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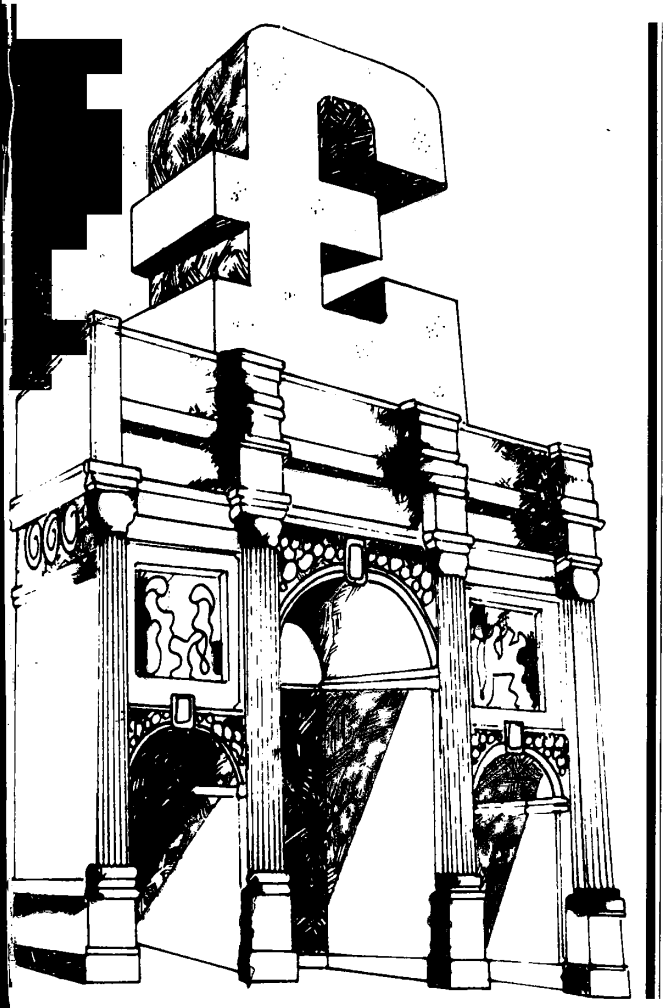

Unfreezing the Assets:
NHS estate management in the 1990s

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King's Fund Institute

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The author

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Summary

Prior to the 1980s the NHS gave scant attention to how effectively its 50,000 acres of estate were managed. Those in charge of the works function, as it was then called, came principally from an engineering and maintenance background. Relatively low land values and the existence of government rules which acted as a disincentive to rationalise the estate conspired to give the issue a low priority on the NHS's agenda.

A spate of land sales where health authorities lost out badly to private developers, together with inflation in land values, created a changed picture by the early 1980s. In 1982 the government set up the inquiry chaired by Ceri Davies into underused and surplus land and property in the NHS, and the team published their report in 1983.

The key themes of the report were that:

- new build is not the only option when expansion or change of services is being considered;
- the estate as an asset must be drawn fully into the planning process;
- the incentives for local health authorities and managers to rationalise land holdings must be strengthened;
- estate management and its status in the organisation must be reviewed;
- without information it is impossible to manage the estate effectively.

Ministers moved quickly to ensure that the recommendations could not be ignored. Changes were made at the Department of Health and a senior individual from outside the service was appointed to the NHS Management Board to lead the implementation of the new approach to estate management. The annual review process was supposed to ensure that general managers followed through the recommendations.

Seven years on the implementation process has proved slower than should have been the case. There have been considerable successes across the country in imaginative land rationalisation, often using the Mereworth strategic planning tool. But implementation of the full agenda of reforms has been patchy and opposition has too often come from estates professionals themselves who saw their positions threatened, as well as from the indifference of general managers.

The NHS and Community Care Act 1990 has brought two major changes. First, the review of functions at regional and district health authority levels has led to a scaling down and sometimes the virtual disappearance of the estate management function. Second, the introduction of capital charges will force managers to give increasing attention to the way space is used in health care buildings and campuses. The NHS will need at least as good estates professionals in the 1990s as it began to grow in the 1980s. The agenda in estate management terms will be even more challenging and scarce professional skills and advice must not be lost.

This report charts developments since the 1983 Ceri Davies inquiry, and drawing upon new and original data it provides an overview of the nature of estate management in the NHS at the beginning of the 1990s. The report concludes by offering an agenda for the 1990s which will help chief executives at both purchaser and provider levels to meet this challenge in a successful way.

Introduction

1

This report examines the history of the series of policy initiatives concerning the use of land and buildings in the NHS which was launched by the publication in 1983 of the report *Underused and Surplus Property in the National Health Service* from the Committee chaired by Ceri Davies.

The study considers the political and managerial intentions which lay behind the Davies report, and charts the extent to which the series of proposals which it produced have been implemented over the subsequent seven years. It also examines the extent to which the initiatives can be judged to have been 'successes' or 'failures' and what the causes might have been.

The key recommendations in the Ceri Davies report are, at the start of the 1990s, far from outdated or irrelevant. The initiative is still of considerable importance to the effective management of resources in the health service, and this study identifies the implications of the changes taking place as a result of the white paper *Working for Patients* (DHSS, 1989) now embodied in the NHS and Community Care Act of 1990.

Six themes have emerged during the course of the study and have been examined in relation to published literature and in the light of discussion with practitioners. These themes can be summarised as follows:

- The extent to which the disposal of land and buildings has met original intentions, generated sufficient additional capital income to meet expectations, and has enabled reinvestment in productive assets.
- Implementation of the recommendations on space utilisation and functional suitability of buildings, which have received less prominence and have to date delivered fewer benefits.
- The organisational issues raised by the report including the development of the role of estate manager, estate management's position in the organisational hierarchy, and the effect of the introduction of general management on the policy initiatives.
- The existence of incentives for authorities and managers to implement the recommendations, including return of land sale receipts, revenue savings through rationalisation, and capital charging.
- The importance of information systems, and in particular the place of the Works Information Management System (WIMS) and the Mereworth planning tool, in achieving some of the report's aims (see Section 3).
- The network of bodies whose involvement is necessary to successfully implement some of the main proposals, particularly those concerning disposal of complex sites or sites in the 'Green Belt'. Groups with a key role to play here include local authorities and their members, town planning officers, district valuers, estates surveyors, and senior NHS managers.

The study highlights the Ministerial intentions behind the commissioning of the Ceri Davies report; reviews whether the implementation timescale has proved longer than expected; and, considers the new developments in the NHS and Community Care Act and the Health and Medicines Act, which take some of the original recommendations a stage further, and set the tone for the 1990s.

In particular, the plans for capital charging and capital asset registers are an important development of the 1983 report's ideas. The study examines not so much the technicalities of these issues, but rather how information from the Capital Asset Register and from the space utilisation section of the estate database will actually make operational managers behave differently, and how this will impact on contract pricing.

Sources

The work draws heavily on interviews with those who have been involved in implementing the Ceri Davies Report over the past seven years. These include Ceri Davies himself, in the Estates Directorate at the Department of Health; regional and district estates managers; general managers at unit and district level; estates surveyors, and architects. In addition, a substantial questionnaire was sent to every director of estate management at district level in the NHS in England and Wales. The results from this have informed the writing of the whole report and are set out in detail in chapters 4 to 8.

2 | The prelude to the Ceri Davies inquiry

The study begins by placing the estate in the context of the NHS in the 1970s and describes steps taken at that time to review the role of those who managed the works function.

Given the considerable inflation in land and property values that has taken place over the past 20 years, it is easy to forget that in 1970 the picture was very different, and estate management hardly existed in the NHS. The amount of land occupied by health authorities, and the way in which it was used, were not seen as important items on the management agenda. There were a number of reasons for this. Some of the most important are set out below.

- Land prices were relatively cheap.
- The health service was experiencing a boom in capital expenditure from the mid-1960s to the late 1970s which seemed to demand more land rather than less.
- The policy at the time was that land sales income automatically reverted to the Treasury, which effectively removed any incentive to local action.
- The inability of health authorities to seek planning permission for change of use in their own right, because of the way Section 266 (1) of the Town and Country Planning Act 1971 was interpreted.

The need for change

Change began with the preparation of proposals for the major reorganisation of the NHS in 1974. The white paper on Health Service Reorganisation published in mid-1972 declared that 'authorities will be given a more direct financial interest in land holdings and land transactions' (DHSS, 1972).

This reflected pressure from regional hospital boards that they should be given a financial interest in disposing of unwanted property. The then Chairman of Epsom Hospital Management Committee, Lord Hayter, wrote to *The Times* in August 1973 to say:

> *... unwanted hospital land is perhaps the most fruitful source of more land for housing in London. There are so many instances where hospitals are surrounded by land surplus to their needs, but there is no incentive for this land to be sold since the Treasury takes all the proceeds (August 10, 1973).*

In fact, the official procedure adopted to that date had been to offer the property first to other Government departments. If there was no interest expressed there, then it would be offered to local government. Only after these avenues had been exhausted would the property be sold as advantageously as possible on the open market.

Sir Keith Joseph announced in a Parliamentary written answer, in advance of the 1972 white paper, that regional hospital boards selling land were to benefit financially by the addition of an equivalent amount to their capital allocation from central funds, the change to start in the financial year 1973/74.

In a public speech at the time these changes were taking place, Sir Keith Joseph described the NHS estate as 'the biggest slum in Europe'. This comment was an indication of the level of ministerial/political concern at the NHS's failure to manage the physical environment in which care was provided.

It was also a more graphic way of making the same point which David Woodbine Parish had made in his Committee's report entitled *Hospital Building Maintenance*. The committee had been set up in July 1968 by Kenneth Robinson, then Minister of Health, and presented its findings in February 1970 to Richard Crossman, Secretary of State for Social Services. Although the report concentrated on the staffing needs in building maintenance, an early paragraph on 'Estate Management' stated:

> *Effective stewardship and management of property are vital functions of the NHS. We are concerned to find that the general principles of estate management, which we would expect to be applied vigorously in any large organisation controlling the substantial amount of property which is at the disposal of the NHS, are not always properly understood or universally applied in the hospital service. We recognise the impracticability of suggesting that in this respect the NHS should operate on commercial lines, but we are confident that there is a great deal to be gained from a close examination of basic principles and commercial practice in the development of a comprehensive property and building maintenance policy for the future (Woodbine Parish, 1970, para. 3.2.4).*

The Committee was so concerned about the inadequate approach to estate management which it had identified that it produced a set of guidelines to inform the development of better practice. These are reproduced in Box 1.

The status of the works function

Until the 1982 reorganisation of the NHS, the estate function at regional, area, district and hospital level was referred to as the 'Works' organisation, with all the implications that this term had for the status and the image of an essentially 'maintenance' oriented organisation. It was only after 1982 that the term 'director of estate management' came into common currency.

One important factor in judging the importance of an issue, and in particular its manageability, is the existence of information, or at least regularly kept data. No information on the extent of the NHS estate, its condition, what had been disposed of, or what was regarded as surplus, was available in the 1970s. Secretaries of State of the time were forced to dissemble by admitting that while no central records were kept, 'regional hospital boards kept the matter constantly under review'. By the time the then NHS Chief Executive, Len Peach, appeared before the Public Accounts Committee (PAC) in May 1988 following a critical National Audit Office (NAO) report on *Estate Management in the National Health Service* (1988), he had very much more detailed data on the Estate with which to respond to scrutiny. Even then, however, there was an element of confusion over the basic statistics of how much land the NHS estate comprised which was eventually explained in the following way.

> *It is extremely difficult with an estate of such varying complexity as that of the NHS...to be precise about it size... As at 31 March 1987, this figure was 46,424 acres. But at best this can only be an approximation since the estate comprises over 100,000 residential and many other small units which are not easily measured or visualised in terms of acres, and it seems reasonable to acknowledge this by adding 10%; which produces a rounded figure of over 50,000 acres (PAC, 1988, Appendix 6..)*

By 1980, the status of estate managers had improved a little, largely because of the management changes post-1974 and the creation of area works officer posts. Frequent references during the late 1970s in articles and in speeches at conferences to 'What is Estate Management?', are testimony to the works officers' concerns that few people outside the leaders of the Works profession in the NHS understood what this new title really implied. For example, one of them wrote:

> *I believe there is still a lack of understanding outside the present works service of what estate management really is. Most people still see works as a sort of two-headed creature; one of which repairs things or keeps them going; and the other which delivers glossy new goodies.*

1

WOODBINE PARISH REPORT

The General Objectives of Estate Management relating to Property Maintenance in the Private Sector

1 The objectives of sound estate management in relation to property can be defined as follows:

1.1 To maintain and improve the value of capital assets.

1.2 To ensure long-term, trouble-free investment in order to provide a continuous and satisfactory return on capital employed.

1.3 To maintain property in such a condition that it continues at all times to fulfil its function efficiently.

1.4 To carry out the above requirements effectively with the minimum expenditure necessary.

1.5 To plan expenditure so that future capital and revenue commitments can be assessed and an even flow of expenditure programmed over a period of years.

2 In order to achieve these objectives consideration must be given to the following main areas:

2.1 The proper definition of property maintenance status within an organisation and the management of such maintenance as a separate activity with an established policy.

2.2 The assessment of maintenance expenditure at the design stage of a building by the capitalisation of operating and maintenance costs using discounting techniques.

2.3 The creation and constant review of property portfolios in order to eliminate the unremunerative items by demolition, disposal or replacement. Major repair and renovation costs always being weighted against replacement costs.

2.4 The integration of maintenance management and related supervisory functions.

2.5 The establishment of uniform management practice and control throughout an organisation.

2.6 The exercise of strict budgetary control by professional and technical staff responsible for the execution of maintenance work at whatever level this occurs.

2.7 The formulation of comprehensive maintenance plans covering all properties and extending over a minimum period of 5 years.

2.8 The maintenance of records of all annual expenditure under different maintenance heads and their retention over as long a period as necessary for review and future reference.

2.9 The establishment of standard feed back systems between maintenance and design to report on performance of construction and materials employed.

Source: **Woodbine Parish, 1970**

Although much has been done to improve the image of works, we are still very poor at the public relations business. We know that estate management covers much more. Unfortunately that 'much more' impinges upon the territory of the administrator and to a lesser extent the treasurer.

We must remember that in the NHS, estate management heavily overlaps many other disciplines ...

Any authority with capital assets running into possibly hundreds of millions of pounds would be very foolish in commercial terms not to employ and listen to sound professional advice. This advice must come through a works officer ... (Walker, 1980).

It is notable that the final point refers to specialist advice coming 'through' and not 'from' a Works Officer; and the remarks allude to the organisational issues posed by the need to involve many people and interests in land and building rationalisation.

The final straw

It was, however, a series of well publicised land deals in which the NHS lost out heavily, suffering from the lack of 'sound professional advice', that led to the setting up of the Ceri Davies Committee in March 1982.

In particular, the sale of Robroyston Hospital, Glasgow, in the late 1970s, the effects of which became public in 1980, caused a political outcry. A TB hospital, Robroyston stood on a 60 acre site on the northern boundary of Glasgow. It was in an area zoned for agricultural use and was sold on that basis for £410,000 to a property development company. Within months, the company had obtained planning permission for residential use, had sold the site on in parcels, and achieved well over £15 million profit. An independent report was commissioned which concluded that the disposal had been handled according to the due procedures. But it was also believed that 'commercial naivety' had led to the situation.

It was clear that the due procedures were in need of overhaul, and that the NHS required access to better and more commercially aware advice. It was, of course, also a reflection of the engine of inflation in land and property prices moving up a gear. On 11 March 1982, in answer to a parliamentary question, the Secretary of State Norman Fowler announced:

Many health authorities have already disposed of surplus land and property with advantage and others have plans in the pipeline. It is important, however, that all health authorities should do as much as they can to rationalise the estate and realise its value, and apply an adequately commercial approach to estate management. Accordingly I have decided to appoint an inquiry team, two of whose members will have relevant private commercial experience.

2

CERI DAVIES INQUIRY: TERMS OF REFERENCE

Within the context of the revised National Health Service planning and management arrangements, to consider measures which will ensure that Health Authorities identify underused and surplus land and property, and where appropriate, dispose of it in ways which will create maximum benefit for the service and to make recommendations.

Membership

Chairman: **Mr C Davies, Directorate of Works Operations DHSS**

Members: **Mr Paul Draper, Imperial Foods Limited**

Mr B D Herbert, Regional Treasurer, East Anglian RHA

Mr D B Leggatt, Area Administrator, Surrey AHA

Mr Idris Pearce, Idris Pearce Chartered Surveyors

Mr Richard Ellis, Richard Ellis Chartered Surveyors

Mr M H Smith, Area Works Officer, Gateshead AHA

Mr W H Healey, Regional Liaison Division, DHSS

The terms of reference and the membership of the inquiry are shown in Box 2.

The central themes which they themselves would promote had thus already begun to appear by the time Ceri Davies and his team started work: the lack of incentives to action and, more than that, the fact that the NHS was forced to transact land and property with one hand tied behind its back; the absence of a commercial approach to land and property management which reflected the status, calibre and attitudes of the staff groups involved; the organisational tensions between the professional groups with a legitimate interest in these matters; and the lack of almost any data on the estate.

The following chapters pick up the threads of all these issues, study their interplay in the subsequent years and, gazing into the ubiquitous crystal ball, point to some important directions in which the policy initiatives may lead over the next decade.

Implementing the inquiry 1983–1990

This chapter describes in general terms how successfully the key recommendations of the Ceri Davies report were implemented in the seven years after its publication in 1983.

The scope of the inquiry

Ministerial concern that health authorities did not know what land they held, and as a consequence should be compelled to take the matter more seriously through a 'rental' system, was the original objective of the Ceri Davies Inquiry. It is fortunate that, through the perceptiveness and vision of a few senior people in the Department and the NHS, Ministers were persuaded to allow broader terms of reference to be written. Ironically, by the time the inquiry reported Ministers had lost enthusiasm for the rental scheme, and it has taken seven years for it to be transformed into the system of capital charges currently being implemented. The main themes of the inquiry report are set out in Box 3.

The scope of the inquiry thus largely reflected the concerns of a few individuals at the Department of Health and in the regions, and the inquiry team itself drew attention to the broad remit that it had carved out:

> *We have interpreted these terms of reference widely. This is because it became clear that we could not sensibly consider the questions of under used and surplus property in isolation from other aspects of estate management.*

The team produced a unanimous report but it is known that there was initial disagreement over the question of the use of capital receipts. This was seen by some members as a crucial issue, providing that all-important incentive to district health authorities to take on the new workload of managing property assets in an active way. The retention of receipts by regional health authorities rather than being returned to the Treasury was an argument that had already been won, and the report came down firmly in favour of districts retaining the proceeds of sale, although certain exceptions were specified.

> *It may be argued that 'over-provided' districts should not be entitled to receive such benefit. We consider, however, that the incentive argument takes precedence; any inequality will need to be dealt with in other ways ... (para 5.13).*

In spite of such firm advice, a surprising diversity and confusion remains to this day in the policies of regional health authorities regarding the use of capital receipts. This emerged from the responses to the questionnaire to district estate managers, which are examined in detail in chapter 6.

The spur to implementation

Ensuring that the Inquiry recommendations were implemented was of major concern to Ministers. Circular HC (83) 22, which was published in November 1983, required action from health authorities on all the major points in the Ceri Davies report, but effective implementation would need people in the service who saw estate management as a pro-active and dynamic activity with close links to the general management of the organisation. The problem was that there was no obvious post suited to implementation at DHSS or at regional health authority level. Both organisations were heavily structured around two traditional concerns; new build and maintenance.

A generation of works professionals had come into the service inspired by Enoch Powell's vision of new build expressed in the Hospital Building Programme of 1962, whose aim was to sweep away the slums of the NHS' Victorian legacy. The last thing such people wanted was to be told to 'make the best of what you've got', and the message of the report that you do not automatically build new was far from welcome with DHSS or regional works officers. The fact that no regional works professional had been a member of the inquiry team did not help ownership of the proposals to be established at regional level. Finally, implementation of most key elements was rightly seen as a district activity. All this appeared to justify ministerial concern about whether the agenda would be carried through effectively and speedily.

Ministers' response was to ensure three things happened. First, the works organisation at the centre was split, with the two traditional functions in one part, and the new responsibilities for estate rationalisation in the other. Second, a powerful external appointment, in the person of Idris Pearce from Richard Ellis and Partners, was made to the new directorate with Deputy Secretary rank and a seat on the NHS Management Board. Third, progress on implementing reforms was brought into the formal review mechanism, which

3

THE CERI DAVIES REPORT: THE FIVE KEY THEMES

1 NEW BUILD NOT THE ONLY OPTION	The NHS ... has many buildings which because of their geometry and soundness of construction have a potential for change (Para. 4.5). Management in general and planners in particular need to be aware of the opportunities in the estate for re-use and adaptation (Para. 4.6). The function of space management should become an identifiable responsibility at Regions and at Districts (Para. 4.7).
2 THE ESTATE AS AN ASSET MUST BE DRAWN FULLY INTO THE PLANNING PROCESS	Service planning and estate planning are interactive processes (Para. 3.14). The estate database should be assembled in time for the interactive exercise described above to be carried out as part of strategic planning (Para. 4.8). The scope of courses on estate rationalisation and planning (Mereworth) needs to be widened to enable a much broader range of disciplines to take part (Para. 71.). An estate control plan for each major hospital site needs to be prepared indicating the physical implications of strategic decisions taken as a consequence of planning (Para. 4.9).
3 THE INCENTIVES TO ACTION MUST BE CLEAR	The removal of statutory impediments to the speedy disposal of surplus NHS property will be of help to health authorities. In other respects we believe that remedies are largely in their own hands (Para. 5.3). Procedures for disposing of surplus property must be streamlined (Para. 3.14) A powerful incentive for a District to make positive efforts to identify and dispose of surplus property is that it should receive the full benefit of the proceeds of sale (Para. 5.11). ... we are convinced that the adoption of a positive NHS property valuation system is essential as being the only realistic way of bringing home to both planners and users the cost of the accommodation occupied (Para. 5.25).
4 WITHOUT INFORMATION YOU CANNOT MANAGE	Systematic identification of underuse hardly exists nor is there much idea of the value of property (Para. 1.2). There is a lack of basic information about the estate described in a way which is convenient for strategic planning (Para. 3.6). ... each District should undertake a review of the potential sale value of its stock ... We have been encouraged to see the development of a Works Information Management System (WIMS) ... (Para. 6.18).
5 ESTATE MANAGEMENT AND ITS STATUS IN THE ORGANISATION	... (there is) too often an assumption that property matters can be undertaken almost entirely without professional advice (Para. 1.3). We were struck by the wide range of attitudes and practice in relation to property matters in different authorities (Para. 3.1). ... Chairmen and members of Health Authorities regard the management of the property in their charge as a peripheral matter of a purely technical nature (Para. 6.2). We ... see the need for a more broadly based function than that currently carried out by works departments at Regions (Para. 6.3). ... fresh consideration should be given to the overall position of the District Works Officer within the DHA organisation (Para. 6.10).

Source: Ceri Davies (1983)

kept it on the management agenda and in front of ministers' eyes.

In addition, Idris Pearce, as head of the new directorate, ensured that implementation was made a concern of general managers and not just works professionals. Regional general managers were held to account for progress made and they in turn stimulated both the regional estates organisations and the district general managers. In this way implementation proceeded and ensured the Report did not gather dust on the proverbial shelf.

A number of health circulars were issued in the following years to back up the other steps taken. The comprehensive agenda set out in HC (83) 22 was followed by the circular 'NHS Residential Accommodation' HC (85) 19. In July 1985, circular HC (85) 26 'The Operation of the Property and Works Functions' both announced the appointment of Idris Pearce as Property Adviser to the NHS Management Board and re-emphasised the need to drive on the rationalisation of the estate. The circular pointed out that 'the main activity lies with districts which may well need to obtain expert consultant advice. The broad role of the RHA is to give leadership and advice to districts in this activity, to monitor their performance, and where necessary to assist them ...'.

In 1986, HC (86) 8 considerably softened the implications of the policy on residential accommodation, although leaving districts in a cleft stick. Norman Fowler, Secretary of State for Health, in an unguarded moment had guaranteed that no-one would be required to move from their present accommodation without being offered a suitable alternative place to live. This effectively prevented authorities from disposing of some accommodation which they wished to sell, and left the original initiative in something of a mess.

Implementation - taking stock

In 1988 the National Audit Office report *Estate Management in the NHS* surveyed the introduction of improved estate management since the issue of the Ceri Davies report. It referred to the reorganisation of departmental responsibilities to emphasise the advisory, awareness-raising and research roles. The three questions which the NAO study set out to answer were:

- has the estate database been developed?
- has the scope for disposal of surplus estate been established?
- have strategies been created to bring the retained estate to an adequate condition?

The diagnosis which emerged is summarised in Table 1. It suggested that implementation has been both patchy and slow. Seven years on there are still

Table 1 National Audit Office diagnosis of estate management

KEY AREA	TASK	LEVEL OF IMPLEMENTATION
ESTATE DATABASE	Property records	Acceptable
	Condition survey	Done, but accuracy and objectivity questioned. No routine re-appraisal.
	Costs of operating estate	Not brought together by Directors of Estate Management
	Suitability reviews	Incomplete and too broad brush, DHSS guidance inadequate.
	Compliance with standards	No systematic reviews done.
RATIONALISATION/ DISPOSAL	Amount of property held	Wide variations across NHS: land holdings still excessive for service needs.
	Management attitudes	Not fully alert to opportunities for rationalisation.
		Problems over liaison with local authorities re: planning permission.
	Policies and process	Closure process cumbersome. Differing regional policies on retention of capital receipts.
MAINTENANCE OF THE RETAINED ESTATE	Backlog maintenance	DoH do not know whether position has improved since 1983.
	Condition	Highest % is in category B or C.
	Maintenance expenditure	Levels vary widely between districts.
	Training	Patchy.

Source: National Audit Office (1988)

important areas of work yet to be properly tackled, in particular those concerning functional suitability and space utilisation. There has been opportunity for foot dragging by unsympathetic regions and unimaginative districts, in spite of the admission in the report that:

> *Space utilisation techniques have been slow to emerge in the health service, an indication perhaps of the considerable complexity of this particular subject (National Audit Office, 1988, para 47.b).*

Although energetic work was carried out by Leicester Polytechnic and Ceri Davies himself, the integrated approach to planning represented by the Mereworth (subsequently renamed Heathbridge) Planning Model was adopted unevenly across the NHS. Mereworth is a database which brings together information about finance, manpower and the estate to establish 'Where are we now?'. This enables the development of a strategy that brings all three into balance. The final element of the model defines 'How do we get there?'. The co-ordinated implementation of Mereworth represented a vehicle for the wider range of tasks which the inquiry had addressed. However, it was seen as something for works officers, and general managers were slow to realise the value of the corporate and integrated approach it offered.

The Department of Health failed to give a lead by urging general managers to adopt the Mereworth approach to planning. The Estates Directorate was left to influence its adoption and it is thus hardly surprising that it gained the reputation of being a tool primarily for estates managers. In 1989 Len Peach wrote to all regions to ask how many districts had adopted the Mereworth model. This appeared to be a defensive reaction to an impending appearance before the Public Accounts Committee, and interest from the centre subsequently died down.

It remains the case that in too many instances land sales are not tied in to the Mereworth approach; they do not follow integrated analysis. Authorities continue to sell off individual squares on the chess board and so limit their room for future moves.

At regional level an important proposal had been the establishment of a Regional Estates Surveyor to lead the new division responsible for estate matters of a non-design nature. Existing professions felt threatened, and in addition only the most farsighted saw the need to change the culture away from one obsessed by new build on the one hand and the technicalities of the boiler house on the other. As always, the leaders were well in front and few in number, while the laggards were well behind; one region took more than five years to appoint an Estates Surveyor.

The Report also recognised that works officers, now renamed estates managers to reflect the broader-based role expected of them, should be involved at a corporate level in the organisation to ensure the three key resources of revenue, manpower and capital assets were held in balance in strategic decision making. A survey by Davison (1987) found that only 67 per cent of the respondents (District Estates Managers) had a place on the top management team. He concluded that 'Estates people seem to be suffering more than most professional groups from low morale and this is surely being fuelled by the perception of their worth expressed by many district general managers'.

The general picture, therefore, is one of substantial progress in implementing the Inquiry's main recommendations, but with clear indications that much remains to be done. It has taken longer to implement the changes across the NHS than should have been necessary, and it is clear from the questionnaire results that the process of estate rationalisation is far from complete. Information systems have been put in place, however, and the accusation that the NHS does not know what property it has can no longer be justly made.

Nevertheless, the NHS still lacks an active and aggressive approach to the portfolio management of its capital assets. To a private sector organisation (an insurance company), this means that:

> *Every existing property should be regularly analysed and if it is felt that the future performance will be relatively poor and the sale proceeds can be reinvested elsewhere to better advantage, we have no hesitation in selling that property. Similarly, every endeavour is made to improve investments by constructing extensions, modernising older buildings, restructuring leases and purchasing freeholds where the existing interest is a leasehold one. Not only does this enhance the overall quality of the investments and increases future growth potential but it enables policy holders to benefit from the marriage values that arise from combining such interests which often create a substantial valuation gain in excess of costs (Rodgers, 1986).*

A genuine boost to capital spending?

Following the Inquiry Report and the action required of health authorities after the Rayner scrutiny on staff residential accommodation, sale of surplus land and buildings added to the capital programmes of regions.

Total hospital and community health service capital expenditure in England has doubled in the ten years since 1980. Explicit Government provision has grown rather more slowly than this,

an increasingly large proportion of expenditure being met by receipts, chiefly from land sales (24 per cent in 1989). The Government first started to include receipts in the public expenditure plans for NHS capital in 1987, incorporating figures retrospectively to 1980. In 1980 some £16m was raised through receipts of one kind or another and this reached over £300m at the peak. Real capital expenditure declined rapidly during the latter half of the 1970s to reach its nadir in 1979. Without the inclusion of receipts it would currently still be below its 1975 level. The extent to which capital expenditure has year on year barely kept up with inflation over most of the last 15 years helps to explain the rundown nature of many hospital facilities. It is worth recalling that the Ceri Davies Report concluded that around £2bn was required to bring the NHS capital stock up to standard. In spite of the ambitious capital plans of first wave NHS Trusts, it is unlikely that there will be a dramatic upturn in capital expenditure in the NHS in the foreseeable future. The recent decisions on the external financing limits for first wave Trusts have confirmed this, and have disappointed expectations both of substantial growth in capital spending and of greater freedoms to raise it.

Integrated estate management

A view expressed by many estates professionals is that managers in the NHS have yet to grasp the importance of looking at the totality of the estate in relation to planning how services should change and develop. The role of the estates department in this exercise is to bring three key sets of information together - data about running costs and comparisons between existing and potential capital values - to inform the planning process.

The question which managers should be asking themselves is, 'am I getting a service benefit from the site equal to the best alternative value which it possesses?'. For example, if the existing use value of a cottage hospital on a valuable site is £2m and the alternative value is £8m, can that manager justify the opportunity cost represented by the £6m difference?

One of the reasons for the failure to undertake this kind of searching analysis is that few authorities have followed the critical path through the seven stages of the Estate Action Plan. This approach outlined in the Ceri Davies report was promulgated in circular HC(86)13 and led to the issue of Estatecode. The seven steps are:

1. Prepare estate database.
2. Performance analysis.
3. Rationalisation.
4. Evaluation of alternative estate strategies/ option appraisal.
5. Investment programme.
6. Estate control plans.
7. Estate operational plan.

Such an exercise remains essential for every provider unit to undertake, as a pre-requisite to its business plan, yet the NHS Management Executive has criticised the estates section of the plans of first wave NHS Trusts for being inadequately researched and described. The state of play in estate management across the country, as described in the next chapter, gives cause for concern that the picture will be no better for the directly managed units and second wave Trusts as they approach the reality of the internal market.

4 | The NHS estate in 1990

This chapter presents the results of the questionnaire to district estate managers. The results give an up-to-date overview of the state of play in estate management, and of the progress made to implement the Ceri Davies reforms.

The view from the districts

What is the situation regarding the implementation of the original Ceri Davies agenda in the 1990s? What real progress has been made and what difficulties have been experienced? How do estate managers see these issues being taken into the future in the new environment of an internal market? In order to answer such questions, a structured questionnaire which asked 26 specific questions and allowed considerable freedom for more general comment was devised.

The questionnaire was sent to every director of estate management in the health authorities in England and Wales. Out of a total sample of 199 authorities, responses were received from 104, representing a response rate of 52 per cent. The response rate across the country is shown in Table 2.

Only four districts positively refused to complete the questionnaire, most because of lack of staff and time to do so, one because it was considered to reflect too much the past rather than the future.

A detailed countrywide picture is available for the first time of organisational arrangements and rationalisation procedures; of incentives to good management and the actual use of sale proceeds; of information systems in place to underpin the decision-making process; of the development of space utilisation work; and of the attitudes and morale of estate managers at a time of great change.

Table 2 Survey response rate

REGION	NO OF DISTRICTS	RESPONSES RECEIVED	RESPONSE RATE %
Northern	16	9	56
Yorkshire	17	13	76
Trent	12	6	50
East Anglian	8	5	63
N W Thames	13	5	39
N E Thames	16	8	50
S E Thames	15	7	47
S W Thames	13	7	54
Wessex	10	7	70
Oxford	8	4	50
South Western	11	5	46
West Midlands	22	11	50
Mersey	10	5	50
North Western	19	8	42
Wales	9	4	44
TOTAL	199	104	52

No two districts the same

The essential backcloth to any study of major change in an organisation like the NHS is a reminder of how varied health authorities are, and that in rationalising their estate their starting points are widely different.

The total size of the authorities' estate (i.e. that of the main hospital sites) varied from 30,000 sq. metres to 2 million sq. metres. The range is set out in Figure 1.

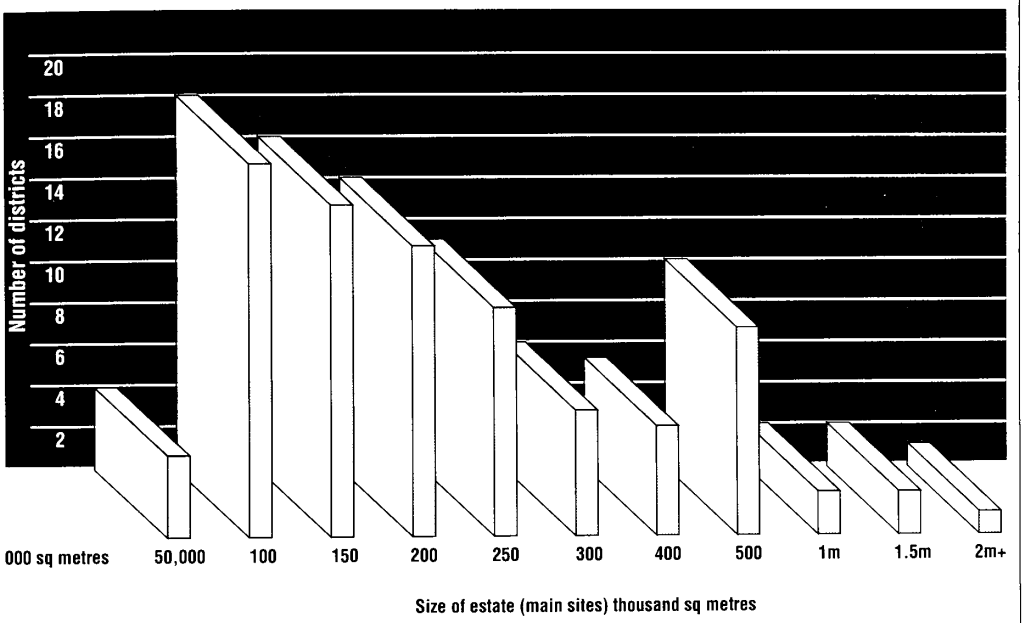
The number of main hospital sites per district ranged from 1 to more than 18. This is shown in Figure 2.

The immediate disposal programme

In purely practical terms the process of estate rationalisation is still far from complete. Respondents to the questionnaire were asked to indicate the number of sites that will be surplus within the next three years. That was taken as a reasonably short term horizon in disposal terms; and should represent firm decisions taken to dispose which are linked to service rationalisation and building schemes. This is work that will continue to require careful handling by providers to ensure that the momentum is maintained and that disposal procedures are understood and implemented effectively. The results are illustrated in Figure 3.

The 102 respondents to the questionnaire describe a short term disposal programme of over 208 individual sites. If even something approaching the same spread holds good for the non-respondents, it could be more than doubled. It is clear that provider units, whether directly

Figure 1 The size of the estate



[Note: in 15 cases respondents were unable to provide information about estate size]

managed or self governing, will need to have access to people skilled in the disposal process.

Those who have built up experience and expertise in the rationalisation and disposal process are largely officers at district and regional level. It is clear from the survey that with the slimming down and in some cases the disappearance of regional estates departments and the fragmentation of the district estates function, a skills, knowledge and resource gap is opening in the service. General managers and authorities must move quickly to ensure that process skills, professional expertise, and the momentum of the rationalisation process are all sustained in spite of the inevitable disruption caused by the NHS reforms.

Figure 2 Number of sites per district

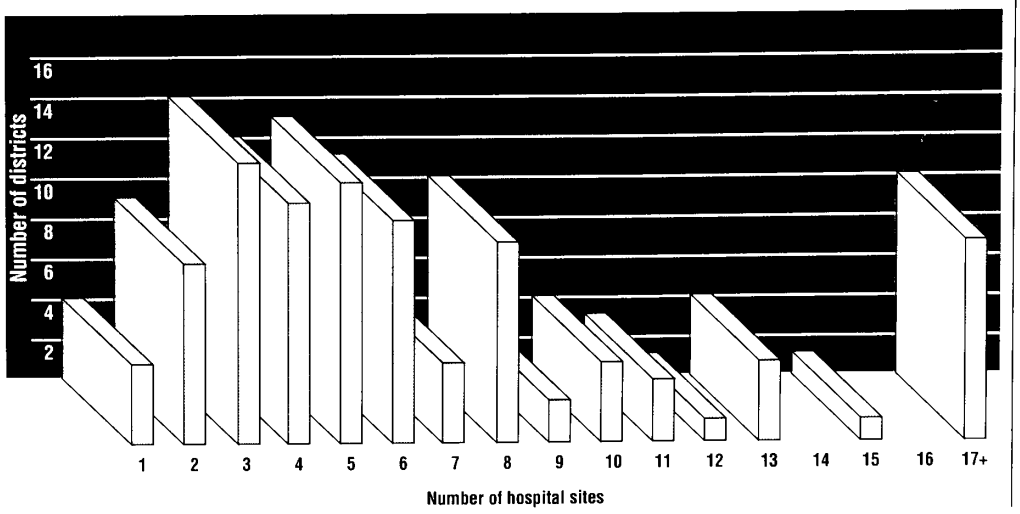
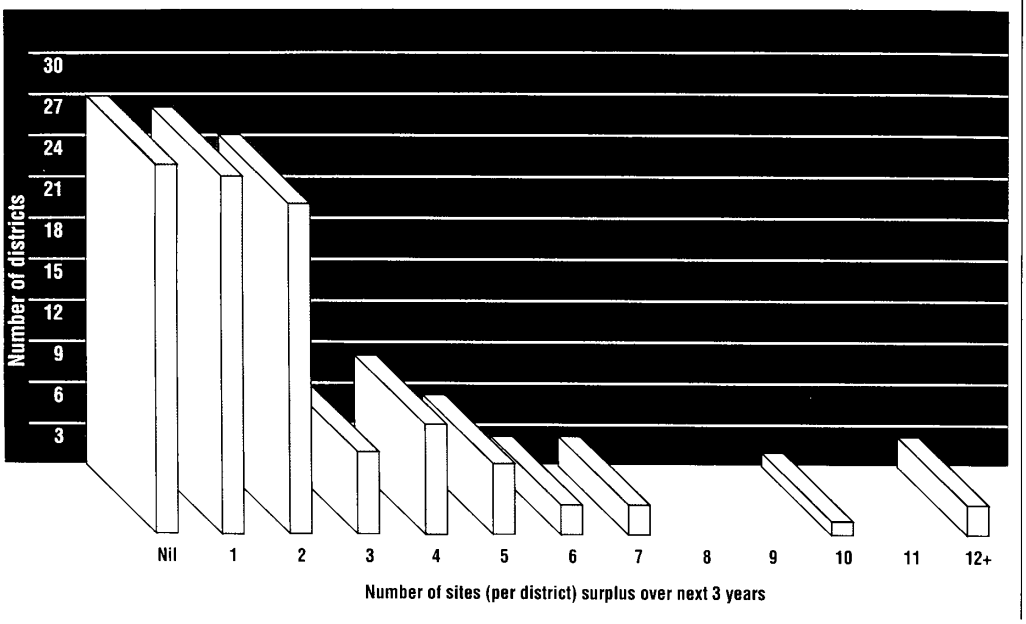


Figure 3 Surplus sites



Managers of the estate

5

The role of the estate manager has been central to the implementation of the inquiry's proposals, but it is undergoing rapid and dramatic change as the NHS and Community Care Act, 1990 is implemented.

The co-ordinating role

Responsibility for handling the process of estate rationalisation has rested overwhelmingly with the director of estate management, or with a senior member of his department. This is the case in 82 per cent of the survey respondents. In 14 per cent of the cases the responsibility was reported to be primarily with the district general manager or director of planning, and in only 4 per cent with the unit general managers. In a few cases multiple responsibility was identified and in one case it was considered that no single person was responsible - decisions were made by a senior management group.

Good management practice dictates that one officer should hold primary responsibility for the rationalisation function, in terms of handling the necessary liaison arrangements, managing the process, and holding the information resource. Nevertheless, complex interests are involved and management of the decision-making process can be helped by forming a multi-disciplinary group which meets routinely. Its main function is to co-ordinate the overall disposal programme and the disposal process itself from the time that a property or site is identified as surplus.

The survey results, in this respect, give cause for concern. Four districts appear to have no liaison arrangements at all, while only 14 per cent stated that a formal group involving both NHS and other officers met on a regular basis. The majority of respondents relied on individual officer to officer contact or ad hoc meetings.

While, as was stated by one respondent, there may well be good informal relationships with the local authority and district valuer, it is not just a matter of getting on well with each other. Complex issues are at stake, a great deal of information must be passed to and fro, negotiation may need to take place, and ideas must be generated to gain better value from the disposal of assets. This works more easily if a multi-disciplinary group exists which meets together and sets deadlines to progress the programme of rationalisation.

Within the health authority, the picture that emerged from the survey was clearer and more positive: property rationalisation issues were discussed at the main decision-making meetings; the Unit Team, District Board and DHA. In some cases this was supplemented by the involvement of a district planning group or a planning sub-group of the health authority. The individuals involved were invariably the appropriate unit general manager, district general manager, planning officer and DHA chairman. The other individual officer mentioned most frequently was the director of finance. The process was seen to be co-ordinated by the director of estate management. Nevertheless, problems over understanding the decision-making process clearly exist as Table 3 shows.

There were positive comments such as:

The procedures are well covered in DHA standing orders...

It is done totally in accordance with HC(86)13 and Estatecode.

There is good communication. Decisions are based on the option appraisal process.

There were also critical comments about the perceived bureaucracy of the system, about the unwillingness to use (or perhaps unavailability of) hard data, and of the tendency of general managers to plough their own furrows:

UGMs tend to progress matters on their own further than is reasonable - they attempt to bypass the procedures and justify this as using their initiative.

Systems appear to be based on the perceptions of general managers. Little value is placed on any quantitative system of utilisation evaluation which is seen as just an estates system.

General management tend to preconceive solutions without testing options.

The objectives of the organisation change layer by layer.

Table 3 Understanding how decisions are made

IS THE DECISION MAKING PROCESS	YES %	NO %
a) Clearly understood?	77	23
b) Written down?	41	59
c) Always followed?	62	38
N = 104		

Comments were made about the procedures seeming unnecessary and bureaucratic to unit general managers. There may be some justification in the latter comments. One respondent said that in his view 'the RHA land policy has been too bureaucratic and prescriptive to be effective or opportunistic'. The results from the questions on 'Incentives' which are analysed in Chapter 6 lend weight to this view: it is clear that the original intentions in the Ceri Davies report have not been followed by all regions in respect of use of capital receipts. This has not helped to achieve a clear understanding of the process and a commitment to follow it.

In 59 per cent of responding authorities there is no reference manual which lays down the local arrangements for handling property rationalisation. Presumably reliance is placed on central guidance in Estatecode. If the service were in a steady state it would be of less concern, but in view of the turbulence caused by the NHS and Community Care Act, and the fact that units will need to have a clear understanding of the system in the future, the lack of good documentation that can enable 'knowledge transfer' is worrying.

The arrival of the internal market

There is great uncertainty about how the process will change when purchasers and providers separate, which is illustrated in Table 4.

A number of respondents made the point that the DHA will retain statutory responsibility for handling property disposal issues in relation to directly managed units. It was therefore felt that recommendations for acquisition or disposal from a provider would have to be approved by the DHA; a variation was the belief that these were decisions that could be taken by the executive directors, and that the full DHA would simply be kept informed after the event.

A few took the view that the management of capital, redistribution of services and consequential land and property rationalisation, were totally a provider responsibility with the DHA exercising a solely monitoring role. In practice that is unlikely, since certain matters concerning authorisation of capital projects and land transactions cannot be delegated to directly managed units.

It is more the case that, as one director stated,

> *Providers will define proposals for rationalisation in their business plans and the DHA will determine their acceptability based on their assessment of health care priorities.*

Thus service changes will derive from the contracting process and it is this that will drive rationalisation of property holdings. An added spur will be the effects of capital charges, which are

Table 4 Handling property rationalisation

Q: HOW WILL THE PROPERTY RATIONALISATION PROCESS CHANGE?	%
A: - Decisions will be made at provider level	25
- Decisions will be made by DHA	8
- Probably no change from present	24
- Unsure: future of estates function uncertain	25
- No response made	18
N = 104	

4

THE ESTATE MANAGEMENT FUNCTION

A. OPERATIONAL

Operations and maintenance on a day to day basis
Grounds maintenance/gardening and landscaping
Clinical Waste Disposal
Incineration of non-clinical waste
Control of substances hazardous to health (under HASAWA)
Monitoring of all statutory safety and technical standards
Pest control
Maintenance of asset register

B. STRATEGIC

Property management
Energy management
Operation/development of WIMS
Space/condition surveys
Production of performance indicators
Property valuation and liaison with town planners
Option appraisal and AIP preparation
Estate control and investment plans

C. PROJECT PROCUREMENT

Complilation of brief/schedule of requirements
Architectural/engineering design
Surveys
Handling procedural issues — Capricode, Concode, Concise
Financial: tendering, fee negotiation, cost control
Project management — liaison with client/ consultants

D. FACILITIES MANAGEMENT

Housing management
Fire prevention
Security services
Appliance workshop services
Nursing home registration input
Telecommunications network
Management of medical equipment budget

examined in Chapter 9. What is needed, out of this uncertainty, is clear agreement within each region and district about four key issues.

- Responsibilities for handling the property rationalisation process at RHA, DHA and provider levels.
- The means by which regions will influence the activity of self governing Trusts in respect of land and capital issues.
- The mechanisms available to consider and achieve intra-district rationalisation across more autonomous units.
- The extent to which land and property holdings, that do not obviously 'belong' to any one unit, should be held at DHA level and how the capital charges should be dealt with.

When attempting to resolve answers to these questions, the position of the estate management department is crucial. The picture that emerges from the survey and from widespread discussion within the services in late 1990 is one of uncertainty and in some cases despair.

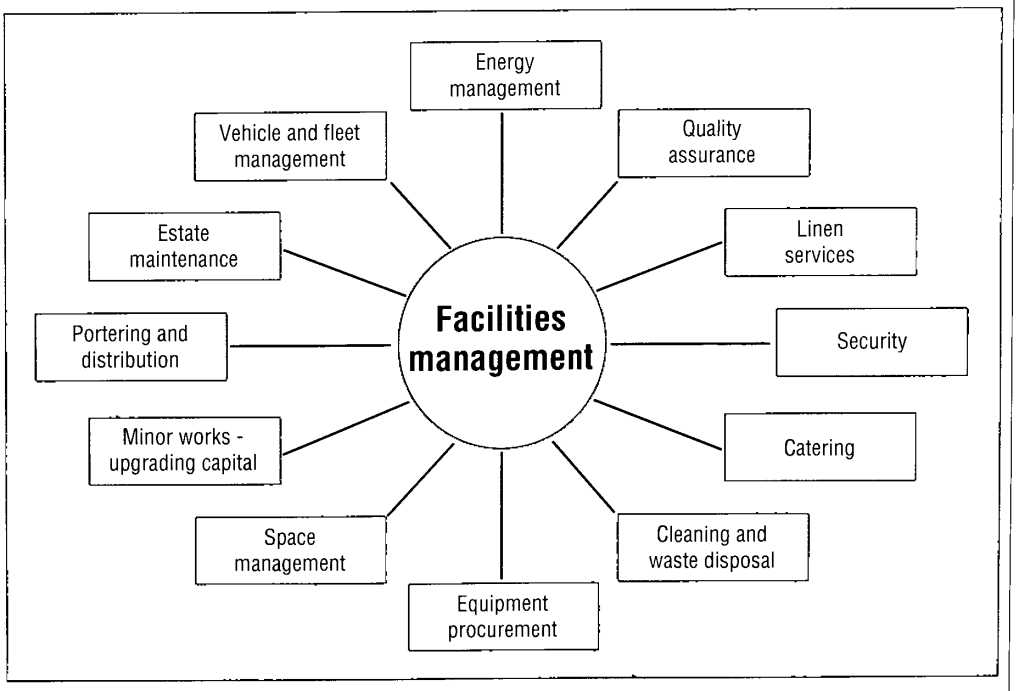
In the rush to devolve functions and concentrate on core activities, regional estates departments have either disappeared or have been drastically thinned down. At the same time, many of those left at region remain unclear about what their role will be in the future. Districts have followed suit and wholesale devolution of the estates function is in progress, since it is not seen as a purchasing activity (see Box 4 for summary of the estate management function). Thirteen per cent of respondents stated that some form of common services agency was being considered or actively being set up, either to serve the units within a district or occasionally on a multi-district basis.

Organisational options for the estate

There is less entrepreneurial spirit at district than at regional level. Only four respondents confirmed they were planning a management buy-out (MBO), although a further ten indicated it might be a possibility. In view of the severe downturn in the construction industry perhaps this is not surprising. A few saw the creation of a common services agency as a route to an MBO at some later stage.

In only rare cases at present is Facilities Management (FM) being actively pursued as a way forward for estate management. FM's responsibilities are interpreted in a wider sense than traditional estate management and incorporate domestic services, transport, laundry, catering, staff residential services, and others, as illustrated in Figure 4.

Figure 4 Facilities management



Source: DoH Estates Directorate

Table 5 Changing organisation of the estates function

LEVEL	ACTIVITY	FREQUENCY OF ADOPTION FROM SURVEY EVIDENCE
UNIT/PROVIDER LEVEL	Day to day maintenance and operation of the estate totally devolved to individual units.	overwhelming majority
	Estate incorporated into broader facilities management function.	Very few
	Common services agency directly managed by DHA with 'contracts' with provider units.	Some
	Majority of estates function moved into major unit (DMU or sometimes Trust) and selling services to other units.	Few
DHA/PURCHASER LEVEL	Monitoring of standards (including estate) through contracting process.	Most
	Some functions (e.g. design, information systems or WIMS) retained as district overhead at DHA.	Unclear
	Approval of land/property rationalisation issues and some handling of process retained at DHA level.	Majority

The organisational options available to authorities for the future management of the estates function can be simplified down to four. There are undoubtedly several variations on each option but these are the only realistic forms of management arrangement.

Option 1: Total devolution to provider units
In this option the present district department disappears; personnel are split and devolved to the existing units in order to strengthen functions previously slim or unavailable at that level. Each unit must be resourced to provide the full operational maintenance function as well as a design and project management role for minor or major capital schemes.

This is the only option in which a full facilities management approach could work.

Option 2: Devolution of district functions to one unit, which provides them on an agency basis to other units.
In this option the majority (or all) of the district's estates department move into one unit, probably the largest unit in the district. The other units may retain some local management presence and maintenance staff to undertake essential day to day work. Local self-governing trusts could either buy into the service in the same way as the DMUs or could choose to go their own way.

Option 3: A common services agency
In this option the present district estate management department, with all its functions intact, and maybe even more added, becomes a directly-managed unit providing support services on contract to provider units. A variation of the DMU concept is that of the trading agency operating a little more at arm's length from the purchaser DHA, probably with its own board. It may be required to survive by the contracts for service which it is able to win. The services provided by such a DMU/agency could range from just a design/build service to a full estate management/maintenance portfolio.

A letter dated June 1990 to finance directors from Sheila Masters, Director of Finance on the NHS Management Executive, concerning how to treat the cost of providing common services appeared to give some support to the adoption of this approach (Masters, 1990).

Option 4: Privatisation
This option would involve the privatisation of the estates function, either through a management buy-out or by transferring the staff into an existing private sector firm. This could cover just the design and project management function, or could extend to the directly employed maintenance labour force through a competitive tendering exercise. To date, however, only a very small minority of districts appear to be contemplating taking such an approach.

Table 5 indicates from the evidence of the survey how the organisation of the estates function is changing. In many cases this represents a fragmentation of estate management skills, systems and knowledge. Unit works officers are as yet unlikely to possess the experience to handle the full estates function, and the service thus faces a period of discontinuity, which general managers must step in to prevent.

Incentives to manage the assets

If the role of estate managers is crucial, the existence of tangible incentives to rationalise the estate is equally important to gain the attention and support of general managers and health authorities.

The members of the Ceri Davies Inquiry Team recognised that if managers were to be asked to develop a more active and imaginative approach to managing their property they had to be offered some incentives, since considerable additional work was involved. Their recommendation is set out in box 5.

The inquiry's recommendation was that all regional health authorities should comply strictly with the relevant paragraphs in what used to be called the Land Transactions Handbook (now Estatecode).

The use of capital receipts

Respondents to the questionnaire were first asked to state what was the regional policy on use of capital receipts. The answers showed both how widely different were the policies between different Regions; and secondly, how confusing they were to those at district level. 'I don't know', said one Director of Estates in response. 'Ask Region.'

Table 6 Use of capital receipts

Category		No of Districts
1	Proceeds return to central fund at Region	8
2	Proceeds return to District (after disposal costs met) - except for MI/MH sites - unless prior Regional capital investment	57
3	District keeps proportion of receipts for immediate local use (this ranged from first £50,000 of proceeds to first £1m); remainder to Region for use on Regionally agreed schemes.	31
4	Position changing because Regional capital programme in difficulties (usually all receipts now being drawn into centre)	5
5	Policy not clear to respondent	3
N = 104		

The range of responses can broadly be classified as set out in Table 6.

The range of responses in category 3 (District keeps proportion of receipts; remainder to Region) is remarkably wide and in some cases Districts within the same Region gave a different version of their Region's policy. This is not surprising in view of the unnecessary complexity of some of the formulae. The category shown in Table 6 which fully reflects the letter of Estatecode is category 2, but this represents only 55 per cent of the sample.

The downturn in the property market has wreaked havoc with regional capital programmes and with their policies on use of receipts. It is clear that, once Regions have begun to resolve the problems caused by this downturn, each should review its policy, bring it into line with Estatecode, and ensure it is communicated clearly to both purchasers and providers. Implementation of the policy will need to take account of the 'banker' role of Regions and operation of a 'building society account' where this arrangement exits.

This issue cannot, however, be considered without examining the wider issue of how regional health authorities decide on the content of their capital programmes. How is the programme

5

INCREASING INCENTIVES

The Ceri Davies report was unequivocal in recommending that incentives should play a central role in good estate management.

A powerful incentive for a District to make positive efforts to identify and dispose of surplus property is that it should receive the full benefit of the proceeds of the sale. In this respect the Land Transactions Handbook states that, with certain exceptions, the proceeds of sales will normally accrue to the hospital or District at which the surplus was declared. The responsibility for ensuring that proceeds are distributed in this way rests with RHAs. Despite this clear advice which we know has been reinforced by correspondence between Ministers and RHA Chairmen, the interpretation by Regions of these paragraphs has produced varying practice across the country. In consequence, the purpose of this section of the Handbook — to promote and sustain local interest in a continuing review of property holdings surplus to requirements — is negated.

Source: **Ceri Davies, 1983, para.5.11.**

divided into sub-sections (e.g. block, scientific, etc.) and what priority weighting is given to each? How does the bidding process work, in terms of deciding individual priorities and their timing? In many regions the process is far from explicit, and does not necessarily involve districts in the process. A much clearer and more explicit policy is needed from RHAs which has the support and confidence of both purchasers and providers. The Treasury undoubtedly assumes that the process of formulating capital programmes takes place in a rational manner, and while politics will always influence choices it should not be the determining factor.

The creation of revenue savings

An incentive equally as important as the provision of capital is the creation of revenue savings from rationalisation of services and the consequential land or property disposal. Twenty-five respondents out of 104 answered bluntly that there had been no revenue savings from their disposal programme, while 23 stated that all such disposals had generated savings. The remainder identified one to six sites whose disposal had created revenue savings. Only one respondent was able to provide precise figures that related specific savings to specific disposals. Most indicated that information was not available in a good enough form; it was not possible to disaggregate from each package the reduction in expenditure from removal of overhead costs, from other non-staff costs, from support staff costs and from front-line staff costs. Several Directors remarked that in overall terms revenue costs had increased, either from more expensive utilities costs in new buildings, from changing the pattern of mental illness and mental handicap services, or from the loss of income when authorities were forced to dispose of staff residential accommodation.

One of the most welcome incentives to rationalisation is that the sale proceeds are seen to have enabled desired service developments. Respondents overwhelmingly considered that the drive to rationalise the estate following the Ceri Davies Report had been of benefit. Examples were given of long awaited extensions to the District General Hospital and in particular of investment in community care projects. A small minority (9 per cent) did not agree that there had been any benefit because, in their view, property holdings had been sold off prematurely, or because some of the proceeds had been misused.

When the incentives fail

Thirty four per cent of respondents stated that in their view land had been disposed of when it would have been better to have held on to it - an unexpectedly high proportion. Short term needs for capital, the ministerial policy decision to reduce staff residential accommodation, piecemeal disposals and pressure from regions whose capital programmes were in difficulty were identified as culprits. But perhaps this is also a reflection of the strong initial drive from the centre to emphasise the disposal of surplus property as a key objective above some of the other messages from the Ceri Davies report.

A second unexpected response from the survey was that 37 of 104 Directors of Estate Management stated that income from land sales had been used inappropriately in their District to support revenue spending. Examples given ranged from £0.2 million to £2.5 million worth of capital receipts used to help balance the revenue account. If the same proportion were to hold true for the 199 Districts in England and Wales it would represent a substantial use of one off capital receipts to balance the revenue account.

Some have, indeed, suggested that it may become a more widespread practice in the future if provider units are forced to react to the short term pressures of the market when they are failing to meet their running costs from the contracts they gain. Managers should surely resist the short termism of such asset sales, since the opportunity cost of failing to use a capital receipt to improve the existing environment or to invest in the potential for new business will mean that they will have won a very limited battle only to lose the war.

A more reassuring response was that in 53 per cent of cases capital receipts had been used directly to deal with backlog maintenance. In addition many of the 47 per cent who said that it had not added the rider that backlog maintenance had been reduced indirectly as a result of new and replacement buildings.

The overall picture from the survey results regarding incentives is that while the benefits of an enlarged capital programme are endorsed by almost everyone, there has been far less emphasis on using capital investment to drive down revenue costs. Asset management in the future will be largely a revenue issue, since capital investment decisions will bear substantial revenue costs of their own.

Information systems

7

Good management needs good information, and the Ceri Davies Inquiry drew attention to the substantial lack of useful data on the estate. This chapter examines the introduction and use of the Works Information Management System (WIMS).

The development of WIMS

The Works Information Management System, or WIMS as it is universally known, has been an atypical computer development in the NHS. It has been neither one of the official systems devised by a cent e of responsibility, nor has it developed as a standard regional system.

WIMS was developed by two staff in the Department of Health in the mid-1970s. It began as a micro version of the Estate Management Information System (EMIS) from Northern Region which ran on a batch processed ICL system. Developments took place largely unofficially, and the mini version was licensed to a company called ABS. The software was officially released in 1979/80 and one of the earliest multi-user versions was in operation at the Royal Free Hospital in 1981.

Unlike other NHS systems there was no compulsion to use a particular hardware manufacturer. Its introduction into the NHS was piecemeal, with districts being left to their own devices. A minority of regions, however, agreed from the start to standardise on one supplier and funded the introduction of WIMS on a region-wide basis.

The objectives of the purchasers of WIMS have varied. Some wanted to set up a planned maintenance system or to produce painting programmes - in other words they used WIMS as a scheduling system; others saw the importance of information to help determine strategic issues - to establish an asset register, to introduce energy management, to handle condition appraisal or contract control. A third group simply saw it as a box of kit in the corner - the 'have I got the latest equipment?' syndrome. In this case there was a danger of WIMS being introduced on an uncoordinated basis, even within the same district. There are examples of one district with different WIMS systems in separate units.

In the early days the software of the system was effectively free to the NHS - only one software licence was required per district. Implementation to begin with was good, and able staff within estates departments learned to handle the system. There is now a danger that those with expertise in handling the technology will leave, and that provider units will find a dearth of staff with experience in what has grown to become a sizeable and sophisticated system.

The WIMS system has recently been improved and the version now available is WIMS 2, which offers a comprehensive asset management system. It should be developed on an integrated basis and be operated by the estates function. One or two finance directors have attempted to assume responsibility for the system, but it is doubtful that they have the technical estates expertise to ensure that they understand what they are looking at.

Implementation of WIMS

From the questionnaire results the current picture is of patchy implementation. Almost no-one has introduced all possible modules; some are too simplistic, while others such as the purchasing and stock control modules need managers outside the estates departments to agree to them. Ten districts reported that their information was still almost wholly in manual form. In addition, four stated that the estate terrier was in manual form. Most were still operating WIMS 1 and were in the process of changing over to WIMS 2. Only three districts claimed to have WIMS 2 fully operational on a networked basis. The most commonly available modules are shown in Table 7.

In response to the question, 'what further modules are planned to be in place by April 1991', 24 per cent answered 'none'. This may reflect uncertainty about the direction in which the estates function is going; a shortage of funds; or, be a practical reaction to the need to 'bed down' the

Table 7 WIMS modules in use

WIMS Module	% In Use
Labour Management System	71
Budget	58
Energy	58
Asset Register/Capital Charging	96
Property Appraisal	48
Stock Control	44
N = 104	

modules that already exist. It could equally reflect a complacency about the importance of improved and more extensive information systems to enable the estate to be well managed.

Of those who were planning to introduce further modules, the majority covered land and property; asset register; capital charging, and financial control. One Director of Estates pointed out that 'capital charges has absorbed all the resources for WIMS implementation this year and last.'

The major drawback of the WIMS system was widely seen to be the cost and length of time needed to input data. The existence of software problems was mentioned by several districts, and the complexity of the system was occasionally criticised. WIMS 1 was widely perceived as unfriendly, with a slow response time, and poor report generation. A constant theme was the personnel management factor; the difficulty in recruiting staff able to operate the system; the cost and time involved in training existing staff; the problems of operator errors, and the difficulty in selling the concept to unit estates staff. One Director criticised the absence of a comprehensive instruction manual. Because of this he believed 'trial and error input is used at present', which caused mistakes, waste of time and some disillusionment.

Future developments

In looking to the future and the development of further systems the need expressed most often was the integration of WIMS with finance systems. Integration with purchasing and stock control systems was also mentioned. Others suggested the possibility of linking a Computer-Aided-Design (CAD) system to WIMS: a low cost CAD system could be linked to briefing and Activity Data Base packages, and data could be compiled from drawings. It is clear that a number of estate departments are contemplating the introduction of CAD, although it is expensive and will need justification in cost/benefit terms.

The system was seen to need a relational database and it was hoped that WIMS 2 would provide this, although some districts commented that the WIMS 2 database needed developing to meet the new demands of the NHS and Community Care Act. Some users spoke of the difficulties experienced introducing the capital charging module: 'If they are suffering anything like the problems we are caused by the capital charging module I suspect many people will be looking elsewhere for a system that works off the shelf'.

Finally, a number of estate managers emphasised the need for WIMS 2 + to be more user friendly to non-estate users. There must be a clearer link between the output of the WIMS information system and general management, and estate professionals must become used to providing information from the system that is genuinely of use to Trust chief executives, general managers of directly managed units, their corporate teams, and the purchasing authorities for monitoring purposes.

WIMS is a largely effective computer-based information system for estate management, and must be developed further. Its future should be:

- as part of an integrated decision-making system;
- as a system used by general managers as much as by estates professionals, which implies the creation of more user-friendly outputs;
- to be fully resourced at local level, either on a stand-alone basis in a large unit, or as a networked system supported from a common services agency central base;
- to develop into a room database system which contains each room's assets and can be 'dialled into' for capital charge manipulation purposes;
- to develop an interface between functional suitability, condition, and cost to maintain;
- to develop a sophisticated modelling device to explore multi-dimentional aspects, e.g. space, cost, manpower.

WIMS should, in other words, provide the information base to show managers how to make the best use of their assets. It should help change attitudes towards the assets of the business from seeing them as a static, financially neutral resource to a dynamic, oportunity-laden element in the decision-making process.

Space utilisation

Enabling managers to use information in order to link site rationalisation to service planning was only one element of the Ceri Davies Inquiry's approach. Linked to this was the need to examine how space is used within NHS buildings.

Who controls the use of space?

Work on improving the way space is used in NHS buildings and on hospital campuses has made the slowest progress of all the recommendations since the issue of the Ceri Davies report in 1983. The inquiry's recommendation that 'the function of space management should become an identifiable responsibility at region and at district' (para 4.7.b iv) has been almost totally ignored.

Because of the introduction of capital charges it can be ignored no longer. One director of estate management has already told the unit works officers in his district: 'you're all into space management now'. It is, however, unlikely that the unit estate manager can become responsible for the management of space on his own. One of the reasons for slow progress in this field has been the fact that effective space management is a general management function. Those units that are currently creating posts with the apparently more prestigious title of facilities manager might pause to consider what real authority they have written into the job description.

The Ceri Davies inquiry report identified the range of issues that surround this subject:

- allocation of space;
- layout of space (functional suitability);
- scheduling of use of space;
- capacity (over or under) of presently-used space;
- location of buildings/space;
- physical condition;
- statutory and fire standards.

In addition, the use of space over time is important. A failing of many of the early space utilisation studies was that they adopted a 'snapshot' approach which ignored either the existence of future plans to change services or patterns of working, or the development of new technology.

The cost of space

The importance of how well space is used in the NHS needs emphasising, because there is no tradition of seeing it as a costly asset. In the commercial world where rents can reach £200 per square metre it is taken very seriously indeed. The Department of Health estimates that the current cost of running the estate is £50 per square metre. Capital charges will at least double that figure, and the Audit Commission has estimated that estate costs, including the capital charge element, will in places be as high as £200 per square metre. The Audit Commission's unbundling of the estate overhead is illustrated in Figure 5.

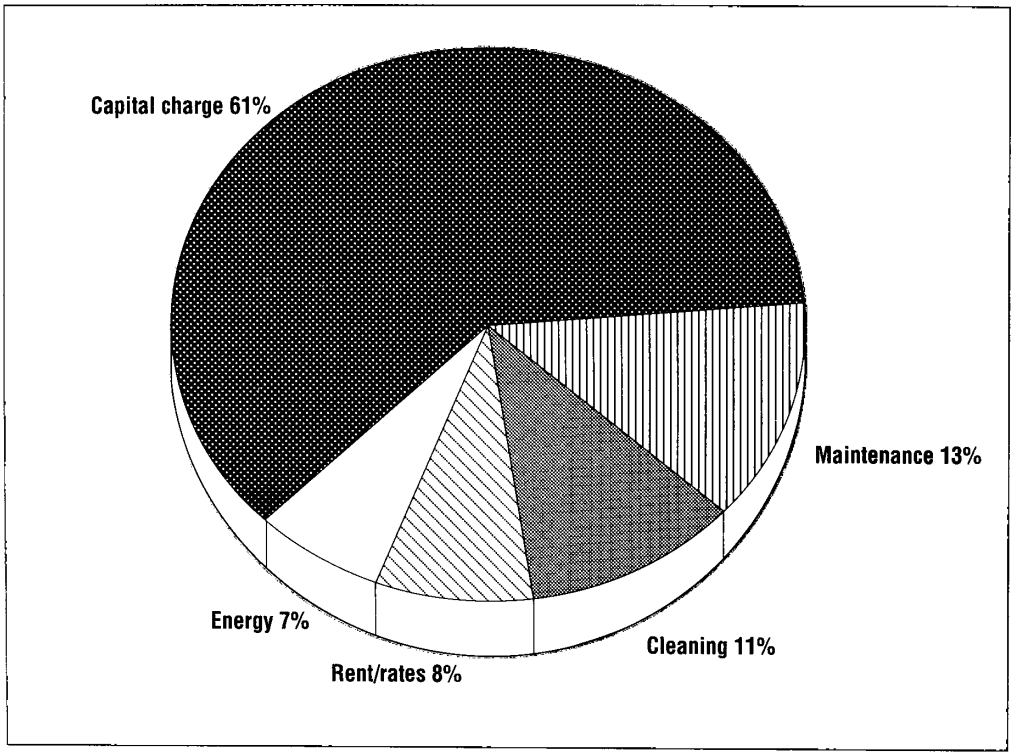
Evidence from the survey

A revolution in thinking about the true revenue cost of fixed assets is needed. What work has been done since 1983 to provide the essential data on how the space in those assets is used? The evidence from the survey is that some form-filling exercises have been carried out, but that little user-friendly information has emerged. While only 13 per cent of respondents stated that nothing was collected in a standard format, 24 per cent reported that the information did not cover the whole district, and 25 per cent said that it was not fed back to managers.

A number of districts indicated that a survey had just begun or had recently been completed. Some considered that the surveys done shortly after the Ceri Davies inquiry reported were a confusing, form-filling exercise which had proved useless or had been too broad in their scope. A few recognised that care had to be taken to present the results in imaginative ways that could be used in discussion with line managers, clinicians and others.

Twenty-four per cent of respondents said that no practical changes had taken place as a result of space utilisation surveys. From the 76 per cent of respondents in districts where change had taken place there was evidence of enthusiasm and examples of imaginative improvements: new maternity wards had been provided within existing accommodation and an old maternity hospital closed; a chiropody appliance laboratory had been relocated into existing accommodation on a more convenient site; unused day areas had been converted to offices; district headquarters had been moved into lower cost accommodation; an exercise within a hospital had resulted in the reorganisation of surgical and paediatric beds and the provision of more day case beds and endoscopy facilities. One

Figure 5 The estate overhead



Source: Audit Commission, 1990

estate manager believed that general managers had been challenged by the studies to think harder.

Other replies, however, presented a less hopeful picture. Some estate managers seemed to confuse the specific exercise of space management with site and property rationalisation. One director replied:

> *The strategic plan is to close all small and subsidiary hospitals and concentrate on two centres of excellence, so space utilisation surveys are non-productive.*

Yet another implied that the exercise would not be worthwhile:

> *Our intention is to dispose of all our old properties with the emphasis on new build to functional requirements.*

Others considered that the exercise had been disappointing because of lack of interest by general managers.

> *UGMs are so overwhelmed with work they tend to address today's problems. Estates is a 'tomorrow's problem'.*
>
> *General managers are too pre-occupied with white paper issues.*
>
> *It is always difficult to persuade managers that accommodation is underused. It can be an advantage if the estate manager has a sound knowledge of the district.*
>
> *Capital charging is my only hope.*

Some practical comments were also made about taking the exercise seriously:

> *Space utilisation studies are costly and management must be prepared to act on the findings. The traditional analysis of utilisation of space is inaccurate and misleading because there is no reference to time. A development in this district based on activity sampling over time produces more accurate and meaningful information on which to base decisions.*
>
> *Tackling space utilisation is the most emotive of all the facets of asset management. It needs the understanding and directive of the unit general manager.*
>
> *Sustained pressure is needed to break the culture of expansion.*

One respondent commented that in his view there was plenty of scope for imaginative space utilisation, and that the momentum must continue.

One problem is that the dislocation caused by the NHS and Community Care Act agenda is making that momentum difficult to sustain. Just as district estate managers were beginning to turn to space in use issues, to examine the data produced by studies, and to try to draw their general manager colleagues into the issue, along came the internal market, NHS trusts and a myriad of other diversions. Estates managers, now thinner on the ground than before, are left pinning their hopes on the pressures created by the application of capital charges, and by the need for general managers to consider more radical options than before when business plans are prepared.

The estate utilisation projects

One of the most useful initiatives in this field has been the work on estate utilisation projects led by a team within the Estates Directorate at the Department of Health. Pilot 'action research' projects were funded during 1989/90 at six sites. This work provided practical help to hospitals or districts facing major rationalisation and needing to expand services within finite building envelopes.

Early work indicated that very large revenue savings from using space more effectively were possible, but the most important lesson learned is that imaginative and lateral thinking are more important than gathering large amounts of data. Geoff Garside from the Department of Health Estates Directorate put it well in a report to one of the conferences held in 1990 to disseminate lessons from the work so far.

> *Could the outcome of such a small experiment (the Nelson Hospital) be scaled up to include large complex district general hospitals? The simple answer is yes, but only by ensuring that the space and facilities assessments did not get bogged down in unnecessary detail. For instance, whole hospital overviews were often all that was required, most large departments took no more than a day to survey. Often critical features such as overall condition were the deciding factor, or internal walls were found to be non-load bearing, or excess capacity existed in kitchens, boilerhouses, etc. However, in some areas further detailed examination of each space and facility was essential and only experienced judgement could make that decision.*

The work so far has been able to identify the factors which lead to successful estate utilisation, as well as the impediments, and is shown in box 6.

The Advisory Group on Estate Management (AGEM) set up a Working Group on Space and Facilities Management which met during 1989 and produced a report in March 1990 (AGEM, 1990). Their conclusions about the four steps needed to address the issues are set out overleaf.

6

MANAGING THE UTILISATION OF SPACE

Factors which lead to successful estate utilisation.

1. **Local ownership of the exercise and commitment to lead by top management within the organisation.**
2. **Knowledge about the cost of providing, operating and maintaining space and facilities by local managers.**
3. **Filling the gap that exists within the organisation regarding the management of space and facilities.**
4. **Achieving the right balance between macro and micro issues.**
5. **A systematic approach to space and facilities management which contributes to the organisations strategic objectives.**
6. **Service planning and estate management should be fully integrated.**
7. **Flexible application of the systematic approach and procedures in recognition of different management styles that exist within the organisation.**
8. **Adoption of decision analysis techniques.**
9. **Availability of key management data on the existing stock particularly plans and maps of site and buildings which are presented in a form and to a scale that managers and users can understand.**
10. **Involvement and recognition of the respective roles of the various tiers of management i.e. Region, District and Unit contributions.**

Organisational and technical impediments.

1. **Lack of awareness of senior management as to the potential of existing space and facilities and its relevance to capital and revenue costs.**
2. **Basic lack of knowledge by local managers of the operating capacity limits of existing space and facilities and the degree to which they are being utilised.**
3. **Continuing absence of key management data of the existing stock, which is presented in a form and to a scale that managers and users can understand.**
4. **Almost total absence from the local scene of those who are professionally qualified in hospital planning and able to provide imaginative feasibility studies to support and demonstrate the full potential of existing buildings.**
5. **Where such utilisation exercise have been carried out, they are in the main mechanistic and do not explore crucial issues of space and facilities management.**
6. **Probably the most common failure is the communication of existing property performance information to those responsible for both strategic and operational planning.**
7. **Present formal procedures in resource planning matters nationally do not seek clear evidence that the existing stocks potential has been fully explored and its utilisation assessed before approval for a capital project is given.**

- **Awareness Training**
  Building on work already undertaken in order to make general managers aware of the importance of facilities management and its role in controlling costs.
- **Demonstration Projects**
  To be funded in a small number of locations in order to set up facilities management within the organisation.
- **Guidance and Information**
  By developing appropriate performance indicators for facilities management in the NHS.
- **Providing the Tools**
  By developing software which allows space utilisation and cost analysis to be carried out and brought together for general managers to understand and use.

The challenge for the future

Carole Rawlinson, previously with the Medical Architecture Research Unit and now a director of Rawlinson Kelly Whittlestone, has also emphasised the importance of space-in-use studies and has linked this to a view of the future. Linking together factors such as shortening in-patient lengths of stay, developments in biotechnology and information technology, and cost containment, she has pictured a future where DGHs are smaller, wards are designed differently, services are organised around equipment with short intensive impatient stays, and care and investigational work is decentralised to community hospitals or large health centres.

This approach is important because it reminds planners and general managers of the dynamic nature of health care. The challenge will be to make buildings more flexible, to adapt what is there rather than always having to build from scratch, and to squeeze every square inch of use out of the space that is available. These challenges are inescapable for general managers themselves, and cannot be faced entirely by estate managers or even by a new breed of facilities manager on their own. There is little sign so far that general managers are prepared to put the issue of space utilisation high enough up on their agenda.

Capital charges

9

The problem of how to insist that managers take seriously the way space is used in their premises has been addressed by the introduction of a capital charge, which is a development from the original Inquiry proposal of a 'notional rent'. The charge means that there will be a real cost to capital. It will be derived from a formula which includes two elements: an interest charge representing the desired return on capital employed; and a depreciation charge on past capital expenditure.

A fresh incentive

Estate Managers overwhelmingly recognise that the introduction of capital charging will be an incentive to further reduce land and property holdings. Eighty-two per cent responded positively with comments such as:

> *Capital charges will be an element of unit costs which could be greater than the total existing estate maintenance bill.*
>
> *Some UGMs are holding out on rationalisation — this will change.*
>
> *There will be a competitive advantage for providers with low costs.*
>
> *The estate must be revenue generating in the new internal market.*

Those who were doubtful expressed concerns about whether the system would be introduced 'accurately, cleanly and quickly.'

> *I have answered this positively but we must remember that the Royal Institute of Chartered Surveyors questioned the advantages of the capital charge. Until we see it working effectively we must qualify our answer.*

Recurring themes in the critical responses are set out below.

- The lack of understanding of the system of capital charges and its effects by almost everyone, together with the danger of it becoming a bureaucratic paperchase.
- The culture of expansion in the service which was regarded as still strong, and which meant that general managers would continue to resist a reduction in their property holdings.
- The link with space utilisation and the difficulty in changing territorial attitudes. 'It has little meaning to users and they show no inclination to limit their requests for space.'
- The mistaken belief of many districts that they had already completed all the rationalisation that was possible, land holdings were at a minimum, and thus the capital charge would not be a further force for change.

The link between the arcane mechanics of the capital charge and the practical problems faced by managers is not always understood. Use of space in future will be a matter of deciding which of two pathways to go down: to identify surplus space and convert it into surplus property, sell it, gain a capital receipt and in the process reduce the capital charge; or to retain it, use it to extend or develop a new service, generate increased revenue, and thus pay for the continuing capital charge.

The size of the issue posed by capital charges is also not widely appreciated. The Audit Commission has calculated that the capital charge will form up to 20 per cent of a hospital's costs. This will change the traditional balance between staff and non-staff costs in the NHS and should indicate the importance of the issue on the management agenda. Within the estate overhead of a hospital (covering energy, rent/rates, cleaning, maintenance and the capital charge) the capital charge could form as much as 62 per cent of the total. It is therefore important that space, buildings and land are not treated as a left-over, but are seen as always having an opportunity cost.

How charges will work

In order to use the opportunities which the introduction of capital charging brings, managers must understand not just the principles behind it but also something of how the system will actually work. The system works on the basis of a closed loop, although there are possibilities of leakages of funds from the loop into the private sector or through cross-regional boundary flows.

The system is different for Self Governing Trusts, but its application to Directly Managed Units is illustrated in Figure 6.

The overall flow of funds in the system is described in Figure 7.

In 1991/92 contracts will be based on existing patterns and flows. Charges will be assessed, but an equal amount will be credited so no effect will be felt.

Figure 6 Capital charge scheme for directly managed units

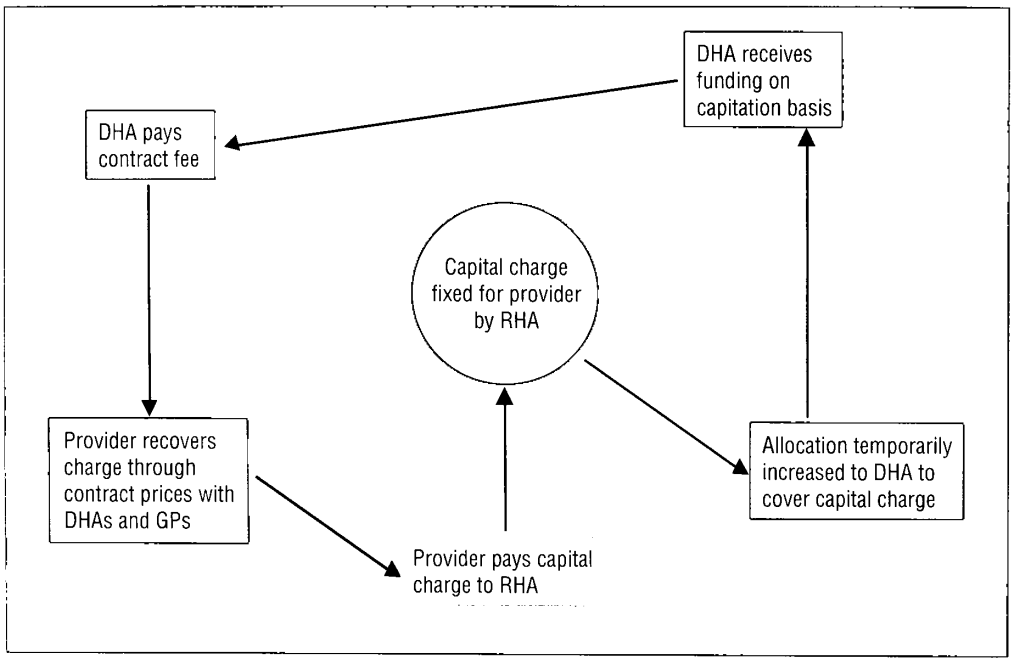
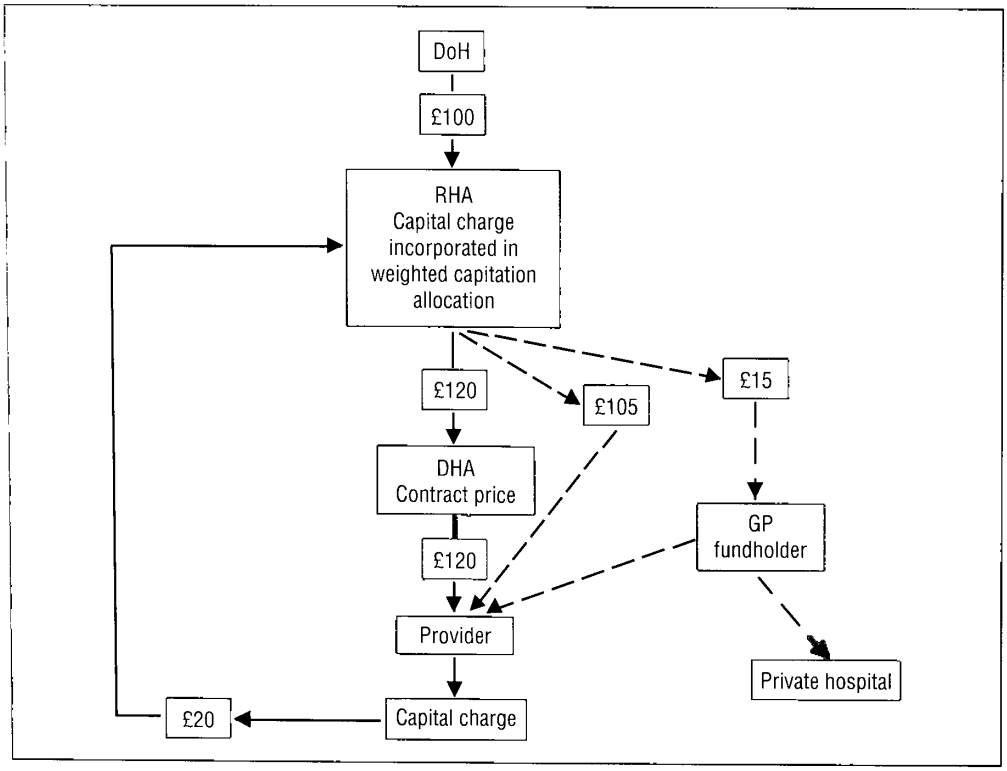


Figure 7 Example showing flow of funds with capital charging



From 1992/93, however, managers may face a loss of overall resources if their total capital charge has increased. It may not be easy to adjust capital spending as quickly as revenue, but that will be a feature of the system and it will force managers to think differently about asset use.

Criticisms of the system

Some people have criticised the potential bureaucracy of the system as for DMUs real money will not be involved. In a discussion about capital charging in the NHS, one Director of Finance has stated:

> *While it is convenient conceptually to envisage the funding of capital charges as a circular flow within each region, Working Paper 9 states that in practice a series of inter-authority accounts will be maintained to minimise cash flows. I have to say that I see great difficulty with this. Surely capital charges will form an integral part of the costs of services for which hospitals will bill health authorities? It must be simpler, more comprehensive and perceptible to have real money changing hands rather than adjusting cash allocations prospectively and/or retrospectively (Kemp, 1990).*

Is this a substantive issue? What is real money anyway? Using cash would cost money — the Treasury must draw it and the Banks will handle it and charge for it. The Paymaster General Office accounts system being introduced from 1st April 1991 will deal with all payments between health authorities. This means that the NHS current account does not have to be funded unless and until funds actually leave the system.

Much comment has concentrated on the very high charges faced by inner city hospitals, especially those in London, and the effect this could have on their viability. Transitional support funding has been provided, but the DoH Capital Charges Unit considers that some hospitals will never get to the end of the transitional period — there will always be a need to adjust for endemic high land values particularly in London in the same way as London Weighting and SIFT recognise special factors. Land values will probably be the only protected factor.

Other criticism has focused on the belief that the system is not commercially based enough. It is suggested that the concept of standard asset lives is a nonsense, and that there should be provision for the creation of a real depreciation fund in the same way as for Self Governing Trusts. It is also argued that valuations should be based on opportunity cost rather than the existing use value, so that the level of 'social benefit' could be made explicit.

A technical concern raised has been the basis on which the district valuer assesses the value of the asset in the first place. His assessment of condition is both subjective and secret. There seems no reason why he should not be able to take account of the formal condition appraisal surveys undertaken by the Estates Department of the health authority and enter into a dialogue on the matter.

The real objective

Sheila Masters, Director of Finance on the NHS Management Executive, has stated that a prime objective of the capital charging scheme is that it should influence managers' action in relation to fixed assets. Whether in regard to existing facilities or to planned new ones, the question to be asked is 'whether the total costs of all services will be sustainable; i.e. can the service with all its costs recovered, be delivered at a price which is acceptable to district health authorities or GP fundholders?'

Capital is thus a revenue issue. The impact of capital charges is not a matter primarily for the Estate Manager or for the Director of Finance. It must be central to the concerns of general managers, of departmental managers, and of clinician budget holders. There is a great deal of education and understanding yet to take place before this is so.

10 | Prospect and retrospect: an agenda for the 1990s

The final chapter draws together an analysis of policy implementation and proposes an action plan to ensure the momentum of the reforms is sustained during the new decade.

Forces for change

The seven years since publication of the Ceri Davies Inquiry Report have been years when the NHS has faced unprecedented pressures. It has become increasingly politicised, more managerial in its culture, and less able to satisfy all the constituencies it tries to serve. It is remarkable that the programme of reforms spelt out in HC(83)22 has been introduced to the extent indicated by the survey results outlined in earlier sections of this report and that estate management remains on the management agenda at all.

Earlier chapters have attempted to analyse both the forces which have helped the Ceri Davies agenda to move forward, and others which have tried to stifle it. Box 7 summarises the main factors which have sustained or hindered change.

The leadership role at the centre has been of undoubted importance. Initially the new appointee Idris Pearce was given a staff of thirty to form the new Estate and Property Management Directorate within the Department of Health. He had a full seat on the then NHS Management Board and was able to establish effective links with the NHS Regions. But this is no longer the situation. The organisational arrangements changed when Idris Pearce retired, and in 1988 the section was amalgamated back into the Estates Directorate. The successor to Idris Pearce, Ian Oddie, sits on the NHS Management Executive as an advisor only and has no power base in the Department.

This change has diluted the influence of those pursuing the cause of effective estate management, and it appears that the agenda of reforms no longer has the importance at the Department that it used to have.

Phases in estate rationalisation

In some ways the most difficult elements of the agenda have yet to be faced. The simpler sites have been sold during an unprecedented property boom; the essentials of the estate database have been assembled; some experience has been gained in information technology and property transactions at district level.

7

IMPLEMENTING CERI DAVIES: FACTORS INFLUENCING CHANGE

FORCE FIELD ANALYSIS

FORCES SUPPORTING IMPLEMENTATION	FORCES OPPOSING IMPLEMENTATION
	MOMENTUM FOR CHANGE SUSTAINED?
Sustained ministerial interests →	← Professional Interests threatened
Key post on NHS Management Board →	← Pressures of the management agenda
Capital receipts add to capital programmes →	← Stagnation in Property Market
Tangible benefits to health authorities →	← Capital income not fully returned to districts
Rayner Scrutiny on residential accommodation →	← Poor value from some land deals
Improved status of Estates professionals →	← Organisational changes following NHS and Community Care Act

In terms of estate rationalisation there are three overlapping general phases which can be identified.

1980-1990	Immediate disposal of smaller easy sites.
1988-1995	Marketing and disposal of complex sites following Mereworth approach.
1990 onwards	Space utilisation studies.
	Internal rationalisation — upgrade rather than new build.

The downturn in the property market, the introduction of a charge on capital assets, continued pressures on the NHS to deliver more than it is able to, the introduction of the internal market and the loss of skills in the estate function are all features of the start of the new decade. A DHA Chairman interviewed during the study believed that managers in the NHS were still not tough enough in their attitude towards the use of buildings, and went on to welcome the new importance given to this issue in the white paper. For the first time there was some recognition that as well as being about looking after patients, the NHS also had a vast estate to care for. The physical environment had begun to move up the agenda. This view gained support from a number of Directors of Estate Management, one of whom said:

> *I personally believe that the issues raised will become more important in a post white paper world, especially as regards NHS Trusts. I expect there to be increased interest in the quality of the environment, reducing areas to the least size for functional facility, and for maintenance to be seen as a higher priority.*
>
> *Buildings and equipment will remain in use for longer and less rebuilding will take place. Option appraisal and value for money studies will increase and more highly qualified people should be involved. Patients and staff views must be canvassed and listened to.*
>
> *Provider units want to know much more about what they own and about its condition — they will want to be proud of it.*

A more pessimistic view was expressed by another Director of Estate Management:

> *The initiatives in the Ceri Davies report have led to a freeing up of under used assets, but the survey work and maintenance/updating of records has a debilitating effect and in my view the use that has been made of the information does not justify the work put into its compilation. Much of the underutilisation is plainly obvious.*
>
> *It is my opinion that if one of the main objectives of the Davies initiatives was to promote capital assets as being a major resource in the minds of NHS staff to rank alongside human and financial resources in the provision of health care programmes, then in general it has failed despite the effort made by estate managers.*
>
> *For the future post white paper world one could be optimistic that the market environment will correct the 'capital free good' misnomer. However, this must be tempered by the forecast demise of the estates function (which runs contrary to industrial and commercial practice in general). It is my view that this demise will reduce the significance of the already weakening Davies policy and do little to help take the provision of health care in an appropriate physical environment into the next century.*

The problem of being swamped by data, and of the time taken to gather it, was commonly referred to by estates staff. Some saw the issue as inadequate resources: 'There is a lack of commitment to the production and upkeep of an accurate database — the issue is not owned by the general manager'. Others identified the problem as too much data and not enough information: 'Too much information is collected with insufficient resources to use it properly. A two year break from new requirements would lead to a better result'. There is, of course, no reason why estate managers should be exempt from the stresses and uncertainties which face many other staff. Many professions face the same pressures outlined by the estate manager who reported that:

> *There will be less flexibility, loss of scale, less goodwill between Units as the competitive edge makes district-wide planning less easy. District mergers may help but districts still won't be able to influence units as they have done. There will be loss of good experienced staff at region and district, lack of understanding of the role and strategic importance of the estate, loss of career structures, downgrading of estates to works in many units.*

In an earlier chapter reference was made to the substantial number of site disposals in the pipeline over the next three years. Rationalisation of services under the pressures of an internal market will continue. The impact of capital charges on the way space is used has already been mentioned. The increased importance of the quality of the physical environment within a competitive marketplace is gradually being recognised. Effective management of energy and other utilities, with fluctuating oil prices, will remain vitally important in helping hospitals to keep their overhead costs down. Thus the Ceri Davies agenda will be more rather than less important in the 1990s and will require high calibre estate professionals on the provider side of the market to build on the achievements of the past eight years.

An action plan for the 1990s

What is now required is a purposeful approach to estate management as the new provider units, both directly managed and NHS Trusts, begin work. A 10-point action plan to raise the profile of the estate and ensure that scarce capital resources are used to best effect is set out in Box 8. All of those concerned with the planning, management and delivery of health services should pay close attention to the steps which are outlined.

8

AN ACTION PLAN FOR THE 1990S

1. Establishment of the WIMS database at provider level.

- Initially this may be undertaken on a consortium basis, but it is likely that, if Trusts increase, independent facilities will be required in each unit.
- Improved training of operating staff in the system. Designation of a database manager with appropriate skills, or linking WIMS management with the role of the IT manager for the whole unit.
  Integration of the system with finance systems.
- Pilot sites funded from the centre to test the potential for linkage with CAD systems.
- Production of regular information in executive summary form for general managers and executive teams.

2. Determination of the organisational option for management of the estate best suited to local circumstances.

- Facilities Management may offer a higher profile for active asset management, but it is not just a new title for former estate managers. it may be too centralist an option for those chief executives keen to push budgetary and management responsibility for all aspects of the patch down to clinical directorate, ward or departmental level.
- Whatever option is chosen, roles and responsibilities must be clearly spelt out. There should be an identified individual at Unit Board level with responsibility for asset management.
- The Regional role in estate management should be agreed. It covers statutory responsibilities, a monitoring role and an enabling role.
- The issues on which the DHA as purchaser will require to monitor the provider should be specified, generally in contract specifications, and in more detail as part of a standard estate audit methodology.

3. The policy on use of capital receipts within the Region should be clarified.

- The existing arrangements should be tested against Estatecode and the spirit of the Ceri Davies report.
- The method by which the RHA makes up the Regional Capital programme should be explicit, and the priorities for expenditure should be agreed with both purchasers and providers.

4. Each provider unit should undertake the full set of steps leading to the production of an Estate Action Plan.

- The Mereworth/Heathbridge planning model should be developed into a business planning format for use by provider units.

5. Units should be required to value assets on a best alternative use basis, to make explicit the opportunity costs involved in decision-making and to encourage an active portfolio management approach to the use of fixed assets.

6. Further work on space utilisation should be commissioned from the Estates Directorate, to extend the studies from the original six sites; to disseminate the lessons of these exercises and in particular their behavioural aspects; and to explore ways of linking the technical issues with decision support modelling tools.

7. RHAs should require formal asset management audits to be undertaken on a regular basis for each provider unit. This would inform the monitoring process and would be a feature in the annual Review mechanism.

8. A range of workshops should be commissioned to assist Trusts to set up the appropriate systems and policies for effective management of their estate.

- Training should be aimed in particular at chief executives, senior managers and clinicians.
- The RHA has a particular role in enabling training and innovation within the Region.
- Seminars should be provided for new DHA members in relation to their responsibility for monitoring estate management in DMUs.

9. Providers and Purchasers should make an explicit move in capital allocation policies towards dealing with the problems of backlog maintenance within a defined time limit, and towards moving the balance away from new build schemes to renovation and refurbishment.

10. Providers should create a standing Property Liaison Group with responsibility for co-ordinating disposals and with a link to the Regional Estates Surveyor. A procedure manual should be prepared for managers and estates professionals at unit level, in conjunction with the Regional Estates Surveyor, to ensure that procedures are known, understood, and can be handed on as staff change.

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