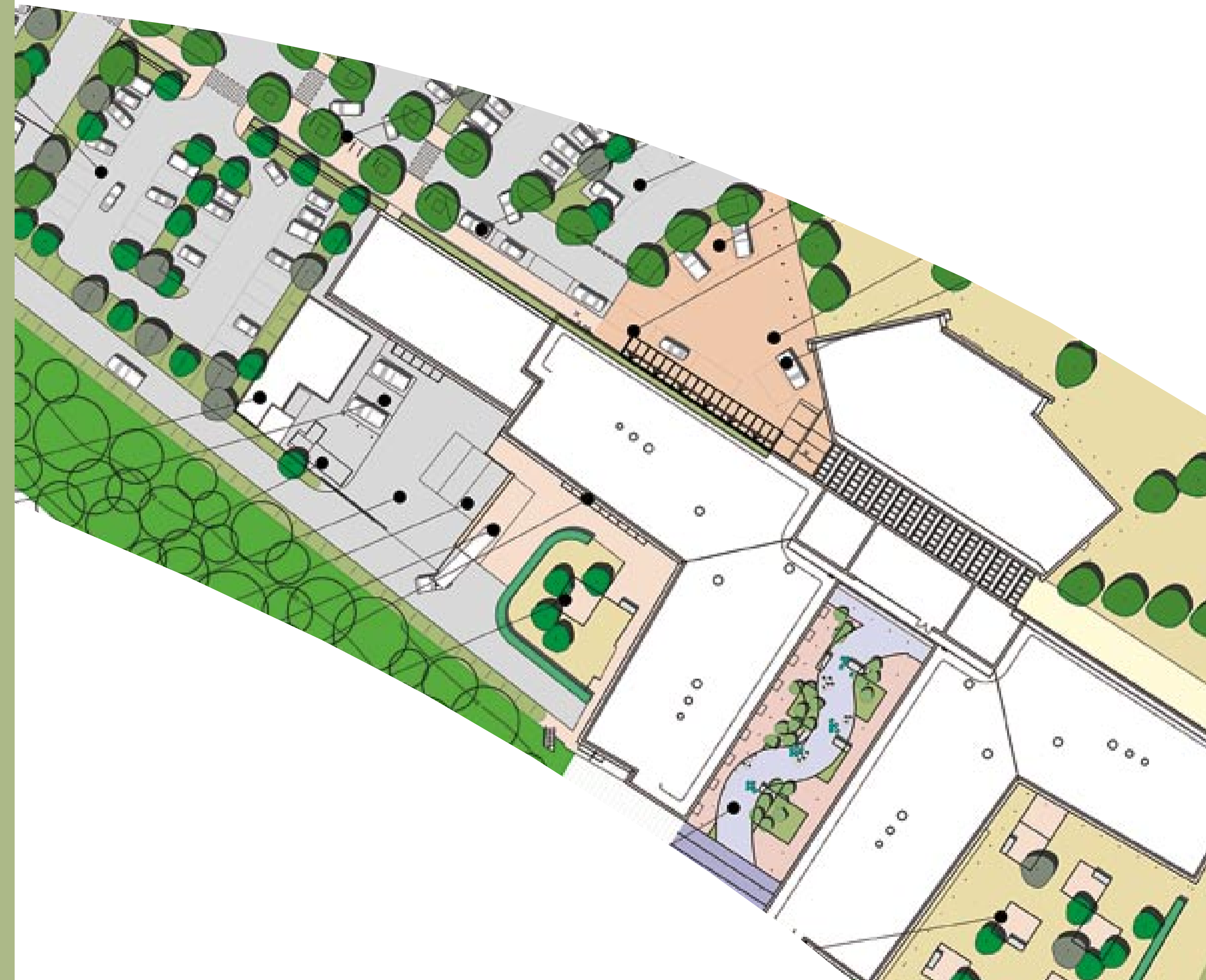
Department of Health

Core elements

Health Building Note 00-08: Estatecode



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Health Building Note 00-08: Estatecode

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Preface

About Health Building Notes

Health Building Notes give "best practice" guidance on the design and planning of new healthcare buildings and on the adaptation/extension of existing facilities.

They provide information to support the briefing and design processes for individual projects in the NHS building programme.

Restructuring of the Health Building Note suite

Healthcare delivery is constantly changing, and so too are the boundaries between primary, secondary and tertiary care. The focus now is on delivering healthcare closer to people's homes.

The traditional division of Health Building Notes into discrete books of information based on hospital departments is therefore no longer appropriate.

Instead, the new Health Building Note framework (shown below) is based on the patient's experience across the spectrum of care from home to healthcare setting and back, using the national service frameworks (NSFs) as a model. This structure better reflects current policy and service delivery.

New Health Building Note structure

The Health Building Notes have been organised into a suite of 17 core subjects.

Care-group-based Health Building Notes will provide information about a specific care group or pathway but will cross-refer to Health Building Notes on **generic (clinical) activities** or **support systems** as appropriate.

Core subjects will be subdivided into specific topics and classified by a two-digit suffix (-01, -02 etc), and may be further subdivided into Supplements A, B etc.

All Health Building Notes are supported by the overarching Health Building Note 00 in which the key areas of design and building are dealt with.

Example

The Health Building Note on accommodation for adult in-patients will be represented as follows:

> "Health Building Note 04-01: Adult in-patient facilities"

The supplement to Health Building Note 04-01 on isolation facilities will be represented as follows:

> "Health Building Note 04-01: Supplement A – Isolation facilities in acute settings"

New Health Building Note number and series title	Type of Health Building Note
Health Building Note 00 – Core elements	Support-system-based
Health Building Note 01 – Cardiac care	Care-group-based
Health Building Note 02 – Cancer care	Care-group-based
Health Building Note 03 – Mental health	Care-group-based
Health Building Note 04 – In-patient care	Generic-activity-based
Health Building Note 05 – Older people	Care-group-based
Health Building Note 06 – Diagnostics	Generic-activity-based
Health Building Note 07 – Renal care	Care-group-based
Health Building Note 08 – Long-term conditions/long-stay care	Care-group-based
Health Building Note 09 – Children, young people and maternity services	Care-group-based
Health Building Note 10 – Surgery	Generic-activity-based
Health Building Note 11 – Community care	Generic-activity-based
Health Building Note 12 – Out-patient care	Generic-activity-based
Health Building Note 13 – Decontamination	Support-system-based
Health Building Note 14 – Medicines management	Support-system-based
Health Building Note 15 – Emergency care	Care-group-based
Health Building Note 16 – Pathology	Support-system-based

Other resources in the DH Estates and Facilities knowledge series

Health Technical Memoranda

Health Technical Memoranda give comprehensive advice and guidance on the design, installation and operation of specialised building and engineering technology used in the delivery of healthcare (for example medical gas pipeline systems, and ventilation systems).

They are applicable to new and existing sites, and are for use at various stages during the inception, design, construction, refurbishment and maintenance of a building.

All Health Building Notes should be read in conjunction with the relevant parts of the Health Technical Memorandum series.

Health Technical Memorandum Building Component series

All Health Building Notes refer to Health Technical Memorandum Building Component documents for specifications and design guidance on building components for healthcare buildings. All Health Building Notes should therefore be read in conjunction with the relevant parts of the Health Technical Memorandum Building Component series.

Activity DataBase (ADB)

The Activity DataBase (ADB) data and software assists project teams with the briefing and design of the healthcare environment. Data is based on guidance given in the Health Building Notes, Health Technical Memoranda and Health Technical Memorandum Building Component series.

1. Room data sheets provide an activity-based approach to building design and include data on personnel, planning relationships, environmental considerations, design character, space requirements and graphical layouts.
2. Schedules of equipment/components are included for each room, which may be grouped into ergonomically arranged assemblies.
3. Schedules of equipment can also be obtained at department and project level.
4. Fully loaded drawings may be produced from the database.
5. Reference data is supplied with ADB that may be adapted and modified to suit the users' project-specific needs.

For further information please refer to the following DH website: http://www.adb.dh.gov.uk/

How to obtain publications

- To find out about publications that are finalised and currently being published, look under "new publications" on the DH Estates and Facilities Division Knowledge and Information Portal homepage at: http://www.estatesknowledge.dh.gov.uk. **NOTE that users should also check the Knowledge and Information Portal for latest versions of all publications, including Health Building Notes, and for any amendments to publications.**
- To find out about all DH Estates and Facilities publications, download the publications list on the DH Estates and Facilities Knowledge and Information web page: http://www.dh.gov.uk/en/Policyandguidance/Organisationpolicy/Estatesandfacilitiesmanagement/DH_4118956
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For further information, contact Danielle Holme on 0113 341 3185; email: Danielle.holme@coi.gsi.gov.uk.

Note

The new Health Building Notes will be progressively rolled out from spring 2007 onwards.

The sequence of numbering within each subject area does not necessarily indicate the order in which the Health Building Notes will be published/printed. However, the overall structure/number format will be maintained as described.

To find out how to access information on published documents, see the "How to obtain publications" section.

Foreword

Changes have been made to Estatecode to reflect the organisational changes in the National Health Service (NHS) and the Department of Health's (DH's) arm's length bodies.

Using Estatecode, all NHS organisations should be able to secure efficient and effective property solutions through the use of property resources in order to deliver better health and social care.

To obtain best value from property assets, NHS organisations have to take a proactive role (especially in town planning and sustainability) and carry out their property undertakings to a high standard.

Previous references to land and property appraisal and asset maintenance have been omitted from this edition of Estatecode. It is envisaged that the six-facet survey will be included in a revised 'Developing an estate strategy' to be read in conjunction with 'A risk-based methodology for establishing and managing backlog' (DH Estates and Facilities Division).

The National Health Service Act 2006 (a consolidating Act) came into force on 1 March 2007. Former statutory references have been retained in brackets to assist ease of recognition of the new sections in this transition period.

Contents

Preface
Foreword
Chapter 1 Overview 3
Scope and purpose of guidance
Structure of the guidance
Target audience
NHS organisations
Individuals
The policy context
Patient choice
Moving healthcare from acute to community settings
Joint provision
Guidance and powers
Land and property ownership
Powers to carry out land and property transactions
Income generation powers
The decision-making process
Delegated limits
The proper exercise of powers
Key recommendations
Acquisitions
Disposals
Leases
Chapter 2 Town planning and the NHS 13
Introduction
Legal background
Primary legislation
Primary statutory instruments
Government planning guidance
Other legislation/policy
Summary of the planning process
Regional planning
NHS involvement
Local planning
NHS involvement
Planning control
NHS involvement
Exclusions
Planning applications
Supporting documentation
Twin tracking
Planning conditions
Planning obligations (Section 106 agreements)
Determination of planning applications

Planning appeals
Other planning control issues
Special interests
Conservation areas
Listed buildings
Trees
The green belt
Enforcement

Chapter 3 Planning strategic investment in the estate 23
Introduction
General principles
Strategic service development plans (SSDPs)
Techniques and tools
Strategic Health Asset Planning and Evaluation (SHAPE)
Health impact assessments (HIAs)
Estates impact assessment
Achieving Excellence Design Evaluation Toolkit (AEDET)
'Developing an estates strategy'
Strategic asset management (SAM)

Chapter 4 Procurement of new facilities and services 29
Introduction
EU rules on procurement
Land and property transactions
Public works contracts
Public services contracts
Procuring works, goods or services – asset maintenance
Private Finance Initiative
NHS ProCure21
NHS Local Improvement Finance Trust (LIFT)

Chapter 5 Acquisition of freehold land and property 35
Introduction
Delegated limits
Principles of acquisition
The business case
Managing the acquisition team
Town planning
Site investigation report
Services/utilities report
Structural survey
Valuations
Negotiating the purchase
Freehold covenants
Conditional contracts
Option contracts (option to purchase)
Heads of terms
The solicitor's role
Key points
Withdrawal of property from the market
Timetable
Post-completion
Compulsory purchase powers

Chapter 6 Acquisition of leasehold land and property 43
Introduction
Delegated limits

Principles of leasing
Operating and financing leases
The business case
Negotiating the lease
Lease term
Rent reviews
Break clauses
User provisions and other specified user restrictions
Alienation provisions
Freedom to make alterations and adaptations
Repairing obligations
Insurance
VAT liability
Contracting out of the Landlord and Tenant Act 1954
Identity of the tenant
References
Signing and sealing the lease
Post-completion
Renewal of leases
Chapter 7 Disposal of freehold land and property 49
Introduction
Principles of disposal
Priority purchasers
Former owners' rights (Crichel Down rules)
The business case
Managing the disposal team
Routine disposals
Major/complex disposals
Town planning
Decommissioning
Asbestos
Contamination issues
Overage or clawback provisions
Disposal of partially surplus sites
Ransom strips
Joint venture with neighbour
Sale and leaseback
Sale of surplus property in PFI and LIFT schemes
Provision of new facilities in exchange for surplus land and property
Forward sale of land and property
When is the sale price assessed?
Enhanced planning
Sales on
Rent and other lease terms
Giving up possession
Disposals that seek participation in development profit
Contracts conditional on planning permission
Phased-sale contracts
Setting the sale price
Transfer value to another NHS organisation
Valuation in preparation of sale of land and property
Role of independent valuer (for complex schemes or where proceeds are likely to exceed £5 million)

Sale at best price
Sale to a selected purchaser (solus transaction)
Sale at concessionary price
Sale methods
Formal tender
Limited formal tender
Informal tender
Private treaty
Late bids
Public auction
Post-completion
Financial credentials
Sale of surplus historic buildings
Simplified disposal process for residential property (tenanted property)
Adjustment to sale price
Disposal of burial grounds and war memorials
Burial grounds
War memorials
Chapter 8 Disposal of leasehold land and property 65
Introduction
Assignment
Surrender
Sub-letting
How marketable is the lease?
Disposal of long leasehold land and property
Lease term
Rent level and rent reviews
Alienation provisions
User provisions and specified user restrictions
Developmental potential
Rights and reservations
Disposal of short leasehold land and property
Lease term
Rent level
Rent reviews
Alienation provisions
User provisions
Freedom to carry out alterations and adaptations
Rights and reservations
Repairing obligations
Existing breaches
Future breaches
Contractual expiry of leasehold interests
Vacant possession
Repairing obligations
Other breaches
Effect of sub-tenancies or licences
Post-completion
Chapter 9 Granting of leases (and licences) 71
Introduction
NHS organisation as landlord
Code of commercial lease practice
Lease term

Rent level
Alienation provisions
VAT implications
Repairing obligations and insurance arrangements
Compliance with statute
Landlord's responsibilities
Freedom to carry out alterations and adaptations
Lease expiry or renewal
Letting concourse shops
Insurance arrangements
Joint ventures
Car parking areas
Aerial leases
Letting of advertising hoardings
Letting of noticeboards
Sub-letting of NHS LIFT premises
Arrangements with other NHS organisations
Disputes between NHS organisations
Arrangements with non-NHS organisations
Arrangements for university medical school facilities
Arrangements with educational establishments (embedded accommodation)
Concessionary leases
Post-completion
Chapter 10 Management of land and property 81
Introduction
Principles of management
The costs of holding land and property
Lifecycle costs
Managing those costs
Management responsibilities
Land and property records
Legal title documents and deeds
Maintenance
Land and property
Boundaries
Under PFI and LIFT contracts
Risk management
Security arrangements
Prevention of trespass
How to deal with illegal occupation
Health and safety requirements
Insurance arrangements
Sustainable development
Easements
Compulsory purchase of NHS property by a local authority
Town and village greens
What can be registered as a town or village green?
Procedure to register a town or village green
Effect of registration
Practicable preventative steps
Town planning
Management of tenancy and other agreements
Minor user rights

Payments towards expenditure on community services (former Section 28A Agreements)
Donated property and charity issues
Use of non-NHS premises for NHS patients
Joint schemes with local authorities
Use of NHS land and property by local authorities
Management of the historic estate
Legislation and guidance relating to the historic estate
The care and management of the historic estate
Repairs notices
The management of burial grounds and war memorials
Appendix 1 References 97
Acts, Directions, Directives, Orders and Regulations
Acts
Directions
Directives
Orders
Regulations
Department for Communities and Local Government (DCLG)
Department for Culture, Media and Sport (DCMS)
Department of Health (DH) Estates and Facilities Division/NHS Estates
Department of Health (DH)
Greater London Authority (GLA)
Higher Education Funding Council for England (HEFCE)
The Joint Working Group on Commercial Leases 2007
Royal Institution of Chartered Surveyors (RICS)
Other Government publications

Part A – Overview

1 Overview

Scope and purpose of guidance

1.1 Estatecode provides best-practice guidance to NHS organisations in England on all aspects of managing their estate.

1.2 It covers a range of issues including legal, financial, regulatory, statutory and administrative.

1.3 Estatecode performs two key functions:

- informs decisions about buying, selling or leasing of land and property, and in particular sets out what constitutes mandatory as opposed to discretionary guidance;
- informs day-to-day management decisions.

Structure of the guidance

1.4 Estatecode is structured in five parts:

- Part A – Overview;
- Part B – Strategy. Includes chapters on town planning and planning strategic investment in the estate;
- Part C – Procurement of new facilities and services. Provides an overview of EU rules on procurement, together with an explanation of private finance initiative (PFI), NHS Local Improvement Finance Trust (LIFT) and ProCure21 procurement methods;
- Part D – Acquisitions and disposals of freehold and leasehold land and property;
- Part E – Management of land and property.

Target audience

NHS organisations

1.5 The following organisations should read Estatecode:

- NHS trusts (including acute, mental health and ambulance trusts);
- NHS foundation trusts (NHSFTs);
- primary care trusts (PCTs);
- care trusts;
- strategic health authorities (SHAs);
- special health authorities (SpHAs);
- the Department of Health (DH).

NHSFTs

1.6 It is anticipated that all NHS trusts (both acute and mental health trusts) will eventually become NHSFTs.

1.7 NHSFTs are regulated by Monitor, the independent regulator and corporate body established under Section 31 of the National Health Service Act 2006 (previously the Health and Social Care (Community Health and Standards) Act 2003). Monitor is responsible for authorising, monitoring and regulating NHSFTs.

1.8 NHSFTs should be familiar with Estatecode, as it constitutes useful guidance and best practice on a number of areas that NHSFTs will encounter with regard to property transactions.

Individuals

Chief executives

1.9 Chief executives are responsible for the estate their organisation owns or manages.

1.10 Whilst responsibility is likely to be delegated, chief executives should be aware of the guidance contained in Estatecode.

1.11 Chief executives should be familiar with Part A (this Part), particularly the section on guidance and powers (paragraphs 1.31–1.86), and should be generally aware of the issues that Estatecode covers.

Board members

1.12 Management of the estate is an area that needs detailed consideration at board level.

1.13 All board members should be familiar with Part A (this Part), particularly the sections on guidance and powers (paragraphs 1.31–1.87), and should be generally aware of the issues that Estatecode covers.

Directors of estates and facilities (and their teams)

1.14 The person responsible for strategic planning and day-to-day operation of healthcare facilities should have a thorough understanding of Estatecode. This person will often (though not always) be a director of estates/facilities.

1.15 The director of estates and facilities should ensure that his/her estates and facilities team, as well as any external advisers, are also familiar with Estatecode.

Shared services organisations

1.16 Smaller NHS organisations, particularly PCTs, often use shared services organisations to deal with estate matters. Such organisations need to be familiar with the contents of Estatecode.

Clinicians and other NHS staff

1.17 Estatecode will give clinicians (and other NHS staff) a general appreciation of DH policies governing land and property transactions.

External advisers

1.18 One of the purposes of Estatecode is to help NHS organisations identify when support is required from internal or external professional advisers. Those advisers (property consultants, legal advisers, auditors etc) need to be familiar with the provisions of Estatecode.

Auditors

1.19 Auditors should be familiar with Estatecode in order to be able to judge whether schemes have been carried out in a proper manner.

The policy context

1.20 The Government's overall aim through DH is to improve the health and well-being of the population through resources available. NHS organisations have a responsibility to:

- ensure that their land and property is used effectively to support Government plans and clinical needs;
- provide and maintain an appropriate level of affordable healthcare facilities in the right location, which are fit for purpose, support the provision of quality healthcare and are sustainable over their lifecycle.

1.21 When addressing estate matters, it is important for NHS organisations to reduce the environmental impact of their operations (both existing and new builds/refurbishments).

1.22 NHS organisations must comply with all statutory requirements, national and international directives.

1.23 There are a number of current policy drivers affecting the NHS. The following sections explain some of the more important ones.

Patient choice

1.24 The patient "choose and book" scheme will enable patient-based commissioning (comes into full effect from 2008).

1.25 Together with practice-based commissioning, patient-based commissioning has the potential to open the market to plurality: commissioning of healthcare services will be determined almost exclusively by patient choice and provided by a mixture of NHS and independent organisations, all of which will require the provision of an appropriate estate.

Moving healthcare from acute to community settings

1.26 Combined with technological changes and use of non-NHS healthcare providers (including social enterprises), this will impact on the existing estate of NHS trusts and PCTs.

1.27 It will challenge traditional estate ownership models, allow trusts to use facilities outside hospitals, secure better use of their own facilities, and inform investment and disinvestment decisions.

Joint provision

1.28 There is a growing acceptance that the NHS should work in a more collaborative way, with priorities for investment in key areas being agreed across rather than within organisations.

1.29 Often this will be with social care departments of local authorities, but increasingly, joint initiatives are being undertaken with education and leisure departments of local authorities, as this type of joint provision has been shown to have real benefits to patient health.

1.30 There is likely to be an increase in joint service provision, with consequential effects on the NHS estate.

Guidance and powers

Land and property ownership

1.31 NHS trusts (an ambulance trust is constitutionally an example of an NHS trust), NHSFTs and PCTs may own or lease land in their own right and name.

1.32 If an NHS trust or PCT is designated a care trust, Section 77(10) of the National Health Service Act 2006 (previously Section 45(9) of the Health and Social Care Act 2001) states that this does not affect its core functions or rights. Any reference within Estatecode to PCTs or NHS trusts also applies to any such body that has been designated a care trust.

1.33 SHAs may own or lease land in their own right, if it is necessary for the discharge of their functions. This is provided for in the Health Authorities (Land Transactions) Directions 1996. (There are a few exceptions to this.) Whether an SpHA may carry out land transactions in its own name is determined by its delegated authority (normally by Directions).

Powers to carry out land and property transactions

1.34 Unlike individuals, NHS organisations do not have the power to carry out any and all types of land and property transactions. They can generally only carry out transactions that are linked to their ability to carry out their functions.

1.35 PCTs, NHS trusts and health authorities are all statutory creations. Under English law, they only have the powers expressly given to them by or through Parliament, or those necessarily implied as a result of what they have to do in order to fulfil their functions. These powers are subject to delegated limits, either set out in Establishment Orders, Directions, or from time to time by DH (see paragraphs 1.68–1.71 on delegated limits).

1.36 The position of the Secretary of State is slightly different since Secretaries of State are, and therefore have the full powers of, natural persons, and do not need to identify a relevant statutory power to carry out land and property transactions.

PCTs

1.37 PCTs are established by a statutory instrument pursuant to Section 18 of the National Health Service Act 2006 (previously Section 16A of the National Health Service Act 1977). Their general powers are set out in Schedule 3 paragraph 15 of the 2006 Act (previously Section 5A paragraph 12 of the 1977 Act). This states:

(1) A Primary Care Trust may do anything which appears to it to be necessary or expedient for the purpose of, or in connection with its functions.

(2) In particular, it may

(a) Acquire and dispose of property…

1.38 It is up to the PCT to decide whether a particular land transaction is “necessary or expedient”, but this decision needs to be reasonable, and does involve consideration of the relevant functions of the PCT.

1.39 The functions of PCTs are set out in the National Health Service’s Functions of Strategic Health Authorities and Primary Care Trusts and Administration Arrangements (England) Regulations 2002. These include the Secretary of State’s duties in connection with the provision of nursing, medical and other care under Section 3 of the National Health Service Act 2006 (previously Section 3 of the National Health Service Act 1977).

1.40 PCTs also have direct statutory duties. These include the obligation to exercise their contracting powers to make arrangements for family health services, namely primary medical, dental, ophthalmic and pharmaceutical services. This is important in the context of land and property transactions as, in connection with these statutory duties, PCTs have an express statutory power to make premises available to contractors.

1.41 PCTs have no power to borrow, and consequently no power to mortgage or charge.

1.42 PCTs have income generation powers (see paragraphs 1.60–1.65 for details).

NHS trusts

1.43 NHS trusts are established by a statutory instrument pursuant to Section 25 of the National Health Service Act 2006 (previously Section 5 of the National Health Service and Community Care Act 1990). Their general powers are set out in Schedule 4 paragraph 14 of the 2006 Act (previously Schedule 2 paragraph 16 of the 1990 Act).

(1) An NHS Trust may do anything which appears to it to be necessary or expedient for the purpose of, or in connection with its functions.

(2) *In particular, it may acquire and dispose of property…*

1.44 This is a similar power to that given to PCTs. As with PCTs, the power is linked to the NHS trust's functions.

1.45 The functions of NHS trusts are set out in their Establishment Orders (though in the case of early Establishment Orders modified so as to ignore any apparent requirement on the part of the NHS trust to own any premises named in the Establishment Order). The principal function is to provide goods and services for the purpose of healthcare provision.

1.46 NHS trusts may not mortgage or charge any of their assets, or use them in any way as security for a loan (Schedule 5 paragraph 3(3) of the National Health Service Act 2006 – previously Schedule 3 paragraph 1 of the National Health Service and Community Care Act 1990).

1.47 Like PCTs, NHS trusts have income generation powers (see paragraphs 1.60–1.65 for details).

NHSFTs

1.48 NHSFTs are established under Chapter 5 of the National Health Service Act 2006 (previously Part 1 of the Health and Social Care (Community Health and Standards) Act 2003). They are part of the NHS but are free from central government control. They possess three key characteristics that distinguish them from NHS trusts:

1. freedom to decide locally how to meet their obligations;
2. accountability to local people, who can become members and governors;
3. they are authorised and monitored by Monitor.

1.49 An NHSFT's power to dispose of land or buildings, owned or leased, is governed by their classification as protected or unprotected assets in Condition 9 of the NHSFT's "terms of authorisation".

1.50 An asset is defined as protected if it is required for the purposes of providing either mandatory goods and services or mandatory education and training.

1.51 Assets that are not required for mandatory goods and services (for example a private wing) are not protected and may be disposed of by NHSFTs without the approval of Monitor. However, an NHSFT must seek Monitor's approval to dispose of a protected asset.

1.52 Disposal includes a part sale of assets or granting an interest in them.

1.53 An NHSFT may not create a floating charge on its property (Section 45(6) of the National Health Service Act 2006).

SHAs

1.54 Unlike PCTs and NHS trusts, SHAs do not have an express power to acquire and dispose of land. Instead, the Secretary of State's power, set out in Section 211 of the National Health Service Act 2006 (previously Section 87 of the National Health Service Act 1977), is delegated to SHAs. Section 211 states:

(1) *The Secretary of State may acquire*

(a) *any land, either by agreement or compulsorily,*

(b) *any other property,*

required by him for the purposes of this Act.

(2) *In particular, land may be acquired to provide residential accommodation for persons employed for any of those purposes.*

(3) *The Secretary of State may use for the purposes of any of the functions conferred on him by this Act, any property belonging to him by virtue of this Act, and he has power to maintain all such property.*

1.55 The functions of SHAs are delegated to them to be exercised for the benefit of the geographical area under their control or to secure the effective provision of services by PCTs and NHS trusts within their area.

1.56 Under their delegated powers, SHAs are able to carry out property transactions in their own name if this is necessary for the discharge of their functions.

1.57 However, their ability to carry out land and property transactions is provided for by the delegated authority set out in the Health Authorities (Land Transactions) Directions 1996. This restricts SHAs to managing for themselves land and property required for the exercise of their functions (that is, normally offices). (There are a few exceptions to this.)

SpHAs

1.58 SpHAs are one of three types of arm's length body (stand-alone national organisations sponsored by

DH) to provide a service to the public. They are established by order under Section 28 of the National Health Service Act 2006 (previously Section 11 of the National Health Service Act 1977). There is no common set of powers for SpHAs, and each individual SpHA will need to consider whether they have specific land-holding powers.

1.59 SpHAs' abilities to carry out land and property transactions are provided by delegated authority set out in either the Statutory Instrument by which they were established and/or specific Directions, issued by DH.

Income generation powers

1.60 Schedule 4 paragraph 20(1) of the National Health Service Act 2006 (previously Schedule 2 paragraph 15 of the National Health Service and Community Care Act 1990) gives powers to NHS trusts, PCTs, SHAs and SpHAs (from 1 April 2005) to acquire land and property by agreement and manage and deal with land and property in order to make money available for improving healthcare services.

1.61 Income-generation activities must not interfere with the duties and performance of NHS organisations.

1.62 Land and property may be acquired to enhance disposal proceeds of surplus land and property (for example by improved road access, or making a site large enough for a specific use).

1.63 Where an individual scheme results in an annual turnover of £50,000 or more, a "memorandum trading account" must be maintained. This is recommended for smaller schemes.

1.64 See detailed guidance notes provided from time to time by the income generation section of the DH website at www.dh.gov.uk.

1.65 Section 43(3) of the National Health Service Act 2006 (previously Section 14(3) of the Health and Social Care (Community Health and Standards) Act 2003) gives NHSFTs the power to make additional income available in order to carry on their purpose better. NHSFTs are not bound by DH rules on income generation but may use them for guidance purposes.

The decision-making process

1.66 Subject to delegated limits (see paragraphs 1.69–1.72) and the requirement to exercise their powers properly (see paragraphs 1.73–1.84), NHS organisations are responsible for making what they believe to be the best decisions concerning land and property for their NHS organisation and the NHS as a whole.

1.67 The decision-making process should be clear, documented and of a high standard in order to satisfy probity, governance and audit purposes. It should be informed by:

- national and local policy requirements for the NHS;
- strategic service development plans (SSDPs);
- estate strategies;
- current property industry practice;
- Estatecode and other guidance, including from the Law Society and Royal Institution of Chartered Surveyors (RICS), and Regulations, including Accounting Standards Regulations and Government Accounting Regulations.

1.68 If NHS organisations have concerns about the decision-making process they should consult with their internal and external auditors and, if appropriate, financial and legal advisers.

Delegated limits

1.69 Each NHS organisation has a delegated limit. Above its limit, the NHS organisation is required to obtain the approval of its SHA to the proposed transaction (which should be set out and explained in a business case and if appropriate, for example when acquiring a capital asset, should comply with the provisions of the 'Capital Investment Manual').

1.70 The delegated limit applies to freehold and leasehold acquisitions and amount of disposals proceeds that can be retained by NHS organisations. These limits do not apply to NHSFTs.

1.71 The SHA will review the business case within a reasonable period of time. Some proposals (that is, those that exceed a certain level as set out by DH from time to time) will be referred to DH for final approval, to be reviewed within a reasonable timeframe.

1.72 Delegated limits for NHS trusts, PCTs and SHAs are set by the Secretary of State in consultation with the Treasury. See website: www.dh.gov.uk.

The proper exercise of powers

1.73 In addition to considering what powers an NHS organisation has, it is essential that those powers are exercised lawfully. There are a number of tests

which any exercise of discretionary power by a public body must pass in order for it to be a proper exercise of that power. These can be summarised as:

- Is the organisation acting legally?
- Is the organisation acting rationally?
- Is there a proper procedure for the exercise of the power, and is it being followed?
- Does the proposed use of the power amount to an abuse of power?

1.74 Each of these has a specific and sometimes quite technical meaning, as follows.

Legality

1.75 In order properly to exercise power, an NHS organisation must ensure that in so doing, it is acting in accordance with that power and not acting in breach of any other legal obligation.

1.76 However, the obligations may take other forms. Of particular importance to the NHS will be the impact of Directions from the Secretary of State for Health and limits on capital transactions. If an NHS organisation carries out a property transaction above its delegated limits without seeking SHA approval, it will be acting illegally.

Rationality

1.77 This is a term that caters for two particular types of legal challenge to a decision by a public authority including an NHS organisation. In extreme cases an NHS organisation may be accused of acting in an unreasonable way. More usually, the NHS organisation is charged with failing to take certain relevant factors into consideration or of having taken account of irrelevant factors. This may include failure to take adequate account of the potential risks to the organisation arising from a transaction.

Procedure

1.78 Where changes in the delivery of services may affect patients, there is a legal obligation for the NHS organisation to inform and consult patients either directly or through representatives.

1.79 The recent case of Smith and North Eastern Derbyshire Primary Care Trust has emphasised the width of engagement of Section 242 of the National Health Service Act 2006 (public involvement and consultation) (previously Section 11 of the Health and Social Care Act 2001). Although the court in the Smith case recognised the need for this engagement to be proportionate to the scale of the change, it needs to be real and meaningful.

1.80 In some cases, consultation with a patient forum may suffice, but in others, a more direct attempt to involve and consult with patients may be required.

1.81 Land transactions should be properly addressed by the board, decisions properly authorised, and relevant paperwork completed.

1.82 Standing orders and financial instructions may limit arrangements for the agreement and execution of documents relating to the acquisition or disposal of capital assets. The former will set out:

- limits of delegated authority from the board;
- expenditure approval processes;
- levels of expenditure requiring tender action;
- decision-making processes;
- delegated authority to sign contracts and agreements, make appointments, agree sales or purchases of land and property;
- processes for affixing an NHS trust's, PCT's, SHA's or the Secretary of State for Health's seal when required.

1.83 Any person signing a contract in respect of a land and property transaction must be authorised to do so, must be fully informed about the transaction, and must have the clear support of professional advisers.

1.84 Separation of duties is required to ensure probity: for example, the same person should not sign a contract that he/she has negotiated, nor should anyone sign a contract where that person has an interest in the outcome of the transaction.

Abuse of power

1.85 There are occasions when NHS organisations have misused their discretionary powers, in particular where there is a legitimate expectation from an individual.

1.86 A leading case relates to Ms Coughlan. She was a resident of Mardon House in Exeter and had been given a "home for life" promise by the then health authority. The Court of Appeal held that that promise gave rise to a public law obligation on the health authority and its successors, which could not be defeated in the absence of an overriding public

interest requiring the health authority to close Mardon House.

1.87 Another area where policy statements may well give rise to legitimate expectations is the application of the Crichel Down rules (see paragraphs 7.18–7.24).

Key recommendations

1.88 Appropriate legal and professional advice (from those with knowledge of NHS policy and procedures) should be obtained for all land and property transactions. This should include existing NHS property professionals within other trusts, shared service organisations and SHAs.

1.89 Where NHS organisations own land or property that is unregistered, they should register such interests at the Land Registry. When coming to deal with such land or property in the future, this may avoid difficulties that may arise around the enforceability and/or relevance of covenants, easements or other provisions.

1.90 In all land and property transactions, the highest possible commercial judgements need to be brought to bear. Any decision-making process should take account of relevant codes of conduct, accountability and probity.

1.91 All land and property transactions should be supported by a robust business case, which should include a comprehensive (and costed) option appraisal resulting in a preferred plan of action. Transactions with other NHS organisations, local authorities and other public sector bodies should be explored before considering transactions with the private sector.

Acquisitions

1.92 Surplus land and property within the NHS or other central or local government departments should be acquired by NHS organisations before going out to the private sector unless there are good reasons for this option. Sustainability is becoming a major consideration in the acquisition of freehold and leasehold property (and other types of procurement). See paragraphs 10.80–10.86 for details.

Disposals

1.93 NHS organisations should notify other neighbouring NHS organisations of any property surplus to their particular needs to ascertain whether there is a healthcare need for the premises. Land and property that is surplus to one NHS organisation but is required for operational purposes by another is not classified as surplus.

1.94 Any surplus land and property must be registered on the 'Register of Surplus Public Sector Land', operated by English Partnerships; for details go to www.dh.gov.uk.

1.95 Where the selling price of surplus land and property is likely to exceed £5 million, in major or potentially difficult disposals (for example where it is difficult to establish what planning consents will be required or prospective uses anticipated), professional advice and a valuation in addition and independent of the selling agent should be secured. This advice may be provided by the Valuation Office Agency (VOA) or suitably qualified private sector valuer.

1.96 The disposal of land and property to a selected purchaser by private treaty rather than testing on the open market should not proceed unless prior professional advice is given that this is the best method of sale.

Leases

1.97 The property industry introduced a new voluntary code in 2007: 'The Code for Leasing Business Premises in England and Wales 2007'. All NHS organisations and their advisers should be familiar with and encouraged to use this code.

1.98 The code is supported by the Government, which is monitoring its use and impact.

1.99 Copies are available at www.leasingbusinesspremises.co.uk.

1.100 RICS published a voluntary code of practice on service charges in June 2006: 'Service Charges in Commercial Property'. The code, which came into effect on 1 April 2007, promotes best practice in terms of service charges for new or renewed commercial leases. It will also be used to interpret service charge provisions in existing leases unless the lease specifies an alternative approach. NHS organisations should follow this code of practice.

1.101 The parties to a lease will be encouraged to be more transparent in dealing with service charge through regular communication between those involved in the service charge chain in relation to the provision, relevance, cost and quality of services provided.

Part B – Strategy

2 Town planning and the NHS

Introduction

2.1 This chapter provides an overview of the town and country planning system at regional and local level and its impact on the provision of healthcare facilities.

2.2 It explains how and why NHS organisations should get involved in the development of regional and local planning policy, and the processes involved in making planning applications.

2.3 Where planning applications affect the demand for healthcare services (for example a major housing development), NHS organisations should consult with their local planning authority (LPA) to seek financial contributions for additional healthcare facilities as a consequence of new development from developers. NHS involvement in local policy development should ensure local planning guidance supports this approach.

Legal background

2.4 Town and country planning is governed by a range of legislation and government guidance.

Primary legislation

2.5 This includes:

- the Town and Country Planning Act 1990 (as amended);
- the Planning and Compulsory Purchase Act 2004;
- the Planning (Listed Buildings and Conservation Areas) Act 1990;
- the Planning (Hazardous Substances) Act 1990;
- the Planning and Compensation Act 1991;
- European legislation.

2.6 The Planning and Compulsory Purchase Act 2004, now largely in force, significantly amended the Town and Country Planning Act 1990. Its purpose is to:

- introduce a simpler and more flexible planning system at regional and local levels;
- increase the effectiveness and quality of community involvement at regional and local level;
- improve the planning control process;
- remove the Crown's immunity from planning procedures.

2.7 In addition, it introduced a number of changes to local planning policy.

Primary statutory instruments

2.8 These include:

- the Town and Country Planning (General Permitted Development) Order 1995 (GPDO);
- the Town and Country Planning (General Development Procedure) Order 1995;
- the Town and Country Planning (Use Classes) Order 1987 (Use Classes Order) and its subsequent amendments;
- the Town and Country Planning (Development Plan) Regulations 1999 (only part is now in force).

Government planning guidance

2.9 Planning policy statements (PPSs) and planning policy guidance notes (PPGs), which are issued by the Department for Communities and Local Government (DCLG), previously the Office of the Deputy Prime Minister (ODPM).

2.10 PPGs set out the Government's policy requirements for the town planning system but are gradually being replaced by PPSs.

Other legislation/policy

2.11 There are many other areas of legislation and policy that may affect the planning process, including:

- highways, transportation and other infrastructure issues;
- compulsory purchase;
- green travel plans;
- sustainable development and environmental issues;
- administrative law.

Summary of the planning process

2.12 The planning process affecting NHS organisations may be divided into a number of broad categories:

1. the regional planning system whereby each region has a regional planning framework;
2. the local planning system whereby each LPA, following public consultation, produces a framework for land development in their area;
3. planning control, which determines whether planning permission is required and, if it is, how it should be obtained;
4. special interests, which includes the system for protecting special trees (tree preservation orders), important buildings (listed buildings), areas of special interest (conservation areas) and preventing urban sprawl (green belt);
5. enforcement, which includes procedures for ensuring planning control systems are followed;
6. general matters, such as the treatment of consecrated land and protection of third parties whose land may be blighted by potential development.

Regional planning

2.13 Each region (Government Office for the English Regions) has a regional planning framework known as a regional spatial strategy or RSS (previously regional planning guidance), which takes account of housing demand, transport, infrastructure and commercial land requirements.

2.14 Regional planning bodies (RPBs) prepare, monitor and update these strategies. RPBs comprise local authority members and representatives from education, business, the unions, the arts, healthcare, voluntary organisations, rural and environmental groups and other regional stakeholders.

2.15 RPBs are expected to take advice from county councils and other bodies with strategic planning expertise. There should also be public consultation.

NHS involvement

2.16 NHS organisations, individually and collectively, should ensure that their interests are reflected at all stages in the preparation, adoption and revision of regional planning strategies. Increasing the awareness of the healthcare agenda at regional level will assist in producing positive healthcare plans at local level.

Local planning

2.17 Each LPA must prepare and maintain a framework for land development in their area (known as a local development scheme or LDS).

2.18 LPAs are expected to take account of PPGs and PPSs in deciding local planning policy.

2.19 Each LDS refers to a series of local development documents (LDDs). The LDS should set out what LDDs will be prepared, along with their timetable and whether they are to be prepared jointly with one or more LPA(s).

2.20 LDDs are gradually replacing structure plans, local development plans and unitary development plans. Where there are no LDDs for a particular LPA area, the old system will apply until the LDDs are formulated.

2.21 LDDs must generally support the relevant RSS (or in London, the ‘Spatial Development Strategy for Greater London’, produced by the Greater London Authority (GLA)).

2.22 The term local development framework (LDF) is also commonly used. This consists of LDDs, supplementary planning documents, a statement of community involvement and annual monitoring reports. The LDF may also include local development orders and simplified planning zone schemes. Taken together, these documents will provide the framework for delivering the spatial planning strategy at local level.

2.23 County councils may participate in the preparation of LDDs (in matters other than minerals or waste, for which they are solely responsible) by becoming part of a joint committee with one or more LPA.

NHS involvement

2.24 NHS organisations, individually and collectively, should ensure that their healthcare and property interests are properly reflected and protected at all stages in the preparation, adoption and revision of LDDs.

2.25 If LDDs do not reflect NHS requirements, it will be more difficult to obtain planning permission for the development of new or existing premises to meet future healthcare needs.

2.26 NHS organisations should get involved in the process as early as possible. Representations must be made at the initial preparation stage of the LDD. Failure to do so may preclude participation at a later stage.

2.27 It is up to the NHS organisation to find out from their LPA where they are in the timetable of preparation and how to become involved. A timetable for submission of comments should be published.

2.28 A good relationship with a senior planning officer in the LPA is essential.

2.29 NHS organisations need to influence the development of local policy on planning conditions and obligations in order to secure contributions towards the cost of healthcare facilities (land or completed buildings). For example, this could relate to a planning condition in a new housing development to provide a site for a local primary care centre or a contribution under a Section 106 Agreement where a development or series of developments will create additional healthcare needs as a result of a population increase. See paragraphs 2.63–2.80 for further details on planning conditions and planning obligations.

2.30 Onerous planning conditions will affect the sale price of surplus NHS property and the acquisition of property by NHS organisations.

2.31 Involvement in the development of local transport plans is particularly important since this is likely to have an impact on planning conditions with regard to transport improvements.

2.32 NHS sites that may become surplus to requirements should be protected by securing specific land-use policies for these sites in the LDD. This is particularly important when considering future disposals of hospital sites in out-of-town locations or green belts, where alternative uses can be difficult to secure unless previously identified by the LPA.

2.33 Where LPAs do not respond satisfactorily to proposals from NHS organisations, consultants should be appointed as soon as possible to negotiate with the LPA and, if necessary, make public representations.

Planning control

2.34 The NHS estate is subject to planning control, and planning permission is usually required for any change of use, new build or development, for example building and engineering works.

2.35 The Crown is no longer immune from English town and country planning law. It now has to apply for planning permission from the LPAs, like any other developer. This will affect any NHS organisation holding property in the name of the Secretary of State for Health.

NHS involvement

2.36 NHS organisations should take an active role in the development of planning applications they are to submit or which are to be submitted on their behalf by third parties, for example LIFT schemes. They should also be aware of significant planning applications that will have a direct impact on the provision of healthcare services.

2.37 As soon as NHS organisations identify land and property as surplus to NHS requirements, they should discuss potential changes of use with their LPA, since this may increase the development potential of the land and property.

2.38 Good communications between NHS organisations and LPAs will ensure NHS organisations are informed, at an early stage, of developments that may have an impact on health or healthcare demand and hence demand for healthcare facilities.

Exclusions

2.39 Certain activities do not constitute development; and some that do, do not require planning permission. Planning permission is not generally required for:

- internal alterations;
- changes of use where both the old and new uses fall within the same use class as set out in the Town and Country Planning (Use Classes) Order 1987 and its subsequent amendments;

- developments permitted by the Town and Country Planning (General Permitted Development) Order 1995 (GPDO).

2.40 It is advisable to contact the LPA or planning consultants if there is doubt about whether planning permission is required.

Use Classes Order 1987 and its subsequent amendments

2.41 NHS organisations should be familiar with uses permitted within their estate under the "use classes order" and its subsequent amendments. The classes of particular relevance to NHS organisations are C2, C2A, C3 and D1.

GPDO 1995

2.42 The GPDO, as amended, sets out a list of types of development for which the order effectively grants planning permission. NHS organisations should be familiar with this list, particularly Part 32, which grants limited rights for developments on hospital sites.

Planning applications

2.43 The principles set out in PPGs and PPSs must be taken into account in the preparation of planning applications.

2.44 General guidance is that:

- where the development proposal is straightforward, the application may be made by the relevant project manager;
- where the development proposal is more complex or contentious, consideration should be given to employing planning consultants at an early stage to prepare the application and negotiate with the LPA.

2.45 Any permission given will relate to the precise details described in the application, so it is important to make sure the application is clear (for example, a "change of use permission" does not permit consequential works to be carried out unless specified in the application).

2.46 Two types of planning application may be submitted to the LPA (full or outline). The type of application will depend on the extent to which the details of the development have been formulated.

2.47 Both types of application must be accompanied by a design and access statement.

2.48 Change of use cannot be dealt with by an outline application.

2.49 Advice should be sought from the LPA (and planning consultants, if employed) about the type of assessments required and documentation to be submitted with the planning application. It is likely that a wide range of supporting information will have to be submitted, for example noise and transport assessments, and environmental information.

2.50 One of the objectives of the planning system reforms introduced by the Planning and Compulsory Purchase Act 2004 is to introduce greater certainty regarding the outcome of planning applications. This is partly being achieved by planning applications being front-loaded with a considerable amount of explanatory information. It will therefore be necessary to allocate time for the preparation of these documents.

Full application

2.51 Full details of the development are submitted to enable construction to go ahead, although some matters may be dealt with by conditions attached to the planning permission. These matters will be approved by the LPA at a later stage, for example a requirement to submit details of landscaping for approval at a certain stage.

Outline application

2.52 The application will set out the size, purpose and type of development and, if granted, will permit the proposed development "in principle" but subject to full details being submitted.

2.53 The following information must be submitted with an outline planning application:

- information on the use of the proposed development;
- indicative amount of development, for example floor space;
- indicative layout;
- scale parameters, that is, upper and lower limits for height, width and length for each building;
- indicative access points.

2.54 Certain matters may be reserved for approval later, including:

- site layout and its relationship to buildings and spaces outside the site;

- scale – the height, width and length of each building proposed;
- appearance;
- access;
- landscaping.

2.55 The above matters will usually have to be approved within three years of granting outline planning permission, otherwise the permission will lapse.

Supporting documentation

Transport assessments

2.56 Transport issues are becoming increasingly significant in determining planning applications.

2.57 PPG 13 – 'Transport' advises that all planning applications likely to have significant transport implications require a transport assessment. This should include a green travel plan in accordance with Health Technical Memorandum 07-03 – 'Transport management and car parking'.

Environmental impact assessments

2.58 Consideration should be given as to whether a proposed development will require an environmental impact assessment (EIA) pursuant to the Town and Country Planning (Environmental Impact Assessment) (England and Wales) Regulations 1999.

2.59 The term EIA describes a procedure that must be followed for certain types of project before they can be given development consent. The procedure is a means of assessing the project's likely significant environmental effects, and the scope for reducing them.

2.60 Advice should be sought from the LPA and/or a planning consultant at an early stage to establish whether an EIA is required.

Twin tracking

2.61 This occurs where two identical planning applications are submitted simultaneously, with the intention of appealing the second one in the event of non-determination of the first by the LPA.

2.62 Twin tracking is to be abolished under the Planning and Compulsory Purchase Act 2004. When the relevant provision comes into force, the LPA will be able to refuse to determine an application where it thinks it is similar to another application that has not been finally decided (either by the LPA or on appeal by the Secretary of State).

Planning conditions

2.63 Planning conditions are generally applied to the granting of planning permission, and limit and control the way in which the planning permission may be implemented.

2.64 Planning conditions can cover a wide range of matters, but often require certain works to be done at specific phases of the development or require further details of the development to be submitted to, and approved by, the LPA prior to the development proceeding.

2.65 For example:

- further details of any highway works will usually have to be submitted prior to the start of the development and constructed prior to occupation of the development;
- landscaping and ecological mitigation measures may be required prior to the start of the development. Mitigation measures will need to be taken into account in the overall programme for the project, as certain measures can only be implemented at certain times of the year;
- any land remediation will usually have to be completed prior to the start of the development;
- car parking arrangements will usually have to be constructed prior to occupation;
- a green travel plan will usually have to be implemented prior to occupation.

2.66 A draft planning permission decision notice will usually be issued to the applicant for review. NHS organisations should ensure that any proposed conditions are not onerous and can be complied with.

2.67 Once a planning permission has been granted subject to conditions, it may be possible to lodge an appeal or submit an application to vary the conditions.

Planning obligations (Section 106 agreements)

2.68 Planning applications may be subject to planning obligations under Section 106 of the Town and Country Planning Act 1990 as substituted by the Planning and Compensation Act 1991.

2.69 Planning obligations might prescribe the nature of the development, secure a contribution to

compensate for loss or damage created by the development, or mitigate the impact of the development.

2.70 NHS organisations should seek to require developers to provide facilities or pay monies for the provision of local healthcare services (where a new development affects local healthcare needs) so that existing facilities are not over-burdened.

2.71 Circular 05/05 – 'Planning Obligations' (DCLG) provides guidance to local authorities in England on the use of planning obligations under Section 106 of the Town and Country Planning Act 1990.

2.72 The circular states that planning obligations are private agreements negotiated, usually in the context of planning applications, between LPAs and persons with an interest in a piece of land (or "developers"), and intended to make acceptable developments that would otherwise be unacceptable in planning terms.

2.73 Planning obligations may also be secured through a unilateral undertaking. This is a deed entered into by the developer (alone) under Section 106 of the Town and Country Planning Act 1990. Unilateral undertakings are often used in an appeal situation where agreement cannot be reached with the LPA regarding planning obligations.

2.74 LPAs are increasingly encouraging applicants to submit a unilateral undertaking with their planning applications. In general this should be resisted, since it is better for the applicant if both parties are involved in the negotiations. This way the LPA is required to enter into specific covenants, for example only use contributions for the purpose intended and return any monies that have not been spent within a specified period.

2.75 Where there is a choice between an LPA imposing planning condition or entering into a Section 106 Agreement (planning obligations), Government guidance states that the imposition of a planning condition is preferable.

2.76 This is because an applicant can appeal against onerous planning conditions that may have been imposed on a planning permission but it cannot appeal against planning obligations once a Section 106 Agreement has been completed. In addition, the enforcement powers relating to planning conditions are more straightforward.

2.77 Planning obligations are unlikely to be required on all developments, but there are not specific rules about the size or type of development that should attract such obligations. However, the planning obligations sought by the LPA must be:

- relevant to planning;
- necessary to make the proposed development acceptable in planning terms;
- directly related to the proposed development;
- fairly and reasonably related in scale and kind to the proposed development;
- reasonable in all other respects.

2.78 Where NHS organisations are selling surplus property, care should be taken not to agree to planning obligations that are unreasonable. Professional (especially legal) advice should be sought before accepting any liability or entering into a Section 106 Agreement.

2.79 Sections 46 and 47 of the Planning and Compulsory Purchase Act 2004 give the Secretary of State the power to introduce regulations to replace Section 106, but to date these powers have not been used.

2.80 NHS organisations should be aware of proposals to amend or replace the Section 106 process, and should keep up-to-date on these changes.

Determination of planning applications

2.81 LPAs should determine planning applications in accordance with national, regional and local planning policies, including PPGs and PPSs.

2.82 They should consult with the public and a wide range of statutory bodies regarding each application. NHS organisations should be involved in the public consultation in order to influence decisions that impact on healthcare provision.

2.83 Once the application has been considered, it may be determined under powers delegated to planning officers. If it is a major application or has attracted a number of objections, the relevant planning officer will make a recommendation to the planning committee. The planning committee is not, however, bound to follow the planning officer's recommendation.

2.84 The final decision will be one of the following:

1. Refuse the application.
2. Grant the application – subject to conditions.
3. Grant unconditionally.

4. Defer approval to allow a Section 106 Agreement to be completed.

2.85 Generally, full planning permission will be valid for three years. If outline permission is obtained, a reserved matters application must be made within three years.

2.86 It is very important to implement a consent within the correct timescale, otherwise it will lapse. Once lapsed, the LPA is not obliged to renew permissions, although it should have a good reason for not doing so (this could, for instance, be where local planning policies have altered).

2.87 NHS organisations should make sure that any conditions imposed are not onerous and can be complied with.

Planning appeals

2.88 Where a planning application is refused, or a decision is not made within the statutory period allowed, or conditions are imposed that are unacceptable, it is advisable to seek specialist advice concerning potential options. The options include:

- negotiating amendments with the planning officer, and following this up with a revised application;
- submitting an application for an alternative scheme;
- appealing against the decision.

2.89 An appeal against refusal or the imposition of conditions must be lodged within six months of the LPA's decision.

2.90 There are three types of appeal procedure: written representations, an informal hearing and a public inquiry.

Written representations

2.91 This is the cheapest and quickest type of appeal, and is most appropriate where the issues being disputed are straightforward.

2.92 The appeal is dealt with in the form of written statements of the case, which are exchanged. The inspector will then visit the appeal site and make a decision accordingly. No opportunity is allowed for an oral presentation of the arguments.

2.93 This type of appeal will typically take a few months from lodging the appeal to receiving the inspector's decision.

Informal hearing

2.94 This procedure is intended for fairly straightforward appeals where the appellant wishes to debate the issues at stake in front of an inspector. No legal representation is normally allowed, although consultants are allowed to present the case in a debate, which is led by the inspector.

2.95 The appeal process may typically take four to six months.

Public inquiry

2.96 This procedure is most appropriate for complex or controversial schemes, where witnesses on the applicant's behalf, and those on behalf of the LPA, can be cross-examined by legal representatives. This procedure is the most costly and time-consuming, although it is the most thorough.

2.97 An appeal decision may take up to a year from lodging the appeal for a typical proposal, and may be significantly longer for particularly complex or contentious appeals.

2.98 The inspector's decision is usually final. In some major cases the Secretary of State makes the final decisions. Appeal decisions are subject to challenge, but only on points of law.

2.99 A careful evaluation of the cost benefits must be taken by an NHS organisation before undertaking an appeal.

2.100 Where early information indicates that there may be a conflict with local or national Government policies, this should be resolved through discussions with the LPA. Discussions should take place before a planning application is made.

Other planning control issues

2.101 The following planning issues should also be considered:

- while all utilities companies and bodies responsible for roads and drains will be consulted by the LPA as part of the planning process, it is advisable to make a direct enquiry to them on a scheme of any substance, before preparing plans for the scheme or applying for planning permission. This should establish whether there are any problems of capacity with services that may prevent any proposed development from proceeding;

- building regulation consents may be required; the architect/building surveyor/project manager should deal with these points;
- other agreements may need to be concluded before implementing planning consent, for example relating to off-site highways work, on-site highways, sewers etc;
- advice should be sought concerning infrastructure charges levied by water authorities. Credits are available on the redevelopment of existing built sites.

Special interests

Conservation areas

2.102 Where the LPA considers that an area has special character that ought to be preserved or enhanced, it may, after due consultation, designate it as a conservation area. There are no rights of appeal against this decision, although representations (prior to the decision being made) will be considered by the LPA.

2.103 Once a conservation area has been designated as such:

- there will be extra controls on the demolition of any property on that land;
- any new buildings must preserve, and should aim to enhance, the character of the area;
- trees, whether or not protected by a tree preservation order (see paragraphs 2.117–2.118 for details), cannot be felled without consent being first obtained;
- more limited development rights will apply, meaning that more types of development will require planning permission;
- outline applications will not normally be accepted.

2.104 If designation as a conservation area will adversely affect future developments, representations to the LPA should be prepared by a planning consultant with conservation experience.

2.105 Once a conservation area has been designated, NHS organisations will need to apply for conservation area consent before undertaking most developments, including demolition. Specialist advice from a planning consultant should be sought if development or demolition of buildings is proposed.

Listed buildings

2.106 The Planning (Listed Buildings and Conservation Areas) Act 1990 contains provisions for the protection of buildings of special architectural or historic interest.

2.107 In England, the Department for Culture, Media and Sport (DCMS) maintains a list of these buildings, graded according to their importance.

2.108 In the case of new listings, English Heritage will provide professional advice (go to www.english-heritage.org.uk for further details). The final decision rests with the Secretary of State at the DCMS.

2.109 If an unlisted building of possible historic or architectural interest is located on a site where a planning application has been made, an application may be made for a certificate of immunity (CoI), to prevent listing from adversely affecting future development prospects.

2.110 An application for a CoI may lead to a listing. However, it is better for this to happen rather than spending a long time preparing development proposals that may become incapable of implementation because of a last-minute or spot listing.

2.111 Specialist historic buildings advice should be sought concerning this procedure.

2.112 The LPA may require the owner of a listed building to carry out essential repairs by serving a repairs notice. It is therefore advisable to keep listed buildings in good repair.

2.113 Listed building consent is normally required for any alteration work (including internal alterations) of any listed building or structure, which would affect its character, appearance or setting, in addition to ordinary planning permission. Failure to obtain such consent is a criminal offence.

2.114 Listed protection includes structures within the curtilage of a listed building such as garden walls and statues.

2.115 Whenever an NHS organisation wishes to alter or dispose of a listed building it should appoint a consultant with specialist historic buildings experience to advise and negotiate the most beneficial planning and listed building consents.

2.116 Permission to demolish a listed building is only granted in exceptional circumstances. Mounting a case to achieve this may be expensive, but should

not be presumed to be impossible. Consideration of this action should only be taken after seeking specialist legal and planning advice.

Trees

2.117 Section 198 of the Town and Country Planning Act 1990 sets out procedure for the protection of trees, whether individually or in groups, through the issue of tree preservation orders (TPOs). These orders prevent the lopping, felling and cutting down of trees without LPA permission.

2.118 On receipt of a notice of a TPO, an NHS organisation has 28 days to object. The following procedures should be followed:

- if the trees are manifestly unsuitable (that is, dead or dangerous), the NHS organisation should inform the LPA that they should not be included in the TPO and make arrangements for removal of the trees;
- if in relation to future developments, the location of the trees will not be an issue, regardless of the TPO, there may be no need to object;
- if the imposition of the TPO will adversely affect potential developments, the NHS organisation should object to the order. A specialist arboriculturalist experienced in appeals work should be instructed to prepare a report on the condition of the trees. If the trees are not worthy specimens, he/she may be able to persuade the LPA to change its mind;
- beware of the penalties for breach; it is a criminal offence, and personal liability may apply. The fine may be considerable, and replanting will probably be required.

2.119 NHS organisations may find it beneficial to develop a tree/woodlands management scheme with their LPA.

The green belt

2.120 The fundamental aim of green belt policy is to prevent urban sprawl, merging of settlements and encroachment on the countryside, by keeping land permanently open. Development within green belts is therefore severely constrained.

2.121 National planning policy on green belts is contained in PPG 2 – 'Green belts'. General policies controlling development in the countryside (mostly contained in PPS 7 – 'Sustainable Development in Rural Areas') apply with equal force to green belts.

2.122 The Town and Country Planning (Green Belt) Direction 2005 clarifies the criteria and processes for referring planning applications for inappropriate development in green belts to the Secretary of State. LPAs now refer applications covered by the Direction directly to the Secretary of State.

2.123 Consent for new buildings or change of use within green belts will only normally be given for proposals that maintain the openness of the site. In practice it is often very difficult to obtain permission for redevelopment. It is advisable to take appropriate advice when considering such development.

2.124 Special considerations apply to redundant hospitals in green belts. Permission to redevelop these sites may be obtained, which would not otherwise be available in green belt areas. PPS 3 – 'Housing' and PPG 2 still need to be complied with. This is a complex area, and hence it is important that NHS organisations obtain specialist planning advice in respect of these issues and negotiate planning consent for alternative use/development.

2.125 The best route is to persuade the LPA to include redevelopment proposals within the LDDs. Sites should be sought to be allocated as major development sites, whether they are redundant or in continuing use.

2.126 Planning consent for the redevelopment of sites within green belts should be sought before demolishing buildings or clearing the site. This will preserve the mass, height etc of the existing buildings and enable a better case to be made for alternative use where this will reduce the mass, height etc of existing buildings, and thus enhance the green belt.

2.127 Once a site has been cleared it will be difficult to obtain planning permission to develop the site, as it will revert to being an undeveloped part of the green belt.

Enforcement

2.128 It is unlikely that the LPA will take enforcement action against an NHS organisation without warning and considerable discussions. If disputes cannot be resolved amicably, it is essential to take the advice of planning solicitors and consultants as soon as possible.

2.129 There are a variety of enforcement powers that are open to an LPA:

- enforcement notice;
- stop notice;
- temporary stop notice;
- planning contravention notices;
- breach of condition notices;
- injunctions.

2.130 On receipt of any of the above notices or injunctions seeking compliance with planning regulations, a lawyer should be instructed immediately. There are very strict time limits for lodging an appeal if required. Once the notice becomes operative, it is a criminal offence not to comply with it.

2.131 The swift procedure for ensuring compliance with conditions annexed to a planning permission should be noted. Here, the LPA may issue a breach of condition notice whereby compliance can be imposed immediately; failure to comply is a criminal offence. There is no right of appeal against a breach of condition notice. There is a chance that personal liability could ensue in these situations, and fines can be considerable.

2.132 LPAs are able to issue enforcement notices against Crown bodies for breaches of planning control, but are not able to enter Crown land without permission or prosecute Crown bodies for failure to comply with planning legislation.

3 Planning strategic investment in the estate

Introduction

3.1 This section describes the use of strategic service development plans (SSDPs) for the planning and delivery of healthcare services, and the various toolkits, techniques and guidance that may be used when developing SSDPs.

3.2 It also describes the use of strategic asset management (SAM) techniques to align property assets with healthcare delivery.

General principles

3.3 Healthcare delivery is changing from a performance management system to a business model with much more emphasis on customer care (see paragraphs 1.24–1.30 for further details on changing models of care).

3.4 Commissioners will need to be able to plan and purchase high-quality, accessible healthcare facilities through a range of providers including NHS organisations, the private sector and third parties (social enterprise units, voluntary organisations and charities).

3.5 To be able to deliver this change, SSDPs should be prepared.

Strategic service development plans (SSDPs)

3.6 An SSDP is a document that should set out expected demand for services within a particular geographical area (healthcare economy) over a 10-year period and examine options for meeting that demand.

3.7 It is owned and developed by a wide range of stakeholders, including the SHA, PCTs, NHS trusts, GP practices, local authorities, charities and voluntary organisations, and the public.

3.8 An SSDP should include:

- innovative methods of service delivery, including those that cut across established organisational boundaries;
- practical applications of current guidance and initiatives;
- local expertise (patient, clinical and strategic);
- contributions from available partners (for example private providers, LIFT companies and voluntary sector);
- details of anticipated and required workforce changes.

3.9 Service delivery options should take account of changing expectations for buildings and facilities, developments in construction, information technology (IT) and medical technology, and financial opportunities and constraints.

3.10 The expected benefits to services from the proposals in the SSDP should be listed, including how each benefit will be achieved, who will be responsible for its achievement, and a target date for completion.

3.11 The principal focus of an SSDP is service development. However, it should (by association) also provide development plans for:

- workforce;
- estates and facilities;
- IT;
- finance.

3.12 The Strategic Health Asset Planning and Evaluation toolkit (SHAPE) and Achieving Excellence Design Evaluation Toolkit (AEDET) may be used to develop an SSDP, together with impact assessments and 'Developing an estate strategy' guidance (DH Estates and Facilities Division). See below for further details.

Techniques and tools

Strategic Health Asset Planning and Evaluation (SHAPE)

3.13 SHAPE is a web-enabled strategic asset planning toolkit being developed by DH's Estates and Facilities Division.

3.14 It will help health and social care organisations improve their forecasting of health and social needs and understand the consequences for service configuration and use of buildings. It will support the integration of health and social care services.

3.15 SHAPE is designed to enable whole-system planning for PCTs and SHAs.

3.16 It is structured to address three strategic questions: "Where are we now?"; "Where do we want to be?"; and "How do we get there?"

3.17 An understanding of the existing position ("Where are we now?") will be informed by a database incorporating information on current clinical activity and the existing estate (physical capacity), linked to a geographical information system (GIS) mapping tool. This mapping tool will significantly reduce the complexity of the process to develop an SSDP.

3.18 Scenario-planning features will explore the potential impact of a range of variables, from emerging care models and new technologies to projections of social and health need/service demand. Spatial planning and modelling features will facilitate the development of the optimum service delivery model ("Where do we want to be"?), which will identify investment needs and disinvestment opportunities in the health economy.

3.19 This in turn will determine the future capacity of the property base and how assets should be held in order to achieve the goals for this model ("How do we get there?").

3.20 This process will aid talks between NHS organisations and LPAs when discussing healthcare policies and service development changes. See paragraph 2.16 and paragraphs 2.24–2.33.

Health impact assessments (HIAs)

3.21 A health impact assessment (HIA) is a method of evaluating the likely intended and unintended effects (beneficial and adverse) of policies, initiatives and activities on the health of a population and groups within it.

3.22 It offers a framework within which to consider, and influence, the broad determinants of health. The aim is to maximise health gain and minimise health risks. It may contribute to addressing inequalities in health.

Estates impact assessment

3.23 When new services and buildings are being planned, an estate impact assessment should be carried out to ascertain how existing services and accommodation will be affected.

3.24 Would increased capacity lead to the closure of units? If so, could surplus accommodation be used for alternative NHS services? If not, should it be disposed of? Alternatively, there may be an opportunity to expand services to complement those being proposed: again, the consequences of this option should be fully assessed.

Achieving Excellence Design Evaluation Toolkit (AEDET)

3.25 This toolkit provides an industry-wide framework to enable the evaluation of healthcare buildings in terms of impact, build quality and functionality. It forms the key agenda of design reviews, and informs decisions of investment and disinvestment. For details go to http://design.dh.gov.uk/content/connections/aedet_evolution.asp.

'Developing an estates strategy'

3.26 An estate strategy document relates to individual NHS organisations and should describe the overall use of the estate, occupancy costs, service and organisational constraints, and capital investment decisions.

3.27 It should demonstrate how the current supply of capital assets meets current service needs and the needs of the community, and how assets will change through investment, acquisition or disposal to meet future needs.

3.28 Each estate strategy will contribute to the development of an SSDP.

Strategic asset management (SAM)

3.29 SAM integrates land and property development with service planning to achieve the most sustainable investment/disinvestment decisions. It should be used at an early stage of service planning to achieve cost-effective solutions.

3.30 SAM should lead to:

- a co-ordinated approach to the implementation of Government policies to modernise the NHS;
- improved co-ordination of public sector investment across communities to improve healthcare;
- better partnership working between all stakeholders;
- improved strategic fit of existing facilities in a sustainable manner.

3.31 SAM brings together the tools and techniques outlined in paragraphs 3.13–3.28 to facilitate a property strategy to ensure that service changes occur quickly and efficiently.

3.32 This should facilitate improvements for better use of existing facilities, use of alternative non-NHS facilities, or provision of new buildings. Underused or unsuitable assets should be identified and sold to release capital for reinvestment in new services or facilities.

3.33 Long-term benefits of SAM include:

- alignment with business direction – property reflects what the NHS organisation wants to achieve and supports delivery;
- capital recycling;
- better procurement of healthcare facilities;
- efficiency reviews.

Part C – Procurement of new facilities and services

4 Procurement of new facilities and services

Introduction

4.1 This section examines formal procurement requirements for NHS organisations in relation to the ownership of land and property, including freehold and leasehold arrangements.

4.2 Brief guidance is given on EU rules governing procurement and their effect on land and property transactions and acquisition of management services. This will clarify issues arising in Parts D and E.

4.3 It also describes other types of procurement outside straightforward freehold and leasehold arrangements, such as Private Finance Initiative (PFI), NHS ProCure21 and NHS LIFT schemes. It outlines the legal structures linked to these initiatives and their effects on NHS ownership of land and property.

4.4 All NHS organisations should take specialist advice in relation to VAT implications in respect of these procurement routes. Failure to do so can be costly. NHS ProCure21 operates a central VAT recovery service for its schemes, which provides specialist advice at no cost to NHS organisations.

EU rules on procurement

4.5 NHS organisations are subject to the European Procurement Rules ("EU Rules") – EC Directive 2004/18/EC and the Public Contracts Regulations 2006 – when procuring contracts for works, goods or services over specified financial thresholds. Even below these thresholds, EC Treaty principles will also apply, namely: equality of opportunity and treatment, transparency, proportionality, and a sufficient degree of advertising.

4.6 The procurement of new buildings is highly likely to fall under the EU Rules.

4.7 Where the sale of an asset (land and/or property) is directly linked to the procurement of new facilities or buildings, the EU Rules will usually apply because the construction of the new facilities or building will be regarded as a public works contract.

4.8 If an NHS organisation has any input into the specification of a new facility that is being constructed and which the NHS organisation is going to lease or part-lease, it is highly likely that the lease will fall under the EU Rules.

Land and property transactions

4.9 Land disposals are not affected by EU Rules unless the land and property is used in lieu of cash as consideration for the procurement of new facilities.

4.10 In general, EU Rules do not apply to land purchases and/or rights related to land. This includes straightforward purchasing or leasing of land with existing buildings or speculatively built new buildings. However, there are exceptions to this general principle and so, when planning a property transaction, it is important to check that none of these exceptions apply.

4.11 If EU Rules do apply, the transaction must be advertised in the Official Journal of the European Union (OJEU) and specific timescales and rules of procedure must be observed. Professional advice should be sought.

4.12 Even if the EU Rules do not apply, the procuring body still needs to ensure that it has considered various alternatives and can demonstrate that the proposed transaction is the best way forward and represents value for money (for example by completing an option appraisal as part of its business case).

Public works contracts

4.13 Some land transactions may be classified as public works contracts and may therefore be subject to the EU Rules. In particular where, as part of the transaction, a new facility is being built to meet an NHS organisation's specified requirements, the contract is likely to be classified as a public works contract to which the EU Rules will apply (subject

to the value of the contract being above the relevant financial threshold).

4.14 Classification as a public works contract may be made regardless of the type of land transaction, who owns the land, and whether the works are paid for through rental payments or a single lump sum.

4.15 For example, where an NHS organisation agrees to take a 20-year lease of new offices to be built by a developer, on the developer's own land, to the NHS organisation's specified requirements, the contract is likely to be classified as a public works contract.

4.16 If, however, the lease is for existing offices or new offices where the NHS organisation does not specify any element of the new build (apart from usual tenant's fittings), it is likely that it will constitute a land transaction and fall outside the EU Rules.

4.17 This is a potentially complex area, and professional advice, especially legal, should always be sought if there is doubt over whether the EU Rules will apply.

4.18 NHS organisations should be aware of probity issues in negotiating with a single developer rather than tendering, as this may raise governance questions.

Public services contracts

4.19 Some land transactions may be classified as public services contracts and may therefore be subject to the EU Rules. This may arise where additional services are provided as part of the land transaction.

4.20 For example, an NHS organisation may agree to take a lease of an existing building but may ask the landlord to provide additional services – over and above those usually provided under a standard full repairing and insuring lease.

4.21 If the value of the additional services exceeds the value of the payments purely attributable to rent, and/or the value of the additional services are above the relevant financial threshold applicable to public services contracts, the EU Rules will apply.

4.22 A typical example of such additional services would be services provided as part of a lease-plus agreement under NHS LIFT. Again, professional (especially legal) advice should be sought if there is doubt over whether the EU Rules will apply.

Procuring works, goods or services – asset maintenance

4.23 Many of the day-to-day operations of the estates/facilities department require the purchasing of resources, whether service contracts or plant, equipment or stores items.

4.24 Many purchases require professional advice and support from the NHS organisation's purchasing and supplies department or the NHS Purchasing and Supply Agency (PASA). The asset manager must lead professionally but use this support and expertise wisely.

4.25 The EU Rules apply to many day-to-day purchasing activities.

4.26 Tendering procedures as set out in standing orders and financial instructions need to be observed.

4.27 Professional advice should be sought from legal advisors, the NHS organisation's purchasing and supplies department or PASA if there is any doubt whether a procurement is subject to EU rules.

Private Finance Initiative

4.28 The Private Finance Initiative (PFI) is a contract for the provision of services by a private-sector partner (namely serviced accommodation and sometimes "soft" facilities management (FM) services, for example portering, catering etc) to an NHS organisation.

4.29 The EU Rules nearly always apply to PFI projects. Guidance from DH's Private Finance Unit should be followed as well as professional (including legal) advice.

4.30 Until 2005 a basic form of lease and leaseback structure was adopted whereby the NHS organisation would let the land upon which the facilities were to be built to the private sector for, say, 60 years and the private sector would then let the same land back for, say, 30 years. The NHS organisation would then grant a licence to the private sector to come onto the land and provide the relevant services.

4.31 This arrangement assumed that there was potentially some "residual value" to the private sector in owning the land once the 30-year lease had expired. However, as PFI matured it became apparent that there was rarely any such residual value. In order to make the arrangement more tax-efficient for the private sector and therefore more cost-effective for the NHS, the lease and leaseback

structure has gradually been abandoned and replaced by the so-called "contract debtor" arrangement.

4.32 The contract debtor structure does not involve the granting of any lease; instead, the NHS organisation grants a licence to the private sector to enter onto the land to build and then carry out the necessary services.

4.33 For further details on PFI go to www.dh.gov.uk.

4.34 See also the Capital Investment Manual for definitive guidance on all PFI/PPP projects.

NHS ProCure21

4.35 NHS ProCure21 is a procurement method for publicly-funded NHS capital schemes.

4.36 It is based on four principles:

- introducing long-term partnering frameworks between NHS organisations and construction companies (principal supply chain partners);
- enabling the NHS to be a best client;
- achieving excellence in healthcare design;
- benchmarking and performance monitoring.

4.37 The framework allows NHS organisations to select a construction partner based on best value and suitability rather than lowest cost.

4.38 ProCure21 meets the selection criteria of the EU, the Treasury, standing orders and financial regulations. Schemes do not need to go through the OJEU process. Contractor-to-site time is therefore accelerated by removing the need to tender for individual schemes.

4.39 Collaborative working is encouraged through the use of the New Engineering Contracts (NEC) contract, which enables issues to be raised and resolved quickly. Continuous improvement is promoted in all projects.

4.40 For further details on NHS ProCure21 go to www.nhs-procure21.gov.uk.

NHS Local Improvement Finance Trust (LIFT)

4.41 NHS LIFT is a Government-led procurement programme for the delivery of community-based health and social care facilities throughout England. The EU Rules will apply to the procurement of LIFT projects, and guidance from Partnerships for Health should also be followed. Professional, including legal, advice should always be obtained.

4.42 NHS LIFT is a public–private partnership (PPP). It has at its core a company (LiftCo), in effect a property development company, acquiring and developing land and property and leasing them to NHS organisations on a fully-serviced basis through a lease-plus agreement. In this context, fully serviced means that the landlord carries out internal and external repairs to the building but does not provide reception or security services.

4.43 LiftCo is a partnership between the public and private sectors. Normally, LiftCo owns the land and property in order to obtain finance against these assets unless the NHS partner determines otherwise. Much depends on the long-term service delivery strategy of the trust involved.

4.44 LiftCo will assess the lifecycle costs to keep all the premises in good repair from day one until the end of the lease and commute these to a fixed annual cost. This cost is index-linked on an annual basis using the retail price index. This is the main difference with standard full repairing and insuring leases, where the repair works are usually organised on a planned and reactive basis; and the costs will fluctuate over the years depending on the amount of work that needs to be carried out.

4.45 In some circumstances under lease-plus agreements, the tenant can undertake repairs at the landlord's cost, if the landlord has not put right the lack of repair, thus giving greater control to the tenant to ensure that the property is properly maintained. Lease-plus agreements are property leases, but a significant number of the operative provisions in these agreements originate from PFI.

4.46 For further details on NHS LIFT go to www.dh.gov.uk.

Part D – Transactions

5 Acquisition of freehold land and property

Introduction

5.1 This section deals with acquisitions by NHS organisations of freehold land and property. Some of the provisions, for example those relating to surveys, heads of terms, and the solicitor's role, apply equally, however, to leasehold acquisitions.

Delegated limits

5.2 All NHS organisations should be aware of their delegated limits before proceeding with any property-related transaction. See paragraphs 1.69–1.72 for details.

Principles of acquisition

5.3 Once an NHS organisation has identified a need for additional land and/or property, the NHS organisation should:

- first check whether another NHS organisation has surplus land and property that it could use;
- check the 'Register of Surplus Public Sector Land' for surplus land (defined as "vacant land or buildings or property that is no longer required for the purposes of the public body"). For details see www.dh.gov.uk;
- if no public sector land is available, conduct a thorough search of private land and property through direct and indirect enquiries either themselves or through an agent.

5.4 A site within the NHS or civil estate should always be chosen unless good reasons dictate otherwise.

5.5 Generally, the re-use of existing property owned by NHS organisations, other government departments and local authorities is more cost-effective and sustainable than new builds or adapting/refurbishing private-sector properties.

5.6 When acquiring land with existing buildings or for new buildings, the following points should be observed:

- check the availability and likely price of the land;
- check general accessibility to the site for all users, especially in respect of public transport;
- check legal title and restrictive covenants that might prevent the proposed development;
- check the business rates for the development options under consideration;
- ensure that the site is capable of being developed as required (that is, services available, ground conditions suitable, density adequate etc) or that the buildings are suitable for the required conversion. Check that the utilities capacity is sufficient without expensive upgrades;
- check that the scheme is capable of implementation – for example, check with the LPA that planning consent for the required use will be granted, and with the Highways Authority that access arrangements for the proposed development are adequate.

The business case

5.6 When embarking on capital expenditure, a business case should be prepared in accordance with the Capital Investment Manual. This includes the acquisition of land and healthcare operational property, or administrative property (offices). For healthcare operational property, a statement about the intended healthcare benefit will be required.

5.7 A number of business cases may be prepared throughout the acquisition process.

5.8 Any purchase, or option contract (see paragraphs 5.51–5.55) made in advance of approval of the business case (the requirements for approval depend on the total capital cost, including the cost of land) could pre-empt the approval process and so should not be undertaken without the prior approval of the organisation's board, acting within their delegated limits. Acquisitions above this limit should seek the consent of DH.

5.9 The business case may identify a need to acquire a new site. This may be either a specified site or a particular type of property (for example staff residences, offices, clinic accommodation or care-in-the-community).

5.10 Private sector property may be used when there are very good business reasons for doing so, and when the benefits over and above using public assets are clearly demonstrated and documented. The analysis should include the holding costs of vacant NHS or civil estate sites not selected, to demonstrate best value for the exchequer overall.

5.11 A detailed option appraisal comparing all available sites should be carried out to allow an informed decision to be made. This information should be included in the final business case for the preferred option.

5.12 As part of the business case approval process, DH requires an environmental assessment of the particular healthcare site to be undertaken, using the NHS Environmental Assessment Tool (NEAT). For details go to www.efm.ic.nhs.uk.

5.13 Any business case requires a NEAT score rating of “excellent” for new builds and “very good” for refurbishments. This rating covers all aspects of environmental management including carbon emissions, waste management, water use, transport and procurement policies – and is in line with the Government’s requirements for sustainable construction.

5.14 In addition, business cases should comply with mandatory energy efficiency targets of 35–55 GJ/ 100 m^3 for new builds or refurbishments.

Managing the acquisition team

5.15 Whenever an acquisition is contemplated, a technical team proportional to the size and complexity of the transaction should be appointed from the outset through to completion of the scheme.

5.16 The team should be led by a project manager (in-house or external), who should act as the informed client to ensure the organisation’s interests are protected and managed at all times.

5.17 The project manager should have knowledge and experience of NHS policies and procedures, particularly in relation to land and property transactions, together with a thorough knowledge of the NHS estate.

5.18 The team should advise on many issues, for example strategic direction setting, identification, selection and management of appropriate consultants and monitoring/management of the entire process, including governance and probity.

5.19 A major new site may require legal, engineering, property consultant, town planning and environmental input, and this should be established at the outset.

5.20 Any legal constraints, such as covenants on the use of the land or other legal restrictions, should be addressed by the solicitor, or the purchase should be abandoned, thus avoiding high abortive costs.

5.21 In cases where compulsory purchase is being considered, as much time as possible should be allowed for (see paragraphs 5.70–5.80 on compulsory purchase powers).

Town planning

5.22 Outline planning permission should be secured prior to purchase, although in certain circumstances NHS organisations may have to obtain full planning permission. See paragraphs 2.43–2.60 for details.

5.23 Early discussions with planning officers are essential to secure support for the proposed use, but these discussions will not necessarily ensure that planning permission is obtained.

5.24 Where applicable, planning advice should be sought in relation to environmental impact assessments and transport matters as well as issues concerning listed buildings, conservation areas or environmental/ecological matters.

5.25 Prior to submitting a planning application, NHS organisations should ensure that the vendor cannot withdraw from the transaction (for example by taking an option to purchase or entering into a conditional contract – see paragraphs 5.49–5.50).

5.26 The acquisition team should assess the impact of any planning conditions and/or obligations (Section 106 Agreements). See paragraphs 2.63–2.80 for details.

Site investigation report

5.27 Before acquiring land for a new building, a site investigation report should be commissioned to ensure that the site is “clean” in environmental terms and has no characteristics (such as poor ground, asbestos or other contamination, in-fill,

Japanese knotweed, badgers, newts etc) that would increase building costs.

5.28 The VOA's minerals surveyors are able to provide reports on mining subsidence. It should be ensured that any adverse conditions are fully reflected in the price and construction estimates.

5.29 Where existing buildings are to be demolished to allow the implementation of a new-build scheme, demolition costs should be ascertained, particularly if the building contains asbestos or other deleterious materials.

Services/utilities report

5.30 It is important to check whether the intended building works (including access arrangements) will involve diverting existing services, as this can be costly.

5.31 If services cross the site and need to be diverted, check the terms of any relevant wayleaves. They may stipulate that the utility company has to divert these at its own cost on notice, but is more likely to be an expense for the developer.

5.32 Check the availability of services without the need for expensive off-site works. Are the services of sufficient capacity to serve the proposed development? Explore availability of requisitioning powers of water authorities for drainage connections before expensive payments are made to third-party landowners for easements.

Structural survey

5.33 When acquiring land with existing buildings intended for use, a structural survey should be carried out before any commitment is made. The survey should include a separately commissioned desktop study into previous site use as well as potential risks from past or existing use of the surrounding land.

5.34 This should ensure that realistic estimates of repair costs and dilapidations are included in the business case.

5.35 The survey should cover:

- the structure of the property, including the walls, foundations, roof etc;
- the condition of the woodwork, including window frames and structural timbers;
- mechanical and electrical installations;
- drainage and other services;
- compliance with building regulations and planning permission;
- compliance with fire regulations and health and safety issues;
- condition of boundary walls and internal access ways;
- presence of asbestos or other contamination;
- presence of bats;
- new energy directives;
- Disability Discrimination Act implications.

5.36 The surveyor must be given full access to the property.

5.37 The survey should be addressed to the NHS organisation, otherwise it will not be possible to make a claim for losses arising from a surveyor's negligence.

5.38 When acquiring a new building, consider how to protect against latent defects (that is, those that will not be revealed by the survey).

Valuations

5.39 While expenditure on formal valuations normally should not be incurred until the business case has identified which purchase is to be pursued, the acquisition figures used in the business case should be the best possible estimates. It may be helpful to include the VOA or a private valuer in the business case team.

5.40 It is important to be aware of changes that might affect the options explored in the business case, such as vendors offering price reductions, the opportunity of securing land using an option contract (see paragraphs 5.51–5.55) and the effect on prices of changing market conditions.

5.41 The price being paid for any acquisition should be kept under review, with help from professional valuers until contracts for the purchase have been exchanged.

Negotiating the purchase

Freehold covenants

5.42 Negotiations at the outset should uncover all positive or negative covenants attached to the site

to be acquired. Legal advice should be taken with regard to these covenants.

5.43 A "positive covenant" is an agreement to do something relating to the use of land (for example build and maintain a fence), the benefit and burdens of which are not readily capable of being passed on to successors in title to the original contracting parties.

5.44 A "restrictive covenant" is an agreement restricting the use of land, and is capable of benefiting and binding the successors to the original contracting parties.

5.45 The Secretary of State's power to override covenants under Section 211 of the National Health Service Act 2006 (previously Section 87 of the National Health Service Act 1977) is not available to NHS organisations.

5.46 If NHS organisations wish to modify or discharge a covenant, an application must be made to the Lands Tribunal under Section 84 of the Law of Property Act 1925. This will only be granted if the Lands Tribunal is satisfied that the covenant "impedes some reasonable user of the land for public or private use". This can be complex and time-consuming, so professional advice is required.

5.47 When acquiring freeholds, avoid imposition of restrictions on use. They should only be accepted where:

- the price is reduced to reflect the restriction;
- on the acquisition of part of a landholding, some restriction is genuinely required to protect the use or value of the vendor's retained estate;
- the restrictions are part of a scheme to regulate the management of, say, a trading estate or business park.

5.48 Where the site is subject to existing restrictive covenants, these will be binding unless the site is newly acquired by compulsory purchase (see paragraphs 5.70–5.80 on compulsory purchase powers).

Conditional contracts

5.49 The purchase of a site may be dependent on the availability of planning permission for healthcare use, and often on the acquisition of improved access or drainage rights etc. To ensure that a site can be purchased on the terms and conditions on which the business case is based, a conditional contract should be considered.

5.50 In negotiating such contracts, ensure that:

- the steps required to satisfy the condition are clearly stated;
- the condition(s) can be waived by the NHS organisation;
- there is an agreed period to obtain satisfaction of the conditions, and that they are sufficiently well described that, if they cannot be met, the contract can be terminated;
- the NHS organisation determines whether or not the conditions have been satisfied, not an independent third party or the vendor. If the conditions of the purchase cannot be met, the NHS organisation may not wish to proceed with the contract, so they need to control the conditionality issues.

Option contracts (option to purchase)

5.51 Under an option contract, the landowner receives an agreed amount of money from a person who in return is given exclusive rights to buy the land over a specified period. Once the specified period is over, the landowner is free to sell the land to others.

5.52 The vendor may prefer the commitment involved in a conditional contract, but an option contract gives the buyer greater discretion on whether or not to proceed.

5.53 An option contract is particularly useful when:

- there are several sites available;
- the business case for the proposed new development has not been completed or approved;
- there are doubts over whether the purchase will proceed;
- a major capital project is to be carried out on a site not currently in NHS or civil estate ownership;
- the timescale from identification of the target site to approval of the business case may be protracted.

5.54 In these situations, it is prudent to seek an option to purchase from the landowner. Much time and money is involved in preparing a business case and securing planning consent and, while the negotiation of an option involves cost, the reduction in risk may make it good value for money. Points to watch for in negotiation are:

- period of option – while it must cover the time for business case approval for the proposed new development, the longer it is, the higher the likely option payment and the more uncertain the price payable;
- option payment – seek to have this offset against the land price if the option is exercised;
- land price – in the context of a short-term option (say up to two years) it may be possible to fix the price. If the vendor wants the payment linked to inflation, this may be preferable to linking to market value. Market values can be volatile, and excessive rises in the land cost could abort the project.

5.55 See paragraphs 5.6–5.14 for approvals required before completing an option contract.

Heads of terms

5.56 Having selected a site and obtained approval to proceed, a "heads of terms" for agreement between the vendor and purchaser should be drawn up. This will form the basis for instructing solicitors, and should include:

- a description of the site;
- the names and addresses of the parties and their solicitors;
- the price;
- the timescale for exchange of contracts and completion;
- any conditions (for example subject to obtaining planning permission, subject to satisfactory ground condition survey);
- any obligations on vendor (for example works to be carried out prior to completion, obtaining vacant possession);
- the tenure;
- a location plan.

The solicitor's role

5.57 The solicitor's role includes ensuring that:

- the vendor has the proper title to transfer the site;
- all planning permission and building regulation consents are in place and conditions complied with;
- roads and sewers serving the site are maintained at public expense;
- there are no major redevelopment proposals in the immediate vicinity (for example motorways) which might affect the suitability of the site for its intended use;
- boundary/fence ownership and maintenance responsibilities are known and understood;
- the required rights of access are available;
- there are no unforeseen third-party rights affecting it (for example public footpaths, rights of light or other covenants);
- the negotiated terms are incorporated in the contract;
- the transfer is completed on the required date.

5.58 Although the solicitor will provide a copy of local searches, it is still beneficial to contact the LPA to check for development proposals that might adversely affect the site at an early stage.

Key points

5.59 Written confirmation of the terms of a transaction should not be given to the vendor without appending the words "subject to contract".

5.60 Once a solicitor is instructed, points in dispute should not be negotiated without reference to him/her.

5.61 Once contracts are exchanged, both sides are committed to the terms of the contract as signed. In exceptional circumstances where the contract needs to be amended after exchange, the terms should not be altered, other than through a solicitor. Even an accurate written expression of an agreed variation can nullify the whole contract.

5.62 From the date of exchange of contracts the risk of holding the site normally passes to the purchaser. Even if the property burns down before completion, the cost of reinstatement will have to be met by the purchaser.

5.63 Ensure that all the usual risks are assessed and appropriate action taken.

5.64 Make sure that when documents are signed and/or sealed, standing orders are observed.

5.65 Signature by an unauthorised officer can bind the purchaser if it seems to the other party that he/she has the authority to do so.

Withdrawal of property from the market

5.66 Whenever an agreement to purchase has been reached, it should be stipulated that the vendor withdraws the property from the market.

Timetable

5.67 The conveyancing process will normally take a minimum of eight weeks (four weeks to exchange of contracts and another four weeks to complete). If either party wishes to depart from this timetable they can either negotiate a variation at the outset or rely on their surveyor or solicitor to accelerate the process.

5.68 Many factors can cause the process to be more protracted, including:

- the vendor's ability to give vacant possession;
- problems arising from the survey;
- unforeseen issues arising from local searches;
- problems on the title.

Post-completion

5.69 When the purchase has been completed, the NHS organisation should:

- update its asset register records and estate terrier, giving reference details of the Land Registry entry;
- obtain from its solicitor a summary of the title information for estate management purposes;
- apportion uniform business rates, and advise the local authority of the new ownership for rating purposes;
- review the rating assessment;
- check the accuracy of the completion statement (a draft of which should be prepared prior to completion).

Compulsory purchase powers

5.70 When a preferred site has been identified and appropriate planning permission obtained, if satisfactory terms for acquisition cannot be agreed with the owner, the NHS organisation may, as an exception, consider acquiring the site under a compulsory purchase order (CPO).

5.71 The prior approval of the Secretary of State for Health must be sought before proceeding with this course of action.

5.72 A robust business case giving full details of why such powers are required should be submitted, via the local SHA and with their support, to DH as soon as it is envisaged that it is likely to be required. Any CPO must subsequently be confirmed by the Secretary of State for Health.

5.73 Approval will only be given in exceptional circumstances. Hence, it is unwise to incur substantial costs by relying on the availability of compulsory purchase powers. Nonetheless, the existence of these powers may ease the process of negotiation.

5.74 In relation to the compulsory purchase of land by NHSFTs, Schedule 4 of the Health and Social Care (Community Health and Standards) Act 2003 (paragraphs 46-49) amends the Acquisition of Land Act 1981. Paragraph 46 states that this process must still be confirmed by the Secretary of State:

(1) An NHS foundation trust may be authorised to purchase land compulsorily for the purposes of its functions by means of an order

(a) made by the trust, and

(b) confirmed by the Secretary of State.

(2) The Acquisition of Land Act 1981 is to apply to the compulsory purchase of land under this paragraph.

(3) But no order is to be made by an NHS foundation trust under Part 2 of that Act with respect to any land unless the proposal to acquire it compulsorily

(a) is submitted to the Secretary of State in such form, and together with such information, as he may require, and

(b) is approved by him.

5.75 These powers can be used where a third party developer, such as LIFT or PFI, is to be used to provide the healthcare facilities.

5.76 The basis for compensation payments is complicated. Professional advice should be taken at an early stage of the option appraisal process. Negotiations should, however, be conducted on the basis that compulsory purchase powers are available.

5.77 Once embarked upon, a CPO process usually commits the NHS organisation to complete a purchase irrespective of the price, which might ultimately be determined by the Lands Tribunal.

5.78 The Crichel Down rules (see paragraphs 7.18–7.24) do not apply where an NHS organisation transfers land and property acquired by way of compulsory purchase to a PFI partner (nor where the PFI partner later transfers the land to another party). It is therefore open to the PFI partner or the later transferee to use the land for a purpose other than that for which it was acquired.

5.79 Responsibility for the costs of promoting a CPO in the context of a PFI arrangement should be detailed in the PFI contract together with the valuation method to assess the value of the land when it is transferred to the PFI partner.

5.80 Similar arrangements would apply where land and property acquired by way of compulsory purchase transfer to a LiftCo in respect of a NHS LIFT scheme.

6 Acquisition of leasehold land and property

Introduction

6.1 This section deals with acquisitions by NHS organisations of leasehold land and property. Many of the provisions for freehold acquisitions apply to leasehold acquisitions.

Delegated limits

6.2 NHS organisations should check their delegated limits before proceeding with leasing arrangements (see paragraphs 1.69–1.72 for details).

Principles of leasing

6.3 Where it is not possible and/or economical/ appropriate to acquire freehold property, an NHS organisation may enter into a leasehold agreement provided it is the best course of action in accordance with the business case.

6.4 Leasing may be chosen where it represents best value, for example in cases where land and property is required for a short term only or the location (for example in a business park) renders a freehold acquisition impossible.

6.5 Leasing is usually the preferred option where:

- the most suitable land and property is only available on lease;
- the requirement is relatively short-term and does not justify the risk of making a capital outlay;
- it provides a means of transferring risk, and provides best value.

Operating and financing leases

6.6 It is important to consider whether the lease will be a finance or operating lease, as they have different balance sheet implications.

6.7 Operating leases do not appear on balance sheets but are subject to rental payments, whilst finance leases do appear on balance sheets and are subject to capital charges and rental payments.

6.8 A finance lease transfers substantially the risks and rewards of ownership of the asset to the lessee. The NHS organisation's balance sheet must show the remaining lease payments payable under this lease.

6.9 If an NHS organisation enters into a finance lease, its capitalised value will be charged to its capital resource limit, reducing its scope to undertake further capital investments.

6.10 For guidance on how to account for lease transactions see the Capital Investment Manual.

6.11 This is a complex area of accounting, with potentially significant consequences for NHS organisations. If an NHS organisation is in doubt about the required accounting treatment for a lease contract, early discussions with its advisors and auditors is recommended.

The business case

6.12 A business case may be prepared at a number of stages throughout the acquisition process culminating in the final report to the NHS organisation's board for approval to proceed and finally to commence completion of the legal documentation.

6.13 The business case should identify the type of premises required. A careful evaluation of space requirements (especially by specialists) may secure significant space savings, and thus energy and cost savings.

6.14 Space savings may result from using open-plan rather than individual offices, shared facilities such as meeting and conference rooms, and more efficient storage systems.

6.15 An appraisal of the various options should be carried out to identify the preferred option. This should consider:

- the "do nothing" option;
- purchase versus build versus lease options;

- availability of suitable premises or accommodation within the NHS, civil estate and open market;
- savings from disposal of surplus premises or accommodation resulting from the proposed acquisition;
- cost/benefit evaluation;
- risk/sensitivity analysis;
- location analysis, for example accessibility for staff and visitors, travel times, and any cost implications.

6.16 Financial appraisals may be carried out to assist in the choice of the preferred option. These should include:

- discounted cash flow analysis (where a longer lease is sought) to give the net present cost of the property (generally over the required period) multiplied at the Treasury discount rate;
- acquisition costs and any opportunity costs of existing accommodation if it is to be retained, or holding costs until it is disposed of;
- the cost of upgrading or refurbishing the space;
- maintenance costs and other expenses – for example gas, water, electricity, telecom, security, rates, cleaning or service charges etc;
- relocation or redundancy costs where appropriate;
- travel costs;
- liabilities such as dilapidations, repairs etc at the outset, and an estimate of future costs upon the lease expiration;
- additional potential expense of using a listed building.

6.17 The business case should contain the agreed lease terms and an assurance that a written professional opinion had been secured confirming that the terms represent value for money.

6.18 This is normally provided by a solicitor for the legal side of the agreement and professional valuer or VOA in respect of value.

Negotiating the lease

6.19 An NHS organisation's covenant strength is exceptionally good. This fact should be used in all negotiations to good benefit.

6.20 In instructing the VOA/external surveyor to negotiate rental terms from a prospective landlord, reference should be made to the "Investment appraisal" section in the Capital Investment Manual, which demonstrates how relative annual costs of renting versus purchasing can be assessed.

6.21 Reference should also be made to the 'The Code for Leasing Business Premises in England and Wales 2007' (see paragraphs 1.97–1.99) to ensure that all the available options are considered and appraised.

6.22 The terms of the lease should include:

- recognition of the tenant's covenant strength;
- favourable rental levels;
- rent-free periods/contributions to fitting-out works;
- avoidance of upwards-only rent review clauses;
- break clauses giving flexibility of occupation;
- break clauses following rent review, enabling the NHS organisation to terminate the lease (without penalty) to relocate to alternative premises if at review the revised rent is higher than acceptable.

6.23 Before entering into a lease, professional valuation and legal advice must be obtained on all aspects of landlord-and-tenant relationships.

6.24 The following factors should be considered when negotiating the lease.

Lease term

6.25 Leases of over five years should be avoided unless there are exceptional circumstances (supported by the business case), appropriate break clauses and assignment provisions, and the user clause is not overly restrictive.

Rent reviews

6.26 Upwards-only rent reviews should be avoided wherever possible.

6.27 Reviews should be no more frequent than every five years, although many landlords insist on three-year reviews.

6.28 Commercial landlords may be unwilling to agree to upward and downward rent review provisions. A compromise would be an RPI-linked annual review.

6.29 A tenant's improvements to the property should be disregarded at rent review.

Break clauses

6.30 Break clauses should be at regular intervals (for example every five years) or rolling, and capable of exercise only by the tenant.

6.31 If the break clause is to be capable of exercise by either party, then the tenant must ensure that the notice period that the landlord has to give is sufficient to enable it to find and move to alternative accommodation.

6.32 It may be useful to negotiate a break clause after each rent review to guard against substantial or excessive rent increases.

6.33 The tenant's right to exercise the break clause must be unconditional. It must not be conditional upon compliance with the tenant's covenants, as the landlord has alternative legal remedies for breach of the tenant's covenants.

6.34 The break provisions should not even be subject to the tenant's "material compliance" with its covenants, as even a relatively minor breach could render the tenant's attempt to exercise the break clause invalid.

6.35 If, for example, a pane of glass is broken at the time the break clause is exercised, the landlord could argue that the tenant is in breach of its repairing covenant and therefore the break clause is invalid, tying the tenant in until the break clause can next be exercised.

User provisions and other specified user restrictions

6.36 Leases with overly restrictive user clauses should be avoided, particularly where long-term leases are being considered, as this may prevent the lease from being assigned (see paragraphs 8.6–8.9 for details of assignment).

6.37 If the use is limited, the lease should provide that the tenant may, with the landlord's consent, use the premises for an alternative purpose to that originally specified.

6.38 The legal advisor should check that the permitted use is authorised by planning permission, as the lease will usually provide that the landlord gives no warranty in this regard.

Alienation provisions

6.39 The exceptional covenant strength of NHS organisations is provided by virtue of the provisions of Section 70(1) of the National Health Service Act 2006 (previously Section 1(1) of the National Health Service (Residual Liabilities) Act 1996).

6.40 This provides that if an NHS organisation ceases to exist, the Secretary of State must exercise their statutory powers to transfer the property, rights and liabilities of that organisation so as to ensure that all its liabilities are dealt with.

6.41 Leases should always provide that where assignment takes place due to an NHS reorganisation, or involves a transfer to another NHS organisation or government department, the landlord's consent is not required – thus saving legal costs in obtaining formal consent.

6.42 The lease should permit sub-letting of the whole building and, where the building allows, sub-letting of part or parts of the leased area.

6.43 Sharing accommodation with other bodies providing complementary services to the tenant (for example midwives at a health centre) should be permitted provided that no relationship of landlord and tenant is created.

Assignments – liability of original landlord and tenant: leases granted before 1 January 1996

6.44 Where the lease is an "old" lease (that is, granted before 1 January 1996), the original parties remain liable for the full duration of the lease even after they have disposed of their interests. However, the original tenant is not liable for any additional obligations that subsequent assignees agree with the landlord.

6.45 In most cases, the landlord will look to enforce the tenant covenants against the current tenant (rather than the original tenant). However, if the current tenant is considered financially incapable of complying with the tenant covenants (for example if the current tenant is insolvent), the landlord would wish to pursue the original tenant.

6.46 As a result it is essential that, on assignment, the original tenant obtains an indemnity from the assignee against all future breaches of covenant.

6.47 Therefore, when assigning an "old" lease, an NHS tenant should ensure that (1) the assignee is of good covenant strength and (2) provides an indemnity against all future breaches of covenant.

Assignments – liability of original landlord and tenant: leases granted after 1 January 1996

6.48 On assignment of a “new” lease (that is, granted after 1 January 1996), the tenant is automatically released from the tenant covenants in that lease unless they have entered into an Authorised Guarantee Agreement (AGA).

6.49 An AGA is a form of guarantee by an outgoing tenant of its assignee’s obligations under the lease.

6.50 Landlords will often require the tenant to enter into an AGA on assignment. This should be strongly resisted. However, given the exceptional strength of the NHS covenant, a landlord may be reluctant to dispense with the requirement for an AGA.

Freedom to make alterations and adaptations

6.51 Non-structural alterations may be permitted subject to the landlord’s consent. Obtain qualification on this so that the landlord cannot unreasonably withhold his/her consent.

6.52 The tenant should ensure they have the right to erect demountable non-structural partitioning without the need to obtain the landlord’s consent. Where the landlord’s consent is required and given, the tenant is likely to be responsible for the landlord’s costs.

6.53 Tenants should resist any obligations to reinstate the premises to its condition prior to any tenant’s alterations and improvements at the end of the term. If this obligation is required, the tenant should clarify the precise extent of any liability for reinstatement at the start of the term with a schedule of condition and photographs. This issue can be a major cause of dispute and cost at lease expiry.

6.54 Structural alterations are likely to be prohibited. If they are required, ensure that a licence for alterations is entered into at the same time as the lease is granted.

Repairing obligations

6.55 As a tenant, the NHS organisation should ideally seek to be responsible for internal repairs only.

6.56 Where the leased premises form part of a larger building, the landlord is likely to be responsible for the repair of the exterior of the building and common areas, recovering the cost from tenants as part of a service charge.

6.57 The NHS organisation should insist that the landlord complies with the code of practice on ‘Service Charges in Commercial Property’ published by RICS (see paragraphs 1.100–1.101).

6.58 Ensure that the method of apportionment of such costs between the tenants is fair.

6.59 Also, seek to cap or limit the service charge costs in general and for future charges for major items to be outlined next.

6.60 Check whether any major item of work (for example a new roof) is anticipated before entering into the lease, so that account can be made of potential costs. The structural survey (see paragraphs 5.33–5.38) should highlight such costs.

6.61 Repairing obligations should be limited by reference to a schedule of condition, particularly when the property is in a poor state of repair at the start of the term. Ensure that the schedule is sufficiently detailed (including colour photographs) and signed by both parties as an accurate record of the property’s condition. Ideally the schedule should be annexed to the lease for ease of reference. This should mitigate any disagreements at the end of the lease.

6.62 While a full structural survey is not required where premises are acquired on an internal repair and decoration-only basis (that is, the landlord is fully responsible for all other repairs and these are not charged to the tenants), the internal condition should be surveyed to determine the likely expenses that the tenant may incur during the term of the lease.

6.63 Prospective tenants should be aware that repair works carried out by landlords may disrupt use of the property. It is helpful to be aware of what work, if any, the landlord intends to carry out.

Insurance

6.64 Where possible, NHS organisations should self-insure under the HSLA’s Property Expenses Scheme. Lease terms should allow for this as long as the tenant is an NHS organisation.

6.65 Exceptions include where the NHS organisation leases space in a multi-occupancy building or office campus and the landlord demands control of insurance for the whole estate.

6.66 If, as a tenant, the NHS organisation is to effect public liability insurance, the lease should allow it

to self-insure under the NHSLA's Liability to Third Parties Scheme.

VAT liability

6.67 It is important to ascertain at the earliest opportunity whether the landlord proposes to charge VAT on rent, by electing to waive exemption, as this will add 17.5% to the rental cost.

6.68 The position in relation to VAT recovery has been the subject of recent changes. In August 2005 HM Revenue and Customs (HMRC) issued revised guideline on VAT recovery for NHS organisations under heading 45 or 53 of the Treasury Directions issued on 10 January 2003 (known as the Contracted Out Services Regulations).

6.69 Previously, VAT was recoverable where a landlord provided management or other services in connection with the provision of accommodation. However, the position has now been tightened, and in order to obtain a VAT repayment an NHS organisation must satisfy certain criteria laid down in the revised guidelines.

6.70 In relation to existing leases there are transitional provisions in place which protect the VAT recovery position of NHS organisations where a prior written ruling has been obtained.

6.71 However, it will now be necessary to obtain prior clearance from HMRC to confirm that VAT will be fully recoverable. VAT suffered on other services may be recovered as eligible service under the Contracted Out Services Regulations.

6.72 VAT recovery is a complex area. NHS organisations should seek independent tax advice on this issue.

Contracting out of the Landlord and Tenant Act 1954

6.73 If the lease is not contracted out of the 1954 Act, at the end of the term the tenant will have the right to request a new lease, which the landlord will only be able to resist if he/she is able to establish one of the grounds set out in paragraphs (a) to (g) of Section 30 (1) of the 1954 Act.

6.74 If the lease is contracted out of the 1954 Act, the tenant will have no automatic right to request a new lease at the end of the term. The landlord can, theoretically, be as unreasonable as he/she wishes in agreeing terms for a renewal lease.

Identity of the tenant

6.75 Any lease that is taken in the name of the Secretary of State for Health should state that notices from the landlord to the tenant should be sent to the occupying NHS organisation in addition to the Secretary of State.

6.76 This is to ensure that important notices, particularly those where time is of the essence, are referred specifically to the occupying tenant to allow for immediate action, and not delayed.

6.77 If the lease is in the name of an NHS organisation, it may also want to consider stipulating that any notices in relation to the property are also sent to its legal advisor, who will be able to advise on the implications of such notices and the action that needs to be taken in response.

References

6.78 Landlords normally require satisfactory references for tenants, and NHS organisations may be required to provide a reference, for example from another landlord, existing supplier, bank, or the local SHA.

6.79 Landlords should be made aware that an NHS organisation is "underwritten" by the Secretary of State for Health and, whether the lease is taken out in his name or that of an NHS organisation, the covenant strength is exceptional.

Signing and sealing the lease

6.80 For land and property transactions where the lease is in the name of the Secretary of State for Health, the way in which a lease is signed and sealed depends on the extent of delegation given to the NHS organisation. This is normally contained in the Directions given to the NHS organisation by the Secretary of State for Health.

6.81 A document may be signed and sealed by those given delegated authority, or if the transaction exceeds the delegated authority, by DH. In these cases, those signing documents (for land and property transactions) on behalf of the Secretary of State for Health should be civil service officers on or above grade 7. Alternatively, the lease may be signed by the appropriate person in the DH branch that approved the business case.

6.82 For leases taken in the name of the NHS organisation, they may be signed by the organisation's chief executive (or equivalent)

following approval by the organisation in accordance with the Directions or individual delegation.

6.83 In all cases, the person signing the lease should be fully informed about the transaction and should not have been involved in the negotiations for the lease nor have any interest in the outcome of the transaction. The lease should only be signed when all proper procedures have been complied with, including approval of the terms and conditions of the lease by the private valuer or VOA, and the solicitor.

Post-completion

6.84 Procedures should be in place to ensure that the terms of the lease are clearly known and complied with, by all within the NHS organisation.

6.85 The legal advisor should provide a summary of the main terms of the lease, although reference to the lease (or, if appropriate, legal advisor) should take place if a specific query arises in respect of the lease.

6.86 Once a lease has been entered into, the NHS organisation must ensure that its terms and conditions are complied with.

6.87 Rent review notices must be promptly referred to professional advisors and responded to within the time limits. Failure to respond appropriately within time limits may be very costly.

Renewal of leases

6.88 Under protocols regarding lease renewals, NHS organisations should be proactive in any renewal negotiations in order to protect their interests and strengthen their position.

6.89 The provisions of the Regulatory Reform (Business Tenancies) (England and Wales) Order 2003, which changed the lease renewal procedure, came into effect on 1 June 2004 and apply where the lease is a business tenancy within the Landlord and Tenant Act 1954.

6.90 A landlord can serve a notice under Section 25 of the 1954 Act stating that it does not oppose the granting of a new tenancy and setting out its proposals as to the terms of the new lease. Previously, a landlord did not have to put forward its proposals until the tenant had made an application to court for a new tenancy.

6.91 If at the end of the term a tenant wishes to take a new lease of the premises, it must serve a request for a new tenancy on the landlord under Section 26 of the 1954 Act at least six but not more than 12 months before the proposed commencement date of the new lease (which cannot be earlier than the date on which the current lease expires).

6.92 The tenant's Section 26 request must set out the tenant's proposals for the new tenancy including details of the property to be included in the demise, the proposed rent, and any other terms.

6.93 If an NHS organisation is aware that its current lease will be ending and wishes to request a new lease from the landlord, it should take advice from its legal advisors at the earliest opportunity to ensure that the correct procedures are followed to protect its right to a new lease.

6.94 If the landlord wishes to oppose the grant of a new tenancy, it must serve a counter-notice on the tenant within two months of the tenant's Section 26 request.

6.95 Previously, only a tenant could make an application to court for a new tenancy. Under the new rules, either the landlord or tenant can apply to court following service of a tenant's Section 26 request.

6.96 If the landlord is not prepared to grant a new lease, it will serve a Section 25 notice on the tenant specifying the ground or grounds on which it intends to oppose any application by the tenant for a new lease.

6.97 If the legal advisor's advice is that the landlord is likely to succeed in opposing the application for a new tenancy on one or more of the grounds set out in paragraphs (a) to (g) of Section 30(1) of the 1954 Act, the NHS organisation should actively pursue the option of finding alternative accommodation. In certain circumstances, a tenant will be entitled to statutory compensation.

7 Disposal of freehold land and property

Introduction

7.1 This section deals with the disposal of surplus freehold land and property.

7.2 Only land and property that is required to enable NHS organisations to fulfil their function of healthcare provider should be retained. The estate should be reviewed regularly to identify surplus property; at least annually, a report should be submitted to the board.

Principles of disposal

7.3 Any decision-making process should take account of relevant codes of conduct, accountability and probity. NHS organisations should have a clear policy on the acceptance of gifts and hospitality to avoid conflicts of interest and probity breaches.

7.4 A property should not be retained in the expectation that the market might improve.

7.5 Once land and/or property has been identified as surplus to a particular NHS organisation, the NHS organisation:

- should check what legal interest it holds and whether the property is registered in its name on the title deeds or at the Land Registry;
- should circulate details of the land and/or property to nearby NHS organisations, the SHA and local authority (see paragraphs 7.15–7.17 on priority purchasers) **and at the same time** must enter details of the land and/or property onto the 'Register of Surplus Public Land' (see paragraph 1.94);
- should allow 40 working days for a priority or other public sector purchaser to emerge before placing the land and/or property on the open market.

7.6 If the land and/or property is not required for healthcare use, the NHS organisation may need to offer it back to the former owners or their successors under the Crichel Down rules (see paragraphs 7.18–7.24 for further details).

7.7 Once the NHS organisation is satisfied that there is no public sector requirement for the land and/or property, it should be sold as soon as possible, unless there are unusual circumstances preventing this. Ideally, the sale should be completed as soon as the property is vacant. This means that the disposal process should be planned as early as possible, if only as a contingency.

7.8 Powers are available to NHS organisations under Schedule 4 paragraph 20(1) of the National Health Service Act 2006 (previously Schedule 2 paragraph 15 of the National Health Service and Community Care Act 1990) to obtain an income from land and property, where it is not possible to secure an early sale, and such income may assist in reducing holding costs during the disposal process.

7.9 All disposals should be fully supported by a business case for the transaction (see paragraphs 7.25–7.31 for details). A cost-benefit analysis of the disposal options should inform the business case.

7.10 Full and appropriate records of all matters relating to the disposal must be kept on file. This should include relevant telephone conversations and discussions at meetings, and should show a prompt response to incoming correspondence and enquiries.

7.11 The performance of the disposal team should be recorded, together with an evaluation of final sale price and timescale for completion against expectations.

7.12 The file should record:

- when the property became non-operational;
- when the property was formally declared surplus to requirements;
- the name of the selling agent and date of appointment;

- the date the planning application was made, if applicable (if not, that a decision was made that a planning application was not required and why);
- when planning consent was obtained (date of issue);
- the date the property was formally placed on the market;
- the date/dates when offers were received;
- the date when an offer was accepted by the vendor and the purchaser notified;
- the date when contracts were submitted/signed/exchanged;
- the date when sale was completed.

7.13 Where surplus land and property is being sold and the infrastructure (for example roads, drains, landscaping, and open space) for that land and property also serves the retained land and property, the purchaser must be obliged to carry out any necessary infrastructure works in an agreed timescale.

7.14 This obligation is normally met by bond from the purchaser. The vendor should only reserve the right of entry onto sold land and property to carry works as a last resort.

Priority purchasers

7.15 A priority purchaser is an NHS organisation or non-NHS organisation that provides social or healthcare services under a contract from a PCT (or joint funding from a PCT and local authority). Where no health or social care service use has been identified, a priority purchaser is any other public-sector organisation, provided the property is required only for its own use.

7.16 NHS organisations wishing to dispose of land and/or property should offer the land/property to "priority purchasers" in the first instance. If these purchasers can re-use the land and/or property, it is not classified as surplus to NHS requirements.

7.17 In the event of doubt over the existence of priority purchasers, the local PCT should determine whether the land could be used for NHS services and, if so, designate their preferred service provider as a priority purchaser.

Former owners' rights (Crichel Down rules)

7.18 The Crichel Down rules require NHS organisations to offer land and property that has become surplus to NHS requirements back to the original owner under certain circumstances.

7.19 The rules apply to land and property that was originally acquired compulsorily or under threat of compulsion.

7.20 The rules do not apply to:

- land that was up for sale at the time of the acquisition;
- agricultural land acquired by a Government body prior to 1 January 1935;
- land and property acquired more than 25 years before disposal;
- land and property whose character has changed during the period of ownership, for example by development or extensive alteration (the cost of reinstatement will be a factor in determining this issue);
- disposals comprising a development site of two or more former land holdings, or part of a site that has been changed, and where a sale in parts would not achieve best value;
- disposals that are, effectively, de minimis;
- various circumstances, with specific ministerial approval, where the land is still required for some other public-sector purpose.

7.21 Solicitors or professional advisers (including the VOA) should be consulted to determine whether the Crichel Down rules apply.

7.22 If the Crichel Down rules do apply, the NHS organisation should:

- establish the identity and location of the former owner or successor;
- assess the terms of the offer and method of fixing the price;
- give the former owner two months to agree the basic terms and a further six weeks to agree the price (with such extensions as appropriate). If agreement is not reached within the timescale, the land and property may be sold on the open market.

7.23 Special consideration will apply where best value can only be determined by extensive planning work or exposure to the marketplace.

7.24 Under Section 66 of the Planning and Compensation Act 1991, where land and property acquired compulsorily or under threat of compulsion after 25 September 1991, within 10 years of acquisition, benefits from planning permission for an alternative use, the original owner should be reimbursed with any added value arising from the new planning permission.

The business case

7.25 The estate records of all land and property for disposal must be checked so that the potential proceeds from sales and savings in overheads from the disposal of different sites may be compared.

7.26 If the sale of land and property is a key part of meeting re-provision costs, consideration should be given to obtaining a preliminary report covering market conditions, planning constraints and legal title in the context of the planned disposal, and timescales, before the business case is finalised.

7.27 Covenants affecting the land and property may prevent its sale at the anticipated or higher price.

7.28 Whenever a property is identified as potentially surplus to requirements, the business case should identify the holding costs, including any exceptional maintenance, security or other costs.

7.29 An assessment should be made of the property's suitability for sale in its present state, and what (if any) work may need to be done to prepare it for sale.

7.30 A clear statement of responsibilities should be developed that identifies the roles to be played by individuals in the disposal team – such as management of the process, and specific areas of work needed to complete the sale.

7.31 The business cases should identify the need for receiving a receipt within any particular financial year, and evaluate any exceptional risks that might arise which may delay completion of the transaction.

Managing the disposal team

7.32 Whenever a disposal is contemplated, a technical team proportional to the size and complexity of the transaction should be appointed from the outset through to completion of the scheme.

7.33 The team should be led by a project manager (in-house or external) who should act as the informed client to ensure that NHS interests are protected and managed at all times.

7.34 The project manager should have knowledge and experience of NHS policies and procedures, particularly in relation to land and property transactions, together with a thorough knowledge of the NHS estate.

Routine disposals

7.35 The sale of small, self-contained sites (for example houses, clinics or stores) may require only the appointment of a solicitor and selling agent. Both should be appointed at the outset, and will be able to advise on any development potential or potential sale with adjacent landowner(s).

Major/complex disposals

7.36 Where a sale is complex, the most valuable alternative use is unclear, or sale proceeds will exceed £5 million (including joint ventures, deferred payments and contiguous payments that cumulatively exceed this amount), it is good practice to obtain independent valuation advice.

7.37 For arm's-length bodies (ALBs) and DH, this requirement is mandatory under Government accounting.

7.38 The VOA or a suitably qualified private-sector valuer may provide this advice, and should be appointed, together with the solicitor and selling agent, at the beginning of the project.

7.39 A planning consultant and highways/transport consultant may need to be appointed.

7.40 A planning brief may aid major/complex disposals; the brief may be prepared by the LPA (after negotiation by the NHS organisation) or the NHS organisation itself for subsequent approval by the LPA.

7.41 The disposal team should produce preliminary reports on the following:

- title (to identify title problems or adverse covenants);
- planning constraints;
- value;
- infrastructure constraints (highways, water, drainage etc);

- ground conditions;
- contamination.

7.42 Using this information the disposal team should be able to identify any obstacles, and the costs and timescales involved in overcoming these obstacles. The required tasks should be established and timetabled, and regular meetings set up to review progress.

7.43 At this stage, it should be decided whether further specialist help is required. If the site includes historic buildings, there may be a requirement for a conservation adviser. There may also be a need for a consultant on contamination or environmental issues.

7.44 A short-term lease on the property (a) to maintain security and/or the property in the short term or (b) to receive an income until the property is sold, should be considered. Professional advice must be taken to ensure that security of tenure is not accidentally granted to the lessee.

7.45 It is advisable to regularly monitor potential sale receipts against potential sale costs (for example the cost of a planning inquiry against the chances of success and the potential added value), as well as changing market conditions.

Town planning

7.46 Planning advice should be sought on the development potential of land and property surplus to NHS requirements.

7.47 Good working relationships between NHS organisations and the LPA are imperative. The LPA is more likely to support an NHS organisation's proposal if they have been consulted at an early time.

7.48 Similarly, NHS organisations should be open with the public and engage them as early as possible in order to consider any objections, and to secure their support.

7.49 If there is development potential, any sale should reflect this through:

- suitable alternative land uses being allocated in the local planning documents (see paragraphs 2.17–2.23 for details); and/or
- a planning brief for the land agreed with the LPA; and/or
- planning permission.

7.50 The option adopted will depend on the type of property being sold. The disposal team should recommend the best course of action.

7.51 The benefits associated with securing planning permission should outweigh the costs of obtaining planning permission, taking into account holding and opportunity costs and potential overage or clawback provisions (see paragraphs 7.67–7.76).

Decommissioning

7.52 Where a site has ceased to be operational, consideration should be given to decommissioning. The extent of the works required will depend on the future plans for the site (for example re-use for health purposes, sale, demolition) and legal requirements.

7.53 Practical considerations include:

- prevention of damage by the elements;
- avoidance of damage by dry rot, woodworm etc;
- prevention of incursion, access and damage by vandals;
- storage of keys and records concerning the management of the site, and mechanical and electrical installations within it;
- revaluation for rating purposes;
- reduction of running costs by adapting plant or renegotiating service supply agreements;
- the provision of an appropriate level of heating to prevent physical deterioration;
- retaining some occupation and use of the site whilst waiting for completion of the disposal process;
- the maintenance of essential security and fire detection systems;
- the isolation of all but essential electrical circuits;
- removal of all hazardous, clinical and other waste from the site.

7.54 Legal considerations include:

- avoidance of injury to third parties coming onto the site, legally or otherwise;
- compliance with health and safety legislation, which remains applicable even though the site is vacant;

- compliance with the Defective Premises Act 1972;
- compliance with any requirements for conservation of buildings under the Planning Acts, particularly if the property is listed;
- compliance with legislation in respect of storage of petroleum products;
- terms of supply of gas, water and electricity;
- rights of third parties in respect of access and services crossing the site, including fire escape routes;
- giving due warning to third parties of the presence of asbestos.

Asbestos

7.55 When disposing of sites, NHS organisations should ascertain whether asbestos (other than asbestos cement products, such as roofing and guttering) is present and, if it is, whether it constitutes a significant potential health hazard.

7.56 Accessible asbestos insulation should already have been identified.

7.57 If asbestos is known or suspected to be present, potential purchasers must be warned by a specific reference in the sale particulars. They should be given such relevant information as is known, and their attention should be drawn to their obligations under the health and safety legislation for dealing safely with asbestos, especially if demolition is envisaged.

7.58 Prominent warning notices should be fixed immediately inside the entrance(s) to buildings when they are vacated.

7.59 Always obtain professional advice in respect of this matter, especially regarding the wording to be included in any sale particulars where asbestos may be hidden within the fabric of the building or other non-accessible areas and how to deal with this issue throughout the disposal process.

Contamination issues

7.60 Whenever NHS organisations sell surplus land, with or without buildings, it is essential they address the issue of contamination.

7.61 Specialist professional advice should be sought on the best approach to be taken in respect of complying with Part IIA of the Environmental Protection Act 1990.

7.62 Where it is recommended that the purchaser should carry out any future remedial works, the adviser will tell the NHS organisation what type of reports it should obtain to inform the prospective purchaser of the potential contamination of the site.

7.63 In conjunction with the legal consultant, the professional adviser should tell the NHS organisation how to minimise the risks in this instance, transfer them to the purchaser and obtain the appropriate indemnities in the legal documentation.

7.64 If an NHS organisation sells land that is later found to be contaminated, the organisation may be liable for the costs of clearing the contamination if it failed to provide the purchaser with sufficient information and/or did not secure suitable indemnities.

7.65 A simple standard clause inserted in each sale contract may not protect the NHS organisation from future liability.

7.66 It is essential that the NHS organisation keep a record of the contamination audit, how any contamination was dealt with, what information was given to prospective purchasers, and what indemnities were sought.

Overage or clawback provisions

7.67 Where the sale price (obtained by any sale method) may not reflect the potential increase in value during development, the inclusion of overage or clawback provisions in the sale documentation should be considered.

7.68 Overage and clawback provisions reserve to the vendor the right to further payments if certain circumstances occur – effectively “sharing” in any future increase in value of the site.

7.69 Overage is a form of profit share on actual or potential sales over an agreed sum. Clawback is the right on some future specified event for the original owner to have a share in that future value.

7.70 Overage may be applied where the value of land sold for residential development is based on an agreed projected sale value of the completed development. Where the final sale price of a development exceeds this figure, the vendor secures an agreed share of the increased value.

7.71 Clawback may be used where an NHS organisation sells land for an agreed price but reserves the right

to receive an additional payment if the land is sold on for a profit (regardless of whether a more valuable planning permission is obtained).

7.72 Professional advice must be taken on overage and clawback options throughout the disposal process. It is important to be aware of what costs need to be deducted when calculating future profits.

7.73 It is important to be realistic on overage and clawback provisions. The legal documentation for such clauses is complex, and monitoring development costs is difficult.

7.74 Overage and clawback provisions should be clear, quantifiable, secure and legally binding. Exceptional cost deductions should normally be avoided (risks should be transferred to the purchaser rather than retained by the vendor). If poorly drafted, the purchaser may significantly depress the final receipt.

7.75 The vendor should ensure that the overage or clawback clause would generate sufficient additional receipts to cover the cost of negotiations, documentation and monitoring.

7.76 The overage or clawback provision should be for the full perpetuity period to prevent the purchaser deferring the development to avoid making further payments.

Disposal of partially surplus sites

7.77 Where only part of a site is declared surplus, consideration should be given to disposing of that part of the site provided:

- it does not remove flexibility for future operational developments;
- it does not limit the achievement of best value from selling the rest of the site.

7.78 The sale of property on a site's frontage, or close to its access, could for example prevent or limit any redevelopment of the retained site.

7.79 Should it transpire that an outright sale is undesirable, the NHS organisation should consider granting a lease (see Chapter 9 for details).

7.80 Where a sale of part of a site is to go ahead:

- make provision for the separation of services;
- consider imposing restrictive covenants to prevent uses that would be incompatible with the operational use of the retained site;
- make provision for maintenance of shared facilities such as access roads and services;
- ensure that the purchaser is not given any control over the future use and development of the retained land, or ransom potential; for example, ensure that the contract provides that the purchaser cannot object to or hinder any future redevelopment proposals on the retained site;
- provide for the creation of new boundaries and their future maintenance.

Ransom strips

7.81 Where NHS organisations are selling land that adjoins land with future development potential, they should consider retaining strips of land (ransom strips) on their site to retain access to the adjoining land.

7.82 Any future development of the adjoining land can then only take place with their consent. Such consent may be subject to a monetary payment.

7.83 A ransom strip may be retained around the entire site earmarked for disposal to prevent its future amalgamation with an adjoining site without the NHS organisation's consent where this action is felt to have development potential.

7.84 Ransom strips should be of sufficient width to be recognised as such, easily identifiable on a plan of an appropriate scale, and fully documented at the Land Registry to prevent ownership disputes.

Joint venture with neighbour

7.85 Where a greater sale price from the disposal of NHS land and property may be realised by combining the NHS organisation's asset with land and property of an adjoining NHS organisation or a third-party owner, a joint disposal should be considered.

7.86 Value for money and risk must be carefully considered by the disposal team, which should make recommendations on how to proceed in these cases.

7.87 Consideration should be given to the following:

- where possible, a legally binding arrangement to avoid one party withdrawing unilaterally;
- cross-options to purchase (each party may acquire the other's interest under specified circumstances);

- where the third party's land and property is relatively minor, the NHS organisation should consider buying it outright or purchasing on the basis that the vendor receives an agreed percentage of the total proceeds;
- the allocation of proceeds should reflect any ransom value that the NHS organisation enjoyed over the third party's land and property.

Sale and leaseback

7.88 Any sale and leaseback arrangement should provide value for money and be supported by a fully documented audit trial on how the decision was reached.

7.89 The NHS organisation must ensure that its right to continue to use the facility is preserved for as long as it is likely to be required.

7.90 A comparison between the Government's cost of capital and the lessor's likely cost of capital should be made. In most cases, it is unlikely that sale and leaseback would provide value for money.

Sale of surplus property in PFI and LIFT schemes

7.91 For information on the principles covering the transfer of surplus land in PFI and LIFT schemes see 'Land and Buildings in PFI Schemes'. Any such transfer should represent value for money and not compromise the long-term delivery of NHS services.

7.92 Details are available at www.dh.gov.uk.

Provision of new facilities in exchange for surplus land and property

7.93 A purchaser may provide a replacement healthcare facility in lieu of cash, as consideration for an NHS organisation's surplus land and property. Professional advice should be obtained to ensure that the procurement of the project complies with European Union procurement rules (see Part C for full details).

7.94 Such schemes are complicated by (1) the need to tie in planning on both the replacement facility and (2) the NHS organisation's surplus land and property.

7.95 Considerable effort should be made to ensure best value is obtained. However, this may be difficult given the relatively limited number of purchasers in the market who are both developers and contractors. A robust business case is required.

7.96 An exchange of assets seldom provides best value against an outright sale of land and property and a new build.

Forward sale of land and property

7.97 "Forward sale" refers to the circumstances where an NHS organisation sells land but remains in occupation for a period of time (possibly years) afterwards.

7.98 It is becoming increasingly common for NHS organisations to consider forward sale of a site prior to vacation.

7.99 Forward sales are more complex than conventional sales, and appropriate professional advice should be taken.

7.100 Value for money and risk must be carefully considered in a business case seeking approval for a forward sale. The following issues, in particular, should be addressed.

When is the sale price assessed?

7.101 The sale price is usually assessed at the time the property is sold.

7.102 Consideration should be given to the possibility of the property value increasing by the time it is vacated by the NHS organisation. Such an eventuality should be covered by an overage or clawback provision (see paragraphs 7.67–7.76 for details).

7.103 The money for the property is usually received when it is sold.

7.104 The sale should reflect (1) the benefit to the vendor of an earlier receipt of money; and (2) the risk the purchaser is taking over the fact that the property value may fall during the period it is occupied and in financing payments in advance of the site becoming vacant.

7.105 Payments may be made at different times, for example if the vacation is to be phased or planning approval is already available for part of the site.

7.106 In all cases, value for money should be rigorously assessed for audit purposes. There should be sound financial reasons why the NHS organisation should not wait to sell the property at the time it is to be vacated.

Enhanced planning

7.107 At the time of the sale, planning permission may not have been obtained or, if it has, there may be the prospect of an enhancement. Such an eventuality should be covered in overage or clawback provisions (see paragraphs 7.67–7.76 for details).

Sales on

7.108 If the contract allows the purchaser to sell the site on (to another buyer or buyers) prior to vacation, adequate provisions should be included to ensure that the NHS organisation obtains a share of any gain made.

Rent and other lease terms

7.109 The purchaser may seek to charge rent during the period of occupation. Such a payment will be a net outgoing and (as opposed to capital charges) the cost should be fully reflected in the value-for-money calculations.

7.110 Extreme care should be taken to ensure that the terms of any leaseback do not include onerous conditions, for example in relation to repairs, and do not restrict the day-to-day operation of the property.

Giving up possession

7.111 The contract will include a date by which time vacant possession has to be given. If possession is not given by that date, penalty clauses are almost certainly going to come into force.

7.112 The NHS organisation must therefore be certain that it will be able to give possession by the due date, and have contingency arrangements should it fail. To avoid unnecessary site security costs, attempts should be made to ensure that early possession may be given.

7.113 Adding a long-stop date may help the NHS organisation to avoid penalties (that is, penalties will not be payable until after a long-stop date).

Disposals that seek participation in development profit

7.114 This may arise when planning permission is not available at the time of selling.

7.115 Where land has a potential high value for alternative use but gaining planning permission for this use is high-risk, a sale may be achieved at a base value subject to additional payment(s). These payments will be based on the development values arising from the planning permission obtained.

7.116 The eventual added value may be paid in one payment or, on larger sites, phased over a number of years.

Contracts conditional on planning permission

7.117 Where planning issues are complex, or an outcome too uncertain for the NHS organisation to risk its own money in pursuing planning permission, the disposal team should consider a sale by way of a contract conditional on the purchaser obtaining planning permission.

7.118 An example is where offers for land for residential development have been received and all are conditional upon receiving planning consent for their particular scheme. In this instance, the disposal team would analyse all the offers and choose a prospective purchaser whose proposal is judged as achieving the best return and having the most likely chance of success in gaining planning approval.

7.119 A contract would be signed between the two parties whereby the agreed sale price is paid on an agreed date after the planning approval has been obtained.

7.120 The disposal team should advise:

- whether a deposit should be paid and whether or not it should be returnable (with or without interest);
- how specific the contractual conditions should be (for example, should housing numbers be specified or a detailed planning application for a foodstore be required?);
- how long the developer should be given to obtain permission;
- whether the NHS organisation should retain some control in the planning process to ensure that irresponsible behaviour by the purchaser does not irredeemably prejudice the land and property value;
- who judges the acceptability of planning conditions or obligations (see paragraphs 2.63–2.80 for details of planning conditions and obligations);

- whether the purchaser should be obliged to appeal if the planning application is refused or no decision made within the statutory time limit;
- whether the contract should specify a timeframe for action;
- whether the responsibility for repair, maintenance and/or insurance should pass to the purchaser (the NHS organisation will still need to continue to monitor and enforce, if necessary, any repair/maintenance issues);
- the inclusion of any overage or clawback provisions (see paragraphs 7.67–7.76 for details).

Phased-sale contracts

7.121 This normally relates to extensive sites where completion of the new development will take over two years and is likely to take place in distinct stages – that is, a phased development.

7.122 A contract will be entered into whereby the developer pays the agreed sale price over a set number of years and may well include overage or clawback provisions (see paragraphs 7.67–7.76 for details).

7.123 The disposal team should provide conclusive evidence that the net present value (NPV) of the deal represents better value than an outright sale.

7.124 The NHS should not provide a "loan" to the developer in such cases.

7.125 Account should be taken of all holding costs including loss of interest on capital not received, capital charges and the cost of administering and monitoring the scheme. This amount should be deducted from the NPV of the sum of the staged payments, in order to compare this with an outright sale.

7.126 The disposal team should address the following:

- comparison of the proposed phased sale with a sale in separate lots over a similar or shorter period;
- retention of the title to the land and property not paid for in full by granting a building licence to the developer prior to completion. Title to the land and property should only transfer to the developer upon payment in full for each plot or phase. This option should be tested against the use of a legal charge, which may achieve a more satisfactory result;
- the creditworthiness of the purchaser. Where the viability of the project is dependent on compliance with planning obligations or conditions (see paragraphs 2.63–2.80 for details), it is vital that the purchaser has the ability to meet these obligations;
- whether a performance bond, bank guarantee or initial legal charge should be sought – the cost of the bond or guarantee being a major factor in the decision;
- whether it is cost-effective to transfer security arrangements for the property to the purchaser.

Setting the sale price

Transfer value to another NHS organisation

7.127 Where the land and property is required for continuing healthcare use by another NHS organisation, it should be transferred to them at the existing book value, that is, existing use value.

Valuation in preparation of sale of land and property

7.128 When there is no other NHS requirement for the land and property, it should be revalued to market value for alternative use, for example residential or retail purposes, in the NHS organisation's accounts and asset register.

7.129 The valuation may be carried out by the VOA or a suitably qualified private-sector valuer. The date and basis of the valuation should be recorded.

7.130 This value becomes the net book value (NBV) and will be the selling price to NHS organisations should one emerge at a later date.

7.131 Where external changes result in a change to the value of the site during the disposal process (for example due to changes in market conditions, firming up of planning requirements), the site should be re-valued. The new valuation and reasons for the change should be recorded.

7.132 In all cases, valuations should be regularly updated at least every six months throughout the disposal process.

7.133 It may be appropriate to produce a range of valuations dependent on different outcomes (for example if there is uncertainty over the use to

which the surplus property will be put). The range of values should be regularly reviewed.

7.134 Where only part of a site is being disposed of, changes in the valuation of the surplus area might affect the decision on which part should be retained for development.

Role of independent valuer (for complex schemes or where proceeds are likely to exceed £5 million)

7.135 The independent valuer (VOA or private-sector valuer) should work with the disposal team to:

- establish the initial price;
- advise, in consultation with the selling agent, on the final reserve price in sales by auction or tender;
- advise on the acceptability of bids received within the sale deadline;
- advise on any authentic late or revised bid received after the closing date but before the sale has become legally binding, which is higher than bids received within the deadline;
- where the final sale price is below the initial price, certifying, jointly with the selling agent, that it is the best offer reasonably available.

Sale at best price

7.136 Ensure that surplus land and property is sold at the best price reasonably obtainable in the open market. The sale process should demonstrate that this is the case.

7.137 The best price should take account of all the factors (market conditions, planning position, legal constraints etc), especially holding costs and other costs required to achieve the sale.

7.138 Any "special purchasers" should be identified. A special purchaser is anyone willing to pay over the "normal" market value. This may be because he/she has a special interest in the property due to its location or development potential or other financial reasons.

7.139 Beware of rogue "high bids" from those likely to negotiate concessions and a lower price after their offer has been accepted.

7.140 Sites with potential "marriage value" should also be identified. Marriage value refers to the enhanced value as a result of combining sites. The acquisition of adjoining sites or joint disposals with neighbours should be considered where an enhanced value may be realised (see paragraphs 7.85–7.87 on joint ventures). However, "speculative" purchases should not be made.

7.141 The value of voluntary conditions imposed by the vendor should be taken into account where they produce a direct or indirect benefit to the vendor that can be quantified in monetary terms.

7.142 These are, for example, retention of an easement over the land, a pre-emption clause allowing the vendor to repurchase on specified terms if the purchaser decides to sell, or covenants that benefit other land in the vendor's ownership. Restrictions on the use of the land may also be included, although this may affect the sale price.

7.143 Land and property with potential for development should normally be sold with the benefit of planning permission for alternative use. Where this is not possible, paragraphs 7.114–7.120 explain the options to maximise the sale proceeds.

7.144 Care must be taken to consider an applicant's need for planning permission that is judged by the professional advisers as unlikely to be forthcoming.

7.145 For the sale of historic buildings, see paragraphs 7.197–7.198 and paragraphs 7.152–7.156 on sales at concessionary prices.

Sale to a selected purchaser (solus transaction)

7.146 Where a disposal involves a negotiated sale, without testing the market, to a selected purchaser – for example a charity or a local authority – the probity of such a sale must be demonstrable.

7.147 A "solus" transaction should only be used in exceptional circumstances and when recommended by a professional adviser.

7.148 NHS organisations wishing to dispose of property in this way should first secure valuation advice from the VOA and private-sector valuer. If both agree to the price, the sale can proceed.

7.149 This type of sale must have an advantage over sale by auction or tender and be fully justified in the supporting business case. Both valuers should confirm that the offered price would be unlikely to be exceeded in a sale by tender or auction and is not a concessionary sale. Otherwise, the property should be placed on the open market.

7.150 The recommended price should be regularly assessed should the transaction sale period exceed the norm.

7.151 A selected purchaser may be a special purchaser (see paragraph 7.138 for details).

Sale at concessionary price

7.152 In some circumstances it may be reasonable to accept a price below market value, for example where the sale would achieve operational and/or wider public benefits that outweigh price considerations alone. The benefits must be clearly identified in the supporting business case.

7.153 For example, a prospective purchaser may offer to provide services or other benefits to the NHS such as a charity using a property for a hospice. Where these benefits can be quantified in monetary terms, and added to the "price", and the total then exceeds the market value, the best price has been secured and the sale can proceed.

7.154 The board must approve any concessionary sales with full knowledge of the business case for the concession.

7.155 Approval is then required from DH if the concession exceeds £250,000 in case the sale is classified as a "gift" and has to be reported to Parliament. Where approval is required from DH, it will brief the Minister, if required.

7.156 An overage or clawback provision (see paragraphs 7.67–7.76 for details) should be included in case the purchaser subsequently sells at a higher price, provided the accountable officer and, where appropriate, a health minister are prepared to defend the sale as a deliberate concession.

Sale methods

7.157 Land and property should normally be sold by auction or competitive tender. However, the method of sale adopted will depend on the type of property, planning considerations, state of the market and type of purchaser.

7.158 Professional advice must be sought on alternative methods of sale. Advisers should comply with public accountability requirements.

7.159 Land and property should be openly marketed other than in exceptional circumstances (for example where there is a selected or special purchaser such as a sitting tenant, GPs in a health centre, or on the specific advice of the selling agent). In these cases, a valuation is required that will certify that the price paid is at least equal to market value and that there would be no benefits obtainable by putting the land and property onto the open market.

Formal tender

7.160 The property should be widely advertised for at least eight weeks prior to the tender date and will be open to all potential bidders.

7.161 Based on the advice of the selling agent (in consultation with a private-sector valuer or VOA for complex sales or where proceeds are likely to exceed £5 million) a reserve tender price should be set.

7.162 All interested parties should be sent an information pack covering legal, planning and infrastructure issues and, if available, a ground condition report. On acceptance of the best tender offer, a binding contract for sale will be put into effect.

7.163 Advantages include:

- the land and property is available to a wide market;
- public accountability is self-evident;
- a purchaser with a particular interest may submit a high bid (for example one bid may be considerably greater than the others, whereas at auction the price bid will only be one bidding step above the last highest offer);
- a price above the estimated market value may be achieved (the best possible price obtainable);
- the sale is certain in that a contract is established on the day.

7.164 Disadvantages include:

- the tender procedure, involving large numbers of interested parties, may be time-consuming and expensive;
- some potential purchasers do not like tendering and may not bid because of the costs involved in bidding and uncertainty of success.

7.165 This option is likely to be used for the sale of land and property with beneficial uses and no obvious constraints to development, and for which there is an active market.

Limited formal tender

7.166 This option is useful where the site is very large and complex or where best value will be obtained

by marketing to a few selected prospective purchasers where a specialist market exists.

7.167 Based on the advice of the selling agent (in consultation with a private-sector valuer or VOA for complex sales or where proceeds are likely to exceed £5 million), a reserve tender price should be set.

7.168 The land and property should be advertised, focusing on the most likely purchaser group. Tenders may be requested from a smaller number of selected potential purchasers when, for example, the land and property has a specific alternative use such as food or non-food retailing. The list of potential purchasers should be based on the recommendation of professional advisers.

7.169 Advantages include:

- reduced tendering costs compared with formal tender;
- opportunist bidders with inadequate financial standing can be excluded;
- the bids are more likely to be meaningful as potential purchasers know that they have a reasonable chance of success;
- the sale is certain in that a contract is established on the day.

7.170 Disadvantages include:

- having a limited number of potential purchasers means there is no certainty that the best price has been achieved;
- questions of public accountability may arise over the selection of potential tenderers.

Informal tender

7.171 This is by far the most common method of disposal other than for dwelling houses. The procedure is very similar to a formal tender. However, the purchaser does not make a binding offer, and negotiation can take place regarding the terms and conditions of the offer. The successful bidder is invited to sign a formal contract for the purchase within a short period of the offer being accepted.

7.172 Advantages include:

- greater flexibility (to the purchaser) over the terms of the offer;
- greater flexibility (to the vendor) to clarify and, if required, negotiate the final terms of the sale (particularly with large complex sites where a simple cash offer may not produce best value, for example where overage or clawback provisions need to be negotiated – see paragraphs 7.67–7.76);
- offers may be increased through post-tender negotiations or by asking for best and final offers;
- may be used to follow up approaches previously made to the vendor, usually as part of a private treaty approach;
- this is a fairly quick way of demonstrating that an attractive offer from a specific individual does indeed offer good value.

7.173 The disadvantage is that the purchaser is not bound to proceed at the price offered.

Private treaty

7.174 The selling agent should widely advertise the site for sale for a reasonable period of time.

7.175 The sale should then be negotiated between the selling agent and prospective purchaser(s), culminating in a best price offer.

7.176 The agent should recommend which offer should be accepted.

7.177 Advantages include:

- administrative costs are minimised;
- a quick sale may be achieved;
- in a difficult market the selling agent will have more scope to negotiate;
- flexibility;
- the selling agent is obliged to report all offers received.

7.178 If marketing results in keen competitive interest, a formal limited tender or informal limited tender may be commenced.

7.179 Disadvantages include:

- questions of public accountability can arise over the selection of the potential purchaser (hence the need for written professional advice and recommendations in all cases);
- there is no firm contract at the point of offer and acceptance.

7.180 Suggested uses include:

- single houses or flats: low-value land and property;
- where there is a special purchaser;
- priority purchase or concessionary sales.

Late bids

7.181 A late bid may be received after a closing date but before the sale has become legally binding.

7.182 If the offer is significantly better than those received before the deadline, careful consideration should be given to it, with professional advice on whether the bid should be taken into account.

7.183 Account should be taken of the requirement to secure the best possible price when disposing of surplus assets against the possibility of the original bidders withdrawing their offer.

7.184 If it is decided that an authentic late bid should be taken into consideration, or the land and property has been sold subject to contract but contracts have not been exchanged, all bidders (including the current prospective purchaser) should be given the opportunity to improve their bids.

7.185 Sufficient time should be allowed for the necessary enquiries into any late bidders' financial credentials to be completed.

7.186 Clear documentation of the reasons for pursuing a late bid, or not pursuing it, should be in the transaction file. Accepting a late bid where a contract for sale has been sent out (but not exchanged) can result in bad publicity for the NHS organisation. Careful consideration should be given to balancing the needs of best price, public accountability and bad publicity.

Public auction

7.187 Land and property should be widely advertised. The selling agent (in conjunction with a private-sector valuer or VOA for complex sales or where proceeds are likely to exceed £5 million) should recommend a reserve price, known only to the NHS organisation and auctioneer (and valuers).

7.188 Advantages include:

- the land and property are available to a wide market;
- conditions of public accountability are seen to be satisfied;
- the vendor can be satisfied that, on the day, the best possible price was obtained;
- the element of competition can lead to a price in excess of the estimated market price;
- the sale is certain in that a contract is established on the day.

7.189 Disadvantages include:

- a failure to sell at auction can blight a site;
- some potential purchasers dislike auction procedures and their bid might therefore be lost;
- "rings" can be formed by interested parties who then deal with the land and property between themselves after one has purchased in the auction room (this may eliminate competition, and thus reduce the selling price).

7.190 Public auctions are best suited to disposals where it is reasonable to expect keen interest from prospective purchasers and it is difficult to establish a clear idea of value, or which present difficulties (for example where no planning consent has been forthcoming).

Post-completion

7.191 When a disposal has been completed, the NHS organisation should:

- update its asset register records and estate terrier, giving reference details of any Land Registry entry;
- ensure that all contracts for the supply of services to the sold property have been cancelled and the local authority has been advised of the new ownership for rating purposes.

7.192 Other than for straightforward sales, the NHS organisation's solicitor should summarise:

- all future payments and dates when payments are due;
- any conditions that may trigger a future payment;
- any legal charges;
- any rights or easements granted to the NHS organisation over the property sold as well as any to the purchaser that affect the retained land of the NHS organisation;

- any obligations that will affect the retained land, such as infrastructure works, together with the agreed timescales for completion of these works.

Financial credentials

7.193 The creditworthiness of bidders should be examined in sales by private treaty, formal or limited formal tender and, where feasible and appropriate, in sales by auction before any bid is accepted.

7.194 Where agents are used to establish the creditworthiness of bidders, recommendations should be obtained in writing, including the basis for the recommendation.

7.195 This is important, in respect of both the recommended bid and any higher bids that are rejected because of doubts about the bidders' financial credentials.

7.196 As bids accepted at auction result in a binding contract and the purchaser has to pay a 10% deposit immediately, it is not normal to check on bidders' creditworthiness except for very large disposals. Even in these cases it will only be feasible to carry out such checks where the identity of bidders is known in advance.

Sale of surplus historic buildings

7.197 When selling surplus historic buildings, the best return for the taxpayer should be obtained. Account should be taken of the following:

- local planning policy (see paragraphs 2.17–2.23 for details);
- Government policy for historic buildings as set out in PPG 15 – 'Planning and the historic environment' and PPG 16 – 'Archaeology and planning';
- the most appropriate long-term use for the building;
- the building's current state and likely costs of future maintenance and repair;
- non-financial and wider regeneration benefits from the future use of the historic building including environmental, cultural and long-term economic impact.

7.198 'The Disposal of Historic Buildings: Guidance for Government Departments and Non-departmental Public Bodies' (DCMS) sets out the following recommendations:

- Before deciding to vacate a historic building, the feasibility of adaptation and alternative uses should be considered. Most historic buildings with sensitive adaptation can give long-term, cost-effective service. In making financial assessments of alternative options, full account should be taken of the cost of responsible disposal, including any potential costs and risks incurred in maintaining and protecting the building if it becomes vacant.
- All surplus historic buildings, and particularly those that are vacant or only partially used, should be disposed of expeditiously: this may point to particular methods of disposal.
- All vacant historic buildings should be regularly inspected and maintained in a secure, safe and stable condition pending disposal, especially the roof, rainwater gutters and downpipes. Water penetration can lead to extensive damage to the internal and external fabric of the building including timber decay to floors, ceilings and roofs.
- Methods of disposal other than open market sale by auction or competitive tender may need to be considered where these will increase the chances of securing appropriate ownership and use of historic buildings.
- In cases of uncertainty, NHS organisations should safeguard taxpayers' interests by the use of overage or clawback provisions (see paragraphs 7.67–7.76 for details) or other means.
- Sites containing groups of buildings should be considered as a whole; they may need to be marketed as a single development package in order to avoid isolating historic elements of the site and potential damage to their setting.
- Disposals of large or complex historic sites can be assisted by a planning brief; this should be informed by an authoritative and independent analysis of the site's architectural or heritage significance.
- Maximisation of receipts should not be the overriding aim in cases involving the disposal of historic buildings. The aim should be to obtain the best return for the taxpayer that is consistent with Government policies for the

protection of historic buildings and areas; these policies are likely to limit opportunities for the realisation of development value.

- Appropriate professional advice should always be taken on the disposal of historic buildings, from advisers with proven experience.
- Early consultation with all interested parties will assist in overcoming any difficult or controversial issues.

Simplified disposal process for residential property (tenanted property)

7.199 Simplified disposal procedures exist for surplus residential houses and flats owned by NHS organisations. These procedures should be used with discretion. They are intended to speed up the disposal process, but retain public accountability.

7.200 The main elements are:

- if, following professional advice, there is no likely development potential that could increase the value of surplus residential houses or flats, sale to a housing association, local authority or registered social landlord (RSL) may be considered, providing market value can be established with reasonable certainty;
- where there is a dispute about the market value of the property, an independent professional valuer (acceptable to both parties) should be appointed to provide a valuation, allowing both parties to make representations (the VOA may carry out this work);
- if there is any possibility of an increase in value resulting from development at some time in the future, the sale should be subject to an overage or clawback provision (see paragraphs 7.67–7.76 for details);
- this procedure may be used as an alternative to selling to a sitting tenant, which may break up existing blocks and thus reduce likely interest from housing associations;
- consideration should be given to the possible re-use of blocks of houses or flats for key worker accommodation within or outside the NHS. Conditions may be incorporated into the sale, for example the housing association will modernise the units and make a proportion available to key workers.

Adjustment to sale price

7.201 A sale to a housing association or RSL should not affect the requirement to sell at the best price reasonably obtainable in the open market.

7.202 However, where a prospective purchaser is able to offer services in kind, this value may be taken into account; for example, a housing association may be able to offer guaranteed nomination rights to staff for whom the vendor has housing responsibility.

7.203 Another example is where the RSL requires a reduced sale price in order to charge the tenant an affordable rent. The NHS organisation should assess the benefits to the health service of the services provided by the RSL. The reduced sale value may be recovered later using overage or clawback provisions (see paragraphs 7.67–7.76 for details).

7.204 In such cases, a financial appraisal is essential to ensure the proposal represents value for money.

Disposal of burial grounds and war memorials

7.205 It is important to recognise the need for sensitivity when contemplating the sale of sites that include burial grounds and war memorials. These need to take account of local circumstances.

Burial grounds

7.206 It is inappropriate for the NHS to retain such land if it is no longer operational. It should be included in any sale of the principal site, or sold to the local authority or local interest groups who would maintain it.

7.207 Specialist advice should be sought from the VOA or private sector valuer regarding the sale value of these sites.

War memorials

7.208 Careful consideration should be given to the disposal of sites that contain war memorials. A purchaser may maintain and preserve the memorial. Otherwise, the memorial could be relocated on NHS land or land owned by local authorities or other interested local groups.

7.209 Where it is proposed to relocate or dispose of war memorials, at least six weeks' written notice should be given to the War Memorials Trusts, who may be able to assist in finding new suitable locations.

7.210 Six weeks' written notice should also be given to the local authority so that checks may be made as to whether the memorial is listed or listable. Once a memorial has been relocated or disposed of, the NHS organisation should inform the UK National Inventory of War Memorials.

7.211 See paragraph 10.194 for contact details of the above organisations.

8 Disposal of leasehold land and property

Introduction

8.1 This chapter deals with the disposal of surplus leasehold land and property.

8.2 Disposal options include assigning the lease to a new tenant, surrendering the lease back to the landlord or sub-letting all (or part) of the leased property to a sub-tenant.

8.3 Restrictions on disposal will usually be contained in the lease itself. These may dictate procedures for dealing with permitted disposals.

8.4 In most cases, the consent of the landlord will be required in advance of a disposal, usually in a formal written licence agreement. The terms of the lease will usually require the NHS organisation to meet the landlord's reasonable legal and professional costs in providing the licence.

8.5 Professional advice from solicitors and valuers should be taken in respect of landlord and tenant issues.

Assignment

8.6 Assignment is the standard form of disposal for long leasehold interests where the NHS organisation no longer requires the leased property and there is a sufficient number of years remaining on the lease term.

8.7 An assignment is a transfer of the unexpired term of a lease to another party. The new tenant (assignee) takes full responsibility for compliance of the lease terms.

8.8 The financial standing of the proposed assignee will dictate the preconditions the landlord is likely to demand when granting consent to the assignment. The NHS organisation will probably be required to guarantee the continuing performance of the assignee in respect of its lease obligations.

8.9 An assignment is not without risk as, if the proposed assignee is financially unstable, the continuing liability under the transferred lease could come back to the NHS organisation.

Surrender

8.10 A surrender is where the lease is disposed of by returning the premises to the control of the landlord. In the majority of cases the tenant has to make a payment to the landlord for the surrender to be completed.

8.11 It may take place without legal formalities, with the tenant returning the keys of the premises to the landlord and the landlord accepting this as evidence of the surrender. However, it is strongly recommended that the surrender is correctly documented to avoid potential disputes.

8.12 A date for surrender may be agreed with the landlord and documented by means of an "agreement to surrender". This gives both parties certainty concerning the terms and timing of the vacation of the property.

8.13 The agreement can also usefully record any terms agreed between the NHS organisation and landlord on how any dilapidations are to be dealt with.

8.14 A surrender may be beneficial to the landlord if it enables him/her to re-let the premises at a better rate to an alternative tenant.

8.15 On the other hand, it may represent the most cost-effective way for the NHS organisation to dispose of a leasehold interest, particularly one which only has a short time to run or where there are ongoing liabilities that the NHS organisation would retain on assignment of the lease.

8.16 Early advice from valuers and other professional advisers should be sought on the terms of the surrender and the calculation of payments to be made in either direction.

Sub-letting

8.17 If neither assignment nor surrender is possible, NHS organisations may dispose of leasehold property by means of a sub-lease. The granting of a sub-lease does not exonerate the NHS organisation

from liability under the lease, but rather passes those liabilities onto the sub-lessee.

8.18 Ideally, as many of the obligations in the NHS organisation's lease should be stepped down into the sub-lease to ensure that, whilst the NHS organisation remains liable to the landlord under its own lease, it is in a position to enforce them against the sub-lessee.

8.19 If the sub-lessee is reliable and financially sound, this arrangement can be beneficial, particularly if the premises are only temporarily surplus and may be brought back into use by the NHS organisation on expiry of the sub-lease.

8.20 However, there may be significant management and administrative burdens if the sub-lessee proves to be unreliable.

8.21 The NHS organisation will be required to meet the landlord's legal and other professional costs incurred in connection with the granting of consent to the sub-lease, unless these costs can be passed onto the sub-lessee.

8.22 The length of the sub-lease is flexible provided it does not exceed the length of the NHS organisation's lease.

8.23 If only part of the leased premises is surplus and the lease permits it, the NHS organisation may wish to sub-let part only. Additional consideration should be given to the contribution required from the sub-lessee to service charges, utility costs and business rates payable under the lease, and the allocation of shared areas in the premises.

How marketable is the lease?

8.24 Key issues affecting marketability, and hence the disposal options, include:

- the length of the lease (lease term);
- rent level (compared with current market rental value) and arrangements for rent review;
- nature of other payments due under the lease (for example service charges, insurance costs etc);
- alienation provisions;
- user provisions and other specified user restrictions;
- development potential (for long leaseholds);
- freedom to carry out alterations and adaptations (for short leaseholds);
- extent of the tenant's repair and maintenance liability (repairing obligations);
- rights and reservations associated with the lease (for example car parking, access etc).

Disposal of long leasehold land and property

8.25 Long leasehold property (over 70 years remaining on the lease) should be treated as though it were freehold property; all the general provisions affecting the sale of freehold land and property apply to the disposal of a long leasehold property.

8.26 Long leases are likely to have less restrictive user and alienation provisions and greater development potential than short leases.

8.27 The normal method of disposal of long leasehold land and property is by assignment. The NHS organisation should be able to demand a premium payment from the incoming tenant, which will reflect the capital value of the leasehold property.

8.28 Sub-letting of long leaseholds is not usual. Short-term sub-lets may be granted, subject to alienation provisions, for example where accommodation is not required in the short term or when letting part of a site for retail purposes.

8.29 Surrender of long leaseholds is unusual unless (1) the landlord is willing to pay a high price for the leasehold or (2) the tenant wishes to extend the lease term to allow for redevelopment and/or extensive refurbishment. In the latter case, subject to satisfactory financial terms being agreed, the remaining term of the lease would be surrendered to the landlord in return for the granting of a new longer lease.

8.30 The factors affecting the marketability of the lease are described in the following paragraphs.

Lease term

8.31 There normally needs to be at least 70 years remaining on the lease to allow an incoming tenant to raise finance against the security of the long lease interest.

Rent level and rent reviews

8.32 A nominal ground rent will normally be charged for the duration of the lease. The key issue is whether or not the ground rent is fixed. If it is not, the terms of any rent reviews, for example frequency and method, will be important.

Alienation provisions

8.33 The landlord may be required to approve the financial standing of an incoming tenant or license an assignment by means of a formal licence.

User provisions and specified user restrictions

8.34 How flexible are these provisions? Are there any user restrictions that may affect the marketability of the lease?

Developmental potential

8.35 If an incoming tenant is looking to redevelop the site, the lease will need to be checked to assess the degree of control that the landlord retains in approving new development works.

8.36 If the landlord's consent is required, this is likely to be by means of a formal written licence agreement, which will be the responsibility of the incoming tenant.

Rights and reservations

8.37 This could be important to an incoming tenant who wishes to carry out significant works to improve or demolish and rebuild the premises.

Disposal of short leasehold land and property

8.38 For the purpose of this guidance, a short leasehold is defined as having at least two but less than 30 years remaining on the lease.

8.39 The marketability of the short lease and disposal options adopted, that is, assignment, sub-letting or possibly surrender, will be affected by the following.

Lease term

8.40 If there is insufficient time remaining on the lease, it may be possible to negotiate, with the landlord, the option of taking a further lease at the end of the current lease. This can then be passed onto the incoming tenant.

8.41 If the remaining lease duration is too long, the incoming tenant may be given the right to assign the lease back to the NHS organisation before the expiry of the lease.

8.42 Another factor is whether the lease benefits from statutory security of tenure rights, that is, the right to renew an existing lease, arising from the Landlord and Tenant Act 1954. It is important to realise that tenure rights may be defeated by the landlord under Section 30 of the 1954 Act.

8.43 If the lease term is short, a surrender may be accepted by the landlord subject to an agreed monetary settlement.

Rent level

8.44 If the passing rent is above current market rental levels, it may be difficult to sub-let the premises (since the lease may not permit sub-lettings for less than the passing rent).

8.45 Under these circumstances, if the property is to be assigned, a reverse premium may have to be paid to the assignee and may be subject to VAT.

8.46 If the passing rent is below current market rental levels and the property is to be assigned, a premium may be offered by the assignee. Alternatively, a similar or higher payment may be available from the landlord, who may find it more beneficial financially to re-let the premises themselves.

Rent reviews

8.47 Is a rent review imminent or outstanding? Uncertainty in this respect can put off a prospective assignee or sub-lessee. Seek to resolve the review issue at the earliest possible time.

Alienation provisions

8.48 Restrictions and preconditions (sought by landlords) on assignments are likely to be more onerous in a short lease than in a long lease. Standard commercial conditions include the right for the landlord to require:

- evidence of the financial standing of the proposed assignee;
- a third party to guarantee the assignee's obligations in the lease;
- a rent deposit from the assignee to underwrite his/her lease obligations;
- a guarantee (known as an Authorised Guarantee Agreement) from the NHS organisation in respect of the proposed assignee's covenants and obligations in the lease.

8.49 The stronger the financial standing of the proposed assignee, the fewer preconditions the landlord is likely to insist upon.

User provisions

8.50 The marketability of the premises may be reduced because of a narrow user clause. The landlord may permit alternative uses, but may also be entitled to withhold consent provided it does so reasonably.

Freedom to carry out alterations and adaptations

8.51 If alternative use of the premises is not possible without significant adaptation, restrictions in the lease on alteration works could seriously affect the attractiveness of the lease to a prospective tenant.

Rights and reservations

8.52 If the lease offers benefits (for example car parking rights) in addition to the standard rights of access required to operate from the premises, this may be a positive attraction to a prospective tenant.

Repairing obligations

8.53 The extent of the tenant's repair liability in a short lease may be a significant issue in assessing its marketability.

8.54 If the tenant has a full repairing liability and significant repair works will be required in the short time that remains of the lease, unless these works are carried out before marketing the lease it may be very difficult to attract a new tenant.

Existing breaches

8.55 A prospective tenant is likely to inspect the premises and make enquiries before completing the assignment or sub-lease to ascertain, amongst other things, whether the NHS organisation has already fully complied with the tenant's obligations in the lease.

8.56 If there are outstanding breaches:

- the prospective tenant or landlord (as a precondition of permitting the assignment) will require that the NHS organisation remedies the breaches before the assignment or sub-lease completes; or
- the landlord may require security from the prospective tenant (for example in the form of a bond or third-party guarantee) that it will remedy the breaches.

8.57 In assignments, the assignee is likely to require that the NHS organisation meets these liabilities either by means of a reduction in the premium paid by the assignee (if any) or a reverse premium paid to the assignee on completion of the assignment.

8.58 For sub-letting, a direct payment or rent-free period to compensate for these works would be demanded by the sub-lessee.

Future breaches

8.59 If it is not possible to protect against future default by the assignee, the NHS organisation should ensure that the assignee and any person acting as guarantor for the assignee will be good for rent payments and other tenant liabilities under the lease.

8.60 NHS organisations should seek to take direct covenants from the assignee's guarantor and reserve the right to consent to any further assignment (again, to protect against the possibility of default by that tenant, giving rise to a claim from the landlord).

8.61 In the case of sub-letting, the NHS organisation has greater control over their tenant through exercising rights reserved under the lease provisions.

Contractual expiry of leasehold interests

Vacant possession

8.62 Ensure that vacant possession and compliance with all lease terms is accomplished prior to the lease expiration date.

Repairing obligations

8.63 Check the repairing obligations and whether they have been complied with. Ensure that any dilapidation works (for example repairs required under the lease terms) are completed prior to the lease expiration date. There are circumstances where dilapidations do not have to be carried out, or where a cash payment in lieu of dilapidations can be made.

8.64 Take professional advice when negotiating a schedule of dilapidations.

Other breaches

8.65 Often, alterations may have been made without formal consent, and those made with formal consent may have been done so subject to the landlord's requirement that they are reinstated at the end of the lease.

8.66 Tenant improvements may have to be removed and/or the land and property returned to the same condition as existed when the lease commenced, although the landlord may agree to take over tenant improvements.

Effect of sub-tenancies or licences

8.67 Sub-lessees or licensees may require notice from the NHS organisation to give up possession. It is better to secure possession from sub-lessees and licensees earlier than required by the head lease to ensure that the NHS organisation does not have difficulty in giving vacant possession to the landlord at the end of the term.

Post-completion

8.68 Details of assignments, sub-lets and surrenders should be recorded on the estate terrier, and the asset register records should be amended.

8.69 The NHS organisation's solicitor should provide a summary of:

- any assignment and guarantees provided;
- the main terms of the sub-lease.

8.70 The solicitor should also provide details of the location of the legal documentation should any problems arise from a defaulting assignee.

8.71 Procedures should be in place in NHS organisations to ensure that the terms of any sub-lease are clearly known and monitored to ensure compliance with the sub-lease terms.

9 Granting of leases (and licences)

Introduction

9.1 This chapter deals with the granting of (new) leases to third parties (whether other NHS organisations, voluntary groups or the private sector) and other forms of occupational arrangement.

9.2 Examples include the letting of temporarily vacant space, surplus property pending disposal, and income generation transactions such as letting units for banks, shops, cafes, hairdressers and voluntary organisations.

NHS organisation as landlord

9.3 Care must be taken when NHS organisations are considering becoming landlords, since property management is not a core role for them. Tenancy agreements should not interfere with the provision of health and social care.

9.4 The aim to obtain good commercial terms should be balanced with the need to operate effectively. The financial benefits of a lease should be considered carefully, as the role of landlord is often management-intensive.

9.5 For detailed information on income generation see paragraphs 1.60–1.65.

9.6 Planning permission may be required if a new facility is created and its use is not regarded as ancillary to the NHS organisation's function.

9.7 Leases should only be entered into once the NHS organisation is satisfied that the tenant has the required financial status to meet the obligations of the lease. A guarantee or deposit should be sought.

9.8 NHS organisations should be careful when granting a licence to avoid creating a lease.

9.9 Licences for the exclusive use of property for a defined period in return for a rental payment should be avoided, since this might well give rise to a tenancy with security of tenure under the Landlord and Tenant Act 1954. However, licences relating to business premises do not fall within the provisions of the 1954 Act.

9.10 Tenants should not be given possession of the property before the lease terms have been agreed and lease documents signed and exchanged, otherwise a tenancy may be established by law that is different from that which was intended.

9.11 Property and legal advice should be taken in relation to the following matters.

Code of commercial lease practice

9.12 NHS organisations should be aware of 'The Code for Leasing Business Premises in England and Wales 2007' (see paragraphs 1.97–1.99 for details), especially in relation to rent review and lease term options to be offered to prospective tenants.

Lease term

9.13 The duration of the lease will depend on individual circumstances, but should be restricted to the life of the property, or a time when the NHS organisation will require the property again, or it is to be disposed of.

9.14 If the precise date on which the NHS organisation will require the property again is not known, the lease may provide for the NHS organisation to terminate the lease early by serving an agreed notice period on the tenant.

9.15 This arrangement avoids the need to grant further leases after the original lease term has expired. Care does need to be taken to ensure that the NHS organisation serves the termination or "break" notice correctly.

9.16 Except for short fixed-term contracts (up to six months), the tenancy should be excluded from the security of tenure provisions of the Landlord and Tenant Act 1954 to retain full control over the tenancy and restrict the term to that agreed with no right to automatically renew the lease.

Rent level

9.17 Unless the tenancy benefits the provision of healthcare, the tenant should be charged full

market rent on normal commercial terms, with rent reviews at specific intervals (usually every three or five years) or increased by RPI.

9.18 The imposition of terms, for example to protect the NHS organisation's business, may reduce the rent which prospective tenants are willing to pay.

Alienation provisions

9.19 It is important to clarify what assignment or sub-letting will be permitted. The NHS organisation needs to have a clear policy on which tenants they require in order to achieve the right tenant mix in terms of use of the premises and type of company or individual tenant they wish to attract. Restrictive covenants may be required to implement this policy.

9.20 Limitations on alienation may restrict rents received.

VAT implications

9.21 It is important to bear in mind VAT implications. A tenant will not be obliged to pay VAT on the rent charged under the lease unless the NHS organisation, as landlord, elects to waive the VAT exemption.

9.22 Advice should be taken from VAT advisers on the merits of waiving VAT exemption. If VAT is not recoverable by the prospective tenant, this would add (at current rates) 17.5% to the tenant's real rental costs.

Repairing obligations and insurance arrangements

9.23 Except in the case of short-term leases or leases of land and property in poor condition, the lease will normally require the premises to be kept in good repair and adequately insured at the tenant's expense. Specialist advice should be taken in respect of existing NHS self-insurance arrangements and the proposed tenant's insurance arrangements.

9.24 Non-NHS tenants should normally be required to take out comprehensive insurance, including public liability, to indemnify the NHS against claims made against the tenant.

Compliance with statute

9.25 The tenant should be required to comply with the requirements of all relevant statutory acts and regulations including the Town and Country Planning Act 1990. This may require the tenant to secure planning permission for a change of use.

Landlord's responsibilities

9.26 A schedule of condition, including photographs, should normally be prepared at the start of the lease. This will avoid disputes, and is fair to both parties, if this is the condition in which the property is to be returned at the end of the lease.

9.27 Regular inspections should be made to ensure that the tenant complies with the terms and conditions of the lease (particularly in relation to repairs).

9.28 Any notices in connection with rent reviews, tenant defaults, termination of the lease etc must be issued in good time and strictly in accordance with the written terms of the lease.

Freedom to carry out alterations and adaptations

9.29 Permitted alterations to the property should be detailed in the lease.

9.30 It should be ensured that the works will not harm the structural integrity of the property and that they are completed in accordance with the provisions in the lease. For example, internal non-structural alterations may be permitted subject to the tenant obtaining the landlord's approval of the works before they commence.

9.31 Solicitors should prepare the appropriate form of landlord's approval for tenant works, and this is usually a formal licence for alterations.

9.32 The Landlord and Tenant Act 1954 may entitle the tenant to compensation at the end of the lease to acknowledge any increase in the letting value of the property as a result of carrying out works.

Lease expiry or renewal

9.33 If the land and property will become surplus to requirements of the NHS organisation at the lease expiry, vacant possession should be secured.

9.34 If the NHS organisation wants the lease arrangement to continue, it should ensure that before the current lease ends, fresh terms for a new lease period are agreed with the tenant.

9.35 The new lease should be put in place immediately after the current lease has expired.

9.36 If this is not possible, terms for the new lease should be agreed for implementation as soon as possible after the current lease has expired, on the basis that the tenant will remain in occupation as a tenant "at will" (a tenant with very limited rights).

Otherwise the tenant may acquire security of tenure under the Landlord and Tenant Act 1954.

9.37 Where the lease does not provide for renewal on stated terms, and where it is intended that the lease is to be renewed, advice from a solicitor should be taken to ensure that the NHS organisation's interests are protected.

9.38 Rent payment (cash or in kind) should not be accepted after the expiry of the lease, as a new periodic tenancy may be created inadvertently, giving the tenant security of tenure.

9.39 A schedule of repairs (dilapidations) should be prepared, if required, before the end of the lease term. This should be submitted to the tenant in good time so that an accepted plan of action can be agreed before the lease term ends.

9.40 On termination of the lease it is usual for the land and property to be reinstated to its original condition. Alternatively, if appropriate, the NHS organisation may negotiate a cash settlement in lieu. Such negotiations will usually need to be completed in a timely manner.

9.41 The legal system governs how terminal dilapidations should be handled by both landlord and tenant through a "pre-action protocol".

Letting concourse shops

9.42 When letting concourse, or similar, shops, the following should be considered:

- restrictions on items to be sold;
- exclusive rights to trade in certain items, as this may make the lease more attractive and so command a higher rent;
- mandatory opening times in order to provide an appropriate service to staff, patients and visitors;
- all-inclusive rents rather than service charge arrangements, which may be contentious and will impose an additional management burden on the NHS organisation;
- concessionary rents where the service is of value to staff, visitors and/or patients (for example banking or hairdressing or services provided by voluntary organisations) but would not be viable if a full market rent were charged;
- turnover rents (possibly in addition to basic rent), as this may better reflect the commercial value of the lease;
- insurance arrangements (pooled premium recovery or commercial insurance taken out by the tenant);
- the need for special fire precautions or other precautions to minimise risk, to take account of occupation of parts of the site by non-NHS organisations (commercial or charitable tenants).

Insurance arrangements

9.43 If the retail unit is stand-alone and independent of the rest of the property, it may be beneficial for the tenant to take out commercial insurance cover and use insurance proceeds to repair or reinstate the property.

9.44 Where the retail unit is part of a larger building that is already insured under the NHS Property Expenses Scheme, it will normally be appropriate for the landlord to take on the insurance responsibilities by reference to the NHS Property Expenses Scheme and for the tenant to insure for other insurance liabilities not covered under the scheme, for example public liability insurance.

Joint ventures

9.45 When letting land and property where joint ventures with others (for example laundry, computer suite, boilerhouse, incinerators, car parks, nurseries) are involved, the following points should be noted:

- the terms of any lease should be consistent with the terms of the service contract;
- the lease should terminate on or before the expiry of the service contract;
- it may be advisable to include a landlord's break clause in the lease in case the service contract terminates early;
- special insurance arrangements may be required (such costs should be passed on to the tenant).

Car parking areas

9.46 Legal advice should be taken on whether a lease or licence of car parking areas should be granted in conjunction with a car park management service contract.

9.47 The NHS organisation will need to ensure that the service provider does not inadvertently acquire a security of tenure of all or part of the car parking

areas, as this may restrict the NHS organisation's ability to manage its estate flexibly.

Aerial leases

9.48 Aerial leases fall within the provisions of the Telecommunications Act 1984 and the Electronic Communications Act 2000 (the so-called "code powers").

9.49 In deciding whether to grant an aerial lease, NHS organisations should take specialist advice and weigh the short-term financial benefits of the rental income against future estate management issues.

9.50 The key consideration should be the NHS organisation's medium- and long-term estate requirements, and the need to ensure that in granting a lease to a telecommunications operator it is not inadvertently sterilizing part of its estate or creating a future ransom situation.

9.51 Leases to telecommunications operators are regulated under the code powers, which means that operators have rights in addition to those given under the Landlord and Tenant Act 1954.

9.52 Contracting out of the Landlord and Tenant Act 1954 rights and including in the aerial lease a landlord's break clause (to be exercised when the land and property becomes surplus or the aerials begin to prejudice the NHS organisation's operational requirements) may not be sufficient to ensure that the NHS organisation can regain possession of the land and buildings subject to the aerial lease.

9.53 The process for obtaining possession under the code powers through the courts (if no settlement can be negotiated) can be lengthy, expensive and uncertain.

9.54 NHS organisations have experienced significant difficulties in obtaining possession of land from telecommunications operators because of the operators' protected rights, and in some cases have had to make substantial payments to regain possession.

9.55 This problem can be acute where the NHS organisation has surplus estate for disposal and a telecommunications operator is aware of the ransom position it holds, or where the geographical location of the property means that it is a highly prized site for an aerial.

9.56 Other considerations include:

- the premises let will include the air-space occupied by the aerials plus any equipment storage area;
- the lease should require the tenant to ensure that the aerials are not readily accessible by members of the public, and are appropriately located and secure;
- long-term leases should be avoided (five years is normally sufficient);
- all equipment should be compatible with the NHS organisation's electronic apparatus;
- the operator's standard lease documentation should be used with extreme caution, as it is often written in favour of the operator;
- there is a need to ensure that the tenant complies with all statutory regulations, including securing appropriate planning permissions;
- specialist valuation advice should be taken.

Letting of advertising hoardings

9.57 When letting space for advertising hoardings:

- impose restrictions on advertising texts to avoid politically sensitive or controversial areas or health risk products such as tobacco or alcohol;
- ensure that the tenant complies with all statutory regulations, including securing appropriate planning permissions;
- take specialist valuation advice on market rents and terms of the proposed tenancy. The prospective tenant's first offer should seldom be accepted, since they will be prepared to negotiate.

9.58 Sections 220–225 of the Town and Country Planning Act 1990, and specific regulations, govern these matters, and care should be taken to ensure that any lease of a hoarding site is properly tied in with the planning requirements. Again, breach of the relevant legislation is a criminal offence.

9.59 Ensure that all necessary consents are in place, as a landowner can be held liable for the display of unauthorised advertisements.

Letting of noticeboards

9.60 NHS organisations should have a clear policy on the use of posters on noticeboards within their premises or premises where NHS services are being carried out.

9.61 Posters should contain non-offensive information.

9.62 Monitoring arrangements should ensure that inappropriate advertisements or fly-posters are not put up or are removed promptly.

9.63 Careful consideration should be given to the content of posters, which might be politically sensitive or controversial, including advertisements for any health risk products such as tobacco or alcohol and those likely to undermine morale or the relationship between staff and patient. For example, advertising by claims management or other legal services within premises that provide NHS services should be avoided and not permitted.

9.64 Where posters or advertisements are permitted as an income generation activity, a clear policy about suitable text, pictures and content should be established. This must not be contrary to Government or NHS policy.

9.65 Consent given to the erection of any advertising poster should have an expiry date, and consideration should be given to designating separate boards for staff as opposed to general patient/visitor information.

9.66 PCTs might wish to suggest to GPs that they adopt similar guidelines in respect of notices in surgeries and clinics.

Sub-letting of NHS LIFT premises

9.67 As part of the NHS LIFT initiative, PCTs may take on the role of both tenant (under lease-plus agreements with the local LIFT company) and landlord (under sub-letting agreements with other (usually) public-sector users of the LIFT premises).

9.68 PCTs are restricted in how they can deal with premises leased to them under lease-plus agreements. They may not grant sub-leases without the prior written consent of the local LIFT company and (usually) the LIFT company's funder/mortgagee.

9.69 PCTs may share their premises with another person/organisation providing ancillary or complementary services, provided that no tenancy is created between the PCT and third party. A tenancy may arise if the third party makes payments to the PCT for use of the premises and/or if the third party has exclusive right to use any part of the premises.

9.70 There is not a nationally accepted standard form of sub-lease in the same way as the standard lease-plus agreement, but the sub-lease is inevitably shaped by the contents of the lease-plus agreement.

9.71 Key considerations in negotiating the sub-lease are likely to include:

- length of the sub-lease and whether or not it is excluded from the Landlord and Tenant Act 1954 provisions. Will the PCT allow the sub-lessee to take a sub-lease for a shorter term than the 25-year lease-plus agreement?;
- the right for the sub-lessee to break the sub-lease before its expiry date. This has been a particular concern for GPs, who are not used to having documented lease or licence arrangements with PCTs, and for whom the prospect of being contractually committed to a sub-lease of just five years is unacceptable. Short-term leases to GP practices may have a number of advantages for PCTs, especially if GPs are approaching retirement or a reconfiguration of GP services is contemplated;
- for GP practice sub-lessees, the setting of the sub-lease payments in line with the provisions of the National Health Service Act 1977 – the National Health Service (General Medical Services – Premises Costs) (England) Directions 2004. Consideration should be given to the possibility of the GP practice ceasing to be the tenant and the provisions of the head lease;
- arrangements for the provision of "soft" facilities management services to the LIFT premises (for example cleaning, security, waste disposal etc) and payment of a proportionate service charge by the sub-lessee. This can be contentious where a sub-lease is put in place before the premises have become operational and service costs are based on estimates. In these circumstances, sub-tenants may wish to negotiate an overall cap on their liability for this charge;
- restrictions imposed on sub-lessees (especially GP practices) to assign their sub-lease. PCTs need to consider their powers as commissioners to regulate the appointment of medical practitioners in their area (under Regulation 3(i) of the National Health Service (Performers

Lists) Regulations 2004 made under Sections 91, 106, 123 and 146 of the National Health Service Act 2006 (previously Section 28X of the National Health Service Act 1977)) and the powers they may wish to exert as landlord;

- GP sub-lessees may request reassurance that the PCT will not allow open competition from other service providers within the LIFT premises for the core services that the GP practice provides. PCTs should ensure that any comfort they are able to give GP practices does not fetter their statutory duty to provide or procure services.

Arrangements with other NHS organisations

9.72 Occupation arrangements between NHS organisations (of three to five years' duration) should be documented by means of a written memorandum of terms and conditions. Alienation provisions should not normally be allowed.

9.73 Arrangements with NHSFTs should be documented by means of a formal lease, as contracts may be disputed in court and obligations formally enforced. Every effort should be made to resolve disputes before proceedings are undertaken through the courts.

9.74 Arrangements between NHS organisations that need (for operational reasons) to be longer than five years may be best documented by a formal lease. This will be helpful if one or both of the parties later become an NHSFT or the freehold interest is transferred to a non-NHS organisation.

9.75 Accommodation within part of a building should be made available to other NHS organisations on the basis of a market rent, plus a service charge. In the case of charities, a nominal rent may be applicable dependent upon the benefits provided by this user.

9.76 However, parties may agree that the capital charges (based on an apportionment by floor area of the capital charge), plus a service charge, should be payable by the occupier. For self-contained buildings, the tenant may take full responsibility for all services etc.

9.77 Where it is appropriate to adopt a memorandum of terms and conditions, the memorandum should:

- apportion responsibility for repairs, insurance and compliance with statutory requirements;
- restrict the use of the premises and the ability of the occupier to assign its rights to a third party;
- provide details of the agreed rental arrangements;
- where the freehold or leasehold interests subsequently pass into the private sector, ensure beforehand that the rights recorded in the memorandum are surrendered and that a formal lease is put in its place providing for a money rent to be paid that is reasonably close to market rent or "capital charge" rent.

9.78 The key terms of any such memorandum should be recorded in the NHS organisation's respective estate terriers. Key documents must be kept in a safe place, perhaps with the organisation's solicitors.

Disputes between NHS organisations

9.79 Disputes between NHS organisations (not including NHSFTs) on the interpretation of memoranda, or any land and property-related matter, should be resolved within the NHS without reference either to formal arbitration or the courts.

Arrangements with non-NHS organisations

9.80 Leases to housing associations, charities or other voluntary care groups or nursing homes will be business leases. Where premises are required for exclusive occupation by local authorities for social services, education, or public health functions, it is generally appropriate for a business lease to be granted on market terms.

9.81 To ensure that the tenant in question does not acquire security of tenure, the NHS organisation should exclude the relevant provisions of the Landlord and Tenant Act 1954.

9.82 Note the following:

- consideration should be given to making the lease coterminous with any corresponding management or service agreement;
- concessionary rental terms can only be given to voluntary organisations where equivalent healthcare benefits are obtained;
- it will usually be advisable to make the user clause specific and restrictive;
- leases subject to restricted user clauses may reduce the rental value of the land and property, and should be the subject of scrutiny. If

adopted, monitoring is necessary to ensure that the occupier uses the land and property in accordance with the user clause, or pays additional rent (price) to bring it back to the unrestricted market value.

9.83 Where a local authority wants to build new premises on NHS land, the relevant land may be sold (at market value) or let on a long lease (for the life of the building) at a ground rent. The appropriate option will depend on the future use and development of the land. The development should not hinder the NHS use of the site.

9.84 Where other NHS organisations or carers provide services on-site on a sessional basis, it is not normally appropriate to create a landlord-and-tenant relationship. A licence for the specified times should be created as part of a service level agreement. The NHS organisation should ensure that exclusive possession of premises is not granted in these circumstances, or the occupier may inadvertently acquire security of tenure.

Arrangements for university medical school facilities

9.85 Where a joint hospital and university medical school development takes place, the arrangement with the university will vary as follows:

- where the NHS organisation purchases a new site for development, the university should pay either a share of the site purchase costs plus a nominal rent, or market rent together with a proportional share (usually based on floor areas) of the total building costs;
- where the development is on the NHS organisation's existing site, the university should pay a proportional share of the building costs and a market rent for the land;
- where existing premises are to be used, the university should pay an open market rent, which may be capitalised if the parties so desire.

9.86 In respect of the terms of the lease, normal commercial considerations will apply. Account should be taken of the benefits and services the NHS organisation receives from the university.

9.87 The NHS organisation should match the lease terms with the purpose of the occupation. For example, if it is tied to its teaching function, the lease should be tied into the education contract, so that if the education contract ceases, the NHS organisation can terminate the lease (so that the premises would be available for another provider).

Arrangements with educational establishments (embedded accommodation)

9.88 Property transactions involving the use of NHS sites by universities are not generally exempt from the requirement to be on commercial terms, except "embedded" university accommodation in NHS-owned buildings that are being redeveloped by the NHS.

9.89 See 'Joint NHS/University capital projects – a guide to the treatment of embedded accommodation in joint projects' (issued in March 1996 by DH and the Higher Education Funding Council for England (HEFCE)).

9.90 Considerable academic accommodation has always existed in NHS-owned and funded facilities. Where this accommodation is being re-provided as a result of NHS reconfiguration, any increase in cost should be funded by the NHS.

9.91 Where the new accommodation offers benefits (for example extra floor space or better equipment), the additional cost should be funded by the party receiving those benefits, which may be the university.

9.92 Each scheme will require local agreement. Where the NHS is planning to replace buildings that include university accommodation, there must be clear agreement at an early stage of the university's requirements and any cost-sharing principles, including where applicable the onward charging of VAT.

9.93 Cost-sharing principles should be agreed before the outline business case to provide a greater degree of financial certainty to all parties during the procurement.

Concessionary leases

9.94 A lease may be granted at a rental level below market value to any organisation proposing to use all or part of an NHS site for services that complement the NHS service or would otherwise have to be provided by the NHS.

9.95 A business case should be prepared for a concessionary lease. The value of the concession must be justified by the expectation that any

financial loss will be matched by an equivalent financial or service benefit.

9.96 A concessionary lease should generally not be considered for:

- Government-funded organisations, who should seek adequate funds from their sponsoring department to pay market rents;
- local authorities, who should be covered by joint financing arrangements;
- commercial undertakings, unless they provide a service to staff and/or patients (for example a bank) and can demonstrate that the service would be uneconomical if a market rent was charged.

9.97 A concessionary lease may be granted to a housing association for the provision of staff residential accommodation, where this is the most cost-effective solution. A value-for-money exercise should be undertaken to prove this is the case.

9.98 Before granting a concessionary lease, a full financial appraisal of the proposal should be made, which should include:

- a current market valuation of the land and property;
- a statement of the reasons for recommending a concessionary lease, including why the prospective tenant cannot afford to pay full market rent;
- a calculation of the value of the concession;
- any additional relevant information.

9.99 The concessionary lease should be as short as possible and not exceed seven years unless there are sound healthcare service reasons. Otherwise, terms should be as for a normal lease but with the addition of the following:

- the tenant should permit regular checks to ensure the terms of the lease are being adhered to;
- the lease should state clearly what the land and property is to be used for, and that the premises will revert to NHS use if they are no longer used for the purposes stated or any attempt is made to change the use;
- the lease should not be capable of assignment or sub-letting;
- if a concessionary lease is to be renewed, a re-evaluation of the proposal and a fresh authorisation should be sought. Any renewal should be considered well in advance so that a firm decision is available before the time the lease expires.

9.100 Any concession must be approved by the board, who will want to consider the business case in order to make an appropriate decision.

9.101 Where the concession has a value of £250,000 or more, approval should also be secured from DH before it is agreed. Proposed concessionary leases that may be novel or contentious should also be referred to DH for consideration. If the concession is seen to be a “gift” it may need to be reported to Parliament.

Post-completion

9.102 Details of any leases and licences granted by the NHS organisation should be recorded on the estate terrier and the asset register records should be amended.

9.103 A summary of each lease and licence should be prepared, and copy documents retained to enable the let premises to be properly managed.

Part E – Management of land and property

10 Management of land and property

Introduction

10.1 This section deals with the management of land and property, whether leasehold, freehold or subject to other contractual arrangements.

10.2 The management of land and property should support the service objectives of NHS organisations.

10.3 Assets in this section include land, property and plant forming part of the building, for example boilers, lifts and air handling units. The maintenance of plant is not covered in this document.

Principles of management

10.4 Efficient and effective management of land and property requires the following:

- the maintenance of an up-to-date and accurate property asset register (see paragraphs 10.21–10.24);
- all statutory obligations to be identified and met (see paragraphs 10.19–10.20);
- proper and regular maintenance of the estate (see paragraphs 10.30–10.49);
- risk management (see paragraphs 10.50–10.79);
- preventing third parties gaining inappropriate rights over land and property (see paragraphs 10.60–10.62 on prevention of trespass);
- consideration of sustainability issues (see paragraphs 10.80–10.86);
- management of easement agreements (see paragraphs 10.87–10.95);
- appropriate action when land and/or property is subject to compulsory purchase powers (see paragraphs 10.96–10.100 for details) or potential or actual applications for registering as a town or village green (see paragraphs 10.101–10.123 for details);
- involvement in town planning issues (see Chapter 2 for details);
- management of tenancy and other contractual arrangements (see paragraphs 10.130–10.151);
- where non-NHS facilities are used for NHS patients, that policies to ensure NHS standards regarding the built environment are adopted and implemented (see paragraphs 10.152–10.155 for details);
- the identification of all listed buildings, conservation areas, registered parks and gardens, burial grounds and war memorials, and policies to deal with the specific requirements of these land and buildings (see paragraphs 10.167–10.194 for details).

The costs of holding land and property

10.5 The main costs associated with assets (excluding capital costs) include maintenance, cleaning, energy and utility costs, capital charges, rates and rent (where applicable).

10.6 Freehold land and property costs include:

- capital charges;
- planned and unplanned maintenance expenditure.

10.7 Capital charges comprise depreciation and interest charges, which vary according to the age of the asset. They represent respectively the cost of "using up" the asset and the cost of tying up capital in the asset. NHS organisations should understand the different types of valuation upon which capital charges are calculated, that is, market value (MV), existing use value (EUV) and depreciated replacement cost (DRC).

10.8 Leasehold land and property costs include:

- where the landlord is another NHS organisation, a rental, often equivalent to a "capital charge" plus a service charge;

- where the landlord is a non-NHS organisation, and additionally for the civil estate, a market rent, which will normally be subject to regular review plus, in most instances, a service charge;
- VAT, which cannot be recovered in all cases;
- repairing and decorating obligations – often on a fixed-period basis;
- dilapidation claims on expiry of the lease.

10.9 Whatever the tenure, liabilities often include:

- uniform business rates;
- charges for utilities (gas, water, sewerage, electricity etc);
- security costs;
- insurance premiums (pooled or commercial arrangements);
- special expenses where buildings are listed or the property is in a conservation area;
- costs incurred to comply with statutory requirements.

10.10 In leases, the items may be paid directly by the tenant or by the landlord and recovered as rent and a service charge.

Lifecycle costs

10.11 Understanding the lifecycle costs of assets is critical to minimising costs and making effective investment, maintenance and replacement decisions.

10.12 Assets have different cost structures at different points of their lifecycles. For example, maintenance costs become proportionately higher as an asset ages. Understanding the position of an asset within its lifecycle and the trade-off between different costs is important in effective asset management.

Managing those costs

10.13 Periodic budgeting will include:

- a review of occupied space, to see whether surplus space can be identified for sale, income generation or beneficial re-use within the NHS;
- consideration of the various contracts, whether for supplies or services, relating to the estate;
- consideration of the efficiency of the existing land and property, the cost of their replacement and value in the market;
- monitoring and review of service charges in leased accommodation.

10.14 NHS organisations should follow the service charge guidance published by RICS (see paragraphs 1.100–1.101) whether they are a landlord or a tenant.

10.15 The guidance, which comes into effect on 1 April 2007, promotes best practice in terms of service charges for commercial property in new or renewed leases. It will be used to interpret service charge provisions in existing leases unless the lease specifies an alternative approach.

10.16 The parties to a lease should be more transparent when dealing with service charges through regular communication about the provision, relevance, cost and quality of services provided.

10.17 Guidance is provided regarding what should and should not be included in the service charges and methods of apportionment. Proposed budgetary charges by the landlord or his/her managing agents should be reasonable and "cost neutral" (that is, the landlord quality service makes neither a profit nor a loss).

10.18 Minimising asset costs does not necessarily mean having only the cheapest assets. The cost of assets needs to be considered in the context of the quality of the service required, and costs need to be assessed over the lifecycle of the asset, including maintenance costs and resale value, not just on the basis of the purchase cost.

Management responsibilities

10.19 Chief executives are accountable for the management of services provided by their organisations. Chief executives have three distinct responsibilities:

- strategic management of assets – regular review of their productivity, cost and fitness for purpose, and subsequent rationalisation and investment;
- operational maintenance of assets – ensuring that the condition of the estate is assessed and reported on regularly, and assets are high-quality, appropriate and safe for day-to-day use;
- seeing to it that all statutory obligations are identified and met.

10.20 Estates/facilities managers (in-house, external or shared services) must provide a service that enables

the other managers in the NHS organisation to know:

- the organisation's land and property holdings;
- the cost to run and maintain the assets;
- that the asbestos register is up-to-date;
- that accommodation is contantly reviewed to ensure optimum use;
- that the estate is maintained to minimise the risk of claims from third parties or statutory regulators;
- that staff and patients enjoy a secure and attractive environment;
- that tenancy arrangements with third parties are properly monitored and contractual obligations honoured;
- that environmental impacts are identified and proposals are in place to reduce/limit harm to the environment;
- the statutory designations (listed buildings etc) and special planning consents required for developments, including alterations;
- town planning policies relating to the property and development of new planning documents locally and regionally;
- that information is available for the strategic service development plan (SSDP).

Land and property records

10.21 Each NHS organisation should have an up-to-date and accurate property asset register. This should include details of all leases and other property-related agreements taken by the NHS organisation, similar transactions to third-party organisations in respect of freehold and leasehold property, and donated assets.

10.22 Where possible, NHS organisations should identify any legal charges where they may receive a future financial benefit.

10.23 Records should be computerised and open to audit, especially if maintained by a third party.

10.24 Records should include an events diary for all leaseholds (whether taken or granted by the organisation), as a reminder for action on notices, rent reviews, rent renewals, break notices, review of service charges etc. Failure to adhere to timescales (for example planned maintenance) can lead to major occupation problems, as well as costs.

Legal title documents and deeds

10.25 All legal documents relating to land and property, including the NHS organisation's Establishment Order, Transfer Order and Directions as well as any legal charges, should be kept in a secure, fireproof safe with a policy for registering when they are removed and returned. This service may be provided in-house or externally by, for example, solicitors.

10.26 NHS organisations should ensure that all legal title is registered in their name, especially after assets are transferred to them, for example under a Transfer Order.

10.27 Where property is unregistered, NHS organisations are encouraged to register such interests at the Land Registry, whether or not they are required to do so under Land Registry rules. This should avoid uncertainties around the enforceability and/or relevance of covenants, easements or other provisions.

10.28 On registration of title, it is advisable to retain original deeds that give details of rights and easements to avoid disputes in the future. Advice regarding this matter should be sought from a solicitor.

10.29 Deeds to historic buildings, particularly if listed, should be retained for possible research use. Pre-registration deeds should not normally be destroyed or sold. If arrangements cannot be made in-house for their safekeeping, they may be stored by the local authority or other interested organisation such as English Heritage.

Maintenance

Land and property

10.30 Records should indicate the condition of land and property, location or suspected location of asbestos and maintenance schedules. They should clearly identify the location of cables, pipes, ducts etc. Where that knowledge is lacking, a survey should be commissioned.

10.31 Property managers should undertake budgeting and space utilisation exercises to identify where existing standards are adequate and where improvements can be made.

10.32 An assessment of lease liabilities will be a factor in planning maintenance programmes.

10.33 Having assembled the basic information, a planned maintenance schedule should be drawn up for a particular time period – usually between three and five years. For historic or listed buildings a quadrennial/quinquennial conservation survey is required.

10.34 Changes in service provision as well as legislation will require regular reviews of the maintenance programme. A routine for carrying out such reviews should be established.

Boundaries

10.35 In general, boundaries should be regularly maintained and notices posted saying that this is "the private property of an NHS organisation [owner]".

10.36 Deeds are often unclear on the issue of boundary ownership. It is therefore usually necessary to inspect boundaries. In the absence of documentary evidence, there are indications that can be helpful but are seldom conclusive:

- "hedge and ditch" rule – a ditch will usually belong to the landowner whose land includes an adjacent hedge;
- retaining wall – usually built by the party whose use of land created the need for it;
- whoever has maintained them in the past.

10.37 The cost of boundary maintenance should be weighed against the required security and resulting benefits.

10.38 Be aware of the procedures and rights contained in the Party Wall etc Act 1996 (extended with some refinements). If in doubt, consult a solicitor.

Under PFI and LIFT contracts

10.39 Under PFI and LIFT contracts, the private sector (contractor) is responsible for maintaining NHS premises. However, NHS organisations should ensure maintenance is carried out properly.

10.40 The normal contractual provisions are set out below, although these may differ on a scheme-by-scheme basis.

10.41 The contractor should schedule the necessary maintenance in the most effective way. Before the start of each year of the contract, it must provide a proposed maintenance programme for that year. At the same time, it must provide an up-to-date five-year maintenance plan.

10.42 If the contractor follows the maintenance programme, usually no deductions will be made for any resulting underperformance of services.

10.43 The maintenance programme is subject to review by the relevant NHS organisation. It may object to the contractor's proposed maintenance programme on the grounds that:

- it would interfere with its operations in a way that could be avoided or reduced by rescheduling the works;
- the proposed hours of maintenance are not acceptable (for example, maintenance involving dust or loud noise in areas that are being used for surgery at that time);
- it is not in accordance with the service specifications in the contract;
- the safety of patients or other users of the premises would be adversely affected by the proposed programme;
- the period proposed for the maintenance works exceeds that reasonably required to carry them out.

10.44 NHS organisations should retain the right to instruct their contractors to accelerate or defer planned maintenance. However, contractors should be compensated for any additional costs (up to an agreed amount) incurred as a result of the requested changes.

10.45 No performance deductions should be made if the reason for the contractor's non-performance is deferral of the maintenance works in accordance with the NHS organisation's instructions.

10.46 Where the need arises (other than in an emergency) for maintenance works not set out in the agreed programme, the contractor must agree the time and duration of these works with the NHS organisation.

10.47 Where an emergency occurs that requires immediate maintenance, the contractor must notify the NHS organisation of the action it is taking and seek to minimise any disruption caused.

10.48 If emergency maintenace is needed or planned maintenance requirements are not complied with, financial deductions may be made.

10.49 NHS organisations should reserve the right to periodically inspect the ongoing maintenance. A separate inspection of the facilities should take place towards the end of the contract to ensure the assets are handed back in a satisfactory condition.

Risk management

10.50 Management of risk is a vital aspect of land and property management. Measures should be introduced that:

- identify the risks arising from the ownership/rental and use of assets;
- assess those risks for potential frequency and severity;
- eliminate high and significant risks associated with sub-standard assets. Moderate and low-risk elements should be addressed by effective management in the medium to long term;
- monitor the effectiveness of risk control measures.

10.51 Areas that should be addressed include:

- statutory compliance, for example the Disabiltiy Discrimination Act 1995;
- security arrangements;
- health and safety requirements including the control of asbestos in buildings;
- pooled insurance arrangements;
- fire risks;
- risks arising from the maintenance of assets and the consequence of breakdowns;
- waste storage and disposal;
- environmental management;
- transport plans;
- contingency planning.

Security arrangements

10.52 NHS organisations should produce and implement a site security strategy. The strategy should be based on the following principles:

- improve the physical security of grounds and buildings;
- prevent illegitimate users from gaining access to the site and buildings;
- raise staff awareness of the importance of security in their area and promote personal responsibility;
- inform staff of how, where and when the public may be admitted to the site and when they should be challenged.

10.53 Security proposals must be tailored to each site, considering its location, use, design and the perceived risk.

10.54 The types of security risk (assault, theft, vandalism, terrorism, trespass and arson) must be analysed, and appropriate measures identified and implemented.

10.55 Certain areas (for example vacant property, car parks and hospital/clinic drugs stores) will have specific security problems that should be highlighted when carrying out the overall security review.

10.56 The security of staff, patients and visitors can often be improved relatively cheaply by better lighting, changes to the landscaping, fitting of security cameras, staff identity badges and a general increase in awareness of security issues.

10.57 Methods of access, control and security patrols should be considered. In the long term, relocation of rights of way should be considered. See also paragraphs 10.35–10.38 on boundaries.

10.58 A checklist of vacant land and property issues (for example key holder, mothballing/maintaining services, perimeter security, building security etc) will help ensure that most problems are avoided. The case for demolition on grounds of savings on security, capital charges or rates should be assessed against other options including alternative use and planning.

10.59 Informal arrangements for the use of vacated land and property should be avoided. It is generally preferable to have land and property kept in use through formal arrangements (lease or licence), in part and/or temporarily, rather than left unused.

Prevention of trespass

10.60 Trespass and encroachment problems may be alleviated by a regular inspection of boundaries, gates and accurately signposted rights of way. Notices at boundary locations should inform that the site is private property and that "legal action will be taken against trespassers".

10.61 Regular checks of the site should be made to ensure that:

- no third party is encroaching, since this could provide access to squatters and over time give rise to squatters' rights (12 years' adverse possession can give a person possessory title to land);
- rights of way on foot or with vehicles are not being established. Check for garden gates being opened into boundary fences. The practice should either be stopped, or be permitted by way of a revocable licence.

10.62 Regular use of a particular thoroughfare or path can give rise to the acquisition of rights by the public at large. A notice should be erected and maintained stating "PRIVATE LAND – No right of way" in a position clearly visible to potential users. If problems persist, consider taking steps under Section 31 of the Highways Act 1980.

How to deal with illegal occupation

10.63 The following steps should be taken to deal with illegal occupation:

- ensure that all managers know to whom the presence of trespassers should be reported;
- in the case of squatters, the appropriate manager from the NHS organisation (responsible manager), with police support if possible, should visit the offenders and ask them to leave. It is not recommended that names of any occupiers are sought, as this makes the service of court proceedings more onerous;
- there are provisions in Section 61 of the Criminal Justice and Public Order Act 1994 which enable senior police officers to direct trespassers to leave premises in certain circumstances. The police should be involved as early as possible, although they often take the approach that trespassers should be removed by the landowner using his rights under the civil law;
- alert the local housing department and social services if action is likely to cause homelessness, and if children, disabled or elderly people are involved;
- make a written record of all conversations and consultations, types of vehicle and registration numbers (discreetly). This will serve as useful evidence should the trespassers leave following a court order for possession and then return soon afterwards.

10.64 If the illegal occupation persists, solicitors should be instructed to initiate possession proceedings. They will take the following actions:

- initially, a "bluff notice" may be served (if appropriate) giving trespassers 24 or 48 hours' notice to leave, failing which court proceedings will be instigated against them;
- issue proceedings in accordance with the current rules of the high court or county court;
- take a witness statement from the responsible manager stating the owner's interest in the land and property (details of title should be supplied to the solicitor), any relevant details concerning the offending parties, and confirm the fact that the land and/or property is occupied without consent;
- the statement should be signed by the responsible manager, having obtained all the necessary information on the matter. The statement should (if appropriate) also confirm that the names of the occupiers are not known;
- arrange for the proceedings to be served personally by a process server (a company that serves legal documents correctly) or in accordance with court rules;
- seek a date for hearing the matter in court which will be at least two clear days (or in the case of residential premises, five days) after service. Where service is not effected personally on the occupiers but is left in a prominent part of the site in accordance with court rules, service would not be deemed to be effected until the following day.

10.65 In the case of trespassers, the court has no discretion other than to order immediate possession, and such an order can be enforced by formal eviction by the sheriff or bailiff. However, the court must be satisfied that the proceedings have been properly served and the occupiers are in occupation without the licence or consent of the owner.

10.66 In exceptional circumstances, the housing department may re-house people, but they will only get involved when a court order for possession has been obtained. Sometimes they may only do so once a date for eviction has been given.

Squatters or travellers will often not seek re-housing.

10.67 Once possession has been obtained, the NHS organisation should take steps immediately to secure the site to prevent further incidents of unlawful occupation. This often requires the erection of fencing or other measures to prevent vehicles getting onto the site.

10.68 If squatters return following the execution of a court possession order, it may be possible to issue a warrant of restitution. Such a warrant instructs the bailiff to re-execute the court order to avoid the need to issue fresh possession proceedings. However, this procedure is not available in all cases, and legal advice should be sought in each individual case.

Health and safety requirements

10.69 NHS organisations should have a written health and safety policy and procedures document, which should be issued to all staff.

10.70 A health and safety consultant may be appointed to advise on statutory health and safety regulations relating to the use, occupation and management of land and property. This is not a substitute for properly trained and experienced in-house staff, but rather should add value to in-house expertise.

10.71 When NHS organisations contract with third parties they must pass on responsibility for health and safety regulations to the contractor. Records of tests must be maintained and monitored to ensure they are being completed.

10.72 The differing needs of staff, patients, visitors and contractors should be taken into account when considering fire safety, security, general safety and welfare, and dealing with the disposal of clinical and other hazardous waste. Access for all, but especially the disabled, must be addressed.

Insurance arrangements

10.73 The NHS Litigation Authority provides a number of risk pooling schemes for the NHS (for further details go to www.nhsla.com/Claims/Schemes/RPST). The property expenses scheme (PES) covers loss and damage in respect of property (buildings and contents).

10.74 NHS organisations do not need to purchase commercial insurance to cover their property portfolio, but rather should subscribe to the NHS scheme.

10.75 An exception applies to NHSFTs, who may subscribe to the scheme or purchase insurance commercially. See Health Service Circular 1998/174 'Insurance in the NHS' and Health Service Circular 1999/021 'Insurance in the NHS: Employer's/public liability and miscellaneous risk pooling' for further details.

10.76 The PES does not provide reimbursement for significant damage. Maximum limits apply depending on the NHS organisation's size and turnover.

10.77 For example, if a hospital were seriously damaged by fire and had to be demolished and rebuilt, the PES would not cover all of that cost. In this event the NHS organisation would need to discuss with its SHA and DH the best way to proceed in terms of strategic planning etc before any funding decisions could be made.

10.78 NHS organisations are required to make risk assessments in order to assess their contribution to the PES.

10.79 The purchase of commercial insurance may be justified in exceptional circumstances. For example:

- in the case of buildings insurance – where insurance is a condition of the lease and the landlord will not accept an indemnity. Insurance is usually taken out by the landlord, who then demands reimbursement of the premium or a proportion of it if the building is occupied by a number of tenants;
- where sites are shared with others and/or where the shared cost is small. Commercial insurance may be cheaper than each party insuring or self-insuring;
- in respect of lifts and boilers that involve periodic expert inspection designed to reduce the risk of loss or damage.

Sustainable development

10.80 Sustainability is taking a more significant role in the management of assets within the NHS. Legislation, regulations and guidance are now focused on sustainable development and the use of sustainable materials.

10.81 Better design and energy efficiency are being demanded, together with the provision of renewable energy sources such as microgeneration and biomass heating sources.

10.82 NHS organisations should ensure that they (and their partners, for example in LIFT and PFI schemes) are kept up to date on this important matter.

10.83 The following legislation should be taken into account:

- the Greenhouse Gas Emissions Trading Regulations 2005. Developments with thermal outputs over 20 megawatts have a legal requirement to apply for carbon allocations under the New Entrants Reserve;
- the Sustainable and Secure Buildings Act 2004 – buildings need to be greener and more energy-efficient;
- the Building Regulations 2000 Part L etc as amended by the Building and Approved Inspectors (Amendment) Regulations 2006 – a whole-building approach to energy/carbon efficiency. Planning approval for extensions/ refurbishments may require energy/carbon efficiency improvements to the whole building envelope;
- waste legislation. This covers space requirements for appropriate storage at ward or departmental level, central storage to meet the requirements of the Hazardous Waste Regulations 2005, Waste Electrical and Electronic Equipment Regulations 2006, Duty of Care, recovery/re-use/recycling;
- the Environmental Liability Directive 2002 – environmental liability included in contract conditions, polluter pays – identify who is the polluter, assess the risks;
- the Energy Performance of Buildings Directive 2002. Energy certification is to become a requirement when existing buildings are acquired or rented. NHS organisations should monitor when this Directive is to come into force in 2007.

10.84 Government policy drivers include:

- 'Building a Better Quality of Life – A Strategy for More Sustainable Construction'. This applies to refurbishments and extensions;
- 'Constructing the Best Government Client – Achieving sustainability in construction procurement'. This advocates use of Building Research Establishment Environmental Assessment Method (BREEAM)/NHS Environmental Assessment Tool (NEAT). For refurbishments and extensions in existing NHS property, a NEAT score of very good should be achieved (NEAT is under revision to become BREEAM for healthcare). BREEAM is also endorsed in 'Achieving Excellence Guide 11 – Sustainability'. For further details on BREEAM go to www.breeam.org;
- 'Procuring the Future. The Sustainable Procurement Task Force National Action Plan' (as explained in Circular 03/2006 (ODPM));
- 'Code for Sustainable Homes' (DCLG). The Government has indicated that all public-sector housing should be built to a minimum standard of Code Level 3 from 2008. DH actively encourages developments for the NHS to be specified to meet this requirement.

10.85 To meet mandatory ministerial energy targets, NHS organisations should achieve:

- 35–55 GJ/100 m^3 for refurbishments and extensions;
- 55–65 GJ/100 m^3 for existing operational estate.

10.86 DH guidance includes:

- Health Technical Memorandum 07-02 – 'Encode: Making energy work in healthcare', which provides advice on efficient energy/ carbon management of the operational estate;
- Good Corporate Citizenship model (DH/ Sustainable Development Commission);
- 'Our health, our care, our say: a new direction for community services' – links to the wider sustainability and communities agenda.

Easements

10.87 An easement is a legal term to describe a right that is enjoyed by a person (grantee) over someone else's land. An easement may be permanent or temporary. In the latter case, it may be for a fixed term or terminated on giving notice. This will be evidenced in the legal documentation.

10.88 An easement may be created where a utility company supplies services to NHS land and/ or property, or more generally to facilitate its operations. In such cases there will be a payment by the utility company to the NHS organisation, in respect of which valuation advice should be taken.

10.89 Prior to the privatisation of the utility companies, standard national agreements existed for electricity, gas and telecommunications easements. These no longer exist.

10.90 Utility companies have their own agreements to deal with easements, and a solicitor's advice should be taken on these agreements.

10.91 NHS organisations must identify all utility facilities on their site, note their exact location, and negotiate a new agreement if no legal documentation exists.

10.92 Major pipelines for gas, water and sewerage together with high-voltage electricity cables will cause land on either side to become sterile: the extent of the sterilization will depend on the size of the pipes and cables.

10.93 Points for NHS organisations to consider when negotiating easement agreements include:

- prior to negotiations, it is worth considering the development potential of the site. Pipes, sewers and cables (and any other utility facilities) on NHS land should be located, designed and installed so as not to restrict the current use of the site or any planned or potential development;
- obtain the right to require diversion of pipes, cables etc at no cost, that is, by use of "lift and shift provision";
- obtain confirmation of the grantee's responsibilities regarding maintenance, improvement and renewal of permitted pipes and cables (or other utility facilities);
- ensure the grantee pays the NHS organisation's reasonable advisers' fees;
- ensure indemnity from the utility companies against any claims arising;
- ensure that all draft documents are checked by solicitors before they are completed;
- ensure that the main terms of the agreement are included in the estate terrier and the completed documentation placed with the deeds of the property.

10.94 Where it is necessary for an NHS organisation to lay utility services over third-party land, negotiations should take place on the understanding that if agreement cannot be reached, the utility company may use its statutory requisitioning powers.

10.95 NHS organisations should take valuation and legal advice over the level of any compensation payments to be sought in these circumstances.

Compulsory purchase of NHS property by a local authority

10.96 NHS organisations may (like other landowners) be the subject of compulsory purchase order (CPO) powers exercised by a local authority.

10.97 If an NHS organisation becomes aware of the possibility of any part of its landholding being compulsorily purchased, or if a notice is received from the local authority in relation to a CPO, specialised legal and valuation advice should be obtained immediately.

10.98 Land held in the name of the Secretary of State for Health, either directly or on behalf of NHS organisations who cannot hold land in their own name, is Crown land, and as such cannot be compulsorily acquired. In these cases, the local authority should be informed accordingly.

10.99 NHS organisations may be able to obtain relief from compulsory purchase under Section 16 of the Acquisition of Lands Act 1981. If as a result of the CPO the NHS organisation would not be able to carry out its statutory function, the Secretary of State for Health's support should be obtained for the discontinuance of the CPO. Again, specialist advice must be obtained in respect of this matter.

10.100 NHS organisation should cooperate with the local authority promoting the CPO to achieve a negotiated settlement.

Town and village greens

10.101 The NHS estate includes many areas of open space, which may be freestanding or located within a hospital site. These open spaces may have belonged to the hospital estate for many years and may be integral to the site or surplus to requirements. Alternatively, they may have been acquired for the provision of a new facility that has not been built.

10.102 Such areas of land may be vulnerable to registration (by local people) as a town or village green. It is not necessary for land to have the appearance of an archetypal village green. An area of wasteland is just as vulnerable to a town or village green application.

10.103 If a town or village green application is successful, the land in question will become incapable of development, which will have consequences both for future healthcare service development and for disposals.

What can be registered as a town or village green?

10.104 Section 22 of the Commons Registration Act 1965 identifies the basis upon which a town or village green registration application may be made. It states that the land in question must be land upon which local inhabitants have indulged in lawful sports or pastimes "as of right" for at least 20 years prior to the date of the application.

10.105 Lawful sports or pastimes include dog walking, football, cricket, bird watching and playing with children. "As of right" means that the recreational facilities have been carried out without the permission of the landowner.

10.106 It is unclear, however, whether the recreational activities should have continued up to the date of the application or registration, and there has been a large amount of litigation relating to this issue.

10.107 The Commons Act 2006 will repeal the Commons Registration Act 1965, although the relevant provisions are not in force at the time of writing.

10.108 The Commons Act 2006 will clarify that an application may be made where a period of 20 years' use can be proved but where those activities have ceased prior to the application being made, provided the application is made within the time periods set out in the Act.

10.109 Legal advice should be sought on the status of the Commons Act 2006 if any town or village green registration issues arise in relation to NHS land.

Procedure to register a town or village green

10.110 An application to register a town or village green may be made by anyone who has an interest in the issue. The application should be made to the county council or unitary authority as appropriate, under the provisions of the relevant Act.

10.111 An applicant is expected to prove his/her case on the balance of probabilities.

10.112 If the county council/unitary authority accepts the application, it will register the land as a town or village green and must give notice of the fact to each person who objected to the application.

10.113 If the application is rejected, the county council/unitary authority must inform the applicant and each person who objected to the application of the reasons for the rejection. The applicant (or anyone else) may then make a fresh application.

10.114 If an NHS organisation becomes aware that a town or village green registration application is likely to be, or has been, made in respect of its land, it should seek legal advice.

Effect of registration

10.115 Registration as a town or village green provides customary recreational rights to the local inhabitants over the land.

10.116 Prospective new landowners should be aware of the established recreational function of the registered land. This will prevent future development on the land where this would be incompatible with its recreational use.

Practicable preventative steps

10.117 Precautions should be taken to prevent recreational use of the land without the NHS organisation's permission. The following measures may be appropriate.

Erection of notices

10.118 The public should be prevented from having recreational access to the NHS estate and (where applicable) should be made aware that they are only using the land with the permission of the owner.

10.119 Notices should be erected and maintained around the perimeter of the site, mainly at access points, and throughout the site.

10.120 Photographs of the erected notices, details of their location, dates of their instalment and records of any damage to the notices must be kept. Damaged or removed notices must also be photographed and replaced as soon as practicable.

10.121 The following are suggested examples of notices:

- "THIS IS PRIVATE LAND – Access to the hospital only for patients, staff and visitors";
- "This is private land and is for the use of staff, patients and those with the permission of the xxxx NHS Trust only";

- "The walking of dogs, playing games or other recreational activities are not allowed on this field".

10.122 It is advisable to close off vulnerable areas for a few days each year and erect a sign that indicates the area is closed to prevent the deemed dedication of the land as a town or village green. Records of such closures must be kept and preserved.

10.123 Legal advice should be sought on the individual circumstances of each site.

Maintenance of boundaries

10.124 The maintenance of boundaries is very important. See paragraphs 10.35–10.38 for further details.

Leasing or licensing land for public use

10.125 Where NHS organisations decide to allow public use of their land by way of a lease or licence, a copy of the relevant lease or licence and accompanying correspondence must be kept as evidence of the private nature of the land.

10.126 NHS organisations wanting to allow public use of their land should make it clear that the use is by permission only.

Implementation of a site security strategy

10.127 The existence and implementation of a site security strategy will deter unwanted access and use of the land. See paragraphs 10.52–10.62 for further details.

Town planning

10.128 NHS organisations should have procedures in place to monitor and influence (1) national and local planning policy and (2) significant planning applications.

10.129 See Chapter 2 for full details.

Management of tenancy and other agreements

10.130 Tenancy and other agreements should be properly managed (whether the NHS organisation is acting as landlord or tenant).

10.131 There are specific management issues in relation to the following:

- minor user rights;
- Section 256 Agreements (former Section 28A Agreements);
- donated assets;
- use of non-NHS premises for treatment of NHS patients.

10.132 These are discussed below. Other contractual obligations will arise from PFI and LIFT projects (see Part C for further details).

Minor user rights

10.133 The occupation of some premises still depends on user rights governed by Article 5 of the NHS (Transferred Local Authority Property) Order 1974 following the 1974 local government reorganisation when land and property used for healthcare was transferred to the NHS.

10.134 Disputes are now comparatively rare, but where they do arise it is often because the major occupier, that is, the local authority, wants the minor user, that is, an NHS organisation, to vacate: for example, where a local authority wishes to refurbish a multi-storey residential property and an NHS organisation is occupying a small part of the basement.

10.135 Where this happens it is almost always sensible to adopt a practical approach, as the minor user will probably have acquired statutory rights to occupy, and obtaining vacant possession through a legal process is likely to be time-consuming and costly.

10.136 The following points should be noted:

- rights are enjoyed on the basis of the parties sharing running costs and outstanding loan charges on a fair basis (floor area is the most usual);
- user rights were not intended to be of infinite duration, and if either party wishes to terminate the arrangement or convert it to a fixed-term lease or licence (where there is no exclusive occupation of space), it can negotiate appropriate terms. Disputes should be resolved locally;
- where the NHS organisation is the major occupier, it is advisable to document the arrangement in the form of a lease and set rent charges to cover the relevant capital charges;

- where a local authority wishes to dispose of its interest in land and property that is the subject of minor user rights in favour of an NHS organisation, it must negotiate appropriate arrangements (usually re-provision or financial compensation) before the NHS organisation is obliged to give up its user rights;
- user rights are only assignable to the statutory body created to fulfil the function and use of the property prior to 1974;
- where any dispute arises, it is generally accepted that user rights are now subject to landlord and tenant law.

Payments towards expenditure on community services (former Section 28A Agreements)

10.137 PCTs may make payments to certain non-NHS organisations under Section 256 of the National Health Service Act 2006 (previously Section 28A of the National Health Service Act 1977) to enable them to acquire privately-owned premises for certain purposes.

10.138 Where premises have been acquired using a Section 256 payment, a legal charge should be registered against the premises (assuming the organisation receiving the payment has the legal power to do so) to protect the PCT's money.

10.139 The charge should stipulate that if the acquired premises are disposed of or cease to be used for the specified purpose, an amount equal to the value of the premises attributable to the payment made under Section 256 should be paid to the PCT.

10.140 For example, if a payment of £400,000 was made for the purchase of NHS premises worth £600,000 (that is, two-thirds the value of the premises), and 15 years later the premises are worth £1,500,000 (as assessed by a suitably qualified valuer), the amount repayable will be two-thirds of £1,500,000, that is, £1,000,000.

10.141 In the past, health authorities made payments (under the 1977 Act) to housing associations to purchase, and in a number of cases refurbish, premises for housing persons with learning difficulties or other health-related needs. The housing associations then used a service provider, for example Mencap, to run the particular service.

10.142 The amounts of money to be returned varied from the original payment or original payment plus interest (at a specified rate) to the market value of the property when the specified use ceased.

10.143 These legal charges should have transferred to the appropriate NHS organisation when health authorities ceased to exist. Where this has not happened, legal advice should be taken.

10.144 Where the charge is registered in the name of the Secretary of State for Health and no audit trail is available to ascertain the health authority's successor, contact the DH's Estates and Facilities Division.

10.145 For existing agreements under Section 256, PCTs may be asked to agree to the transfer of the payment to another property where the property does not meet the current requirements of the client group. Legal advice is required in these cases.

10.146 PCTs should seek specialist advice when considering applications under Section 256.

10.147 PCTs should be clear on the purpose of these payments when briefing their legal advisers to document the correct legal charge. The brief should state (1) how any repayments are to be determined and whether the payment is to be transferable (that is, portable) and (2) whether any flexibility regarding subordination will be allowed, that is, allowing the organisation who received the payment to raise further monies based on the value of the property and diluting the PCT's powers of recovering their proportion of the value of the property.

Donated property and charity issues

10.148 Donated land or property is likely to have been given for a specific charitable purpose, as opposed to a donation or gift, which can be used for any purpose. Alternatively, land or premises may have been purchased with donated charitable money.

10.149 Where NHS organisations own such assets, the assets will be subject to trust and charity law and must be distinguished from other assets.

10.150 If the donated asset is land, the following points need to be taken into account:

- evidence of the purposes for which the land was given must be maintained, and any

restrictions imposed by the donor on its use or disposal must be observed;

- the Land Registry issues guidance on the registration of charitable land to ensure that suitable restrictions are noted on the Register;
- separate trustees of the land may be appointed under Schedule 4 paragraph 10 and Sections 213(1), 214(3), 217(1) and (3) and 218(4) of the National Health Service Act 2006 (previously Section 11 of the National Health Service and Community Care Act 1990). PCTs should refer to the 1999 Health Act;
- Section 36 of the Charities Act 1993 lays down the steps that need to be taken to dispose of such land. The consent of the charity commissioners is no longer required (except in the case of a sale to a person or company related, in terms of family or business, to the charity or its trustees), provided a report is obtained from a qualified surveyor and acted upon;
- if any change of use is required, advice must be sought and the consent of the charity commissioners will probably be needed;
- if such land (or part of it) is sold, the NHS organisation may not be able to deal with the proceeds freely, as they will be subject to the same restrictions as were originally imposed on the land or money used to buy it. For example, if land is donated on the basis that it is to be used for a specific community, the proceeds of sale will probably have to be applied in relation to the same community. Legal advice should always be sought on these types of issue;
- there is special treatment of such property for capital charging purposes.

10.151 There are no exempt charities in the NHS. Any fund has to be separately registered with the charity commissioners if it relates to the use or occupation of donated land. It will be subject to all accounting requirements and other provisions of the Charities Act 1993.

Use of non-NHS premises for NHS patients

10.152 Commissioners of NHS services are entering into a variety of new contractual arrangements for the delivery of healthcare from premises owned by independent providers of healthcare services.

10.153 Before entering into such contracts, appropriate due diligence should be carried out in relation to the premises from which the services are to be provided. This should relate to, for example, its condition, repair, health and safety and accessibility.

10.154 Appropriate provisions should be put into the contract regarding the maintenance of these premises, provision of a safe and secure environment for patients, compliance with all statutory duties and obligations, and emergency preparedness.

10.155 NHS organisations should have the ability to make random periodic checks to ensure that these provisions are being adhered to.

Joint schemes with local authorities

10.156 It is becoming increasingly common for PCTs and other NHS organisations to enter into joint arrangements with local authorities for the commissioning and provision of joint services. Partnership Agreements under Section 75 of the National Health Service Act 2006 (previously Section 31 of the Health Act 1999) are a good example. DH guidance on partnership agreements is available at www.dh.gov.uk.

10.157 Where existing premises are used, it would be normal for the partner who owns (or leases) the premises (“owning partner”) to grant a lease or licence to the other partner (“sharing partner”).

10.158 The decision to lease or licence will depend on whether the sharing partner is in “exclusive occupation” of a defined space, or whether the sharing partner has a number of seconded staff distributed amongst the owning partner’s staff.

10.159 In the former case a lease will probably be appropriate, whereas in the latter case a licence will probably suffice. Legal advice is always needed, however (because of the dangers of inadvertently granting security of tenure).

10.160 Additional considerations apply if the premises are leased by the owning partner (for example under a lease-plus agreement in an NHS LIFT scheme) because any such sharing arrangement will need to comply with the terms of the owning partner’s lease.

10.161 Where new premises are acquired, specific arrangements will need to be agreed between the partners, particularly if a Section 75 (previously

Section 31) partnership agreement (or other scheme) is terminated (joint ownership rarely happens due to the complexities in terminating such ownership).

10.162 A more common approach is the use of powers under Sections 265 and 76 of the National Health Service Act 2006 (previously Sections 28A and 28BB of the National Health Service Act 1977), which allow the transfer of capital monies between NHS organisations and local authorities. The grant agreements needed may include provisions for repayment if the relevant premises are sold or their use changes. DH issues guidance and Directions in relation to these grant-making powers.

Use of NHS land and property by local authorities

10.163 The Secretary of State has a duty under Section 80(6) of the National Health Service Act 2006 to make land and property available to local authorities, so far as is reasonable and practicable, to enable them to discharge their functions relating to social services, education and public health.

10.164 A formal lease, on terms recommended by a specialist valuer (possibly the VOA), is generally appropriate for the use of land and property under such circumstances.

10.165 Where local authority social workers are based on NHS premises to provide a service for NHS patients, it is desirable for the NHS organisation to bear all the accommodation costs. A licence would be appropriate assuming that there is no exclusive occuparion of space, otherwise a lease would be appropriate.

10.166 Where a special school needs to be constructed on a hospital site, land may be leased or sold to the local authority.

Management of the historic estate

10.167 The historic estate includes listed buildings, scheduled ancient monuments, registered parks and gardens, and buildings that contribute to the character and appearance of conservation areas.

10.168 Good management of the historic estate improves patient environments, increases disposal values and decreases repair costs.

10.169 Early contact with a local authority conservation officer will identify heritage issues and avoid potential conflicts between the NHS and local authorities.

Legislation and guidance relating to the historic estate

10.170 Current legislation is contained within the Planning (Listed Buildings and Conservation Areas) Act 1990.

10.171 PPG 15 provides guidance on the historic environment in relation to the planning system. PPG 16 provides guidance on archaeology in the planning system.

10.172 See 'Historic buildings and the health service' (DH Estates and Facilities Division) for guidance on historic estate matters.

The care and management of the historic estate

10.173 The management of historic buildings in government ownership is informed by 'The Protocol for the Care of the Government Historic Estate' (DCMS).

10.174 Copies of the protocol may be obtained from the Government Historic Estates Unit at English Heritage, 1 Waterhouse Square, 138–142 Holborn, London EC1 2ST (phone: 0207 973 3801). Alternatively, it can be viewed on the DCMS website, www.culture.gov.uk.

10.175 The Government Historic Estates Unit (GHEU) in English Heritage provides central advice on, and monitoring of, all conservation matters for the Government's estate. NHS organisations may refer to this Unit for general advice on their historic estate.

Repairs notices

10.176 Crown immunity no longer applies to planning and listed building controls. All property registered in the name of the Secretary of State for Health and the NHS is subject to the Planning (Listed Buildings and Conservation Areas) Act 1990.

10.177 If the LPA (in London, English Heritage) considers that a listed building is not being properly preserved, it may serve an urgent works notice or repairs notice on the owner. NHS organisations must respond promptly to legitimate concerns about the condition of buildings in their ownership.

The management of burial grounds and war memorials

Burial grounds

10.178 Special considerations apply to the management and development of consecrated land and burial grounds. Sections 238–239 of the Town and Country Planning Act 1990 apply. The LPA has full control over the alternative uses to which the land may be put.

10.179 Such sites need to be dealt with in a sensitive way to take account of local circumstances. Sites may, for example, be fenced off to create "gardens of rest", especially when there are known relatives of the deceased who might visit the grave from time to time.

10.180 See paragraphs 7.205–7.210 for guidance on the disposal of burial grounds.

War memorials

10.181 War memorials feature within the estates of many NHS organisations, and range from plaques to small buildings. Many are publicly recognised and in a good state of repair, but some have been neglected or are within sites earmarked for disposal. It is important to recognise the need for sensitivity when war memorials feature on NHS land. See paragraphs 7.205–7.210 for guidance on relocation and disposal of war memorials.

10.182 The Home Office published a code of practice for custodians of war memorials in December 2002, which should be followed by all NHS organisations. Throughout this document, "War Memorials Trust" should replace "Friends of War Memorials", and "UK National Inventory of War Memorials" should replace "National Inventory of War Memorials".

10.183 Under this code of practice, any physical object erected or installed to commemorate those killed as a result of conflict or military service should be regarded as a war memorial. Memorials to civilian casualties should be included. Most, but not all, memorials relate to the First and Second World Wars.

10.184 The Department for Constitutional Affairs is now responsible for this code. NHS organisations should contact this department for details on any revisions.

10.185 NHS organisations should undertake a survey of the location, description and condition of memorials within their estate. Records should be regularly reviewed and updated. Interested local or national voluntary groups may be willing to assist in this matter. Contact the War Memorials Trusts for details.

10.186 Statutory protection is given to memorials that are, or form part of, a listed building, scheduled ancient monument or conservation area. Advice should be sought from the relevant LPA as to whether a memorial is protected, and whether proposed works to, or removal of, such a memorial require consent under the Planning (Listed Buildings and Conservation Areas) Act 1990 or Ancient Monuments and Archaeological Areas Act 1979.

10.187 Memorials in Church of England churches or churchyards owned by the NHS may come under the faculty jurisdiction of the church authority rather than the LPA. This depends on which jurisdiction the NHS has adopted.

10.188 Although responsibility for maintaining, preserving and restoring war memorials falls on whichever individual or organisation originally established the memorial, NHS organisations are recommended to meet the maintenance or restoration costs themselves. In most cases, these are modest.

10.189 In certain cases, grants may be available to assist with these costs, and advice regarding the availability of grants should be sought from the War Memorials Trust or, also, the local authority.

10.190 Under the Local Authorities (War Memorials) Act 1923, local authorities have the power, though not a duty, to maintain, repair and protect war memorials.

10.191 English Heritage, in partnership with the Wolfson Foundation, offers grants for the repair and conservation of free-standing war memorials. The scheme is administered by the War Memorials Trust, which operates its own small grant scheme.

10.192 Funding is also available from DCMS (until 2008) for VAT incurred on the construction, renovation and maintenance of eligible memorials. For details, go to www.memorialgrant.org.uk/index.htm.

10.193 NHS organisations should not attempt to repair or restore damaged memorials without the assistance of appropriate conservators or other

suitably qualified persons (contacts provided by the War Memorials Trust). Cleaning memorials should be avoided unless professional advice has been obtained.

10.194 Contact details:

War Memorials Trusts, 4 Lower Belgrave Street, London SW1W 0LA
Phone: 0207 259 0403
Email: info@warmemorials.org
Web: www.warmemorials.org

UK National Inventory of War Memorials, Imperial War Museum, Lambeth Road, London SE1 6HZ
Phone: 0207 207 9863/9851
Email: memorials@iwm.org.uk
Web: www.ukniwm.org.uk

Appendix 1 – References

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