

House of Commons  
Committee of Public Accounts

**THE MANAGEMENT OF  
SURPLUS PROPERTY BY  
TRUSTS IN THE NHS IN  
ENGLAND**

Sixty-first Report of Session 2001–02



House of Commons  
Committee of Public Accounts

**THE MANAGEMENT OF  
SURPLUS PROPERTY BY  
TRUSTS IN THE NHS IN  
ENGLAND**

Sixty-first Report of Session 2001–02

*Report, together with  
Proceedings of the Committee,  
Minutes of Evidence and an Appendix*

---

*Ordered by The House of Commons to be printed 17 July 2002*

---

HC 765  
Published on 19 September 2002 by authority of the House of Commons  
London : The Stationery Office Limited  
£10.00

## Committee of Public Accounts

The Committee of Public Accounts is appointed by the House of Commons to examine “the accounts showing the appropriation of the sums granted by Parliament to meet the public expenditure, and of such other accounts laid before Parliament as the committee may think fit” (Standing Order No. 148).

### Current Membership

Mr Richard Bacon MP (*Conservative, South Norfolk*)  
 Mr Ian Davidson MP (*Labour, Glasgow Pollok*)  
 Geraint Davies MP (*Labour, Croydon Central*)  
 Rt Hon Frank Field MP (*Labour, Birkenhead,*)  
 Mr Barry Gardiner MP (*Labour, Brent North*)  
 Mr Nick Gibb MP (*Conservative, Bognor Regis and Littlehampton*)  
 Mr George Howarth MP (*Labour, Knowsley North and Sefton East*)  
 Mr Brian Jenkins MP (*Labour, Tamworth*)  
 Mr Nigel Jones MP (*Liberal Democrat, Cheltenham*)  
 Ms Ruth Kelly MP (*Labour, Bolton West*)  
 Mr Edward Leigh MP (*Conservative, Gainsborough*) (Chairman)  
 Mr George Osborne MP (*Conservative, Tatton*)  
 Mr David Rendel MP (*Liberal Democrat, Newbury*)  
 Mr Gerry Steinberg MP (*Labour, City of Durham*)  
 Jon Trickett MP (*Labour, Hemsworth*)  
 Rt Hon Alan Williams MP (*Labour, Swansea West*)

### Powers

Powers of the Committee of Public Accounts are set out in House of Commons Standing Orders, principally in SO No. 148. These are available on the Internet via [www.parliament.uk](http://www.parliament.uk).

### Publications

The reports and evidence of the Committee are published by The Stationery Office by Order of the House. The Committee’s reports are on the Internet at: <http://www.parliament.the-stationery-office.co.uk/pa/cm/cmpublic.htm>; press notices are at: <http://www.parliament.uk/commons/selcom/pacpnot.htm>. A list of reports of the Committee in the present Parliament is at the back of this Report.

### Contacts

All correspondence should be addressed to The Clerk of the Committee of Public Accounts, Committee Office, 7 Millbank, London SW1P 3JA. The telephone number for general inquiries is: 0207-219-5708. The Committee’s e-mail address is: [pubaccom@parliament.uk](mailto:pubaccom@parliament.uk).

### Footnotes

In the footnotes of this Report, references to oral evidence are indicated by ‘Q’ followed by the question number; references to the written evidence are indicated by the page number as in ‘Ev .....’.

## TABLE OF CONTENTS

	<i>Page</i>
<b>SIXTY-FIRST REPORT</b>	
Introduction and list of conclusions and recommendations . . . . .	5
Identifying surplus estate while ensuring future NHS needs are safeguarded . . . . .	6
Obtaining best value from sales of surplus estate . . . . .	9
Disposal of the retained estate . . . . .	10
PROCEEDINGS OF THE COMMITTEE RELATING TO THE REPORT . . . . .	12
EVIDENCE ( <i>Monday 15 April 2002</i> ) (HC 765-i, Session 2001–02)	
WITNESSES	
Sir John Bourn KCB, Comptroller and Auditor General . . . . .	Ev 1
Mr Rob Molan, Second Treasury Officer of Accounts . . . . .	Ev 1
Mr Nigel Crisp, Permanent Secretary, Department of Health and Chief Executive, NHS Executive; Mr Peter Wearmouth, Chief Executive, NHS Estates . . . . .	Ev 1
APPENDIX	
1 Supplementary memorandum submitted by the Department of Health . . . . .	Ev 23
LIST OF REPORTS PUBLISHED IN SESSION 2001–02	



# SIXTY-FIRST REPORT

**The Committee of Public Accounts has agreed to the following Report:**

## **THE MANAGEMENT OF SURPLUS PROPERTY BY TRUSTS IN THE NHS IN ENGLAND**

### INTRODUCTION AND LIST OF CONCLUSIONS AND RECOMMENDATIONS

1. The NHS in England owns one of the largest estates in Europe. It was valued in 2000 at £23 billion in terms of the cost of replacing the assets as they stand today, or at £76 billion if they were replaced to meet modern standards.<sup>1</sup> NHS Trusts own 95 per cent by value of all land and property held by NHS bodies<sup>2</sup> and in the three years to March 2003 they have estimated that sales of surplus land and buildings could exceed £700 million at existing use value.<sup>3</sup>

2. Policy leadership and guidance on managing the NHS estate is provided by NHS Estates, an executive agency of the Department of Health formed in 1991.<sup>4</sup> It is also responsible for the disposal of the 'retained estate'. This comprises properties whose ownership was not transferred to NHS Trusts as they were created in the early to mid 1990s, and deemed not to be essential to longer term NHS delivery. In April 2001, NHS Estates formally commenced pursuit of a Public Private Partnership to sell the majority of remaining properties, valued at some £400 million in the retained estate.<sup>5</sup>

3. Based on a Report by the Comptroller and Auditor General,<sup>6</sup> we looked at how well the NHS has identified surplus estate, while ensuring future NHS needs are safeguarded, whether the NHS obtains best value from sales, and disposal of the retained estate.

4. Our main conclusions and recommendations are as follows:

- Given the price of land, especially in London, and shortages of accommodation for nurses and other essential workers, too aggressive a disposals policy risks high costs in the future as operational needs change. Estates strategies should therefore pay particular attention to the longer term operational and accommodation needs of the NHS and the wider public sector, and should also consider other options, including leasing the land or buildings.
- In developing and updating their estate strategies, Trusts need a clear view of what estate they are likely to need to deliver services. At April 2001 only 28 per cent of Trusts had developed estates strategies to "exemplar standards". The Department and NHS Estates should ensure that all Trusts, including the new Primary Care Trusts, have such strategies in place by the end of 2002.
- Where property has development potential, it should normally be sold with the benefit of planning permission. The case of Napsbury Hospital, where the value with planning permission was £66 million compared to £10 million without, amply demonstrates this point. NHS Trusts therefore need to ensure that they maintain good contact with local authorities, both to ensure that health care needs are reflected in local development plans, and that they maintain effective relationships with local planners.

---

<sup>1</sup> Qs 145–150

<sup>2</sup> C&AG's Report, para 1.4

<sup>3</sup> *ibid*, para 1.4 and Figure 2

<sup>4</sup> *ibid*, paras 1.10–1.12

<sup>5</sup> *ibid*, paras 1.5–1.7

<sup>6</sup> C&AG's Report *The Management of Surplus Property by Trusts in the NHS in England* (HC687, Session 2001–02)

5. Our more specific conclusions and recommendations are as follows:

- (i) NHS Trusts can retain some of the proceeds of sales, of up to £1 million for most Trusts but up to £5 million for top performing Trusts. Proceeds above these thresholds are available for use within the wider local health economy. To ensure that these funds are spent on NHS priorities, each of the new Strategic Health Authorities should also put in place “exemplar” estates strategies by the end of 2002.
- (ii) A key factor in getting the best price for disposals is having up to date and accurate valuations. On average the sale prices achieved by the NHS exceeded valuations by 32 per cent, and some of the largest differences arose when Trusts did not update valuations. The Department should ensure that valuations are revised in all cases where there is a material change after marketing or if the sale is delayed. They should also make it the norm that clawback is included in all sales where there is potential for development at a later date.
- (iii) The limited information available to us so far provides insufficient assurance as to the benefits of the planned sale of most of the remaining “retained estate”, under a Public Private Partnership deal, and whether the arrangements will achieve an appropriate balance of risk transfer to the private sector. We will look at this deal, which is due to be completed this autumn, on the basis of a further report planned by the Comptroller and Auditor General.
- (iv) Following the planned sale of most of the retained estate and NHS Estates’ trading arm under a Public Private Partnership deal, the role of NHS Estates will be to offer guidance, support and expertise to the NHS. This role may however be insufficient to justify a separate Agency at arms length from the Department. The Department should look again at the cost effectiveness of their plans.

IDENTIFYING SURPLUS ESTATE WHILE ENSURING FUTURE NHS NEEDS ARE SAFEGUARDED

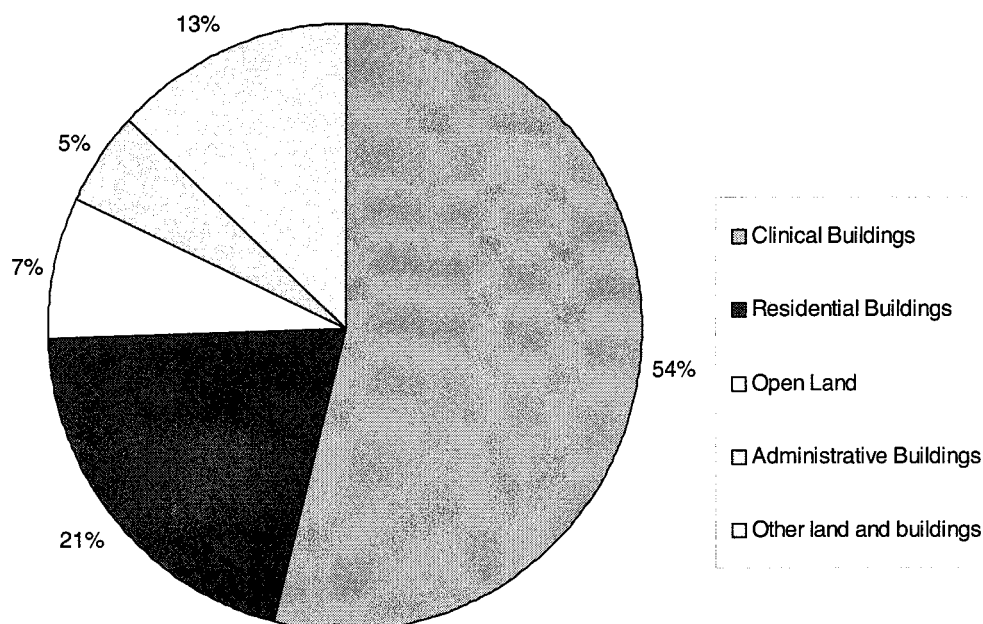
6. The NHS estate in England includes a wide range of land and properties, such as hospitals, clinics, and administrative and residential buildings. Turnover in property assets can arise from changes in patterns of healthcare provision, modernisation and technological advance.

7. In the three years to 1999–2000 NHS Trusts reported receipts from sales of property of some £380 million. A revaluation of assets 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). In the three years to March 2003 NHS Trusts estimated that sales of surplus land and buildings could exceed £700 million at existing use value. The types of property involved are shown in Figure 1.<sup>7</sup>

---

<sup>7</sup> C&AG’s Report, para 1.4 and Figure 2

**Figure 1: Types of property NHS Trusts plan to sell between 2000–01 and 2002–03 as a proportion of total estimated existing use value of £700m.**



8. The Department told us that they oversaw the NHS estate through an overall estates strategy. This looked at assessing what the NHS needed to deliver its services, bringing assets up to good utilisation and high quality so that the estate was fit for purpose and did not have a high maintenance bill. On disposals, the strategy was to retain the core and dispose only of land and property which could no longer be used effectively. Over two thirds of the disposals had been associated with the policy of increasing care in the community and disposing of mental institutions. In this case, even if a 30 year policy of ‘Care in the Community’ were to be reversed, those sites would not be reused as the NHS would build a different sort of asylum. The Department assured us that the price of a site was not a factor in considering whether to dispose of it.<sup>8</sup>

9. NHS Trusts own 95 per cent by value of all land and property held by NHS bodies. Each trust is required to have an estates strategy, and research by the Comptroller and Auditor General found that where one was in place disposals were significantly higher. For example, if Trusts without estate strategies had been able to match the higher rate of disposals of Trusts with them, sales of £116 million might have been brought forward in the three years to March 2000. Moreover, if Trusts without exemplar strategies matched the rate of property disposal of those with them, sales of £102 million would be brought forward in the three years to March 2003.<sup>9</sup>

10. In December 1999, NHS Estates issued revised guidance as an aid to Trusts in developing “exemplar” estate strategies. By April 2001, 82 per cent of Trusts had a strategy in place, and there would have been more but for the organisational changes taking place in the NHS, for example the creation of Primary Care Trusts and the reduction in the

<sup>8</sup> Qs 14, 35, 40, 52–56, 122–127, 151–153

<sup>9</sup> C&AG’s Report, para 2.7

number of NHS Trusts. Of these, only 28 per cent of the strategies met “exemplar standards”, but most expected to meet these standards by the end of 2002. A strong incentive is that investment plans will not be approved unless there is an estates strategy.

11. The Department see the management of the NHS estate as very much the responsibility and role of NHS Trusts, and it is important to ensure that Trusts have the expertise and that their Boards in particular understand the issues. NHS Estates will provide help and support, and will review performance with strategic health authorities and ensure that Trusts review their asset base annually. In addition, chief executives of Trusts now have to sign a controls assurance statement each year to say how they have handled significant infrastructure, accountancy and probity issues including estates.<sup>10</sup>

12. Disposals planned by NHS Trusts in 2000–01 to 2002–03 include 7 per cent open land and 13 per cent of “other land and buildings”. The Department told us that each Trust’s estate strategy should consider whether land might be required to carry out its health care functions in the future, looking 5 years ahead. Strategies should also address issues such as the location of hospitals and the costs and difficulty of travel by patients, and the case for leasing land rather than disposal. For example, for some residential accommodation the NHS may retain the long term leasehold of the land. There were also cases such as the University College London Hospital, where land had been bought through compulsory purchase. The Department had also been looking with the Department of Transport, Local Government and the Regions at how health bodies could be more involved in planning decisions, so that when a development plan is put forward by a local authority, health issues are included so that the NHS can allocate land for its future purposes.<sup>11</sup>

13. We explored one case looked at by the Comptroller and Auditor General of the sale of an unused nurse’s home in Lambeth, which had accommodation for 240 nurses. The Guy’s and St Thomas NHS Trust declared the property surplus and sold it for £3.8 million rather than refurbish it, which would have cost £4 million. We asked why, at a time when nurses could not afford to live in London. The Department told us that the nursing home had not been used since 1993 after fire damage, was in a poor state of repair and was not popular with staff due to its location. The Trust had submitted a separate business case to refurbish the General Lying-in Hospital, with office accommodation and 40–70 residential units, part-funded by the sale of the property in Lambeth. In addition, The Guy’s & St Thomas’ Charitable Foundation was shortly to appoint a partner to make a further 407 units of key worker accommodation available adjacent to the St Thomas’ site.<sup>12</sup>

14. Before selling surplus properties, vendors are required to check with the Property Advisers to the Civil Estate (now part of the Office of Government Commerce), to see whether there is a wider public sector need for the land or property. The Comptroller and Auditor General found that compliance was patchy, and he recommended better notification procedures. The Department told us that it was now proposing to introduce a clearing house, with NHS Estates, for larger properties of interest to other government departments. Discussions would also continue to take place with local authorities to see whether they needed the land, for example for educational purposes.<sup>13</sup>

---

<sup>10</sup> C&AG’s Report, paras 2.5, 2.9; Qs 3–6, 13–17, 30–33, 118–121, 192–193

<sup>11</sup> C&AG’s Report, paras 2.27–2.32; Qs 34–40, 71, 127, 229–231

<sup>12</sup> Qs 181–188; Note by the Department of Health at Q181; Ev 24

<sup>13</sup> C&AG’s Report, paras 3.28–3.29; Qs 170–171

## OBTAINING BEST VALUE FROM SALES OF SURPLUS ESTATE

15. Having identified surplus estate, Treasury guidance is that it should be sold within 3 years. We looked at whether the incentives used to encourage Trusts to dispose of surplus estate protected the public interest and whether Trusts got the best prices.

*(a) Whether incentives to sell surplus estate protect the public interest*

16. Trusts have three main incentives to dispose of surplus estate. The first is to reduce running costs, for example maintenance. Second, Trusts can retain some of the proceeds of sales for re-investment locally. Third, they make savings on capital charges, comprising depreciation and an interest charge attached to all property assets. However, a major review of the management of NHS estate, *Sold on Health*,<sup>14</sup> recognised that depreciation charges on surplus estate were usually low because it was coming to the end of its useful life, and that rather than retaining proceeds within a Trust, projects in the local health economy might have greater priority.<sup>15</sup>

17. Trusts are allowed to retain the first £1 million of any sale for re-investment without the Department's authority, although the investment should be based on a business case. Following *Sold on Health*, however, the Department are introducing "earned autonomy freedoms" to allow top-performing Trusts to retain the first £5 million of receipts from property sales. If Trusts are failing, and where private sector managers are brought in, any proceeds will still be re-invested in the NHS. If sales net more than these thresholds, the surplus is available for use within the local health economy, subject to submission of a business case to the Department. From 2002–03 management of the NHS capital programme will move to 28 Strategic Health Authorities. This will allow proceeds from sales above the thresholds to be available for local reinvestment within these redrawn boundaries.<sup>16</sup>

*(b) Getting the right price for properties that are sold*

18. The C&AG found that NHS Trusts and their agents strove to maximise competition, in accordance with NHS Estates' guidance, achieving prices in most sales which comfortably exceeded valuations. Most sales—90 per cent—are made competitively, sometimes through auctions. This provides assurance that the market has been tested.<sup>17</sup>

19. An important factor in getting the best price is having accurate and up to date valuations. Valuations by the District Valuation Office are also a safeguard against corruption. However, the Comptroller and Auditor General found that prices obtained met or exceeded valuations in 95 per cent of cases, and on average exceeded valuations by 32 per cent. The Department assured us that they required valuations of all property disposals, but that these could be affected by a variety of factors. Following the Comptroller and Auditor General's report, they are looking, prior to marketing, at having a range of valuations dependent on what opportunities there are for the estate. If planning consent is granted or there is another material change during marketing, they will carry out another valuation. Finally, if marketing takes longer than six months, they will do another valuation as well.<sup>18</sup> Where there is potential for further development at a later date, the NHS introduces clawback into the transaction. NHS Trusts negotiated clawback in almost 50 per cent of sales by value in sales between 1997–98 and 1999–2000.<sup>19</sup> Where there are

---

<sup>14</sup> Public Sector Productivity Panel and Department of Health, *Sold on Health*, May 2000

<sup>15</sup> C&AG's Report, para 2.18; Qs 137–141

<sup>16</sup> Qs 73–76

<sup>17</sup> C&AG's Report, paras 7, 3.2–3.5; Qs 82–84, 131

<sup>18</sup> C&AG's Report, paras 8, 3.7; Qs 10, 79–89, 114–116

<sup>19</sup> C&AG's Report, paras 3.24–3.27; Q130

preferred bidders from other parts of the public sector, they have the right to buy the land at the District Valuer's valuation.<sup>20</sup>

20. 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, but might be worth many millions with it, for example for residential schemes.

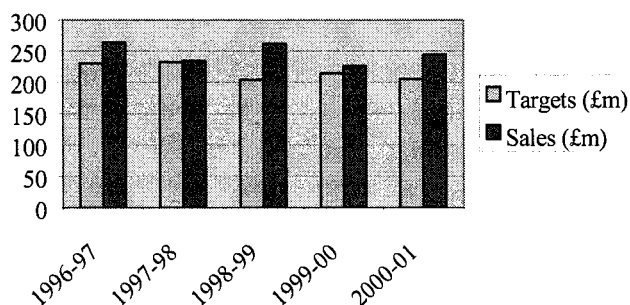
21. NHS Estates' guidance advises that, where a property has potential for development, it should normally be sold with the benefit of planning permission for the alternative use. In negotiating planning consents and related planning obligations, applicants must take account of the statutory planning 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. However, the Comptroller and Auditor General found wide variation in involvement between NHS Trusts and local planning authorities. Over a third of NHS Trusts created prior to the preparation of the relevant local authority development plan (and therefore assumed able to participate in its formulation) indicated that they had not been involved in the formal consultation process.<sup>21</sup>

22. A prime example of the value of gaining permission planning is Napsbury Hospital. Without planning permission the site would have been worth £10 million but with it was valued at £66 million. However, planning permission was only achieved after a protracted appeal and considerable cost, which the Department put at £1.1 million, of which they recovered £300,000. This case emphasises the need for close liaison with local authorities. NHS Estates were putting good practice on their website, and had prepared guidance for local authority officers and NHS Trusts about the relationship between NHS modernisation and local authority development plans.<sup>22</sup>

#### DISPOSAL OF THE RETAINED ESTATE

23. When NHS Trusts were set up in the early to mid 1990s, properties that were surplus or soon to be surplus were not transferred to them; instead they were held by NHS Estates in the so called "retained estate". At its peak, in 1994-95, the retained estate was valued at £1.2 billion. Since then, NHS Estate has conducted a major programme of annual disposals. In total £1.2 billion of surplus estate has been sold, exceeding targets set by the Department and at April 2001 the balance remaining was valued at £600 million, (Figure 2). Since then a further £200 million has been sold.<sup>23</sup>

**Figure 2: NHS Estates' disposal programme in the retained estate has met successive annual targets**



<sup>20</sup> C&AG's Report, para 3.28; Q130

<sup>21</sup> C&AG's Report, paras 2.27-2.30; Qs 45-51

<sup>22</sup> Qs 7-9, 78

<sup>23</sup> C&AG's Report, paras 1.5-1.6; Q21

24. The retained estate had taken some time to sell, mainly because some properties had been occupied by Trusts in the short and medium term. NHS Estates have an incentive to dispose of the estate as quickly as possible, because maintenance costs are around £35 million a year.<sup>24</sup>

25. The remaining retained estate is now subject to a one-off sale through a Public Private Partnership, expected to be operative in 2002–03. This had been outlined in *Sold on Health* and was supported by an independent option appraisal. The options considered were:

- the status quo;
- a one-off sale with a single up front payment;
- a one-off sale through a joint venture with an initial payment plus future payments when development value was realised; and
- a combination of the first and third options, which was the one preferred.

26. The preferred approach also envisaged that the public private partnership would take over NHS Estates trading arm “Inventures”, which offers paid services including advice and support for NHS Trusts and other health clients including bespoke consultancy, property and project services, training and technical guidance.<sup>25</sup>

27. The Department have placed land and property requiring development work into a joint venture. The private sector is taking part in a competitive process and the selected partner will make an upfront payment and further payments (clawback) linked to the maximisation of the development value of a property. The private sector partner will provide development funding and share the risk, for example the cost and risk of obtaining planning consent. At the same time, NHS Estates will continue to dispose of land and property where development potential has already been achieved. Offers were due to be received in May from four short-listed consortia and completion of the sale is programmed for Autumn 2002.<sup>26</sup>

28. The proposed public private partnership raises a question mark over the future of NHS Estates. Following the quinquennial review of NHS Estates, it will retain its policy lead and role in the provision of guidance to NHS Trusts. The Department said it was important to retain central expertise within the NHS, and NHS Estates will be working closely with NHS organisations on important estates matters, such as the design of operating theatres, and how to meet standards for environmental cleanliness.<sup>27</sup>

---

<sup>24</sup> Qs 18–20, 90–92

<sup>25</sup> C&AG’s Report, paras 1.5–1.7; Ev 26-27

<sup>26</sup> Qs 199, 204–205, 211–219; Ev 27

<sup>27</sup> C&AG’s Report, para 1.7; Qs 193–196

MINUTES OF PROCEEDINGS OF  
THE COMMITTEE OF PUBLIC ACCOUNTS

SESSION 2001-02

MONDAY 15 APRIL 2002

Members present:

Mr Edward Leigh, in the Chair

Mr Geraint Davies	Mr George Osborne
Mr Barry Gardiner	Mr David Rendel
Mr Nick Gibb	Mr Gerry Steinberg
Mr Brian Jenkins	Mr Alan Williams

Sir John Bourn KCB, Comptroller and Auditor General, was further examined.

The Committee deliberated.

Mr Rob Molan, Second Treasury Officer of Accounts, was further examined.

The Comptroller and Auditor General's Report on The Management of Surplus Property by Trusts in the NHS in England (HC 687) was considered.

Mr Nigel Crisp, Permanent Secretary, Department of Health and Chief Executive, NHS Executive, was further examined; Mr Peter Wearmouth, Chief Executive, NHS Estates, was examined (HC 765-i).

Mr David Rendel declared an interest in that his wife is a General Practitioner and is on the board of a Primary Care Trust.

The witnesses were further examined.

The witnesses withdrew.

The Committee further deliberated.

\* \* \* \* \*

[Adjourned until Monday 22 April at Four o'clock.

\* \* \* \* \*

WEDNESDAY 17 JULY 2002

Members present:

Mr Edward Leigh, in the Chair

Mr Richard Bacon	Mr George Osborne
Geraint Davies	Mr David Rendel
Mr Frank Field	Mr Gerry Steinberg
Mr Nick Gibb	Jon Trickett
Mr Brian Jenkins	Mr Alan Williams
Mr Nigel Jones	

Mr Tim Burr, Deputy Comptroller and Auditor General, was further examined.

The Committee deliberated.

\* \* \* \* \*

Draft Report (The Management of Surplus Property by Trusts in the NHS in England), proposed by the Chairman, brought up and read.

*Ordered*, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 4 read and agreed to.

Paragraph 5 postponed.

Paragraphs 6 to 28 read and agreed to.

Postponed paragraph 5 read and agreed to.

*Resolved*, That the Report be the Sixty-first Report of the Committee to the House.

*Ordered*, That the Chairman do make the Report to the House.

*Ordered*, That the provisions of Standing Order No. 134 (Select Committees (Reports)) be applied to the Report.

\* \* \* \* \*

[Adjourned until Monday 21 October at Four o'clock.]



# MINUTES OF EVIDENCE

TAKEN BEFORE THE PUBLIC ACCOUNTS COMMITTEE

MONDAY 15 APRIL 2002

---

Members present:

Mr Edward Leigh, in the Chair

Geraint Davies  
Mr Barry Gardiner  
Mr Nick Gibb  
Mr Brian Jenkins

Mr George Osborne  
Mr David Rendel  
Mr Gerry Steinberg  
Mr Alan Williams

---

SIR JOHN BOURN KCB, Comptroller and Auditor General, and DR JAMES ROBERTSON, Director, National Audit Office, further examined.

MR ROB MOLAN, Second Treasury Officer of Accounts, further examined.

## REPORT BY THE COMPTROLLER AND AUDITOR GENERAL:

### The Management of Surplus Property by Trusts in the NHS in England (HC 687)

#### Examination of Witnesses

MR NIGEL CRISP, Permanent Secretary, Department of Health, and NHS Chief Executive, and MR PETER WEARMOUTH, Chief Executive, NHS Estates, examined.

#### Chairman

1. Good afternoon and welcome to the Committee of Public Accounts. We are very honoured today to be joined by Mr Jozef Stayl, who is the President of the Supreme Audit Office of the Slovak Republic. We welcome Mr Crisp, who is going to be talking to us about the management of surplus property by trusts in the NHS in England. Before we start, Mr Crisp, can I raise one point with you. Following our hearings on 19 November and 14 January you promised us notes and we are still waiting for these notes. This makes it very difficult for us to produce our reports. Do you think we could have them?

(*Mr Crisp*) My apologies, Chairman. In fact, you have got all the notes apart from one particular question delivered today. I appreciate that is late, so my apologies.

2. Thank you very much. Would you like to introduce your colleague.

(*Mr Crisp*) Could I introduce Mr Peter Wearmouth, who is the Chief Executive of NHS Estates.

3. Would you like to start by turning to Page 13 of the Comptroller and Auditor General's Report and looking at Paragraph 2.5, where you see that 18 per cent of the trusts had no estates strategy, that is about a fifth. If you go over the page to Paragraph 2.9 you will see that a fifth have still to meet the NHS Estates' exemplar standards. How are you going to ensure that strategic planning improves and when?

(*Mr Crisp*) There are three or four points I would make. The first point is that the very big issue here is are we achieving value for money through the disposals of the estate, and this Report shows that indeed the NHS is doing that, which I think is extremely encouraging. However, we need clearly to

improve some of the processes. The actual facts are that as of April 2000 every trust was meant to have an estates strategy and from that date as well we introduced arrangements for exemplar strategies. At April last year 82 per cent had achieved it, which is the figure to which you are referring. That would have been higher if we had not been involved in some reorganisation at the time, so there are a number of these trusts which are just going out of existence or indeed a number just coming into existence. The same is true at this year end so the figure is of the same order right now. However, I believe we are now entering a period of organisational stability and so our intention is to see 100 per cent by December of this year. In terms of sanctions there are two. The first is how do we help people to achieve it, and that is very much the job of Peter and his colleagues in NHS Estates, where their role is to help and support people in developing the estates strategies. In terms of what we are doing where that is not happening, we have two strategies. One is the traditional management performance process of holding people to account and reminding them of their targets and helping them to achieve their targets where they can, but probably the more powerful role in this particular instance is that people do not get investment plans unless they have an estates strategy. It is a very simple mechanism.

4. Perhaps I could ask Mr Wearmouth to turn to Paragraph 2.14 where we read the NAO "found that only 66 per cent of NHS trusts in our survey complied fully with the guidance." It seems extraordinary that a third of trusts are not following your guidance to review their estate annually. We are talking about a very important subject here. We are talking about possibly one of the largest, if not the largest, estates in the world. I find it rather strange

15 April 2002]

MR NIGEL CRISP AND MR PETER WEARMOUTH

[Continued

[Chairman Cont]

and I am sure my colleagues find it rather strange that such a large number of trusts apparently have no strategy to review their estate. You would have thought that would be the first thing they would do.

(*Mr Wearmouth*) If I can outline when the guidance was actually issued to carry out an annual review of the trust estates and, secondly, look at the timescales and dates that the NAO review took place and then look at the board level report and how we can performance manage NHS trusts in the delivery of estates strategies. Guidance was issued in mid to late 1999 to come into effect in April 2000. This coincided with the NAO survey that was being undertaken. An estates strategy is essentially a five-year forward look into how the trust itself can deliver its assets to provide health care and, as such, 97 per cent of trusts did say in the NAO Report that they had reviewed their estate. We do request in the guidance that was issued in late 1999 that a control assurance statement is signed by the trust accounting officer who acts on behalf of the board to make sure they have done their reasonable best to deliver an estate that is fit for purpose. We will ensure that that is taken forward by performance management and by reviewing with strategic health authorities the performance of NHS trusts in delivering estates strategies. I think we have tried to put in place a strategy that will deliver an annual review by NHS trusts of their asset base. 97 per cent of trusts did state within the Report that they had carried out a review.

5. If you were going to come back here in two or three years' time, you would be able to convince us that you had a successful strategy to ensure that all these trusts have identified property that is no longer required and that they are freeing it up for the wider benefit of the NHS?

(*Mr Wearmouth*) 97 per cent of trusts have undertaken it now. The question is should they undertake it on an annual basis.

6. Exactly. And you will ensure that?

(*Mr Wearmouth*) Yes.

7. Thank you very much. I wanted to refer you next to Section C, Pages 18 to 21, that is liaison with local authorities. I was going to ask a general question about that but since then the question of Napsbury Hospital has come up which is just an example. Mr Peter Lilley has raised this with me. This was a sorry saga where because of lack of liaison with the local authority literally hundreds of thousands of pounds were wasted. I accept that it was not necessarily the fault of the NHS; it was perhaps more the fault of the local authority changing its mind, but what lessons have you learned from Napsbury to try and ensure that this does not happen again?

(*Mr Crisp*) Let me make two points and ask Mr Wearmouth if he might add into that. One of the big things about Napsbury was that it was big and complicated. It was very important that we as the NHS did take it to planning appeal. As you know, at the beginning of the process the land was valued at £10 million and having got the planning approvals it was valued at £66 million. There was at a simple level view a very important lesson to the NHS about being really professional and proficient in our evaluation and assessment. That was a good example of that. The bit that is depressing about this is that it took a

long time to go to a planning appeal at some considerable cost, although we won the planning appeal. Whether getting a better relationship with the local authority and better liaison with the local authority at an earlier date would have made any difference or not, I think it is quite difficult to tell within that. Again, it makes the simple point that the more we in public service are working together on issues and looking together at the issues, the more fruitful it is. Those are the two general points. We must be extremely professional, as we were, and, secondly, we must work better with the local authority. On the specifics Mr Wearmouth may be more familiar with the example.

8. It is always better to proceed by way of practical examples. If there had been better liaison with the local authority, how much money could you have saved on planning issues? The figure I have been given is that up to £800,000 was wasted in this process in one hospital.

(*Mr Crisp*) The figure I am going to give you is the same one. £1.1 million was the cost of the planning appeal and we got £340,000 back. So you are right.

9. Can you give us reassurances about the future in terms of better liaison with the local planning authorities?

(*Mr Crisp*) You cannot legislate for every case. There are personalities and individuals and individual circumstances and so on. This Report from the National Audit Office reinforces the importance of NHS/local authority relationships. It does say that most trusts—and again I will try and bring Peter in here—have a good relationship and they do work together. Some of the recommendations are saying, effectively, that 100 per cent of NHS trusts and 100 per cent of local authorities need to be in close liaison all the time, which is probably unrealistic given the fact that many trusts and NHS organisations, PCTs, will not have large estates disposals or planning issues all the time, but when they do—and Napsbury is a classic example—you need to have prepared the ground for some time. We do give people very clear guidance around that. Can I leave the slightly more general point to Mr Wearmouth.

(*Mr Wearmouth*) I think it would be true to say on Napsbury that it cost the NHS £800,000 but the site was valued at some £66 million as opposed to the £10 million it was valued at if we had not gone to appeal. That might not be the right answer in terms of joined-up government but it does show that the NHS was right in trying to achieve value for money by going to appeal in that particular situation. If I can look at how we work with local planning authorities, this particular Report is focused on estates and town and country planning matters. It would be true to say that we do need a close relationship between our local authority colleagues and delivering the health and social care agenda. Although the NAO Report did state that around three-quarters of trusts reported moderate to good contact with local town and country planning officers within local authorities, there is a need to bolster that and ensure that we do have a better working relationship. It is not just at local area, it is at regional area and on the national scene. When property has become surplus for the NHS and the NHS wishes to dispose of it, it follows

15 April 2002]

MR NIGEL CRISP AND MR PETER WEARMOUTH

[Continued

**[Chairman Cont]**

a different procedure than it would normally follow in delivering health care services. There is a Green Paper on planning that is in preparation at the present time. It states clearly there is a need to update the town and country planning process. It does point out that local authority town and country planning officers feel they are over-stretched and in some instances we have undertaken work in development briefs to assist them in bringing forward land sales for disposal. We are taking on board the points that were raised in the Report about good practice and putting this on a website and we have prepared some guidance for local authority officers and NHS trusts about the relationship between NHS modernisation and local authority development plans.

10. Thank you, Mr Wearmouth, for that very full answer. When my colleagues are asking questions, just try and keep the answers a bit briefer if you can. It does not matter so much for me but they are time-limited. Thank you for your consideration. Can I ask Mr Crisp about these out-of-date valuations. This is mentioned particularly on Page 24 at Paragraph 3.8. Obviously this is going to affect what the NHS gets on sales and it is quite an important point. If you look at Paragraph 3.7 on Page 23, on average, sale prices exceeded valuation by 32 per cent. What do you plan to do to make sure that valuations reflect the true worth of surplus NHS property?

(*Mr Wearmouth*) We do require valuations of all property disposals before marketing commences but, as the Report states, there can be instances where these valuations become out of date. What we agreed to do is to accept the Report and we are looking at (prior to marketing) having high and low valuations dependent on what opportunities there are for the land. During marketing if planning consent is granted or there is another a material change, we will look at carrying out another valuation. Finally, if marketing takes longer than six months we will do another valuation as well.

11. Thank you for that. To wind this up, can you turn to Page 25, Paragraph 3.15. It says there that cutting six months off sales taking over 24 months would have brought forward receipts of £80 million. Can you tell us a bit about the improvements you intend to make in the future to get value for money?

(*Mr Crisp*) Very briefly the context. Firstly, the Report demonstrates that we do get good value for money. Apart from the cases where we have had to give prior consideration, there is only one case where we have not achieved or bettered the district valuer's valuation and that is only by £800. What is noticeable about this group that is referred to here is that what the Audit Office has done is to take those that have taken more than 24 months. Most sales should be done within that period and indeed most sales are done within that period. What happens with those over 24 months is that there are often exceptional circumstances. They may be particularly big sites. Napsbury is an example of that. If you look at the Napsbury example it took some years to sell but in fact the marketing bit of it was only a relatively small part of it. On these complex and longer term sales we need to look at them one by one and in doing that to then pull out the lessons. I do not think the Audit Office is arguing that you could bring forward all of these sales to two years. The maximum date we are

meant to do them in is within three years. It also says in some cases you may not want to bring them forward because that may affect the price. The issue here is let's look at them all one by one and see if there are particular circumstances. In these long and complicated sales, I think they are long and complicated.

Chairman: We had better break there for ten minutes for a division.

*The Committee suspended from 16.21 to 16.27 for a division in the House.*

**Chairman**

12. Perhaps we will start then. Mr Crisp, there has been a very substantial reorganisation and we all have our own constituency experiences. How are you going to ensure that these new strategic health authorities and new primary care trusts are going to be able to handle the estates in the way we would all like so they know the property they have and they are getting the benefit from it as efficiently as possible?

(*Mr Crisp*) There are two things. The first point to make is that NHS Estates still exists and their role is still there to support people and they will be working through into the 28 strategic health authorities around the country. We have got a back-up mechanism. The second point is that this sort of report means that we need to make sure that we draw people's attention to this more than we have perhaps done in the past. This report is useful in doing precisely that. I suspect that as we devolve responsibility more and more to the 300 primary care trusts—they will be the people who will be the primary landowners within this—that we will get more local aspects and much better joined up locally. The strong safeguard is that we have a mechanism which has demonstrated itself in working with NHS trusts that it will work in the new world as well.

Chairman: Thank you very much. Mr George Osborne?

**Mr Osborne**

13. Mr Crisp, people go into the Health Service because they want to be involved in improving the health care of people in this country. They do not really go into the NHS to be estate agents and property managers. Is there a danger that really people's attention in the NHS is not hugely focused on this area of the behind-the-scenes, rather dry stuff of the Health Service?

(*Mr Crisp*) You are absolutely right, that has been the traditional position. I hope the first bit of your statement is the current position, that people are going in there to make a difference to health, but that means that we as an organisation need to buy in support where we can, we need to get support, and we need to build up NHS Estates and other parts of our organisation to make sure that these services are there. The one structural thing we have done that is worth drawing out is we have introduced these new arrangements for controls assurance which is something which chief executives have to sign off at the end of every year saying how they have handled a whole lot of infrastructure, accountancy, probity-type issues. We are putting on chief executives'

15 April 2002]

MR NIGEL CRISP AND MR PETER WEARMOUTH

[Continued

[Mr Osborne Cont]

agendas estates, fire, health and safety, all of those sort of things, which in the rush towards improved clinical services can seem second order, but which are fundamentally important. We have got that structure as to what chief executives are there for.

14. Has there also been a tendency in the NHS to regard selling off assets as like selling off the family silver?

(Mr Crisp) There may have been. It is hard to answer on behalf of the NHS on an attitudinal point. However, we did identify a very substantial amount of estate which we put into this retained estate in the 1990s which was clearly identified as surplus. If you look at the land and property we have been selling off, you will see that most of it is associated with change of policy. A significant amount is about large mental institutions and is where the money has come from. I think that what we have been doing is sensibly restructuring the estate around the new service.

15. It is just that I have read an article and indeed a researcher of mine has spoken to a chap called Mr David Jones, who is the Chief Executive of the Association of Health Asset Management. He says: "Within trusts, precious few people understand asset productivity and those that do understand it do not care. The focus is on 'do we have enough?' rather than 'do we have too much?'" Do you think he is fair?

(Mr Crisp) It does not in the least surprise me that people in the NHS do not understand concepts of asset productivity in any technical sense. People in the NHS at all levels do understand it in the practical sense of trying to get the best out of their beds and their wards and their property and so on. Where we have been getting better is in how we make that happen professionally. That, as I say, is by becoming more professional in how we manage our assets. We do not need everyone to understand the professional detail, we need Mr Wearmouth and his colleagues.

16. In his article in the *Health Service Journal* he says that there is a gulf between the Department of Health's policy and action at local level. "There is a whole section on Estatecode about getting the most out of the asset base, but when you get down to the ground not many people know. It is not a subject that gets to the top of the management agenda. There may be top level interest (I guess he is referring to you) in rationalising the asset base, but when you get down to the ground there is a knowledge and ability gap."

(Mr Crisp) I do not recognise the quotation or recognise what he is trying to do in this particular article or whatever it is.

17. I will buy you a subscription to the *Health Service Journal*.

(Mr Crisp) That is very kind of you. There really are two points here. The first is does the trust board understand it. I do not know whether he thinks that is people at the top or whether that is people at the grass roots, but the important thing is that the trust board is the people who have responsibility for the utilisation of all the assets. The important thing is that we get the expertise there, not lodged in Richmond House but there. I would not expect it to be lodged at the ward sister level. I do not know what this chap is talking about and whether he is saying it

is not even lodged at trust management level. I believe it is increasingly lodged at trust management level.

18. And you are satisfied. Can I turn to another part of this Report. I want some clarification here. On Page 8, Paragraph 1.6 of this Report it says that £600 million as of April 2000 remains as part of the retained estate, ie, the bit that was not given to trusts. Why has it taken so long for the NHS to dispose of it? This was property which at the time five or six years ago was deemed as surplus to requirements and property soon to be got rid of, so why are you still holding on to more than half a billion pounds' worth property?

(Mr Crisp) There are a number of reasons for that. One of them is that quite a lot of that which was declared surplus was still in use for the time being. Whilst they were declared surplus in the period 1991 to 1994 roughly, some of those properties were still occupied by trusts in the short and medium term. There was an element of that that was straightforward. There is also the important point about how we planned those sales both so as not to flood the market but also to provide income over the period. A set of targets was set each year from—and Mr Wearmouth can check for me—some time in the mid-1990s each year we have reached those targets for sales. So actually we have been selling it at the pace we planned to, just slightly ahead of the pace we planned to.

19. How much of this £600 million retained estates are from empty buildings and how much is from places that are still being used?

(Mr Crisp) Can I ask Mr Wearmouth to answer on that.

(Mr Wearmouth) Out of a thousand non operational sites that are identified within the Report, 30 per cent are still actually operational, that is about 300 still operational. We have sold 370 of those particular sites, about 180 are on the market and the remaining 15 per cent are either to be marketed or have other issues that surround them, for example town and country planning issues. Predominantly the majority have either been sold or are still in use.

20. It must cost quite a lot to just maintain them over the years you have been waiting to get rid of them?

(Mr Wearmouth) That is true, that is why we attempt to sell the property as fast as we possibly can.

21. You do not know how much of a cost there has been maintaining these £600 million worth of retained estate?

(Mr Wearmouth) On average the actual costs of consultancy and maintaining them runs at around £35 million a year. Of the £600 million we have disposed of £200 million of that in the last two years and the remaining £400 million is in a one off sale as identified in the NHS plan and we are on the disposal of it at the present time.

22. If I could turn to another issue. I am correct in saying one of the incentives you give to trusts to dispose of property is that they get to keep some of the proceeds of the sale, that is correct, is it not?

15 April 2002]

MR NIGEL CRISP AND MR PETER WEARMOUTH

[Continued

**[Mr Osborne Cont]**

(*Mr Crisp*) For part of the estate. There is a bit of the estate which is surplus which then passes to the Secretary of State but the bit which is retained by trusts, you are quite right.

23. If one of the reasons why the NHS has to constantly juggle its assets is because of changing health needs of the country and the changing health practices, one of the changes will be demographic changes. We are all familiar with the arguments about Central London hospitals for example. Is there not a danger that if you are letting the trust retain the money, does that not defeat the object of trying to allocate the resources elsewhere in the health service?

(*Mr Crisp*) There are two points. On the retained estates, which is the £600 million we were talking about —

24. Yes.

(*Mr Crisp*) — that is all within the Secretary of State, that is national.

25. I understand.

(*Mr Crisp*) In terms of local money, trusts can sell property up to a million pounds without permission. Over a million pounds they have to put a business case to us suggesting how the money should be reinvested so that we have to agree that. Now the money is not automatically reinvested, the money can be moved elsewhere.

26. In paragraph 2.19 of this Report, it talks about your “earned autonomy” trust.

(*Mr Crisp*) Yes.

27. “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 health economy, subject to submission of a business case. This is expected to act as an incentive...”. Do you see the point I am getting at? There are various empty properties precisely because there are not the same health needs in the area. You dispose of them, you get a lot of money and you are just ploughing them into an area which does not have the health needs but it has the cash.

(*Mr Crisp*) I understand the point entirely and anywhere where you shift incentives you shift behaviour a bit. Let me just put it in context. The context is that land sales each year are of the order of £350 million and capital investment is of the order of £3 billion. Actually, whilst we may be shifting incentive and behaviour on a proportion of that £350 million, it is a small proportion of the overall capital investment. I do understand the argument “Why should wealthy X place retain something when actually we have a need elsewhere”. That is why on, whatever that is, 85 per cent of capital investment, we take the view on a national perspective. There is some local incentive but national otherwise.

28. You referred, I think it was you, I cannot remember, in the opening questions from the Chairman to the organisational changes in the NHS which may have delayed the implementation by some trusts of their plans.

(*Mr Crisp*) Yes.

29. Do you have any figure you can put on how much that might have cost the NHS, the delay in getting these plans into place?

(*Mr Crisp*) No, that is not a question that I have asked. If I take the current position, we have a number of new organisations which came into existence at the beginning of this year. They will not be able to say that they have got an estate strategy in place in the sense that we are talking about until they have worked through that strategy of their predecessors and had it signed off by their boards. Now actually they have probably inherited the estate strategy of their predecessor, do you see what I mean? It is the same point that I think Mr Wearmouth has made that actually 97 per cent of trusts have given reports to their boards. You will inevitably have a start up period of a few months before everything has gone through the board in the appropriate fashion. I do not think we will see anything significant in terms of sales delayed by that.

30. It says in paragraph 2.11 that nine NHS trusts in response to the NAO survey “... volunteered information suggesting that pending mergers would delay improvements to their strategies.” Then if you look on the opposite page you can see various projections of the cost of not having an estate strategy in certain trusts. For example, one is looking at paragraph 2.7, a cost of £116 million in the first bullet point and £102 million.

(*Mr Crisp*) Yes.

31. There might be a cost to the organisational change but maybe an unpredicted cost in the implementation of estate strategy.

(*Mr Crisp*) If you look at page 15, which is the one with 2.10 on it, the bottom right hand corner, there are nine NHS trusts without a strategy “... did not say when they would achieve an exemplar strategy”. I am not sure if those are exactly the same nine but I have asked about those nine and I am told that five of those trusts no longer exist, three have strategies and one is in the process of developing a strategy. That is just an example of where the questioning throws up the fact that trusts are about to go out of existence.

32. I will ask the NAO if they are the same nine?

(*Dr Robertson*) Yes.

33. The nine in the diagram are the same nine in 2.11? “Nine NHS trusts in our survey volunteered information suggesting that pending mergers would delay improvements to their strategies”.

(*Dr Robertson*) Yes, they are.

(*Mr Crisp*) Undoubtedly they will be affected by organisational change.

Mr Osborne: No further questions.

### Mr Steinberg

34. I have only got one or two questions, I am not going to take up my 15 minutes here simply because I am not really in sympathy with the Report at all. I am a little uneasy about it all to be quite honest. The Report is written from the perspective of the National Audit Office who are auditors, who are out to make as much money as they can for the Government and for the taxpayer but I look at it a different way. Clearly the National Audit Office in the Report and yourself want to see the maximum sale of surplus property and surplus land. You want to see the receipts coming in because you believe that is an asset that is there to be sold. I can remember in

15 April 2002]

MR NIGEL CRISP AND MR PETER WEARMOUTH

[Continued

[Mr Steinberg Cont]

the 1980s and the 1990s when there was a rush to sell off playing field land and local authorities were forced to sell off their land and ten years, 15 years later, there are some nice housing estates around but there are no playing fields and kids if they go to a secondary school no longer have the privilege of being able to play football or rugby or whatever on fields because they are no longer there, it has happened in my area. I have this great worry that this could be happening here. My question is not only to you Mr Crisp but also to the National Audit Office. How can you persuade me that it is to the benefit of the British taxpayer that we actually do sell all this land without thinking what the everlasting problems might be or what the situation might be in the future?

(Mr Crisp) Which one first?

35. Either?

(Sir John Bourn) The first point to make of course is that the Auditor is not concerned with policy, it is the policy of the Government to do this. It is then for me to look at how well they do it. The second point that I would make here is that we are not in our Report advocating that people should sell off what they might really need. What we are saying is that you should have a proper examination of the property that you own, decide if there is any property that is surplus to your requirements that you are not using, that you cannot see a use for, and then see how that can be released into other economic sectors, thus bringing into the National Health Service the money that is raised. So rather than keep assets in a form that you are not using and do not anticipate a use for, better, given the fundamental purpose of the National Health Service, to translate those assets into resources that you can use for front-line care. That is really from those two points of view how we have looked at this matter.

(Mr Crisp) I agree with that. That is how we have looked at it as well. The key point here is "surplus to requirements". There are a couple of figures I could give you that would reinforce it and Mr Osborne may think it is a reply to his question as well. 71 per cent of sales have been mental institutions and 27 per cent have been replacement hospitals, where we have built a new one and sold off the other, and only two per cent have been others. The sales of land over a five-year period have been very concentrated in those policy areas. We have not been selling off the core and there is an argument that we should be looking more closely at our asset utilisation, as Mr Osborne has said, in that. That is how we have been looking at it. This money is then all re-invested.

36. I appreciate that. Sir John seemed to say that what the Report is saying is that land that cannot be foreseen to have a use in the near future is the land that is envisaged should be sold, but what do you mean by the "near future"? I am not sure you used that phrase.

(Sir John Bourn) No, I did not!

37. What were you actually saying?

(Sir John Bourn) What I am saying is of course that if you think that there will be a use for it, even if you —

38. What is the timespan of whether there is a use for it or not? 10 years, 20 years or 30 years?

(Sir John Bourn) I do not think it is for the external auditor to try and lay down these timespans. What the external auditor can do is say think about this. If there is uncertainty and the possibility of using it within a reasonable period—and it is not for us to say what would be reasonable because we do not know the circumstances of individual cases—what we have said is think about this, think about it carefully because you may have a lot of resources tied up in something that is producing no benefit for the National Health Service. So it is really an encouragement to thought, care and planning.

39. Mr Crisp, how do you judge, if that is the case, what land may be needed in the near future or far future or whatever? How do you judge that? You were talking about mental hospitals but what about surplus land? In the Report there was a pie chart (I am not sure which page it was on) which gave you a percentage of buildings and land and land was approximately ten per cent.

(Dr Robertson) Open land 7 per cent and 13 per cent "other land and buildings."

40. 13 per cent land, that is even higher. How do you know that that land that you sell off now will not be needed for a new hospital for example in 20 years' time when you will have to go out and buy land probably at extortionate cost rather than keeping it in a land bank when it would have been there?

(Mr Crisp) Let me answer the bigger question and then on the specific technical point bring in Mr Wearmouth. We have to have an estates strategy just as trusts do. We have to look across the NHS as a whole and say where have we got our current estate, where are we currently invested, what money are we going to put in and what is the result that we are going to have coming out at the other end. We have a number of targets on this part of the Report such as making sure that we bring assets up to good utilisation and high quality so that we do not have a huge backlog maintenance bill. Our estates strategy is to do that, to dispose of properties like the one on the front page of the Report, for example, which no longer can be used effectively for what we want to use it for. There is a big strategic set of questions there about what we are trying to do with this huge asset. We have got of £23 billion, and every individual decision needs to be made in the context of that strategy and every individual decision needs a business plan which demonstrates the answers. The answers will be different in different cases. Take this property on the front (which is not land) this property had effectively become unuseable in terms of its use as a nurses' home or as residential accommodation. The more sensible thing to do and what happened here was the property sold and the money re-invested in local services and, indeed, some more residential accommodation. That would fit into this category. I do not think, unless Mr Wearmouth corrects me, that we have a statement that the "foreseeable future" is ten years or 15 years or 20 years. I think it depends on the context.

(Mr Wearmouth) We do not have a statement in that regard. I think it is essential and that is why every NHS trust or trusts should have an estates strategy. What that tries to look at is a five-year forward look at what property, be it land or buildings, it would require to carry out its health care functions. Also we

15 April 2002]

MR NIGEL CRISP AND MR PETER WEARMOUTH

[Continued

[Mr Steinberg Cont]

have been involved with DTLR in looking at the new Green Paper and how we can involve health more in planning decision, so that when a development plan is put forward by a local authority that health issues are included in that development plan so we can allocate land for purposes in the future. We are working very closely with local authorities. The trust itself develops an estates strategy that feeds into that.

41. I will come back to that in a minute. On Page 15, Paragraph 2.10, it is clear from that, as has been mentioned, that a number of trusts certainly have not planned for the future in terms of their disposal strategies and they appear to be being criticised for it in the Report. Also in the Report many trusts have not decided yet what are their most important or what are their least important assets or surplus property that can be sold. They seem to be being criticised for it. I personally would not criticise them for that because my view is that if you make rash decisions on getting rid of land or property you may well live to regret it. What is the old saying? "It is eating no meat." I do not think they should be criticised for that.

(Mr Crisp) May I take the alternative point because I absolutely understand that and we have recently re-looked at what we are saying is surplus to make absolutely sure that there is not something there we can use for extra capacity. If you look at something like Napsbury for which in the end we got £66 million, frankly, we were not going to turn it into something of use to the Health Service in the foreseeable future, by anyone's definition of the foreseeable future—

42. Let me explain why I have gone down this track. As you are well aware, we have just had a new PFI university hospital in Durham at a cost of something like £100 million. For 20 years we argued with both governments that we should have this new hospital and eventually persuaded them that there should be one built. The main stumbling block all the time was where this hospital should be built. They went to York University for surveys, they went here for surveys, they went there for surveys and greenfield sites came up on the agenda here and there. The very site that they have built the new hospital is on spare land on the existing site. What happens if they'd sold that off? We would not be able to build there. We now have a situation where on that site there is now a huge amount of land and I know the trust will want to sell that land. I know that Tesco's have been very interested in buying it. I want to come on to this in a minute regarding planning. If that land has been sold or if this land now is sold that debars you in the future from doing anything else. You have a situation now where the hospital has not got enough beds, frankly, and they may well need to expand in the future. If they sell this land off where are they going to expand? They may make £10 million selling it off but to buy extra land eventually might cost a lot more than that.

(Mr Crisp) What you illustrate is that people have to make decisions. The Napsbury example I gave you—

43. They have to be pressurised into doing something that they are uneasy about.

(Mr Crisp) I hope and believe that trust boards in this country are trying to get the best deal for their patients locally and they are trying to use the assets for the best deal. If you are responsible for something like Napsbury, then I think in a sense it is a no-brainer as to whether or not you sell it and reinvest it. The example you use, it sounds as if the decision was made the right way round, they did not sell off the land.

44. That was not down to the management, it was luck.

(Mr Crisp) I am not going to comment on individual cases because I do not know about it. My point is that people need to make decisions and we have a responsibility to get the best out of the assets we have got and that is what I understand you are holding me to account for.

45. Okay. I did not think I was going to last 15 minutes but I am told I have two minutes left. The one question I want to go back to is the planning issue. This is where I find it a little difficult to accept what the National Audit Office is saying. As I interpret what they are saying, they seem to be saying "Go along to your local authority and have a little fiddle there. Get the heads together and see what you can do". Clearly that is not how you do planning, surely, is it? For example, the one in Durham, the local authority clearly told the trust "Get lost, there is no way that we will give permission to build a bloody supermarket on the site of this land" which might be worth £12, 13 or 14 million. There is no way I would expect the local authority to capitulate on that. I hope this Report is not suggesting that the trust should go along and have this cosy relationship with local authorities where planning could be given for virtually anything they want because it happens to be the National Health Service which wants it.

(Mr Crisp) That is not how we have interpreted it. We have interpreted it as being appropriate liaison with the local authority and not turning up at the last minute with a planning application which they have not heard of and they do not understand and which may have an impact on their local infrastructure and so on. May I just apologise, I quoted you a wrong figure. I quoted you 71 per cent for mental institutions, that is a percentage of hospitals sold, it is not a percentage of the total property sold. Can I just correct the record on that.

46. Can I ask the National Audit Office: what does the Report really mean in terms of this liaison with local authorities?

(Sir John Bourn) It meant what Mr Crisp has said.

47. That is the first time, Sir John, I have ever had such a short answer. You would expect any organisation or any individual who is wanting to build something or develop to talk to the local planning authority. You would not expect a special relationship, that is open to criticism and corruption, surely?

(Sir John Bourn) Yes, but we are not suggesting a special relationship of a kind that could be regarded, as you say, as cosy or as the harbinger of corruption, of course not. Both sides need to know enough about what they are concerned with in order to meet and come to some sensible view of the way forward.

15 April 2002]

MR NIGEL CRISP AND MR PETER WEARMOUTH

[Continued

**[Mr Steinberg Cont]**

48. What do you mean by sensible?

(*Sir John Bourn*) What I mean by sensible is that it is important the local authorities should know about—

49. The local authority would have a local plan and within that local plan certain developments can take place whether it is National Health Service or not the National Health Service. You are not saying the National Health Service should have some sort of priority.

(*Sir John Bourn*) No.

50. Because it is the National Health Service.

(*Sir John Bourn*) No, but I am saying they should be there and their concerns should be fully understood by the local authority and within the local authority's discretion properly recognised, that is what I am talking about. I am talking about sufficient sharing of understanding and knowledge, I am not talking about some overbearing of the law or some underground or underhand set of arrangements, of course I am not recommending that.

51. Thank you, Sir John. Sorry.

(*Sir John Bourn*) No. Fine.

**Mr Davies**

52. Value of the asset base in terms of land lies around trust estates is worth £23 billion, that is correct, and you spend something like £47 billion, do you not, in the NHS. Do you feel that the basic ratio between asset value and turnover is the right balance or have you got any sort of idea how large that asset base should be given you are selling it off at something like £700 million a year, is it not?

(*Mr Crisp*) £350 million a year is what we are selling off. We have been looking at this in estate strategy terms not in terms of a financial ratio but in terms of getting an estate that is fit for purpose for the Service so we do not actually have a financial ratio, I do not believe, that we are aiming for.

53. Tell me, the overall asset management strategy, is the idea, in basic terms, to sell off those assets so the assets you end up with and reinvest are disposable assets which then could be reconverted into land or do we run the risk, as has already been mentioned by other Members, of selling off land once and for all?

(*Mr Crisp*) There are three steps. The first one is to make sure that we understand absolutely what we have got and the condition of what we have got. The condition is a very important point. We have actually had a rising bill for some years of repairs.

54. I am obviously short of time. What I am getting at, when we sell off the £350 million per year of land—

(*Mr Crisp*) Land and buildings.

55.—that money is reinvested.

(*Mr Crisp*) Yes.

56. Are local trusts in a position where they can buy back land or basically is this a once and for all sale?

(*Mr Crisp*) It depends on particular conditions but trusts can also purchase land. This is only looking at surplus land but we may well want to purchase lands.

57. Are the proceeds from the sale of the assets reinvested in assets which then can be liquidised to buy land or are they just used up in depreciating assets, machinery and the like, and we end up with less value and no ability to repurchase land to enlarge facilities?

(*Mr Crisp*) The present use value of the land is £23 billion, of what we have got, and even though the land area has reduced by 20 per cent in five years, the value has increased by 8.5 per cent. We have actually been investing in higher value land and facilities.

58. We have been losing the amount of land. Obviously the amount of land, that value would be a lot more because land is going up very quickly, is it not?

(*Mr Crisp*) It depends on the use for the land. It depends on the planning permission.

59. Can I just ask you about the regional distribution of asset management, if you like. My understanding of this is we are moving from a centralised approach to giving trusts the right to sell land and then to reinvest it, that is correct, is it not?

(*Mr Crisp*) They have always had that right up to a certain level.

60. Yes.

(*Mr Crisp*) For those who get earned autonomy, we are going up from one million to five million pounds which is not a huge sum.

61. Have I got this right: you enable trusts to sell a bit of land for up to a million pounds without a business plan, you said that earlier, that has been redefined to five million?

(*Mr Crisp*) For those who get earned autonomy, and it is not without a business plan but it is without our authority. They have to have a business plan, nevertheless, and be subject to audit in the normal way.

62. Right, that is slightly worrying. What if they get the land worth between two or ten million pounds and split it into two so there are two lots, before we know it, it is going through on the nod on a business plan?

(*Mr Crisp*) They will have corporate governance arrangements and audit which will be there to identify something that is a fiddle if it is a fiddle, if I can put it that crudely. If they are breaking the rules then they have got auditors who should be holding them to account.

63. In terms of the increasing use of land, no doubt you know there are some very steep projections for population growth in London and property prices are growing accordingly.

(*Mr Crisp*) Yes.

64. Clearly if land is sold in London then the price of rebuying that land is more and, secondly, if population growth is going up the health needs are rising. Have you got a strategic solution to this of selling off some of the assets elsewhere in Britain and reinvesting them in London?

(*Mr Crisp*) This Report only deals with half of the equation, it deals with sales, it does not deal with investment.

65. Yes, but what I am getting at, is there a facility for sales in the regions to go to another region?

15 April 2002]

MR NIGEL CRISP AND MR PETER WEARMOUTH

[Continued

**[Mr Davies Cont]***(Mr Crisp)* Yes.

66. What is that? It seems to me it is all ring fenced.

*(Mr Crisp)* Capital investment each year is about £3,000 million. £350 million of that comes from land sales, so land sales is about 12 or 13 or 14 per cent of the total investment and only that 13 or 14 per cent is directly subject to local decision in the way that we are talking about.

67. What percentage?

*(Mr Crisp)* £350 million out of £3,000 million, but the other £2,650 million is subject to decisions effectively from the centre. Some of it is for routine maintenance across the country which is spread differentially across the country and some of it is for investment. That is why, for example, we are able to invest in heart surgery in the North West where we need it.

68. Have you brought land nett in London given that there is a projected increase in population and that we will need more land?

*(Mr Crisp)* The only property I am personally aware of is the London Heart Hospital which you are looking into which is not land but expensive property in the centre of London. I am not sure as to whether we have purchased land apart from some land swaps around Paddington of which I am aware.

69. At a time we know the population is growing and we also know from Page 24, Footnote 10 at the bottom of the page, which is very illuminating, that not only is there an escalation in the price of land generally but particularly in London, and since the current Government have moved forward on the use of brown field sites, it is obvious that in the future the price of land will go up and up and up and instead of holding back and selling at a higher price, which would be a rational maximisation strategy, we are selling it off cheap in the knowledge that we will want more because the population is going up. This Report seems to suggest that we are managing the assets sensibly. It seems to me that it is dire.

*(Mr Crisp)* Let me answer that two ways. Firstly, this Report does not attempt to look at purchases and therefore I am not briefed on the question so do not take it from me that we have not been buying land in London—

70. Can I ask your colleague. I assume I am right in saying that in London there is not a net purchase of land at this time? You could buy land and you could sell it down the road much more sensibly.

*(Mr Crisp)* We are also not allowed to speculate. You ought to understand that as well.

71. It is not about speculation, it is about sensible financial management. Mr Wearmouth?

*(Mr Wearmouth)* All NHS trusts in London should have an estates strategy. They look at their five-year forward projection of what land and property requirements they need. Within that, if they need to purchase any land that is put forward. There has been a compulsory purchase of land, for example, to build the UCLH hospital but this is included within the trust's five-year strategy. It is for NHS trusts themselves to identify what their building and land needs are and to come forward with proposals. Any land that was sold off, as Mr Crisp has said, was predominantly large mental

institutions. When we do sell land off such as mental institutions, we discuss with the local trust and the local authority any land requirements that would be needed within the five to ten-year period within the trust strategy or the development brief.

72. I understand that, yes, but my central point is that still we are selling off land when the price is going up when we know that we will need more, which does not seem a sensible strategy. Can I turn you towards this particular point to which you may not have an answer. I understand that the North Wales Hospital used to be a mental institution Denbigh way and was sold off for peanuts—

*(Mr Crisp)* I am only responsible for England.

73. I will not pursue that any further. There have been suggestions by the Government that in the case of trusts being mismanaged that they are then handed over to the private sector or others and alongside that will be the facility to sell off land and the like more flexibly. Perhaps you can illuminate me briefly on that. Are there greater freedoms given to privatised trusts to sell off land once and for all leading to net provision for local people?

*(Mr Crisp)* Firstly, there are not any privatised trusts and, secondly, the proposal is only to buy in management—

74. Not to give them greater freedom to asset strip?

*(Mr Crisp)*—In the same way as we might buy in other services. The freedoms that trusts that earn autonomy have will apply to whatever trusts they are. If you have private sector management in any organisation, you would only be willing once it had proved itself sufficiently—

75. What are the extra freedoms to asset strip, whether it is private or non-private?

*(Mr Crisp)* There is no freedom to asset strip, let me be clear.

76. To sell off land.

*(Mr Crisp)* The freedom potentially to sell assets for re-investment in the business plan within their territory is up to £5 million as opposed to up to £1 million.

77. That is very worrying. In terms of this issue about the cosy deals with planning, I am not quite with this. Is the idea that the health authority goes along to the planning authority and says, "Look, we are thinking of selling this land and we are all together in the public boat. Give planning permission for housing on this, will you, and we will get a load more money"? Is that it?

*(Mr Crisp)* No. It is that the Health Service is a very big property owner locally in every local authority area I would guess and it is very sensible for that property owner to be talking to its planners about what is possible, to be looking at the fact that if we develop something it will put a strain on the roads, and to think about ways you can get the most benefit out of selling something.

78. When you answered the question by the Chairman, you used the example given by another Member where the value went up from £10 million to £66 million. Presumably that was because planning permission was given by the local authority and the

15 April 2002]

MR NIGEL CRISP AND MR PETER WEARMOUTH

[Continued

**[Mr Davies Cont]**

NHS said, "We were not told about this, we want some more money." It was implied that there was some sort of cosy deal.

(Mr Crisp) No, what happened there is the NHS put in for planning permission, it was refused by the local authority, we took the local authority to appeal (not in the least cosy) and as a result got the planning permission that we wanted through the appeals mechanism and as a result the value of land went up from £10 million to £66 million which was then re-invested in the NHS, which is a sensible activity by the NHS.

79. Excellent answer. On Page 24, Table 13, at the bottom of the page Footnote 10 again mentions the reality (that we are all aware of) of a massive escalation of land and property values in London and elsewhere. It is obviously the case that if a buyer of your land agrees a price and you set the valuation at the beginning of the year and then you end up selling it at the end of the year, there is an appreciation and there is a danger that he wins more money. Against that, you have got various clawback facilities. Do you feel the fact that only in 32 per cent of cases the valuation was exceeded by the price illustrates that you are not really getting value for money in the environment of a rising market-place?

(Mr Crisp) Let me just check that this was sales over a period.

(Mr Wearmouth) This is months to completion of sale.

80. What they are saying is that you take ages to sell your property because you have to get a valuation price, agree a price, and then the person with the money drags their heels and keeps the money in a bank account, gets the interest, and gets an asset that has appreciated over time. This is the fear, is it not?

(Mr Crisp) If I take you further down that page, what the Audit Office is actually reporting is that there is no evidence one way or the other that if you had sold it quicker you would have got more money for it. If you look at that bullet point three-quarters of the way down it says: "This would have brought forward receipts of some £80 million, assuming that doing so would not depress the prices achieved", because we do not want a fire sale either.

81. Do you think it is rather strange, given the state of the property market, that in only one in three cases (32 per cent) are more than the pre-sale valuations, when there is often a big gap between the valuation and sale? Do you not think that is rather bad value for money contrary to the rather strange conclusion here?

(Mr Crisp) That sounds to me like you are making a comment on the valuations being made by the district valuer. What other mechanism can we have?

82. You misunderstand me. At the time the district valuer makes the valuation that is a fair valuation, I agree that, but I am saying if it is sold down the line, because of these delays we have seen in Table 13, I am surprised we do not then achieve a higher price in more than one in three cases in a rising market.

(Mr Crisp) Firstly, we ought to be clear that 90 per cent of these properties are sold on the open market and are therefore competitive as well, so that is the other mechanism.

83. Why do you not use the competitive tender? Why not use an auction like we did for the spectrum mobile phone wave lengths, that made loads of money, did it not?

(Mr Crisp) We do with some.

84. If you do an auction over time you would escalate the price rather than fixing it.

(Mr Crisp) Sometimes they are sold by auction. What, again, this document says is that we use different mechanisms within an overall arrangement depending on what the local circumstances are and what the properties are.

85. Finally, is there any evidence of any corruption or collusion at a local level between local estate managers who are negotiating these sales and basically organisations that are buying them? Have you pursued any investigations or do you just assume nothing is going wrong?

(Mr Crisp) No, no. This is part of the point using the district valuation office to make sure that we know what price we should be getting for things but maybe Peter could pick that point up.

(Mr Wearmouth) Yes. The 32 per cent you referred to was the average increase in income we received from the pre-valuation. The pre-valuation is only a guide price so we have received an extra 32 per cent, we did not actually lose 32 per cent. There was an extra 32 per cent received in income.

86. I thought in 32 per cent of cases the price exceeded the pre sale valuation?

(Mr Wearmouth) It did, that is right.

87. 32 per cent increase in value, I am talking about 32 per cent of cases the price was more than the valuation, the others were the same or less.

(Mr Wearmouth) 95 per cent of sales by value exceeded the valuations. In 32 per cent—

88. The same or exceeded 95 per cent.

(Mr Wearmouth) The same or exceeded.

89. 32 per cent exceeded.

(Mr Wearmouth) 95 per cent by value met or exceeded the valuations, the pre-sale valuation for sales. 32 per cent was the average increase in value between pre-sale valuations and sale price.

(Mr Crisp) It was not the number, it was the average increase. Have we got time to just answer the point on corruption?

(Mr Wearmouth) Again, it is down to the controls assurance of NHS trusts to ensure that the correct processes are followed. Also the district valuer does carry out a valuation of properties over five million to ensure that the correct valuation has been achieved.

Mr Rendel: Mr Crisp, may I just start by reminding you, as I always do, that my wife is a GP and also a member of a PCT. She is on the board as an executive.

Chairman: I think, Mr Rendel, that you are a man of the highest integrity and you do not need to repeat this every time. We know your wife is a GP.

Mr Rendel: As long as you are happy, I do not mind.

Chairman: There is no question about this.

Mr Gardiner: You keep declaring it, mate.

15 April 2002]

MR NIGEL CRISP AND MR PETER WEARMOUTH

[Continued

**Mr Rendel**

90. Mr Wearmouth, I think you said earlier that we try to sell property as fast as we possibly can and Mr Crisp said earlier in relation to the question of the £600 million worth of retained property still unsold that part of the reason for that is that it is unsold in order not to flood the market and it is sold according to a plan, so much each year. Those two statements seem to me to be slightly in conflict. It cannot be both going as fast as possible and going according to a plan not to flood the market, which is correct?

(*Mr Crisp*) I understand the point you are making. Part of the reason, as I said also, was to do two things, to stage the sales but also part of it was because some of the land was still being used.

91. I understand that. If it is staged, you cannot be doing it as fast as possible, can you, which appears to be what Mr Wearmouth is saying?

(*Mr Wearmouth*) If you take the Treasury guidance it clearly states that if land has become surplus to operational requirements we need to dispose of it as quickly as we possibly can. There are instances where we may not dispose of a particular piece of property because we may not have the right planning permission or it may be still occupied or there may be other instances where we cannot do that and that is the view in terms of being staged. Treasury guidance is quite clear on this.

92. Staging is surely rather different from waiting until you have planning permission. Maybe I misunderstood Mr Crisp but what I understood Mr Crisp to be saying was that in order not to flood the market you deliberately did not sell some things which you could sell or were ready to sell, you did not sell them in order not to flood the market.

(*Mr Crisp*) I think I did say that and I think actually Mr Wearmouth is giving you the correct representation which is that actually it is mostly for reasons that you can only do it at a certain pace so I think I ought to withdraw that statement.

93. That has got that clarified. What further incentives for sales are going to be introduced? You talked about the possibility of incentives to enable trusts to keep some of the money, are there further incentives?

(*Mr Crisp*) The one significant one was the point made, the ability to reinvest locally going up to £5 million.

94. That has been introduced?

(*Mr Crisp*) That is being introduced.

95. Are there further incentives?

(*Mr Crisp*) I think there will be some others that are looked at but at this moment I am not aware of any that we are specifically doing on that.

96. The slight worry I have about this is that if people know that they are going to get better incentives in a year or two's time, there is an incentive not to sell until the incentive to sell has been introduced.

(*Mr Crisp*) I understand that. Again, if I may just go back to the point about the estate strategy. This is actually about making sure that we do develop a plan for doing this and actually if you are keeping surplus property you are incurring charges while you are doing it so people do have to make decisions as they

go on. People have a capital charge against land or property that they are not using and increasingly we need to come under scrutiny by you and others for making sure we use it.

97. Do you accept that in practice it will be best for all concerned if you say just what incentives are going to be introduced and introduce them as quickly as possible rather than saying "If you wait a bit, you do not know, you might get a bit more for yourself. Okay, you may have to pay property charges meanwhile but you will have to judge whether that is worth it or not in terms of holding off and perhaps getting more for yourself later on"?

(*Mr Crisp*) I understand that but, again, let me come back to the point that actually the big asset sales are on the retained estate or where we are replacing a hospital. Small asset sales are generally pretty small beer. They are not the biggest issue for us in asset management.

98. They may not be the biggest issue for you but do you accept that if you are going to introduce incentives then you ought to introduce them as quickly as possible and not say "They may be coming in two years down the line"?

(*Mr Crisp*) In a sense we are not actually even saying that, we are saying that in answer to questions it may be possible that we can look at other incentives. We are not actually saying at this moment, that I am aware of, that we are introducing any new incentives in two years' time. I am telling you a very straight forward answer which is that in looking at a system where we are trying to devolve as much responsibility locally as possible, all kinds of issues may be looked at in terms of that. People may then speculate and all the rest of it, and there is a lot of speculation, as you well understand. We are saying what we are doing.

99. Figure nine on page 17 does seem to indicate a lot of sales coming in in the last month of the year.

(*Mr Crisp*) Yes.

100. I do not quite understand why accounting deadlines will be important. Are they important to the purchaser or to the seller?

(*Mr Crisp*) Again, can I bring Mr Wearmouth in to explain this pattern. I think the answer is both.

(*Mr Wearmouth*) Yes, I think the answer is actually both. If you look at sales, the actual value that you are going to dispose of a property is agreed some months before contract completion. The actual income that is identified here will take place at contract completion. The value will have been known some time before the graph indicates incomes coming in to the NHS or the number of disposals which have taken place. We will know the income. There is no reference within the document to say that value for money was not achieved. We have carried out a review and looked at the graph to see if it has any issues—

101. You are not quite answering my question. My question was why does it help you to have that money suddenly coming in in March rather than before March? You set up a deal in, say, September, apparently you set up deals such that you do not pay until the following March. Why do you always insist

15 April 2002]

MR NIGEL CRISP AND MR PETER WEARMOUTH

[Continued

**[Mr Rendel Cont]**

on payment the following March rather than, say, the following April or any other point? I do not see why you have an advantage.

(Mr Wearmouth) I think the actual income profile of the sale is predominantly down to the private sector and actually paying us before the end of the financial year to meet their income projections and targets financially.

102. What you are saying is that it is the buyer's wish that so much of the money comes in in March as opposed to anywhere else?

(Mr Wearmouth) It is normally the buyer's wish, yes, we try to push it as fast as we can to get the money in as quickly as we can. This graph normally, I would say, would be down to the private sector and their accounting processes rather than the NHS.

103. Do you use that as a negotiating tool? Presumably if they want, so to speak, to shift all the money coming back to you so they make the payment as late as possible, right at the end of their financial year, presumably you might say "Pay a bit more because you are holding up the money for us"?

(Mr Wearmouth) If the sale was protracted and went on for a period of time of course we would have to seek another valuation. We may need to look at a remarketing situation depending on how long the sale actually takes.

104. What I am saying is if you are making an agreement and perhaps signing a contract in September and you agree to allow them to make the largest part of the payment in March, as is apparently happening quite a lot, are you at the same time saying, "In return for us agreeing that you will not pay the final sum until six months later in March, we want to insist on a higher payment of some sort to make up for the interest we have lost"?

(Mr Wearmouth) If we have the sort of arrangement where we have staged payments we do have some compensation, some interest payment that is paid there.

105. You are getting a lot of staged payments and most of the staged payments are through to the end of the financial year.

(Mr Wearmouth) These payments are always made in the last minute of the financial year and this is the practice of the private sector and the property development industry.

106. Are you getting the benefit of that through your negotiations or are you just allowing them to pay late?

(Mr Wearmouth) We do not allow them to pay late. We have the valuation, we agree the valuation, we agree a sale price, the property is subject to the market-place, the market-place determines what the value of that property is. We then conclude the sale through due legal process and we try to achieve payment within the financial year. However, it is predominantly down to the private sector when they pay us for something. We try to pursue them and we try to get the money as quickly as we possibly can, but this graph indicates when normally we receive income and again it is down to the private sector.

107. Is the payment date not specified in the contract or do you just ask them for money and keep asking them and they keep putting you off?

(Mr Wearmouth) There is a payment date when the contract is signed and completion takes place but it is a difficult time. What we are doing here is selling property for the best possible price.

108. Mr Wearmouth, you are missing the point. Either you are setting up a contract in September that says we will be paid in March because the private sector wants to pay right at the end of financial year, and if that is the agreement between you and the private sector, it seems to me that you have the right to say, "If you are not going to pay us for six months we will accept that but in return for that we expect to have an extra £5,000 on the price to make up for the interest we have lost." That may be what is happening. The alternative that seems to be happening is you are saying in September we have got a contract for a certain sum and we expect to be paid that. The private sector says, "Yes, okay, we will pay it to you", and you are hoping that they will pay in November or December but, in practice, year after year you find they always put it off until March. In that situation you are losing out it seems to me by not setting up a contract properly so you know exactly when you are going to be paid.

(Mr Crisp) May I suggest that we give you a written response to this as to whether or not we invoke a penalty or use this in contract negotiations.

109. I would be happy to have a written response rather than no response, but I am quite surprised that you cannot tell me now.

(Mr Wearmouth) If contract completion is delayed we would expect extra monies.<sup>1</sup>

110. If completion is delayed beyond what you say. The fact you are being paid so often in March either means you are getting extra monies because you expected it in December or it means that you agreed it to be paid in March, in which case you would expect to include that in the contract price in some cases.

(Mr Wearmouth) Yes.

Mr Rendel: I am glad to hear that is the case.

Chairman: If you do a note could we have it some time within the next three months please!

111. Can I ask what happens when a site becomes part redundant. We have a case in my constituency where a hospital has been part redundant for a long time and the part that is redundant is just sitting there until the rest of the site becomes redundant. What guidelines do you give to trusts as to whether they should try to sell off the part of the site that is redundant and get at least half the money early or whether it is better to carry on and wait until the whole site is ready for development?

(Mr Wearmouth) We normally carry out a site development brief in conjunction with the local authority and if we can dispose of part of the site as part of the process of developing additional housing or additional recreational facilities we would carry that forward.

112. So the advice to them is to at least look into it as a possibility?

(Mr Wearmouth) Yes.

<sup>1</sup> Ev 23, Appendix 1.

15 April 2002]

MR NIGEL CRISP AND MR PETER WEARMOUTH

[Continued

**[Mr Rendel Cont]**

113. What about change of plan as to how the site is going to be used. Given that it takes up to five years to develop a site, it may be that the market changes and initially you may have thought the best use is to sell it off as an office site and five years down the track suddenly housing is what is important and the value of the land goes up. Are you flexible enough to be able to change like that halfway through?

(*Mr Wearmouth*) Providing we can get planning permission, yes.

(*Mr Crisp*) It is part of the point of the annual review, which is the point made in the Report.

114. Can I turn to Paragraph 3.7 on Page 23, this is the point that Mr Davies was talking about a moment ago, when 95 per cent of the valuations turn out to be below the outcome price and your average excess price is 32 per cent above the valuation. That is one of the reasons you said you are having problems in getting good value for money out of your sales.

(*Mr Crisp*) Yes.

115. If I had those figures I would go back to my valuers and say, "You are getting your valuations wrong mate", because, frankly, I would expect valuations in general to turn out in the middle of the final outcome and that the average excess would be zero and you would have as many below as above if the valuations were correct. Why are the valuations almost always below?

(*Mr Crisp*) I cannot answer that question. I have no comparisons with district valuers' valuations in other market. No doubt we can find that out. I do note in this Report that the NAO did not think that was unusual in terms of making any particular comment on that. I do not know what the normal pattern is in any other market.

116. Perhaps I could ask the NAO whether district valuers are always bad at valuations. I should say it is not my experience in local government but perhaps it is the NAO's experience. Or is it that the valuations are coming in so much in advance in many cases that they are way out of date by the time the sales are made, which I suspect is the case.

(*Dr Robertson*) I think it is the latter. We observe in Paragraph 3.8 that some of the largest differences between prices and valuations arose because NHS trusts did not update the valuations. That is the biggest factor but we did take up the broad issue of valuation with the Valuations Office and we discuss that in Paragraph 3.10 where they say that their service is providing a reasonable pre-sale guide price but they also commend a move away from single point valuations to take account of uncertainties so that you can take into the picture a wider range of factors. So there are improvements that are possible.

Mr Rendel: Thank you. Thank you, Chairman.

Chairman: Thank you. Mr Brian Jenkins?

#### Mr Jenkins

117. Like Mr Steinberg I probably shall not take 15 minutes either because a lot of the questions at this stage have been answered but I would like to run over one or two things again just to clarify them in my mind. The newly created primary care trusts have to put strategies into place. You have got a lot

experience on this so what guidance are you offering to these new trusts, particularly bearing in mind that on Page 15 we see that in existing strategies with existing trusts a large number do not at the present time itemise their estate so they can tell which is the least operationally important, and therefore we do not know when they sign off what they might need in the future and we do not seem to have a reasonable set of incentives for them to indicate what is true surplus estate.

(*Mr Crisp*) Let me again start the answer and then ask Mr Wearmouth to pick up some more of the detail. The first point is that the PCTs are almost always taking over from an organisation something similar in shape and size so there may well be an estates strategy for them to build on. The second point is about the exemplar strategies which were only brought in in 1999. Mr Wearmouth happens to have here a couple of documents including one which very carefully takes you through step-by-step what is expected in developing an estates strategy. Alongside that there are people from Mr Wearmouth's organisation who are available to help people to do that. Those would be the sort of steps. Firstly, there is almost certainly something already there in existence. Secondly, we have a very clear methodology for doing it. Thirdly, there are people there to help and support them to bring the strategies into existence.

118. 81 trusts do not even know and have not got a strategy for optimal use of resources for their estate.

(*Mr Crisp*) This was mid-2000 and a number of those organisations have gone out of existence and, again, we have moved on since then. We do not have a figure for right now as to how many have got strategies but we anticipate by the end of this year that it will be everybody.

119. My experience shows that the trust goes out of business but the personnel do not, they move from trust to trust.

(*Mr Crisp*) Some, that is right.

120. Are they taking their bad practice with them?

(*Mr Crisp*) Hopefully they are taking their good practice with them. Where people move from one to another, and that was my point about if there has been an estate strategy developed before, we have not lost it necessarily.

121. So if there has been a bad strategy before, we have not lost that necessarily either.

(*Mr Crisp*) That is perfectly fair but the point that I made in answer to the Chairman's very first question is that there are incentives to get your strategy right. One is the performance management, the second one is that you will not get investment unless you have got an adequate estate strategy and that is a strong incentive.

122. I shall bear that in mind when I read the Report. Does price determine what we get rid of rather than operational use?

(*Mr Crisp*) What we get rid of?

123. Not in the retained sector, I know that is quite simple, I know how to deal with that. I am more interested in this residual part, the smaller part albeit. Does price bear an implication on where you decide which part to get rid of?

15 April 2002]

MR NIGEL CRISP AND MR PETER WEARMOUTH

[Continued

**[Mr Jenkins Cont]**

(*Mr Crisp*) There is a process the estate strategy goes through to look at what assets you have got and whether you are making full use of them in the first place, clinically, and secondly whether the money that is tied up in them, including the maintenance cost on keeping them redundant, you can invest that money better. Now in that sense the value of the property does play a part because it is part of what you are calculating in.

124. So you may get rid of a very good operational unit which is in a prime site to reinvest that money into a less prime site?

(*Mr Crisp*) No, my first point was that you first of all look at what you need operationally. Therefore, if you have got a good and well functioning hospital, clinic, whatever it is, of the right size that is being used in that clinic well that is what you stay with, that is what the estate strategy starts with. What do you need to deliver your services? That is the first point, that is the starting point, and that overrules everything else. Having established that there may be some property surplus after that the way in which you deal with that may depend on what it is, how much it is costing you to keep it and how much if you have a very expensive asset that is tied up there that is doing nothing for you, that is not operationally useful, whether you can use that money better. It is at the second level. The first point that people are looking at is can we deliver today's service with the facilities we have got now. This is not about selling the hospital in an expensive area and moving to a cheaper area.

125. If I was to tell you of a hypothetical case where two hospital units within a town were shut down and a new one was built on a greenfield site and the old hospital buildings were in such an appallingly difficult state to maintain that the developer who bought them refurbished them and said that the structure, the building, was so good that they did not have to bother maintaining it, it was built by the Victorians, but the reason it was sold was to maximise the income of development land, both sites being used for housing, and the investment taking place in green belt land, would you be surprised at that outcome?

(*Mr Crisp*) I would be surprised unless you had missed out an important part of that argument which is that the two hospitals were not providing the service that was needed by the local population. That is the starting point. Are these hospitals providing the service for the local population? That is the starting point. If after that you end up deciding you need a new replacement hospital then you make the decisions about disposal. It is that way round. You do not get rid of the hospitals because they are on an expensive site.

126. Yes. I think it was suggested that the cost of refurbishing the existing hospital to bring it up to the modern standard was far less than building a new hospital but the sale of the land would have been of benefit at that time because the price of buying the agricultural land was so cheap that they might be able to make a profit.

(*Mr Crisp*) This is all very, very hypothetical. I hear lots of anecdotes about the NHS all the time and my experience is they are worth investigating and

looking at properly. If a developer is telling you this story, I wonder why the developer is telling you this story? If I was presented with a case like that I would like to see the facts because what you are describing to me is extremely unlikely. We start off by looking to see whether or not the Service is providing the services needed and only subsequently then look at what is surplus.

127. Unfortunately as a business, as the health service, you look at your bottom line and do not take into consideration the cost imposed on the public by having to travel to a hospital in a green belt area.

(*Mr Crisp*) I do not think that is true either. Though this is not what the subject is about, planning services, it is very important in planning services that we take account of all those issues as well as the clinical ones.

128. I think Mr Davies asked a question about salami slicing and you said it would not be in the rules but if I had an estate and I knew I could sell off a million pounds without seeking permission and the surplus was five or six million, I would have no difficulty going to my board and my accountants and explaining that we now seem to have a little money back here and I can salami slice the estate up just under a million pounds per year for the next five years and I would be within the rules. Since I have to reinvest the money on the estate itself, improving the provisions of the members of the public locally, the incentive will be there to do it, so what is to stop them?

(*Mr Crisp*) The mechanism again, as I said, is that we have a framework and set of rules and we have methods for checking up whether or not people are following those rules, including quite simply the local auditors. We can actually ask for an investigation, we can look at it. What you have described implies that the only other alternative to that would be to make decisions centrally about relatively small disposals of land. We have very carefully worked out a strategy which has gone through the Treasury Public Services Productivity Panel whereby we put in place a very clear set of frameworks and rules and these are managed locally in the appropriate fashion and we have checks through audit.

129. I have got no difficulty with people selling surplus land, surplus assets, I do not want to see a million pounds, five million pounds is no problem at all as long as the money is reinvested and gives an incentive for people to maximise the facilities for the benefit of the people and the public. I have got no difficulty doing that at all.

(*Mr Crisp*) Good.

130. When you answered the question about corruption and the district valuer giving you totals for figures, did I hear you say that the district valuer goes back and checks on the site at any future time to ensure that the site sold did not acquire a new value very shortly into its future under new ownership which meant that the NHS could have and should have assumed a higher price for that asset?

(*Mr Wearmouth*) What we have when we carry out property transactions is we normally have advisors which could be the district valuer or could be local property planning or legal advisers. The transaction takes place. If it is felt there is potential for further

15 April 2002]

MR NIGEL CRISP AND MR PETER WEARMOUTH

[Continued

**[Mr Jenkins Cont]**

development at a later date we introduce claw back into the transaction. 50 per cent of the transactions you will see have had claw back introduced into them which actually ensures that at a later date if further development is actually achieved on that site and the value would have been more than we would have originally got, we receive a percentage of the extra over and above what we received for the original transaction.

131. Excellent. When you have a sale, do you have a list of preferred purchasers? Do you work with people in areas or is it just open competition?

(Mr Wearmouth) There are a number of competition routes to follow but normally if it is for housing development it would be a tender process and it would be open to the market-place. There would not be any preferred purchasers. The only preferred purchasers we have are other government departments, other NHS trusts or people who have a right under the Housing Act.

132. So there is no preference or giving first refusal to the county council or the local authority.

(Mr Wearmouth) As priority purchasers they would have the right to purchase at the price of the district valuer's valuation.

133. Which would be a bargain, would it not!

(Mr Wearmouth) The district valuers value it at the value we should have sold it. The issue we have got to remember is it is being transferred between one public sector organisation and another public sector organisation. If we moved it into the private sector it is subject to the market to ensure that we get best value.

134. But my recollection of the district valuer was that they always set a value on the project that should be expected to be met in the market-place. In fact, I can never ever remember an occasion when the value was lower than the value the district auditor set. Would you say that is your experience as well?

(Mr Wearmouth) The true test of value of any property is subjecting it to the market-place.

135. But an open market-place, a market-place where the purchaser gets full information and where bids can be accepted in an open manner?

(Mr Wearmouth) That is right.

136. So it takes preferred purchasers?

(Mr Wearmouth) The only preferred purchasers are the local authorities and other government departments. The rules that we follow are that the district valuer's valuation will be the valuation we use to transfer between one government department and another.

Mr Jenkins: Thank you, Chairman.

Chairman: Thank you, Mr Jenkins. Nick Gibb?

**Mr Gibb**

137. Do you think that capital charges are sufficient to give incentives for efficient use of capital assets?

(Mr Crisp) I am not sure they are absolutely sufficient. They certainly do give an incentive and they do make people look at how they are using capital assets as well. In many cases I think they do change behaviour.

138. How are they devised? What is the basis for them?

(Mr Wearmouth) There are two elements of capital charges. One is a depreciation element on the value of the asset and the second one is return on investment of that particular asset, so there are two elements.

139. The return on asset is what percentage?

(Mr Wearmouth) Six per cent.

140. What is the value basis of the asset that you use?

(Mr Wearmouth) It is based on the district valuer's valuation every five years.

141. The same article that my colleague George Osborne was citing gives the example of Hairmyrs and Stonehouse Hospital Trust. They had derelict land worth £4 million on the open market but they bore an annual capital charge of £22,000. Why is there such a discrepancy between the open market value of £4 million and the capital charge of £22,000?

(Mr Wearmouth) We would have to look at that in further detail. There would be no depreciation element on the land because it is not depreciating. The only element would be a six per cent return on £4 million. If there were this discrepancy we would have to go and have a look at it.

142. Would it be possible to have note on that? It does seem extraordinary. You would expect a five per cent increase on the value of that land every year at least, maybe more, so the incentive would be to keep it and not to dispose of it. Can trusts sell capital assets and then reinvest the money in long-term financial assets and then use the income from those financial assets?

(Mr Crisp) Effectively, trusts can gain income from money in the bank but there is a very, very restrictive range of uses that you can put money to in financial assets. You are talking about can we buy stocks and shares?

143. Anything that is long term, not speculation. I get the impression sometimes that there is too much capital spent in the NHS and too little revenue spending. We hear examples of plush, brand spanking new hospitals being built but with wards closed because they cannot afford to staff them. The incentive would be to sell a bit of capital, stick the money in the bank and use the income to employ nurses instead of building that extra wing.

(Mr Crisp) I cannot give you the exact chapter and verse but that would not be something we would normally expect trusts to be doing—to be using money for long-term investment in financial markets.

144. So if they do not have any need for a new building there is no real incentive to dispose of surplus land or to declare it as surplus other than these capital charges?

(Mr Crisp) Trusts can build up some assets. It is at the margins is the short answer that I am giving you. There are very few trusts in the happy position that you are talking about to be able to do that.

145. Is the notion of the £76 billion replacement figure for NHS stock the same as the market value in that sense?

15 April 2002]

MR NIGEL CRISP AND MR PETER WEARMOUTH

[Continued

**[Mr Gibb Cont]**

(*Mr Wearmouth*) No, the replacement value is the value you would replace it as you would have it today. If we were replacing it in relation to new NHS buildings we would have a different arrangement, extra single bedrooms, additional waiting areas, or better facilities, for example, in front entrances. The £76 billion is to replace NHS hospitals to the standards we would expect today.

146. So £76 billion is a higher value than the market value of the properties?

(*Mr Wearmouth*) That is right.

147. What is the market value then of the properties? Presumably it is higher than the £20 billion?

(*Mr Wearmouth*) The replacement figure is £23 billion. The market value is not undertaken. We only value properties at market value when they are coming forward for disposal.

148. They would presumably form the basis of the calculation of £23 billion.

(*Mr Wearmouth*) The £23 billion is the replacement value of assets as they stand today. £76 billion would be to replace it to modern standards introduced to the NHS. The open market value (which is the disposal value) is something that we only take a valuation on when a property is offered for disposal.

149. So how do you calculate the £23 billion if you do not have reference to the open market value of land?

(*Mr Wearmouth*) It is calculated by the district valuer every five years.

150. So it is, in effect, a market valuation?

(*Mr Wearmouth*) If we are buying hospitals it is.

151. £350 million sales out of £76 billion is only 0.46 per cent, less than half a per cent of turnover of assets. Is that a normal turnover figure in large organisations with large property portfolios. Is that in line with that, less than that or more than average?

(*Mr Wearmouth*) When the Public Services Productivity Panel carried out their review looking at the disposal of NHS surplus properties and also when the NAO carried out their review, they involved private sector organisations, property developers and people who had large portfolios and they identified that we were carrying out the best practice and that we were using best practice whether this was the public or private sector. It would be difficult to say if that does compare to the turnover of property that would occur in other organisations because other organisations are different to operating health services, for example the retail sector or the leisure sector. What we could say is that there has been a high turnover of our assets over the last five to seven years which generated in the NAO Report over £1 billion worth of asset sales, but when a property—this would be outside of London of course—comes on the market its open market value can be anything up to 50 per cent of its hospital value because we have to seek development potential to change it from a hospital into something else.

152. Okay. I think that is an answer. Going back to this mental hospital issue, you said that 71 per cent was not the figure so presumably it is some other percentage, but what happens if there is a change of

policy by government and they say “care in the community” is no longer our policy and there should be large institutions catering for people with mental problems? What happens then?

(*Mr Crisp*) We are venturing into care in the community more widely. It was 71 per cent of hospitals or mental institutions.

153. What is the actual figure?

(*Mr Crisp*) I think there are two things. As you know, very many of these big hospitals that have been disposed of, even if you were to reverse 30 years of policy, you would not use those ones, you would build a different sort of asylum.

154. Can I just ask, Mr Wearmouth, what is your property experience and qualification in managing a large property portfolio?

(*Mr Wearmouth*) Actually I am a Chartered Engineer. I actually worked within the NHS for a number of years and I managed a number of property disposals in the NHS. For the last five years I have managed the property disposals within NHS Estates which was initially examined by our colleagues in the Audit Office and a number of examples brought forward as best practice. I was the author of *Sold on Health* which was a Public Services Productivity Panel Report which was accepted by Ministers in the Treasury and in the Department of Health. I actually was responsible for preparing the development of an estate strategy. The NAO Report on Disposal of NHS trusts that you have today pointed to much good practice which had been identified within the NHS and it has all come about, I believe, through the work of NHS Estates and the NHS locally and estate managers locally in grasping this particular situation.

155. Mr Crisp, is it not rather odd to have somebody in charge of a £76 billion worth of property who is a chartered engineer and has five years' experience in property management?

(*Mr Crisp*) Not firstly if he is good at it, as he is, and secondly if he has got access to the best professional advice when and where he needs it. I think the document he has referred to, *Sold on Health*, which was produced for the Public Services Productivity Panel, makes it clear that we should put in place a sensitive and appropriate framework and then we should buy in expertise locally. I am very pleased with it.

156. A final question to you, Mr Crisp. You said earlier in the session that this Report is useful in bringing these issues to the attention of the trust.

(*Mr Crisp*) Yes.

157. Which is a doubled edged kind of statement really because in effect you are saying that the Report is a useful management tool.

(*Mr Crisp*) Yes.

158. I see this Report not as a useful management tool but rather as an oversight tool by Parliament. My question really is this: are there any other areas of the NHS management which would benefit also from the use of such a tool? It seems to me if you are relying on this as a tool, which it should be an oversight tool, that you are relying too much on management tools which really are not yours.

15 April 2002]

MR NIGEL CRISP AND MR PETER WEARMOUTH

[Continued

**[Mr Gibb Cont]**

(*Mr Crisp*) I do not think I intended to imply that it was my audit in that sense of an audit, that I had asked for or wanted to use it as a management tool either locally or nationally. I was merely commenting on the fact that this sort of study does raise to prominence particular issues.

159. Should you not have raised these issues to prominence already which really is my point?

(*Mr Crisp*) I think the documents that Mr Wearmouth has been showing to you indicate that we have. I think this Report itself does show that we have documents on developing estate strategy, we have got the *Sold on Health* approach, we have got a clear estates strategy nationally and all those sort of mechanics.

160. It is a very useful tool.

(*Mr Crisp*) It is helpful. It is not the purpose of this document, as you quite rightly say. It is a purpose for you to take oversight and to hold me to account financially.

161. Are there any other areas of management which you think would benefit from an NAO report we have not prepared?

(*Mr Crisp*) Certainly not.

Chairman: I did not think you would answer that one. It would be very interesting information if you could tell us which assets of the Department the NAO should be investigating. I think we are unlikely to get very far on that. Mr Barry Gardiner.

#### Mr Gardiner

162. Mr Crisp, could I ask you, the Oxford Brookes Report, which did a survey of 94 per cent of the trusts, has that given you a complete picture of the NHS assets and surplus assets in the country? Are you satisfied that you have as complete a picture as you are likely to get?

(*Mr Crisp*) It slightly relates to the last point in that this is a Report prepared for you and that is a survey carried out on your behalf. We collect information also on the estates through the normal mechanisms. If I was looking for detailed information on some part of the estates I would be turning to Mr Wearmouth and see what information he has got, to which the Oxford Brookes Report might be something that he might refer. I would not see it as the definitive vehicle for us in any way.

163. What I am concerned about, I hope I am not going to have to be concerned about it but I want to probe, is that you do have a central overview of where your property surplus is. Let me give it to you in economic terms. If you were looking at the economic management, the financial management of the trust, you would say that there was a prudent level of balances or reserves that should be carried. What I am wondering is do you have a prudent level of surplus land that at any stage the NHS should be carrying for future development?

(*Mr Crisp*) We have a number of indexes that we are interested in such as, one I keep mentioning I am afraid, backlog maintenance. What is the state of it, how much of it is of a certain age, how much of it is fit for purpose according to certain categories. We do not have a figure that says for overall within the NHS we should have X amount of land that is surplus to

current requirements. I think we have used quite a stringent definition of surplus to requirements so we have not got anything which says we should be carrying a certain amount of surplus. That is right, is it not, Peter?

(*Mr Wearmouth*) Yes. We do collect information on a yearly basis from NHS trusts in their annual accounts and their estates performance data. What we do at the centre is we evaluate, for example, their building to land ratios and we produce a number of ten key indicators that look at space efficiency but also look at capital charges and the ratio of land to buildings to equipment and we compare these across the country with various trusts of a similar nature so it gives an understanding of how efficient a trust is actually undertaking its management of its estates. We look at its asset productivity, the quality of that particular estate, its deployment and what it costs us to actually run. We do carry that out at the centre. We have an idea at the centre of every NHS trust's ratios so we compare like with like.

164. Yet you do not have, as it were, a reserves figure that you would apply locally?

(*Mr Crisp*) A reserve figure in the sense of saying "We know that we are carrying 10 per cent of our property that we are not using and what it costs is a sensible amount for us to be carrying" is that what you mean?

165. Yes, that is right.

(*Mr Crisp*) We do not, I believe, do that. I actually think that would be quite difficult to measure, to determine ten per cent of what, if you see what I mean. Are we talking here about land, are we talking here about reserve bed capacity?

166. No, we are talking about land.

(*Mr Crisp*) Talking about land, no we do not keep that figure.

167. In the same way that, for example, the Department of Culture, Media and Sport is looking to produce a Doomsday Book that sets out all the capital assets that it has, that the nation has, as a bedrock for seeing where they should be investing and doing different things, you do not have that then for your estate assets? What you have is you have individual local views that you can amalgamate?

(*Mr Crisp*) No, I think we do have what you just described but it does not include within it a statement that we are going to carry ten per cent of spare capacity. I do think we have a picture of what we need in Service terms.

168. If I asked you to break down for me by local authority across the country a picture of the identified surplus land by each NHS trust in that local authority you would be able to do that for me?

(*Mr Crisp*) We could get access to that data, could we not? Yes.

(*Mr Wearmouth*) Yes.

169. Thank you very much. Could I ask you to provide that to the Committee.

(*Mr Crisp*) That might be a very large undertaking. Before I reply absolutely can I check how much work that will be to do and then come back to your Clerk.<sup>2</sup>

Chairman: Absolutely.

<sup>2</sup> Ev 23, Appendix 1; and Ev 29, Appendix 1, Annex A.

15 April 2002]

MR NIGEL CRISP AND MR PETER WEARMOUTH

[Continued

**[Mr Gardiner Cont]**

170. Can I take you to Annex 1 and Paragraph F it says “NHS Estates should work in partnership with other government departments on new initiatives to facilitate better inter-departmental guidance for local authorities.” What I am interested in here is the very first part of that which talks about the inter-departmental working but not so much as it relates to guidance to local authorities. You will remember, Mr Crisp, that you were a member of one of the highest level series of witnesses we have ever had when we were studying an NAO Report into obesity. You were there, the Permanent Under Secretary for Education was there, as were a whole series of chief executives and so on. When you are looking at your assets in terms of which are surplus, is there any work that is done cross-departmentally on identifying where other departments might work with you where they have a need for land assets and where—and I am talking simply about inter-governmental sales here—those would specifically achieve targets which you in the NHS have? I am thinking very specifically about the obesity report. One of my colleagues, Mr Steinberg, referred earlier to the sale of school playing fields and the loss of those, which is proving not only a problem for the Department for Education but of course for your own Department in the tremendous rise in obesity that we have seen this country and which that particular Report has looked to. Have you discussed with the Department for Education ways in which land you have identified as surplus might be able to be used to provide playing fields and sports facilities for schools and other departments? Mr Wearmouth referred earlier to the fact that there is a group of priority purchasers and certain terms which we talked about for purchasers which include other government departments. Can you tell us about the mechanics of that and how it works?

(*Mr Wearmouth*) We accept the NAO’s Report that we should do more in relation to priority purchasers at a government level. We are proposing to introduce a clearing house with NHS Estates looking at large properties that would be of interest to other government departments. The reference was to should we have local playing fields and when hospitals are coming up for disposal should we be involved at local level. Of course, that discussion takes place with local authorities as part of the process that we have and the discussions that we have with them.

171. With respect, that is the wrong person on the whole for it to take place with because with the devolved management to schools local authorities and the Department for Education are often not responsible now for those sorts of decisions for secondary schools within their catchment. Within my own authority there are only two secondary schools that you would be dealing with through the local authority, all the other 13 you would not. The reason I asked Mr Crisp to prepare that information about the breakdown for this Committee is because I believe it is important in looking at how we responded to the previous obesity report, that we are able to use this to do exactly that sort of matching. I think it is important that Parliament can see where objectives which this Committee has clearly identified in different reports might be able to be

matched and come together. Whilst I appreciate it might be a body of work and it might be quite costly to do it, I think the benefits of it could be quite substantial if we were able to do some matching.

(*Mr Crisp*) I will see how easily we will be able to do that. I hope we will be able to do that. I understand the point. I echo Mr Wearmouth’s point about the strategic health authority, level which is the bigger level, looking for example at North West London.

Chairman: You will do what you can to help.

172. In response to Mr Rendel you disavowed your remarks that sales were staged to stop the flooding of the market and hence depression of prices. What I thought Mr Rendel was going to go on to say is what are you doing to ensure that you do not depress prices by flooding the market? I think it is a fair question to ask you that.

(*Mr Crisp*) Again, I am going to turn to Mr Wearmouth. Let me be clear that the normal Treasury arrangement is that we should dispose of surplus property within three years. That is the arrangement that we should live within. That gives you a little bit of scope for making sure that you get your timing right within that, but in general we have to sell it as quickly as possible. Mr Wearmouth, I do not know if you want to respond in more detail?

(*Mr Wearmouth*) We do follow Treasury guidance. I am not aware of any instances where we have depressed property prices within any of our disposals.

173. So what you are saying is that so far the problem has not arisen. What it would be fair for this Committee to ask you then is what policy or strategy do you have to check that it does not arise?

(*Mr Wearmouth*) As we mentioned, if we had a true test of valuations to the market-place and the market was depressed and we did not receive value for money, we do have a second valuation undertaken by the district valuer when the prices for the property in disposal have been opened.

174. I am having difficulty hearing you.

(*Mr Wearmouth*) We have a process where when we seek competitive tenders for property disposals the tenders are reviewed not only by ourselves but by the advisers and by the district valuers themselves or an independent valuer to ensure that we have got value for money.

175. Let’s not misunderstand one another. What the valuer will do is tell you that in a current market situation that is the price you are likely to achieve for that particular sale. Of course, that will take account of how much property is available in the market. What I am asking you, though, is what strategy do you have to make sure that the price the valuer is giving you, which may well be correct, is not depressing the market? I understand that it may be the correct price given the flow-throughs onto the market at that particular time the laws of supply and demand being such, but what we are trying to establish is that you are not supplying too much to make sure the price goes down.

15 April 2002]

MR NIGEL CRISP AND MR PETER WEARMOUTH

[Continued

**[Mr Gardiner Cont]**

(*Mr Wearmouth*) If we had a number of large sites like this the guidance is quite clear, we want to discuss this with our colleagues. What we could do is look at developing parts of sites rather than the whole site and releasing it on a phased basis.

176. Finally, I thought that Mr Rendel's wife might not be a doctor but a dentist because he eventually extracted from you that March payments if delayed would attract a penalty. I just want to check that there is not a chink we are going through here and that we are not misunderstanding one another. Could you confirm whether sales completed in different months have different lengths of time before final payment is made on them? For example, perhaps it would be standard in most months of the year that, let's say, 80 per cent of the contracts concluded stipulated that it had to be within three months. Can you confirm that when it is a March final payment that does not drop below the standard percentage of 80 per cent down to 60 per cent so that what we are looking at is a genuine like-for-like over time and there are not extended credit facilities built into contracts that conclude in March. That was not something that you specifically answered.

(*Mr Wearmouth*) If a contract had been delayed and completion had been delayed then we would expect extra monies. The issue for us is that when a number of contracts are exchanged or there are a number of sites taking place, there are different circumstances and what the NAO said is that there are different requirements at different stages.

177. Do not misunderstand me. I understand that if the contract is delayed there will be penalty payments. What I am asking you to confirm is that contracts where final payments are due in March are not concluded on a substantially different basis to contracts where final payments are due at any other time of the year, such that at any other time of the year you might have three months until final payment whereas when it comes in March it might be four months. I am wanting to know that the contracts are concluded on a like-for-like basis throughout the year.

(*Mr Wearmouth*) Yes, they are.

178. So your response is that they are the same and there is no differential in the time before final payment for contracts that are concluded in March?

(*Mr Wearmouth*) Value for money has been achieved on all sales whatever time of year they have been sold. Actually, are you talking about timescales or value for money here? This is what I am slightly confused about.

Mr Gardiner: I am not quite satisfied here. I thought I had got a definitive answer from you. Please let me just be clear that it is a definitive answer. That is that all contracts are concluded on a like basis when it comes to the period between signing the contract and final payments such that any contract that is concluded throughout the year will always have, let us say, three months between signature and final payment so that there is absolutely no difference from one contract to another. Is that correct? I am not saying it is three months.

**Chairman**

179. Do you understand the question and can you answer it?

(*Mr Wearmouth*) Yes, I do understand the question, Chairman.

180. Right, well then a brisk answer and we will move on.

(*Mr Wearmouth*) Yes.

Chairman: Yes. Thank you. Is that all right, Mr Gardiner?

Mr Gardiner: Yes.

**Mr Williams**

181. You told us earlier this photograph on the front of the book shows a nurses' home that was sold in Lambeth two and a half years ago for £3.8 million. What nurses' accommodation was built with that £3.8 million since we know there is a desperate shortage of nursing accommodation?

(*Mr Crisp*) Let me just find the figure.

182. Which figure?

(*Mr Crisp*) I have a note on this. I need to find you the answer.

183. Were any nurses' homes built?

(*Mr Crisp*) Yes.

184. There were.

(*Mr Crisp*) It was something associated with Guy's Hospital and the London Lying In Hospital that was converted into accommodation for staff as a result of using part of that money.

185. How many?

(*Mr Crisp*) The point of the question, it was a smaller number of residential units which were provided than were in that bid.

186. How many did this originally accommodate?

(*Mr Crisp*) That was the figure I was trying to look for. I am sorry I have not actually found the page. 240.

187. How many did you rebuild?

(*Mr Crisp*) It has got accommodation, because I think part of the project is still going on, of up to 70.

188. 70, so we lost 170?

(*Mr Crisp*) Yes.<sup>3</sup>

189. Pity in a way, is it not, when we are so desperate for nurses' accommodation and they cannot afford to live in Central London? Right, let us move on to the NHS Estates. When was that set up?

(*Mr Wearmouth*) I will have to look it up.

190. Approximately.

(*Mr Wearmouth*) I think it was approximately ten years ago.

191. How many?

(*Mr Wearmouth*) Ten years ago?

192. Ten years ago. Yet we still find only 82 per cent, as Mr Gibb has pointed out and others have referred to, 82 per cent of trusts have an estate strategy?

<sup>3</sup> Ev 24, Appendix 1.

15 April 2002]

MR NIGEL CRISP AND MR PETER WEARMOUTH

[Continued

**[Mr Williams Cont]**

(*Mr Crisp*) The definition of an estate strategy was only prepared the year before that. There was not a requirement on trusts to have an estate strategy ten years ago.

193. That makes it worse, does it not? That actually makes it worse. You only thought of getting it that recently. What on earth have you been doing in the mean time? Is not the reality that you have no confidence whatsoever in NHS Estates?

(*Mr Crisp*) No.

194. In that case, how do you explain paragraph four which points out, on page two, "... a Public Private Partnership initiative, expected to be operative ...." from this current year "... with a property portfolio worth up to some £400 million". If we go then to paragraph 1.7 on page we are told a Public Private Partnership will be "... to sell the majority of the remaining properties in the retained estate and to take over the Agency's trading functions". What do we find the Agency is left with "NHS Estates will itself retain its policy lead and role ..." I must say that fascinates me as a full time occupation "...in regard to the provision of guidance...". Well, we had better hope it is better than the guidance they have given in the last ten years, had we not? The reality is there is no reason for this organisation to exist at all is there now? You have passed a vote of no confidence in it, why on earth are you keeping it?

(*Mr Crisp*) Right. Well, let me attempt to go back ten years. Over this period the decision was made as I understand it to create NHS Estates to group together the expertise that was available within the NHS to make sure that we did some of the things that we talked about earlier, about raising the profile and the management skills and the professionalism of how we handled estates matters over the last ten years. You can see a number of things have happened over that period, including the fact that for the first time ever, in I think 1988—

195. With respect, you know I am time limited. Will you answer my actual question. What is left to justify keeping that organisation in existence?

(*Mr Crisp*) I think I have to answer first of all that I have confidence in NHS Estates and that they have achieved a whole series of things which now it is appropriate that we ask other people to do. Organisations change and move like that. What they will be doing in the future—if you are asking me that—is they will be working much more closely on the thing that is absolutely central to what we do in the NHS which is looking after patients.

196. There you will be giving policy leads and to whom? Are they giving policy leads to the Private Public Partnership?

(*Mr Crisp*) They will be working very closely with NHS organisations on all those important policy matters like how you design an operating theatre, what are the requirements you need for an operating theatre, how you make sure that you meet the environmental cleanliness health and safety standards which are much more strict in hospitals than they are in other sorts of properties. Where else would we get that expertise than from a body that is actually accustomed to working and dealing with hospitals? There is a core set of things which it is right

we keep centrally to help and support people working in the NHS. There are a whole series of other things which as these various reports done, commissioned in part by NHS Estates, show that we can work more effectively by involving the private sector in disposals or whatever else. There are certain things which it is very important that we keep as expertise within the system.

197. Can I tell you I hope my colleagues are a lot more convinced than I am by that answer. Tell me, what is this Public Private Partnership needed for? You have been selling properties up to now and suddenly this body is to be created with a £400 million portfolio. Now you are hoping to sell £350 million a year, are you not? What is this Public Private Partnership for? Why is it needed and, more importantly, what is it going to cost?

(*Mr Crisp*) The reasons for establishing it have been about making sure that we do all the things that I just talked about which is to make sure that we make the best use of both our own expertise but actually the expertise that is out there in the market. It has been established—

198. Why do you not get a good agent or a consultant, why do you need a Public Private Partnership? Why a Public Private Partnership simply to undertake a fairly normal operation where there are plenty of bodies in existence, namely selling property? Why do we need suddenly this new gimmick?

(*Mr Crisp*) The big point about it—and then again let me ask Mr Wearmouth if he will fill in some of the details—is that actually this is about making sure that we get the best deal. The view that we have taken is that this will maximise the incentives both for whoever our private partner is to get the best deal and for the NHS.

199. What is a private partner going to be contributing? What is the partnership? Tell me what it is about; what form will it take and what it will cost and how much it will save of your costs?

(*Mr Wearmouth*) The NHS Estates was subjected to its five year quinquennial review like any other agency and actually the review did highlight the good work the agency had undertaken.

200. That is why they are getting rid of you.

(*Mr Wearmouth*) I would refer you to the five year quinquennial review of the NHS Estates Agency. What came out of the quinquennial review is that NHS Estates should focus on the core activities of delivering health care and ensuring that buildings were fit for purpose in delivering that health care.

201. You have been talking about a public-private partnership and I am asking why it needs to be in that form.

(*Mr Wearmouth*) It also suggested that we look at the public-private partnership for NHS Estates' trading activities, which were predominantly operationally based to deliver services to NHS trusts. Therefore our agency was looking two ways. Firstly, it had a responsibility to deliver policy, set standards and guidance and hold the system to account and, secondly, to offer operational consultancy services to the NHS. What the public-private partnership is

15 April 2002]

MR NIGEL CRISP AND MR PETER WEARMOUTH

[Continued

**[Mr Williams Cont]**

about is moving those particular staff where their skills would be best served in delivering it through a private-public partnership.

202. I am sorry, it is not about moving staff, it is about £400 million of portfolios. What is it going to do that you could not do more cheaply by other means?

(*Mr Wearmouth*) If I move on to the second point—

203. I was hoping you would get round to the main point.

(*Mr Wearmouth*)—Which is the £400 million sale of assets. There are a number of arrangements which you could arrive at with the private sector, and this is a complex transaction that is going to involve a joint venture where we bring to the table the expertise of the Health Service and our private sector partners, as they have always done in the past, bring private sector expertise to the table and develop our sites with us.

204. You are putting £400 million of capital in. What are they putting in?

(*Mr Wearmouth*) They are going to purchase the properties and there will a clawback arrangement in place where we will share in the benefit of the added value that the private sector can bring to property disposals.

205. Okay they buy it, if they then sell it, who gets the proceeds of this money?

(*Mr Wearmouth*) There has been an open marketing period to bring forward bidders for this particular process. The actual sale of the property will be no different to the sales that take place at this time.

206. Will the subsequent sale be a private sale or will it be an NHS sale?

(*Mr Wearmouth*) The subsequent sale will be a private sale because—

207. Why do we need a partnership? What on earth is the partnership for? Mr Crisp, this is a policy issue, it is not fair for Mr Wearmouth to answer this.

(*Mr Crisp*) The reason for the partnership, as you say, is that we had £400 million of land to sell and there are a number of options for doing that. Having worked through all those options, the view that was taken was the one that Mr Wearmouth is describing, which was to set up a body which managed those sales on our behalf. As you say, they become private sales but we also retain an interest in the income that comes from them.

208. How?

(*Mr Crisp*) Because that is the contractual arrangement between us and our partners.

209. What will the terms be?

(*Mr Crisp*) As far as we are concerned—

210. I am astonished that here we are dealing with the management of surplus property in the NHS and you have got a nebulous scheme that the Committee cannot understand (or at least I cannot) from the description that I have had from either of you that is now going to be taking over responsibility for £400 million of public assets. I want a full and comprehensive report on this to this Committee and

I want it within time, none of your three months' wait for a reply. We want a reply within two weeks. What is it going to cost?

(*Mr Crisp*) Let me come back and give you a full report if that is what you want.<sup>4</sup> We have looked at the different options for doing this and this is the option that provides best value for money in our view to the NHS, and we can go through all the arrangements of that. The reason that we are being partly vague on this is that the terms are being negotiated, but I think the principles are clear, the principles are that the NHS will benefit from enhanced value for these sales as a result of setting this up.

211. There is one further point—and I am sorry, Chairman, I realise I have slightly overrun but I think you will agree the witness has not exactly been terribly forthcoming or has been rather circuitous in getting to answer this—in what position will this Private Public Partnership stand as compared with, say, a trust when it is looking for planning permission in relation to property? When it is sold to them—your colleague said it is going to be sold—will everything already have planning permission or is it going to be sold to this partnership without planning permission?

(*Mr Crisp*) The mechanisms will be the same as we employ today, it depends on the particular piece of property.

212. Yes but you see at the moment the trust technically owns the property and therefore gets the planning permission so are you saying now that this Public Private Partnership, nebulous beyond description at the moment, will have this property and will assume it at values based on value with planning consent or without planning consent?

(*Mr Crisp*) I am not being obtuse, this depends on the individual piece of property. The point about the relationship is that if planning permission is subsequently achieved then the NHS benefits from that as well.

213. This is a final point, it is very important. The whole process of privatisation of hospitals and NHS land has involved an implicit corruption of the planning process. I had a nurses' home sold in my own constituency, a placed called Park Beck, associated with my biggest hospital. The Welsh Office issued a circular, which I assume was identical to the one that went out here in England. It said that trusts were to seek to sell whatever property they could. Where possible they were to get funding but seek to sell with planning permission. In the event of their failing to get planning permission from a council they were expected to appeal to the Welsh Office, the same party which is going to judge the planning appeal. That is effectively what we have here but now we have got in the middle of it some strange animal, this PPP. We do not know yet what is going to happen to the incremental value but they are going to be in the middle of benefiting if you have not extracted all the incremental value before you enter into the PPP, is that correct?

<sup>4</sup> Ev 24-28, Appendix 1.

15 April 2002]

MR NIGEL CRISP AND MR PETER WEARMOUTH

[Continued

**[Mr Williams Cont]**

(Mr Crisp) We have got two steps on that. The first one is what you have described. The second one is precisely because it is a partnership the NHS will benefit from any subsequent increase in value before it is sold on.

214. All of it?

(Mr Crisp) The NHS has two bites.

215. 100 per cent?

(Mr Crisp) Not 100 per cent.

216. 70 per cent?

(Mr Crisp) That is part of the negotiations.

217. 60 per cent?

(Mr Crisp) That is exactly the position we are in now.

218. 50 per cent?

(Mr Crisp) It is exactly the position that we are in now, is it not, when we sell to anyone. If then they subsequently sell on at a higher value we need to be able to negotiate with them "Are we having 50 per cent of the places".

219. Your job is to ensure they cannot sell it on at a higher value if possible because you are supposed to have got the proper price in the first place.

(Mr Crisp) You know that there are plenty of places where people have got, by all standards, the proper price and then two years further something odd happens in the property market and people get more for it.

Mr Williams: Chairman, this is an unbelievable shambles and I want a full note on this for the Committee, and I want it as quickly as possible please. Thank you, Chairman.

**Chairman**

220. Can you provide a full note to the Committee as quickly as possible?

(Mr Crisp) I will provide a note on what the Private Partnership arrangement is and why it will provide, we believe, better value for money.<sup>5</sup>

Mr Williams: A full and detailed note!

**Chairman**

221. The Committee would like to know where is the private sector risk in this arrangement?

(Mr Crisp) Okay.

222. Do you want to answer that now?

(Mr Crisp) If you would like that put in the note, we will put that in the note.

223. Well, I think it would be quite interesting to have your comments now.

(Mr Crisp) The private sector risk in this is the fact that they are putting assets into this.

**Mr Williams**

224. What?

(Mr Crisp) They are purchasing this from us as has been described.

225. At what price?

(Mr Crisp) And using their expertise. At the price we might get on the open market now. The point about this is to get better value for the NHS from this arrangement.

Chairman: We are still trying to understand the risks that they are undertaking. It is not entirely clear to us.

**Mr Gardiner**

226. If you refer to Paragraph 3.33 it says that the average cost of sale across all disposals was two per cent of average prices. Of course, what we would have to be able to see is that the PPP arrangements that you are instituting mean that the average cost of sales is going to cost the Department less than two per cent of those sale prices. Certainly from the remarks that Mr Williams and the Chairman have made, it is very difficult to see where that will come and where the risk element that the private sector is bearing here lies.

(Mr Wearmouth) We could provide a full and frank account of this. There have been a number of option appraisals undertaken by international, professional property advisers on what would be the best option to proceed. We are following the best option to proceed and in relation to town and country planning permission, the NHS and NHS trusts are no different to any private sector organisation when it goes to attempt to get town and country planning permission.

**Chairman**

227. There is a full series of studies?

(Mr Wearmouth) Yes.

228. Have these studies been shared with the National Audit Office?

(Sir John Bourn) Not yet but it is a subject which we intend to examine. The whole of this PPP will be one of the subjects we shall be examining.

Mr Williams: On a point of order, Chairman, in view of the unbelievably unsatisfactory and nebulous answers we have received from the witnesses, I hope the Committee will reserve the option of calling them back again if we think it is appropriate when we receive this note, rather than waiting until it has all been set up and happened and we then get a post-dated detailed examination by the NAO. So you may be back here in couple of weeks' time, gentlemen.

**Chairman**

229. We certainly look forward to seeing this note. I am sure Mr Crisp is very happy to assist us in any way he can. There is one last question which is perhaps a bit easier than the last from Mr Geraint Davies, which is a good line of questioning from his constituency point of view and a London point of view about leasing land in London and the ever rising value of land in London. He asks why do not you lease land in London for 20 years so you do not lose it forever?

(Mr Crisp) You mean leasing to other people land which we regard as surplus, whether it is better to dispose of it on a long lease?

<sup>5</sup> Ev 24–28, Appendix 1.

15 April 2002]

MR NIGEL CRISP AND MR PETER WEARMOUTH

[Continued

[Chairman Cont]

230. Do you want to answer that now?

(Mr Crisp) I am not sure I can give you a straight answer—an immediate answer on that.

**Chairman**

231. We only want straight answers! Mr Wearmouth?

(Mr Wearmouth) If we carry out any PFI transaction the land is normally leased on a long lease to the PFI provider, which is the hospital. If we are undertaking any developments that may have future use in the NHS, for example some of the residential accommodation refurbishments that the NAO looked at in the Report, we may retain the long leasehold of the land there as well. It is all down to the specific case on whether we retain it or not.

Geraint Davies: Can I suggest to Mr Crisp that he does look at that option in the future because of the problems we have already discussed in this Committee.

**Chairman**

232. I think that concludes a very interesting session. The press gallery and public gallery are hardly heaving with people but the fact is this is a very important subject. The NHS is a hot political potato. All we ask in this Committee is that you abide by your own guidelines and you maximise the benefits available to the NHS for all of our benefit. I think it has been a very useful session. We are very grateful to you for coming.

(Mr Crisp) I trust we will be able to reassure you when we return with a paper on the PPP.

---

## APPENDIX 1

### Supplementary memorandum submitted by the Department of Health

*Questions 100–109: Where there are delays between completion of a contract and receiving payments, does the Department benefit from compensation (penalties for late payments) or interest payments in such cases?*

It is usual for there to be a defined period between the date of exchange of contracts and completion of a sale. The period may vary but is normally 28 days throughout the year.

In some cases it may be agreed that there would be a longer period between exchange and completion. In these circumstances a higher payment would be expected, the amount depending upon the time period.

These arrangements may also provide for the payment of a non-returnable deposit.

If a purchaser failed to complete, a completion notice would be served and interest at a per cent above London Inter Bank Offered Rate (the rate would be defined in the contract) would become payable on the amount owed. If the purchaser still failed to complete the contract would be rescinded and the deposit monies retained.

*Questions 168 and 169: Can you provide a breakdown by local authority of identified surplus land by each NHS Trust?*

The Committee requested a note setting out NHS properties declared surplus, presented by local authority. This entailed writing to every NHS Trust in the country, including the new Primary Care Trusts, asking them for details of surplus properties, which could then be plotted against local authority boundaries. This information has taken around two months to obtain.

The table at **Annex A** shows NHS property either for sale or that may become surplus by Local Authority area. In some cases a formal decision to sell has not yet been made and in some instances it will not be the whole site. Properties currently under contract to sell have been excluded.

---

15 April 2002]

[Continued

---

*Questions 181–188, and subsequent written question: How much of the £3.8 million proceeds from the sale of Lambeth Nurses Home was spent on nurses accommodation, and how many new nurses units were provided to replace the 240 sold?*

The former Nurses Home was disposed of having been formally declared as surplus estate by Guy's and St Thomas NHS Trust. The London Regional NHS Executive Office, local health authorities and other local NHS Trusts were all consulted prior to disposal and there was no interest in the site.

The building had not been used as a nurses home since 1993 when it was partly damaged by fire. It was in a poor state of repair and was not popular with staff due to its location in relation to the main hospital sites and the need for refurbishment. The estimated costs of refurbishment were £4,000,000.

The former Nurses Home had been leased as office space to the neighbouring Guy's and St Thomas Mental Health Trust. This Trust was undertaking a major reconfiguration programme at the time which was subject to the submission of a full business case. The property was declared surplus when the business case was approved.

Guy's and St Thomas NHS Trust submitted a further separate business case to refurbish the General Lying-in Hospital, a property substantially closer to the St Thomas' site which is held on a long lease. Part of the costs of this will be met from the proceeds of sale of the Lambeth Nurses Home. This business case has been formally approved. The Trust envisaged redevelopment of the General Lying-in Hospital with 40–70 residential units, dependent on final design of the reconfigured units to suit family needs and office accommodation. The office accommodation would enable the Trust to release a further property currently housing their Procurement department. This property is under consideration (please see below) for development by the NHS Housing Co-ordinator, to provide further key worker accommodation when the site can be vacated.

The General Lying-in Hospital scheme has been designed and tendered. It is planned for refurbishment works to commence shortly subject to landlord approval. Part of the costs of the works will be met from the proceeds of the sale of the Lambeth Nurses Home, the proceeds in the interim are being brokered by the Department of Health.

#### *NHS Plan*

The NHS Plan set a target of securing an additional 2,000 residential units in London by July 2003. To date around 1,000 units have been secured through the NHS Housing Moderniser which is project managed by NHS Estates. We are on target to meet the NHS Plan.

In addition the Guy's & St Thomas' Charitable Foundation is shortly about to appoint a development partner to make a further 407 units of key worker accommodation available adjacent to the St Thomas' site.

*Questions 210–220 and subsequent written questions:*

- (i) *Provide a full report on the PPP arrangements—costs, private sector risks etc?*

#### INTRODUCTION

This note describes the background to the Public Private Partnership (PPP) for disposal of the NHS Retained Estate, provides details of the decision to opt for a PPP and sets out proposals for the future of "Inventures", the trading arm of the NHS Estates Agency.

#### BACKGROUND

##### *The Retained Estate*

The NHS in England owns one of the largest estates in Europe. At April 2000, it was valued by the Valuation Office Agency 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.

When NHS Trusts were created, the Secretary of State for Health "retained", rather than transferred to NHS Trusts, properties that were continuing in operational NHS use for a period of time, but for which only a limited short to medium term operational need existed. This is the Retained Estate. The value of the Retained Estate at April 2001 was some £600 million.

The NHS Plan—published in July 2000—announced the disposal of the remaining Retained Estate through a one-off sale. This was outlined within the Public Sector Productivity Panel report, Sold on Health, and supported by an independent option appraisal.

---

15 April 2002]

[Continued

---

### *Policy Background*

HM Treasury policy guidance, *Selling Services into Wider Markets*, states that the Government is committed to increasing the efficiency of the public sector, both through the more effective management and delivery of public services and the fuller utilisation of public assets. To this end the government published the National Asset Register (NAR) in November 1997. At the same time it announced incentives for departments and agencies both to sell off surplus assets and to make the best use of those retained.

### *NHS Estates*

The NHS Estates Agency's role is:

- to ensure optimum use of the NHS estate and facilities management services for better healthcare by advising and supporting SoS, the Department of Health and NHS on developing and delivering a range of policies and other DH work on estates and facilities issues, including building planning and design, the patient environment, capital procurement and professional and technical issues;
- to oversee the operational management and delivery of the NHS Estate and Facilities services;
- the management and disposal of surplus NHS property owned by the Secretary of State and corporately overseeing all sales by Trusts, and
- through its Trading Arm, Inventures, offer paid services including advice and support for NHS Trusts and other health clients including bespoke consultancy, property and project services, training and technical guidance.

### *Progress Since the NHS Plan*

The NHS Plan set out a target of £600 million to be realised through a one-off sale of the retained estate. We have adopted a twin track approach following Treasury guidance and industry best practice by:

- placing land and property which requires development work into a joint venture, where we will receive a base offer for the land and then share development profit with the private sector partner who will provide development funding and share the risk, and
- continuing disposal of land and property where development potential has been achieved (ie, planning permission for housing on old hospital sites).

Income of £280 million was achieved between the launch of the NHS Plan in June 2000 and 31 March 2002.

### THE PUBLIC PRIVATE PARTNERSHIP FOR THE RETAINED ESTATE AND INVENTURES

The public sector works with the private sector through Public Private Partnerships which come in many forms from establishing limited companies, joint ventures, licensing, sponsorship, contracts, leasing and lettings.

This PPP is proposed to be:

- a joint venture for the retained estate and provides a way to involve private sector expertise whilst ensuring the taxpayer receives a fair share of the rewards and, at the same time, protecting public interest, and
- contracts with Inventures providing goods and services to the Department, NHS organisations and other healthcare providers.

### *Option Appraisal*

An independent strategic level option appraisal, carried out by a leading professional practice within the industry, sought to test the merits of various options for releasing the latent value within the Retained Estate through working with the private sector. The options considered were:

- Status Quo—Continuing with the sale of properties individually as and when they become available;
- A one-off sale with a single upfront payment and no further payments;
- A one-off sale through a joint venture with an initial payment plus future payments when development value has been realised, and
- The preferred option—a combination of the first and third options.

---

*15 April 2002]**[Continued*

---

NHS Estates Quinquennial Review in April 2000 concluded that the functions are all necessary, and NHS Estates should carry them out. It went on to say the Agency should, however, focus its efforts on providing direction in meeting the implications of the modernisation agenda, and should divest itself of those elements of Trading activities that are non-core. These activities should be undertaken by the NHS itself or by the Private Sector as appropriate

The option appraisal concluded that VFM was unlikely to be achieved by a one-off sale with no further payments but that the preferred option offered the prospect of worthwhile added value to the public sector over the status quo option. Following the taking of market and customer soundings, having due regard to NHS Estates' Framework Review and the synergy which exists between the retained estate and much of the work carried out by Inventures, Inventures were included within the PPP. In April 2001, NHS Estates formally commenced the pursuit of a Public Private Partnership to dispose of the majority of the remaining properties in the Retained Estate and NHS Estates Trading Activities "Inventures".

#### RISKS AND VALUE FOR MONEY

The private sector is taking part in a competitive process and the selected partner will be making an upfront payment and further payments (clawback) linked to the maximisation of the development value of a property eg the receipt of planning consent. However, it is anticipated the upfront payment will also include an element of "hope value" which would be at risk as there may be delays in resolving uncertainties about the planning position or doubt as to the use which would generate best value, this being whether the value of the site will increase following, for instance, the receipt of planning consent. The onus for achieving this added value will fall to the private sector.

The PPP partner will be under obligation to maximise the value of the properties in the retained estate and will be responsible for all the costs associated with achieving this. They will also be responsible for the costs associated with environmental or contamination work, maintaining and securing vacant sites and obtaining the necessary planning approvals. As these costs, which are estimated to amount to £10 million per annum for the next three-five years, will not be a deductible expense from the public sector, the risk associated with them rests solely with the selected partner.

In order to ensure that value for money is achieved, following receipt of offers a separate exercise involving the District Valuer will be undertaken. This will also ensure government accounting and Estatecode are fully complied with.

#### TAKING FORWARD THE PPP

This PPP, in strict legal terms, is not a partnership but a further Joint Venture in the format of a contractual arrangement. A Joint Venture can describe a range of different commercial arrangements between separate bodies. This will be a more complex contractual arrangement whereby joint inputs from the private sector and NHS Estates are required to achieve the full development potential of retained estate to maximise income. The nature of the agreement will be similar to that which is currently adopted for some existing individual sales. We further propose to secure ongoing interests with Inventures as a simple contract structure as used in the everyday purchase of goods and services. The PPP has therefore been assembled on the basis of the two elements being disposed of together. However, separate offers for each element will be considered if they demonstrate better value for money.

#### CONTRACTUAL ARRANGEMENTS FOR THE RETAINED ESTATE

The Joint Venture for disposal of the retained estate has a number of key characteristics:

- The retained estate is comprised of some vacant and some (currently) operational NHS properties, whose underlying value is considered to be greater for alternative uses (probably achieved by radical physical redevelopment in many cases) once declared surplus and no longer required for continuing NHS uses;
- The retained estate is varied in terms of many factors, such as built form, scale of individual properties, quality of title, planning uncertainty, age, functional obsolescence and location (region and urban/rural);
- "Target" dates for the achievement of vacant possession of individual properties have been set, and
- NHS Estates will continue to be the informed client, retaining skills and experience and the wider perspective of the NHS's needs.

---

15 April 2002]

[Continued

---

#### CONTRACTUAL ARRANGEMENTS FOR INVENTURES

Inventures is looking to establish itself within the private sector and trade with the DOH, the NHS and other health bodies. It will start out with a simple contractual relationship with the Department (NHS Estates) and NHS organisations that reflects its current workload, other than with regard to the retained estate and this contract will be with the joint venture retained estate partner. We are working closely with staff and Trade Unions who are part of the selection process and to ensure their interests are protected.

#### TENDERING PROCESS

The tendering process is following best practice and is subject to OGC Gateway reviews. Firm expressions of interest were received from fourteen consortia. Following a detailed evaluation, four consortia were selected.

Offers from the shortlisted consortia are due to be received on 7 May 2002. Following receipt of offers, a separate value for money exercise will be undertaken with completion of the sale programmed for Autumn 2002.

#### COSTS AND INCOME EXPECTATIONS

Since the publication of the NHS Plan, income of £280 million has been achieved by 31 March 2002 with further estimated sums of £300 million by 31 March 2003 and £250 million by 31 March 2005, giving an estimated total gross income of £750 million.

Within the option appraisal, sale values were discounted in all options by six per cent to produce a current net present value (NPV) to take account of time and cost of individual disposals. The difference in NPV between the preferred option and the status quo being 33 per cent.

The cost of sales associated with the PPP are estimated to be around two per cent of total costs. These costs are similar to that identified within the NAO report. There is an opportunity cost which is afforded by the PPP ie, to release capital funds tied up in surplus assets at an early stage and reduce capital charge payments. It is anticipated that the preferred option will also reduce costs to the NHS of £10 million per annum over the next three to five years.

#### CONTINUED RELATIONSHIP FOLLOWING DISPOSAL

Following completion of the sale, NHS Estates will be working closely with the partner to ensure that the maximum value is obtained from the properties included within the joint venture.

Inventures present work for NHS Estates will continue for a number of years to meet the requirements set out in the present service level agreements.

(ii) *Will the PPP be set up with guidance that property should be sold with planning consent—ie will the NHS have the full development value?*

Disposals of property are made in accordance with the requirements of Government Accounting, as set out in Chapter 24 Disposal of property, and Annex 24.1 Disposal of land and buildings and other land transactions'.

Government Accounting Annex 24.1 at paragraphs 13–18 deals with “Sites with development potential”. Whilst paragraph 16 says that “land which has potential for development will normally secure the best price if sold with the benefit of planning permission”, it also says that “sales ‘subject to planning permission’ are permissible”. When land sold without the benefit of planning permission occurs, paragraph 19, Clawback applies.

There is no specific requirement that surplus land should be sold with planning consent for alternative use. Section 25.2.4 (Valuation) says that “Advice should also be sought on development potential (which may lead to the need for a claw back clause in any sale agreement) and marketing strategy.”

The guidance on clawback is contained in Paragraph 19 which deals with the situations that arise where a disposal of land is made without the benefit of planning consent. The reasons for this is that there may be delays or uncertainties about the planning position, or doubt about the use which would generate the best practice. In these circumstances a “clawback” clause in the sale contract is appropriate that reserves all or a substantial part of any increase attributable to the grant of planning consent in the future.

We have made a careful evaluation of what will represent best value from this disposal taking account of the professional advice secured. We are of the opinion that better value will be secured by transferring the responsibility, cost and risk of obtaining, for example, planning consent to the PPP.

15 April 2002]

[Continued

The NHS will benefit from an up front payment, and will further benefit from any higher values secured by the PPP through their negotiating development planning consents through a claw-back/participation arrangement. The private sector takes the risk, and the NHS secures the benefit.

Thus the PPP disposal process complies with Government Accounting guidance.

Department of Health

April/July 2002

## Annex A

### Table showing major NHS Property either for Sale or that may become Surplus by Local Authority area

In some cases a formal decision to sell has not yet been made and in some instances it will not be the whole site. Properties currently under contract to sell have been excluded.

#### SOUTH REGION

<i>Local Authority</i>	<i>Property</i>
Adur DC	Southlands, Shoreham
Aylesbury Vale DC	Land at St Johns Hospital, Stone
Basingstoke and Deane BC	Park Prewett, Basingstoke
Bristol City Council	Barrow Hospital, Barrow Gurney, South Bristol
Canterbury City Council	St Augustines, Chartham
Chichester DC	Graylingwell, Chichester
Chichester DC	Land at St Richards Hospital, Chichester
Dartford BC	Mabledon, Dartford
Dartford BC	Stone House, Dartford
Dartford BC	Joyce Green, Dartford
Dover DC	Eastry Hospital, Eastry
East Dorset DC	St Leonard's Hospital, Ringwood
East Hampshire DC	Lord Mayor Treloar, Alton
Eastleigh BC	The Mount Hospital
Epsom & Ewell BC	St Ebbas, Epsom
Epsom & Ewell BC	West Park, Epsom
Fareham BC	Coldeast, Sarisbury Green
Gloucester City Council	Part site Gloucester Royal, Gloucester
Maidstone BC	Linton Hospital, nr Maidstone
Mid Devon DC	Belmont Hospital, Tiverton,
Mid Devon DC	Tiverton District Hospital, Tiverton
Mid Sussex DC	Land at St Francis Hospital, Haywards Heath
New Forest DC	Tatchbury Hospital, Totton
North Cornwall DC	East Cornwall Hospital, Bodmin
Oxford City Council	Littlemore, Oxford
Oxford City Council	Radcliffe Infirmary, Oxford
Oxford City Council	Warneford Meadow, Oxford
Oxford City Council	Park Hospital, Oxford
Portsmouth City Council	Land at St James' Hospital, Portsmouth
Reading BC	Battle Hospital, Reading
Reigate & Banstead BC	Queen Elizabeth Hospital, Banstead
Restormel BC	St Austell Hospital, St Austell
Runnymede BC	St Peters Central Site Area, Chertsey
Salisbury DC	Old Manor Hospital, Salisbury,
Slough BC	Land at Heatherwood Hospital
Slough BC	Land at Wexham Hospital, Slough
South Oxfordshire DC	Fairmile Hospital, Wallingford
South Oxfordshire DC	Watlington Hospital, Watlington
Stroud DC	Cashes Green Hospital & Allotments, Gloucester
Swale BC	Sheppey Hospital, Sheppey
Tandridge DC	Oxted Hospital
Tonbridge & Malling BC	Leybourne Grange Hospital, Maidstone
Tunbridge Wells BC	Kent & Sussex Hospital, Tunbridge Wells
Waverley BC	Milford Hospital, Milford
West Devon BC	Okehampton District Hospital
West Devon BC	Land at Beacon House, Stone
West Devon BC	Okehampton Castle Hospital, Okehampton

15 April 2002]

[Continued

## NORTH REGION

<i>Local Authority</i>	<i>Property</i>
Allerdale BC	Workington Infirmary, Workington
Blackburn with Darwen BC	Blackburn Royal Infirmary, Blackburn
Bury Metropolitan BC	Bury General Hospital, Bury, Lancashire
Castle Morpeth DC	St George's Hospital, Morpeth
Castle Morpeth DC	Birney Hill Farm, Ponteland
Castle Morpeth DC	Stannington Children's Hospital, Stannington
Chester City Council	Countess of Chester, Chester
City of Bradford	Morton Banks, Keighley
City of Wakefield MDC	Southmoor Hospital, Wakefield
Derwentside DC	Maiden Law Hospital, Lanchester
Derwentside DC	Shotley Bridge Hospital, Shotley Bridge
Doncaster MBC	Loversall Hospital, Balby, Doncaster
Fylde BC	Wesham Park Hospital, Kirkham, Preston
Harrogate Borough Council	Middleton Hospital and Lodge, Ilkley
Hull City Council	Hull Maternity Hospital, Hull
Lancaster City Council	Lancaster Moor, North, Lancaster
Leeds City Council	Land at Seacroft Hospital, Leeds
Leeds City Council	Wharfedale General Hospital, Otley
Leeds City Council	Killingbeck Hospital, Leeds
Leeds City Council	Cookridge Hospital, Leeds
Middlesborough DC	Middlesborough General Hospital
Middlesborough DC	North Riding Infirmary
Newcastle City Council	Part of Newcastle General Hospital, Newcastle
Newcastle City Council	Hunters Moor Hospital, Newcastle
Newcastle City Council	Sanderson Hospital Site, Gosforth, Newcastle
North East Lincolnshire	Land at Northside, Scartho Road, Grimsby
North Tyneside DC	Killingworth Stores, Killingworth
Preston BC	Ribbleton Hospital, Ribbleton
Preston BC	Sharoe Green Hospital, Fulwood, Preston
Preston BC	Whittingham Hospital, Goosnargh, nr Preston
Rochdale BC	Birch Hill Hospital, Rochdale
Sheffield MBC	Land at former Norton Aerodrome, Sheffield
Sunderland DC	Cherry Knowle Hospital, Sunderland
Tynedale DC	Prudhoe Hospital, Prudhoe
Wakefield MDC	Clayton Hospital, Wakefield
Wansbeck DC	Ashington General Hospital
Wear Valley DC	Tindale Crescent Hospital, Bishop Auckland
Wear Valley DC	Homelands Hospital, Crook
Wigan MBC	Billinge Hospital, Wigan
Wirral MBC	Clatterbridge Hospital, Bebington, Wirral

15 April 2002]

[Continued

## MIDLANDS &amp; EASTERN

<i>Local Authority</i>	<i>Property</i>
Basildon DC	Heath Close, Billericay
Birmingham City Council	Selly Oak Hospital
Bolsover DC	Land at Bolsover Hospital, Bolsover, Derbyshire
Braintree DC	St Michael's Hospital, Braintree
Breckland DC	Wayland Hospital, Attleborough
Broadland DC	St Michaels Hospital, Aylsham
Bromsgrove DC	Barnsley Hall South, Bromsgrove
Chelmsford BC	St John's Hospital, Chelmsford
Chelmsford BC	Runwell Hospital, Wickford
Colchester BC	Severalls, Colchester
Derby City Council	Manor/Kingsway Hospital, Derby
Dudley MBC	Wordsley Hospital, Dudley
Dudley MBC	Part of Corbett Hospital, Dudley
Dudley MBC	Part of Guest Hospital, Dudley
Epping Forest DC	St Margarets Hospital, Epping
Fenland DC	Land at Doddington Hospital, Doddington
Hertsmere DC	Harperbury Hospital, Radlett
Ipswich BC	St Clements Hospital, Ipswich
Leicester City Council	Towers Hospital, Leicester
Leicester City Council	Stretton Hall Farmland, Oadby
Lincoln City Council	St George's Hospital, 4 Ward Block, Lincoln
Peterborough City Council	Gloucester Centre, Peterborough
Peterborough City Council	Gables Drive, Peterborough
Shrewsbury & Atcham BC	RSH, Shelton
St Edmondsbury BC	Part Hospital Road site, Bury St Edmonds
Stoke on Trent City Council	Land adjacent to Bucknall Hospital, Bucknall
Thurrock DC	Orsett Hospital, Thurrock
Worcester City Council	WRI Castle Street, Worcester
Wyre Forest DC	Lea Castle Hospital, Kidderminster

## LONDON REGION

<i>Local Authority</i>	<i>Property</i>
Barnet	Edgware Hospital
Barnet, Enfield & Haringey	Colindale Hospital
Bexley	Goldie Leigh Hospital
Brent, Kensington & Chelsea and Westminster	Paterson Centre, South Wharf Road
Bromley	Cheyne site, West Wickham,
Camden	Elizabeth Garrett Anderson Hospital
Camden	Southwood Hospital
City of London Corp	London Chest Hospital
Croydon	Cane Hill, Coulsdon
Croydon	Queens Hospital
Greenwich	Greenwich Hospital
Harrow & Hillingdon	Harrow Hospital Sites
Havering and Redbridge	Land at Harold Wood Hospital, Oldchurch
Lambeth	Dulwich Hospital
Newham	St Andrew's Hospital, Bow
Newham	Plaistow Hospital Site
Richmond upon Thames	Land at West Middlesex University Hospital
Tower Hamlets	St Clement's Hospital
Waltham Forest	Land at Whipps Cross
Wandsworth	Atkinson Morley Hospital
Wandsworth	Queen Mary's, Roehampton

REPORTS BY THE COMMITTEE OF PUBLIC ACCOUNTS  
SESSION 2001–02

		<i>Publication Date</i>
1	Managing Risk in Government Departments (HC 336) . . . . .	23/11/01
	Government Reply (Cm 5393) . . . . .	14/02/02
2	Improving Construction Performance (HC 337) . . . . .	05/12/01
	Government Reply (Cm 5393) . . . . .	14/02/02
3	The Cancellation of the Benefits Payment Card Project (HC 358) . . . . .	06/12/01
	Government Reply (Cm 5393) . . . . .	14/02/02
4	The Renegotiation of the PFI-type Deal for the Royal Armouries Museum in Leeds (HC 359) . . . . .	12/12/01
	Government Reply (Cm 5450) . . . . .	28/02/02
5	Ministry of Defence: Major Projects Report 2000 (HC 368) . . . . .	28/11/01
	Government Reply (Cm 5450) . . . . .	28/02/02
6	Ministry of Defence: Major Projects Report 2000—The Role of the Equipment Capability Customer (HC 369) . . . . .	28/11/01
	Government Reply (Cm 5450) . . . . .	28/02/02
7	Sale of Part of the UK Gold Reserves (HC 396) . . . . .	19/12/01
	Government Reply (Cm 5470) . . . . .	14/03/02
8	Office of Water Services (OFWAT): Leakage and Water Efficiency (HC 397) . . . . .	04/01/02
	Government Reply (Cm 5470) . . . . .	14/03/02
9	Tackling Obesity in England (HC 421) . . . . .	16/01/02
	Government Reply (Cm 5477) . . . . .	20/03/02
10	The Acquisition of German Parcel (HC 422) . . . . .	11/01/02
	Government Reply (Cm 5477) . . . . .	20/03/02
11	Office of Gas and Electricity Markets: Giving Domestic Customers a Choice of Electricity Supplier (HC 446) . . . . .	17/01/02
	Government Reply (Cm 5481) . . . . .	09/05/02
12	The Radiocommunications Agency’s Joint Venture with CMG (HC 447) . . . . .	23/01/02
	Government Reply (Cm 5470) . . . . .	14/03/02
13	Regulating Housing Associations’ Management of Financial Risk (HC 470) . . . . .	09/01/02
	Government Reply (Cm 5470) . . . . .	14/03/02
14	The Millennium Dome (HC 516) . . . . .	01/02/02
	Government Reply (Cm 5487) . . . . .	25/04/02

15	How English Further Education Colleges can Improve Student Performance (HC 528) .....	07/02/02
	Government Reply (Cm 5487) .....	25/04/02
16	Access to the Victoria and Albert Museum (HC 559) .....	14/02/02
	Government Reply (Cm 5487) .....	25/04/02
17	Ministry of Defence: Maximising the Benefits of Defence Equipment Co-operation (HC 586) .....	15/02/02
	Government Reply (Cm 5487) .....	25/04/02
18	Inland Flood Defence (HC 587) .....	01/03/02
	Government Reply (Cm 5512) .....	23/05/02
19	Ship Surveys and Inspections (HC 608) .....	15/03/02
	Government Reply (Cm 5512) .....	23/05/02
20	Educating and Training the Future Health Professional Workforce for England (HC 609) .....	08/03/02
	Government Reply (Cm 5512) .....	23/05/02
21	Better Value for Money from Professional Services (HC 309) .....	14/03/02
	Government Reply (Cm 5512) .....	23/05/02
22	The Channel Tunnel Rail Link (HC 630) .....	21/03/02
	Government Reply (Cm 5512) .....	23/05/02
23	Report on Inland Revenue Appropriation Account (HC 631) .....	22/03/02
	Government Reply (Cm 5524) .....	20/06/02
24	Ministry of Defence: The Risk of Fraud in Property Management (HC 647) ..	20/03/02
	Government Reply (Cm 5512) .....	23/05/02
25	Excess Votes 2000–2001 (HC 648) .....	07/03/02
26	Better Regulation: Making Good Use of Regulatory Impact Assessments (HC 682) .....	12/04/02
	Government Reply (Cm 5524) .....	20/06/02
27	The Medical Assessment of Incapacity and Disability Benefits (HC 683) ....	10/04/02
	Government Reply (Cm 5524) .....	20/06/02
28	Better Public Services Through Joint Working (HC 471) .....	18/04/02
	Government Reply (Cm 5524) .....	20/06/02
29	Non-competitive Procurement in the Ministry of Defence (HC 370) .....	19/04/02
	Government Reply (Cm 5524) .....	20/06/02

30	The Auction of Radio Spectrum for the Third Generation of Mobile Telephones (HC 436) .....	26/04/02
	Government Reply (Cm 5524) .....	20/06/02
31	Postcomm: Opening the Post (HC 632) .....	01/05/02
	Government Reply (Cm 5549) .....	16/07/02
32	The Implementation of the National Probation Service Information Systems Strategy (HC 357) .....	03/05/02
	Government Reply (Cm 5549) .....	16/07/02
33	Income Tax Self Assessment (HC 296) .....	09/05/02
	Government Reply (Cm 5549) .....	16/07/02
34	Policy Development: Improving Air Quality (HC 560) .....	24/05/02
	Government Reply (Cm 5549) .....	16/07/02
35	Losses to the Revenue from Frauds on Alcohol Duty (HC 331) .....	17/05/02
	Government Reply (Cm 5549) .....	16/07/02
36	Progress on Resource Accounting (HC 349) .....	19/06/02
37	Handling Clinical Negligence Claims in England (HC 280) .....	13/06/02
38	NIRS 2: Contract Extension (HC 423) .....	07/08/02
39	Giving Confidently: The Role of the Charity Commission in Regulating Charities (HC 412) .....	03/07/02
40	NHS Direct in England (HC 610) .....	10/07/02
41	Ministry of Defence: Major Projects Report 2001 (HC 448) .....	04/07/02
42	Managing the Relationship to Secure a Professional Partnership in PFI Projects (HC 460) .....	11/07/02
43	The Use of Funding Competitions in PFI Projects: The Treasury Building (HC 398) .....	17/07/02
44	The Misuse and Smuggling of Hydrocarbon Oils (HC 649) .....	18/07/02
45	Inpatient and Outpatient Waiting in the NHS (HC 376) .....	18/09/02
46	Inappropriate Adjustments to NHS Waiting Lists (HC 517) .....	18/09/02
47	The Landfill Tax Credit Scheme (HC 338) .....	25/07/02
48	Department for International Development: Performance Management— Helping to Reduce World Poverty (HC 793) .....	01/08/02

49	Ensuring that Policies Deliver Value for Money (HC 541) .....	31/07/02
50	Pipes and Wires (HC 831) .....	08/08/02
51	Agricultural fraud: The case of Joseph Bowden (HC 684) .....	22/08/02
52	e-Revenue (HC 707) .....	29/08/02
53	Reducing Prisoner Reoffending (HC 619) .....	05/09/02
54	Improving Public Services through e-Government (HC 845) .....	28/08/02
55	Fraud and Error in Income Support (HC 595) .....	11/09/02
56	Ministry of Defence: Combat Identification (HC 759) .....	21/08/02
57	The Operation and Wind-up of Teesside Development Corporation (HC 675)	14/08/02
58	Improving Student Achievement and Widening Participation in Higher Education in England (HC 588) .....	12/09/02
59	Delivering the Commercialisation of Public Sector Science (HC 689) .....	15/08/02
60	Royal Travel by Air and Rail (HC 529) .....	04/09/02
61	The Management of Surplus Property by Trusts in the NHS in England (HC 765) .....	19/09/02

ISBN 0-215-00553-8





Distributed by The Stationery Office Limited and available from:

**The Stationery Office**

(mail, telephone and fax orders only)

PO Box 29, Norwich NR3 1GN

General enquiries 0870 600 5522

Order through the Parliamentary Hotline *Lo-call* 0845 7 023474

Fax orders 0870 600 5533

You can now order books online at [www.tso.co.uk](http://www.tso.co.uk)

**The Stationery Office Bookshops**

123 Kingsway, London WC2B 6PQ

020 7242 6393 Fax 020 7242 6394

68–69 Bull Street, Birmingham B4 6AD

0121 236 9696 Fax 0121 236 9699

9–21 Princess Street, Manchester M60 8AS

0161 834 7201 Fax 0161 833 0634

16 Arthur Street, Belfast BT1 4GD

028 9023 8451 Fax 028 9023 5401

The Stationery Office Oriel Bookshop

18–19 High Street, Cardiff CF1 2BZ

029 2039 5548 Fax 029 2038 4347

71 Lothian Road, Edinburgh EH3 9AZ

0870 606 5566 Fax 0870 606 5588

**The Parliamentary Bookshop**

12 Bridge Street, Parliament Square

London SW1A 2JX

Telephone orders 020 7219 3890

General enquiries 020 7219 3890

Fax orders 020 7219 3866

The Stationery Office's Accredited Agents

(see Yellow Pages)

*and through good booksellers*

© Parliamentary Copyright House of Commons 2002

Applications for reproduction should be made in writing to the Copyright Unit,

Her Majesty's Stationery Office, St Clements House, 2–16 Colegate, Norwich NR3 1BQ

– Fax 01603 723000

ISBN 0 215 00553 8