Plan and locality plans

- Develop further granularity on the investment 'ask' – gaining better understanding and detail including pipeline development and prioritisation
- Convert the investment 'ask' into a prioritised investment pipeline for the next 3 years
- Develop the funding / delivery mechanism options available to support the investment pipeline -
 - Assess appetite for NHS to enter into corporate partnerships and for boroughs to borrow using PWLB
 - Potential for structured market sounding/funder events (once detail on investment ask known)
 - Financial modelling of different funding routes – potential for a pilot scheme with funding competition to enable some financial modelling (i.e. to test cost and benefit of each on a like for like procurement/commissioning structure)
 - Business case development
- Identify priority enablers – progressing these and identifying gaps
- Strengthening links and coordination/integration with GM IM&T and Workforce programmes
- Consider a proposal for resources to develop Next Steps

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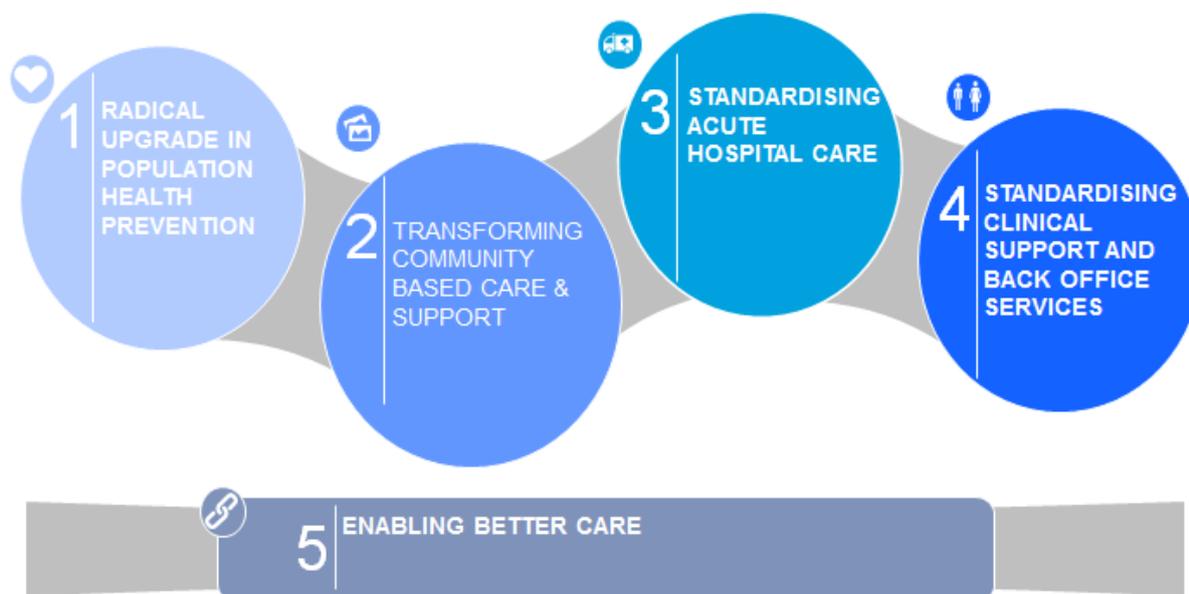
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1.0 INTRODUCTION AND BACKGROUND

- 1.1. The Greater Manchester health and social care strategic plan, “Taking Charge” describes how partners across GM will secure the clinical and financial sustainability of health and social care through a programme of transformational change between 2016/17 and 2020/21. The strategy outlined the themes through which transformation would be delivered. These themes are shown in the diagram below:



- 1.2. Theme 5, “Enabling Better Care”, details the changes which will be required to support the delivery of health and care in the future. In addition to work on workforce, digital, research and development, incentives and new organisational structures, theme 5 sets out the work that will be required to ensure the buildings from which we deliver care are appropriate for the services we will deliver as well of being high quality and cost effective.
- 1.3. The scarce NHS Capital position means it is important for GM to develop a clear and robust capital investment programme to support our transformation activities. This will give us the opportunity to accelerate change, allow early surpluses to be invested in later schemes and balance the allocation of scarce NHS Capital with the potential restrictions on use of alternate investment options including market failure. This report aims to outline the current position and the options available to fund future capital requirements.
- 1.4. Whilst some of the capital investment needed to support GM’s HSCP transformation could be funded through direct savings created, there are likely to be many projects that will need some form of NHS capital (CDEL), grant, debt or equity funding to be deliverable. Notwithstanding the need to prioritise scarce investment

effectively, to significantly improve utilisation and to maximise capital receipts, GM will need to explore alternate sources of funding beyond scarce NHS, on balance sheet, capital.

1.5. Strategic Estates Aims

1.5.1 ***‘Greater Manchester will seek to drive maximum value from the public estate by enabling more efficient use in order to deliver local strategic objectives and national policy objectives’.***

1.5.2 The GM Health and Social Care Partnership Strategic Plan “Taking Charge” requires reconfiguration of the health and social care estate to ensure our vision can be delivered from a property base that is fit for purpose in terms of location, configuration and specification.

1.5.3 The estates support requirements to successfully deliver ‘Taking Charge’ ambitions include:

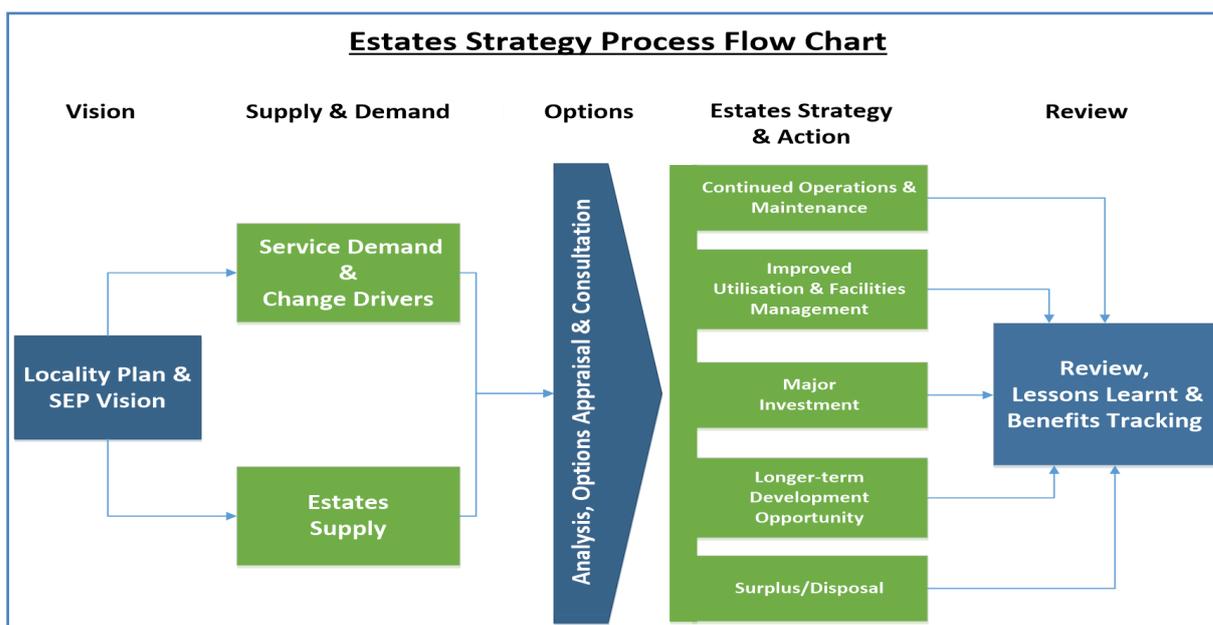
- Through the combined effect of a radical upgrade in prevention, scaling up primary care, the integration of community health and social care and the standardisation of clinical support and back office services, there should be **a reduced need for hospital capacity** due to inappropriate demand; and
- There will be requirements for **multi-purpose community based hubs** accommodating integrated primary care, community health and adult social care services and enhanced provision of step down services preventing inappropriate demand for acute beds.

1.5.4 Estates Targeted Outcomes:

- Provide **increased economic and social value through the re-use of surplus land and property for housing and employment opportunities**
- **Rationalise the surplus estate**
- Use **property as a catalyst for service transformation and integration**
- Efficient management and utilisation of the public estate to **reduce total property running costs**
- Support **improved health and social care outcomes**

1.6. Strategic Approach

1.6.1 The approach to the development of locality Strategic Estates Plans (SEPS) is in line with One Public Estate (OPE) principles and takes account of service strategies and the estates implications are driven by them. The process is illustrated in Table 1:



1.7. Estates Memorandum of Understanding

1.7.1 In 2016 the GM HSCP worked with stakeholders to develop two Memorandums of Understanding (MOUs):

- A National MOU between GM and the national bodies - DH, HMT, DCLG, NHS Improvement and NHS England;
- A GM MOU between all GM organisations, NHS PS & CHP

1.7.2 Key Principles:

- Decisions to be focussed on people and patients of GM and delivery of 'Taking Charge', not organisational self-interest alone;
- Organisations will collaborate to prioritise requirements at a locality and GM level;
- GM parties to take a transparent and open book approach on estates;
- All parties to take a reasonable endeavours approach to helping DH achieve its targets, while supporting GM ambitions
- Estate transformation will also contribute to our devolution agreements on the GM Land Commission and One Public Estate, helping to join up the management of the public sector estate as a whole to underpin the reform of public services

1.7.3 A joint working group with the DH has been established to develop and deliver national and local land sales and housing targets.

1.8. Key Estates Enabling Work Streams

1.8.1 The key estate programmes of work currently under development in GM include:

- (i) Capital Pipeline development & Prioritisation
- (ii) GM Capital Financing Strategy
- (iii) Acute Site Master planning
- (iv) GM Utilisation Strategy
- (v) NHS Office Rationalisation Project
- (vi) Neighbourhood Asset Review (NAR) Process
- (vii) One Public Estate (OPE)

1.8.2 Details of the work undertaken so far are included in section 2, 5 and at appendix 3.

1.9. Estates Governance

1.9.1 We have established a clear governance structure for the delivery of estates transformation both within localities and at a GM strategic level.

1.9.2 Each locality has an established Strategic Estates Group (SEG) with a wide public sector membership and established Term of Reference working to OPE principles. They report into a GM Strategic Estates Board which has been established for a year and is chaired by Eamonn Boylan. The Strategic Estates board reports to GM Transformation Portfolio Board.

1.9.3 The GM governance structure is illustrated in the diagram at appendix 1.

1.9.4 The SEGs and Estate Board closely link with the GM Land and Property Panel and adopt OPE principles. A “Health Check” of each SEG is currently being undertaken, this will be completed by the end of April 2017, and the results will be presented to the Strategic Estates Board including a review of governance arrangements.

1.10. Naylor Report

1.10.1 On 31 March 2017 Sir Robert Naylor published his independent review?

1.10.2 ***NHS Property and Estates: Why the estate matters for patients. This is an important piece of work and sets out a vision for how the NHS can make best use of its estate, taking opportunities release value and transform infrastructure to deliver the NHS plan for change, the Five Year Forward View.***

1.10.3 It highlights the opportunities available to support sustainability and transformation plans (STPs) and optimise the use of NHS land and buildings.

- 1.10.4 The government is already acting on some of the recommendations by:
- creating a new NHS property body
 - making a £325 million capital investment over the next 3 years to develop local STPs - as announced in this year's Budget
 - developing an incentive scheme to guarantee that proceeds of sales are available for reinvestment
- 1.10.5 The government has stated that it will consider the recommendations carefully and respond in due course. We will consider the implications for GM and note the Governments response.

2.0 DEVELOPMENT & PRIORITISATION OF THE GM CAPITAL ESTATES PIPELINE

- 2.1. To enable GM to deliver the service transformation required to implement the strategic plan "Taking Charge" a pipeline of priority capital estates projects has been developed. This helps to define the quantum of capital investment required for GM and supports the development of a Capital Financing Strategy.
- 2.2. The broad range of investment currently identified reflects the "top down" approach taken to date to estimate capital need. Further work to refine the overall capital requirement for GM is required via the development of Locality Implementation Plans, which will develop a "bottom up" project based estimate of need.
- 2.3. Strategic Estates Groups (SEGs) own the pipeline data at a locality level and are responsible for checking and updating the information. The spreadsheet excludes backlog maintenance, IM&T and equipment.
- 2.4. The projects identified within the pipeline can be broadly categorised into 3 main groups. These are:
- (i) Neighbourhood/Community Developments – including community beds
 - (ii) Acute service reconfiguration
 - (iii) Large scale Acute Site Master Planning
- 2.5. The total value of pipeline projects identified by the 10 strategic estates groups is approximately £787m (as at the end of January 17).
- 2.6. Going forward it is proposed that "community based" projects are developed locally by SEGs with "acute" projects developed by Trusts in partnership with the GM HSCP, with appropriate SEG /locality representation.
- 2.7. A prioritisation model has been developed to assist SEGs /localities target scarce financial and technical resources at the most important projects. Given there is very

limited availability of both capital and revenue funding it is essential to prioritise projects early on in the development phase to reduce wasted time and funding and target them at the most important projects.

- 2.8. The business case process will require robust justification for capital or revenue expenditure based on improving service provision and reducing demand and expenditure. The prioritisation model has already been piloted across all localities in January 2017. The next iteration is under development and this splits projects into two cohorts, community based and acute which will allow different criteria and weightings to be used. This will be shared with relevant groups and refined over the next few months.
- 2.9. GM HSCP transformation will depend on an ability to fund and deliver necessary investment projects and for those projects to provide savings (both cashable & demand reduction). A key step in increasing confidence over both delivery of outcomes and the ability to finance interventions will be the ongoing development of the existing pipeline of projects, and to build, bottom-up, a programme of investments linked to the health and social care benefits they are expected to deliver. This work will be aided by the Strategic Estate Groups ongoing work and will drive greater pipeline visibility, understanding of capital need, prioritisation and the emergence of more “early win” projects. The pipeline will need to be agreed by the GM HSCP as part of its strategic plan. This work should include:
- Ongoing review of the SEG pipelines, and prioritisation of them, against specific investment criteria with a view to identifying priority projects. The pipeline is updated by the GM Strategic Estates Groups on a quarterly basis
 - A thorough analysis of identified priority projects, with a view to working up robust business cases that include analysis of how the initial investment can be repaid (i.e. cashability of benefits) and how risk is shared.

3.0 ESTATES RELATIONSHIP WITH OTHER THEMES

- 3.1. All of the individual work streams contained within theme five are enablers of the first four strategic transformation themes. As such the independency between the themes and their enablers are both critical and complex. In the case of the estates enabler this is particularly true of themes one, two and three which, taken in concert, will support the development of new models of care from prevention and self-care, to the creation of integrated neighbourhood health and care facilities and the delivery of reconfigured acute services.
- 3.2. This future model of care, and therefore the estate required to deliver it, will also be heavily influenced by the digital work stream. From digitally enabled self-care to the electronic transfer of patient data to different settings, the estate required to deliver the transformed care envisaged by our strategic plan will be very different from today's estate.

3.3. There is also a connection with the work of theme four on sharing clinical and non-clinical support functions. The housing of administrative staff has been identified as one of our key work streams above and the digitally enabled transfer of diagnostics results, for example through the PACs network, will allow the potentially consolidation of clinical support services to deliver to community and acute services across the region.

3.4. **Theme 3 Estates Implications & Stranded Costs**

3.4.1 Whilst we have identified that there are many and significant interdependencies between most transformation activity and the health and social care estate, this is especially true within the work to reconfigure the acute healthcare provision across GM.

3.4.2 The results of early work through locality plans and emerging theme three plans such as the Healthier Together programme (this actually predates the GMHSCP but has been subsumed into theme three) suggest a significant impact on the acute hospital sites across GM. If the work delivered in theme one and two is effective this will reduce the delivery of acute services across GM. The individual theme three projects such as Healthier Together will then reconfigure individual services leading to shifts in the location of services across GM. If we take Healthier Together as an example this will consolidate high acuity surgery on four hubs in Salford, Manchester, Stockport and Oldham. The implications for those non hub sites currently providing surgical specialties will be to reduce ward and theatre requirements and could, if transacted in isolation, leave estates and other costs to be incurred without any services being provided or income stream received.

3.4.3 Urgent work is therefore need to ensure that the impact of theme three service transfers and theme two acute services reductions are mitigated in terms of the stranded costs of redundant estate.

3.4.4 The theme three governance structure now includes a finance and estates reference group to ensure the implication of these services changes are clearly understood.

3.4.5 A number of actions will need to be delivered if the costs are to be mitigated as much as possible. These include but are not limited to:

- (i) Development of a hospital site clinical services strategy across GM
- (ii) Producing forward looking master plans for all acute sites significantly affected by change or with significant backlog investment requirements
- (iii) Seeking service “swap” arrangements across the theme 3 work streams and wider at both a GM and sector level.
- (iv) Ensuring the appropriate use of acute site estate for the delivery of community and primary care facilities
- (v) Where stranded costs are unavoidable in the short term producing a set of rules or principles for managing the impact across individual organisations.

Similar to the “*Scampion Rules*” adopted in the North West in the 1990s and 2000’s.

4.0 CAPITAL FINANCING STRATEGY

4.1.1 To enable Greater Manchester to deliver the service transformation required to implement the strategic plan “Taking Charge” a pipeline of capital estates projects has been developed. This has enabled us to assess the quantum of capital required for GM and in turn will help support the development of a Capital Financing Strategy for Estates.

4.1.2 The GM Strategic Plan “Taking Charge” aims to reform H&SC delivery that aims to achieve clinical and financial sustainability by 2020/21, to eliminate the potential £1.8bn deficit. The Strategic Plan highlights that a major programme of extraordinary investment – capital and revenue - is needed to enable H&SC transformation and to allow more care to be delivered in community settings rather than in expensive acute environments.

4.2. Transformation Funding

4.2.1 The transformation of health and social care will require significant investment over and above the recurrent allocations available to CCGs and. The following transformation funding routes have been identified:

(i) Greater Manchester Transformation Fund

As part of the devolution agreement signed between NHS England and Greater Manchester, GM received £450m of additional non recurrent funding over 5 years until 2020/21 to develop the new models of care and create the conditions to deliver clinical and financial sustainability. This funding is revenue only.

(ii) GM Digital Fund

GMHSCP are currently in negotiations with NHS England and the Department of Health to secure a fair share of the national digital transformation funding announced in 2016.

(iii) Transformation Capital Funding

Nationally there is very little identified capital funding within the current spending review assumptions. The DH has set a capital resource limit of £4.8b for the NHS in 2017/18 however £1.2bn of this has been converted to revenue monies to invest in frontline services and the majority of the remaining funding is required to deliver business as usual work in the provider sector (£2bn) and a number of preapproved programmes including the national digital capital funding detailed above.

The transformation priorities identified in the 44 Sustainability and Transformation Plans (STPs) across England have no identified funding sources.

4.3. **2017 Budget**

4.3.1 In the budget statement on 8th March 2017 the Chancellor of the Exchequer announced two strands of additional capital funding for the NHS. These are:

(i) STP Funding of £325m

Funding of £325m was announced to support the best and most advanced STPs across the country. The allocation of this funding is not known at the time of writing but GM played a significant role in the submissions made by the NHS to HM Treasury in advance of the budget and it is hoped this will ensure GM is well placed to receive a share of this funding. The £71m capital requirement associated with delivering healthier together across GM was the most positively received element of the GM pipeline shared with colleagues in the DH and Treasury during this process.

Further consideration will be made by HMT of the case for further capital investment in the NHS at the time of the Autumn Statement. This will be informed by the results delivered against the initial investment of £325m.

(ii) A & E Capital

The Chancellor also announced £100m capital to support A & E streaming investment across England. Areas have been asked for initial bids for how this funding could be utilised in up to 100 emergency departments across the NHS.

4.4. **Availability of Capital & GM Requirements**

4.4.1 Aside from the two elements identified above it is clear there is a potential shortage of identified NHS funding to support the GM HSCP transformation requirements.

4.4.2 Localities have indicated within their locality plans that up to £1.6bn of capital funding is required over the five years of the plan to service business as usual capital as well as transformational programmes. This capital covers estates, IM&T and plant & machinery. Business as usual capital within GM providers, funded through internally generated resources equates to circa £900m with around £700m of transformation capital projects without identified funding sources.

4.4.3 In response to this anticipated lack of capital for GM we will need to:

- Release and re-use as much capital as possible;

- Dispose of capital assets no-longer required to free up capital and /or release revenue to invest in new developments;
- Consider options for all sources of capital including private sector funding
- Prioritise capital around those projects that maximise impact;
- Make best and most appropriate use of the capital available in GM across the wider public sector;

4.4.4 Given the ambition and planned savings associated with GM's transformation plans, the pace and urgency at which GM can deliver enabling investment will be a critical factor in GM's ability to drive-out transformation benefits on time.

4.4.5 Analysis undertaken by the partnership highlights some potential for capital receipts from disposals but these are expected to be very limited and in many cases likely to rely on further enabling capital investment (e.g. demolition or infrastructure) before any receipts can be secured. Capital receipts are therefore unlikely to provide a material source of capital back to GM stakeholders.

4.5. **Capital Investment Need in GM**

4.5.1 The GM localities have indicated within their locality plans that up to £1.6bn of capital funding is required over the five years of the plan to service business as usual capital in addition to transformational programmes. This capital covers estates, IM&T and plant & machinery.

4.6. **GM Capital Funding Options**

4.6.1 The scarce NHS Capital position outlined above means it is even more important we develop a clear and robust investment programme to support our transformation activities. This will give us the opportunity to accelerate change, allow early surpluses to be invested in later schemes and balance the allocation of scarce NHS Capital with the potential restrictions on use of alternate investment options including market failure.

4.6.2 Whilst some of the capital investment needed to support GM's HSCP transformation could be funded through direct savings created, there are likely to be many projects that will need some form of NHS capital (CDEL), grant, debt or equity funding to be deliverable. Notwithstanding the need to prioritise scarce investment effectively, to significantly improve utilisation and to maximise capital receipts, GM will need to explore alternate sources of funding beyond scarce NHS, on balance sheet, capital. Development of a capital funding regime, with partners across GM, could include:

- Further analysis of the potential ability to fund capital investment from within GM e.g. testing the appetite of local authorities to either directly fund or use their covenant to raise capital for investment;

- Further consideration of how capital investment is prioritised; addressing the ability to fund projects which deliver direct financial returns with the need to deliver projects that underpin wider savings in the GM HSCP that cannot self-fund. This will require development of investment criteria that can deal with both the cashability of savings and a wide variety of project types e.g. proposals where funding flows across geographic boundaries where one party invests and another benefits.
- Building on the principles set out in this report; understand in more detail how key issues such as balance sheet treatment, tax, risk sharing, stakeholder roles and returns will impact on ability to fund.

4.6.3 A single oversight committee for health and social care capital planning within GM with appropriate resourcing will be established. The committee must have the appropriate governance, representation and powers to ensure good financial governance of the GM capital planning process. The committee should report to the GM Health and Social Care Executive via the FEG. The role of the committee would be to ensure that capital spending in GM is in line with the overall GM strategic plan. The strategic plan needs to have sufficient definition as to service strategy to enable this, although developing such definition would be outside the role of the group.

4.6.4 There are several sources of capital funding available to GM public sector bodies and the details are laid out below. The key sources of funding are as follows:

- NHS Provider Capital – Capital Resource Limits - CRLs are set each year for NHS trusts based on agreed spending plans for that year; Foundation Trusts in financial distress operate under a similar regime with some additional freedoms available to FTs not in financial distress
- NHS England Capital (ring fenced for Primary Care Developments) - GM received a total allocation of £17.6m in 2016/17
- Local Authority Funding – Prudential Borrowing – Councils are typically only able to borrow for capital expenditure, i.e. for the creation and acquisition of assets. There is no legal limit to the amount a Council can borrow and they set their own limits based on the Prudential Code. The Gorton Hub project in Manchester is planned to be funded via Prudential borrowing.
- Local Improvement Finance Trust – LIFT;
- A new Public Private Partnership for GM;
- Third Party Developments (3PD);
- Development Partner(s);

4.6.5 NHS Foundation Trusts, NHS Trusts and NHS England capital spend all scores against the Department of Health capital limit (CDEL). This is the case regardless of

whether funding is provided through a central allocation in the form of Public Dividend Capital (PDC) or a loan, or if it is sourced locally through depreciation or accumulated surpluses (see appendix 2). It is the availability of CDEL rather than the cash for central funding which is the constraining factor for NHS Capital in the spending review period.

4.6.6 It is anticipated that all of the capital sources will be used to deliver the GM estates capital requirements over the next 5 years.

4.6.7 A more detailed description of the different funding options is provided in Appendix 2.

4.7. **Capital Financing Strategy Options Summary**

4.7.1 The key considerations in developing the investment plans are described in the table below:

What & when?	What are the full range of assets under consideration? (GP surgeries \ primary care centres, acute provision, intermediate care, extra care etc.)
	Has the project been prioritised in the estates pipeline?
	What are the services to be delivered in these assets, who will be responsible for commission and who will provide?
How	In establishing a programme of investment, how can procurement cost be minimised?
	Does a market for exist, what are typical returns and are there commercial partners already delivering services from similar assets? What considerations need to be taken into account to determine the best funding solution?
	What security is required and would be available for the investor or commercial partner? With respect to long term ownership how significant an issue is balance sheet treatment for public sector?
	How attractive are alternative operating models - such as extending partnerships between NHS and independent operators.
Financial	What are the capital and revenue savings from a One Public Estate approach that could accrue from the creation of new assets and how can these be captured and recycled to invest into the future investment pipeline?
	What is the length of commissioning contracts provided in each asset and how do these impact on leases, liquidity and cost of finance? Is asset flexibility important? How important is it to transfer asset/maintenance risk to private sector?
	What is the appetite for public sector investment – either short term to pump prime investment or as a long term asset owner? What is the ability of public sector to pool

resources together?

How can the deal be structured to provide value for money for the public sector (ie different ways by which the investment can be de-risked through different covenant solutions: lease structure, arranging tenancies, block commissioning contracts)?

4.7.2 The identified capital financing options identified above allow a number of possibilities to be considered across the different projects within the pipeline. The table below maps the projects within the pipeline against the most appropriate funding source.

Funding types Vs project Type

Project Category	Type of Funding						
	NHS Trust Capital	NHS FTs Capital	NHS E Capital	Prudential Borrowing	LIFT	New PPP	3PD
Acute standardisation and specialist reconfiguration	✓	✓		?		✓	
Healthier Together	✓	✓				✓	
Intermediate/community care beds	✓	✓		✓	✓	✓	✓
Multi-purpose community based hubs	✓	✓	✓	✓	✓	✓	✓
Business As Usual – Primary Care & Community	?	?	✓		✓	✓	✓
BAU – Acute	✓	✓				✓	

4.8. Challenges in Securing Additional Capital Funding

4.8.1 Capital funding to support GM transformation will need to come from grant, equity or debt. No grant funding at scale has been identified to date so freeing up revenue to pay for debt or equity funding is a major consideration. Potential challenges are expected to arise both due to the nature of the investment projects envisaged and the complexity of the stakeholder environment. Key challenges identified included:

- **Project & Programme Challenges** - identifying which projects offer the best contribution to GM's objectives and understanding how payback, from a funding and a transformation perspective, is best assessed.
- **System Issues** -There will be different scenarios where capital investment may be made primarily in to one locality or by one party, with benefits due to flow to another. As a principle it will be important to have a mechanism that aligns the benefits from an investment with the risk of that investment. It will be necessary to consider capital funding operating beyond a single locality or even at a GM level, supported by a mechanism to share collective investment risk and return that aligns stakeholder interests.
- **Technical Issues**; taking on any additional capital funding to support investment raises further issues such as balance sheet treatment. For example, where will any additional debt / liability be recorded? Changes to both leasing and accounting rules make it increasingly difficult for investment to appear off balance sheet for an occupier.

5.0 DUE DILLIGENCE AND PRIORITY ENABLERS

- 5.1. In order to commence development of the business case process for a project requiring capital resources or revenue support it is essential that localities, via their SEGs, can demonstrate that the necessary due diligence work has been undertaken to prove that the development is required. Due diligence around key estates enabling work is a must-do and precursor to commencing the business case process.
- 5.2. This section outlines the key due diligence and priority enabling work which includes:
 - Ensuring that the Pipeline of Capital Estates Projects is up to date, accurate and has been prioritised;
 - Adopting the GM Masterplanning Process for use as required;
 - Implementation of the Utilisation Strategy at a locality level;
 - Implementing the NHS Office Rationalisation Project;
 - Undertaking a Neighbourhood Asset Review (NAR) of each Locality;
 - Adopting and working to "One Public Estate" (OPE) principles;
- 5.3. Effective Strategic Estates Groups (SEGs) with the appropriate governance, leadership, membership and resources are crucial to drive forward the estates strategy in GM. A "Health Check" of each SEG is being undertaken during March and April 2017 and this will help to highlight any changes required to ensure they

are fit for purpose and the recommendations arising will be included in their 2017/18 implementation plans.

- 5.4. The key Enabling work streams are outlined below and more detail is included at Appendix 3.
- 5.5. **Capital Pipeline development & Prioritisation (refer to section 2 for more detail)** - A GM wide integrated Health and Social care capital pipeline has been developed. A project prioritisation process has been developed to assist localities target resources at the most important projects.
- 5.6. **GM Capital Financing Strategy (refer to section 4 for more detail)** - GM is developing a strategy to facilitate the availability of capital and revenue funding to support the development of the capital pipeline. This includes flexible options to deal with the wide range of projects under development including multi-purpose community based hubs, community beds and acute projects.
- 5.7. **Acute Site Master planning** - A Master planning Framework has been developed for acute sites. The GM Neighbourhood Asset Review (NAR) process provides context for the development of Masterplans and over the next 12 months several masterplans will be completed including Bolton FT, North Manchester General, Rochdale Infirmary, Fairfield and a neighbourhood masterplan in Leigh including the Leigh Infirmary site. The process will include consideration of the opportunities to locate community hubs on hospital sites in new or existing accommodation.
- 5.8. **GM Utilisation Strategy** - Work has commenced to improve the utilisation of health and social care facilities. Forty seven individual utilisation studies have been undertaken across GM. We have established a key objective: *“To optimise the utilisation of modern, long-term, multi-use Health Centres to a target utilisation better than 80%”* Going forward it will be important to carry out utilisation studies at acute sites to support reconfiguration and business development as well as re-visiting community sites to measure improvements in utilisation.
- 5.9. **NHS Office Rationalisation Project** - A project has commenced to rationalise the NHS owned and leased office estate across GM:
 - The NHS PS estate comprises approximately 50 office property interests across twenty nine properties within Greater Manchester
 - Total floor area of c42k sqm
 - The majority of the estate is leasehold with a significant number of contractual opportunities before 2020
 - Target of 30% reduction in costs
 - In addition, across GM the public sector is reviewing the use of back office space within the public estate to support public sector reform, integration of services and the efficiency agenda.

5.10. **Neighbourhood Asset Review (NAR) Process** - The Neighbourhood Asset Review process looks to develop a process to understand:

- Local community need;
- The public sector services provided ;
- How organisations work together to improve community outcomes and be more successful
- How a range of right sized, appropriately located and efficiently used assets can support this;

5.11. The NAR Process has been developed and refined via a joint project between Tameside and Stockport Councils and the GM H&SC team and agreed at GM SEB and the Land and Property Board in late 2016. The process is now being rolled-out in Bury and Oldham localities. This work will underpin master planning work on acute sites in those areas.

5.12. **One Public Estate (OPE)** - OPE is a pioneering initiative delivered in partnership by the Cabinet Office Government Property Unit (GPU) and the Local Government Association (LGA). It provides practical and technical support and funding to councils to deliver ambitious property-focused programmes in collaboration with central government and other public sector partners. The GM OPE Partnership has secured funding to support:

- Strategic governance framework and resource for GM OPE programme
- Land Commission Map
- OPE 4 funding to support development of 4 integrated service hub projects
- OPE5 5 funding to support development of 2 strategic health and social care projects

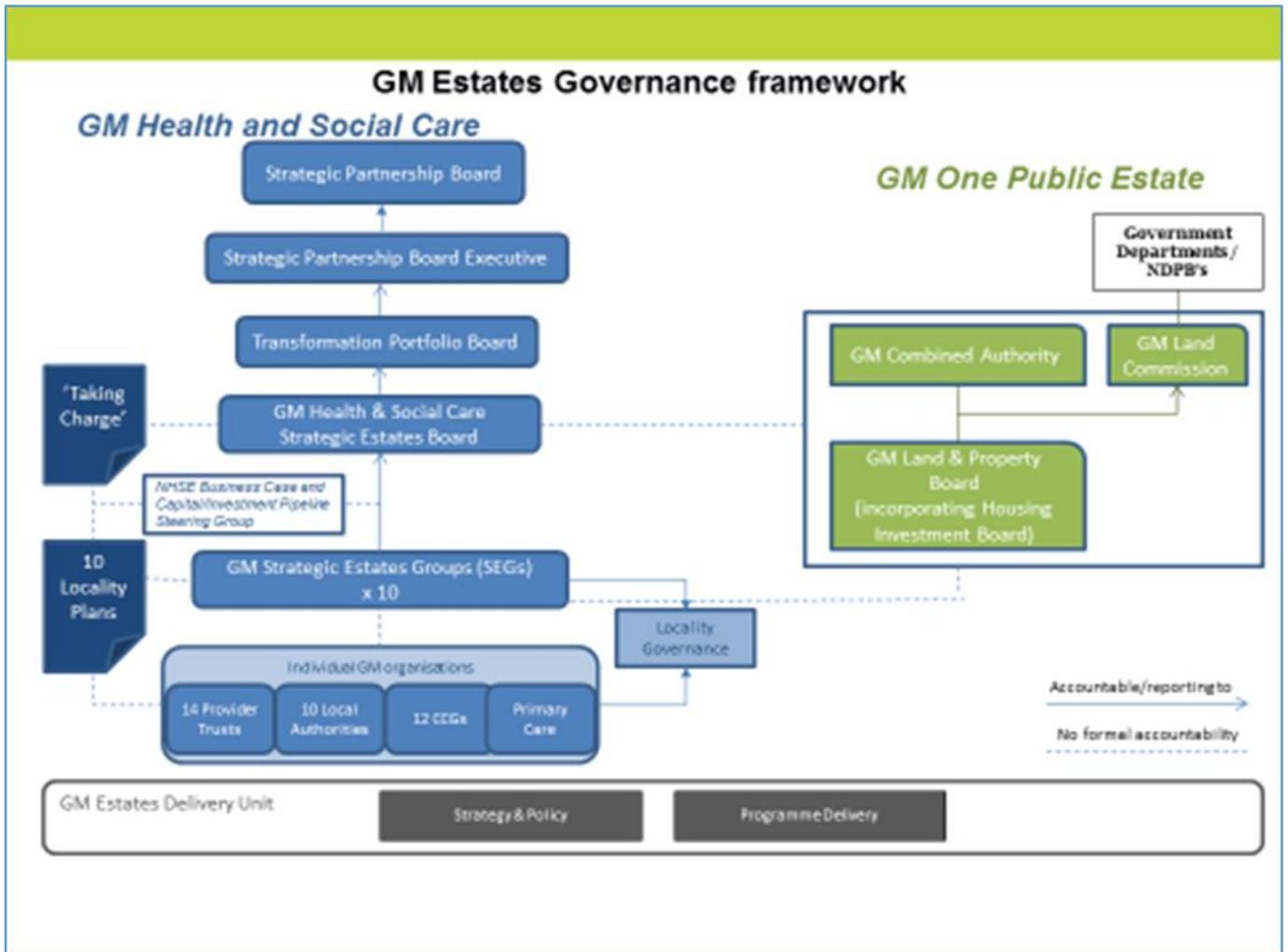
6.0 CONCLUSIONS & RECOMMENDATIONS

6.1. The Strategic Partnership Board Executive is asked to approve the following work streams to be completed:

- Develop a commissioning map to link into the investment ask – to ensure that capital proposals support delivery of the GM Strategic Plan and locality plans. Develop granularity on the investment ‘ask’ – getting better understanding and detail including pipeline development and prioritisation
- Converting the investment ‘ask’ into an investment pipeline for the next 3 years – i.e. place investment ask into a draft pipeline – priorities, inter-relationships between sources of funding etc

- Develop the funding / delivery mechanism options –
 - Asses appetite for NHS to enter into corporate partnerships and for boroughs to borrow using PWLB;
 - Potential for structured market sounding/funder events (once detail on investment ask known);
 - Financial modelling of different funding routes – potential for a pilot scheme with funding competition to enable some financial modelling (ie to test cost and benefit of each on a like for like procurement/commissioning structure)
 - Business case development
- Priority Enablers – progressing these and identifying gaps.
- Strengthening links and coordination/integration with GM IM&T and Workforce programmes
- Consider a proposal for resources to develop Next Steps

APPENDIX 1 – GM ESTATES GOVERNANCE



Appendix 2 – Capital Financing Options

1.0 NHS PROVIDER CAPITAL (NHS TRUSTS AND FOUNDATION TRUSTS)

- 1.1. Guidance issued in November 2016 by NHS Improvement sought to broadly align the NHS Trust and NHS Foundation Trust capital regimes. The powers to impose limits on foundation trust which are not in breach of their licence is restricted so in practice the guidance created rules which apply to all NHS Trusts and all Foundations Trusts which are in financial distress and therefore acting under restrictions imposed by NHS Improvement. Foundation Trusts which are not in financial distress have more freedom to act.
- 1.2. NHS Providers can fund capital in two ways:
 - Through internally sourced funding which is generated through depreciation, income and expenditure (I&E) surpluses and working capital movement,
 - External funding for additional expenditure as agreed with NHS Improvement. This will be through agreed loans or public dividend capital (PDC) or through the allocation of central programme budgets.
- 1.3. NHS Trusts are set an annual Capital Resource Limit (CRL). The CRL limits the amount of capital expenditure an NHS trust may incur in a year. CRLs will be set each year for NHS trusts based on agreed spending plans for that year. NHS trusts require CRL to cover all capital expenditure and must not incur expenditure in excess of this limit.
- 1.4. Each NHS trust will be set an initial CRL by NHS Improvement. This will change during the year if additional capital resources are allocated. Additionally, NHS trusts credit the carrying value of asset disposals to CRLs. This may, at the discretion of the Department of Health (DH)/NHS Improvement, allow the trust to use the proceeds of such disposals to incur capital expenditure.
- 1.5. NHS trusts must not overspend against their CRL. This is a regulatory and departmental duty. It is a requirement that NHS trusts have a confirmed source of funding prior to committing capital expenditure. There is no carry forward of underspends of CRLs.
- 1.6. NHS trusts are permitted to credit the carrying value of asset disposals to the CRL, to enable them to use the proceeds of disposals to incur capital expenditure when the disposal has happened. NHS trusts should notify NHS Improvement when 3 disposals have taken place and the proceeds received so that an adjustment can be made to the NHS trust's CRL.
- 1.7. For Foundation Trusts under financial distress a similar set of rules apply with spend on schemes greater than £15m requiring approval from NHS Improvement.
- 1.8. The delegated limits for NHS Trusts and FTs in distress are shown below.

Financial value of the capital investment or property transaction*	Approving person/committee/board
Up to £15 million	Trusts approve under their own governance arrangements (subject to paragraphs 3.14 and 3.18)
£15 million to £30 million	NHS Improvement executive director of resources/deputy CEO or NHS Improvement director of finance and DH
£30 million to £50 million	NHS Improvement Resources Committee and DH
Over £50 million	NHS Improvement Resources Committee, NHS Improvement Board, DH and HMT**

* Financial value applies to capital investment and property transactions, asset disposal and whole-life cost business cases.

** Investment business cases subject to whole-life cost rules where the whole-life cost exceeds £50 million will not require NHS Improvement Board approval but will require NHS Improvement Resources Committee approval (unless these cases are specifically referred to the NHS Improvement Board for a decision by the NHS Improvement Resources Committee). NHS Improvement will discuss individual whole-life cost cases that exceed £50 million with DH to confirm whether or not DH and HMT approval is required for the business case.

- 1.9. For Foundation Trusts not in financial distress the internal governance of the FT will determine the investment decision unless the transaction is classed as material. Where a capital or property investment is classified as material, NHS Improvement, as part of its overall assessment of financial and governance risk, will request evidence to support the transaction and certification from the trust board in line with Supporting NHS providers: guidance on transactions for NHS foundation trusts, Appendix 8: Board certification.
- 1.10. NHS Improvement will decide to classify the transaction as significant and therefore requiring a detailed review according to whether the transaction meets one of the following criteria:
- a relative size of greater than 40% in any of the tests in Table 1 above
 - a relative size of between 25% and 40% of the tests set out in Table 1, where required as part of a risk assessment
 - a relative size of between 10% and 25% of the tests set out in Table 1 above, when in NHS Improvement's view one or more major risks or other risk has been identified and is considered relevant.

		Reporting requirements		Notes
Ratio	Description	Non-healthcare/ international	UK healthcare	
Assets	The gross assets subject to the transaction* divided by the gross assets of the foundation trust	>5%	>10%	Gross assets are the total of fixed assets and current assets
Income	The income attributable to the: <ul style="list-style-type: none"> • assets or • contract associated with the transaction* divided by the income of the foundation trust	>5%	>10%	None
Consideration to total foundation trust capital	The gross capital or consideration associated with the transaction* divided by the total capital of the foundation trust following completion, or the effects on the total capital of the foundation trust resulting from a transaction*	>5%	>10%	Gross capital equals the market value of the target's shares and debt securities, plus the excess of current liabilities over current assets Total capital of the capital of the foundation trust equals taxpayers' equity

* For the purposes of this capital guidance, transactions cover capital and property investments only.

2.0 NHS ENGLAND (NHSE) CAPITAL

- 2.1. A limited amount of capital is made available to GM HSCP annually by NHS England which is ring-fenced for specific use. The capital is mainly used to support primary care developments. The Department of Health publishes an annual mandate to NHS England which includes a financial direction in relation to capital

funding. GM received a total allocation of £17.6m in 2016/17 and this included £4.43m of slippage .

- 2.2. There are two main routes for accessing NHSE capital which are Business as usual capital (BAU) or Estates & Technology Transformation Programme (ETTP) both of which are managed by GM HSCP. Alternative capital routes include NHSPS customer capital or CHP Investment capital, although these are separate funding sources to NHSE managed by NHSPS or CHP respectively, there is still the requirement for these schemes to be signed off by GM HSCP and the National team.
- 2.3. BAU capital is required to fund GPIT, LD, Hospice, CCG corporate and GP Improvement grants. Unlike the ETTP these are not transformational schemes, they do not need to be aligned to the strategic direction of CCGs although the schemes will still need CCG support before they can progress.
- 2.4. ETTP is a National programme and there are strict criteria that schemes have to meet before they can access this fund. BAU capital is more general but any improvement schemes have to be eligible under premises directions, and GPIT should be part of the IT strategy agreed across GM. In GM we can use BAU capital to support ETTP schemes, if this is required due to lack of capital resources, however ETTP cannot be used to support BAU schemes because of the strict criteria used to access this fund.
- 2.5. The National criteria for this scheme included the following:
 - Improved access to effective care
 - Increased capacity for primary care services out of hospital
 - Commitment to a wider range of services as set out in the CCG's commissioning intentions to reduce unplanned admissions to hospital
 - Increased training capacity
- 2.6. As part of the devolution agreement, GMH&SC partnership has been directly allocated a weighted capitation share of the national NHS England capital funding. It therefore is not required to participate in the applications process to NHS England for funding in relation to BAU and ETTP schemes.
- 2.7. In 2016/17 GM received a capital allocation of £8.98m for business as usual (BAU) for Direct Commissioning / CCG commissioning and corporate requirements. An additional capital allocation of £4.2m has been advised being the weighted share of the capital element of the ETTP fund. GMH&SC Partnership are expected to be managed against the GM capital control total (Capital Resource Limit) of £13.18m. CCGs are not issued directly with a Capital Resource Limit; this comes via GM HSCP within the overall £13.18m. As at Month 7, GM received notification that they would receive an additional ETTP Capital allocation of £4.43m giving a total 16-17

ETTP allocation of £8.63m. This is in addition to the £8.98m BAU capital allocation already reported. Therefore the 16-17 overall GM capital allocation was£17.6m.

3.0 LOCAL AUTHORITY FUNDING - PRUDENTIAL BORROWING - LOCAL AUTHORITY CAPITAL EXPENDITURE AND FINANCING

- 3.1. Local Authorities have a degree of flexibility to determine their own capital investment plans within the Prudential Framework. The Prudential Framework is an umbrella term for a number of statutory provisions and professional requirements that allow authorities largely to determine their own plans for capital investment, subject to an authority following due process in agreeing these plans and being able to provide assurance that they are prudent, affordable and sustainable. Prudential Borrowing schemes are often approved as self-financing on an invest-to-save basis as they create adequate additional revenue income or reduced revenue costs to cover the MRP and interest costs and this will be a key consideration in the decision on funding route given the requirement to make savings across GM.
- 3.2. There are three routes by which expenditure can qualify as capital under the framework:
- The expenditure results in the acquisition of, or the construction of, or the addition of subsequent costs to non-current assets (tangible and intangible) in accordance with 'proper practices'
 - The expenditure meets one of the definitions specified in regulations made under the 2003 Act
 - The Secretary of State makes a direction that the expenditure can be treated as capital expenditure
- 3.3. Local Authority capital expenditure must be fully financed in year. Financing in this respect does not refer to a payment of cash but the resources that are applied to capital expenditure, whether at the point of spend or over the longer term. There are a number of financing options that are applied at the time the expenditure is incurred, i.e. capital receipts, capital grants, external contributions or revenue contributions. Where capital expenditure is not financed at the point of spend, it is dealt with over the longer term with prudential borrowing.
- 3.4. A Local Authority's ability to enter into long term borrowing is regulated by the Local Government Act 2003 which introduced the concept of Prudential Borrowing and the need for adherence to the CIPFA Prudential Code for Capital Finance in Local Authorities. The objectives of the Prudential Code are to ensure, within a clear framework, that the capital investment plans of local authorities which are to be funded by long term borrowing are affordable, prudent and sustainable, and that treasury management decisions around the timing and the structure of long term borrowing are taken in accordance with good professional practice.

- 3.5. It is important to note that the Council is typically only able to borrow for capital expenditure, i.e. for the creation and acquisition of assets. There is no legal limit to the amount the Council can borrow (within the General Fund. There is a debt cap within the Housing Revenue Account), rather the Council sets its own limits based on the Prudential Code. In exceptional circumstances, borrowing may be used to fund one-off revenue costs (for example redundancy costs) but permission to do this must be granted by the Secretary of State for Communities and Local Government.
- 3.6. It is also important to understand the principle that when a capital scheme is approved to be funded by Prudential Borrowing (PB) there is not an immediate need to take on external borrowing at the point that the capital expenditure on that scheme is expended. A Council's treasury position and cash flow management is complex and actual long term borrowing decisions are made with reference to many factors. Examples of factors which influence actual long term borrowing decisions are the incidence of the capital programme which is to be funded by PB and the availability of other cash resources such as earmarked reserves, government grants, council tax receipts and general fund balances.
- 3.7. Capital expenditure financed by PB increases the Council's underlying need to borrow. This is measured, monitored and reported through variations to the Capital Financing Requirement (CFR).
- 3.8. The CFR measures the cumulative amount of PB used to finance capital expenditure and this represents the Council's underlying need to finance capital expenditure by borrowing. Therefore, when capital expenditure is not resourced immediately, the CFR will increase.
- 3.9. The CFR does not increase indefinitely as the Council must provide for prudent repayment of any PB it undertakes and it does this by way of making a revenue budget provision known as an annual Minimum Revenue Provision (MRP). This revenue budget provision reduces the CFR each year and it is calculated in line with the life of the assets that the PB has funded.
- 3.10. In summary the CFR and MRP mechanisms in effect amortise/pay back the capital expenditure covered by PB over the life of the associated assets through the Council's revenue budget. Therefore it is vital that the impact of this along with additional interest incurred is adequately modelled and budgeted for when PB schemes are being developed for approval.
- 3.11. As part of a Local Authorities Treasury Management Strategy there will be consideration of their borrowing strategy. All decisions on whether to undertake new or replacement borrowing to support previous or future capital investment plans will be subject to evaluation against the following criteria:
- Overall need: whether a borrowing requirement to fund the capital programme or previous capital investment exists;

- Timing: when such a borrowing requirement might exist given the overall strategy for financing capital investment and previous capital spending performance;
- Market conditions: to ensure borrowing that does need to be undertaken is achieved at minimum cost, including a comparison between internal and externally financed borrowing.
- Scale: to ensure borrowing is undertaken on a scale commensurate with the agreed financing route.

3.12. The main source of long term funding for Local Authorities is provided by the Public Works Loan Board (PWLB), however other sources of long term funding are considered that may provide a cheaper alternative including market loans and bonds.

4.0 LOCAL IMPROVEMENT FINANCE TRUST – LIFT

4.1. Across the Greater Manchester area there are five Local Improvement Finance Trusts (LIFTs). The local authorities in Manchester, Salford and Trafford have shareholding in one, MaST LIFTCo, with Community Health Partnerships (CHP) holding shares in all five on behalf of DH. These companies are active in managing a substantial health and social care estate portfolio and providing support services into the GM HSCP. They are ready-made public private partnerships and pre-procured delivery vehicles which can hold assets and risk, access funding and are immediately available to GM HSCP and its constituent bodies. The only area in GM not covered by LIFT is Stockport.

4.2. A LIFT company is a Public Private Partnership (PPP) company formed to deliver a range of estate services across a geographical area to a number of health organisations and local authorities. LIFTCos can provide support via the identification, specification and development of proposals for new projects including capital funding and provision of ongoing facilities management and lifecycle services for the term of the lease period.

4.3. Nationally, over £2.5bn of new investment through LIFT has delivered a portfolio of 339 modern, purpose built, integrated health and social care facilities, occupied by over 1,200 NHS and local authority organisations. There are 38 LIFT buildings in GM.

GM LIFTCos & Structures:

LIFTCo Name	Locality	CCGs covered	Number of LIFT/CHP buildings
One Partnership (Foundation for Life)	Wigan	Wigan	8
One Partnership (BRAHM)	Bolton, Heywood, Middleton &	Bolton and Heywood, Middleton & Rochdale	6

	Rochdale		
MaST	Manchester, Salford Trafford	North Manchester, Central Manchester, South Manchester, Salford, Trafford.	12
BTG	Bury, Tameside & Glossop	Bury, Tameside & Glossop	4
Community First Oldham	Oldham	Oldham	8

4.4. LIFT Cos - Governance and Structure - LIFTCos and their subsidiaries are governed by a board of directors and an independent chair. The public private directorship ratio is proportionate to the shareholding. There is strong local and active involvement of the local health economy and local CCG (or other) representatives are appointed to the LIFTCo boards. Subsidiary companies (FUNDCos) are established to develop, fund and operate individual buildings.

5.0 PROJECT PHOENIX – A NEW PUBLIC PRIVATE PARTNERSHIP MODEL TO DELIVER SOCIAL INFRASTRUCTURE ?

5.1. In late 2015 Community Health Partnerships (CHP) were formally asked by its shareholder (DH) to investigate and develop thinking around how a future new PPP model could be deployed to meet national strategic estate management objectives. DH had 4 key objectives:

- To increase the pace of delivery of estates transformation across the healthcare estate and provide solutions for a capital constrained system.
- To provide a national approach which can deliver schemes across the full range of providers to complement other approaches.
- To provide innovative solutions to meet identified needs arising from Strategic Estates and Strategic Transformation Planning.
- To demonstrate Value for Money and provide financially sustainable solutions for the local healthcare economy.

5.2. A project board including senior representatives from DH, NHSE, NHSI, CHP and NHS Property Services is overseeing the development of this model to ensure that it will meet future needs. Extensive stakeholder engagement has taken place with DH, NHSI, NHS PS, commissioners, providers, private sector partners and potential partners, advisors (legal and financial) and the debt market. External scrutiny to the options, process and methodology adopted by the project team has been provided by PWC.

5.3. The DH preferred option is a regional PPP which builds on the success of existing PPPs and ensures the right commercial arrangements to attract private sector bidders and deliver for the health system. A Business Case has been submitted to the DH for approval, following which Treasury approval will be sought. Phoenix is currently targeting the issuing of the first OJEU Notices in late June 2017, with the first PPPs going live later in 2017.

5.4. Implications of project “Phoenix” for GM - GM has a short window potentially to take advantage of the DH Phoenix workstream. Options include:

- **Do Nothing** - The business case presently with DH proposes 6 regional PPPs but currently excludes GM (and Greater London)

GM would be free to carry out its own separate PPP procurement later (solely at its own cost) should it choose to do so. GM would continue to have access to the existing LIFT and other PPPs available to its constituent bodies.

- **Participation in DH procurement** - GM “Participation” could take a number of forms:
 - Engage with the wider process to seek a GM area specific procurement but on the DH standard template
 - Engage with the wider process to seek a GM area specific procurement with GM specific characteristics. Examples may be:
 - A local rather than National DH partner/shareholder
 - Broader “user” and “sector” bases e.g. education or others?
 - Urgent discussions would be needed with the “Phoenix” team to confirm that these options would be potentially achievable. This would be a relatively low cost option if it remains within the DH sponsored procurement with the principal commitment being GM personnel time.
- **Own procurement run alongside DH procurement** - Use DH/CHP work to date to assist in the design and procurement of a GM specific PPP running alongside DH procurement.

6.0 THIRD PARTY DEVELOPMENT

6.1. Third Party Development (3PD) is the term often used to describe GP developments where the GP partners with a private developer and takes the head lease on the building. This form of funding can be used for a wide range of capital developments within the public sector and is not limited to Primary Care developments.

6.2. Third Party Developments (3PD) have been one of the most popular development options in providing primary and social care leased premises having an overall cost of less than £15m, with a proven track record of delivering value for money. 3PD developers are prepared to work up the schemes to full business case (FBC) at no

cost to the commissioner/client, with no formal contract, thus taking the risk if the proposal doesn't progress.

- 6.3. The occupational options are flexible including shared ownership, abated rents to reflect funding towards fit out costs, flexible lease terms and the possibility of the 3PD developer purchasing the interest in existing premises as part of the package. Some 3PD's are able to project occupational pass through costs and, if the tenant requires, provide both soft and hard facilities management.
- 6.4. 3PD developers have the ability to borrow money competitively in the market place and are regulated by the District Valuer on an open book basis to ensure value for money.
- 6.5. Usually the structure of a 3PD scheme will see two main documents being entered in to: an agreement for lease (the contract setting out what the developer will build, and the commitment by the GP partners to sign up to a lease); and the lease itself (which will regulate the occupation of the premises and sets out the obligations on the landlord and tenant).
- 6.6. The 3PD model could be used to develop other community based facilities if capital funding was not available.

7.0 DEVELOPMENT PARTNERS

7.1 Several GM Councils and other public bodies already have development partners in place who support them via the provision of a range of technical and other skills. Existing Partnership/contract arrangements in GM include:

- Unity – Oldham MBC
- Urban Vision – Salford MBC
- Stockport Property Alliance - Stockport Metropolitan Borough Council
- Amey – Trafford MBC
- Carillion Joint Venture – Tameside Council
- Strategic Estates Partnership (Bruntwood) – Central Manchester Foundation Trust

Appendix 3 – Due Diligence and Priority Estates Enablers

1.0 UTILISATION STRATEGY

- 1.1. At the heart of the GM strategic plan is an integrated model for efficient delivery of quality health and social care for the population of GM. Making optimal use of estates in GM is a key enabler to the delivery of this ambition. The GM estate varies considerably in terms of quality and suitability for service provision, with a number of good quality buildings underutilised and others no longer fit for purpose.
- 1.2. This section provides an update on the work which has been undertaken by the GM Strategic Estates Groups (SEGs) to understand levels of utilisation in key buildings across the health and social care estate. Across GM there are approximately 250 community health facilities in total.
- 1.3. Over the last 12-18 months the GM SEGs have undertaken a series of utilisation surveys across some of the key community health facilities. Forty seven utilisation studies have been undertaken across GM. The studies undertaken used a combination of electronic monitoring with data collected via sensors or observations by trained professionals. The studies are conducted over a survey period of around five to fourteen days, which provides an accurate picture of the actual level of day to day building use.
- 1.4. **Developing a GM Wide Approach to Improve Utilisation**
 - 1.4.1 GM commissioners are currently responsible for the cost of most of the community based accommodation in GM and therefore pay for any unused space in CHP and NHS Property Services buildings. The results of utilisation studies present a significant opportunity to make better use of the estate and meet the transformational changes outlined in the individual GM Locality Plans.
 - 1.4.2 The aim of the strategy is to turn the utilisation of complex buildings into an active dynamic process. Estate is a hugely valuable and costly resource and the NHS needs to extract every last ounce of value from it, but more importantly it is a major enabler to the type of health and social care we want to provide. Estate needs to be fit for purpose, accessible and drive value. Failure to achieve optimum use of the estate results in wasted resource, inefficiencies and potentially generates a requirement for additional capital investment.
 - 1.4.3 Managing high value/high cost space is a complex process. Mechanisms or measures can be put in place – but these need to be actively and intensively managed in order to achieve real improvement in space use. The way in which buildings are managed needs to change from a passive unstructured approach to an active asset management model. There should be gain share for partners from successful utilisation.
 - 1.4.4 Remedial measures can be difficult to effect, requiring a great deal of ‘on the ground’ activity by a number of professionals including local estates and Property

Teams, Building Managers, and Property/Estates Managers from Acute and Primary Care Providers as well as leaseholders such as, CHP, NHS PS and GP Practices and service providers. To facilitate the transfer of new or existing services into under-utilised facilities it is likely that there will be a requirement for some new capital to undertake refurbishment making the facilities fit-for-purpose to accommodate the services.

1.4.5 The GM SEGs have a key role in bringing partners together and initiating strategies to improve utilisation and generate significant savings. An open dialogue between partner organisations will be needed, which can reflect the differences between sessional and contractually allocated space and how to deal with these individually to reduce voids and under-utilisation.

1.4.6 Clear practical approaches are required to tackle underutilisation. It is proposed that the action plan and next steps across GM include the following;

- Establish a GM wide Utilisation Working Group
- Establish Utilisation sub-groups (of the SEGs) in each locality
- Identify a Senior Utilisation Champion for each locality from the local health and social care economy;
- Develop a GM utilisation league table of the top 20 or so high cost/long commitment properties that are underutilised so we have more visibility at a higher level. The data will be based at a locality level and aggregated in summary on a GM basis ;
- Agree that we are going to tackle underutilisation at a GM Strategic level and work together to move to target 82% with agreed steps and a timeline.
- Commissioner and estates advisers to identify opportunities for moving more services into the under-utilised property;
- If there is no additional clinical demand for under-utilised space then consideration should be given to other uses for the space given it is already being paid for, e.g. back office.
- Develop a plan to implement effective building management across GM community facilities;
- Develop a plan to implement effective room booking systems across GM community facilities;
- Consider options to consider to support increased utilisation:
- LCO to hold main underlease and manage all void & bookable space;

- GM commissioners to hold all the funding for the space in a building and the estates funding being taken out of the service contracts;

2.0 ONE PUBLIC ESTATE (OPE)

2.1. OPE is a pioneering initiative delivered in partnership by the Cabinet Office Government Property Unit (GPU) and the Local Government Association (LGA). It provides practical and technical support and funding to councils to deliver ambitious property-focused programmes in collaboration with central government and other public sector partners.

2.2. OPE partnerships across the country have shown the value of working together across the public sector and taking a strategic approach to asset management. At its heart, the programme is about getting more from our collective assets – whether that’s catalysing major service transformation such as health and social care integration and benefits reform, unlocking land for new homes and commercial space, or creating new opportunities to save on running costs or generate income. This is encompassed in four core objectives:

- Creating economic growth (new homes and jobs)
- More integrated, customer-focused services
- Generating capital receipts
- Reducing running costs

2.3. The GM OPE Partnership has secured funding to support:

- Strategic governance framework and resource for GM OPE programme
- Land Commission Map
- OPE 4 funding to support development of 4 integrated service hub projects
- OPE5 5 funding to support development of 2 strategic health and social care projects

3.0 NEIGHBOURHOOD ASSET REVIEW (NAR) PROCESS

3.1. The NAR process looks to develop a process to understand:

- Local community need;
- The public sector services are provided ;
- How organisations work together to improve community outcomes and be more successful;

- How a range of right sized, appropriately located and efficiently used assets can support this;

3.2. The process to undertake NARs includes:

- Analyse community performance and needs and understand the services that are currently provided to them and through what property / asset base;
- Translate how different service transformation programmes interact and what future models of service delivery workforce reform is planned;
- Forecast how co-location models can support this and what Assets can be released;
- Assemble property solutions which support transformation and reduce Asset cost base

3.3. The NAR Process has been developed and refined via a joint project between Tameside and Stockport Councils and the GM H&SC team and agreed at GM SEB and the Land and Property Board in late 2016. The process is now being rolled-out in Bury and Oldham localities.

4.0 GM MASTERPLANNING PROCESS

4.1. GH HSCP has developed a master planning framework which will be used to undertake a full options appraisal of the study area in consultation with all key stakeholders with the aim of creating a long term masterplan that will better support modern health and social care delivery across the wider area which it serves, contribute more positively to the local community and release land for potential new housing and growth investment.

4.2. The masterplan will align with the GM vision to create integrated health and social care hubs in strategically important locations and consideration should be given to the hospital's place in this strategy as part of the review and masterplan. This is aimed at delivering more services in resident's homes or within the communities that they live, closer to their homes. This redevelopment masterplan will support fundamental service redesign incorporating acute services, primary care and step up/step down facilities on the one site and link to existing Theme 3 work.

4.3. Key dependencies are effective collaborative working across all local partner organisations, IT and finally sufficient funding. Funding will either be sourced through traditional but rare capital grants or could potentially emerge from the capitalisation of revenue savings (repaying debt.) or new funding streams to be identified.

4.4. The masterplan brief should deliver the following core outputs:

- Improved health and wellbeing outcomes.

- Positive impact on place and community sustainability, resilience and empowerment
 - Improved accessibility of services
 - Long term sustainability – both financial and meeting future needs
 - Integration of public service provision to support community based care, support and public services
 - One Public Estate principles adopted
 - Rationalisation of the estate and generation of revenue savings
 - Delivery of new housing and growth development opportunities
- 4.5. The master planning framework is being piloted at Bolton FT with additional work to commence at North Manchester General Hospital, Rochdale Infirmary and Fairfield hospitals during early 2017/18 and plans for additional sites are under development.

5.0 NHS OFFICE RATIONALISATION PROJECT

- 5.1. In 2016 a project aimed at rationalising the NHS office accommodation in GM commenced with the aim of reducing cost and rationalising services. The project is led by NHS PS.
- 5.2. The NHS PS estate in GM comprises c50 office property interests across 29 properties within Greater Manchester. Total floor area of c42k sqm (would equate to approximately 5,000 workstations at 8 sqm per person). The office accommodation is used by a wide range of NHS commissioners and providers across GM.
- 5.3. The majority of the estate is leasehold with a significant number of contractual opportunities before 2020. In 2016/17 there were 5 lease event disposals completed with running costs of c£500k. This represents an ongoing revenue saving to GM.
- 5.4. An aspirational target of 30% reduction in cost has been set.
- 5.5. Progress to date:
- The focus of the initial review has been on the NHS PS estate and builds on the work already underway across a number of CCGs
 - Due diligence of key data
 - Site visits to key properties
 - Review of live projects/initiatives and where additional support is needed to develop vacation options

- Prioritising resources to manage individual office reviews and projects
- Improving dialogue with GPU in respect of Government Hub proposals for the North West

5.6. Office Rationalisation Project – Next steps:

- Strategic Estates Planning (SEP) team to work with partners to review in flight projects and individual opportunities to develop options assessment to OBC/FBC
- SEP team to carry out further due diligence and site inspections
- SEP team to carry out occupancy and utilisation studies on key sites to better frame consolidation opportunities at Parkway, Piccadilly Place and Stockport offices
- Consider the adoption of policy and standards for GMO offices for consistent provision and allocation: building on GPU estate policy and best practice. GM could be an exemplar STP for back office consolidation
- Continued dialogue with GPU, and specifically options and timing for central Manchester