Prime Minister (1)

There is big money in this - according to the scrutiny, several hundred million pounds. Agree to welcome this announcement?

Yes pls

PRIME MINISTER

NHS RAYNER SCRUTINY OF RESIDENTIAL ACCOMMODATION

DHSS 13/7

Over the last few months I have been publishing the results of the first round of NHS Rayner scrutinies. Those already published - on transport, non emergency ambulance services, recruitment advertising and central stores - have demonstrated substantial scope for savings in the way the health service runs some of its back-up services. I am pursuing the implementation of those scrutinies both through central action by the Department and through health authorities. The scrutinies have provided important evidence in the public debate about the need for improved general management in the NHS.

I am now ready to publish the fifth of these scrutinies - on the provision of residential accommodation for staff in the NHS. This is potentially the most important of all the scrutinies because of the substantial sums of money involved - the NHS owns over 100,000 units of accommodation, much of which is currently vacant and still more need not be NHS-owned. It also means that we will be able to give another boost - although limited by the fact that the NHS only owns some 20,000 houses - to our strategy of spreading home ownership more widely; where accommodation is no longer needed by the NHS, tenants will be able to buy on right to buy terms.

There have been one or two stories in the press about the possible impact of the scrutiny on the position particularly of nurses, but we believe that this criticism can be successfully rebutted. The attached draft Press Notice, which I intend to issue when the Report is published on 17 July, sets out the case.

I also enclose a copy of the report and the covering letter which I will send to Chairmen of health authorities and to interested parties.

You will see from the report that the scrutineers estimated the potential income from sales as being very large, although I cannot give any precise estimate until we have settled the criterion for retaining accommodation - which I am proposing should be more restrictive than did the scrutineers - and until health authorities have worked out what they need to keep, how much it is worth, the position with sitting tenants, and how to maximise returns.

Nor do I think it is sensible to get hooked publicly on a particular figure at this stage. Our objective in the first instance is to win the argument that it is unnecessary for the health service to keep much of the accommodation which it now has and that selling it can be to the benefit rather than to the detriment of staff. We are also anxious to ensure that health authorities see the benefit which they themselves can gain from selling surplus accommodation in terms of additional finance available for investment. We intend to leave open until the autumn how the resources released should be treated because, if the income reaches the levels we hope for, it may be necessary to treat it differently from the proceeds of other sales in order to avoid particular health authorities benefiting disproportionately and in a way unrelated to their investment needs.

I am copying this to Peter Rees, Nick Edwards, George Younger and Jim Prior and to Sir Robert Armstrong.

13 July 1984

NF

DRAFT PRESS NOTICE

NEW POLICY ON NHS STAFF RESIDENTIAL ACCOMMODATION - NORMAN FOWLER

Norman Fowler, Secretary of State for Social Services, today published plans to release extra resources for the development of health services by selling unneeded houses and flats owned by the NHS.

Mr Fowler said:

"All in all the health service owns over 100,000 flats, bedsitters and houses across the country; and the fact is that too many of them are standing empty. In some Districts up to one-third can be vacant at any time. And in many other cases property is being occupied by people for whom the NHS does not need to provide accommodation. That means the health service has many millions of pounds tied up in property when it could be used to develop services, to build new hospitals and to improve the standard of the staff accommodation which is kept.

"Of course the health service must provide accommodation for some staff - especially junior doctors, nurses in training and staff working in isolated hospitals. What we need to decide is how much. I am asking health authorities and professional organisations to let me have their views by September on the criteria we should use in deciding what accommodation to keep.

"After that, I shall expect health authorities to get on with selling surplus accommodation as quickly as they can. Where it is already vacant it can be sold on the open market. But we certainly do not intend to turn people out of their homes. On the contrary, existing tenants will have the opportunity to use their "right to buy" at a discount, just as local authority tenants can.

It will probably take five years to dispose of all the surplus property we have, but I expect the result to be that many health service staff will be able to buy the homes they now live in and that many millions of pounds will be freed for use where it is really needed - in improving services to patients."

Mr Fowler's proposals were set out in a letter to health authority Chairmen, sent with copies of a Rayner study into health service residential accommodation. The study - the fifth in a series of nine studies undertaken by NHS staff - found that:

- health authorities currently provided over 112,000 units of accommodation for staff worth many millions of pounds;

- "few, if any, authorities had a considered policy on accommodation". Rather the present situation was the "result of historical accident and ad hoc decisions";

- "at any one time nearly a fifth of the total accommodation stock is unoccupied"; in individual authorities the vacancy rate ranges from 4 per cent to 33 per cent.

The report's authors concluded that there was scope for a substantial reduction in the current stock of accommodation.

Mr Fowler has proposed that in future health authorities should offer accommodation:

- to junior doctors, who work in districts for relatively short periods and who often have to be available "on call" near their hospitals;

- to other staff only where providing accommodation is necessary to recruit or retain staff. An example might be student nurses, where there was insufficient accommodation to rent available within reasonable travelling distance.

e has asked health authorities and professional and staff interests for their comments by mid-September, and expects to announce firm criteria in the autumn. Authorities would then have up to five years to sell off accommodation surplus to requirements, wherever possible by selling to existing tenants at a discount off the market value.

Note to Editors

The Rayner study is the fifth one published in the first round of NHS scrutinies. The previous reports covered transport, the non-emergency ambulance service, recruitment advertising and central stores. It was undertaken by Mr Peter Hill, Deputy Regional Personnel Officer, North West Thames Regional Health Authority (currently on secondment to the Department) and Mr Alan Fallows, lately Management Services Officer, Oxford Regional Health Authority.

10 DOWNING STREET

From the Private Secretary

16 July 1984

NHS Rayner Scrutiny of Residential Accommodation

The Prime Minister was most grateful for your Secretary of State's minute of 13 July about the Rayner scrutiny of residential accommodation for staff in the NHS.

The Prime Minister was pleased to note the extensive benefits which should flow from implementation of the scrutiny's recommendations. She warmly endorses your Secretary of State's approach to these matters, and is content - subject to the views of colleagues - for him to proceed with his proposed announcement.

I am sending copies of this letter to Graham Sandiford (Northern Ireland Office), John Graham (Scottish Office), Colin Jones (Welsh Office), John Gieve (Chief Secretary's Office) and Richard Hatfield (Cabinet Office).

David Barclay

Steve Godber Esq
Department of Health and Social Security.

BF with x

BT 12/2

10 July 1984

MR TURNBULL

nbpm Dmb 16/7

c Mr Ingham

NHS ACCOMMODATION

attached.

Mr Fowler's office should be writing to you this week to say he wants to publish a Rayner Report on NHS accommodation. This is a good opportunity to thank Mr Fowler and also to put over a positive message to the public.

The Rayner Report shows that the NHS has over 110,000 units of staff accommodation, and 20 per cent are vacant at any one time. One-third of the units are needed by people like on-call junior hospital doctors with a genuine need. The remainder are occupied by less deserving cases, including even NHS administrators living in houses off site. So the new policy outlined in the consultative paper is to apply clear criteria of need and to sell off the surplus accommodation - possibly 70,000 units - over the next 4-5 years.

At a conservative estimate of £10,000 per unit, this means savings of up to about £0.75 billion over a 5-year period. There may be press criticism that nurses are being thrown out to fend for themselves against Rachmans and rapists. But we can get over four positive points:

i. Deserving cases will not lose out. Mr Fowler proposes to keep accommodation for junior doctors, student nurses etc. And anyway, over 20 per cent of units are vacant.

ii. The savings of up to £0.75 billion will release extra resources: some can be used for health care aimed directly at the patient.

iii. Existing tenants will be given priority, so furthering of the Government's aim of extending home-ownership.

iv. This is a good example of the success of the Rayner scrutinies. The report is in refreshing blunt prose, not boring officialese.

So the message is that improved health care and tough cost-effectiveness can go together.

David Willetts

DAVID WILLETTS

JP

CC(86)6

Dear Chairman

NHS SCRUTINY PROGRAMME - RESIDENTIAL ACCOMMODATION FOR STAFF

I enclose a copy of the report on residential accommodation prepared under the joint oversight of Dame Betty Paterson and Sir Gordon Roberts, Chairmen of the North West Thames and Oxford Regional Health Authorities.

The report's authors estimate that the NHS has a stock of over 110,000 units of accommodation for staff, probably worth over £1 billion. They found that few health authorities had explicitly considered the level of accommodation they needed to provide in order to recruit and retain staff, and in some districts up to a third of existing accommodation was empty. Overall, they judge that a reduction in the present stock by about two thirds is practicable.

The Government is vitally concerned to ensure that Health Service resources are used efficiently and, wherever possible, are spent on services to patients and the community. We agree with the report's authors that there is scope for a considerable reduction in the present stock and propose to establish criteria against which health authorities can judge the levels of accommodation they need to provide.

The purpose of this letter is to seek your Authority's comments on the proposed criteria, which are set out in the annex to this letter. Comments should be sent to [name of official] by 14 September. (We are, of course, also consulting professional and staff interests). I hope it will be possible to announce firm criteria in the Autumn, when we have had the opportunity of taking account of comments received.

Once firm criteria are announced, I shall require authorities to reduce their current holdings to levels consistent with the new policy within five years, wherever possible by selling property to existing tenants at the appropriate discount off the current market price. (The discount to be determined under the arrangements set out in Appendix 32 of the Land Transactions Handbook). This policy will therefore provide a further opportunity of extending home ownership, which is a major aim of the Government.

Authorities will be able to retain a proportion of the proceeds of the sale of surplus property. I shall, however, require them to regard improving the standard of the remaining stock of residential accommodation, where necessary, as a first charge on proceeds.

NORMAN FOWLER

Department of Health and Social Security

NHS SCRUTINY PROGRAMME 1983

RESIDENTIAL ACCOMMODATION

Conducted on behalf of the North West Thames and Oxford Regional Health Authorities by

P A Hill Esq
Deputy Regional Personnel Officer
North West Thames Regional Health Authority

A Fallows Esq
Management Services Officer
Oxford Regional Health Authority

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Additional copies may be purchased from DHSS Leaflets Units, PO Box 21, Stanmore, Middlesex, HA7 1AY - price £1.15. Cheques should be made payable to Department of Health and Social Security.

May 1984

CONTENTS

NATIONAL HEALTH SERVICE
RAYNER SCRUTINY
RESIDENTIAL ACCOMMODATION IN THE NHS

TERMS OF REFERENCE

1. The terms of reference approved by the Secretary of State were: "To examine the very notion of NHS residential accommodation and to look at alternative provision for staff who need to be resident for practical or training needs. To calculate the loss per resident per year to the NHS, and compare with other possible resources including housing associations and local authorities."

STUDY PROGRAMME

2. The approach has been to examine the present system of providing accommodation for staff in the Service and to consider possible alternatives which might be adopted in the future.

3. From the beginning of the study it was clear that the information available on NHS staff accommodation was sketchy. One of the main tasks was, therefore, to establish an acceptable information base from which an examination could be made of the present system of providing accommodation. A census was undertaken in the two Regions initiating the study, North West Thames and Oxford, together with a sample survey of the remaining health authorities throughout England. The examining officers discussed the details of the survey directly with the local officers involved. In all, 47 of the 192 districts in England took part in the exercise.

4. Apart from discussion with NHS managers, staff and staff interests (whose views have been reflected in this report) the study also involved consultation with representatives from a wide range of other organisations both inside and outside the NHS:

- Department of the Environment
- Property Services Agency
- Department of Health & Social Security
- Police Authorities
- Local Authorities
- Housing Corporation
- Housing Associations
- Building Societies
- University Grants Committee
- Private individuals with detailed experience in the housing and property market
- Whitley Councils
- British Medical Association
- Royal College of Nursing
- Royal College of Midwives
- English National Board for Nursing, Midwifery and Health Visiting
- NHS Retirement Fellowship

STRUCTURE OF THE REPORT

5. Our report has four main parts. First, we describe the current position. Then we identify the extent to which authorities need to provide residential accommodation. Third, we outline a strategy for moving from the present position to a more rational one. Finally, we suggest how the management of the remaining NHS residential accommodation could be improved.

THE CURRENT POSITION

6. Statutory framework and Ministerial policy. Under current legislation health authorities have the power to provide residential accommodation for staff, but the duty to do so only in respect of a small number of medical staff - rather less than 3,000 pre-registration house officers who are specifically required by the Medical Act, 1956 to be

resident. Over and above this statutory minimum, current policy, as reflected in paragraphs 173-178 of the Terms and Conditions of Service for Hospital Medical and Dental Staff, is that certain other junior doctors may be required to be resident as part of their conditions of appointment. Various DHSS circulars deal with the mechanics of administering accommodation arrangements for other categories of staff, but there is no central overall policy guidance.

7. The present stock. Our enquiries show that health authorities provide much more residential accommodation than necessary to meet the statutory requirement. We estimate that authorities have approximately 112,000 units of accommodation. These comprise more than 20,000 houses and flats and more than 70,000 residential places in bedsitter and hostel-type blocks. There is tremendous variation between districts, but on average each DHA has the capacity to provide accommodation for over 500 staff - about 10% of its work force - and manages on average 100 houses and flats and between 300 and 400 residential places.

8. Who is accommodated ?

We estimate that approximately 11,000 junior doctors (out of the total of approximately 21,000) live in health authority accommodation. The main staff group accommodated is nurses; our sample suggests that approximately 35,000 learner nurses (out of approximately 79,000) and 29,000 other nurses (out of approximately 371,000 - 155,300 part-timers, 215,700 full-timers) live in Health Service accommodation. Much smaller numbers of other staff groups are accommodated. At any one time nearly a fifth of the total accommodation stock is unoccupied; in individual authorities the vacancy rate ranges from 4% to 33%.

9. Authorities' policies. We discovered great variations both in the amount of residential accommodation DHAs provided and in the categories of staff to whom it was offered. The most striking finding was, however, that few, if any, authorities had a considered policy on accommodation. Rather, the level of the present stock and the categories of staff living in it, are in large measure the result of historical accident and ad hoc decisions.

10. How much is the stock worth ?

Health authorities have little systematic information about the value of their properties. In this situation, and without a survey of each property by a valuer, it is difficult for us to give a soundly-based national estimate. Some property probably has little or no market value - nearly a quarter is integrated within the main hospital fabric. (It may, however, have value to the NHS, by virtue of possible alternative Health Service uses). A third of the total consists of free-standing purpose-built accommodation on hospital sites. The remainder consists of off-site properties either owned, leased or rented by the NHS. Some of these are extremely valuable - we heard of one house which with planning permission was sold for approaching £600,000. On the assumption that each unit is likely to be worth at least £10,000, we estimate that the total stock must be worth in excess of £1,100,000,000. Taking a very conservative view, based on information supplied by districts themselves, there are nationally over 8,500 off-site properties which are potentially saleable. We judge these to be worth on average at least £20,000 each. As a minimum, therefore, the market value of this part of the stock would be £170,000,000.

11. Forward capital programmes suggest that £75,000,000 of further capital expenditure is scheduled during the next six years.

12. What does it cost the NHS to service and maintain the stock ?

As capital is a "free good" in the NHS, the cost of maintaining the stock is artificially low, taking little account of depreciation and no account of the cost of having at least £1,100,000,000 tied up in fixed investment. Since the abolition in 1977 of the requirement to maintain a specific account most authorities seem to have abandoned the preparation of any form of accounting for residential accommodation as a specific item. The accounts we studied had obvious limitations. There were discrepancies where global figures had been allocated; for example one DHA showed the annual heating costs of its residences to be a mere £8.36 per unit. Overall we estimate that, nationally, providing residential accommodation costs the NHS at least £65,000,000 per year in revenue alone and that the income collected from staff is of the order of £41,000,000. In effect, therefore, the NHS is subsidising each person among its 95,000 staff who live in residential accommodation to the tune of at least £5.00 per week before any account is taken of the capital investment. We are aware that under current Whitley agreements staff are required to pay increased rent charges which are being brought somewhat more in line with the economic costs. We feel it should be mentioned, however, that even these increased charges do not reflect the true cost to the Service of providing the accommodation.

THE NEED FOR HEALTH AUTHORITIES TO PROVIDE RESIDENTIAL ACCOMMODATION

13. Having discovered the extent of provision, we next discussed the question "why should the NHS provide any residential accommodation at all ?". After all, the overwhelming majority of employees in all other industries or occupations are either owner-occupiers or rent their homes privately or from a public housing authority. Providing residential accommodation is not a prime purpose of a health authority; it generates much work, and diverts scarce managerial time from other purposes. We were reinforced in our wish to find satisfactory answers

to this fundamental question by the fact that many of the staff we spoke to saw real drawbacks in living in NHS residential accommodation. First, as has been highlighted by the Nursing Mirror study, many units of accommodation are in a poor state of repair, and DHAs were often reluctant to improve them. Second, being in residential accommodation might seem an advantage at first, but in later life many staff realised that it has delayed their entry into the housing market, with the associated benefits of security and the building up of personal wealth. Third, there are problems when leaving the employment of the DHA - either to work elsewhere or on retirement. For example, nurses who retire having lived in a health authority flat for ten or twenty years suddenly find they have to make alternative arrangements, losing their home as well as their job.

14. "Operational Need". This was the main reason advanced by authorities and their senior officers for providing residential accommodation. This took various forms:

i. it was essential for some staff to live in or near the hospital in which they worked to maintain services to patients

ii. without providing accommodation authorities could not attract staff because:

(a) the hospital was remote and there was no other housing, or

(b) property in the area was too expensive, or

(c) the district was generally an unattractive place in which to live and offering accommodation gave a compensating "edge" in the recruitment market, or

(d) "short-term" staff, such as junior doctors working in the district on rota for six to twelve months, could not reasonably make any other arrangements

15. Other reasons advanced were:

i. accommodation was needed for newly recruited staff from other areas to occupy on a short-term basis, while they looked for permanent accommodation;

ii. junior doctors/learner nurses needed to live in residential accommodation as an integral part of their training;

iii. accommodation was needed for very short-term visitors, such as visiting tutorial staff

We have considered all these reasons in detail.

16. Staff need to live on or near the hospital site to maintain the service to patients. The argument here is essentially in respect of junior medical and some nursing staff. It is certainly the case that many doctors are "on-call" at times when they are not undertaking planned work such as clinics, ward rounds and operating sessions. It is for individual consultants to judge what "on-call" means in particular circumstances. In some specialties it might, for example, be quite satisfactory for a doctor

to be constantly obtainable by "bleep" provided he was within, say, thirty minutes travelling time of the hospital. In other cases "on-call" might mean being physically present on the hospital site. In such cases, however, the corollary is not necessarily that the doctor concerned should live in NHS accommodation. Rather, it is that adequate "on-call" rooms should be available for whichever members of the clinical staff need to be "on-call" at any particular time. Similar arguments could be applied to support the case for the provision of "on-call" rooms for those paramedical staff who would appear to meet the same criteria as doctors and nurses insofar as the element of direct contact with patients is concerned. In view, however, of the small numbers involved, it would seem that such accommodation can easily be incorporated in the calculations relating to medical and nursing staff.

17. The hospital is too remote. It is certainly the case that some hospitals, particularly mental hospitals, are some way from major towns. We have, however, yet to find an example of a hospital which is more than ten miles from several villages and small/medium sized towns. Where the problem is lack of public transport (and this can be a real problem over much shorter distances) it is open to authorities to lay on, and charge reasonable fares for, staff transport.

18. Property is too expensive. While we accept that in certain districts the argument that property is too expensive holds some weight, in general it seems to be overplayed. Apart from some more obvious examples in inner-city areas, there are not many hospitals without average-priced property within reasonable travelling distance. If it is the case that in certain areas learner nurses' pay is too low for them to be able to afford private accommodation, or even to rent local authority accommodation, the rational response would seem to be in the area of adjustments to renumeration rather than for the NHS to provide residential accommodation.

19. Unattractive Districts. There is evidence that, particularly for staff groups in very short supply such as the professions supplementary to medicine, some districts are markedly less attractive places in which to work or live than others. The offer of residential accommodation may well help such districts. In the circumstances the "carrot" of residential accommodation is, in effect, a supplement to pay. We believe it would be more straightforward to tackle problems of mal-distribution by other means rather than by increasing the extent to which health authorities are in the essentially ancillary activity of managing residential accommodation.

20. "Short-term Staff". The need for accommodation for staff who it is known in advance will work in particular districts only for a very short period is a very real one. Some DHAs help such staff find private or local authority rented accommodation and have good long-term relationships with the local authority and landlords concerned. We believe that often this should provide a satisfactory alternative at much less cost to the authority. Where, however, it could be demonstrated that there was no accommodation to rent within a reasonable travelling distance, and no "pool" could be generated by the prospect of a regular flow of NHS tenants, an operational need for residential accommodation would exist. We would, however, expect such situations to be rare.

21. Transitional accommodation for newly recruited staff from other areas. Many other employers face this problem. Most expect (and may help) staff to find short-term rented, or hotel, accommodation until they make permanent arrangements. Authorities may pay staff moving in such circumstances a transitional allowance. It would seem preferable for this arrangement to be developed rather than to use this factor as an argument for retaining expensive residential accommodation.

22. Junior medical and nursing staff need to live in residential accommodation as an integral part of their training. For junior doctors (mainly pre-registration and early post-registration house officers) the argument is essentially that they need to have had the experience of living at a hospital 24 hours a day, 7 days a week. This argument sits alongside the "on-call" one, for in the case of junior doctors being on-call, in their own right and covering for others as required, for much of the week, "home" and "hospital" must become largely indistinguishable. This is the very group who work in districts for a relatively short period. We conclude, therefore, that there is an operational and training need for some residential accommodation for junior medical staff, and believe it to be between the level needed to meet the present statutory requirement and the present 11,000 places occupied by medical staff.

23. For nurses, the argument is rather different. In essence the argument put to us is that having learners in residential accommodation for their first six or twelve months is an essential feature of training as it enables "discipline" and "esprit de corps" to be engendered. This is accompanied by the argument that the nurses concerned are relatively young, often living away from home for the first time, and moving to residential accommodation offers a "half-way home" between living at home and living independently in local authority or privately rented accommodation. These arguments can be seen as patronising and a statement of the inadequacy of trainers who, it could be argued, ought to be able to train their students to be responsible nurses without putting them through the experience of "living-in". We feel, however, that there is some force in these arguments and would regard it as appropriate but certainly not essential, for authorities to decide to provide residential accommodation for first year learners.

24. Short-term Visitors. We regard this as an entirely fatuous reason, with hotel accommodation providing the obvious answer for visiting lecturers.

25. Overall conclusions on need for residential accommodation. In summary, in our judgement the "essential need" is at most for residential accommodation for:

i. some junior doctors, perhaps 8,000

ii. first year learner nurses, a maximum of 29,000 places (if the average length of residence were reduced to six months, this would of course reduce to 14,500 places)

iii. exceptionally, where no local authority or private rented accommodation is available, or could be generated, for short-term staff. Possibly 2,000 units of accommodation might be needed to cover this category.

We would thus envisage a possible reduction from the present 112,000 units of accommodation to no more than 39,000 (and, depending on authorities' decisions about providing NHS accommodation for first year learner nurses, possibly considerably less). In addition, we envisage that adequate "on-call" rooms should be available for whichever members of operational staff need to be "on-call" at any particular time.

ADVANTAGES OF REDUCING THE STOCK

26. Before proposing a strategy for reducing the stock as envisaged above, we summarise the advantages and disadvantages of such a policy:

- a once-and-for all tranche of money from the proceeds of sales. This is likely to be at least £170,000,000 from the sale of off-site properties which have already been identified by districts as potentially saleable; it could

rise to as much as £750,000,000 if full advantage were taken of the development potential of certain properties and if it were possible to include all detached on-site residential accommodation in the sales programme.

- a considerable reduction in new investment on residential accommodation - perhaps reducing the proposed £75,000,000 expenditure over the next six years by three-quarters.

- a considerable reduction in the cost of managing residential accommodation, which we believe to be broadly proportional to the number of units. In the short-term this might be offset - indeed more than offset - by the need to help generate a pool of rented accommodation (discussions and setting up arrangements with local authorities, housing associations, private landlords etc).

27. By way of disadvantages, there would certainly be some loss of "flexibility" - for example to offer a "carrot" to attract staff who might otherwise go elsewhere, and some loss of convenience - being able to offer new staff or visitors short-term accommodation.

THE MAIN OPTIONS

28. If our view is accepted that the "essential need" for residential accommodation is well below the present stock, two issues arise:

    i. should authorities be required to reduce their holdings to such as would meet "essential need" as described in paragraph 25, i-iii above or should districts continue to use their discretion to provide accommodation over and above "essential need" ?

ii. what strategy should be pursued to ensure either that authorities reduce their stock to "essential need" level or positively review their stock so that it is at a consciously chosen level ?

29. Our view is that the reasons for holding residential accommodation over and above that required to meet "essential need" take insufficient account of current circumstances in the Service, and that the benefits of disposing of such property are very tangible. Further, given the uneven pattern of demand for residential accommodation at present, and the apparent lack of a common approach to accommodation strategy, we expect that some authorities would not make rapid progress towards a lower level of accommodation holding. We therefore feel that authorities should be required to reduce their holdings to the "essential need" level as quickly as practicable, and to hold it at that level.

30. As to implementation, given our preference for a national policy initiative, we believe that the right approach would be for the Secretary of State in consultation with the Regional Chairmen to require authorities to determine local requirements taking into account the definition of "essential need" as outlined in paragraph 25. This should be followed by an action plan for the disposal of accommodation surplus to those requirements, incorporating alternative arrangements to encourage staff to take up accommodation outside the NHS, as discussed in subsequent paragraphs.

31. We suggest therefore that, as a first step, all health authorities should be required to analyse their current stock of residential accommodation (a specimen questionnaire is attached as Appendix I). The next step would be for them to assess their operational need on the criteria in paragraph 25. The third step would be to produce an action plan for the reduction of stock to the requisite level. In

Appendix II we outline a scheme which authorities could adopt without legal difficulty. We believe that this approach, together with the arrangements for the re-accommodation of staff in the "low priority need" categories, will achieve a large proportion of the required reduction within five years with minimal disturbance to staff. Such a policy could involve offering some accommodation to existing tenants at, we suggest, the same sort of preferential rate at which council houses are sold.

32. We are, of course, aware of the comments contained in the Ceri Davies report with regard to the proceeds arising from the disposal of surplus property. In general, we favour giving authorities a direct incentive to maximise proceeds from the sale of their properties. We also agree with the view that there are circumstances when it would not be right for authorities to retain all these proceeds. For example, this could unfairly reward those with, by historical accident, a large stock and take no account of the relative health needs of districts. In addition, the suggestions noted below give rise to the need to consider the redistribution of some of these funds. We suggest that authorities be allowed to retain at least 50%. Some of the remainder should go towards a pump-priming exercise to encourage local authority and Housing Corporation initiatives as indicated below. The remaining funds would be the subject of some sort of pooling and distribution system to be worked out by RHAs.

RE-ACCOMMODATING STAFF WITH THE ASSISTANCE OF ORGANISATIONS OUTSIDE THE NHS

33. There appears to be much scope for re-accommodating "non-essential" staff by such means as the expansion of programmes of collaboration with such interests as local authorities, housing associations, development corporations and possibly private developers.

34. It seems to us that this sort of activity might well be accelerated to the benefit of all parties by an appropriate transfer of resource from the Health Service into the pro-

vision of housing to meet the particular needs of the Health Service. Through a very simple system of percentage-based nominations similar to the Local Authority National Mobility Scheme, some of the problems of long-term under-used property might be avoided. Indeed, a start in the right direction has been made with the introduction of the DHSS circular on Care in the Community. The problem would still appear to be the provision of financial support to the very worthy proposals contained in the circular. It would seem, therefore, that to encourage this type of development, it would be desirable for central government to make NHS monies available to local authorities. One way of obtaining at least part of the funds required could be to earmark some of the money obtained by the sale of excess or under-used properties. One further possibility is that local authorities could undertake responsibility for the provision of on-going management of NHS residential property or, in fact, utilize housing associations to carry out this task.

35. This takes us on to the consideration of the possibility of the direct involvement of housing associations in these arrangements. A possibility here is that money could be made available from central government to the Housing Corporation which would be in addition to existing allocations granted to the Corporation, exclusively for the provision of NHS residential properties. Once the "NHS money" is directed into the Housing Corporation allocation system there would appear to be no reason why the provision of such new accommodation could not be carried out as in housing association new build development, utilizing the criteria and procedures already in existence as laid down in the Housing Corporation scheme work procedure guide. Such accommodation provided in this way would be the subject of a housing association grant and would, therefore, be let on a fair rent basis to those individuals who were responsible for their own housing costs. One major advantage would be that the NHS already possesses land on which some of this can be done.

36. Obviously, it would be impossible to get such an approach off the ground at individual district level unless agreement in principle has previously been reached at national level. It would seem sensible for the appropriate Government Departments to consider the transfer of resources from the National Health Service to local authorities and to the Housing Corporation to enable these authorities to assist in meeting some of the accommodation needs of Health Service staff. Negotiations could then take place nationally between representatives of the Housing Corporation and associated housing associations, local authorities and the NHS, to:

(a) agree a formal pattern of working at regional/district level

(b) agree an initial programme of experimentation by health authorities in joint venture schemes

37. It may be appropriate to co-ordinate such development under the aegis of the National Property Advisory Group, whose creation is recommended by the Ceri Davies report.

38. The building society industry could also become a useful partner in the disposal of NHS properties and land. It has been suggested that an appropriate approach might be made to the Chairman of the Building Societies Association, to seek specific ways in which societies could help. We have every reason to believe that this would be a most fruitful avenue to explore. The aim would be to achieve central strategic support for subsequent negotiations between district health authorities and building society regional offices. To support this approach we cite the example of the Abbey Housing Association, sponsored by the Abbey National Building Society, whose objective is to provide low cost housing for sale on a non-profit basis, by developing land surplus to requirements or possibly refurbishing older units.

IMPROVING THE MANAGEMENT OF RETAINED ACCOMMODATION

39. There is considerable variation in the way NHS accommodation is managed. Different functions and disciplines - general administration, personnel, finance, works, nursing - all contribute to the administrative effort but in no consistent pattern. Management of the property is often delegated to managerial units, thus reducing further the number of properties looked after by each manager. Such small holdings are not likely to be conducive to efficient management.

40. It became clear at the outset that there was a dearth of management and financial information to enable managers to control the accommodation resource effectively. There is very little evidence to show that residential accommodation is thought out as part of an overall policy; rather, it is left to fairly low levels of management in the structure to exploit what is largely an inherited resource. There is an urgent need for reappraisal of the existing management and financial arrangements - the reporting processes in particular.

41. With regard to the management of the operational situation, it is hoped that two major factors would be very much to the fore:

    i. the need for senior officers at district to be involved in the monitoring of the process in such a way as to ensure that there are firm links between the strategic and operational aspects of the problem

    ii. the need for a more commercial approach to financial management

42. Management arrangements vary enormously. In some cases, management is centralised at district level, in others it is a unit responsibility. A few districts employ a specialist housing manager with accommodation as his/her central responsibility with in our view significant benefits. Managers who are not specialists often seem to give a fairly low priority to accommodation as compared with work more directly in support of patient services.

43. The evidence from the survey, therefore, would lead towards a preference for a structure based on the appointment of a specialist housing manager rather than one which involves fragmented responsibility. Although much will depend on management style and geography at district, the key element is the existence of a clear pattern of managerial accountability to the District Management Team.

44. Whatever pattern of management is adopted, there will be a need for authorities to operate within a framework which obliges them to compare the benefits and costs of providing accommodation. Such a framework should:

i. encourage a frequent review of their aims in providing accommodation as circumstances change

ii. lead to the search for more cost effective ways of achieving these aims

iii. ensure that in providing accommodation they manage this efficiently so as to minimise the cost to the NHS in the long run

45. We do not believe that the present situation comes anywhere near this ideal. We set out below some suggestions for improvement arising from our analysis of the issue:

Memorandum Trading Accounts

We considered the possibility of using Memorandum Trading Accounts for residential property to reveal the extent of the implicit subsidies. The investigation of "unreasonable" subsidies could then be the responsibility of audit or might feature as an issue in regional reviews.

The Association of Health Service Treasurers has set up a working group to produce some common rules for allocating expenditure that is not directly charged to residences. We understand that they are also considering the reintroduction of a form of Memorandum Trading Accounts - a development which we strongly support.

Performance Indicators

We refer above to the need for more adequate reporting mechanisms to senior management. Although changes to the financial framework will do much to improve the situation, we also feel that authorities should become aware of the way their existing stock of staff accommodation is used and how it meets the purposes for which it is held. A basic requirement here is a set of tools for monitoring performance. We suggest the following additional information is or could be readily available and would be useful to local management:

i. occupancy rates of each property

ii. percentage of resident staff by staff group

iii. percentage of staff in residence for over one year/two years/five years

iv. percentage of rents abated due to condition of property; percentage abated for other reasons

Such basic information can also be made available to regions and through them to the DHSS enabling a wide range of comparisons to be made between districts by the districts, by regions and by the Department. This should aid each level in judging the policies it pursues in relation to residential accommodation.

Periodic Reviews of the Stock

From our enquiries it appears that current reviews of accommodation stock are irregular and far from universal and where they do take place amply repay the effort they entail. We recommend, therefore, that whether or not the wide ranging changes discussed in this report are implemented, authorities should be encouraged to undertake periodic reviews, paying particular attention to any changes in market value and site development potential. We believe the maximum interval between such reviews should be five years.

SUMMARY OF RECOMMENDATIONS

46. The summary of recommendations which follows is divided into three groups - recommendations which require initiative at national level, those which call for action by regions, and those which require action by districts.

47. These are aimed principally at reducing the NHS involvement in the provision of staff accommodation by suggesting a more realistic approach to the definition of need, establishing alternative arrangements for staff with a lower-priority operational call on accommodation, and putting forward improvements to the general arrangements for the management of the resource.

Action at National Level

1. The Secretary of State, in consultation with the Regional Chairmen, should:

   (a) promulgate a definition of essential need as described in paragraph 25 i-iii of the report

   (b) require all health authorities to analyse their current stock of residential accommodation using a form such as that at Appendix I and to give their assessment of operational need using the criteria in paragraph 25

   (c) require all health authorities to dispose of accommodation surplus to their operational needs, on the lines described in paragraphs 30-38 and in Appendix II of the report

2. The Secretary of State should arrange for the appropriate government departments to consider the possible transfer of resources from the National Health Service to local authorities and to the Housing Corporation to enable these authorities to assist in meeting some of the low-priority accommodation needs of Health Service staff. This action will be needed in order to facilitate the arrangements described above which are aimed at encouraging staff to transfer from in-house accommodation.

3. Negotiations should take place nationally between the representatives of the Housing Corporation and associated housing associations, local authorities and the NHS, to:

   (a) agree a formal pattern of working at regional/district level

   (b) agree an initial programme of experimentation by health authorities in joint venture schemes

4. The Secretary of State should also initiate national discussions with representatives of the building society industry to seek ways in which societies can help in dealing with the situation, particularly with regard to the disposal of NHS properties and land, and in the provision of low-cost housing for sale or rent on a non-profit basis.

5. Pending the outcome of these national negotiations, it would seem sensible for Whitley Councils and any bodies set up to succeed them to consider deferring further discussion on any agreements involving staff accommodation.

Action by Regions

6. Each region should agree with its districts a regional programme to facilitate the developments projected in this report.

7. Each region should monitor progress through the Regional Review process.

8. Each region should ensure that a periodic review of accommodation stock is incorporated in its strategic plan.

9. In the light of the findings of this review, each region should appraise any proposed programme of capital expenditure involving staff accommodation.

Action by Districts

10. Each district should urgently review its management procedures in order to:

(a) establish a clear pattern of managerial accountability and financial reporting to the District Management Team

(b) establish an appropriate procedure for monitoring the utilization and management of accommodation using the performance indicators mentioned in paragraph 45 in the main report.

(c) initiate, in conjunction with the region, a system of periodic reviews of accommodation stock with particular reference to any variation in market value and site development potential

COST OF STUDY

48. Staff Costs

	£	£
Scrutineers	11,646	
Support Services	197	
Secretarial Support	2,043	13,886
Non-Staff Costs		
Travelling & Subsistence	2,950	
Miscellaneous	200	3,150
TOTAL COST		17,036

ACKNOWLEDGEMENTS

49. We would like to thank the officers of the health authorities who have helped us in the survey by completing the questionnaire. We are particularly indebted to those authorities which we visited and who provided most useful back-up information based on first hand experience.

50. We are also grateful to our colleagues in the Northampton, Aylesbury and Victoria Health Districts, who together with finance colleagues in the North West Thames RHA and Milton Keynes District, and Management Services colleagues in the Oxford RHA, played a useful and formative part in the development of the fact finding part of the survey.

51. We would also like to thank the officials of the various authorities and organisations mentioned in paragraph 4, page 2, of the report. We found the visits instructive and enlightening. A wide range of information showing how their structures operated was readily made available and this stimulated most productive discussions. Their willingness to submit written evidence encouraged us to incorporate their positive contributions into the report.

RAYNER SCRUTINY
NHS STAFF ACCOMMODATION
Notes on completion of the questionnaire

INTRODUCTION

The questionnaire consists of a list of units of accommodation and a summary sheet.

Notes on Questionnaire

When completing the list of accommodation units it would be helpful if the three main categories of buildings, Houses, Flats, and Other, are listed in separate groups.

DATE OF SURVEY

Any convenient recent data may be chosen. The results should represent a "snapshot" rather than an average over a period.

DESCRIPTION/NAME OF BUILDING

Each residence should be listed separately. A nurses home will occupy one line, a block of 6 flats will occupy six lines.

TYPE OF ACCOMMODATION

Please complete according to current use. A family house occupied by a single resident should be classed as "SINGLE". If a building contains both single and married staff please enter the numbers in each column.

STAFF UNITS

TOTAL: The maximum number of staff who would be accommodated if fully let.

LET/UNLET: These should add up to TOTAL. Please enter a comment in the "notes" column if there are any special circumstances, for example, a building which is unoccupied while re-decoration takes place.

CATEGORY

FLAT: A self-contained residence which forms part of a building.

HOUSE: A building which was originally designed as a house even though it may be adapted for bedsitter use.

OTHER: Any building which does not fall into the above categories, for example, nurses home, converted ward, mobile home, etc.

LOCATION

NHS INTEGRATED: Where a unit of accommodation is owned by the NHS and is integrated into buildings used for non-residential purposes, e.g. a flat in the main hospital building.

NHS FREE-STANDING: Where a building is owned by the NHS and is used solely for residential purposes, e.g. a nurses home.

NON-NHS: Where a unit is not owned by the NHS. If trustee-owned please enter a comment in the "notes" column.

OFFSITE AND SALEABLE: This refers to those properties which could be considered of "commercial" value on the property market.

TYPE OF OCCUPANCY

The figures should add up to the sum shown in the "Staff Units LET" column.

RESIDENTIAL CATEGORY

The figures should add up to the sum shown in the "Staff Units LET" column.

The cagegories are as shown in Advance Letter (NM)2/81 and Building Note 24, i.e:

Scale A - Bedsitting room with 4-6 sharing common facilities.

Scale B - Bedsitting room with 3-4 sharing common facilities.

Scale C - 1-bedroom and living room each, with 2 sharing common facilities.

Scale D - 1-bedroom self-contained flat.

Scale E - Self-contained 4-room flat.

Scale F - Self-contained 2-bedroom flat.

RAYNER SCRUTINY: NHS STAFF ACCOMMODATION: QUESTIONNAIRE ON LIST OF UNITS OF ACCOMMODATION

HEALTH AUTHORITY..... DATE OF SURVEY..... SHEET NO:..... OF.....

DESCRIPTION/NAME OF BUILDING	Type Of Accom. (S)ingle (M)arried		Staff units (numbers)			Category (tick)			Location (tick)			Type of Occupancy (number let)					Residential Category (number let)						OFF-SITE AND SALEABLE (tick)	notes
			TOTAL			HOUSE			NHS INTEGRATED			DOCTORS-COMPULSORY												
				LET			FLAT			NHS FREE-STANDING			ON-CALL ROOMS											
														LEARNER NURSE										
															OTHER NURSE									
	S	M			UNLET			OTHER			NON-NHS					OTHERS	A	B	C	D	E	F		

RAYNER SCRUTINY
NHS STAFF ACCOMMODATION
QUESTIONNAIRE SUMMARY SHEET

1. Staff Units

CATEGORY	NHS INTEGRATED	NHS FREE-STANDING	NON-NHS	OFF-SITE & SALEABLE	TOTAL
HOUSES					
FLATS					
OTHER					
TOTAL					

2. Vacancy Rate: Units unlet at: .....

CATEGORY	NHS INTEGRATED	NHS FREE-STANDING	NON-NHS	OFF-SITE & SALEABLE	TOTAL
HOUSES					
FLATS					
OTHER					
TOTAL					

In case of difficulty please see "Notes on completion of the questionnaire".

APPENDIX II

OUTLINE OF A SCHEME FOR AUTHORITIES TO REDUCE THEIR EXISTING STOCK OF RESIDENTIAL ACCOMMODATION

1. Once the DHA has assessed how many units of accommodation it needs to retain on the criteria of essential need (paragraph 25 i-iii of main report) it will need to consider which units to retain as its "bank" and which are "disposable". The presumption should be that the "bank" should consist, first, of units integral to hospital fabric; where these are insufficient the "bank" should then include free-standing units on hosptial sites and only where both categories together are insufficient should it include units off-site.

2. The DHA should aim, within three years, to ensure that:

   i "bank" units are only occupied by "essential need" staff

   ii. "essential need" staff only occupy "bank" units

3. Ensuring that "bank" units are only occupied by "essential need" staff. The DHA should identify staff apparently occupying "bank" units who do not come within the "essential need" categories. Any not expected to vacate their accommodation during the next three years in the normal course of events should be advised to make alternative arrangements within that period as the accommodation will be needed for "essential need" staff.

4. Ensuring that "essential need" staff all occupy "bank" units. This should be relatively easy, as all "essential need" staff are, by their nature, accommodated for relatively short periods. The DHA needs to ensure that new "essential need" staff are offered "bank" units (rather than "disposable" units) as such units are vacated. Given the speed of turn-over of such staff it should be possible to ensure that all are accommodated in "bank" units at the end of three years without asking anyone to transfer from a "disposable" unit.

5. The sale of "disposable" units. Authorities can begin to sell off such accommodation virtually immediately by disposing of any empty properties. By adopting a policy of only offering new "essential need" staff "bank" accommodation, by not offering accommodation to other staff, and by selling "disposable" units as they fall vacant the stock can gradually be reduced.

6. Where "disposable" units are occupied by permanent staff not expected to vacate the accommodation within three years in the normal course of events, the DHA should first offer the property to the tenant on the same sort of preferential terms as council houses are sold to sitting tenants.

NB: An integral part of these arrangements will be the development of programmes of collaboration with housing associations/local authorities etc, as described in the main report.