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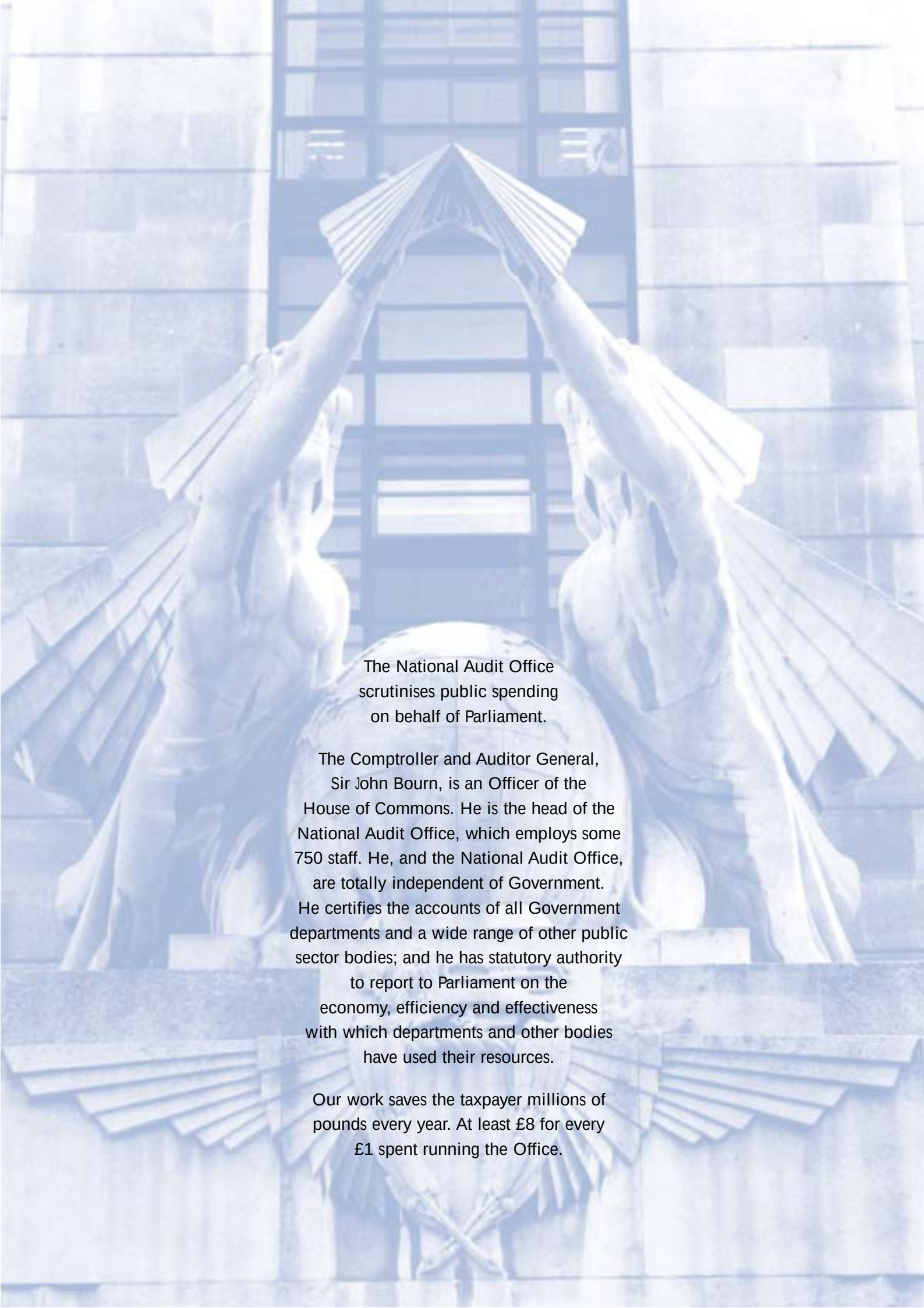
The Management of Surplus Property by Trusts in the NHS in England

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL
HC 687 Session 2001-2002: 21 March 2002



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John Bourn
Comptroller and Auditor General

National Audit Office
6 March 2002

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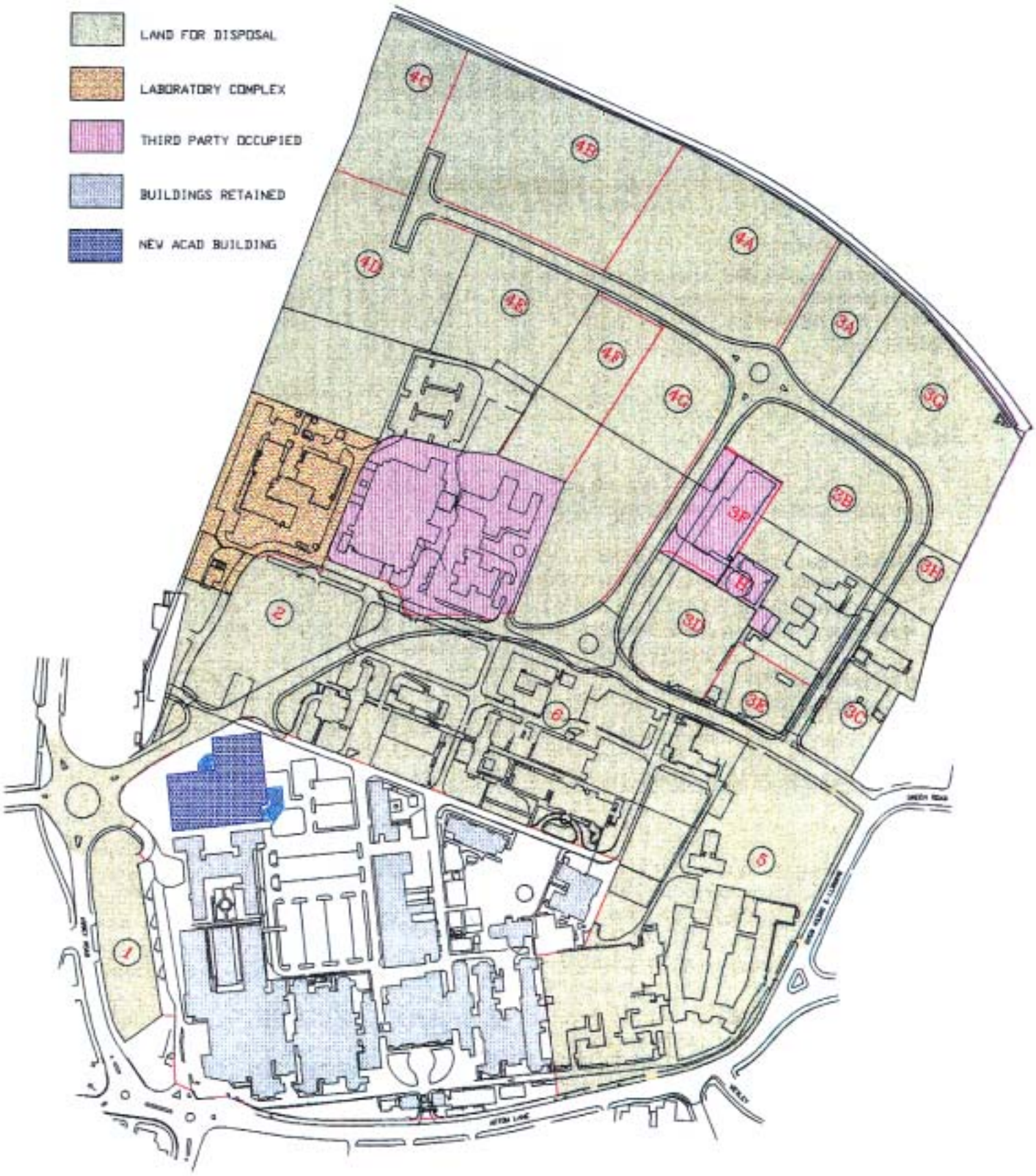


CENTRAL MIDDLESEX HOSPITAL - NHS TRUST *OPTION 7*

executive summary & recommendations

1 In April 2000, NHS trusts[1] owned some 95 per cent by value of all land and property (8,750 hectares by area) in the NHS in England. At that date, the total NHS estate was valued at some £23 billion (existing use basis[2]). It has an estimated replacement value of £76 billion. Turnover in property assets is substantial. We found that NHS trusts obtained at least £380 million from the sale of surplus property in the three years 1997-98 to 1999-2000 and planned to sell surplus property worth over £700 million (at existing use value) from 2000-2001 to 2002-03. The Auditor General for Wales has looked at NHS Estate management and at NHS property disposals in Wales[3].

2 Taking account of best professional practice, we examined:

- how well the strategic environment in which Trusts operate promotes the effective identification and disposal of surplus property (Part 2 of the report);
- how far value is achieved in actual sales (Part 3).

3 NHS trusts were established from 1991 and onwards. As this happened, only property thought to be required for their long term operational use was transferred to them. Remaining properties were retained by the Secretary of State in the so-called *retained estate*. Most of these properties have since been sold by NHS Estates, an executive agency of the Department of Health, which provides the policy lead on all aspects of estate management in the NHS. Targets for disposing of the *retained estate* have been consistently exceeded by NHS Estates.

1 The term "NHS trusts" refers in this report to acute, community / mental health and ambulance trusts in existence at March 2000. We use the term "Trusts" to cover these NHS trusts, Primary Care Trusts (which began to be created in April 2000) and Care Trusts (which will begin to be established from 2002-03).

2 NHS properties are not valued at open market value until declared "non-operational".

3 Managing the Estate of the National Health Service in Wales (November 2001). The results of a follow-on examination on the modernisation and renewal of the estate and the identification and disposal of surplus property in Wales will also be published in due course.

4 Most of the properties that would have remained in the *retained estate* after 2001-2002 are now subject to a sale through a Public Private Partnership initiative, expected to be operative in 2002-03, with a property portfolio worth up to some £400 million. Our work focused on the identification and disposal of surplus property owned by NHS trusts. We also directly tapped into experience and expertise built up by NHS Estates in selling the *retained estate* by including five large and complex sales by NHS Estates in a series of case studies in this examination.

5 Trusts frequently need to obtain planning consent for change of designated use to enhance prospective proceeds from disposals. This puts a premium on maintaining good liaison and contact with local planning authorities. We also looked at the interface between Trusts and English Heritage on the sale of historic and listed properties.

6 Our examination took place against a background of considerable change in the management of the estates function in the NHS and in the organisation of the NHS generally. In May 2000 the Public Services Productivity Panel and Department of Health published *Sold on Health*, a major review of the management of the NHS estate. This reinforced the lead policy, strategic and advisory role of NHS Estates, signalling a new, more corporate national framework for the estate in England. NHS Estates will in future assess the performance of Trusts against corporate objectives more closely than previously and promote more corporate outcomes.

7 We found much good practice:

On strategic issues

- revised guidance on developing an estate strategy provides a generally good guide to rationalising NHS estate (paragraphs 2.2-2.4);
- a majority of NHS trusts reviewed their estate and reported the outcome to their boards sufficiently frequently to meet the requirements of a recently introduced Controls Assurance Programme Standard on buildings, land, plant and non-medical equipment (paragraph 2.14); and
- there was evidence, including examples in our case studies, that some NHS trusts and local planning authorities had worked well together to improve joint working and liaison on planning issues, in ways which are more widely applicable (paragraphs 2.30-2.32 and Figure 12);

On obtaining best value from sales

- evidence suggests that NHS trusts and their agents strove to maximise competition in accordance with NHS Estates' *Estatecode* guidance, achieving prices in most sales which comfortably exceeded valuations (paragraphs 3.2-3.8);
- our case studies pointed to some good practice, applied in the disposal of higher value and more complex property (paragraphs 3.16-3.32), including cost management (paragraphs 3.37-3.42).

8 We did, however, note some areas for further possible action by NHS Estates **(Figure 1)**.

1 Areas for further action

		Report paragraphs
Estate Strategies:		
a	Setting targets for all Trusts to achieve estates strategies to exemplar standards	2.5-2.11
b	Strengthening elements in estate strategy guidance to improve information in regard to disposal programme plans	2.2-2.4
Estate review and report to the board		
c	Ensuring consistency and clear support in guidance for the principle that Trusts should review their estate at least annually	2.12-2.17
d	Establishing whether there is a persistent concentration of sales completed at the year-end and investigating the value for money provided by these sales	2.20 & 2.21
Managing liaison and contacts with local planning authorities		
e	Encouraging Trusts to report good practice and to continue to develop and improve contact and ways of working with local planning authorities	2.24-2.32
Obtaining best prices		
f	Strengthening guidance on the best use of pre-sale valuations	3.6-3.12
g	Consideration of more extensive use of valuations encompassing a range of figures, including a most likely price within a range of acceptability	3.11
h	Scope to complete some sales more quickly with potential to bring forward receipts and reduce sales costs	3.13-3.15
i	Improving the basis for management and review of sales by recording sufficient standard information on time to sell properties	3.13
j	Making best use of NHS Estates' new Knowledge Network to record good practice and lessons arising from sales	3.16-3.32 & 3.37-3.42
k	Creating a named clearance house arrangement to improve notification procedures for priority purchase sales	3.28 & 3.29
Managing costs of sale		
l	Improving routine systems for monitoring the costs of sale and investigating outcomes	3.36

9 Recommendations arising from our analysis, linked to each of the Areas for further action identified in Figure 1, are primarily aimed at NHS Estates, as the policy lead. We recommend that NHS Estates should:

On strategic issues

a set explicit targets for the achievement of estates strategies to exemplar standards by all those Trusts, including newly created Primary Care Trusts, which have not yet developed them, while continuing to explore options to develop shared service arrangements to support smaller Trusts.

b strengthen its exemplar strategy guidance to cover the following points, in regard to disposal programme plans, including links to NHS Estates' *Estatecode* guidance:

- identification of holding costs for surplus property, including any exceptional maintenance, security or other costs;
- assessment of suitability for disposal of property in its present use and condition;
- view on dates for disposal; and
- allocation of responsibilities for the management and completion of sales.

c review and where necessary amend existing NHS Estates' *Estatecode* guidance, exemplar strategy and Controls Assurance guidance to ensure consistency and clear support for the principle that Trusts should review their estate at least annually to identify surplus property and report it to the board.

d in its new role in corporately overseeing all sales by Trusts:

- investigate whether the concentration of sales completed at the year-end revealed in our survey of sales by NHS trusts is a persistent trend and provides value for money; and
- consider any need to strengthen *Estatecode* guidance to require business cases for sales to identify and evaluate any exceptional risk involved in completing sales to a financial year-end deadline.

e encourage Trusts to report good practice and to continue to develop and improve contact and ways of working with local planning authorities, to ensure that NHS interests are reflected fully in local development plans and that planning applications on particular sales are effectively handled.

On obtaining best value from sales

f while recognising that the key test of value remains whether a property has been properly marketed, strengthen *Estatecode* guidance on obtaining and making use of pre-sale valuations for their intended purpose as a price guide, to make clear that:

- Trusts should ordinarily obtain a pre-sale valuation, recording its date and basis in all cases;
- where pre-sale valuations are affected by material factors during marketing (or simply become outdated in lengthier, more complex sales), Trusts should formally update and record amendments to it; and
- Trusts should formally review proposed sale prices against pre-sale valuations, recording reasons for variations in all cases.

g adopt more extensive use of valuations encompassing a range of figures, including a most likely price within a range of acceptability based on prospective uses in current market conditions, and amend *Estatecode* guidance accordingly.

h in its new role in corporately overseeing all sales by Trusts, pay close attention to opportunities to speed up very lengthy sales, particularly those which are also higher value and more complex, due to the potential value in bringing forward receipts and reducing sales costs.

i to improve the basis for management and review of sales, strengthen *Estatecode* guidance to propose that Trusts record sufficient standard information on time to sell properties, to include dates when:

- properties became non-operational;
- properties were declared surplus to requirements;
- selling agents were appointed;
- planning application was made (if applicable);
- planning consent was obtained;
- properties were marketed;
- offer was approved; and
- sale was completed.

j ensure that NHS Estates' new Knowledge Network includes an appropriate access point to enable Trusts to record good practice and lessons arising from sales for the benefit of future sales.

k strengthen *Estatecode* guidance in regard to sales to priority purchasers by directing Trusts to a named clearing house contact in the local health economy (and to NHS Estates for properties that may be of interest to other government departments) to ensure that notifications of available properties to priority purchasers are more effectively handled.

l in its new role in corporately overseeing all sales by Trusts, set up a routine system of monitoring costs and variations in costs, based on existing *Estatecode* requirements on Trusts to record the costs of sale, and review any unusually high cost patterns.

Part 1 Background

Trusts are the main owners of surplus NHS property

1.1 The NHS in England owns one of the largest estates in Europe. At April 2000, it was valued by the Valuation Office at some £23 billion (existing use basis) and had an estimated replacement value of £76 billion. The estate includes a wide range of land and properties, such as hospitals, clinics, administrative and residential buildings.

1.2 Turnover in property assets is continuous. It arises from changes in patterns of healthcare provision, modernisation and technological advance. For example the move towards treating more patients in the community has increasingly made many very large long stay hospitals obsolete. Many of these have been sold for redevelopment in the last decade, especially for housing.

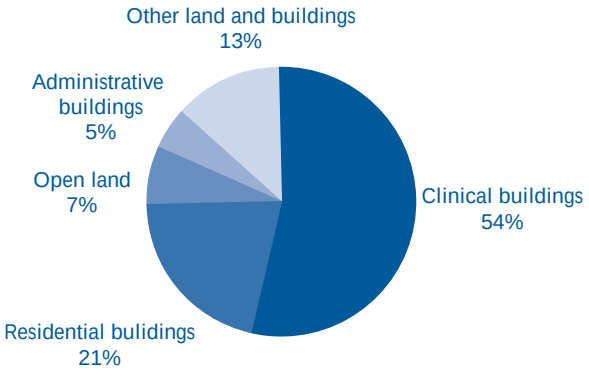
1.3 At present, data are not routinely collected on levels or sales of surplus property across Trusts in the NHS, in a way that enables them to be identified separately from the sale of other fixed assets, such as equipment. However a revaluation of assets held within the NHS carried out by the Valuation Office showed that, in April 2000, NHS bodies held some 1,000 non-operational sites with an estimated open market value of some £912 million (of which £258 million were held by NHS trusts). A site is taken to include anything from an individual dwelling to a redundant hospital complex. Properties identified as non-operational are eventually sold as surplus unless required for longer-term use.

1.4 Trusts are the main owners of assets held within the NHS, including a substantial proportion of surplus property in the NHS. Trusts together own some 95 per cent by value of all land and property held by NHS bodies (8,750 hectares by area). In mid-2000, we asked NHS trusts in our survey to estimate how much property they intended to dispose of in the financial years 2000-01 to 2002-03. Based on existing use value, which may be higher than prices eventually realised, this indicated that sales to 2002-03 could exceed £700 million. **Figure 2** breaks down the types of property that NHS trusts planned to sell as a proportion of this value. In the three years to 1999-2000 NHS trusts which responded reported receipts for sales of property of some £380 million[4].

NHS Estates has consistently met targets for the sale of its *retained estate* and now plans a Public Private Partnership to handle further sales

1.5 In addition to Trusts, NHS Estates, an executive agency reporting to the Secretary of State for Health, manages the sale of surplus properties in the so-called *retained estate*. This comprises properties whose ownership was not transferred to NHS trusts as they were created in the early to mid 1990s. Retained in the Secretary of State's

2 Types of property NHS trusts plan to sell in 2000-01 to 2002-03 as a proportion of total estimated existing use value of £700m. About half of properties to be sold were used for clinical purposes



Source: Information supplied by NHS trusts in response to the National Audit Office survey carried out by Oxford Brookes University, response rate 94 per cent

4 *As details of individual Trust sales are not centrally identified, our figures cannot be validated by centrally held information. Trust final accounts show that sales of all fixed assets by Trusts in the three year period to 1999-2000 was £675 million. A further £574 million (cash) was planned to be realised in the three year period from 2000-01.*

ownership, these properties were deemed at the time not to be essential to longer-term delivery of service by NHS trusts. They were either surplus or expected to be shortly surplus. Properties in the latter category were usually leased back to NHS trusts for a limited period.

1.6 At its peak, following the fourth major wave of NHS trust creation in 1994-95, the *retained estate* had an estimated value of £1.2 billion (at then prevailing prices). Since then, NHS Estates has conducted a major programme of annual disposals, in each year exceeding targets agreed with the NHS Executive **(see Figure 3)**. In total, £1,230 million of surplus property in the retained estate was sold in the period 1996-97 to 2000-01. These figures reflect rising property values over the period. The value of the *retained estate* at April 2001 was some £600 million.

1.7 In April 2001, NHS Estates formally commenced the pursuit of a Public Private Partnership to sell the majority of the remaining properties in the *retained estate* and to take over the Agency's trading functions. This developed from a recommendation in *Sold on Health*, a major review of the management of NHS estate, published in May 2000. Following an extensive competitive process, NHS Estates expects to appoint a private sector partner for the Public Private Partnership, with a view to completing the sale to the new entity in 2002-03. The Public Private Partnership will be able to tender to act as managers of the disposal process for the sale of surplus properties on behalf of individual Trusts. NHS Estates will itself retain its policy lead and role in regard to the provision of guidance on the management of the estate by Trusts.

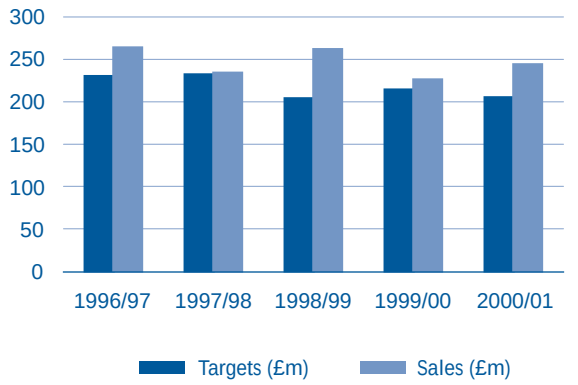
NHS Estates and local planning authorities have a key bearing on decisions by Trusts in regard to surplus property

1.8 **Figure 4** shows the wider planning and administrative context within which Trusts manage and dispose of their surplus properties.

1.9 In addition to interaction with a wide range of third parties, including developers, professional advisers and other statutory bodies, key decisions by Trusts in regard to surplus property are particularly influenced by:

- NHS Estates - which provides a policy lead and detailed guidance on managing the wider NHS estate; and
- Local planning authorities - which determine planning applications.

3 NHS Estates' disposal programme in the *retained estate* has met successive annual cash targets



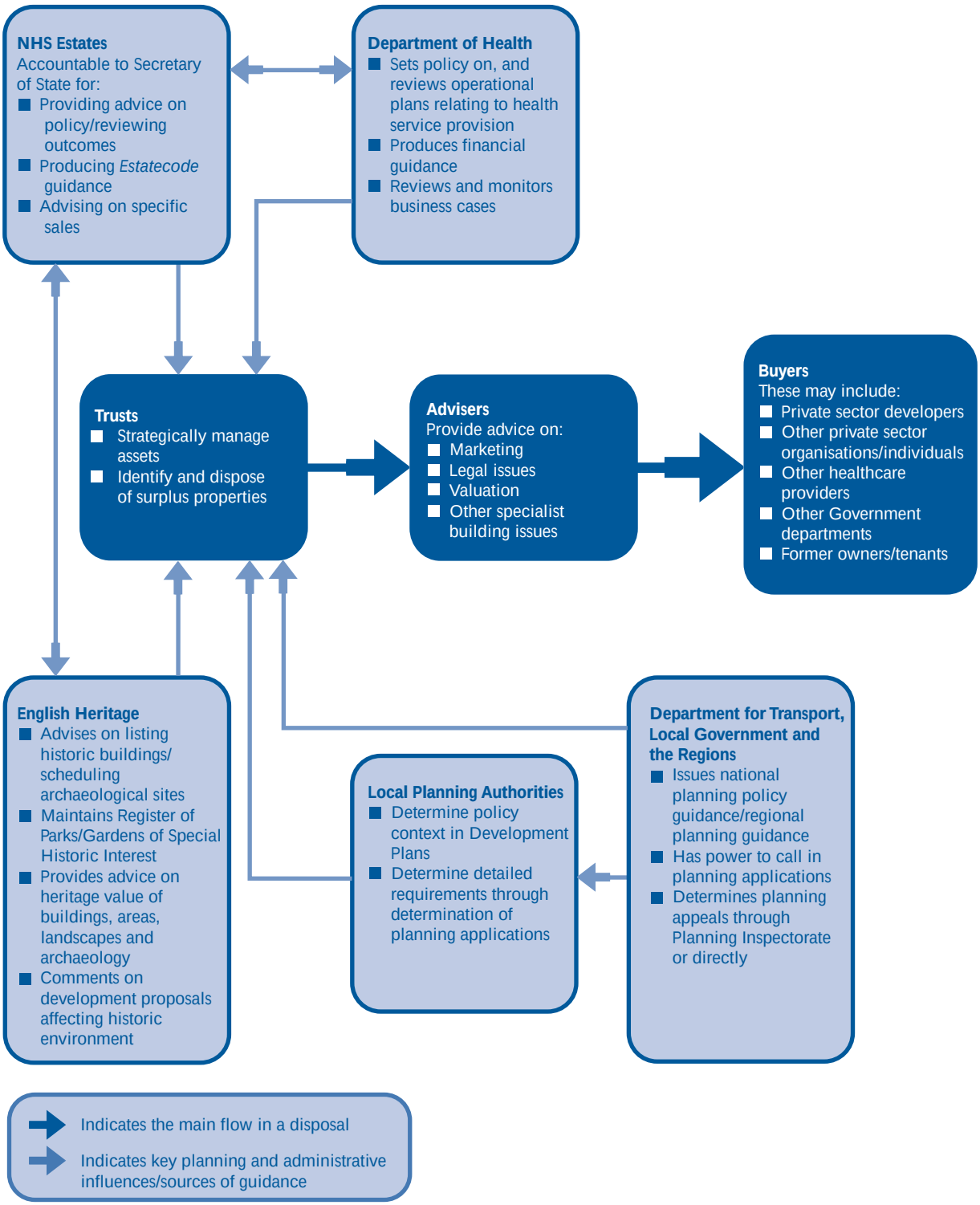
Source: NHS Estates

NHS Estates provides policy leadership and guidance on managing the estate

1.10 NHS Estates was formed as an executive agency of the Department of Health in April 1991, coinciding with the creation of the first wave of NHS trusts. It was set up to encourage effective, efficient and economical management of NHS property and promote excellence of design, together with value for money for new buildings. In April 1996, following the abolition of the then regional health authorities and the creation of regional offices of the NHS Executive, it took over formal responsibility for the disposal of the *retained estate*. It also provides advice to ministers on health estates policy and detailed guidance for Trusts and other NHS bodies for the effective management of the wider estate.

1.11 In carrying out their property management activities, Trusts are required to take account of guidance issued by NHS Estates, known as *Estatecode*. Trusts must manage and dispose of their assets in accordance with strategies that take full account of healthcare delivery plans. They must also review and appraise the quality of the estate to identify surplus sites periodically. Having identified properties as surplus, Trusts must seek to dispose of them competitively and as quickly as possible. In selling properties, Trusts must, however, first have regard to rights to buy that may be available to so-called *priority purchasers*, including other NHS bodies or Government departments, or to former owners of property acquired by or under threat of compulsory purchase as set out in *Disposal of Surplus Government Land - the Crichel Down Rules* (DoE/WO 1992).

4 The main planning and administrative influences on sales of surplus property by Trusts



Source: National Audit Office

1.12 *Estatecode* guidance on disposing of properties derives formally from Treasury guidance, published in Government Accounting, which is binding on all government departments. *Estatecode* is amplified from time to time by the publication of other guidance. We make further reference in particular in part 2 of this report to the impact of :

- *Developing an Estate Strategy* (NHS Estates 1999) - this emphasises the need for all decisions on the estate to be firmly linked to service needs and an analysis of existing assets, including condition and performance;
- *Historic Buildings and the Health Service* (English Heritage and NHS Estates 1995) - this deals with the management and disposal of historic and listed buildings and has formally been included as an annex in *Estatecode*. It should be referred to in conjunction with *The Disposal of Historic Buildings* (Department for Culture, Media and Sport 1999), a guidance note applicable to all departments; and
- *Controls Assurance Standard on Buildings, Land, Plant and Non-Medical Equipment* (NHS Executive 1999) - this specifies a minimum set of control requirements to provide NHS boards with assurance on the effectiveness of their system of internal control as a basis for signed statements of assurance in their financial accounts.

NHS Estates' influence on surplus property management by Trusts has been enhanced following the publication of *Sold on Health*

1.13 In May 2000 the Public Services Productivity Panel and the Department of Health published *Sold on Health*, a major review of the management of NHS estate. This reinforced the lead policy, strategic and advisory role of NHS Estates. Following the formal abolition of the NHS internal market, *Sold on Health* signalled a new, more corporate national framework for the estate in England. NHS Estates will in future assess the performance of trusts against corporate objectives more closely than previously and promote more corporate outcomes.

1.14 Since *Sold on Health*, NHS Estates has taken steps to develop its new role. Progress to date on recommendations most relevant to this examination is summarised at Annex 1.

Local planning authorities are key arbiters on all planning applications

1.15 Responsibility for deciding planning matters rests, in the first instance, with local planning authorities, part of local government. Like all major property owners, Trusts are bound by planning legislation and policy guidance issued to local planning authorities and developers by the Department for Transport, Local Government and the Regions. There is a right of appeal to the Secretary of State for Transport, Local Government and the Regions against the refusal of planning permission and the non-determination of planning applications and these are sometimes determined through a public inquiry. The Secretary of State for Transport, Local Government and the Regions also has powers to call in a planning application to determine himself, instead of leaving the decision to the local planning authority. He will, in general, only take this step if planning issues of more than local importance are involved.

1.16 Planning guidance for local planning authorities and developers is set out in a range of *Planning Policy Guidance Notes* issued by the Department for Transport, Local Government and the Regions. These cover issues as various as Green Belt protection, housing, transport, town centre and retail development, and planning and the historic environment. They are a key source of advice for local planning authorities when drawing up their development plans and in determining individual planning applications. In a recent Planning Green Paper, *Planning: Delivering a Fundamental Change* (Department for Transport, Local Government and the Regions, December 2001), the Government proposes to review all Planning Policy Guidance (and Minerals Policy Guidance), considering in each case whether it is needed, and seeking to more clearly distinguish between national policy and advice on process. There will be a greater focus on describing policies in terms of objectives and outcomes[5].

1.17 Because of the previously specialised clinical nature of many of their surplus properties, Trusts frequently need to obtain planning consent for change of use to significantly enhance sales income. Certain properties may also be listed and Trusts may face other problems, such as contaminated ground conditions. Such issues put a premium on maintaining good liaison and contact with local planning authorities both of an ongoing strategic nature and on specific disposals. NHS Estates has developed a national development plan monitoring service. This can be accessed by Trusts wishing to establish details of development plans covering their properties.

5 *The Planning Green Paper aims to simplify and speed up the planning process. It proposes to replace local plans with new Local Development Frameworks, containing local action plans. It also includes proposals aimed at improving the planning system for business and for engaging community participation. Following a process of consultation, the Government will announce its further plans later in 2002.*

1.18 We collected details on the three largest sales by value at each NHS trust in our survey, over the three year period 1997-98 to 1999-2000. Of these over 30 per cent (£180 million of receipts) involved a planning application for alternative use. **Figure 5** shows typical steps taken by NHS bodies in applying for planning permission for alternative use in such sales.

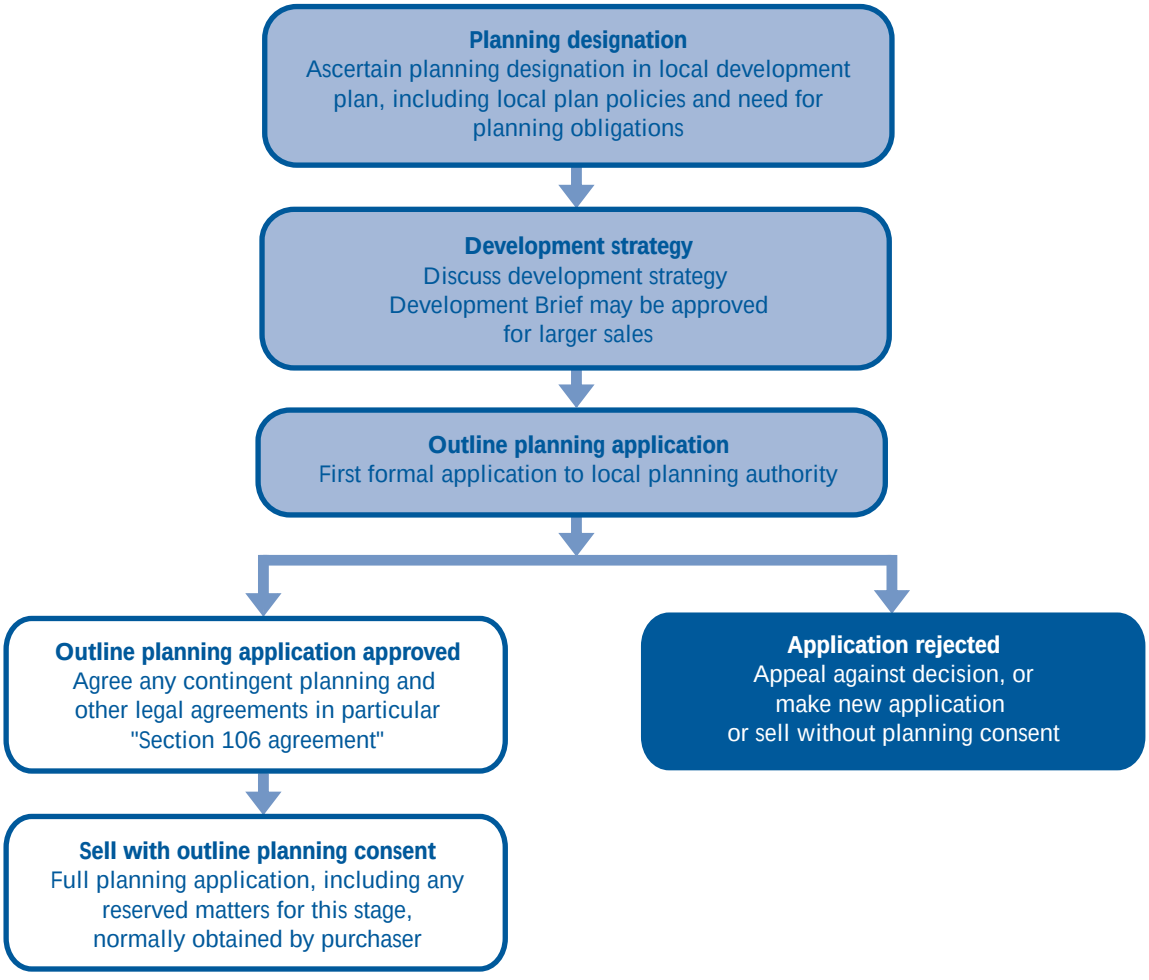
1.19 Figure 5 points to the value of early participation in local development plan consultation. It shows that the consequences of obtaining outline planning consent, particularly on larger sales, may include reaching agreement on a range of planning obligations, summed up in most cases in a *Section 106 Agreement*. Planning obligations cover contributions by the developer towards affordable housing, road and other transport improvements, amenity spaces, educational facilities and other facilities arising from the development. In most cases, agreements on obligations will be concluded by developers prior to purchase from Trusts, so that their likely costs will be reflected in lower bid prices. Full planning consent is normally taken forward by a purchaser, who, unless the issues are straightforward, is usually best placed to agree final plans[6].

Why we examined the management of surplus property

1.20 We had two main reasons for examining this topic:

- the size of the surplus NHS estate is substantial, and disposals provide valuable additional resources to fund NHS developments. It is therefore important that sales are conducted to achieve best value; and
- the role played by local planning authorities in processing planning applications provides an opportunity to examine the quality of joined-up government in an area where good cross-agency co-operation is likely to result in significant benefit.

5 Applying for planning permission for alternative use



Source: National Audit Office

6 *The steps outlined in Figure 5 may be affected by proposals in the Government's recent Planning Green Paper, particularly in regard to planning obligations. In place of a negotiated process, the Government proposes to introduce a system of local tariffs, determined locally in consultation with local businesses and local people. The Government aims to achieve an open and simpler community benefit policy that sets out clearly the community contribution developers will be asked to make if planning permission is granted.*

Scope and methodology of our examination

1.21 Our examination considers the management of surplus property by Trusts in the NHS in England. We concentrated on activity by Trusts because of the substantial and ongoing nature of the management of surplus property by Trusts in the NHS and the importance of obtaining best value in disposals.

1.22 We did not directly set out to examine the performance by NHS Estates in disposing of surplus properties in the *retained estate*, both because it has been greatly reduced in size and because of the Department's plans to create a Public Private Partnership. We did, however:

- take account of NHS Estate's strategic leadership role, which is continuing and has been enhanced following the publication of *Sold on Health*; and
- examined five large and complex sales by NHS Estates in a series of case studies at 14 NHS locations, to ensure that we tapped into experience and expertise built up by NHS Estates in its major programme of annual disposals in the *retained estate* since the mid-1990s.

1.23 We examined two main issues:

- how well the strategic environment in which Trusts are required to manage surplus property promotes the effective identification and disposal of surplus property including through co-operative working with local authorities and others (Part 2);
- how far value is achieved in actual sales (Part 3).

1.24 NHS estate issues in Wales have been examined separately by the Auditor General for Wales in two studies. The first, *Managing the Estate of the National Health Service in Wales* (November 2001), deals with strategic management and other broad issues of estate management. The second, which will be published in due course, deals with modernisation and renewal of the estate as well as the identification and disposal of property.

1.25 Annex 2 provides more detail on our methodology. Its key features were:

- reference to a number of detailed issues relevant to the achievement of value for money arising from recommendations by the Committee of Public Accounts in previous reports on a wide range of disposals of surplus estate;
- a census survey sent in mid-2000 to all NHS trusts in England to establish information about existing strategic arrangements, the management of disposals in the three years 1997-98 to 1999-2000 and their disposal plans for the next three years. The survey, carried out on our behalf by our advisers, Oxford Brookes University, had a 94 per cent response rate;
- in-depth case studies at 14 NHS locations, addressing 16 high value, more complex disposals in four NHS regions in England, chosen to get a good geographic and regional market spread and to illustrate the range of issues arising in such sales;
- file examination and interview at NHS Estates headquarters and at NHS trusts where we carried out case study work;
- research by our advisers into key characteristics of good practice in the strategic management of surplus property;
- a telephone-based survey by our advisers, on good practice in working constructively on managing land-use planning issues at 13 local planning authorities, chosen because we understood them to have developed good practice in liaison and contact with Trusts and other large landowners;
- discussion of key issues in three focus groups of major parties with an interest in the effective management of surplus NHS properties. Facilitated by our advisers, the groups comprised representatives from: NHS trusts and NHS Estates; planning authorities, strategic housing and regeneration organisations; commercial developers, marketing agents, solicitors and the Valuation Office; and
- an expert panel which we consulted throughout the study. A full list of its members is at Annex 2.

Part 2

Strategic foundations

2.1 Effective rationalisation of the NHS estate requires careful forward planning, taking account of the requirements of the land-use planning system. This Part of our report considers three key elements:

A the adequacy of Trusts' strategies for rationalising their estate;

B Trusts' effectiveness in identifying surplus property; and

C managing liaison and contacts with local planning authorities.

A: The adequacy of Trusts' strategies for rationalising their estate

New guidance on developing an estate strategy provides a generally good guide to rationalising NHS estate, though more advice on planning sales would be helpful within it

2.2 In December 1999, NHS Estates issued revised guidance as an aid to Trusts in developing "exemplar" estate strategies[7]. These are single integrated, analytical documents that act as a basis to improve review and decision-making for all aspects of estate management, including the rationalisation of surplus property, with full integration with NHS service plans. As such, they provide a useful aid to value for money.

2.3 Overall, we found that the exemplar strategy guidance provides a good match against seven of eight key planning stages **(Figure 6)**. These stages were drawn from a review of best practice in the public and private sectors (see Annex 2 for details). There was however scope to strengthen the guidance in relation to determining the disposal programme (Stage eight). The guidance indicates that a list of potential disposals and expected prices should be drawn up. Our review concluded that it should also cover:

- identification of holding costs for surplus property, including any exceptional maintenance, security or other costs, to help determine priorities for disposal;
- assessment of suitability for disposal in present use and condition, to enable decisions to be made on a range of site factors, such as demolition, refurbishment or decontamination;
- a view on dates for disposal; and
- allocation of responsibilities for the management and completion of sales.

2.4 At present, rather than being a part of what is required in an estate strategy, the four additional points raised in paragraph 2.3 are implicit in *Estatecode* guidance. NHS Estates has undertaken to review how these points might be addressed in estate strategies, including links to *Estatecode*, by amendment to existing guidance.

At April 2001, 18 per cent of Trusts had no estates strategy, risking poor handling of surplus property and delayed sales

2.5 Since 1997, NHS Estates has set internal targets which required Trusts to submit annual returns on the development of estate strategies. At April 2001, 82 per cent of Trusts indicated that they had an estates strategy. NHS Estates considers that this figure would have been higher but for the organisational changes taking place within the NHS including the creation of 164 Primary Care Trusts and a reduction in the number of NHS trusts from 402 to 318 in the three-year period to 2001-02. Newly created Trusts will need to draw up up-to-date estates strategies which reflect the new Trusts' service strategy. As part of the Primary Care Trust approval process, a stage involves the consideration by NHS Estates of property required for its establishment based on service needs known at the time.

7 *Developing an estate strategy, NHS Estates (1999).*

6 The new guidance is comprehensive except on questions of determining the disposals programme

	Strategic Issue	Adequate coverage?	The basis for judging adequacy of coverage
1	Create a property database	Yes	Advocates detailed analysis of Trust's existing estate, including condition and performance.
2	Establish a hold/sell analysis	Yes	Through the preparation of development control plans for each site.
3	Choose retained properties	Yes	Establish priorities for improvement, development or disposal.
4	Establish portfolio income and operating costs	Yes	Establishing the occupancy costs of the Trust's estate. Use the District Valuer's reports prepared for each Trust every five years.
5	Establish sell criteria	Yes	Consider estate performance indicators in the context of implications arising from the Trust's service strategy.
6	Establish internal consensus	Yes	Secure broad internal approval for estate strategic plans from the Board and Directorates, both clinical and administrative.
7	Create portfolio financial model	Yes	Investment and disposal strategies based on projected cashflows.
8	Determine the optimal disposals programme	No	Exemplar only indicates a need for a summary of disposals proposed and the anticipated proceeds.

Source: Oxford Brookes University analysis carried out for the National Audit Office

2.6 Trusts without an estate strategy are likely to be disadvantaged in managing their surplus property, with a less tight match between property holdings and those required for service needs. In our survey returns, received mainly in mid-2000, we found that:

- NHS trusts that reported that they had an estates strategy before April 1998 sold a higher proportion of their property by value, between 1997-98 and 1999-00, than NHS trusts that either had no strategy or developed one after April 1998 - 2.7 per cent by value compared to 1.7 per cent; and
- NHS trusts that reported that they had a strategy to the new (December 1999) exemplar standards planned to dispose of a higher proportion of their property by value from 2000-01 to 2002-03 than NHS trusts without a strategy to exemplar standards - 4.8 per cent by value compared to 3.8 per cent.

2.7 These differences cannot be explained by regional differences in property value. There was little regional variation in these patterns. Many factors bear on decisions to identify and sell surplus properties, including the amount of surplus property a Trust is likely to have. There is therefore no guarantee that having an estates strategy will enable a Trust to identify and dispose of more surplus property and a simple extrapolation of these findings can provide only a general guide. However:

- if all NHS trusts without estates strategies before April 1998 had been able to match the higher disposal rate of NHS trusts with them, this might have brought forward sales of £116 million over the three year period 1997-98 to 1999-00; and
- if all NHS trusts without an exemplar strategy were able to match the higher projected disposal rate of NHS trusts with one, this would bring forward potential sales of £102 million over the three year period 2000-01 to 2002-03.

2.8 Having an estates strategy to the enhanced exemplar standards required by *Developing an Estate Strategy* in December 1999 is a helpful development. Such strategies are likely to sharpen future rationalisation decisions by Trusts, in particular by alerting boards on a regular, updated basis to options in the estate. This will reduce scope for surprises and improve readiness to react to and debate opportunities.

Just over one-fifth of NHS trusts did not expect to have estates strategies to exemplar standards in place until 2002 or beyond, in part due to NHS reorganisation

2.9 NHS Estates expects all Trusts to have an estates strategy to the new exemplar standards by December 2002. However, our survey, conducted in mid 2000, suggested that progress might be slower towards this target. Of 331 NHS trusts that provided information, we found that 94 (28 per cent) considered that their strategies already met exemplar standards. A further 167 NHS trusts

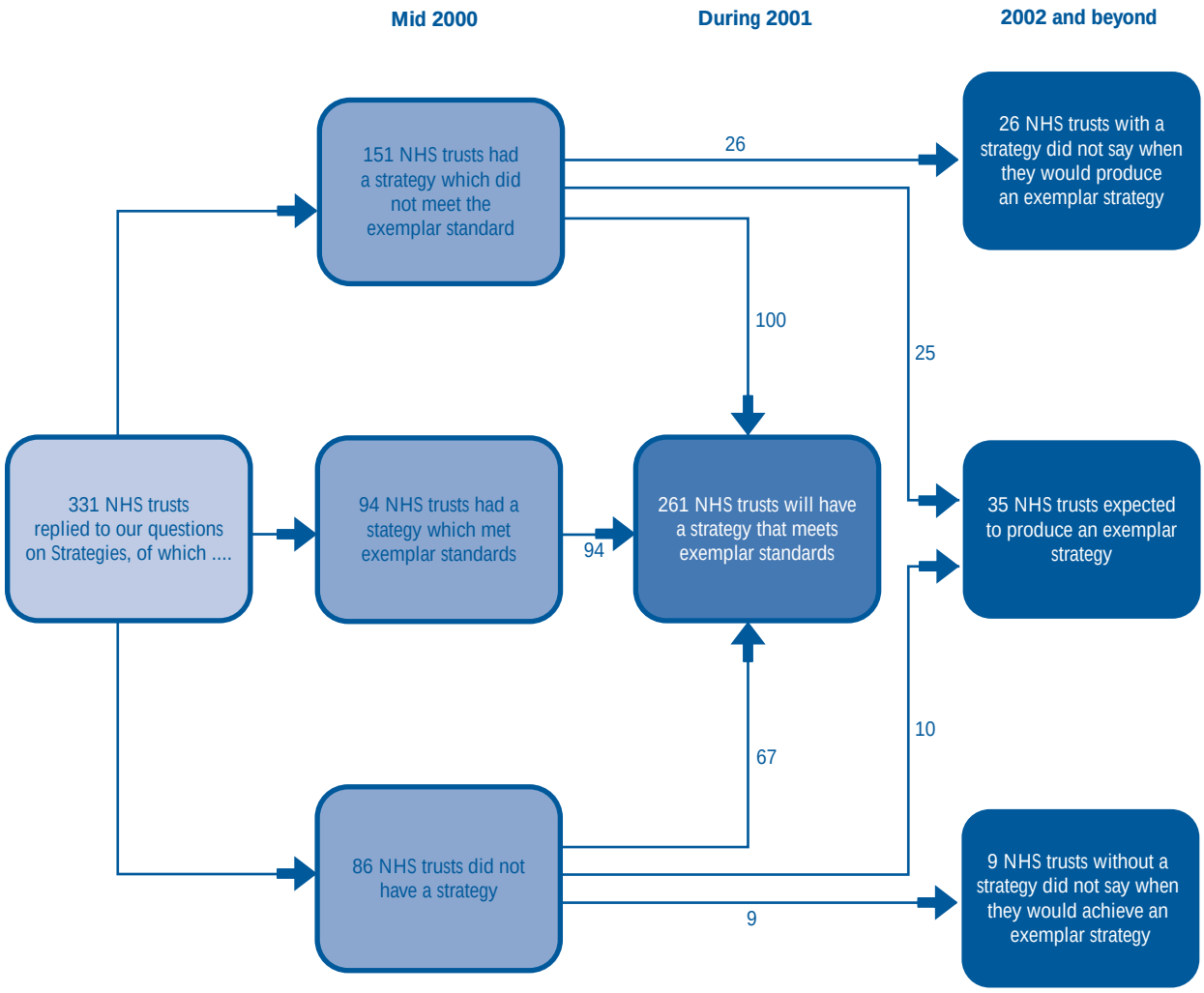
(51 per cent) expected their strategies would meet exemplar standards during 2001, bringing the total to 261. Of the remaining 70 NHS trusts (21 per cent) 35 expected to produce a strategy to exemplar standards in 2002 or beyond, and 35, of which 26 had an existing strategy, did not say when they would produce an exemplar strategy **(Figure 7)**.

2.10 Of the 245 NHS trusts (151 plus 94 in **Figure 7**) that had a strategy, 134 reported that they needed to improve them to meet the standards in one or more of the following respects:

- inclusion of performance indicators that enable judgements to be made about the optimal use of the estate (81 NHS trusts).
- inclusion of a future disposal and acquisition programme (63 NHS trusts).
- establishing which parts of the estate are of greatest and least operational importance (56 NHS trusts).

2.11 There is a variety of reasons for this mixed progress including changes in NHS organisation. These include mergers and the reorganisation or dissolution of many NHS trusts and creation of 164 new Primary Care Trusts up to April 2001. Nine NHS trusts in our survey volunteered information suggesting that pending mergers would delay improvements to their strategies. Our case studies also indicated that lower levels of in-house estates expertise at smaller bodies, such as Ambulance trusts, is also an issue. Following *Sold on Health*, NHS Estates is currently exploring options to develop shared service arrangements to support such trusts across these and other skills categories.

7 The main planning and administrative influences on sales of surplus property by Trusts



Source: Information supplied by NHS trusts in response to the National Audit Office survey carried out by Oxford Brookes University

B: Trusts' effectiveness in identifying surplus property

Only 66 per cent of NHS trusts met guidance to review their estate at least annually to identify surplus property and report the findings to the Board

2.12 Regular review of the estate allows Trusts to identify potentially surplus property and put plans in place to dispose of it at best value. *Estatecode* requires Trusts to maintain up to date information on the condition, suitability and life expectancy of its assets, but until 1999 there was no guidance on the frequency of review.

2.13 Separate guidance contained in an NHS Controls Assurance Programme standard on building, land, plant and non-medical equipment, effective from May 1999, requires Trusts to review their estate annually to assess the condition, suitability and life expectancy of its assets. This guidance indicates that Trust boards should be notified of the results through an annual report, with recommendations that are linked to estate strategies, including priorities for improvement, development or divestment.

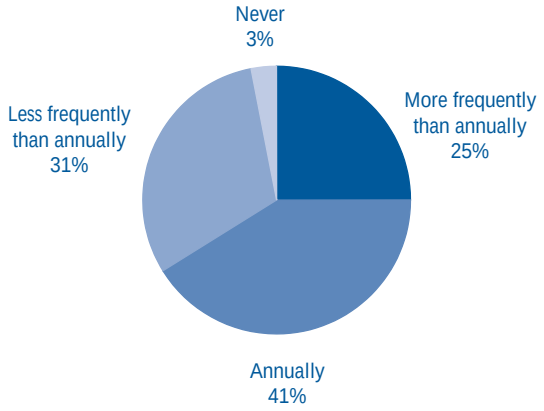
2.14 We found that only 66 per cent of NHS trusts in our survey complied fully with this guidance **(see Figure 8)**.

2.15 However, some 95 per cent of NHS trusts indicated to us in our survey that they had a named director directly responsible to the board for management of the estate, including disposal issues. This provides assurance that structures of accountability are in place to enable material decisions on the estate to be discussed at board level. For the minority of NHS trusts that did not indicate such clearly identified board leadership, we considered that strategic direction and value for money from disposals might be particularly at risk. Regular review of the estate and report to the board might increase or bring forward the amount of property sold by Trusts.

2.16 NHS trusts that undertook review and reported to their board at least annually in the years 1997-98 to 1999-2000 disposed of 2.2 per cent of their property by value on average over this period. This compares to 1.4 per cent for NHS trusts that reviewed less frequently. The differential in relation to future sales is, however, very small.

2.17 We have already noted that many factors may bear on decisions to identify and dispose of surplus property, so that a simple extrapolation of these findings can provide only a general guide (paragraphs 2.6 and 2.7). Nevertheless if all NHS trusts had achieved the higher rate of disposal associated with more frequent review and report to the board, this would have yielded an extra £35 million in sales between 1997-98 and 1999-2000.

8 Only 66 per cent of NHS trusts reviewed their estate and reported the outcome to the Board at least annually as required by guidance



Source: Information supplied by NHS trusts in response to the National Audit Office survey carried out by Oxford Brookes University

The Department of Health and NHS Estates are seeking to improve financial incentives available to Trusts to identify and dispose of surplus property

2.18 *Sold on Health* identified a need to improve incentives for Trusts to declare properties surplus and dispose of them. It referred to the current incentives being retention of proceeds from sale and release of capital charges, comprising depreciation and an interest charge, attached to all property assets. *Sold on Health* considered that the main issue was the risk that in some cases proceeds from disposal might be subject to regional reinvestment elsewhere. It also noted that capital charges on surplus estate were usually low because the asset has reached the end of its useful life, providing little incentive to release the estate.

2.19 Building on an approach taken up in Scotland and recommended by the National Audit Office in *The NHS in Scotland: Making the Most of the Estate* (HC 224, 1998-99), *Sold on Health* recommended that the link between Trust asset disposals and capital allocation needed to be reconsidered with distribution of the receipt being weighted in favour of the local health economy. Two recent developments are germane:

- Recently introduced "earned autonomy freedoms", allow top performing Trusts to retain £5 million of the receipt from property sales, instead of the previous £1 million, without the need for a business case. If sales net more than £5 million then these top-performing Trusts will retain £5 million and the surplus will be available for use within the local health economy, subject to submission of a business case. This is expected to act as an incentive to other

Trusts to achieve *three star* status in the *NHS Performance Ratings* to be published annually from 2001-02

- From 2002-03 management of the NHS capital programme will move from the existing eight regional offices of the Department of Health to 28 Strategic Health Authorities. This will allow proceeds from sales to be available for local reinvestment within these redrawn boundaries.

The end of the financial year saw unusually high levels of property disposals by NHS trusts that may not in some cases provide value for money

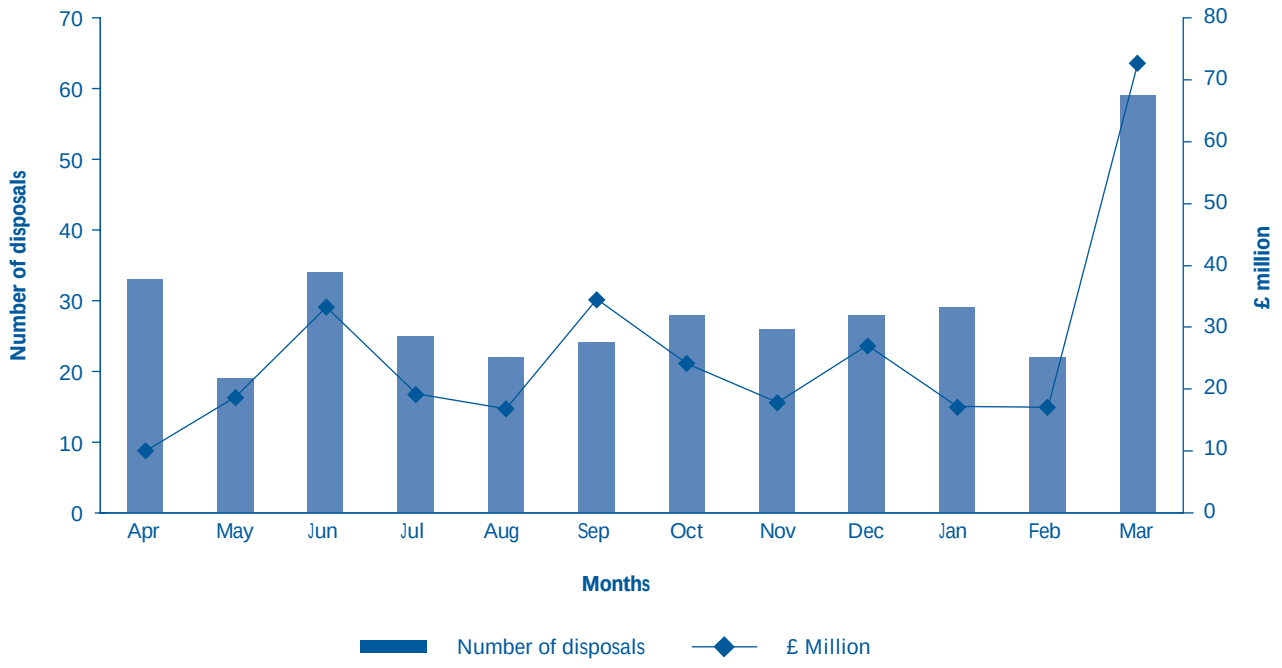
2.20 NHS trusts that responded to our survey concluded broadly similar numbers of disposals in each month of the year, except for the last month of the financial year, when numbers broadly doubled, representing 16 per cent of all disposals (24 per cent by value) in the years 1997-98 to 1999-00 **(Figure 9)**. A follow-up survey did not reveal any clear reasons for this pattern, which may be entirely justifiable. But it raised the issue of whether value for money was put at risk by the need to meet an accounting deadline.

2.21 About half of the NHS trusts that completed sales in the last month of the financial year in our survey reported that completion by the year-end was either "important" or "crucial". None, however, reported any negative impact on these sales as a result of the deadlines. *Estatecode* does not require business cases for sales to identify and evaluate any exceptional risk involved in completing sales to a year-end accounting deadline.

2.22 NHS Estates considers that year end deadlines have not adversely affected receipts in sales in the *retained estate*. Indeed, it has occasionally used year end deadlines to encourage performance by purchasers who may be being dilatory. NHS Estates also mentioned that planned payments from earlier sales are often received towards the end of a financial year.

2.23 We found no evidence in our case studies to suggest that NHS trusts unduly rushed sales to ensure completion within a given financial year. This included one sale, in which as part of a two-year recovery plan, the **Royal Wolverhampton Trust** used an auction to sell 23 residential properties to achieve a quick cash in-flow before the end of the financial year, followed by a competitive tender for the 54 remaining properties in the next financial year. *Estatecode* supports both methods of sale, which are both competitive. And both sales provided value for money by comparison against pre-sale valuations. However, the Trust did not formally evaluate the option of selling all properties by competitive tender as there was no alternative to an auction for some of the properties to obtain receipts before the financial year-end.

9 The monthly pattern of disposals accumulated in 1997-98 to 1999-00 was spread over the year except for a peak in March



NOTE

The analysis shows the three year totals for each month in the period. The patterns are similar in each financial year.

Source: Information supplied by NHS trusts in response to the National Audit Office survey carried out by Oxford Brookes University

C: Managing liaison and contacts with local planning authorities

Good contact with local planning authorities is frequently key to getting best value from disposals

2.24 Planning permission can dramatically affect the value of surplus NHS property. A major site, such as an old mental asylum set in its own substantial grounds, and involving both heritage and Green Belt issues, might have a negligible or even negative value without planning permission, for example for residential schemes, and may be worth many millions with it. For example, with such permission, one of our case studies, **Claybury Hospital**, sold by NHS Estates, was worth over £15 million (plus an overage payment linked to an expected increase in the level of development consent after sale completion). Without planning permission the value of the site would have been no greater than £5 million.

2.25 *Estatecode* advises that, where a property has potential for development, it should normally be sold with the benefit of planning permission for that alternative use. In negotiating planning consents and related planning obligations, applicants must take account of the statutory planning environment, particularly local development plans and national policies. This puts a premium on the effective handling of land-use planning issues with local authority planning departments.

2.26 *Estatecode* stresses that NHS bodies must work constructively with local planning authorities. Mutual benefits are obtainable by both Trusts and local planning authorities seeking to maximise effective contact at each of three key stages in the land use planning system **(see Figure 10)**.

Levels of on-going contact between NHS trusts and local planning authorities were low, although contact improved during the course of particular sales

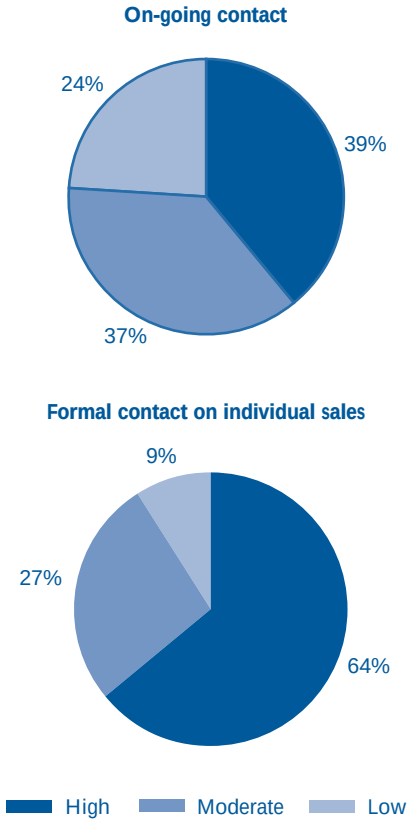
2.27 We found a wide range of levels of involvement between NHS trusts and local planning authorities **(See Figure 11)**. Many NHS trusts in our survey indicated that there was a relatively low level of on-going contact (covering stage 1 in Figure 10). Some four in ten NHS trusts rated the levels of these contacts as high. But over a third of NHS trusts created prior to the preparation of their local authority development plans (and therefore assumed able to participate in their formulation) indicated that they had not been involved in the formal consultation process. This might in part be explained as there are no statutory consultees in respect of local authority development plans. Although local authorities are advised to consult with a large range of organisations, it is nevertheless possible that an NHS trust may not have been aware that a local development plan was being prepared in their area.

10 Mutual benefits are obtainable by effective Trust and local planning authority contact at the three key land use planning stages

Land use Planning Stages	Stage 1: Ongoing contact	Stage 2: Before submission of planning application	Stage 3: Post submission of planning application
Mutual Benefits	■ Better informed Local Development Plans, which take full account of the impact of the health estate on the local environment, economy and wider policy issues. ■ Better informed NHS planning, which takes full account of Development Plan parameters and constraints, including the impact on the NHS of major non-health development. ■ Clarity on specific site development potential, by establishing appropriate land use designations in the Local Development Plan.	■ Early agreement on the principle and detail of potential proposals, based on full discussion of the range of issues involved. ■ Early agreement on the appropriate level of planning consent to apply for (and the stage at which to invite the views of possible developers) based on full discussion of the size, nature and complexity of the proposed development. ■ Early agreement on the possible conditions and planning obligations associated with the new development, based on full discussion of the transport, social housing or key worker accommodation, education, play-space or other community benefits.	■ Speedy negotiation of planning applications based on clear understanding of conformity with Development Plan principles. ■ Speedy negotiation of conditions and planning obligations, based on clear understanding of implications for community benefit and planning guidance requirements. ■ Avoidance of unnecessary appeals and inquiries, based on commitment to transparency and joint-work on issues giving rise to potential conflict.

Source: National Audit Office

11 Levels of contact between NHS trusts and local planning authorities varied considerably



Source: Survey of NHS trusts carried out for the National Audit Office by Oxford Brookes University

2.28 NHS trusts, however, also indicated that formal contact on individual sales (covering stages 2 and 3 in Figure 10) is higher, with almost two thirds of NHS trusts reporting contact as high. We also noted that this figure rose to 70 per cent for the 83 NHS trusts in our survey requiring planning consent to be obtained in at least one sale.

2.29 NHS Estates is clear about the importance of relevant ongoing and sale specific planning contact between Trusts and local planning authorities. Its value is not only stressed in *Estatecode* but is evident in other initiatives. These include the provision by NHS Estates of a local development plan monitoring service that can be accessed by Trusts through NHS Estates regional offices, and preparation of a guide on the relationship between development plans and NHS modernisation to be issued to all Trusts and local planning authorities. In addition, NHS Estates has held a number of meetings with the Department of Transport, Local Government and the Regions on both general and specific town planning matters and sought to have regular meetings with the Government Offices for the Regions.

2.30 The benefits of good contact were also clear in our case studies. For example:

- at the **Central Middlesex Hospital**, the Trust took a positive approach to establishing good relations with the planning authority, through active involvement in making representations during the Unitary Development Plan process, and direct meetings between senior executives of the Trust and local leaders to explain major planned developments at the hospital.
- The same Trust also developed formal and informal contacts with the local planning authority through the Park Royal Partnership for local regeneration, in which both parties played an active part. This enabled the Trust to gain the maximum benefits from a constructive planning environment for a £25 million programme of disposals essential to the financing of the further development of the hospital. Good networking with the local planning authority and other agencies led to speedy resolution of negotiations on traffic and other planning obligations and frequently helped identify buyers for plots sold in a phased programme over six years.
- At **Birch Hill Hospital**, the Trust worked closely with the planning authority in the initial stages of a major review of the delivery of acute services. Joint consultation, involving both officers and members of the local authority in key decisions, helped establish which of two hospital sites was to be identified for retention. The early involvement of the planning authority enabled NHS plans to proceed to full business case quickly. Following NHS approval, the Trust benefited by a speedy conclusion to the detailed planning issues presented by disposal of the site chosen, as a result of its earlier close work with the planning authority.
- At **Old Lambeth Hospital**, the Trust successfully adjusted its strategy to cope with severe staff shortage at the local planning authority. It applied for outline rather than full planning consent and took the lead in drafting a Section 106 agreement to speed matters. It also put a premium on continuous high-level contact between board members and senior councillors to help get action. Advised by the local authority, the Trust also consulted directly with residents' representatives and local councillors to reflect and obtain grass roots support for its plans.

Some NHS trusts and local planning authorities have developed ways of working constructively together to improve contact and this is more widely applicable

2.31 Because local circumstances vary considerably, we found that there was no single model of good practice of working between NHS trusts and local planning authorities. Some have, however, developed ways to improve contact, taking account of such factors as lack of co-terminosity of borders between organisations, resource issues and widely differing agendas. This is a two-way process. Good practice is likely to be most achievable where all parties are prepared to work closely together to obtain mutual advantage.

2.32 To look at these issues from the perspective of the planning authorities, we took soundings from 13 local planning authorities considered likely by our advisers to exhibit good practice in dealings with NHS and other large local employing bodies. We found they were keen that NHS bodies (and others) should consult planners earlier, take more advantage of opportunities for more liaison and close working and ensure that individual applications were made in the context of overall site strategies and clearly understood local development plans and statutory guidance. They provided a number of examples of initiatives that had improved the levels of understanding with trusts, helping to ensure that, when property was put up for sale, the planning process went ahead more quickly and with fewer surprises **(Figure 12)**.

The sale of historic and listed properties in the NHS benefits by joint guidance and other joint work by English Heritage and NHS Estates

2.33 The NHS has inherited many historic buildings, ranging from Georgian infirmaries to Victorian city hospitals and county asylums. Many of these have been subject to recent adaptation or disposal. We found that there had been 81 disposals of listed buildings or property in conservation areas and the sale of five ancient monuments between 1997-98 and 1999-2000.

2.34 In disposing of such heritage property, Trusts are expected to obtain the advice of English Heritage. Their view is that Trusts have acted on this guidance and that contact with Trusts has generally been good. English Heritage and NHS Estates have formed a historic hospitals working group, which promotes good practice, seminars and training events. It also acts as a sounding board for officials to discuss matters affecting heritage properties owned by NHS bodies. Jointly produced guidance incorporated in *Estatecode* provides a firm basis for partnership working.

2.35 The benefits of early involvement by English Heritage in specific disposals can be substantial. For example, they actively advised on and supported NHS Estates' planning application at **Claybury Hospital**, and acted as a witness in NHS Estates' successful appeal against the non-determination of their planning application by the local planning authority. This support, on the highest value and probably most complex of our case studies, played an important part in eventually determining that the property could be approved for residential development. The advice of English Heritage on architectural conversion and other design issues was also valuable, both to NHS Estates and the eventual buyer.

2.36 Following the sale of **Claybury Hospital**, the historic hospitals working group organised a seminar to consider lessons arising from it. A wide range of public and private sector participants in the sale confirmed that the following lessons, all incorporated in *The Disposal of Historic Buildings*, (Department for Culture, Media and Sport 1999), were important:

- specialist rather than generalist consultant advice is essential to understand the historic, architectural and ecological complexities of such sites;
- effective partnership with local planning authorities, including council members, is essential at all stages in such sales (and may best involve a representative from the relevant regional Government Office in very large sales);
- in accordance with government policy, there must be a clear recognition that the most appropriate long-term use for a historic building may not be the use which generates maximum income;
- commissioning fully detailed planning proposals for such schemes is of doubtful value;
- while recognising the interest of vendors in selling on the basis of an outline planning permission, obtaining agreement to a planning brief with a local planning authority has potential value to progress matters on a more flexible basis in such sales; and
- there may be value in agreeing a conservation plan with the local planning authority and English Heritage prior to preparation of a planning brief.

Government has identified deficiency in good contact with local planning authorities as a cross-departmental issue

2.37 In 1998, a report on the management of the Ministry of Defence's surplus estate[8] recognised tensions inherent in relations between the Ministry of Defence and local planning authorities, which it considered were common across government departments. It advocated improved inter-departmental guidance on handling land-use planning issues, noting that:

8 *Development of the Redundant Defence Estate (Department of the Environment, Transport and the Regions Research Project).*

12 Examples of good local authority planning initiatives to improve contact with trusts

Land use Planning Stages	Stage 1: Ongoing contact	Stage 2: Before submission of planning application	Stage 3: Post submission of planning application
	Joint planning forums East Hampshire District Council has established a Corporate Health Group, comprising local authority planners and surveyors and local health authorities to discuss all mutually relevant planning issues on a regular basis. Sheffield City Council has included the local health authority as a member of the strategic regeneration partnership for the city. A Partnership for Health Committee helps the health authority, Trusts and other healthcare providers get more involved in local authority planning issues, especially in reinforcing the role of health improvements in the city's regeneration strategy. **Papers on planning topics** Oxford City Council, as part of local plan review, has prepared a number of issues papers on various topics, including one on hospitals covering growth of hospitals, site allocations, transport and key worker accommodation. All papers are circulated to Trusts and local health authorities for comment.	**Planning for key sites** In consultation with the NHS, Birmingham City Council has prepared master plans for key sites being released by local Trusts. These have contained a raft of policies guiding development, including a framework governing the terms for negotiating developers' planning obligations, with the intent to reduce planning uncertainty for all stakeholders. Sheffield City Council has been prepared to develop planning briefs for the sale of surplus hospitals, providing a guide for residential development on the sites, protecting adjoining Green Belt land and listed buildings. Hampshire County Council has encouraged local health authorities to be actively involved in drawing up master plans for four major development areas identified in the County Structure Plan Review, focusing on establishing benchmarks for community provision, including health care needs. **Co-ordinated representation of NHS views** In Oxford, Capitec, a trading subsidiary of NHS Estates, co-ordinates NHS responses to the City Council's local plan review and informs the local authority of any imminent disposals, NHS policies or service change that might affect land-use planning.	**Guides for potential applicants for planning applications** Seeking to improve the basis for detailed negotiations on applications, a number of Councils have developed guidance on the local planning requirements that need to be covered by applicants. For example: ■ Birmingham City Council has issued guidance on planning obligations; and ■ East Hampshire District Council has produced guidance on design issues. Kent County Council has, together with its district councils, prepared a good practice guide on development contributions for community facility provision (such as education, social services and roads) generated by new commercial and residential development.

Source: Oxford Brookes University analysis carried out for the National Audit Office

- departments may sometimes seek to maximise "best price" at the expense of reasonable demands by local planning authorities to constrain planning applications in ways that reflect the wider regeneration, social inclusion and sustainability aims of the government; and
- local planning authorities, sometimes driven by local authority members acting implacably to plans to close or adapt existing facilities, may sometimes delay or make unreasonable demands on departmental planning applications.

2.38 The former Department of the Environment, Transport and the Regions subsequently established an inter-departmental Land Transactions Committee, which includes NHS membership, to review these issues. Discussions by this Committee, particularly in respect of handling planning appeals and disposals at less than market value, have been taken into account in developing guidance in a new edition of *Government Accounting* published in December 2001.

Part 3

Obtaining best value from sales

3.1 *Estatecode* requires Trusts to obtain best value from their sales of surplus property. The costs of appointing professional marketing, legal and other agents to carry out much of the work involved in actual disposals have also to be well managed. This Part of our report therefore considers how well Trusts:

- have acted in partnership with their agents to achieve best prices, as quickly as possible, subject to land-use planning and wider value for money constraints; and
- managed the costs of sales.

A: Obtaining best prices from sales

NHS trusts sold nearly 90 per cent of their properties by value competitively, providing assurance that prices had been market tested

3.2 Competition is the only sure way to test a market. *Estatecode* expects vendors to sell by competitive means, though there may be exceptions, particularly where a sale serves the wider policy interests of the NHS or government departments. Called priority purchases, such sales may be directly negotiated with a single party. They must be supported by an independent open market valuation and an appropriate business case. The sale of any property at a price below open market valuation requires prior approval by the Department of Health.

3.3 We collected details of the three largest sales by value at each NHS trust in the period 1997-98 to 1999-2000, accounting for nearly 90 per cent of all sales by value in our survey (see Annex 2). NHS trusts sold 81 per cent by value of this total (59 per cent of sales) by competitive tender and held a small number of public auctions (two per cent of all sales, 0.5 per cent by value). A further seven per cent by value (21 per cent of sales) were concluded by private treaty.

3.4 Almost all of the remaining sales (11.5 per cent by value, 18 per cent of sales) were sold on a directly negotiated basis to priority purchasers or sitting tenants. A very small number of sales were directly negotiated with other purchasers, and in all but one case in these cases, where a small loss was incurred, prices exceeded the marketing agent's or valuer's valuation.

3.5 This picture suggests that NHS trusts and their agents strive to maximise competition in accordance with *Estatecode*. We confirmed that vendors employed appropriate methods of sale, obtaining prices that had been fully market-tested, in all of our case studies. They included ten sales by competitive tender and one by public auction.

NHS trusts achieved prices in most sales equal to or greater than pre-sale valuations by a considerable margin, but some aspects of the valuation process might be improved to establish a better basis for comparison

3.6 Before offering a property for sale, *Estatecode* advises vendors to obtain an open market valuation to establish a price guide. This may be provided by the District Valuer, marketing agent or a suitably qualified in-house professional. Properties worth more than £5 million require independent valuation advice to be obtained from the District Valuer or firm of valuers. The District Valuer is also required to approve prices in such sales, prior to sale completion.

3.7 We examined the relationship between valuations and prices reported by trusts in our survey (information was available to do this for 82 per cent of all sales in the survey). We found that prices met or exceeded valuations (in all cases provided by District Valuers and/or marketing agents) in 95 per cent by value of these sales[9]. On average across all sales, sale price exceeded valuation by 32 per cent.

9 *Virtually all sales where prices were less than pre-sale valuation were either sales to priority purchasers or sitting tenants, in which permissible discounts are not uncommon to reflect approved policy, including concessions to housing associations to reflect contributions to backlog maintenance and right to buy terms.*

3.8 While recognising that the key test of value remains whether a property has been properly marketed, this provides some additional evidence that value for money was obtained in sales. It may, however, also in part reflect rising prices and other factors in respect of sales where there was a significant interval between valuation and completion of sale[10]. We found that some of the largest differences between prices and valuations in our survey arose when NHS trusts did not update valuations to reflect a variety of improvements in market conditions that had occurred since the initial valuation.

3.9 *Estatecode* does not discuss circumstances in which Trusts should update valuations. But professional advisers, including District Valuers, will usually state that their valuation advice is likely only to hold for a limited period (often up to six months but less in an active market). Valuations need to be kept up-to-date, though recognising that doing this has some cost. Effective marketing should provide some protection, but out of date valuations may lead Trusts into thinking that they have a good price, when in fact rising prices or changes in market demand may support an even better one.

3.10 The Valuation Office considers that, on balance, our findings support the view that valuers are providing a service that meets the principal reason for having a pre-sale guide price, to help ensure probity and accountability. But the Valuation Office agrees that valuations are prone to change in lengthier sales and that a lack of an update in such cases may fail to pick up movements in price levels and improvements in informational certainty (such as site decontamination or Section 106 requirements) since initial valuations.

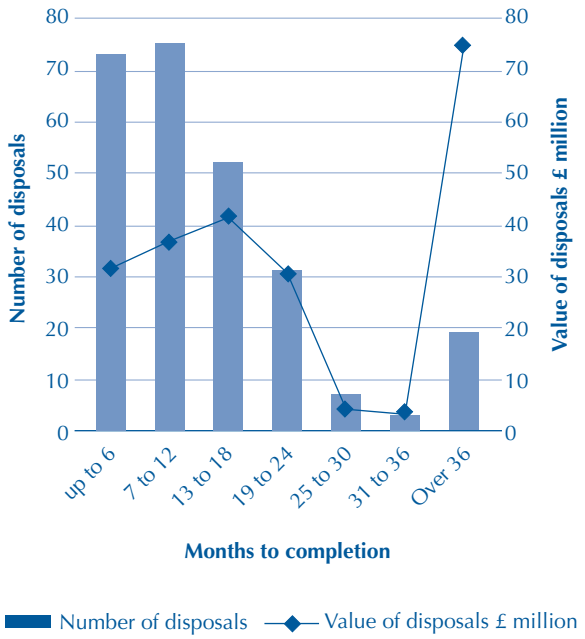
3.11 The Valuation Office also commends a move away from traditional single figure pre-sale valuations, which it most usually provides to its NHS and other public sector clients, to valuations that encompass a range of figures. Such valuations would include an opinion on the most likely price within a range of acceptability based on prospective uses in current market conditions. The range would tend to reduce as certainty increased. Valuers would have to set out and take full account of uncertainties rather than take a "cautious" view, providing a more challenging target for vendors. At the end of the disposal process a statement would be required for the financial accounts referring to the acceptability, or otherwise, of the sale price. The Valuation Office, however, cautions against high valuations, as some bidders may be put off if there is a perception that advice on open market valuation is pitched too aggressively.

3.12 Our case studies confirmed the difficulty of valuing certain complex properties and the potential usefulness of a valuation range. For example, valuations varied widely for **Winwick Hospital,** a highly attractive, large and complex property sold for residential development by NHS Estates. The District Valuer estimated open market value at £6 million to £7 million, some six months before the sale. Valuations by parties bidding to be marketing agents ranged from £6 million to £13 million, within a year of the sale. NHS Estates considered that some £10 million would be a good price. Unconditional tender bids ranged from £9 million to £13 million. In a highly competitive sale, the eventual price was almost £13 million.

There is substantial unexplained variation in the time taken to sell properties and scope to complete some sales more quickly

3.13 *Estatecode* requires all surplus property to be sold as quickly as possible consistent with obtaining good value. There is a considerable range in the time taken to sell properties (from five weeks to over five years) **(Figure 13)**. There is no requirement on Trusts to declare a property formally surplus. We therefore took as our starting point the date of appointment of selling agents, which in general marks the beginning of the disposal process. The underlying data for the 261 sales for which we could analyse outcomes revealed that:

13 There is considerable variation in time taken to sell property, with larger sales taking longer



Source: Information supplied by NHS trusts in response to the National Audit Office survey carried out by Oxford Brookes University

10 *The Valuation Office Property Market Report indicates that prices for residential bulk sites (not London) rose by 59 per cent between Spring 1997 and Spring 2000 (the period covered by our survey of NHS trusts). In London prices rose by 32 per cent. The issue of planning guidance PPG3 in March 2000, which set out higher building densities for brownfield sites (such as surplus hospitals), has since accentuated increases in value for properties like these.*

- the average time taken to complete a sale was 14 months. Within this time 64 per cent of property was sold, 34 per cent by value;
- the average time taken to complete the 130 sales that had planning issues was 18 months and for the 131 sales which did not have planning issues was 10 months;
- within 24 months, most sales (89 per cent, 63 per cent by value) were completed; but eight per cent of sales (35 per cent by value), which realised an average £3.6 million, took more than 30 months to complete.

3.14 A relationship between time to complete a sale and site value would be expected, and analysis confirmed this. Our more detailed analysis of the main influences on time taken to sell based on a wide range of factors (see Annex 2), showed that price remained the strongest determinant although other factors, particularly the existence of planning issues in sales, were statistically significant. But overall only 29 per cent of the variation in the time taken to sell properties could be explained.

3.15 Our findings suggest that the time taken to sell properties is strongly influenced by factors that vary on a sale by sale basis. Because of this, we cannot conclude that the sales in our survey could have been completed more quickly without compromising prices. But nor can we conclude that they could not be. Our case study examination (paragraphs 3.16-3.32 below) points to some good practice which enabled vendors to speed up sales effectively. If these kinds of benefit could be more generally achieved the financial impact could be significant, particularly in respect of higher value, more complex sales. Without attempting to comment on the detailed conduct of sales in our survey, for illustrative purposes:

- if a reduction of six months in the time taken to sell the 11 per cent of sales in our survey (37 per cent by value) taking more than 24 months to complete could have been achieved, this would have brought forward receipts of some £80 million (assuming that doing so would not depress the prices achieved).

Our case studies pointed to some good practice by which higher value and more complex sales might be managed better and more quickly

3.16 Our case studies were deliberately skewed towards high value and more complex sales in part so that we could investigate in detail the handling of this type of property sale and also to focus on good practice. Our case studies included some good practice lessons, particularly in respect of action to:

- challenge adverse planning decisions, including rejections of planning applications;
- safeguard value in negotiating Section 106 obligations;
- move sales forward effectively in sales with high levels of planning uncertainty;
- protect any value at risk not captured in the price through overage or clawback arrangements; and
- obtain best value in priority purchase sales.

NHS Estates has recently collaborated in establishing a Knowledge Network aimed at promoting core estates and facilities expertise, which can now consolidate good practice for the benefit of the NHS in the United Kingdom as a whole (see Annex 1).

Challenging adverse planning decisions, including rejections of planning applications, should be considered in exceptional circumstances

3.17 *Estatecode* is clear that vendors should not normally contest views already adopted in local development plans or supported by wider local or national policy guidelines. At the same time it recognises that in the event of decisions by local planning authorities that do not appear to be supported in these ways, vendors should consider the financial benefits of contesting these decisions. In doing so, they should bear in mind the risk of possibly heavy costs and delay involved in defending cases which may have to be fought through planning enquiries. In this regard, it is also important to stress the value of building effective partnerships with local planning authorities (paragraphs 2.24 to 2.38 above).

3.18 Successful challenges were made against adverse planning decisions in four of our case studies. They illustrate the value of a sound understanding of the planning environment and considered action well before any sale and in the run-up to it. In each case, the additional costs and time investment involved in resolving matters were clearly outweighed by the beneficial outcomes:

- In 1988, ten years before the sale, the then Regional Health Authority successfully challenged a County Council decision to incorporate the **Stoke Park Hospital** site into Green Belt contrary to a planning inspector's recommendation and the Council's structure plan. A favourable High Court decision safeguarded eventual revenue of over £20 million for this and other sites earmarked for future closure, whose value without development potential, effectively as agricultural land, would have been low.

- Successful appeals against failure by the local planning authorities to consider "change of use" development planning applications within the statutory time period were upheld by formal planning enquiries at **Claybury** and **Hillingdon Hospitals**. The **Claybury** decision took over a year and cost some £850,000 in solicitors' fees, but enabled premium residential development to go ahead worth over £15 million (plus overage). At **Hillingdon Hospital**, the enquiry took about six months, but enabled the Trust to safeguard its interest in prime residential development and to sell property worth some £4.8 million at least a year earlier than would otherwise have been possible.

- At **Barnsley Hall Hospital,** following rejection of NHS Estates' planning application and a formal planning appeal, the local planning authority eventually agreed to an amended application just before the commencement of an enquiry. This avoided further costs and enabled a sale worth over £10 million to be completed without further delay.

Negotiating Section 106 obligations should be conducted in full awareness of the local development plan, wider planning legislation and of scope for innovative outcomes

3.19 *Estatecode* advises that any Section 106 obligations should be in reasonable accord with local development plan or other relevant local or national policy guidelines. In negotiating agreements, it is important to act flexibly and reasonably with the local planning authority, but also, taking professional advice wherever necessary, to be prepared to challenge decisions by the local planning authority if they do not appear to accord with planning guidance.

3.20 Our case studies indicated that most negotiations on Section 106 obligations between vendors and local planning authorities were resolved flexibly and reasonably on the basis of planning guidance. But both sides had to be prepared to make allowance for sometimes very lengthy elapsed times to resolve complex negotiations, such as those dealing with substantive social housing, educational or road-building obligations. Two examples of good practice with wider applicability were:

- at **Claybury Hospital**, where during the planning enquiry to decide its development planning application, counsel for NHS Estates showed that education provision requested by the local planning authority was excessive. The local development plan already included provision for the local authority to meet the educational needs of a 650 dwelling residential development. NHS Estates had, however, been asked to meet the educational needs arising from all new dwellings rather than the net increase (some 770 dwellings were eventually permitted, approximating to a requirement for the equivalent of a small school).

- at **Central Middlesex Hospital,** following a road safety audit, the local planning authority proposed that the Trust should build a large roundabout and road on site at a cost in lost development land worth some £426,000. The Trust commissioned consulting engineers at a cost of £15,000. They proposed an alternative mini-roundabout, which was acceptable to the local authority, at a cost of some £27,000, with no loss of development land.

The early involvement of potential purchasers in discussions with local planning authorities may speed up sales where there are high levels of planning uncertainty

3.21 Where there are high levels of planning uncertainty, *Estatecode* advises vendors to consider ways to involve potential bidders in planning negotiations. How far this is necessary will depend on judgements in specific sales about the difficulty in obtaining planning consent without the involvement of potential bidders. It is intended that the Public Private Partnership that NHS Estates are currently pursuing will ensure that the early involvement of potential bidders will occur in respect of all relevant sites. Final agreement on detailed levels of development type and density, and Section 106 obligations will generally depend in large and more complex sales on contact between the local planning authority and the eventual buyer.

3.22 At **Stoke Park, Claybury** and **Barnsley Hall Hospitals,** NHS Estates successfully used an early informal tender process to appoint a preferred purchaser (obtaining a deposit on an agreed price) subject to concluding negotiations with the local planning authority. This enabled NHS Estates, purchasers and the local planning authority to resolve planning issues, including final levels of planning permission, very quickly.

3.23 All of the vendors reported benefits:

- at **Stoke Park Hospital,** NHS Estates estimated that they saved ongoing revenue and planning costs of £350,000 by completing the sale in this way before obtaining outline planning permission and a Section 106 agreement.

- at **Claybury Hospital,** the early appointment of the preferred buyer, prior to the opening of the Claybury planning enquiry, ensured that NHS Estates, the buyer and the local planning authority were able to agree outline planning permission shortly after conclusion of the enquiry.

- at **Barnsley Hall Hospital,** complex Section 106 negotiations in respect of site conditions could be pursued by NHS Estates with the purchaser in tandem with discussions with the local planning authority, thus reducing the overall time taken to reach agreement by all three parties.

Protecting any value at risk not captured in the price through an overage or clawback arrangement should be considered wherever such value can be specified

3.24 *Estatecode* advises that where property is disposed of before uncertainties over the planning position have been resolved, or whenever the market has not been fully tested, vendors should consider the value of a clawback or overage condition. Clawback or overage conditions aim to enable the seller to reserve a reasonable share of any enhanced value secured by the purchaser after completing such sales, which is difficult to achieve in the initial price[11].

3.25 Our survey showed that NHS trusts negotiated clawback or overage clauses in 64 disposals (49 per cent by value of all sales). The average price of these sales, at £2.7 million, was three times the average price for all disposals. 58 per cent of these sales realised prices greater than £1 million. Given the complex and non-standard nature of these clauses, we cannot fully assess whether clawback and overage clauses were used to their full potential across all sales in our survey. Nevertheless, we obtained some reassurance from the fact that clawback and overage clauses tended to be most common in our survey in higher value and more complex sales, where planning and development uncertainties were more likely.

3.26 Although *Estatecode* recognises that clawback or overage clauses may not be appropriate in many sales, particularly where there is keen competition, unconditional bidding and certainty about planning permission, value for money may be put at risk if appropriate clauses are not included in sales where there are clear risks. This is also a point made clearly by the Committee of Public Accounts **(see Annex 2, Figure 16)**.

3.27 We found that NHS Estates and NHS trusts fully investigated the scope for overage or clawbacks in our case studies. Clauses were agreed in nine sales, covering clearly specifiable risks that full value might not be fully realisable in the sale price, reflecting a balanced view of risk in all cases. Key features are summarised in **Figure 14**, which shows the four main types of risk that clawback or overage clauses provided protection for in our case studies.

Procedures for notifying the availability of surplus property to priority purchasers could be improved.

3.28 *Estatecode* defines a priority purchaser as any "health-related user", either another NHS organisation or public body, including care in the community organisations, general medical practices and other government departments. Priority purchases may be made on a non-competitive negotiated basis with such users if they serve health-related or wider government policy purposes based on an appropriate business case. *Estatecode* sets certain notification and pricing requirements:

- before selling surplus properties, vendors are required to check with local NHS bodies and with the Property Advisers to the Civil Estate (now part of the Office of Government Commerce), whether there might be priority purchase demand by these organisations;
- priority purchase deals should ordinarily be priced on the basis of an open market valuation by the District Valuer, but the parties have some discretion to strike a price below open market valuation, subject to Department of Health Regional Office approval, based on a case establishing that the concession is merited on exceptional policy grounds.

3.29 We found, however, in two of our case studies that notification of the availability of surplus property to potential priority purchasers did not work effectively. Although *Estatecode* rules require notification to take place, checks may not always happen. For example, interest by a neighbouring NHS trust in properties for sale at the **Royal Wolverhampton Trust** and by the Prison Service at **Winwick Hospital** occurred only by chance personal connections. The existence of potentially surplus property may be flagged up when Trusts consult the public on health service change, but there remains a need for better notification procedures, perhaps based on named contacts at local and regional levels. This was a point supported by our NHS focus group.

3.30 We also noted that the interpretation of the guidance on pricing priority purchase deals where a bid is less than the District Valuer's open market valuation might prove difficult. In the case of **Scott Hospital**, it took almost a year to resolve matters. In this sale, a health benefits case acceptable to the NHS trust and its health authority led to the approval of a price reflecting a "shortfall" of £325,000 against the District Valuer's open market valuation of £1.375 million. But accepting that price would have required an unacceptable write-off of the technical "loss" in the Trust's revenue accounts.

3.31 To avoid this, the NHS Executive eventually agreed to pay a grant covering the "loss" to the purchaser, a local authority, to enable it to pay at market value. This amount was then recovered from the Trust by an adjustment to its external financing limit. In reaching this decision, the NHS Executive emphasised that the outcome was exceptional and should not be seen as a precedent.

11 The terms clawback and overage have to a degree become interchangeable. Strictly "clawback" applies to additional value that has been "realised", e.g. proceeds from the onward sale of part or a whole of a property. "Overage" applies to additional value that is potentially realisable, e.g. value due to improved planning permission.

14 Risk protected by clawback or overage clauses in our case studies

Type of risk protected against	Nature of overage or clawback clause	Case study examples
1 Increase in level of development consent that is generally expected to occur after a sale has been completed	Percentage payment related to enhanced value generated when consent realised	The "classic" form of overage. Frequent in sales sold on basis of outline planning permission, e.g. **Claybury Hospital,** particularly where a preferred buyer is appointed and the sale completed before conclusion of planning negotiations with the local planning authority. Bidders are generally invited to propose suitable clawback arrangements in their tenders. Amounts may be substantial, e.g. up to 100 per cent or more of the initial sale price at **Claybury Hospital.**
2 Increase in level of development consent that the parties might consider possible after a sale has been completed	Percentage payment related to enhanced value if consent realised	A more speculative form of overage. Frequent where planning policy may marginally change. E.g. at **Old Lambeth Hospital,** an overage clause allows for an amount to be paid to the Trust per additional habitable room, if planning policy changes to allow build to a higher density than stated in the local development plan. At **Winwick Hospital**, a 21-year overage clause ensures a share to the NHS of gains in the event of permission to build more widely on a Green Belt site to reflect a decision by the local planning authority to allow a superstore to be built on an adjacent site.
3 A priority purchaser may sell a site bought for a specific health or other government policy purpose realising a windfall development gain	Percentage payment related to estimate of realised funds or actual proceeds	A specific safeguard, frequently advisable in concessionary sales. E.g. at **Scott Hospital**, a 21-year clawback clause binds the local authority purchaser (and any future owner) to pay the difference between the initial sale price and the open market value of any future sale for development gain. At the **Archway Wing**, NHS Estates agreed a similar 6-year clawback on the proceeds of any sale to a developer, if the University purchasers should decide to relocate its activities from the purchased property.
4 A buyer (or local planning authority) might gain by not applying all agreed funds to meet S106 obligations	Repayment of unapplied funds	A further safeguard, frequently advisable where there is uncertainty about S106 costs. E.g. at **Hillingdon Hospital**, the Trust attached a clause to an uncertain S106 educational agreement requiring the local planning authority to show that the funds were used for their purposes within a reasonable time or to repay them. At **Stoke Park Hospital**, based on an assessment of local planning authority requirements, NHS Estates obtained an agreement to receive additional payments from the buyer if parkland refurbishment costs allowed in the sale were less than the amounts expected.

Source: National Audit Office

3.32 This sale exemplifies a known cross subsidy problem. In the event of a sale at a discount to open market valuation to reflect a wider policy interest, there is no straightforward answer to the question whether the buyer or seller should cover the "loss". In the absence of more objective cross-departmental cost-benefit criteria, government policy continues to be to treat cases like these on their merits.

B: Managing the costs of sale

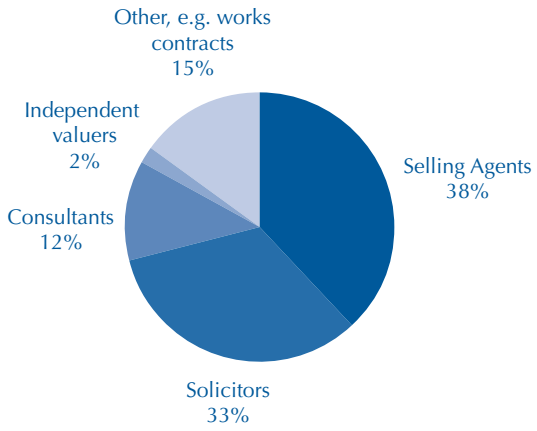
Selling costs depend mainly on sale price

3.33 *Estatecode* expects vendors to minimise the costs of sale, subject to appointing expert advisers of appropriate quality. The main costs in a sale are generally professional fees. Our survey showed that the average costs of sale across all disposals was some £17,500 (two per cent of average prices).

3.34 Trusts spent proportionately most of these costs on selling agents and solicitors **(Figure 15)**. Less than 30 per cent on average was spent on a range of other consultants, such as planners, decontamination and conservation experts and on works contracts, such as maintenance, security and demolition works. Comparatively little was spent on independent valuation advice, a one-off and relatively specialised requirement, applicable mainly in very high value or unusually complex properties.

3.35 Selling costs are quite strongly associated with prices, which reflects in part that the costs of selling agents (usually paid on a percentage basis related to price) and solicitors (usually paid on a time-basis) are the highest costs in most sales and tend to rise significantly in higher value and more complex sales. There is also an increasingly high degree of variation in absolute costs as prices increase, reflecting the often unique nature of very large sales.

15 Costs of sale as a percentage of total costs: almost three quarters of costs are selling agents and solicitors



Source: Information supplied by NHS trusts in response to the National Audit Office survey carried out by Oxford Brookes University

3.36 Almost 70 per cent of the variation in costs in our survey could be statistically explained by the influence of prices and a range of other factors (see Annex 2). In addition to prices, total land area and the length of time it took to complete a sale were the next most significant influences on costs. Since length of time to complete a sale is a significant determinant of sales cost, good practice identified in paragraphs 3.16 to 3.32 which might bring forward sales revenue is also likely to have an impact on reducing sales costs. There remains a significant degree of statistically unexplained variation in the outcome (over 30 per cent). This points to possible scope for cost savings, although there are special cases, and there will inevitably be local factors which we could not take into account in our survey.

Our case studies pointed to some good practice for the management of costs in the day to day handling of sales

3.37 Paragraph 3.16 has already noted that our case studies were chosen with a view to investigating detailed management on high value and more complex sales and to focus on good practice. They included some good practice, particularly in respect of:

- taking account of quality in appointing marketing agents;
- managing maintenance and security costs; and
- scrutinising costs essential to bring sites to a condition enabling development.

Appropriate assessment of quality as well as cost remain critical in the appointment of professional advisers

3.38 Care in the selection of advisers can pay clear dividends. For example, at the **Old Lambeth Hospital**, the winning selling agents were costlier than their main competitors, but put forward a convincing case that the Trust should apply for outline rather than full planning consent. This course of action was fully vindicated by subsequent events. One of the main reasons for the Lambeth decision was the thoroughness with which they carried out the selection procedure, which in this case benefited by the availability of professionally qualified estates staff to conduct the process.

3.39 More generally, we confirmed in our case studies that all except two vendors appointed their selling agents competitively. These two vendors placed reliance on qualitative recommendations by a neighbouring Trust and solicitors to appoint on a non-competitive basis. Solicitors were all appointed competitively, although in a number of cases the appointment was from within firms appointed (competitively) to act as a Trust's agent on all legal matters. Selling agents typically placed other works contracts on behalf of trusts, usually after a competitive process for any substantive work. It remains important however for trusts to be clear that they are obtaining the best value for money services at all stages of their sales.

Managing maintenance and security costs

3.40 Vacant properties may deteriorate rapidly and are frequently at high risk of vandalism. Government guidance on the disposal of historic buildings, referred to in *Estatecode*, requires Trusts to regularly inspect and maintain historic buildings, which stand vacant pending disposal. Failure to do so will make disposal more difficult and is likely to incur greater repair costs, which will be reflected in the sale price. *Estatecode* advises that plans should be prepared early and security put in place immediately properties have been vacated and that the time between vacating such sites and selling them should be minimised.

3.41 Our case studies illustrate the advantages of tight management of security and maintenance costs as part of the effective overall handling of sales. For example:

- at **Claybury Hospital**, the large size and open nature of the site made it an early target for vandalism. To protect the listed Victorian buildings, NHS Estates built a perimeter security fence at a cost of some £180,000 and paid £20,000 a month for a 24-hour guard by a security firm. Unable to sell early, due to planning objections and a lengthy planning enquiry, it incurred security costs for well over a year. It took effective steps to minimise the impact of these costs, by adopting a strategy of speeding up the sale by

appointing a purchaser, which took over the liabilities, and involving them in the planning issues prior to and during the enquiry.

- at **Winwick Hospital**, due to successful resolution of the main planning issues in the two years prior to the hospital being fully vacated, NHS Estates was able to quickly market and sell the property, confining security costs of some £10,000 a month to a minimum period.

Any agreement with purchasers to incur costs essential to bring sites to a condition enabling development should be subject to careful scrutiny

3.42 *Estatecode* recognises that it may sometimes make sense for purchasers to bear certain costs of bringing a property to a condition where it can be developed. Such arrangements need to deliver value for money. We found that our case study vendors had applied shrewd judgement in this respect, highlighting some good practice lessons for NHS vendors generally:

- at the **Royal Oldham Hospital**, in negotiating the purchase of residential property, the purchaser proposed that it carry out certain essential additional repairs at a proposed charge of £150,000. On examining the proposal, the Trust estimated that it could carry out the repairs using in-house staff at a substantial saving. It rejected the proposal, eventually carrying out the work and achieving estimated savings of some £60,000;
- at **Barnsley Hall Hospital,** NHS Estates and the purchaser were faced with major site issues on a large site, eventually sold for some £10 million. These included land decontamination issues and a requirement for infrastructure development in the form of plans to build a substantial access road before the site as a whole could be developed. In these circumstances, it made sense for the purchaser to draw up the plans to tackle these issues. In the event, NHS Estates appointed consultants to assess the purchaser's plans. This led to amendments in respect of issues on soil quality, drainage and the depth of the road, which achieved savings in these costs, improving net proceeds, by almost £1.2 million.

Annex 1

NHS Estates' progress against *Sold on Health* recommendations

1 In May 2000, the Public Services Productivity Panel published *Sold on Health* with a joint foreword from the Secretary of State for Health and Chief Secretary to the Treasury. This major review of modernising procurement, operation and disposal of the NHS estate reinforced the lead policy, strategic and advisory role of NHS Estates. The report contained 17 recommendations. Implementation of the recommendations aims to bring about significant improvements in how the NHS estate is managed. Progress on recommendations most relevant to this study, and information about the development of a new Knowledge Network to support the development of expertise in health estate and facilities management, are detailed below.

A: The introduction of a national framework and regional overviews to support local estate strategies

2 NHS Estates has produced a framework document which is currently being tested. However *Modernising the NHS: Shifting the Balance of Power within the NHS* (Department of Health, September 2001) announced the creation of a new structure including the abolition of the current Department of Health Regional Offices and the introduction of Strategic Health Authorities. NHS Estates is therefore reviewing the framework document to reflect these changes. NHS Estates is currently preparing a comprehensive compendium of information on the NHS estate within each Strategic Health Authority to be sent to newly appointed Chief Executives. This information includes details of the current position on local authority development plans and re-emphasises the importance of active involvement by NHS bodies in the consultation processes leading to their development.

B: The disposal of the surplus estate should be overseen corporately by NHS Estates

3 This recommendation has now been implemented but widened to not only include other major property transactions but also those being undertaken by Health Authorities. Corporate oversight will include ensuring *Estatecode* guidance is being followed, advising on the appointment of consultants, the preparation of strategic directions i.e. how the sale will be carried out (including key actions and dates), pre-marketing and marketing, consideration of offers and recommendations being made. NHS Estates staff have become key members of Trust professional teams particularly on large disposals.

C: Consideration of a one-off disposal of surplus estate

4 NHS Estates has now implemented this recommendation. The disposal by means of a Public Private Partnership of around 120 properties within the *retained estate* with an estimated value of £400 million has commenced. The sale is due to be completed in 2002-03.

D: Greater use of auctions for the sale of lower value properties

5 Following the appointment of national auctioneers by NHS Estates, over £9 million has been realised from the sale of over 100 properties within the *retained estate*. Trusts were also advised of the appointment and a further £3 million has been realised.

E: The link between trust asset disposals and capital allocations needs to be reconsidered

6 Work on this is being led by the Department of Health's Finance Department with NHS Estates providing input. Details are at paragraph 2.19 in this report.

F: NHS Estates should work in partnership with other government departments on new initiatives to facilitate better inter-departmental guidance for local authorities

7 NHS Estates has held a number of meetings with the Department of Transport, Local Government and the Regions on both general and specific land use planning matters. It has also sought to have regular meetings with the Government Offices for the Regions. It is about to issue to all local authorities and the NHS a guide on *Development Plans and NHS Modernisation*. A version has already been issued to the London Boroughs.

G: The potential benefits of managing all estate and support services across organisational boundaries to be explored

8 A number of these shared service arrangements are already in place. Following consideration of the options and consultation with Trusts, NHS Estates is undertaking a pathfinder feasibility study known as *Health Facilities, National Standards - Local Solutions*, which if successful will be rolled out nationallly.

Knowledge Network

9 In collaboration with the health estates departments of Wales, Scotland and Northern Ireland, NHS Estates has introduced the Knowledge Network. This is intended to harness the knowledge and expertise within the health service and make it widely available by linking it to a central information centre. The Knowledge Network will also assist in identifying areas of knowledge that need to be addressed whether by training, research and development or publications. The Network will be based on six Knowledge Groups: engineering standards; building design; facilities management; procurement; property management; and medical technologies and systems.

Annex 2 Methodology

1 We used a variety of methods to examine the issues identified for this study. These included reference to previous recommendations of the Committee of Public Accounts on a wide range of disposals of surplus estate, a questionnaire to all NHS trusts, case studies, a good practice research paper, a telephone-based survey of local planning authorities, focus groups and an expert panel.

Previous recommendations of the Committee of Public Accounts

2 The Committee of Public Accounts has in the past reported on a wide range of disposals of surplus estate and other assets. **Figure 16** contains some of the more recent recommendations made by the Committee of greatest relevance to this report. These are also cross-referred to paragraphs in this report which deal with the issues raised.

16 Relevant recommendations by the Committee of Public Accounts

Issue	Report recommendation	Reference to this report
Strategic	Health departments to ensure that health authorities and boards link estate matters with service plans for strategic planning purposes *(40th report 1987-88, para 2 (iii) (e), HC 405: Estate Management in the National Health Service)*	2.2-2.4 & Figure 6
	Department to take urgent action to strengthen their strategic planning for the estate as a whole. We find it hard to see how estate planning can be at all effective when some budget holders have estate strategies for the property they occupy and others do not *(10th report 1998-99, para 4(x), HC 14: Ministry of Defence: Identifying and Selling Surplus Property)*	2.5-2.11
	Department to take a proactive role in ensuring that surplus land and buildings are identified and disposed of quickly *(39th report 1998-99, para 9 (viii), HC 224: The NHS in Scotland: Making the Most of the Estate and Other Issues)*	2.12-2.17
	It is important that the budgetary arrangements within the Department encourage budget holders to identify and release surplus property *(10th report 1998-99, para 4(xiii), HC 14: Ministry of Defence: Identifying and Selling Surplus Property)*	2.18 & 2.19
	It is important that public bodies explore fully the potential for obtaining planning permission before disposing of surplus sites *(43rd report 1994-95, para 3, HC 502: Sale of the Mount Vernon Site, Hampstead)*	2.24 & 2.25
	Treasury guidance makes clear that to obtain best price when disposing of property proposals for the future use of property should accord with the local authority development plan. The Department should give urgent attention to how they can improve their liaison with local planning authorities *(10th report 1998-99, para 4(xv), HC 14: Ministry of Defence: Identifying and Selling Surplus Property)*	2.26-2.32, Figure 12, 2.37 & 2.38
Selling	Assets should be sold in competition unless there are compelling reasons to the contrary. It is not only that this is generally the best way of securing the highest price; it also helps demonstrate that public assets have been sold transparently and with due regard to probity *(22nd report 1993-94, para 3(iv), HC 210: English Estates: Disposal of Property)*	3.2-3.5
	Departments should ensure they have up-to-date valuations including, where appropriate, potential development values of land and other assets *(13th report 1989-90, para 3(v), HC 449: Further Examination of the Sale of Royal Ordnance)*	3.6-3.12
	Valuations should be based on the likely proceeds from the sale so that Departments will be better able to judge bids and strengthen their negotiating positions *(32nd report 1995-96, para 2 (iii), HC 29: Sale of London Transport's Bus Operating Companies)*	3.11
	It currently takes 18 months to sell property and 15 per cent of sales examined took more than three years to complete. The importance of seeking to reduce the time taken is underlined by the fact that for each month's reduction in the average time there could, in broad terms, be savings of some £450,000 *(10th report 1998-99, para 4(xvi), HC 14: Ministry of Defence: Identifying and Selling Surplus Property)*	3.13-3.15
	We encourage bodies to consider the use of clawback provisions over, say, five years in all cases where there are real doubts over the basis for valuation and the possibility of windfall profits to the purchaser. Clawback should not be so frequently used as to interfere with orderly and timely disposal, but it remains an important safeguard of the public interest *(10th report 1986-87, para 20, HC 234: Disposal of New Town Assets)*	3.24-3.27 & Figure 14

NHS trust census survey

3 In the summer of 2000, assisted by our advisers, the School of Planning at Oxford Brookes University, we sent a census survey to all NHS trusts in England to establish information, none of which was readily available centrally. A total of 341 NHS trusts responded to the census (a 94 per cent response rate from the total of 362 NHS trusts which we contacted).

4 We collected a range of data on property holdings, past and future disposal programme information, estate strategies, management guidance, relationships with local planning authorities and other matters. We asked for specific details, including costs of sale, on the three largest disposals by each trust of freehold property in the three financial years 1997-98 to 1999-2000. The information provided related to almost 90 per cent by value of all sales in those years by the 302 NHS trusts that replied to our census with adequate data.

5 We have referred to the information collected and to relevant analysis of the data that were available in the text of the report. At paragraphs 3.14, 3.15, 3.35 and 3.36 we refer to analyses of the main influences on the time taken to sell surplus properties and on the costs of sale. These analyses involved multiple regression techniques and they are therefore set out in a little more detail here. The analysis involved the following steps:

- we first calculated two statistical measures of association between, firstly, the times to sell and, secondly, the costs of sale and, in each case, a group of factors that might be considered to have an influence on them; and
- having ascertained that these associations were statistically significant, we applied stepwise regression techniques to investigate the degree to which bringing in each of the seven main factors one by one provided a statistically based explanation of the variation in time to sell and costs of sale in the population.

6 Our analysis of the influences on time to sell is summarised in **Figure 17**, and supports our statements at paragraphs 3.14 and 3.15 of the main report. The figure shows the overall outcome in regard to the whole group of factors included in the first, overall regression. It also shows the relative influence of the most significant factor, price. The adjusted R square shows the proportion of variation explained by the analysis, 1.00 being 100%. The standard error of the estimate is an indication of the accuracy of any model in estimating the time to sell a particular property. The analysis shows that the impact of price and the other general factors was therefore limited, suggesting that time to sell is strongly influenced by factors that vary on a sale by sale basis.

7 Our analysis of the influences on costs of sale is summarised in **Figure 18**, and supports our statements at paragraphs 3.35 and 3.36 of the main report. The figure shows the overall outcome in regard to the whole group of factors included in this second overall regression. It also shows the relative influence of the most significant factor, price. The adjusted R square and standard error of the estimate have the same meaning as in the work on time to sell (paragraph 6). The analysis thus shows that although the impact of price was strong, that of the other general factors was limited, suggesting that costs of sale as well are to some extent influenced by factors that vary on a sale by sale basis.

17 Price and a range of other factors only explain some 29 per cent of the variation in time taken to sell properties

	Degree of association (R)	Explanatory statistic (R square)	Adjusted R square	Standard error of the estimate (weeks)
Influence of all factors	.620	.384	.291	51.1
Influence of price only	.449	.202	.199	54.3

NOTE

Pearson's correlation coefficient used throughout. Other factors considered were: property type (including listed building issues); total floor space; total land area; existence, date and frequency of review of strategy; type of NHS trust; region; operational planning, legal, site and priority purchaser issues; planning problems; withdrawal of purchaser.

Source: National Audit Office analysis

18 Price and a range of other factors explain some 67 per cent of the variation in costs of sale

	Degree of association (R)	Explanatory statistic (R square)	Adjusted R square	Standard error of the estimate (£)
Influence of all factors	.840	.706	.674	23,696
Influence of price only	.767	.588	.586	26,710

NOTE

Pearson's correlation coefficient used throughout. Other factors considered were as for Figure 2, with the addition of time to sell

Source: National Audit Office analysis

8 There were some deficiencies in the data we were able to collect to support all our analyses, and these should be borne in mind when assessing the consequent robustness of the work. Overall, 210 responding NHS trusts completed at least one sale in the relevant period, providing data on 422 disposals. In 44 cases the price achieved was not given. Trusts were also invited to provide several data to enable us to calculate a time to sell statistic. We ruled out 159 cases because the data provided did not enable us to establish this statistic with sufficient confidence in accordance with the definition which we later adopted in our analyses.

9 In total, 245 transactions (58%) had data sufficient to be used in all the analyses we carried out based on Trust transaction data. We cannot rule out that missing data may have resulted in some bias, but investigated some specific anomalies, in some cases involving follow-up questions with a number of Trusts. It should also be borne in mind that some degree of association will exist between the explanatory variables in our regression analysis, for example between price and floor space or land area. This may have led to marginal overstatement of the explanatory force of the variable shown in Figures 17 and 18.

Case studies

10. This part of our work addressed the detailed conduct of disposals and lessons for good practice, adding depth to the across the board information provided by our questionnaire responses. We examined 16 high value, more complex disposals at 14 NHS locations in four regions in England, chosen on a judgemental basis, with a view to obtaining a good geographic and regional market spread and to illustrate the range of issues arising in such sales.

11 We included five sales by NHS Estates, to ensure that we tapped into experience and expertise built up by NHS Estates in the course of disposing of *retained estate* properties since the mid-1990s. Four of these sales were of particularly high value and complex properties of a type that NHS Estates has had greater recent experience of selling than most Trusts. All sales had been completed by the time of our examination.

12 In total, the value of receipts represented by our case study examination exceeded £75 million. See **Figure 19.**

Good practice research paper

13 To add academic breadth to our work, we commissioned our advisers, Centre for Real Estate Management Oxford Brookes University, to investigate "good" practice in the following two main respects:

- key characteristics of "good" strategic management of surplus property, to be based in part on a review of recent professional literature; and
- how other bodies (private and public) have improved their strategic management of surplus property in the recent past, to include three in-depth interviews with the heads of real estate at a public body, the Post Office, a privatised body, British Telecommunications plc, and a private sector company, Lloyds TSB.

14 Addressing the first of these two areas led, in particular, to the identification of eight key steps in achieving the rationalisation of a corporate estate. These steps derive from a paper by M. Buckley (1999)[12] . They were used as a set of tests by which we assessed the adequacy of guidance on rationalising the NHS estate at paragraphs 2.2 and 2.3, and Figure 6 of our report.

12 *Eight Steps to a Strategic Plan for Corporate Real Estate and Possible Exit Strategies, Journal of Corporate Real Estate Vol 1 No 4*

19 Case studies examined in our examination

NHS Estates sales	Method and purpose of sale	Price excluding any overage terms (£m)	Completion date
Archway Wing, Whittington Hospital	Priority purchase Mainly health educational expansion	£2.5	October 1998
Barnsley Grove Hospital, Bromsgrove	Competitive tender (15 offers) Residential development	£10.4	March 1999
Learning Disabilities Unit, Stoke Park Hospital, Frenchay	Competitive tender (10 offers) Residential development	£13.5 (phased two years)	March 1998
Winwick Hospital and grounds	Competitive tender (12 offers) Residential development	£13.0 (phased three years)	December 1998
Claybury Hospital and grounds	Competitive tender (13 offers) Residential development	£15.5	April 1998

NHS trust sales	Method and purpose of sale	Price excluding any overage terms (£m)	Completion date
North site (various buildings), Hillingdon Hospital Trust	Competitive tender (10 offers) Residential development	£4.8	August 1999
Truro Ambulance Station, Westcountry Ambulance Services Trust	Private treaty Extension to adjacent non-food retail development	£0.8	December 1998
Residential properties, New Cross Hospital, Royal Wolverhampton Trust	Public auction, priority purchase, competitive tender (part leaseback) Residential ownership rationalisation	£1.9 (all sales)	January - March 1999
Nurses home, Old Lambeth Hospital	Competitive tender (20 offers) Residential development	£3.8	August 1999
Scott Hospital, Plymouth Community Trust	Priority purchase Regeneration Budget and Health Action Zone development	£1.4	December 1999
Pelsall ambulance training centre, W. Midlands Ambulance Trust	Competitive tender (10 offers) Residential development	£1.1	February 1998
Staff accommodation, Royal Oldham Hospital Trust	Competitive tender (4 offers, open to housing associations only) Sale and leaseback plus capital improvements	£1.5 (plus £0.4 capital funds)	June 1999
Birch Hill Hospital (land), Rochdale Healthcare Trust	Competitive tender (10 offers) Residential development	£2.2	May 1998
Three land plots, Central Middlesex Hospital Trust	Private treaty Commercial development	£2.8	February 2000

15 Work done in addressing the second of these two areas informed our thinking but is not referred to specifically in the main text of our report. Our advisers drew particular attention to the value in good systems of:

- proactive estates strategies based on the overall objectives of an organisation and the integration of real estate professionals in mainstream organisational business planning;
- effective financial incentives, including capital charges for the use of property by owners of assets;
- clear accountabilities and responsibilities for rationalisation of the estate, to include review of usage and disposal arrangements, focused clearly on corporate goals; and
- exploring scope to establish teams which bring together scarce specialist skills to operate across

units within an organisation and regional call-off contracts for key advisers, for example selling agents, to limit tendering costs.

Survey of local planning authorities

16 To obtain a perspective from local planning authorities on the quality of liaison with NHS bodies on disposal programmes and specific sales with an impact on the statutory planning regime, we also asked our advisers to undertake a telephone-based review of 13 selected local planning authorities. These were chosen judgementally, with a deliberate bias towards local planning authorities where our advisers considered that there might be particularly good practices in evidence.

17 The key outcomes of this work are fully summarised at paragraphs 2.31 and 2.32, and Figure 12 in the report. It involved the following local planning authorities: Leeds City Council; Bradford City Council; Sheffield City Council; Gateshead MBC; Middlesborough MBC; East Hampshire District Council; Hampshire County Council; Oxford City Council; Oxfordshire County Council; Salford City Council; Kent County Council; London Borough of Camden; and the London Borough of Bromley.

Focus groups

18 To deepen our understanding of the practical issues facing parties involved in the management of surplus property, we ran three focus groups, which were facilitated by Oxford Brookes University, with a representative of NHS Estates Head Office and ourselves present as observers. Rather than attempt to bring together representatives of all parties in one group, which we considered would be unwieldy, we decided to run groups limited to representatives from each of the following interest groupings:

- **Group 1:** an NHS group comprising representatives from a range of acute, community, mental health and Ambulance Trusts, and NHS Estates regional offices. This group discussed: disposals and strategic management; property markets, techniques and information; and relations with other strategic bodies.
- **Group 2:** a group comprising representatives of local planning authorities and a range of strategic housing and regeneration organisations. This group discussed: ongoing strategic co-operation; co-operation and liaison between planning authorities and NHS Trusts; and co-operation during the formal planning process; and
- **Group 3:** a group representative of development companies, legal advisers and selling agents. This group discussed: disposals and developers; disposals and the planning process; and disposals and market conditions.

19 A full list of participating organisations in the focus groups is at **Figure 20.** The groups were run along Chatham House rules and views expressed by participants remain confidential. While no views arising from the groups have been directly attributed in our report, we drew assurance from the outcomes of these discussions that our conclusions and recommendations addressed material concerns and had practical value.

Expert panel

20 To ensure that our developing thinking obtained the benefit of experts in the field, we discussed our plans, fieldwork and emerging findings with an expert panel which met formally three times during the work and contributed to final clearance of the report and its recommendations. Members of the group were:

- Bryan Loder, Valuation Office Agency;
- Tim Cooper, Charles Butters & Sons (Royal Institution of Chartered Surveyors nominee);
- Simon Birch, Head of Planning, Director of Environmental Services, Swindon Borough Council (Royal Town Planning Institute nominee);
- David Tomback, Chief Property Advisory English Heritage;
- Professor Paul Syms, Centre for the Built Environment at Sheffield Hallam University;
- David Gubb, Head of Property, NHS Estates;
- Martin Leigh Pollitt, Land and Property Division, Urban Policy Unit, Department for Transport, Local Government and the Regions; and
- Bridget Riches, Chief Executive, Ravensbourne NHS trust (NHS Confederation nominee).

Acknowledgement to all participants in our work

21 The National Audit Office would like at this point to extend thanks to the many individuals and organisations that helped us in carrying out this examination, including our advisers at Oxford Brookes University: Stephen Walker, Peter Smith, Peter Dent and Professor Martin Avis.

20 Organisations in our focus groups

Group 1	Group 2	Group 2
NHS Estates ■ Northern and Yorkshire Regional Office ■ South East Regional Office NHS trusts: ■ North Staffordshire's Combined Healthcare ■ Exeter and District Community Health Service ■ Blackpool Wyre and Fylde Community ■ Kent Ambulance Service ■ North Bristol ■ Salford Royal Hospitals Acute ■ Good Hope Hospital, Birmingham ■ Oxfordshire Community Health ■ Norfolk Mental Health Care	■ Weatherall Green and Smith ■ Birmingham City Council ■ Kent County Council ■ Dartford Borough Council ■ Mayor's Office, Greater London Authority ■ English Heritage ■ English Partnerships ■ Leeds City Council ■ National Housing Federation ■ Housing Corporation ■ Government Office for the South East ■ British Property Federation ■ SERPLAN ■ Greenwich Waterfront Development Partnership ■ Macclesfield Borough Council	■ Crest Homes ■ Chesterton ■ Dacre Son and Hartley ■ Bigwood ■ Save British Heritage ■ Lambert Smith Hampton ■ S.J. Berwin and Co ■ CAPITEC ■ English Partnerships ■ Beechcroft Wansboroughs ■ Weatherall Green and Smith