Shell and core options - FAQs

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This document is for information and to provide initial answers to some of the more common questions emerging around shell and core opportunities. It does not provide definitive answers; early discussion should take place with either:

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Frequently Asked Questions:

1. **Who can take the head lease on shell and core space and what are the implications?**

As part of the project development it should be determined who will be best placed to take a head lease on fitted out space. Factors to consider include, the number and type of tenants to be included in the space, as well and the fact that void risk will usually sit with the head leaseholder. It is not acceptable for commissioning organisations to take void risk, for example, for new leases.

It should be noted that the head lease holder will usually negotiate the terms of the lease.

2. **If a requirement for shell and core medical facilities (primary care/community care health space) arises in an area of population growth, what should a CCG do to secure the space?**

See process plan forming part of the Shell and Core toolkit.

3. How can a CCG help to ensure that the Local Planning Authority (LPA) involves the CCG at an early stage of the planning process and secure any shell and core required?

The LPA has a responsibility to identify the infrastructure required to support its local plan when this is being prepared. While this is infrequent, boroughs typically refresh their infrastructure plans and schedules on a more regular basis. CCGs can keep LPAs updated by sharing their estate strategies, attending LPAs' infrastructure planning meetings, inviting LA planners to their LEF, and advising where they are looking for new or expanded premises. Local authorities hold important data necessary for infrastructure planning including housing and population data, property information and public health data. LPAs are also under a duty to co-operate with CCGs in relation to infrastructure planning and will usually engage with CCGs where approached.

CCGs should engage in both the Local Plan and planning application processes to identify and secure shell and core if required, and/or developer contributions via s.106 agreements or funding via the Community Infrastructure Levy (CIL).

CCGs should provide LPAs with service and space requirements (size and type of the space), initial specification and design requirements, for example of standard shell and core and fit out, and the cost of operating and maintaining the infrastructure. Costs to provide, improve, replace, operate or maintain infrastructure required to support population growth can be paid from CIL receipts. CIL may also be applied to meet additional costs associated with running a new or improved facility, or the provision of enhanced services that directly address additional demand associated with new development. CCGs should seek contributions towards these costs in addition to fit-out costs.

LPAs should be informed that NHS infrastructure is not fully funded by government. CCGs must make clear the amount of DHSC funding secured to improve existing infrastructure and services (e.g. Wave 3 bids, ETTF), the amount of DHSC funding (if any) secured to support future population growth, and the funding gap towards which CIL receipts will be put.

4. At what point should a CCG appoint a health planner to advise on likely space requirements and when that space may be required?

A health planner should be appointed when population growth data and health and wellbeing assessments are available as the space requirements should inform the LPA's infrastructure planning. Flexibility should be built into negotiations, policies, and documentation (including legal agreements) to take account of changes in population and space requirements which may occur or become evident between the time planning permission is granted/ the Local Plan is adopted and developments become occupied. Requirements and costs should be reviewed when planning applications are being considered.

Whether it's a professional health planner, or a professional that is experienced in space requirements for primary/community care schemes, for example an architect with relevant experience, the space requirements need to be finalised by the OBC stage, which should occur before the planning application is submitted or the LPAs' Local Plan is drafted and made available for public consultation. Flexibility should be built in so that changes can be made to the requirements where changes are made to the development proposal or local plan during the planning application and local plan processes respectively.

CCGs are reminded that changes to space requirements and costs may require reconsideration of the OBC.

5. How can we make early stage assumptions about revenue costs/savings?

When considering a shell and core as the preferred option in a business case, it is important to understand all funding flows and seek advice from finance colleagues on what the revenue consequence of the scheme will be. Depending on who is involved in the scheme, this might involve conversations with NHS Property Services, the developer / landlord and the District Valuer. It is reasonable to assume estimates of the revenue impact at PID stage, these should be more refined and, eventually, finalised as the business case reaches final approval.

As part of project development, it is also key to recognise the current revenue cost as this will inform the assumptions about revenue cost / savings. This may involve looking at existing premises costs where services are expected to move from old premises to the new premises. If it involves integrating care, it should also look at the existing costs of the services that are to be affected.

6. At what point would a CCG expect to decide on their delivery partner for fitting out the space?

Part of the OBC development should be to have the finalised position for fitting out the shell and core space. The fit out could be funded via a number of sources, depending on who will take the head lease or ownership of the space.

A decision should, therefore, be made at OBC stage.

7. When will the funding be required (both capital and revenue)?

If there is a requirement for a shell and core, the CCG should identify the funding requirements, funding options (including CIL) and funding delivery routes as part of its options appraisal. This will include consideration of ownership arrangements, and capital costs.

The OBC will not be approved if the funding source, capital costs (including initial capital outlay, fit out costs and on-going premises operating costs) and revenue implications are not affordable or represent VfM.

CIL/s.106 are developer contributions, not funding from public borrowing and cannot be treated in the same way as DHSC funding. Therefore, there can be no revenue implications for CIL and s.106 funding as for DHSC funding. This should be taken into account when determining the revenue implications of a scheme.

8. What timescales should be allowed for the business case and construction process?

The timescale of the business case process will be driven by the complexity of the quality of the case submitted. In addition, depending on the scheme, it may not need national approval (but it will almost certainly require regional approval at a minimum).

Construction (or works) will, again, depend on the complexity of the case. It is not a case of 'allowing' a specified time. Rather, it is about understanding (at an early stage) what works are required, what the design will be and what timescales are involved. All of this should be reflected in the business case accordingly.

9. How will the rent eventually charged be calculated – especially when PS are involved, and how might a S106/CIL or an ETTF contribution be reflected in this rent analysis?

Where possible, the NHS should attempt to acquire the freehold of buildings for the system, particularly in areas outside of London, in the same way Local Authorities do.

If a lease is being granted for the building and the landlord is a 3rd party, rent will be calculated based on the landlord's charging principles, which may be influenced by a variety of factors. If NHSPS are involved the charge will be based on the NHSPS charging policy.

A S106 / CIL contribution should give a benefit to tenants as it is, in effect, a capital contribution towards the works. There is, therefore, an expectation that it should be reflected in the rental charge and CCGs / STPs are advised to engage early with the landlord and / or NHSPS in this regard.

ETTF contributions toward shell and core schemes is possible although the funding routes, and associated rules, are no different to any other scheme. Funding can be provided as grants for improvement works as per the rules laid out in the current Premises Cost Directions. Any grant to the GP should result in a revenue benefit. Up to 100% can also be allocated to NHS Property Services by way of an equity injection and this will be charged as per the NHSPS Charging Policy.

The key point is that the rent charged should be assessed to be delivering value for money, in all cases. Early engagement is important to ensure that the funding flow rules are understood as well as the impact of these on the revenue consequence of the scheme.

10. When should the CCG ensure that they have an agreement in place for the preferred Headlessee?

A CCG must ensure that there is a signed agreement for lease as part of the submission of the Full Business Case. This is necessary to provide assurance that the value for money, financial, and commercial case laid out is going to be secured by way of legally binding document.

CCGs should also ensure that agreements for leases have also been signed for any underleases associated with service providers as this will also be required to secure business case approval.

The assurance requirements for bookable space / shared space are still being discussed, although the key point is that there must be a demonstrable articulation and confirmation of how the space will be utilised fully and efficiently. This may involve the use of booking systems.

CCGs should ensure that flexibility is built into the agreement to take account of any changes in space requirements, ownership arrangements, or the development proposal.

11. At what point would a CCG expect to finalise the layout/service requirement for this space?

At OBC the service requirements should be pretty well thought through and finalised. This is the point where the designs are developed to 1:200 level of detail and, whilst not ‘frozen’, are pretty much settled and the capital/revenue costs identified.

An issue that has often arisen is that the timing of the OBC should be able to influence and inform the shell and core development requirement, rather than the other way around which appears to be the case in many instances.

12. How should a digital requirement be included in the specification?

Digital requirements should be included in the specification, if they are relevant to the services to be tendered. CCGs / STPs should ensure that there is early engagement to ensure that any requirement is captured.

13. How does a CCG deal with any growth space and associated cost between the space becoming available and the space being used for clinical services? Are there any ways of mitigating the cost of the growth space?

This is a key issue and should be part of the negotiations and agreements with the developer and LA. The system should not have to fund void spaces and CCGs should work closely with developers and LAs on phasing plans and on the proposed and actual sale of plots to predict and monitor occupation of the development. Obligations on the developer to provide space should be triggered to tie in with significant (what is significant should be agreed with the developer) occupation of the development.

Alternatively, agreements should be made that ensures the building is only handed over to the NHS when the services are required to be up and running, for example on substantial or full occupation of the site.

14. How does the CCG secure a good commercial model?

If a project is assured correctly a good commercial model will be secured. How that done will be specific to the project.

15. At what point in negotiations would a CCG expect to know the commercial model offered by the prospective developer?

Ownership arrangements and Heads of terms (if applicable) should be agreed at Outline Business Case stage. This will include agreement of heads of terms with any potential tenants of the space.

CCGs are encouraged to ask for the freehold to buildings rather than taking leases. Appropriate legal advice about the acquisition of a freehold v a leasehold should also be sought.

16. Who should a CCG use to negotiate the commercial model offered by the prospective developer?

The first issue to be considered is the form of ownership arrangements. Who will take the freehold or head lease for the space? If it is NHS Property Services, for example, then one would expect them to lead on negotiations. Usually it is the head lease holder who will take responsibility for lease negotiations.

The proposed lease terms should be negotiated as early as possible in the planning process and well in advance of the shell and core being constructed. Heads of terms should be agreed to Outline Business Case stage. This will include agreement of heads of terms with any potential tenants of the space.

17. How might a pharmacy be included in the developer space or the CCG space?

A pharmacy would normally be a dedicated space so would expect to be managed via a lease. The contract may be tendered, the process for which is subject to specific processes and timelines.

Any requirement for a pharmacy should be included in the space requirements communicated to the LA and developer.

18. How much should a CCG allocate for the Business case process?

There is not a ‘right’ value for how much a CCG should allocate for the business case process. A CCG may, for example, use its own internal resources. They key point for a

CCG is that it understands the process and what is required from a good business case so that a 'right first time' approach is targeted.

19. How might fixtures, fittings and IT be funded, and how much might that be?

It is likely that these costs will need to be funded by the health system but could potentially be part of a wider negotiation.

CCGs should include these costs in the overall costs submitted to the LPA and seek to negotiate a contribution from s. 106 or CIL to cover some of these costs where possible.

20. How partners might share administrative/public/community space be included in the specification?

Needs local discussion and consideration of funding needed.

21. What is the baseline specification to be required of a developer for the health space?

The health space should be fitted out to the architectural plans whilst complying with the tenant's requirements (or equivalent) and the relevant sections of the DHSC HTM and HBNs.

For primary care space, the DV's Valuation Office Agency questionnaire for primary care premises can be useful to ensure that the key technical requirements are met.

Standard NHSPS and CHP leases can be obtained from NHSPS and CHP where required.

22. Can a LA invest in the property and lease the property to the health sector, how can the implications be managed?

A LA can invest in a property and lease it to the health sector. This will often come at a cost to the NHS as the LA will invariably recover the cost of any investment, which may include costs of borrowing. Usually, this will come in the form of a lease / cost of occupation.

Implications need to be considered from a value for money perspective and from an affordability perspective (capital / CDEL and revenue). This should be done as part of the options appraisal.

23. Can a Trust invest in the property using its own capital and lease to the other providers/GP?

Yes, in principle; a trust is able to invest in its own capital in a shell and core space. However, they must ensure they adhere to the NHS Improvement business case

process. Additionally, the trust should be aware of the risks associated with such models given that they will be an effective landlord. This requires further discussion.

For further information please contact the London Estates Delivery Unit via Healthy London Partnership: england.healthylondon@nhs.net.