Department of Health

PCT Estate Guidance – FAQs

General

Q1. The document focuses on community services premises. For the avoidance of doubt, does it also encompass PCT run mental health and learning disability services and associated premises?

Yes, the guidance is intended to encompass mental health and disability services and associated premises.

Q2. What about a property that is wholly or majority occupied by a Social Enterprise?

This guidance relates only to proposed transfers to NHS Trusts, a-CFTs and FTs. Any estate not transferring to these bodies should be retained by the PCT for the time being. All third party occupations should be documented as appropriate as detailed in Estatecode Chapter 9.

Q3. If the current service provider acquires the asset, won't alternative service providers be at a disadvantage?

The guidance makes provisions for the Secretary of State to re-acquire assets where the current service provider fails to retain the contract and make them available to alternative providers (sections 2.7 and 2.20).

Q4. How should equipment included in PCT asset registers at transferring premises be dealt with? Presumably plant, machinery and fixed equipment will be regarded as an integral element of a building and the book value of all related assets will determine the overall transfer price. Please confirm. How should PCTs expect to deal with:

- **IT assets and infrastructure and moveable equipment at the same premises that has a balance sheet value; or**
- **equipment not associated with any particular premises (eg vehicles)?**

This will be set out in detail in the guidance relating to accounting treatment. PCTs and Trusts will need to agree what assets/equipment should transfer with the estate.

Property Transfers

Q5. The guidance applies to "service critical clinical infrastructure…..integral to the provision of community services". Does

this mean that Acute Providers can request the transfer of PCT community hospitals where space has been made available to them to deliver maternity services, diagnostics and other out-patient services?

Where acute providers are delivering community services and the provisions of the guidance apply, they should be given the opportunity to acquire the assets.

Q6. Only "service critical clinical infrastructure" can transfer. Appendix B specifies administrative buildings cannot transfer. Therefore, it can be argued that administrative buildings should not be transferred, even if they are wholly occupied by community staff.

Individual sites will have to be considered locally on a case-by-case basis, but as a general principle it is anticipated that areas which fall within the definition of 'service critical clinical infrastructure' will be those spaces which are used mainly for patient consultation, diagnosis and treatment. Inevitably, this will also include any embedded space that is used for associated administrative and support purposes. The aim is to produce a coherent estates portfolio, in each case.

Any proposed derogations from the principles in the guidance will need to be identified in the approvals template.

Q7. If premises held on 'other informal arrangements' is 'service critical clinical infrastructure' and is more than 50% occupied by the provider, should the portfolio of property that the transfer order relates to be extended to transfer such right title and interest as the PCT has in those premises? (Sections 2.2/2.3)

Yes, where possible.

Q8. If, as a PCT, we identify nine properties that meet the criteria for transfer to an FT, but the FT determine that they only wish to take on six of these properties and not the remaining three (although they will be continuing to provide services from them), is the entire transfer disallowed? Will the PCT retain ownership of all nine properties; is partial transfer allowed as the FT prefers, or is the FT required to take on all properties? (Section 2.3)

The guidance excludes 'cherry picking'. Trusts are not expected to be selective, unless otherwise agreed, in line with the provisions in section 2.3.

Q9. What should be regarded as 'occupation of a property on a temporary basis or for a short period only' given that the underlying community services agreements with prospective property recipients are themselves relatively short term? (Sections 2.4/2.16)

The way to look at this is from the temporary nature of the estate arrangements or unusually short service contracts. If the service contract is a standard length then the general arrangements for transfer should be applied.

The reference to a 'short term occupation' relates to an arrangement where the accommodation being used will only be used for part of that term. In other words, where it is known that the accommodation solution is only temporary, e.g. it may be unfit for purpose and due for replacement within the contract period. Under these circumstances the property should not be transferred.

Where service contracts are already part way through it would be reasonable for transfers to be made on the basis of the balance of the service contract, even though the tenure would now be less than standard length. The buy back is there to pick up a situation where the service contract is lost once the initial contract comes to an end.

Q10. How will investment in transferred property be encouraged, if the Secretary of State’s ‘option to acquire’ or overage provisions do not recognise any investment made?

Providers should be incentivised to ensure that the estate from which services are delivered is appropriate through various means, such as patient choice and competition for future contracts.

Further detail will be provided along with the guidance on accounting treatment of transactions.

Q11. How are dilapidations to be treated on buy back? What is the accounting treatment if the property has to revert on loss of contract?

Further guidance will be issued in relation to the accounting treatment and the mechanics for the buyback provisions in due course.

Q12. Within what time-frame will SoS be required to make a decision to re-acquire or not? (Section 2.8)

This will be the subject of separate guidance, at a later date.

Q13. What process is envisaged for securing the appropriate Land Registry entry and verifying that it has been properly recorded?

The transfer order will oblige a transferee to register a restriction on the title to the property in favour of the Secretary of State and provide evidence of compliance with this obligation to us. **(Section 2.14)**

Q14. Will Transfer Orders to Trusts be by Statutory Instrument?

In the case of property transferring from an existing PCT to an existing NHS trust (or newly established a-CFT), the relevant power to transfer such property by order is in paragraph 9 of Schedule 4 to the NHS Act 2006. Such

orders are not Statutory Instruments, and so will be made by means of being signed by a member of the Senior Civil Service within the Department of Health.

Q15. Who will meet the legal and other costs of transfers?

The properties will be transferred using Transfer Orders. Transfers to FTs using a Transfer Scheme will be possible, once the Health and Social Care Bill is enacted. The Department will issue a standard form Transfer Order as soon as possible, but each party will be expected to meet their own costs.

Q16. Despite the intention of DH to produce a standard form Transfer Order there is going to be a lot of work for lawyers, and the NHS needs to ensure that the legal costs are reasonable and that there is consistency. Would it be sensible for the SHAs and their constituent PCT clusters to agree to use the same law firm to give consistency of approach and economies of scale? The problem here though is that in the short timescale there would not be time to tender the work, so it would probably default to firms habitually used for land transactions. Are we at risk of challenge? (Section 2.24)

With regard to the Transfer Order, the Department will issue a standard form as soon as possible. Transfers to FTs using a Transfer Scheme will be possible, once the Health and Social Care Bill is enacted. Given the length of time allowed for the approval timetable, there should be time to tender for legal firms if required. We would encourage collaborative working where this will produce efficiencies.

Q17. Although this may become clearer when guidance around accounting treatment is issued, it is almost certain that a change in the basis of ownership, occupation and servicing of some premises will require renegotiation of elements of the financial arrangements put in place under CSCs and associated BTAs. Do you expect these variations to have been fully scoped and agreed before the related transfer order is actioned by the Secretary of State?

Variations will need to be fully scoped and agreed. Changes resulting from any asset transfers will need to be in place at the point of transfer to ensure that all transactions are appropriately recognised and documented.

Q18. The major occupier may have, e.g. 48% use and all other users may have no more than e.g. 10% use each. Is there any flexibility over the 50% ruling on major occupier so that a major occupier is defined as one who occupies the greatest majority of the space in an asset, which may not be 50% or more?

As stated in the guidance, individual cases will need to be considered on a pragmatic basis. Where there is derogation from the principles outlined, this must be identified in the approvals template and an accompanying rationale should be provided.

Q19. Please define "lettable floor area". How does this reconcile to either Net Internal or Gross Internal Area?

The lettable floor area equates to the Net Internal Area.

Q20. Can you provide any guidance on how vacant space should be accounted for in any transfer arrangements? Where should the landlord risk sit?

If the property transfers to the Trust, landlord responsibility transfers with it.

Q21. How are 'primary care users' defined?

Typically, this will include GPs, dentists, pharmacists and opthalmists. NB: this is not just organisations that are PCT reimbursed, but refers to all primary care contractors. **(Section 2.27)**

Q22. SHAs are intending to obtain statements from PCTs that appropriate legal advice has been obtained. Trusts will need to have undertaken an appropriate level of due diligence. If SHAs obtain this level of assurance will this be sufficient to meet the DH criteria regarding properly documented legal arrangements?

Proper legal arrangements does not refer to legal advice, but refers to the need to ensure that the occupations of minority occupiers etc. are properly documented (section 2.27).

Q23. Documenting historic occupation is likely to take a very long time; agreeing shared cost split less so. Can transfers not take place subject to whatever rights other occupiers have and leave the acquirer to formalise – either an occupier has rights or it doesn't and a change of landlord should not improve or prejudice that position as a matter of law? (Section 2.27)

It is preferable that present occupations are documented prior to transfer, to remove any possibility of dispute later.

Q24. Will DH be issuing model documents for the memoranda of occupation, leases and licenses?

It is not planned to introduce model documents.

Q25. Guidance on the treatment of associated FM contracts with assets would be useful. It is likely to be almost impossible to assign an FM agreement as it relates to properties carved out from what was formerly a coherent and larger whole. Clearly there needs to be a strategy for existing arrangements to be run off/ varied/ terminated, but transferring/novating part of a contract will be impossible unless the contract so provides. A possible work-around might be for the PCT or

transferee, following transfer, to provide FM services to the other at pass through cost pending an orderly realignment via expiry, termination or variation of the FM contract. (Section 2.31)

In general, contracts should be assigned/novated alongside the asset. However, the guidance envisages a situation where the FM contracts are divisible. Where this is not the case local solutions may have to be identified. The work-around you suggest is the sort of solution we would expect to see developed locally if a simple transfer/novation isn't possible. However, any solutions developed should not tie the hands of the PCT successor bodies.

Q26. Guidance on dilapidations and liabilities would be helpful. What if the receiving organisation requires backlog maintenance funding - in these circumstances what is the level of mutuality in agreeing the transfer?

PCTs will be expected to maintain buildings up and until the transfer. They will not be expected to make a grant for backlog maintenance.

Approvals Process

Q27. We assume that the no cherry pick rule applies to a provider across all of its community service commissioning PCTs so it cannot take all relevant (more attractive), say, freehold estate from one PCT without also taking all 50%+ occupied (less attractive) leasehold estate from the other PCT(s)? (Section 4.1)

Yes. The objective is to create balanced portfolios, rather than leaving behind a portfolio of the less attractive estate.

Q28. This approvals process is essentially PCT-led. Should the approvals template confirm on its face that the relevant provider Board has agreed in principle to take the relevant property?

The process is PCT led, but the transfers are on the basis that the transfer is requested by the Trust.

Q29. The guidance is not specific about the need for Clinical Commissioning Group approval to inform the PCT approval decisions. This SHA takes the view that the PCT Cluster Boards will need to approve these transactions, and their decision will need to be properly informed by the views of the CCGs (or emergent CCGs). It would be helpful if you could clarify the extent to which our submissions to DH for approval will need to provide evidence of CCG agreement / approval.

PCT Cluster Boards will need to approve these transactions, and their decision will need to be properly informed by the views of the Pathfinder CCGs, or local GPs via the usual stakeholder networks in the areas of the country where no Pathfinders have been set up yet.

DH will assume that the PCT/PCT Cluster has consulted either Pathfinders or the local GP stakeholder network and gained their agreement, and that any objections will be highlighted to the relevant SHA and resolved during the approvals process.

Q30. How does current DH guidance – Delegated Limits for Capital Investment December 2010 – apply to the approvals process?

The relevant SHA will be required to approve all proposed transfers and SHAs will in turn have to submit the provisional lists to DH for final approval. This applies regardless of the delegated limits that apply to the transfer of these assets. The guidance does not envisage the need for business cases - how each SHA manages the approval mechanisms set out in section 4 is a matter for each SHA to decide.

Q31. Clarification on whether there is a prescriptive approach to 'SHA approval' would be helpful or whether this can be in line with SHA's internal Corporate Governance requirements.

The SHA approvals are expected to be in line with SHA's appropriate internal Corporate Governance requirements

Q32. The timetable does not allow sufficient time for appropriate Board approvals for the transfer of assets; what governance arrangements are anticipated for these transfers?

The timetable refers to provisional agreements and does not anticipate a full due diligence process at this stage - how each SHA manages the approval mechanisms set out in section 4 is a matter for each SHA to decide.

Q33. What is the planned transfer date?

A specific date for legal transfer is not being set at this stage. There is a need for flexibility and local requirements may vary.

Remaining Estate

Q34. The guidance does not differentiate the treatment of development sites from redundant property, is there a subtlety regarding the categorisation of sites for which there are agreed development plans?

Development sites and redundant sites both fall into Appendix B and should be retained by the PCT for the time being.

Q35. The definition of the '3 year asset life' could be used to ensure that no assets transfer as service contracts are for no more than 3 years. Does this only apply where there is a disposal plan for the building within three years and that there is evidence that alternative arrangements are being actively pursued? (Appendix B)

The intention behind this clause is that an asset should not be transferred to a Trust if it is likely to be included in a plan for disposal on the open market in the next three years.

Q36. Can assets procured via LIFT but outside of LIFT areas eg. Local Educational Partnership, where there is no SPA/SPB, be transferred to FTs?

All assets procured via LIFT should be retained by PCTs for the time being