A new approach to **capital funding and project delivery**

Key points

- Strategic estates partnerships (SEPs) have helped around a dozen trusts to access capital and deliver projects expertise since 2010.
- The SEP model can be extended to cover health economies or integrated care systems with one trust acting as a host for the benefit of the entire economy or system in question.
- Like SEPs, these local development partnerships (LDPs), work best for a series of smaller builds or refurbishments, supported by land or property disposals or redevelopments.
- The LDP can be used by a wide range of public sector health and care organisations, so it can help them to work together to develop the more suitably-located, efficient and modern facilities they need to actually achieve the aims of integrating health and social care. The LDP creates a bigger, long-term, opportunity for private sector partners and investors.

Accessing capital funding for projects big and small has been a major concern for trusts over the last few years – and despite some money being made available, capital funding remains an issue.

Yet many trusts are sitting on unused land or property which could be leveraged to develop improved facilities. This might take the form of disposal to release capital or a major refurbishment to adapt estates for new uses. In the current climate many trusts are struggling even to access funding for much-needed maintenance. Hempsons has developed an innovative way for a variety of organisations within a health economy to work together in a way which secures expertise and releases capital funding to bring projects to fruition.

The model, called a local development partnership (LDP) uses an existing, proven vehicle which around a dozen trusts across the country have successfully procured, operated and adopted – a strategic estates partnership – to progress capital projects across a wider geographical footprint that is aligned to the relevant health economy or system. It builds on the successful features of existing LIFT, LABV (local asset-backed vehicles) and SEP models in the health and care sectors and it is specifically designed to meet the current challenges facing project delivery.

SEPs have been used in the NHS since 2010. A SEP is basically a partnership to cover the strategic development of a trust's estates. It's not the same as a private finance initiative arrangement – a trust entering into a SEP does not offer the chosen provider any exclusivity and is not required to commit to a massive new hospital (or any other development necessarily). Instead, a SEP is a flexible long-term partnership which allows trusts to work within a framework covering a wide range of activities and allowing them to access additional capital.

Potential new projects and services are developed from an initial concept stage through a tried and tested approval process, that enables trusts to decide whether to go ahead on a project-by-project basis. Trusts go through an OJEU procurement process to find a partner and set up a SEP in the first place, but do not have to go out to procurement each time they work with the partner to deliver an individual project within the scope of the SEP.

Up until now, SEPs have been used by individual trusts to address their own estates needs. The model is already attractive to trusts looking for extra capacity and support for their strategy, estates and facilities teams. However, Hempsons believes that the SEP model can be adapted successfully to work across a wider health economy by using one trust as the lead to host and administer the joint venture vehicle, creating an LDP. Others can then use this LDP to develop and, if appropriate, deliver new estates related projects or services. LDPs could be created across integrated care systems and there could be opportunities for other partners such as local authorities and even the third sector to become involved.

Such an arrangement needs to be scoped appropriately from the outset and to use a firm and well established legal structure. Hempsons has previously advised several organisations setting up SEPs, including throughout all stages of the procurement process and during the lifetime of the arrangement.

The capital spending within the SEP or LDP structure will still count towards the Department of Health and Social Care's capital departmental spending limit (CDEL) – which may mean that organisations will need to dispose of an asset to raise the money or to create the headroom to invest in a new one, whilst remaining within the overall permitted capital expenditure envelope. However, local health economies may not need to wait for the CDEL rules to loosen before making real progress. The SEP/LDP model is an iterative one that delivers small projects and service improvements just as well as it delivers the more eye-catching multi-storey car parks, retail developments and intermediate care units.

One of the potential benefits of an LDP structure is that in some cases organisations may want to collaborate with other NHS organisations, to undertake developments that would otherwise be impossible to deliver on their own. For example, this could enable trusts to structure asset ownership and occupations in new more more flexible ways; or they may be able to sequence their projects, potentially using money released by one trust's asset disposal to kickstart a project in another, with both organisations (and the local economy/system) benefitting from the new project that is delivered in the long term.

Private sector partners will bring skills in developing these projects and finding appropriate funding. LDPs may also be more attractive to the private sector than SEPs because they will potentially be bigger in monetary terms and cover a wider geographical area with an increased pipeline of potential projects over at least a ten-year timeline.

The LDP approach is likely to work well for smaller projects and service improvements which can be considered and developed on a case-by-case basis. It is less likely to work for very large new builds. But these smaller developments will also mean that organisations are less exposed to the risks of a builder going bankrupt: there is little prospect of a second Carillion, where a provider insolvency could result in bills of hundreds of millions to get the development underway again. Shorter, smaller projects also allow the supply chain to be re-evaluated as each one is developed and tested. It also means that the value for money of each project can be fully evaluated before proceeding with that individual project.

The non-exclusive nature of the LDP means that if the relevant new project or service will not deliver satisfactory value for money, there is no obligation to proceed with it or to use the LDP to deliver it at all. If needs have changed since the original estates strategy was conceived, it is also possible to go back to the drawing board and develop an alternative – and still deliver it through the LDP.

If you are exploring how up-coming projects can be delivered in your health economy, an LDP is worth considering. It will offer extra options without restricting access to other service delivery routes, frameworks, partners and investors.

If you would like more information or to discuss LDP model further, please do not hesitate to contact the authors.

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