Equity and excellence: liberating the NHS
Future ownership & management of PCT-owned estate
By aspirant Community Foundation Trusts (CFTs)

Frequently Asked Questions (FAQ Sheet) – Gateway reference 1599

The nature of the PCT-owned estate is diverse, including for example; freeholds, leaseholds and licences. The extent of the legal interest, which can be offered, will therefore vary and be subject to local discussions between aspirant Community Foundation Trusts (CFTs) and their PCT on a case-by-case basis. Any proposals will be subject to SHA consideration and approval process. It should be noted that NHS LIFT and PFI interests are excluded for the time being from this process. For further assistance on NHS LIFT and PFI please contact/Email ***John Mann john.mann@dh.gsi.gov.uk 0113 2545358***

This paper provides answers to frequently asked questions (FAQs) which are intended to provide helpful prompts on issues related to transfer of PCT-owned estate to CFTs. However, it should be noted that transfers will be subject to the usual transfer and accounting requirements for NHS Bodies. Any queries from PCTs and aspirant CFTs should in the first instance be addressed to their SHA for local resolution. Issues not resolved locally should be addressed to ***Pam Chapman pamela.chapman@dh.gsi.gov.uk 0113 2545581***

Frequently asked questions

Q1. What is the timetable for transfer of property?

The 'first wave' of aspirant CFTs was established as NHS Trusts last year - one in April and the remaining seven in November 2010. Six aspirant CFTs of the 'second wave' are working towards NHS Trust establishment on 1 April and two more second wave aspirant CFTs are working for establishment in June or July.

Transfer orders do not need to be made simultaneously with Establishment Orders. However, the properties to be transferred must be identified no later than the end of this financial year and completed by September 2011.

TCS policy doesn't require estate to be transferred in entirety, and PCTs and aspirant CFTs can still agree new leases (though they might need to be subject to approval given they grant a 'proper' legal interest in the estate), licences or Memoranda of Occupation in order to provide continuity of service provision.

Q2. Why are aspirant CFTs being given special treatment?

There is no special treatment. Collective CFTs estate requirements represent a small proportion of the PCT-owned community estate. Transfers are being arranged in support of the TCS Programme and continuity of access by patients to community services.

Consideration is being given to the treatment of the greater proportion of the PCT-owned estate and a decision should be announced shortly.

Q3. Who referees if more than one provider is occupying the same building and wants the asset?

TCS policy is that the critical clinical infrastructure required to support services being transferred under TCS to aspirant CFTs is made available to them. Assets are not at this stage being made available to other Providers.

Therefore the PCT should agree with the aspirant CFT which assets (and associated liabilities and obligations including employment contracts, equipment and IT) are for transfer. Accommodation classified as being in the clinical services category, but shared by a number of users, should be transferred to the major occupier. Where this is not clear, the SHA, as part of its approval role, may adjudge the most appropriate solution for a multi-occupancy site on a case-by-case basis. In each case, the occupation of other users should also be properly documented.

Q4. Will there be any conditions placed on the transfer of assets to aspirant CFTs?

Two restrictions will apply in the transfers to CFT, and these will be incorporated in the transfer documentation.

Firstly, where a CFT fails to retain a service contract or the CFT itself ceases to exist, the asset(s) from which those services are provided will be transferred to the Secretary of State or a body nominated by him.

If it is agree that there will be a transfer to another NHS organisation, it is envisaged that the transfer value would be net book value.

Much will depend on the circumstances of each case on what would constitute an asset – it may be part of the whole building or part of a CFT portfolio. Each case must be determined individually.

In the event that the SofS agrees that the estate may remain with the CFT and it is sold for non-NHS purposes, then the disposal should be at market price. A further 50% of any gain over the highest of either, the original transfer value on acquisition or net book value at the time of sale, will be payable to the Secretary of State.

Q5. What if a CFT loses the contract to provide community services?

Responsibility for service provision, estate and associated liabilities and obligations including employment contracts/TUPE should be made in accordance with legal requirements. The mechanisms for transferring assets are explained in Q4.

Q6. Who forces aspirant CFTs to acquire the whole property rather than 'cherry pick' parts of a site? How far will it be mandatory for aspirant CFTs to take all of the estate from which they provide services or will there be scope for an element of choice? Will this include leasehold properties where the lease sits currently with the PCT and could be novated to the new organisation?

TCS policy excludes ‘cherry picking’.

Where aspirant CFTs wish to acquire PCTs' freehold/leasehold property interests, approval will only be granted where they are taking all of the property interests associated with the services transferring to them, regardless of the property’s age and condition. This will include any liabilities and obligations related to such property interests.

All transfers of legal interests agreed by the PCT will be subject to approval by the Strategic Health Authorities. This is an extension of the Assurance and Approvals process for PCT community services.

Q7. What if aspirant CFTs do not wish to take on any assets and their associated liabilities?

Where a CFT requests that estate is transferred to them they must take the whole, not part, of the estate currently used for the provision of those services which they will be delivering. However, where the receiving aspirant CTF has no use for parts of the operational estate, administration or support buildings and they can be relatively easily separated and disposed of they may, at the discretion of the PCT, be excluded.

Q8. What if an aspirant CFT only partially occupies some premises?

The nature of the occupancy arrangement and agreement will be made on a case-by-case basis. In the interests of good estate management it may be sensible for the CFT to take the whole unless it is possible to split it. If there are other NHS users occupying the premises, then their rights should be properly documented – see question 7.

For freehold property, the principle interest in the premises would pass to aspirant CFTS to which landlord responsibilities, relating to minor occupiers, would also pass.

For leasehold property, where the PCT currently holds a head lease and sub-lets to the occupiers, that principal head lease arrangement would pass to the aspirant CFT. If the other occupiers hold their own head lease, those arrangements would continue.

NB Where the PCT guarantees the rental paid by GPs this obligation will not transfer to the CFT but will transfer to the NHS Commissioning Board in due course.

Q9. Can I transfer assets to an organisation other than a CFT?

No. Guidance relating to the transfer of parts of the PCT estate not taken by aspirant CFTs will be issued separately.

Q10. Why have aspirant CFTs been given such a tight deadline?

Providing certainty around the treatment of assets including estates and the staff associated with, it is vitally important for CFTs and related PCTs. The deadline of September 2011 has been set to reflect the deadlines for the establishment of the remaining second wave CFTs and the subsequent resolution of the asset transfer issues.

Q11. What if aspirant CFTs cannot identify their desired estate by the given deadline?

This outcome is not anticipated. Should an aspirant CFT request further time, this will be considered by the PCT and SHA. However, it is extremely important that the list of required estate is correct as there will be no opportunity to revisit it once submitted.

Q12. Will it be possible for another organisation to make a counter offer to the DH, or are the CFTs being given "first refusal"? If aspirant CFTs choose not to will other organisations or the independent sector be able to buy the estate? Will social enterprises be allowed to do the same?

TCS policy is that the critical clinical infrastructure required to support community services being transferred under TCS to aspirant CFTs is made available to them. PCTs are expected to retain ownership of any estate which is not being transferred to aspirant CFTs.

Q13. Why are LIFT and PFI being treated separately?

Due to the Public-Private Partnership nature of LIFT and PFI and the complex legal and financial frameworks under which LIFT and PFI premises have been procured, we are looking at these in more detail.

Q14. What will happen to PCT estate that is not taken by CFTs?

Assets are not at this stage being made available to other potential providers. Consideration is being given as to what arrangements should be in place for the future ownership and management of the remainder of the PCT-owned estate.

Q15. You state that any transaction will be subject to SHA approval. By what criteria will SHA assess the proposed transfers?

All transfers of legal interests agreed by the PCT will be subject to approval by the Strategic Health Authorities. This is an extension of the Assurance and Approvals process for PCT community services.

Q16. Will these transactions benefit or prejudice aspirant CFTs in their bid for FT authorisation?

Monitor will decide on whether to authorise an aspirant CFT using their standard criteria.

Q17. I thought CFTs were supposed to be 'asset light'?

Original policy was that CFTs were supposed to be Asset Light and to an extent they will be in that they will not be able to accumulate beyond what is required for them to provide the services for which they have been commissioned. In addition, in the light of the intention in Equity and Excellence – and subject to Parliamentary approval of the current Health and Social Care Bill - to abolish PCTs, there is an overriding need to provide certainty for PCT estate, associated services and staff associated with its provision. It has therefore been agreed to offer CFTs the assets involved in providing their services whilst maintaining commissioning leverage and SofS ownership interest through the overage clauses.

Q18. What about transfer of property to non-aspirant CFT providers of community services.

Property transfers to aspirant CFTs will proceed to support introduction of the TCS CFT Programme. Consideration is currently being given to the potential solutions for the estate, where services are being provided by other providers.

Q19. Can DH provide legal advice on property, employment/TUPE etc. obligations & liabilities?

PCTs will need to obtain their own legal advice on property and other matters (eg TUPE) the costs of which will be met locally. Peculiarities of local circumstances mean that central advice would not necessarily be appropriate.

Q20. At what value will assets transfer to aspirant CFTs?

All acquisitions of freehold interests or capitalised leasehold interests should be made at net book value and will be financed by Public Dividend Capital (circular flow).

Q21. You have said that you are no longer going to provide public dividend capital to Foundation Trusts – why have you used PDC in this case.

It is true that we will no longer be providing PDC to foundation trusts in the future and we are removing the powers to do this in the Bill. However, the transfer of services and assets out of PCTs is an exceptional and one-off structural change to the NHS as part of a wider reform programme. In these circumstances it is appropriate to use public dividend capital as structural form of financing.

Q22. Will CFTs need to pay an annual charge to the Government at the standard Public Dividend Capital rate of interest?

Yes, all NHS trusts and Foundation trusts pay a return on the net value of their assets - these assets will be no different. The current charge is 3.5%.

Q23. Will it be possible for the CFT to effectively purchase the asset over a number of years through its payment of the PDC charge (ie like paying a mortgage)?

CFTs will gain full title to the assets on completion of the transfer from the PCT (subject to the restrictions outlined in the answer to Q4.

Q24. Is it the case that transfers will not involve cash but instead the estates will appear as public dividend capital on the CFT's balance sheet? (ie the CFT will not need to "buy" the assets but it will be clear the asset has been funded with PDC rather than with the CFT's own surpluses?)

The transaction is a sale and purchase and will involve cash. The Department will issue funding in the form of public dividend capital to CFTs and they will use this financing to purchase the assets from the PCTs. The PDC will sit on the CFT balance sheet and is owed back to Government.

Q25. How will existing recurrent funding for the upkeep of transferred assets be made available to CFTs?

As for any service delivered in the NHS, the price paid for the services being delivered from the transferred assets should include an element for the upkeep of the assets

Q26. How will CFTs access additional capital?

CFTs will access capital in the same way as any other Foundation Trust or NHS trust. The primary route for accessing capital requirements that exceed their own internally generated funds will be through loans. In addition, PFI, or other arrangements whereby the private sector supplies funding direct to FTs or their schemes, will continue to be an option for investments in Foundation Trusts.