NAYLOR AND THE NHS ESTATE: UPDATE BRIEFING FOR HCT

INTRODUCTION

Since this is an update briefing, it focusses on the key arguments against Naylor, and how we might campaign effectively against sales of NHS land. If you wish to review what the Naylor report is, please read Appendix 1 first.

It is intended that this briefing should stimulate further discussion, so please do not hesitate to criticise and add to its arguments.

ARGUMENTS AGAINST SELLING NHS LAND

The chief arguments that have emerged against the sale of NHS land are:

(A) Sale without a comprehensive estate strategy would be an unprofessional gamble, causing poor value for money and loss of estate necessary for the future

Naylor reveals that the NHS has no estate strategy, and he states that it is essential to create one. He discloses that the NHS has lost the capacity to create such a strategy, and that it will require the creation of a powerful land board to lead the process. Of course, only within a comprehensive land strategy may one identify which land ought to be retained, and which sold, and why. However, Naylor proposes a hasty sale of NHS land *in advance of* the creation of the estate strategy -- an undeniable methodological error. Of this, a senior NHS manager states (privately), "this is arse about face." It is a major professional weakness of the Naylor report. It should be of strong concern to NHS and estate professionals and all those who care about efficiency in public-sector management.

(B) If it is policy to integrate health care with social care, land sales cannot proceed until the land requirements of social care are determined

The scarcity of affordable social care, and the collapse of some private providers means that there will need to be substantial public provision of social care. Until the estate needs of foreseeable social care are determined, NHS land should not be sold, because (1) this land will be needed. It would be scandalous to sell off land only to have to buy it back again at a higher price, or not be able to do so because it is no longer available, and to have to replace it with less suitable or more expensive sites. (2) NHS land is often co-located near to hospitals or other health facilities, where it would be beneficial to locate social care homes, for reasons of safety, economy and convenience. This matter is of great concern to local councils in their responsibilities for health and social care.

(C) The NHS estate strategy should be enabled to benefit from other public land strategies of the Councils and the Government

Other public land strategies than that of the NHS are already in existence or evolving, such as The One Public Estate programme of the Local Government Association and the Cabinet Office. A clearing house of all public-sector land not required by current owning departments and councils should be set up, so that the NHS, and other public bodies, can carry out land swops or land purchases and sales *within* the public sector to improve the

convenience and quality of their land holdings for public purposes. Sympathetic local councils may find some leverage in this argument. As planning authorities, they are responsible for drawing up the land use plans for their localities.

(D) Land sales not complying with the above considerations do not maximise value for money

Naylor and the Government's claim is that their sales policy is driven by financial benefit. However, narrowly targeting short term financial receipts is no way to achieve value for money. Already, this argument is becoming clear – see the example of step-down care, later in this briefing. We need to research further the duties of the District Auditor, or other audits, in today's NHS, to see whether it is possible to challenge NHS accounts for want of delivering value for money when sales are contemplated or made. Under cover of making good the government-contrived underfunding of the NHS, huge land sales are contemplated that would pre-empt the options open to future governments not committed to achieving the "small state", but rather seeking to use greater state investment to stimulate our failing economy. This tactic of pre-emption will cause significant loss to the public.

A POSITIVE MESSAGE FOR ANTI-SALES CAMPAIGNERS

The case against land sales also has a positive aspect: to publicise the wonderful opportunities that the NHS estate holds for the people of the UK. To illustrate this, we should publicise an outline of how NHS land might be used within a proper estate strategy.

ASPECTS OF AN ESTATE STRATEGY FOR THE NHS

National perspective

The estate strategy of the NHS should be formulated at national level, and not fragmented between the 44 STP footprints, since there will be significant co-location and other factors across STP and other boundaries.

Time-scale

Naylor reasonably argues that the NHS estate needs to be aligned with the future clinical direction of the NHS and the integration of services across health and social care.[1] Whilst this in unobjectionable as a general statement of principle, at present, this future clinical direction is being driven by the new models of care proposed in the Five Year Forward View.

The 5YFV adopts two time-frames. It sets itself the objective of meeting the service demands on the NHS for the next ten years. But it also assumes the heroic aim of bridging a deficit gap calculated at between £20bn and £30bn within the five years to 2021/22. However, not one of the UK's expert think tanks believes that this financial target can be achieved, nor that the 5YFV is adequately funded to achieve it. Therefore, only irresponsibly hasty sales of NHS land, prior to the formulation of the missing estate strategy,[2] could have any impact on the financial outcome of the 5YFV.

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[1] Op cit Chapter 5.

[2] Indeed, in answer to a question at a conference about the NHS estate at the King's Fund on 28/09/2017, Naylor agreed that a five-year forward view is too short for any land plan. He considered "at least ten years"

Indeed, the time-scale of the 5YFV is itself under challenge from experts who consider that a 15-year forward view is more realistic, and that the estate time-frame should be 25 years.[3] That is consistent with the land plans of local planning authorities, which extend 15 years ahead, and infrastructure strategies, which look forward 30 years or more.

A comparison made by John Keyes, a planner and surveyor who advises the NHS, is the far smaller and simpler London Olympics project, which was given a £9bn budget, a 7-year time-frame, compulsory purchase powers and an accelerated planning process. "Well, the NHS is more important than the Olympics," says Keyes. However, in contrast with the up-front money allocated to the Olympics, the government is telling the NHS, "'Save money first, in order to invest,' but it would be more realistic to invest so as to save — a pump-priming argument."[4]

A SEQUENTIAL TEST

Sequential tests are common in many aspects of land planning.[5] In the case of any NHS land that may be identified as not being in clinical use,[6] a sequential test should be adopted to determine an alternative use for the land. The test should involve an agreed hierarchy, a list in priority order, of preferred health and social uses against which to test the suitability of the said land. NHS land should be safeguarded from sale into the private sector unless and until it has been demonstrated that all of the following potential uses, listed below in a suggested 6-step priority sequence, have been considered, and rejected for good reason.

(1) Buildings currently in clinical use

The useful life of a healthcare building today is often as few as 30 years. Furthermore, clinical services change frequently, driving frequent internal reorganisation within buildings. Where there is a backlog of maintenance, it will be important in each case to consider whether there is a business case for carrying out the maintenance backlog. This must be compared with a business case for renovating, adapting or even replacing the building.[7] Until these determinations are known, there can be no responsible decision to sell any NHS land that is available for this purpose.

(2) Expansion, replacement, and new facilities

Where the NHS owns land that is convenient for expansion and replacement of facilities, this should be retained. Those who argue that efficiency will *reduce* the amount of estate required by the NHS are overlooking projected population increase and the ageing of the

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to be necessary, and referred to the development of University College Hospital during his 16 years as Chief Executive, a six-phase project, which had only reached stage four by the end of his office.

[3] For example, John Keyes, an estate expert, speaking at the Kings Fund conference.

[4] Ibid.

[5] For example, a sequential approach to development goes to the heart of the planning system. Essentially it means going through a sequence of tests when considering the location of new development. Another example is flood risk management, where a sequential test compares the site you are proposing to develop with other available sites, to find out which has the lowest flood risk.

[6] Including uses ancillary to clinical use, such as administration, laboratories, kitchens, etc.

[7] This determination will be different if the existing building is historic and/or listed.

population. Furthermore, the ongoing specialisation[8] in medicine generates a need for additional specialist equipment and facilities. Moreover, it is far more efficient to preserve the co-location of health facilities by replacing them *on site* than by being forced to rebuild elsewhere.[9] Land in this category must be retained.

(3) Step-down care

Experts consider that it is bad value for money for the government to sell NHS land for private house-building when such land, much of it co-located with hospitals, could be used for "step-down" care to relieve acute beds.

> The revenue benefit from this, over time, far outweighs the sale proceeds of the land … The government is saying 'save money first, in order to invest,' but the more realistic approach is to invest so as to save—a pump-priming argument.[10]

Appendix 2 sets out a rough calculation of this point, by way of illustration. The figures powerfully show that land that is suitable for step-down care should be developed by the NHS <u>urgently</u>.

(4) Residential units for NHS staff

Building co-located residential units for NHS staff mitigates many problems in a single sweep. <u>Housing</u>: NHS staff, many of whom are on average to low pay, already form a significant proportion of those who are in housing need. <u>Sleep</u>: At the same time, they work 12-hour shifts, which, according to recent sleep research, is a factor in reducing life expectancy. <u>Fatigue</u>: Co-located housing mitigates this, and reduces staff fatigue (thus increasing patient safety), by eliminating time spent travelling to work. <u>Prosperity</u>: It also acts to increase pay in effect, by eliminating travel expenses to work. <u>Recruitment</u>: The availability of such accommodation can be expected significantly to reduce recruitment problems faced by the NHS. Whether this housing is "social", "affordable" or at market rents, it is clear that the NHS would be left in profit whichever of these terms of letting pertained. Moreover, the age profile of staff means that more family housing is required than the "nurses' hostels" of yesteryear.[11] This gives us the opportunity to impact the housing shortage significantly and in a targeted way that multiplies the benefits.

(5) Land swaps with other public-sector land

The *One Public Estate Programme*[12] is an arrangement between the Local Government Association and the Cabinet Office to bring all public land owners together to work collaboratively. So far, the programme helps to bring partners together for local projects. It

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[8] which is an aspect of the inevitable ongoing division of labour discussed by Adam Smith in the first three chapters of his *Wealth of Nations* (1776).

[9] For example, the North London Waste Authority is currently replacing its Edmonton incinerator with a new heat and power facility. The size of the Edmonton site permits the new build to proceed on the same site, without disturbing the ancillary facilities and route network of refuse trucks, etc. None of the available space is squandered, since it can be used for ancillary waste management activities such as composting, sorting and waste transfer.

[10] John Keyes, a chartered surveyor and town planner, Head of Public Sector at property consultant Cushman & Wakefield, and advisor to the NHS and public-sector bodies, speaking at MTV Conf 2017

[11] Today the average age of a student nurse is 29, and the average age of a qualified nurse is 47 years.

[12] https://www.local.gov.uk/topics/housing-and-planning/one-public-estate

provides some funding, and it fields dedicated regional teams. More than a quarter of its projects are in Health. Currently, it has £9m of revenue funding to kick off projects, including studies and the development of business cases.

There is a strong case to develop this work into a clearing-house for all public-sector land. In this way, the NHS, local authorities and other public bodies would be able to negotiate land swaps and/or purchases to improve their own estates and assemble required development sites, by securing more convenient sites from other public-sector holders of land.

As an initial step, it is urgent that there is a moratorium on all sales of NHS land until such a clearing house is in place to prioritise the disposal of NHS into the public sector before it is considered for sale into the private sector. This will ensure that, after NHS land has been considered for priority NHS uses, it becomes available for general social housing provided by local authorities.

Campaigners should ask their local authorities to call for NHS land not to be disposed of until it has been considered for other public uses by all local stakeholders.

(6) No unsuitable developments on former NHS land near hospitals
If, at the end of this sequential test, there is a case for selling any NHS site into the private sector, then there must be planning policy in place that prevents any type of development that would be unsuitable near any nearby hospital, for example by causing disturbance to patients or congestion preventing access to ambulances.

POLICY INCOHERENCE

The speedy disposal of valuable NHS land is only one of many attacks facing the NHS. Readers of this paper will be familiar with a range of other policies, some conflicting with others, which attempt to undermine different elements of the founders' intent — a nationally owned NHS, paid for out of general taxation, employing its own staff, using its own equipment and buildings, giving high-quality, comprehensive health care to the whole population, without individual payment by patients.

As is well-known, in 1945 there were sectional interests who opposed some, or all, of these principles from the outset, for ideological reasons and/or for reasons of personal financial interest. When the post-war Labour government was elected on a manifesto that included a national health service, one leading member of the British Medical Association reckoned this was "the first step, and a big one, towards national socialism", in which health minister Aneurin Bevan would fill the role of "medical Führer". Faced with the threat of a BMA strike, Bevan conceded that GPs would retain the freedom to run their practices as small businesses. The consultants were given more money, and allowed to keep their private practices. In Bevan's own blunt words: "I stuffed their mouths with gold."[13]

Similar interest groups, ideological and/or commercial, have continued to agitate against or undermine the NHS throughout its existence. Various right-wing currents, and commercially

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[13] "The Birth of the NHS," Andy McSmith, *The Independent*, 27 June 2008 http://www.independent.co.uk/life-style/health-and-families/features/the-birth-of-the-nhs-856091.html

interested parties, disapprove of the state's provision of services to the public funded by taxation, or they seek to reduce taxation, or want a "smaller state," or want the NHS to contract out a valuable element of its business to them. Some of these policies are in conflict with others, since contractors want their businesses to be underwritten by a guaranteed stream of income from the taxpayer, whilst the tax cuts brigade want the opposite. Logic is stretched when both of these objectives are advocated by the very same person!

It is the existence of multiple different interests who are exploitative of, or hostile to the NHS that has given rise to the confusing array of conflicting policies with which the NHS is attacked,[14] to the dismay of the great majority of us who support the NHS with its founding aims.[15] These multiple attacks are also consistent with the neo-liberal ideology that dominated policy after 1980. As economist Milton Friedman stated,

> the transformation from liberal, Keynesian capitalism to an unregulated free market economy would require "shock therapy". Friedman knew that the implementation of his program of privatization, deregulation and social spending cuts would meet with strong resistance in countries with a powerful labour movement and democratic institutions.[16]

However, as mentioned, the social base of these attacks is different interest groups who, with their lobbyists, have promoted their various policies through successive governments since then. This has resulted in <u>policy incoherence</u>, which is an important weakness that pro-NHS campaigners can exploit.

THE FUTURE OF NHS LAND — A COHERENT METHODOLOGY

The Naylor review is an example of policy incoherence, as is demonstrated by setting out a coherent methodology for determining the future of NHS land, that is:

- the <u>responsible stewardship</u> of NHS land, that respects the objects for which it is designated;
- <u>safeguarding</u> NHS land until it has been subjected to a sequential test;
- a <u>sequential test</u> that prioritises supporting health care, value for money, and the wider needs of the public sector.

Upon these principles, there is scope for HCT to network all our supporters who have the interest and skills to publicise the themes of a beneficial estate plan, and opposition to sales, amongst our supporter groups, local authorities with their planning, housing and

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[14] I am grateful to my colleague Dr. Nollaig Whyte for this valuable insight.

[15] Hence the popularity of the private member's NHS (Reinstatement) Bill 2015, which was presented to Parliament with cross-party support, including the backing of Labour leader Jeremy Corbyn, the SNP's health spokesperson Philippa Whitford, Green Party leader Caroline Lucas and Liberal Democrat MP John Pugh.

[16] Jim MacFarlan, former President, British Columbia Teachers' Federation, in *Just Labour: A Canadian Journal of Work and Society*, Vol 11, p. 81

social care responsibilities, and the general public, and to engage with other campaigners on land use on the themes of “who owns Britain?”, “This land is our land”, etc.

THE GOVERNMENT HAS NO MANDATE FOR SALES OF NHS LAND

The Conservative Party’s Manifesto for the June 2017 general election made no mention of the Naylor review, nor any intention to sell NHS land.

Misleadingly, avoiding any reference to land sales as the intended source of funding, the manifesto promised that the Conservatives would deliver “the most ambitious programme of investment in people, technology and buildings the NHS has ever seen.”[17] This would sustain “exceptional healthcare, whenever, wherever, delivered by an NHS with the money, buildings and people it needs.”

Indeed, the manifesto specified:

> we will increase NHS spending by a minimum of £8 billion in real terms over the next five years, delivering an increase in real funding per head of the population for every year of the parliament.

The Conservatives promised to build and upgrade “primary care facilities, mental health clinics and hospitals in every part of England,” “over the course of the next parliament.”

If the Conservatives did not intend to mislead the public, their opportunity to clarify soon came when, in a pre-election interview[18] with Andrew Neil, Theresa May broadly reiterated the pledges of her manifesto, including the £8 billion, causing Neil to probe how she would fund her manifesto’s investment claim:”

> ANDREW NEIL: The manifesto pledges, quote, “the most ambitious programme on investment and buildings and technology the NHS has ever seen.” Is that part of the 8 billion?
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> THERESA MAY: No, that’s, er, separate, because it’s the money you spend on, as I’m sure you know, Andrew, the money you spend on buildings and capital is separate from the money you spend on the day-to-day running costs. So that money will be following. There’s a report that was done on the NHS, the Naylor Report, which set out what was needed and we’re backing the proposals in the Naylor Report.
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> AN: So how much?
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> TM: It’s £10 billion.
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> AN: And where will that come from?

[17] Conservative & Unionist Party Manifesto, 2017, page 4.
[18] Andrew Neil, interviewing Theresa May, reported in *The Spectator*, 22/05/2017.

TM: That will come from a variety of sources, it's capital money, it's separate from the 8 billion that's going into the National Health Service. But any of this money can only be provided if we've got a strong economy to fund it.

The Government has no electoral mandate for large-scale sales of NHS land. Naylor was omitted from the Conservative manifesto, and when Neil's questioning forced Theresa May to mention Naylor, she specified that the "money you spend on buildings and capital", was wholly dependent on "a strong economy," thereby concealing that the true intended source of such money was to be receipts from the sale of NHS land.

Retaining public sector land for future use is far better value for money than selling it only to replace it at a higher price later. Therefore, there should be a halt on any sale of freehold NHS land or long leaseholds, until all these necessary and viable uses have been competently assessed by democratically accountable bodies spanning the NHS and central and local government.

PRESERVATION OF STATE-OWNED CAPITAL

A final reason to safeguard public sector land relates to the economic prudence of preserving the capital assets of the public sector at this time, rather than erode them.

"Eight billionaires own the same wealth as the 3.6 billion people who form the poorest half of the world's population," Oxfam reported at the start of year 2017.[19] The report also showed that in 2015, the world's richest one percent owned more than the other 99 percent of the population combined.

It is obvious that these figures demonstrate that the world has reached an economic turning point, causing the Bank of England's Chief Economist, Andrew Haldane, to warn that a "rebirth of economics" is needed to replace out-dated models. "The Great Depression [of the 1930s] … brought us [John Maynard] Keynes and the birth of modern macro-economics. Out of this crisis, there could be a rebirth of economics." [20]

This concentration of capital in few hands creates a pathological imbalance – a shortage of effective demand (spending money in the hands of the population, including producers) for goods and services, including production goods, together with the corollary of an oversupply of capital. The latter is why real interest rates have fallen to zero or below. Private owners demand a given return on investment at little or no risk to their capital, but the quantity of productive industries where investment of such a growing mountain of capital is available on favourable terms is limited by the suppressed buying-power of the majority of society.

We in the UK are therefore fortunate that the UK's largest enterprise and largest employer,[21] the NHS, remains largely in public ownership – so far! This gives the next

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[19] Oxfam press release dated 16 January 2017, posted by Melanie Kramers, Senior Press Officer.

[20] Op cit and https://www.theguardian.com/business/2017/jan/05/chief-economist-of-bank-of-england-admits-errors and https://www.holyrood.com/articles/news/bank-england-chief-economist-economic-forecasting-crisis

[21] In fact, the 5th largest employer in the world

government an advantage that many countries do not enjoy. It can deploy the land of the NHS, already paid for and owned by the public, for the public benefit (rather than divest it).

With that "head start", the next government can invest[22] in the NHS, social care and housing in a manner which will stimulate a wide range of related supply chain industries, including construction, IT, medical and technology research, equipment, furnishings, health care supplies, etc.

(Also see two appendices, below)

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[22] The 20th century's most eminent economist, John Maynard Keynes, theorised this experience in his *The General Theory of Employment, Interest and Money* (1935). He concluded that investment played the determining role in the economy: "the fluctuations of output … depend almost entirely on the amount of current investment." This has since been confirmed by modern statistics. Since investment is financed by borrowing, Keynes advocated very low interest rates, such as exist today, to incentivise investment.

But Keynes judged, correctly as it turns out, that this alone would be insufficient to maintain an adequate investment level. It was therefore necessary for the state to play a direct role in setting the level of investment:

> I am … sceptical of the success of a merely monetary policy directed towards influencing the rate of interest … **I expect to see the state … taking an ever-greater responsibility for directly organizing investment** … **I conclude that the duty of ordering the current volume of investment cannot safely be left in private hands** … **I conceive … that a somewhat comprehensive socialization of investment will prove the only means of securing an approximation to full employment**. (emphasis added)

Consequently, Keynes, envisaged an economy in which a private sector existed but in which the state sector was sufficiently dominant to set overall investment levels. (With thanks to *Socialist Economic Bulletin* for this concise summary of Keynes's argument.)

APPENDIX 1 – INTRODUCTION TO THE NAYLOR REPORT

WHAT IS THE NAYLOR REPORT?

The Naylor report[23] is a report by Sir Robert Naylor, the former Chief Executive Officer of University College Hospital, who is one of the government's advisors on NHS land and buildings. In 2015, the Chancellor's Autumn Statement failed to increase the capital budget of the NHS in line with inflation. Instead, it committed the NHS to finding £2 billion from NHS land sales by 2020/21.[24] Jeremy Hunt, the Secretary of State for Health asked Naylor to develop a new NHS estate strategy which supports this target.

Naylor has exceeded his brief, and considers that up to £5.7bn-worth of NHS land and buildings can be sold. He states that the sales proceeds are to be "reinvested" in the NHS. He has arrived at the government's pre-determined solution without comparing the benefit of these sales with the benefit that might be obtained by reasonable alternative uses of the land, other than sales, by the NHS itself, or for social care, or elsewhere within the public sector. Moreover, in today's context of underfunding, and the existence of a maintenance backlog of £5bn to £10bn of works, there is every likelihood that sales proceeds would be diverted to revenue spending, and not comprise "reinvestment" to any material degree. It is notorious that capital sums voted by Parliament to the NHS in the past have been expended as revenue for similar reasons. The 2015 Autumn Statement set a 5-year target. Two years later we need to assess how far any sales, or preparations for sales have got.

WHAT IS THE PRESENT SIGNIFICANCE OF NAYLOR'S REPORT TO THE NHS?

The government is persisting with the failed austerity programme adopted by the Conservative-Liberal Democrat coalition government in 2010.[25] Therefore, it is under-funding the NHS, and wants NHS property to be sold to plug the gap. Such sales would also satisfy an agenda of privatisation, the "small state," and disposing of public assets.

Years of careless reorganisation and neglect have left the NHS without a national estate strategy, and lacking the capability to create one.[26] Without these in place, the proposal to sell-off of £5.7bn-worth of NHS land and buildings is for heedless asset stripping,

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[23] *NHS Property and Estates: Why the estate matters for patients*, an independent report by Sir Robert Naylor for the Secretary of State for Health, March 2017.

[24] *NHS estates: Review of the evidence*, Wenzel et al, King's Fund, October 2016, p. 9. As to the future use of such land, the Autumn Statement posited that the sell-off would release land for 26,000 houses.

[25] Former Chancellor George Osborne aimed to eliminate the government's spending deficit within five years. Ten years later, Chancellor Philip Hammond is still pursuing austerity, and has abandoned plans to eliminate the deficit by 2020.

[26] Naylor recalls that, in the past, "the various estate functions, particularly building and engineering, were well represented at the senior levels of regional, area and district health authorities …" However, "successive reorganisations of the NHS have seriously eroded these capabilities to the extent that they hardly exist today. This has resulted in substantial reliance on external services and serious deficiencies in strategic estate planning." Reforms such as the Health and Social Care Act 2012 "removed the last elements of regional and national strategic estates planning as none of the resulting national bodies have this capability." Therefore "there is currently no overarching estates strategy for the NHS: it is not clear where the leadership for NHS estates strategy lies."

deliberately driven by underfunding, since common sense dictates that such a sale, to be prudent, must be justified rigorously as part of an overall plan of NHS estate management.

Naylor's report outlines the elements that a future estates strategy would have to cover, and recommends that a powerful new NHS Property Board be set up to create and manage this strategy. But a serious land strategy would require time and expertise to collect and analyse more data, consult all stakeholders, and take complex decisions to align the estate with present and future patterns of health and social care, and many other considerations. Despite this, the weight of the report is on estimating the quantity of NHS property that could be sold off briskly, and Naylor recommends that a Property Board be set up immediately "in shadow form" to drive forward the proposed sales as soon as possible.

The report therefore creates an appearance that prudent strategic management of the NHS estate is being rebuilt, whilst providing political cover for the swift sale of valuable NHS assets in advance of any possible creation of a serious estate strategy.

WHY WE SHOULD RESIST THIS SALE OF NHS LAND AND BUILDINGS

Naylor's value to the government, as a former hospital manager,[27] is to coax and cajole current managers, who are hard-pressed by underfunding, to identify and sell precious land and buildings now, to fund patient care—hence the sub-title of his report, *Why the estate matters for patients*. Lest they are not convinced, since competent managers will comprehend how damaging it is not to operate strategically,[28] Naylor proposes that NHS bodies who sell before a tight deadline should be rewarded by a one-for-one payment (i.e. matched to sale proceeds) from the government.[29] And capital investment is to be withheld from those who fail to sell in time, side-lining districts where there is no surplus NHS land, or where speedy sale is impractical.

Poor value for money

The sale of NHS land and buildings, in advance of there being a democratically accountable leadership and estate strategy in place, should be resisted. Pre-empting a considered estate strategy, can only produce poor value for money. Hurried, "incentivised" sales favour the buyer, and distract the seller from seeking the best price. Retaining land for use by the NHS and other public-sector providers will save far more money over time than the one-off sales money from a sale.[30]

Failure to recognise the value of co-location

Naylor ignores the huge significance, and irreplaceable value of co-location. NHS land that is not presently in clinical use is generally co-located with or near existing NHS uses. The

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[27] His nickname "Bob the Builder" does not derive from any formal qualifications such as surveying or planning
[28] First identify land required for future uses, allowing for population forecasts, the co-location of step-down care to relieve expensive acute beds, homes for NHS staff, sheltered accommodation for the elderly, etc. Solving the housing shortage also involves building social housing (for which land already in the public sector is a valuable resource) as against the mainly higher-cost homes envisaged by Naylor. Only at the end of that process would it be possible to identify land as "surplus" to be sold into the private sector.
[29] Objections from districts who are equally in need of investment, but have no surplus land to sell, highlight the irrationality of proceeding prior to having a *national* estate strategy for the NHS.
[30] Examples in the main body of this briefing demonstrate this claim.

value of this land to the NHS is therefore far more than the price that can be raised for it on the open market, because land co-located with hospitals gives economy, convenience, opportunity and other synergies between collateral uses. For example, it is ideal for step-down care to free critical care beds, or as accommodation for hospital staff, or medical research, or training, or laboratories, or for future replacement or expansion of existing facilities.

REASONABLE ALTERNATIVES TO SALE

Naylor is aware that there exist many reasonable alternatives to sale,[31] but he fails to weigh the benefits of those options against the claimed benefits of sale, including financial benefits. For Naylor to choose land sales against the other options is therefore irrational and unreasonable. It is not the outcome of any demonstrated independent analysis, but merely a justification for the government's preconceived, preferred plan.

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[31] He lists some of them.

APPENDIX 2: SIGNIFICANT SAVINGS ARE AVAILABLE BY PROVIDING STEP-DOWN CARE

On average, 6,137 expensive acute care beds are presently out of clinical use due to delayed patient discharge.[32] The cost to the NHS of the occupancy of these acute care beds averages £222 per day[33]. That puts the total cost of the "misallocated" beds at £417,281,110 per year.

Drawing on published figures for the construction of budget to medium-priced hotels gives us around £70,000 per room with furniture and its own en-suite bathroom.[34] So the capital sum required to vacate all 6,137 dischargeable patients from blocked acute beds into hotel-style accommodation is £70,000 x 6,137 = £430 million.[35] Strikingly, a single year's savings nearly recoups the cost of the new build. Even before refining this calculation[36], it is abundantly clear that the provision of step-down care is a money-saving, and beneficial measure which the NHS should take <u>more</u> urgently than a fire sale without a plan. There is no net cost to the NHS, and the NHS would be in profit for the remaining life of those buildings.

The taxpayer should be asking why the NHS is not doing so, since the private sector is already alive to the profits it might make by exploiting the carelessness of successive governments with the NHS estate.

CareRooms, an Essex company, proposes to match convalescent patients with "homeowners [who] will be paid £1,000 a month to 'host' patients in their spare rooms in a bid to combat bed blocking." [37] If this private sector bid to vacate these beds is accepted, this will cost £73,644,000 per year. Is it better for this sum to accrue to CareRooms and similar businesses, or for the NHS to build step-down care accommodation on land that it already owns?

Is it not deplorable that the NHS in Essex is considering this proposal and not building step-down care for itself? What would the public think if they knew?

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[32] "Bed delay transfer figures reveal areas worst affected," Daniel Wainwright, BBC News, England, 23 March 2017.

[33] NICE costing statement December 2015, para 3.18, citing the national tariff 2015/16.

[34] The standard can be gauged by comparing with en-suite student rooms which average £40,000 per unit.

[35] Rounded up to the nearest million.

[36] For example, as to whether the patients discharged to step-down care then have their living costs paid from the budget of the NHS or, as is more logical, paid by the patients and/or social care budgets or housing benefit.

[37] *Homeowners offered £1,000 to host NHS patients in spare rooms in "Airbnb-style scheme,"* Sarah Knapton, Science Editor, in The Telegraph, 26 October 2017.