BRITISH BROADCASTING CORPORATION RADIO 4

TRANSCRIPT OF "FILE ON 4" – "ON THE CRITICAL LIST? BRITAIN'S AGEING HOSPITALS"

CURRENT AFFAIRS GROUP

TRANSMISSION:	Tuesday 20th February 2018	2000 – 2040
REPEAT:	Sunday 25th February 2018	1700 - 1740

REPORTER:	Lesley Curwen
PRODUCER:	Rob Cave
EDITOR:	Gail Champion

PROGRAMME NUMBER: 17VQ6238LH0

"FILE ON 4"

Transmission:	Tuesday 20th February 2018
Repeat:	Sunday 25th February 2018
Producer:	Rob Cave
Reporter:	Lesley Curwen
Editor:	Gail Champion

ACTUALITY IN ST HELIER HOSPITAL

FITZGERALD: Here you are. So you're looking at three large boilers that are generating the steam, which is then distributed through all these pipeworks that we're seeing, through to the hospitals. That then will heat up local water to actually provide our hot water and our heating for the whole hospital.

CURWEN: We are in the bowels of St Helier Hospital in the London borough of Sutton - one of the few hospitals still heated by steam. I'm with Trevor Fitzgerald who, as its estates manager, faces a daily battle to keep the ageing infrastructure functioning.

FITZGERALD: So I'm just going to take you into the start of the undercroft. Please do mind your head and we are walking ….
Well, as we go deeper down, you can see that there's very narrow tunnels, etc. These tunnels go across the whole of the hospital. They're the whole distribution for our heating and hot water.

CURWEN: So that hissing we can hear, that's steam which is leaking from the pipes?

FITZGERALD: That's leaking steam, yeah. It's obviously costing me money because that's energy just being wasted, but the problem is that we'd have to do a main hospital shutdown to get to that.

CURWEN: So what effect does it have if you have to shut down?

FITZGERALD: If we were to do it at this time of year, an hour or two shutdown would probably mean that we lose effective heating to our wards for a good eight hours.

CURWEN: So you can't do that?

FITZGERALD: So we can't do it, so we have to plan this in the summer when actually all we're having to worry about is the hot water rather than heating.

CURWEN: It's a well-loved local hospital, but as the plaque by the front door shows, it was opened by Queen Mary in the year 1938. It's even older than the NHS itself. And its age is showing, as patients and volunteers in the tearoom have noticed.

ACTUALITY IN TEAROOM

MAN: It's not at all like you would expect in a modern building, but it functions pretty well under the circumstances.

WOMAN: I mean, it really does need an update. Obviously patient care is second to none, but actually coming into the building, people do get lost.

MAN 2: Well, I know there are problems, because I know water penetrates in various areas and I know there are problems with ancient wiring and plumbing and those sort of things. It's a jumble.

CURWEN: On my tour of the hospital, I saw the water penetration, leaking windows, damp walls and wet floors. And the design of the 80 year old buildings has

CURWEN cont: some real effects on patients' health. Cramped spaces make life tough for the staff, according to Louise Tiernan, Nursing Manager in Accident and Emergency.

TIERNAN: Very difficult to manage. We haven't got a good view of the patients all the time, so that requires extra staff. The area is too small for rapid assessment when they come in by ambulance - we need a larger area, we need a larger observation bay. You know, there isn't enough space between the beds. We've got curtained areas too near the nurses station.

CURWEN: What effect could it have on infections if you have got beds quite close together?

TIERNAN: Obviously it has a massive effect. Infection control is very important to the Trust, so we need to maintain the standards, but it can be very difficult to manage.

ELKELES: I thought I knew what I was coming into when I applied to be Chief Exec of Epsom & St Helier, but it's only when you take up the post and you walk around and you get shown everything that you really understand how hard it is to provide great care.

CURWEN: When he arrived in 2015, Daniel Elkeles soon realised that looking after the two ageing acute hospital buildings - here in Sutton and seven miles away in Epsom - was going to be crucial to the wellbeing of his patients. A visit from the Regulator highlighted that the backlog of required maintenance stood at around £37 million and an outbreak of MRSA had been partially due to a lack of isolation facilities.

ELKELES: So the CQC came after about nine months of me taking up post to do their routine hospital inspection. I am pretty sure that they thought they were going to give us the highest level of enforcement action because of the fabric of the building, but what they saw were so many people working so hard to mitigate the impact of the buildings on the patients, that actually they gave us a lower level of enforcement action, but said, you really,

ELKELES cont: really do need to secure the money to sort out the critical infrastructure of your buildings.

CURWEN: The CQC said they needed to improve, and since that critical report in 2016, further funding has been released to spend on the backlog of repairs. The CQC have been back and Daniel Elkeles is hopeful the next report, due in spring, will recognise improvements to the buildings and care. But the crumbling infrastructure still means they sometimes have to take extreme measures to protect patients.

ACTUALITY OUTSIDE HOSPITAL

ELKELES: So we're now standing outside the children's hospital, and as you can see, it's a building that isn't actually connected to the main hospital buildings. How do you get patients from the paediatric wards to the main hospital, where theatres and x-ray and all the diagnostics are? And the answer is – a lift. So let's go and have a look at the one lift in this building.

CURWEN: So, this one lift – what happens if it's not working?

ELKELES: So when the lift doesn't work, we have to hire ambulances to take people from this building to the main hospital, and we have the same issue …

CURWEN: How far is that?

ELKELES: It's about 20 yards.

CURWEN: And why do you have to hire ambulances?

ELKELES: Because there's no other safe way of taking patients who are ill when you have to go essentially outside to get between bits of the hospital.

CURWEN: So that uses the ambulances?

ELKELES: So we hire our ambulances for that purpose, and there is this building for children, which is like this, but so is the women's health building.

CURWEN: The Epsom and St Helier Trust has a black hole in its accounts - a deficit which, according to the Chief Executive, will be hard to eradicate.

ELKELES: Almost since the Trust was created, almost twenty years ago, it has made a loss every year. The loss this year is almost £40 million and it is increasing every year. And the reason why the loss increases every year is because quality standards improve every year and we have to invest money in additional staff and we can't make savings to equate to the investments we're making. And the reason we can't do that is we're in quite a unique position of running two hospitals with full acute services only seven miles apart.

CURWEN: So you're talking about duplication?

ELKELES: Yes - so we are duplicating six acute services, and it is not sustainable to carry on with this model.

CURWEN: His proposed solution is to change the setup of acute services in future, which would mean the building of a 500-bed hospital on one of three possible sites. It may be controversial, but it is not untypical of the kind of plans we are seeing for the radical redrawing of hospital services.

NAYLOR: We need to rebuild our NHS. It's falling down around our ears.

CURWEN: In March 2017, Sir Robert Naylor, the Government's adviser on the NHS estate, produced a major report which measured the cost of building and repair work to be done in England. He came up with a dizzying figure.

NAYLOR: The normal annual allocation to the NHS from Government for capital spending on major infrastructure costs is £4.8 billion per year. So, taken over a five year timescale, five times 4.8 is £24 billion, so what we're asking for is an

NAYLOR cont: extra £10 billion to top up that amount of money, so that there's sufficient capital for us to substantially reduce the backlog maintenance of many of our decaying hospitals, but also to invest in the new models of care to meet the 21st century demands of healthcare set out in the five year forward view by the Department of Health.

CURWEN: The Naylor Report was a landmark moment. After many years of neglect, the NHS estate was finally under scrutiny. Naylor calculated that half of the £10 billion of extra money would be needed to deal with urgent repairs. But the other half would be needed to rebuild the NHS to deliver new models of care. Under a five-year plan, regional bodies called Sustainability and Transformation Partnerships will reconfigure the NHS estate, concentrate expertise into fewer acute hospitals and provide more care in local GP surgeries and the community. But that's a huge undertaking against a backdrop of what Sir Robert Naylor said was 'historic underinvestment.' Part of the neglect is down to the fact that money earmarked for capital investment - buildings and infrastructure - has been quietly disappearing. Last week, Treasury papers showed that £1 billion had been siphoned off in the last financial year and used to fund the day to day revenue budget. And it's been happening for years, says Nigel Edwards, Chief Executive of the healthcare think-tank, the Nuffield Trust.

EDWARDS: The first problem is that capital has been very heavily rationed by the Government over the last few years. A lot of money that was put aside for capital has been transferred to keep the day to day running of hospitals going, so we've had a backlog of maintenance which has been left undone as people try and make the money go further. So I'm afraid it was a simple cash grab, which was then applied to run the day to day services.

CURWEN: Does that make sense?

EDWARDS: I think it's very short-sighted. One thing we've learnt over the years is skimping on capital does come back and bite you, both in terms of corridors that leak, but also issues about patient care and patient safety, and also you can see it in the fact that the UK has one of the lowest rates of CT and MRI scanners per thousand population of any country in the EU 28 or the OECD.

CURWEN: Those raids on capital, which are set to continue until 2020, mean that some parts of the NHS struggle to cope when the pressure is on. And that can have consequences for patients.

ACTUALITY IN HOUSE OF COMMONS

ASHWORTH: How about my constituent, Mr Geoff Brooker was diagnosed with cancer of the bladder. He had his …

CURWEN: Shadow Health Secretary Jonathan Ashworth in the Commons, asking a question about a patient from his Leicester constituency, who became the public face of the winter pressures.

ASHWORTH: …. and when Mr Brooker was asked about the Secretary of State's apology, he said, 'He may have apologised for postponements, but it was as if he was apologising for the cancellation of a jumble sale.'

ACTUALITY IN HOUSE

BROOKER: … it does if you're in here enough, just in this room. But it's good, love it. Love it.

CURWEN: 69 year old Geoff Brooker is back in the comfort of his own home, stoking the open fire to keep warm. He was diagnosed with bladder cancer last August after he found blood in his urine.

BROOKER: I spoke to the surgeon and he has all the information and he's written down what's happening, and it's words like extensive, aggressive, Grade 1, Grade 2, growth inside a diverticulum, which means in the folds and that's dangerous. And so he didn't recommend a chemical treatment. He wasn't too confident that that would work. Then I'd have to come back and have the operation anyway, and it might have got worse in the meantime, despite this chemical stuff, so bite the bullet, go for it straightaway.

CURWEN: The solution he agreed to was drastic - the removal of his bladder. In December, Geoff was gowned up in Leicester General Hospital, ready to go into theatre. But there was a problem - not enough beds.

BROOKER: So they went off to find the bed or check there was one there and there wasn't one. So they came back and said, it's off really, at which point I said, well, what do I do then?

CURWEN: You had to go home that day?

BROOKER: Oh yes. Yes, had to arrange a lift and get myself back home, unpacked everything and went back to just as before - waiting.

CURWEN: That must have been hard to take.

BROOKER: Well, it was hard to take, isn't it, because obviously you build up to the operation - it sounds silly, but you are looking forward to it – good, great, the day's arrived, great. Everybody wishes you good luck and off you go. You're not supposed to be back that afternoon, waiting to start again.

CURWEN: At the time, he was told the cancellation was due to a lack of intensive care beds, when the hospital was full due to emergency admissions. He was given another date for the operation - January 6th. Two days before the surgery was due came a phone call to say that was cancelled too.
What went through your mind?

BROOKER: Well, thing is I didn't expect it and it just didn't seem right. There's not spare capacity, is there? If there were spare capacity, that wouldn't have happened, but there's very little, so they're jammed up in Leicester, there's nobody to move anywhere else, so the second one should never have happened, should it? That was just wrong, to cancel a cancer operation that had already been cancelled once. Everybody says, be positive, and then they ask a silly question like, 'How worried are you then?' and that's nearly impossible to answer, because I can answer, 'I'm keeping positive, I'm 10/10.' But on

BROOKER cont: the other hand, of course I'm not 10/10, even though I'm trying to keep positive I'm 4/10, I'm … in moments I'm maybe less than that, so it's very difficult to answer that question.

CURWEN: Geoff Brooker finally had his bladder removed a month after the first cancellation. University Hospitals of Leicester NHS Trust apologised that the operation was cancelled twice and said they did not make the decision lightly - it was a reflection of how difficult a position they found themselves in with the increase in emergency patients needing a bed. The Trust had been grappling with a financial deficit of £27 million last year and had a backlog of repairs worth £60 to £70 million. It recently got the funding for a brand new £40 million Emergency Department, but other than that it has had a long history of underinvestment. On top of that, demand is increasing, and the local STP is putting together plans to reconfigure the three Leicester hospitals, plans which call for investment of £397 million over five years. Where will the money come from for projects like this? The once favoured method of obtaining private finance now lies in tatters, thanks to the collapse of Carillion and years of scandals about inflated costs. There are only a handful of projects being built using the new latest version of private finance, including only one hospital.

KERSLAKE: It's fair to say that PFI did a lot in refurbishing our hospitals, albeit at huge cost and all the issues we know about with PFI, but it didn't do the whole job.

CURWEN: Lord Kerslake is the former Chair of King's College Hospital Foundation Trust in London. He stepped down in December, just before the Trust was placed in special financial measures. He's a former Head of the Civil Service and was on the advisory committee to the Naylor report. One of the problems he faced at Kings was how to maintain the huge expanse of buildings after years of severe financial pressure.

KERSLAKE: So if I take, for example, Kings at the Denmark Hill site, we got the new Jubilee wing, but large parts of the rest of the estate now are not fit for purpose and will need replacing over a period of time. And the problem was, in a way, that PFI went, but we didn't establish a new model for investment, and crucially I think the NHS needs a long term investment plan.

CURWEN: How difficult did you find it trying to get money for capital spending?

KERSLAKE: Oh, very difficult, it has to be said, and this works at two levels. There's the capital for the current year, say, to do the repairs and renewals and finish off the smaller projects, and in that situation, I'm afraid, the pressures on the revenue budget have squeezed out capital, so it was very hard to get even one year's capital budget approved, never mind a long term plan. And then there's the bigger issue which Kings …

CURWEN: So did that mean you just didn't spend the money in the end?

KERSLAKE: We spent the absolute bare minimum to keep the show on the road, truthfully, and often we were well through the year before we got anywhere near an agreed number, which is not a way to do capital investment and maintenance. And so we have to think about what's coming next and we must have a thought to what is going to be a hospital that's fit for purpose in 15, 20 years' time - not whether we can make it just about work now.

CURWEN: But there is a new plan, which will generate some of this much needed cash. In his 2017 report, not only did Sir Robert Naylor outline a £10 billion black hole, he also came up with a big idea - to get Trusts and other parts of the NHS to sell off land they don't need to fund building, to get the new model of care the Government wants to see. His task was to assess just how much could go up for sale.

NAYLOR: The original target that we were set was to identify, if you like, wasted NHS assets. These are assets that are not being used or being underutilised, to identify how they can be disposed of in order to raise capital matched by Government funds to reinvest back in improving the quality of the environment of hospitals and primary care premises across the NHS.

CURWEN: And were you given targets about how much could be raised?

NAYLOR: The headline target that was originally suggested was that we should try and identify £2 billion worth of wasted assets and release land to build up to 26,000 new homes, which particularly in the South of England are desperately needed. But it's selling land which is either currently not used or underutilised or selling land in order to raise capital to build new facilities. This is all about regeneration, it's about improving the provision of the infrastructure that the NHS has, which it's been very poor to do so over the last 20 or 30 years, and that's evidenced by the ever increasing level of backlog maintenance. There's no point in pouring money into a hospital that's falling down when you have the opportunity of building a new one somewhere - perhaps just down the road.

CURWEN: Most of the Naylor recommendations have been accepted by the Government. To reach that £10 billion target over five years, a third of the money will come from the Government itself, a third from private investment, and the remaining third - £3.3 billion - will be raised from land sales. The report identified 1,300 hectares of spare land - that's a third of the land owned by acute hospitals, which may be sold. It's already underway. Last year, Trusts sold £200 million worth of surplus land. The Department of Social Care acknowledges it's critical to invest in the NHS estate. They told us they are determined to seize the opportunity and meet the challenge laid down by the Naylor review. But none of this is quite as simple as it sounds, and getting access to the pot of Government money is not just a matter of filling out a form. Saffron Cordery is Director of Policy at NHS Providers, which represents Trusts. She says in the past Trusts have fallen foul of technical conditions, which prevent them from getting their full slice of funding.

CORDERY: I think this is one of the real challenges about our current situation, which is we've got Sustainability and Transformation Partnerships, which are local groupings of organisations, and we also have what are called control totals, which is basically the budget that people must meet at the end of the year. If you either don't meet that budget or you don't sign up to it, then you forfeit access to a number of elements of funding, including capital funding. Now this is a good incentive for those Trusts that can, can actually achieve their yearend targets. However, if you're a Trust that's already in a challenged situation or you're part of an STP that is particularly challenged, then you are going to be pushed further along the path of being challenged by not being able to access these additional pots. So if you are desperately in need of capital investment in order to transform your

CORDERY cont: services but you don't reach your yearend target, you of course are then in a situation where you cannot invest.

CURWEN: One of the Trusts which lost out in this way is Kings College. It was placed in financial special measures in December, the Regulator calling its performance the worst in the NHS. It is now reported that Kings will need nearly a quarter of a billion pounds in loans from the Government to get by in this financial year, and it must pay higher than usual rates of interest. It's faced a perfect storm, with winter pressures, repairs in theatres affecting its ability to carry out operations, and funding withheld because it failed to meet financial targets. Kings admits it has a challenging estate to manage and maintain, but told us it ensures maintenance is completed quickly to ensure minimum interruption to services. Kings' former chair, Lord Kerslake, refused to comment on the Trust's current finances. Lawrence Dunhill is a senior journalist at the Health Service Journal.

DUNHILL: Kings hasn't been able to meet its financial targets, which are called control totals. If Trusts can meet their control totals, they then access their share of what's called the Sustainability and Transformation Fund. I think Kings will have been allocated at least £20 million and so it's missed out on that funding because it hasn't met its targets.

CURWEN: Does that make sense?

DUNHILL: There are lots of people who say that this is a fairly bizarre way to run the system, because those Trusts which are weak and already struggling with their finances are penalised further. This is seen as an effective way to restore financial discipline into local organisations and incentivise them as far as possible to meet their targets, because the ultimate aim for them is for the Department of Health to balance its books each year and avoid an overspend in the overall budget, which is extremely embarrassing for the Department when that happens, and a big deal when it comes to reporting at the end of the year.

CURWEN: Under the new Naylor plans, there will be other hoops to jump through for Trusts seeking money, as Sir Robert Naylor explained.

NAYLOR: It isn't just a question of targets for land sales; it's benchmarking, so we found that there was a three-fold variation in the best performing Trusts in the use of their assets and the worst performing Trusts, and therefore it would be inappropriate to give Government funds to organisations that weren't using their assets very well. So we recommend - and the Government have accepted - to set up a much more sophisticated benchmarking system that can compare performance between different hospitals and different parts of the country. So one of the incentives here is to say to those geographical areas of the country that are performing badly that they should not have access to public sector funds until they've improved their performance, otherwise it's a question of pouring good money after bad, which clearly would be inappropriate.

CURWEN: When you say 'performing badly', what sort of examples would you give?

NAYLOR: Where a hospital, for example, may be sitting on a large amount of poorly utilised estate, perhaps lots of spare land which was underused, or it was using its hospital facilities less intensively than other parts of the country. So this is all about the Government trying to improve efficiency and productivity across the public sector and, particularly in this case, across the NHS, to encourage people to use their assets more efficiently and more productively and not to be given additional funds until such time as they can demonstrate that.

CURWEN: Evidence given to the Naylor Report admits that data on the NHS estate is limited. So how reliable are the valuations of what that land is worth? Lawrence Dunhill of the Health Service Journal.

DUNHILL: Well, there's no real incentive for Trusts to submit their data accurately. There's a complex accounting mechanism which Trusts have been encouraged to use, which is within the relevant guidelines, where they assumed that all their estate could be consolidated onto a single site. It would therefore take up a smaller footprint of land and the book value within their accounts comes down. But this is purely a mechanism to revalue the estate downwards, which then reduces the ongoing capital charges that they have to pay.

CURWEN: This sounds like an accounting wheeze.

DUNHILL: That is certainly how many NHS finance directors would describe it. There seem to be two schools of thought: one where finance directors are very uncomfortable to do this sort of thing and feel that it goes against the grain of their professional guidance. The other school effectively think that, well, you should use every trick in the book, and as long as auditors sign it off, then it's fine.

CURWEN: What do the regulators say to this, if it's deliberately undervaluing the estate?

DUNHILL: The regulators ultimately aren't that concerned about this because their main worry is balancing the books within the revenue account and this is all producing benefit to the revenue account, so they are not concerned about this, and to an extent have been encouraging it. Guidance went out last year, which said this is the type of thing that Trusts should be doing and indeed this is within the national accounting guidance.

CURWEN: We spoke to a former finance director of a hospital Trust who confirmed this does go on. She wants to remain anonymous. Her words are spoken by someone else.

MUSIC

FINANCE DIRECTOR: Capital is really tightly squeezed – the pressure now is on cash, day to day. So understating the value of land and buildings is encouraged. So each year you have to pay a 3.5% capital charge on the total value of your assets, including estates, to the Government. So if you had a site, say, valued at £100 million and you get it reduced to £80 million, you are paying less cash out in percentage terms for the capital charge. Basically, it reduces your deficit, which everyone is desperate to do.

CURWEN: How do you do it in practice?

FINANCE DIRECTOR: So you pay £20,000 or £30,000 to property surveyors. You ask them, where could we build a notional 600-bed hospital in a tall tower which would

FINANCE DIRECTOR cont: contain all our services? Trusts do that and they get £20, 30, 40 million knocked off their asset base. Much of it is legitimate and highly subjective, but there are clear cases, in my view, where people have gone beyond creativity and they have cooked the books. It's the NHS's dirty little secret. It's all about hitting the numbers.

CURWEN: But the really interesting thing is what happens when the Trust comes to sell the land that's been undervalued. Normally, proceeds of selling land, if that land was correctly valued, would go back into other capital spending. But not in this case.

FINANCE DIRECTOR: So let's say they've got a site valued at £100 million. They value it down to £80 million. And if they sell it at £100 million, then they would record a £20 million one-off benefit to their profit and loss account, so they are quids in. They've reduced ongoing costs every year by doing this revaluation, and now if they manage to sell it, they are going to maximise the value. Now the point is, when you sell a public asset, you should immediately revalue it the moment you know its true value. But no one will do that, because, well, why would they? They would lose the opportunity to take a massive one-off benefit being shown on their profit and loss account, and everything is about in year control totals. Throw the kitchen sink at it to improve the position.

CURWEN: We're told there are checks and balances to prevent such windfall gains. But if the account we've heard is true, then hard-pressed Trusts have found a clever way to divert some of the money from land sales back into their revenue accounts. The end result is that, yet again, money which should go back into capital projects is being used to plug the widening deficits in Trusts' yearly accounts. So does this undermine the Government's new drive for billions of pounds of land sales as a way to raise fresh capital? I asked the Government's advisor, Sir Robert Naylor, whether money raised from land sales will be ploughed back into capital spending.
How sure can we be that the money that is raised from land sales will go back into capital rather than being used on running costs?

NAYLOR: The Government's response to our report guarantees that the capital that is raised through land sales will be reinvested back into the NHS directly and on top of the normal annual allocation of £4.8 billion.

CURWEN: And are you confident that will happen?

NAYLOR: Well, the Government have guaranteed it and if you're confident in Government guarantees, then the answer is yes.

CURWEN: We asked the Department of Health and Social Care the same question, but they didn't answer it. Sir Robert Naylor also recommended the setting up of a central body, the NHS Property Board, to oversee strategy for the estate - one of its jobs is to improve the collection and use of data.

ACTUALITY IN CAR

ELKELES: As you can see, it's really large …

CURWEN: Back at St Helier Hospital, Chief Executive Daniel Elkeles drives us to see some land his Trust recently sold to the local council.

ELKELES: So, we're just coming into Sutton Hospital and you can see this first bit of land is becoming a secondary school ….

CURWEN: That money from land sales is part of the pot being spent on urgent repairs, along with £25 million from the Department of Health. But he still needs something like £400 million to develop the 500-bed acute hospital that he would like to build on one of the existing sites, if he gets permission. He thinks there might be another kind of financing that could fill that gap.

ELKELES: At the beginning of the process, we went and approached a number of pension funds and said, 'Would any of you think this was a good investment for you?' and we did quite a lot of work with one of them, which has resulted in a

ELKELES cont: letter where they're saying, in principle, we would want to invest in building a new hospital facility for you.

NAYLOR: I've been struck by the number of sovereign wealth funds and pension funds who've approached me informally, who are interested in investing in the NHS.

CURWEN: Sir Robert Naylor has seen the potential of this too.

NAYLOR: Interest rates are at an all-time low at the moment and now is a great time to take advantage of that. Indeed, there was one major pension fund who provisionally informally suggested that they would be willing to invest up to £5 billion at a starting interest rate of 2%. That's - in inflationary terms - almost free money.

CURWEN: And is this going to happen?

NAYLOR: Well, this is obviously for the NHS Property Board and the Government to decide. I think this is a great opportunity for the Government to take advantage of low interest rates. We need to strike while the iron's hot, while pension funds and sovereign wealth funds are keen to invest money in infrastructure in the NHS and interest rates are at an all-time low. If we wait too long, we may well rue the day that we didn't take advantage of it.

CURWEN: It sounds great - in theory. But in practice, there is a huge snag, as Daniel Elkeles admits.

ELKELES: As it currently stands, whether I get the money to build a new hospital from the Government or from a pension fund, it counts on the Government's debt. So the Government say to the NHS, you can have x billion pounds of capital a year across the whole NHS, and it doesn't really matter whether the capital is coming from the Treasury or the private sector; it's counting against that amount of money that the Treasury have told the NHS they can have. So the limiting step is actually getting the business case for Epsom & St Helier to be right at the top of the priority list of what the Government wants to invest in the NHS in terms of buildings.

CURWEN: How frustrating is that?

ELKELES: Well it's the process that we know we have to go through.

CURWEN: The basic problem is about the strict Government spending limits, which affects even private money spent on public projects - such as the old PFI projects. Nigel Edwards of the Nuffield Trust.

EDWARDS: The problem with private sources of funding of this type is the Treasury limit; they will count against that if they appear on the sort of public balance sheet. And people over the years have worked out various schemes to try and get round that, the most obvious one being PFI. What we've found, however, is that the accountancy standard bodies change the rules and say, well, actually this really is a Government investment, even though the money's come from the private sector and therefore it counts against the Treasury limits, so you bump up against the Treasury limit. And if you're going to make an investment that does that, you will need all sorts of approval, so the availability of the capital is only one of the battles. You've got to get past the Treasury limit and you've got to be able to service the debt, and that debt will be more expensive than the money that you could have got from other public sources.

CURWEN: Any chance the Treasury might change its mind on that?

EDWARDS: The Treasury has got a lot of concerns and quite a lot of this issue about controlling public spending and capital spending is related to the position the British economy will be in when we exit the European Union, and issues about the price of Government debt and other macroeconomic concerns, which are a very long way from the concerns about building hospitals, which are frankly probably a very long way down their list of issues.

CURWEN: It's a conundrum at the heart of providing public services - how to spend money on what we need but without putting it on the Government's

CURWENT cont: books and adding to the public debt. Lord Kerslake, who has become an adviser to the Labour leader, Jeremy Corbyn, doesn't think we should be trying to solve it.

KERSLAKE: Personally, I think Government should bite the bullet and borrow to fund whatever is needed in terms of the agreed capital programme rather than seek to secure it through private finance routes. All the evidence would tell you that the cost of finance is much lower for Government than it is through other avenues, and you can see that in the costs of PFI, for example.

CURWEN: But it would balloon the public debt.

KERSLAKE: Well, I think we've got to think about what we're trying to do here. We are borrowing to fund assets to maintain the health and care and wellbeing of the population. I think that is a perfectly legitimate reason to borrow and needs to be seen in the wider context of what the Government wishes to do on public finances.

CURWEN: With emergency departments under pressure as never before this winter, the Government's aim is to build new models of care, to see fewer, but better state of the art hospitals. The theory is this will ultimately save the NHS money and improve our health. But the big unknown about this visionary ambition is still, will there be enough capital, wherever it comes from, to make it happen? Saffron Cordery of NHS Providers.

CORDERY: I think a lot of the ambitions of STPs, when we are talking about changing the ways of delivering services, bringing in new state of the art systems and services for patients absolutely depends on being able to invest in new buildings, invest in new types of services, different infrastructures, bringing different parts of the public sector together. That all requires capital investment, so we absolutely have to get this right.