A People-Driven Approach. **Delivering NHS homes.**

2023

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Foreword

The NHS is under the greatest pressure it has seen in the last 75 years. One of the most significant challenges to overcome is the recruitment and retention of its people, with the current shortfall of 154,000-plus staff set to more than triple over the next 13 years.

Housing is a critical part of this staffing crisis – specifically, the lack of quality, available, affordable homes close to work for staff and their families. With the NHS continuing to shoulder the burden of an ageing population and the long-tail impact of COVID-19, we need to look for creative, sustainable solutions to attract new staff by providing affordable, relevant housing options, using an approach that also drives value back into the NHS Trusts and Integrated Care Board (ICBs).

Good-quality homes, close to work, in attractive, sustainable communities should not be a pipe dream for health and social care workers. Without it, staff are being driven to live further and further away from where they work in order to find affordable options that meet their and their family's needs, often resulting in long, expensive commutes on top of demanding shifts.

We need to ensure that the talented people working in the NHS and social care have housing that supports their needs. We must be able to recruit and retain the staff we need without a lack of decent, affordable housing being a barrier.

Since 2019, I have been working with Oxford University Hospitals NHS Foundation Trust FT as a Non-Executive Director and have examined close-up the barriers to finding a route through these issues for both staff and the Trusts themselves.

I have seen the toll that COVID-19 has had on the NHS. I have also seen the rise in support from the private sector following the pandemic, and a desire to pull together to find answers to the challenges that face all the health and social care systems. This collective will has given rise to the NHS Homes Alliance, an extensive collaboration of representatives from private and public sector organisations that has evolved over the last year and officially launched in June 2023.

The representatives of the 25-plus organisations have pulled together to deliver this White Paper, including NHS Trusts and ICBs; pension funds and institutional capital; financial, legal and real estate advisors; Housing Associations; and architects and developers. They gave their time and expertise – and, in many cases, their IP – for free. Such is the shared ambition to support and sustain the NHS and social care.

The Naylor Report (2017) highlights the opportunities for surplus NHS land assets to deliver over 25,000 new homes and release funds for investment in healthcare facilities. This White Paper builds on that report and recommends that surplus NHS Estate be developed in line with the specific recruitment needs of local health and social care services, creating homes for the required staff at all levels of primary, secondary and social care. There is an opportunity to provide housing that will attract and retain the talent needed, as well as maintain control over the communities created, while retaining the ongoing value of the land assets within the NHS.

Yet as this plan for utilising existing assets developed, barriers started to emerge. It is challenging for Trusts to compete for land with open market rent and other grant-funded social rent and shared ownership developers. Historical principles such as the NHS Estate Code and NHS accounting rules limit the ability of Trusts and ICBs to realise the potential breadth of environmental, economic and societal benefits of using existing land assets for NHS homes. At the same time, it is only by pulling a consistent, NHS-wide understanding of people's needs – and the way they live and work – that we will be able to build communities that provide all these benefits to staff and their families.

This White Paper provides potential solutions for all these challenges and calls for a people-centric approach to delivering NHS homes. It provides a comprehensive outline of the work involved to deliver a compelling case for establishing new funding approaches and managing costs. It advocates for building housing to meet known demand while protecting the long-term value and flexibility of use for the NHS by providing these homes for long-term rental, retaining the freehold interest.

With this collective attention to the specific challenges faced by NHS Trusts and ICBs, and a shared desire to pull together to find solutions, we have a unique opportunity before us. By capitalising on the collaborative strength already building through the NHS Homes Alliance and joining forces to create an HM Government cross-departmental NHS and private sector taskforce, we can take the next steps towards fulfilling the potential available in the NHS's second greatest asset: its land.

Sarah Hordern
Non-Executive Director at Oxford University Hospitals NHS FT; CEO at Perspicio

Executive summary

○ Staffing is the most important issue currently facing the NHS and social care. NHS Trusts currently report a shortfall of more than 154,000 staff, and that shortfall is set to worsen amid growing demand for healthcare. Reports suggest the figure could rise to 570,000 by 2036.[1]

○ The impact of the lack of available affordable, quality homes in appropriate locations on recruitment and retention of staff is a common theme across NHS Trusts and Integrated Care Boards (ICB). When asked, 68% of NHS staff surveyed at one Trust said that lack of affordable housing would be a key driver in deciding to leave their current employment within the next two years.[2]

○ The Naylor Report of 20173 advocated selling NHS land to deliver 26,000 homes, funding regeneration of hospital facilities. The Naylor Report was predicated on freehold disposal of the surplus land to support funding of NHS capital expenditure on clinical facilities. However, land assets and the requirements for new clinical facilities do not always align, and open market sale has not generally delivered homes for NHS people.

○ When considering the staffing challenges facing the NHS in 2023 and beyond, retention of the freehold interest and entering partnership arrangements to facilitate NHS Key Worker Homes development will, in many instances, create more long-term value than simple freehold disposal. When defining 'NHS Homes' and 'NHS Key Worker', this paper includes primary care, secondary care and social care workers.

○ Retention of the freehold interest will guarantee delivery of housing units within a timeframe linked to need rather than market economics while protecting long-term value and flexibility of use. UK plc derives a deep well of environmental, economic and social benefits from housing healthcare Key Workers close to their workplace in well-built, high-quality, sustainable homes and communities when compared to one-off land sales.

○ The NHS should take interest in the model used by the many private and public sector landowners who retain long-term control while using development capital to deliver enjoyable places to live and work. There is a great opportunity to leverage the weight of capital currently available through pensions, which are looking for long-dated, inflation correlated returns, without an explicit requirement for ultimate ownership. Assets with Environmental, Social, Governance (ESG) benefits are increasingly attractive to investors as they look to improve upon the ESG credentials of their portfolios. Using medium-term 30 to 60-year leases would enable Trusts to deliver integrated communities with genuinely affordable rents that support recruitment and retention, funded by pensions. Buildings and income streams would then revert to the Trust at the end of the lease terms.

○ HM Treasury's own Value for Money benefits evaluation framework for infrastructure business cases contains robust, monetisable benefits in cash flow terms. This is in the context of wellbeing uplift, efficient workforce and treatment improvements, air quality benefits, reduced recruitment costs, and accelerated skills escalation. In this way, the approach to NHS Key Worker Homes is not a land deal exercise but an exercise in maximising the broader output of the NHS and social care through the use of its available land. The value of that output in economic terms is far greater than the land value itself.

○ Any proposed model for the delivery of NHS Key Worker Homes will require an innovative approach to land value, developer risk and profit, and low-cost capital to create viable schemes. It will also require a structure that, in the majority of cases, ensures the homes do not impact on a Trust or Integrated Care Board's Capital Departmental Expenditure Limit (CDEL) envelope. In practice, this typically rules out the use of any additional borrowing or leasing arrangements. This paper accepts the constraints posed by CDEL and NHS risk appetite in relation to underwriting voids and explores three models with different approaches to dealing with this challenge. For comparison and completeness, additional delivery models provide options for Trusts where there is CDEL capacity for housing, and where the use of corporate joint ventures (not currently supported by NHS England) are explored.

○ Investment market feedback to date has reacted well to the 'demand risk' model, where the investor takes the risk of voids. Investors recognise the captive population of NHS and social care staff and its well understood housing shortage in the sector, as well as the growing population and resultant growing workforce required to support that. Equally, the demand risk model is widely understood and used in sectors including Higher Education.

68%

of NHS staff said that lack of affordable housing would be a key driver in deciding to leave their current employment within the next two years.

154k

the shortfall of staff currently reported by NHS Trusts.

570k

the predicted shortfall of NHS staff by 2036.

Recommendations

Here we present a summary of this report's recommendation, across finance, procurement, planning, design, sustainability, modern methods of construction, and operations.

Financial Recommendations

HM Government should accept and support the principle that NHS Trusts can use their land and long-term pension scheme (or other institutional capital) to deliver NHS Homes, outside of CDEL. The Government should:

- Create a pipeline of projects, simplified governance, and standardised yet flexible structures to unlock long-term, lower-yield, ESG-focused capital, thus increasing the investment value of the net rent and improving viability.
- Develop a methodology for establishing rents that supports recruitment and retention reflective of health and care salaries, not simply a discount to open market rents.
- Establish a Homes England or other Government-funded Gap Fund for schemes that aren't financially viable for an investor alone or where NHS land is not available. The Gap Fund would act as an infrastructure grant for abnormal infrastructure or capital housing grant.
- Establish a revolving loan fund with Homes England, HM Government and private sector contributions to enable NHS Trusts and partners to undertake initial feasibility work. The work should scope development potential across estates, thereby reducing risk and establishing viability for future development partners.

Procurement Recommendations

NHS Trusts are bound by public sector procurement rules and the extensive NHS business case process. These combined complexities create delays that stymy deals and increase costs. There is an opportunity to devise an efficient, cost-effective procurement model that is robust, flexible, and capable of delivering a people-driven approach. To address this HM Government should:

- Create an NHS Homes Centre of Excellence. The Centre would have the knowledge to support Trusts and ICBs to deliver at pace, using a toolkit of pro-forma documents and a model process potentially underpinned by a revolving loan fund for initial feasibility work, project management resource and residential procurement expertise. Trusts receiving loan funding would commit to an accelerated decision-making process to maintain momentum.
- NHSE, Department of Health and Social Care, and HM Treasury should approve a Strategic Outline Case for NHS Homes that incorporates a range of delivery models to support individual Trust and ICB circumstances. Outline Business Case and Final Business Case approval, where required under Department of Health Rules, would be delegated to ICB and Trust Boards with support from the NHS Homes Centre of Excellence.
- Create a flexible NHS Homes procurement framework based on a Formal Procurement Process (formerly OJEU) for pilot schemes. This should be supported by a working group with private sector and cross-departmental expertise to shape the viability model, finance, lease and operating structures. The framework would provide scale and efficiency of transaction through standard process and documentation while providing a pipeline of projects to attract capital backing pensions.
- Update the NHS Estate Code to determine Best Value based on the HM Treasury Value for Money framework as opposed to the current definition of RICS Red Book Value, which solely reflects market value for land and not

operational recruitment and retention value or wider economic and social value.

- Capture the demand data through dedicated Voice of the Customer surveys, specific to each Trust, across the NHS and the pipeline of potential projects so the market is clear on the opportunity and can 'tool up' accordingly, including MMC delivery partners.
- Make use of existing pre-procured frameworks, such as NHS Local Infrastructure Finance Trust Companies (LIFTCo'sand Strategic Estates Partnerships (SEPs), as appropriate to allow for the delivery of pathfinder projects at pace.

Planning Recommendations

Navigating the planning process competently and with efficiency is a key factor in controlling risk, timelines, cost and therefore deliverability of NHS Homes. Extended timeframes of two years or more to achieve consents mean that construction and finance markets are subject to change, resulting in a loss of momentum, risk of personnel change and, potentially, schemes that are no longer viable. HM Government should:

- Introduce a distinct planning Use Class for NHS Key Worker Homes to standardise, de-risk and fast-track delivery of NHS Homes. A dedicated classification would remove the need for extensive negotiations with each Local Authority on the relationship between NHS Key Worker Homes and the provision of Affordable Housing for the Local Authority List. These discussions result in significant cost and delay or prevent schemes being developed.

- Make NHS Key Worker Homes exempt from Section 106, CIL and highways contributions to assist with the viability of schemes, given that the capitalised value of genuinely affordable rents is unlikely to cover construction cost and fees.

- Expand the Health Care Land Use classes to include employer-related accommodation for health and social care workers so that planning Change of Use for NHS Homes does not have to be negotiated on a case-by-case basis.

Design, Sustainability, Modern Methods of Construction, and Operations

Design, Sustainability, Modern Methods of Construction, and Operations Recommendations

People-driven approach to NHS Homes, focused on long-term retention and recruitment, requires focus, commitment and funding for the design and delivery of quality homes as well as quality places and communities. These developments should:

- Put sustainability at the forefront to reduce operational costs and minimise environmental impact. Sustainability measures span all aspects of development, from site optimisation and layout to building and landscape design and user monitoring and maintenance.

- Reimagine NHS Estates to include better amenities for NHS staff, patients and visitors that improve quality of life by striving for a campus-like 10-minute hospital concept that better meets the needs of daily life.

- Explore modern methods of construction (MMC), using modular and panellised off-site production to speed up construction time and reduce costs, improve quality and precision, reduce waste, save energy, and minimise deliveries and associated noise and pollution impacts.

- Select an operational model that ensures developments are well maintained and managed so they deliver the ambition of attracting and retaining people in the long term.

When asked, 68% of NHS staff responding to a survey said that lack of affordable housing would be a key driver in deciding to leave their current employment within the next two years.

1. The challenge: A people problem

1.1. When asked, 68% of NHS staff responding to a survey said that lack of affordable housing would be a key driver in deciding to leave their current employment within the next two years.[4]

1.2. Staffing is the most important issue currently facing the NHS and social care. NHS Trusts currently report a shortfall of more than 154,000 staff, and that shortfall is set to worsen amid growing demand for healthcare. Reports suggest the figure could rise to 570,000 by 2036.[5]

1.3. The UK's ageing population widely suffers from chronic conditions that require frequent access to care. In its June 2022 report on the health and social care workforce, the House of Commons Health and Social Care Committee reported that an extra 475,000 jobs would be needed in health and 490,000 jobs would be needed in social care by the early 2030s.[6]

1.4. Staff retention within the NHS is in crisis. While it is a challenge to put an exact figure on the current shortfall of staff, as of September 2022 over 130,000 posts in secondary care were vacant, the largest number since June 2018, with the greatest proportion in nursing (over 47,000 unfilled posts). It has been reported that NHS workforce vacancies increased by around 30,000 between 2018 to 2022, with vacancies also increasing in adult social care and NHS support workers.[7] To provide just one example, turnover of social care staff in Dorset is currently around 40%.[8]

1.5. The problem of retention is particularly acute in areas where the cost of housing is prohibitively high, both to buy and to rent. The average house price in the UK is around nine times the average earnings. The average salary in the UK is around £33,000.[9] Band 1 staff in the NHS, which includes nursing assistants and domestic support workers, is £20,270.[10]

1.6. The environment in which the workforce operates is also a challenge to retention. Nearly a fifth of the NHS Estate was built before the health service was established in 1948. As a result, many estates offer little by way of amenities that might contribute towards improved quality of life or wellbeing. They are often isolated places, surrounded by vast car parks and other surplus land, thereby lacking quality outdoor space, with limited food offerings or other neighbourhood services.

2. The proposition: Retain the ‘family silver’

2.1. NHS Trusts have a significant asset in their surplus land. The NHS Estate can be one of the key enablers of change in the health system and is a major source of untapped value and potential.

2.2. The Naylor Report of 2017 advocated selling NHS land to deliver 26,000 homes, funding regeneration of hospital facilities. The Naylor Report was predicated on freehold disposal of the surplus land to support capital funding of NHS clinical facilities. Some progress has been made in the delivery of healthcare facilities funded by the sale of land for open market housing. However, land assets and the requirements for new clinical facilities do not always align, and the open market sale has not generally delivered homes for NHS people.

2.3. Retaining the freehold interest and entering into partnership arrangements to facilitate NHS Homes development will, in many instances, create more economic value than a simple capital receipt for a freehold disposal. It will also guarantee delivery of housing units within a timeframe linked to need rather than market economics.

2.4. Instead of ‘selling the family silver’ through land disposal, which abandons long-term flexibility for healthcare sites, the NHS should instead realise the potential within and establish a means of delivering homes and communities for NHS and social care staff that will improve quality of life for them and for their patients.

2.5. Up to 60% of operational cost expenditure among NHS Trusts is people,[11] which for a large Trust could represent a figure in the region of £800m per year. There is huge potential for long term savings through investment in an NHS Key Worker Homes initiative that aims to reduce a proportion of the expenditure on high-cost temporary staff, recruitment fees and training costs, as well as the impact on morale, quality and productivity of relentlessly changing and understaffed teams.

2.6. The NHS should take interest in the model used by the many private and public sector landowners who retain long-term control while using development capital to deliver enjoyable places to live and work. There is the opportunity to leverage the weight of capital currently available through pensions, which are looking for assets offering long-dated, inflation correlated returns, without an explicit requirement for ultimate ownership. Using medium-term leases (30 to 60 years depending on viability) would enable Trusts to deliver high-quality community-enriching developments with genuinely affordable rents, funded by pensions. Buildings and income streams would revert to the Trust at the end of the lease term.

2.7. The need for improved staff retention varies from Integrated Care Board (ICB) to ICB and is diverse, representing porters and domestic services, community health staff, social care staff, and the nursing and student nursing cohort, through to the junior doctor cohort, opticians and dentists, each comprising UK-based and overseas recruits. There is an opportunity to create diverse housing communities, encouraging and enabling NHS people to put down roots. Many existing schemes have prioritised cluster and one-bedroom apartments with limited amenity offers, where the operational vision and need has not been at the forefront of design and delivery. Schemes should be led by the operational need to create an appropriate variety of product on a site-specific basis, with a potential for rent and part-rent/part-buy.

2.8. Due to the large nature of many suburban NHS sites, there are often few nearby amenities available. NHS Estates should be reimagined to include better amenities for NHS staff, patients and visitors that improve their quality of life. Estates should strive for a campus-like hospital concept that can meet people’s daily needs.

2.9. NHS salaries are consistent across the country outside of London, yet rental costs often vary significantly across relatively small geographic areas – for example, Torbay in Devon has significantly higher house prices and rents than Exeter or Plymouth.12 A consistent approach to target rents linked to salary could support retention across all locations, promoting equity and inclusivity across the health and social care sectors.

2.10. Active management of accommodation over time will be key to ensuring that when staff leave Trust or ICB employment they relinquish their housing. Equally, linking rent levels to a proportion of salary would allow for upward movement to market rent as careers progress, ensuring consistent equity.

2.11. Not all NHS Trusts have surplus land available to facilitate Key Worker housing development; many operate on constrained sites that create clinical challenges. An alternative solution is needed for the many organisations in this category. This might involve working with HM Government departments or agencies, or a local or regional Housing Association. It could also involve entering into partnership with a housing developer, taking some or all of the social housing allocation under the terms of any planning consent where CDEL capacity is available.

3. Creating Great Places

3.1. The NHS holds a portfolio of sites of varying size and condition, many of which are car parks or brownfield sites that contribute little to a Trust or its wider area. Collectively, these sites hold the opportunity to set a new exemplar for sustainable and affordable housing communities in the UK.

3.2. The fundamental principle of longevity in these sites unlocks an alternative way of thinking about the delivery of high-quality neighbourhoods that are deemed a success over generations. When land is being retained, a Trust can adopt a stewardship approach to placemaking that shifts the value-added argument towards investments that benefit the wider community, and that measure success not just in monetary terms but through social, socio economic, environmental and design quality lenses.

3.3. The character of the new developments would vary with the scale of sites available. Larger sites have capacity for mixed-use communities that incorporate a blend of uses, such as commerce, community facilities, education, leisure and recreation. Other sites would be smaller and primarily residential in use. Irrespective of size, the aspiration is to nurture a collegiate environment around the hospital with characterful living communities that are homely and welcoming. NHS staff work long hours; the home should be a place that is distinct from the commitments of the job, where they can relax and spend time with family and friends.

3.4. A varied mix of housing typologies will support a multicultural and multi-generational population, reflecting the diversity of NHS staff. Families, small/single households, young professionals and graduates should all have a choice of homes, with the opportunity to upgrade and downsize within the neighbourhood to support them through life stages and ensure liveability long term.

3.5. The new developments should be conceived as integrated neighbourhoods that belong to and connect with their surrounding area, with streets, walkways, and cycle routes designed to stitch into the wider movement network, increasing site access and permeability. As such, the sites can invite wider footfall, which will enliven the new neighbourhoods, with the natural surveillance of activated streets and spaces helping residents feel safe and secure.

3.6. The ambition for the new developments is to put sustainability at the forefront to reduce operational costs and minimise environmental impacts. Sustainability measures should span all aspects of development, from site optimisation and layout to building and landscape design and user monitoring and maintenance.

3.7. The NHS ambition is to achieve net zero carbon by 2040. The design of NHS Homes and communities should support these goals by minimising material use, choosing long-lasting, resilient materials, and using recycled, low-carbon or carbon-negative materials wherever possible. Operational carbon can be reduced through a fabric-first approach that maximises air tightness, optimises solar gain, regulates shading, and uses natural ventilation and heat recycling.

4. The CDEL challenge

4.1. HM Treasury sets a Capital Departmental Expenditure Limit (CDEL) for the Department of Health and Social Care that covers the capital spend of the NHS. CDEL is allocated to Integrated Care Boards (ICBs) by NHSE. The ICB then allocates expenditure between individual Trusts and central ICB projects.

4.2. Regardless of cash and funding, a Trust cannot exceed its CDEL in a financial year. The CDEL envelope is typically insufficient to cover competing needs from the healthcare estate, medical equipment and digital infrastructure, let alone support investment in housing to help solve people challenges. Both across the UK and on a regional basis, Trusts and ICBs can typically only access CDEL for capital projects with clinical outcomes (i.e., measurable changes in health or quality of life that result from care) and core delivery outcomes. From an existing budgetary standpoint, DHSC does not currently include housing development on its list of priority projects in the NHS to which CDEL is allocated.

4.3. Housing is therefore to be delivered outside of the priority projects lists. Any proposed model for the delivery of NHS Key Worker Homes will require external funding but also a structure that, in the majority of cases, ensures that the homes do not impact on a Trust or ICB CDEL envelope. In practice, this typically rules out the use of any additional borrowing or leasing arrangements.

4.4. In addition to the technical CDEL constraints, the NHS remains cognisant of long-term risk exposure. Recent structured consultation and testing on this matter with the Department of Health and Social Care has revealed that the NHS cannot expose the Department to long term financial risk (i.e., voids/demand risk). As a result, schemes requiring a Trust or ICB to underwrite demand, even if off balance sheet, are unlikely to be approved by NHSE.

4.5. This paper accepts the constraints posed by CDEL and NHS risk appetite, and explores three potential models with different approaches to dealing with these. The models show that delivery is potentially possible while adhering to the NHS capital and accounting restrictions. As the market matures, other models may be developed that also satisfy these issues and should be welcomed.

4.6. Two additional alternative models provide options for Trusts where there is CDEL capacity for housing, where viability or other challenges require the Trust to take the demand side risk, and where the use of JV structures is explored.

A varied mix of housing typologies will support a multicultural and multi-generational population, reflecting the diversity of NHS staff.

5. Delivery Structure Models

5.1 Five delivery structure models have been considered as part of this paper. The detailed models and table summarising the differences and similarities are in Appendix 1. Of these, models 1 to 3 do not require CDEL for the delivery of NHS Homes.

5.2. Model 1: NHS New Homes Solutions Developed by Global Cities Futures (GCF)

5.2.1. The proposed commercial structure is represented in Figure 1. The base case model involves a third-party partner (the "Partner") providing high-quality staff accommodation through an outsourcing arrangement within a single contract between the Trust and its Partner where construction, availability, demand and void risks are passed to the Partner. The Trust takes on no financial risk.

5.2.2. The Trust provides the land on a 100-year-plus head lease in exchange for peppercorn rent.

5.2.3. Under a single outsourcing contract arrangement for circa 60 years, the Partner finances and carries out the construction work in accordance with a specification developed by the Trust via the preferred option in its business case, and is responsible for maintaining, letting and operating the accommodation to standards set by the Trust for the agreed term.

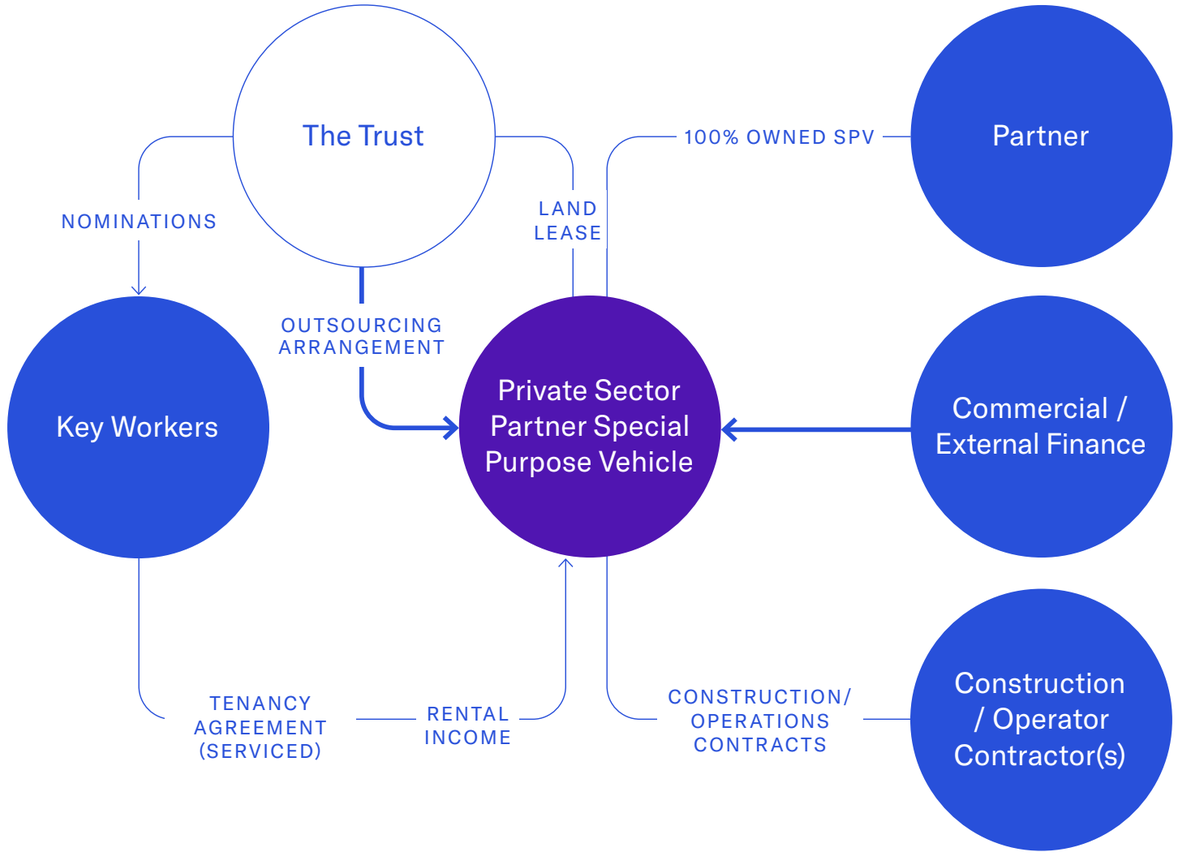
5.2.4. There are no minimum lease payments to be made by the Trust. Rather, units are rented directly to Key Worker tenants, with the Partner collecting rents and taking on demand and credit risk.

5.2.5. The Trust or ICB has nomination rights for the units, such that it is able to nominate its own NHS staff as primary tenants. Thereafter, the Trust can nominate other Key Workers and, where there is availability beyond that, the scheme could market the units freely. The rental price is set by the outsourcing contract.

5.2.6. At the end of the outsourcing arrangement, the accommodation would return to the Trust for £nil consideration, with the remainder of the head lease falling away.

5.2.7. The model has accounting and budgeting opinions confirming CDEL compliance, provided by external auditors and qualified accounting specialists in the field.

Figure 1 NHS: New Homes Solution



5.3. Model 2: Medium-Term Lease and Lease Premium

5.3.1. The proposed commercial structure is represented in Figure 2 in the Appendix. The base case model involves a development agreement, an agreement for lease and a mid-term lease. As in Model 1, construction, availability, demand and void risks are passed to the investor or operator in the same way and with the reversionary terms the same as Model 1. The Trust takes on no financial risk.

5.3.2. From a CDEL perspective, the model constitutes an outsourcing arrangement akin to Model 1 and results in a similar off-balance sheet treatment for budgets.

5.3.3. This model has been tried and tested in Spain with local authorities and affordable housing. An obligation exists in the lease granted to the investor to rent homes at an agreed amount, with the Trust or ICB having nomination rights for the homes. If the investor or its operator cannot find tenants, it can rent them on the open market.

5.4. Model 3: ICB Estate Code Solution

5.4.1. The proposed commercial structure is represented in Figure 3 in the Appendix. The base case model involves the ICB and Trusts and other public sector bodies agreeing a strategy for the delivery of health and social care housing and identifying possible sites.

5.4.2. The ICB markets sites collectively to operators and/or investors ("the Operator") to create scale. Marketing includes a due diligence pack, expected lease terms, and requirement to offer homes to Key Workers at a discounted price as part of a nominations cascade, but there is no nominations agreement directly with a Trust.

5.4.3. The Operator finances and carries out the construction work in accordance with a specification developed by the Operator based on its market analysis. The Trust provides oversight on its own site.

5.4.4. Prior to completion, Trusts can secure a number of units on Assured Shorthold Tenancy. The Operator markets the remaining units through the cascade routes. Where post cascade voids exist, the Operator markets them openly on a profit share basis with the ICB.

5.4.5. At the end of the arrangement, the accommodation returns to the Trust for a peppercorn consideration.

5.4.6. The model widens the opportunity for potential development from just NHS land to all Integrated Care System partners.

5.4.7. The model is based on the Operator market testing core requirements in terms of units, rents and demand. The Operator determines the potential housing numbers/ mix and commercial terms, although this could be influenced via the Local Authority developing a Design Guide for the site in question. The market incentive is for the most profitable units (e.g. cluster flats) as opposed to identifying the most urgent people need for an individual Trust. Homes are not ring-fenced for NHS Key Workers.

5.4.8. There is no direct NHS contractual control or guarantee on the rents, and so there would be no CDEL.

5.4.9. The model assumes that the specification and rents are entirely determined by the market, and as such under the NHS Estate Code this model falls outside of the procurement regulations, despite the requirement in the lease to offer homes to Key Workers at discounted price. Care must be taken to ensure that increased oversight or specification does not inadvertently bring the scheme into procurement rules.

5.5. Model 4: Hard nominations with Housing Associations of S106

5.5.1. This model considers situations in which Trusts have limited surplus land to offer for NHS Key Worker housing, or no surplus land at all.

5.5.2. The Trust works with a nominated Housing Association, housing developer or student accommodation provider to take up a proportion of existing stock or stock under development specifically for Key Worker Homes, based on nominations from the Trust.

5.5.3. The Trust enters into a development agreement with the housing provider to guarantee a specific number of employees as occupiers of NHS Key Worker homes. In return, the developer will build, and offer to the nominated parties, the housing described in the development agreement.

5.5.4. The housing provider will own and manage the property and have a direct contractual arrangement with the health and social care Key Worker.

5.5.5. Where a hard nominations agreement is inclusive of a Trust guarantee over voids, this option could potentially result in a CDEL implication for Trusts. In the absence of such a guarantee, the CDEL implication is potentially minimal. This guarantee could be for a time limited period (e.g., five years) to provide the housing provider certainty over occupancy in the early years, thus reducing risk.

5.6. Model 5: Corporate Joint Venture

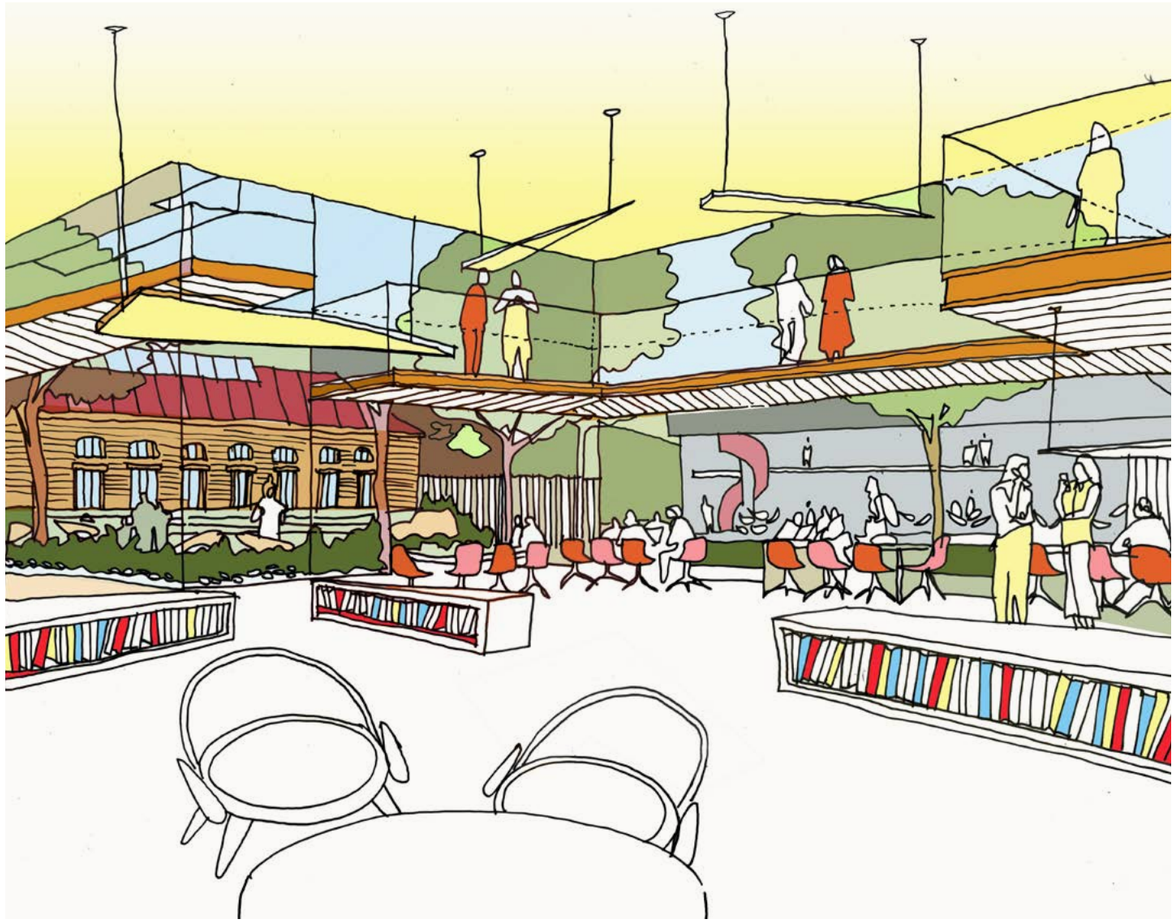
5.6.1. Under this approach, the Trust potentially takes non-controlling share of a joint venture (JV), between 1% and 49%.[13]

5.6.2. The majority stake will be held by the delivery partner. The Trust will transfer its land, via a long lease, into the partnership vehicle in exchange for its equity stake. The delivery partner will match this with cash in exchange for equity commensurate with its own stake.

5.6.3. In this structure, the separate entity partnership or JV is capitalised by a mixture of land value from the Trust, cash from the delivery partner and commercial borrowing.

5.6.4. The Trust provides the land on a 100-year-plus head lease. Thereafter, the JV replicates the commercial and delivery terms described in Model 1, with the facility returning to the Trust at the end of the arrangement for £nil consideration.

5.6.5. The rental price is set by the outsourcing contract either as a set discount to market rates or linked to blended Key Worker salaries for the target occupiers.



Institutional and pension scheme investors are looking for low-risk, long-term assets to match fund their liabilities, and are actively seeking opportunities to improve the ESG credentials of their assets.

6. Viability

6.1. Whether a scheme is viable is determined by the value of the completed asset less:

- The cost of delivering the asset (construction, technical fees, planning fees, development management fees, taxes including VAT inefficiencies).
- The developer's margin.
- The land value.

6.2. The market value of the completed asset will be the annual net rent after management, maintenance and sinking fund costs, divided by the yield (or cost of capital). The yield is reflective of interest rates in the market – i.e. the return the investor can get for its funds elsewhere, and the investor's assessment of the transaction risk and the quality of the building.

6.3. The market value is based on a snapshot moment in time in a market cycle. The economic and social benefit of recruitment and retention of healthcare workers deliver long-term value which is not captured in the market value.

6.4. Where the occupier's rents are discounted below the open market, the value of the asset will be lower than the same asset at market rent if the yield is the same, all things being equal.

6.5. Assuming that build costs are broadly fixed for the size and quality of building envisaged, the key levers for the viability of NHS Homes are:

- Level of rent or discount to open market, including any irrecoverable VAT.
- Land value.
- All-risks yield (cost of capital) required by investors.
- Project risk and subsequent developer's profit.
- Grant funding to support abnormal infrastructure and/or housing grant.

6.6. The land value can either be market value of the land or the sum left over after the cost of delivering the asset and the developer's margin have been accounted for.

6.7. Depending on the economic cycle at any point in time, land value (if any) and grant funding may need to flex to deliver a rental price point that supports the Trust or ICB's recruitment and retention requirements.

6.8. Institutional and pension scheme investors are looking for low-risk, long-term assets to match fund their liabilities, and are actively seeking opportunities to improve the ESG credentials of their assets. Homes designed with strong environmental performance and low long-term running costs align with these ESG ambitions. The factors influencing the all-risks yield are discussed in more detail in the Securing Finance Section 7.

6.9. If the purchase of the completed leasehold buildings can be agreed in advance with institutional investors, developers are not taking market risk on the sale of the completed building. The level of margin required by developers can therefore be reduced from the market norm of circa 20% for BTR or student development to something more akin to a development margin of circa 8%, as seen in the healthcare development market for forward sold assets (e.g., health centres). As the sector matures and the perceived risk of working with the NHS reduces, investor margins will reduce and market competitiveness will increase.

6.10. The ability to attract and secure institutional investment is key to changing the market dynamic and therefore supporting viability for NHS Homes.

6.11. Grant funding may be required to bridge a viability gap either due to the costs of enabling work and abnormal infrastructure or as the result of higher yields driven by market conditions, as illustrated in the diagram below.

Figure 2 - Illustrative Development Value Stack

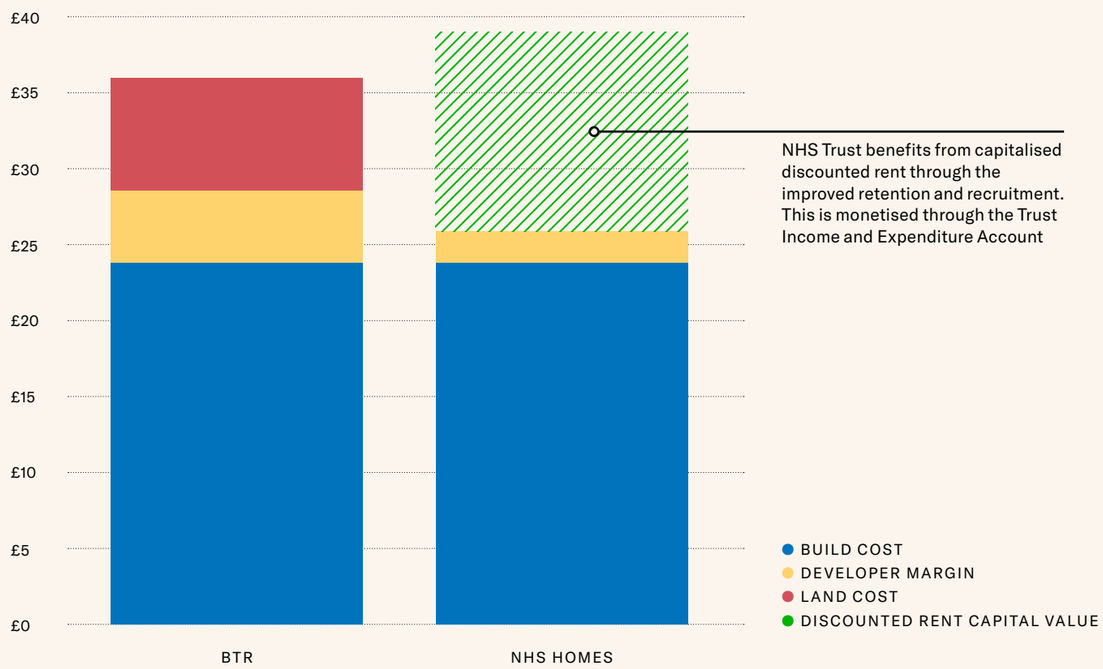


Figure 2

Example data	BTR	NHS Homes
Number of homes	100	100
Beds per home	2	2
Home size (sq ft)	750	750
Gross to Net	77%	77%
GEA (sq ft)	97,000	97,000
Turn key cost exc land per sq ft	£245	£245
Turn key cost exc land	£24m	£24m
Monthly open market rent	£1,700	£0
NHS Homes rent per month	-	£1,224
Yield	4.25%	4.25%
Capital value	£36m	£26m
Developer Profit %	20%	8%
Housing grant	£0	£0
Lease length (years)	freehold	60

Figure 3 - Development Value Stack Examples

- All values used are illustrative and will move depending on the GILT yield at the time of contracting.

- The Buy To Rent (BTR) model provides the baseline for comparison with a capital value of £36m driven by annualised net rent of £1.5m and a yield of say 4.25% with a developer profit of 20% or £4.8m.

- In the target NHS Homes model the capital value falls to £26m due to the lower rent level. This is offset by lower development margin under the NHS Homes model and no payment for land with the freehold being retained under the NHS Homes model. In this example the value of the completed asset equals the build cost plus the developer's margin and no gap funding is required.

- Illustrative yield is the same in both scenarios assuming CPI rent increases. This potentially produces an affordability gap over time if inflation outstrips rent increases. This could be managed via a cap and collar albeit with an impact on yield and potentially availability of funds.This would reduce the capital value and increase the potential need for gap funding.

- It is assumed that the impact on the yield of the retention of the freehold by the NHS under the NHS Homes model is offset by the reduced void risk from sub- market rents to maintain yield at a constant level.

- Further reductions in the NHS Homes rent would require either an improvement in yield or capital funding.

- In addition to the traditional property perspective the NHS Homes value stack includes the capital value of the discounted rent. This reflects the impact of the discounted rent in improving retention and recruitment of staff. The NHS Trust retains this value monetising it through the Income and Expenditure account.

7. Securing finance

7.1. This report recognises the key pillars for delivery of NHS Homes as:

- Addressing staff needs.
- Viability.
- Scale.
- CDEL restriction compliance.
- Void risk underwriting.

7.2. The goal is to secure institutional funding, at scale, for the overall programme and vision set out in this paper.

7.3. Market feedback to date has reacted well to the outsourcing, demand risk model (Model 1 in this paper). The model responds to the needs of NHS staff, the affordable housing shortage, a growing population and a growing workforce required to support it. Equally, the commercial model is widely understood; it has been successfully delivered for some time in the Higher Education sector to provide student housing and is now being early adopted for some Key Worker housing in the NHS at Royal Devon University Hospitals NHS Foundation Trust, North Bristol Trust, Great Western Hospitals Foundation Trust and East Kent Hospitals University Foundation Trust.

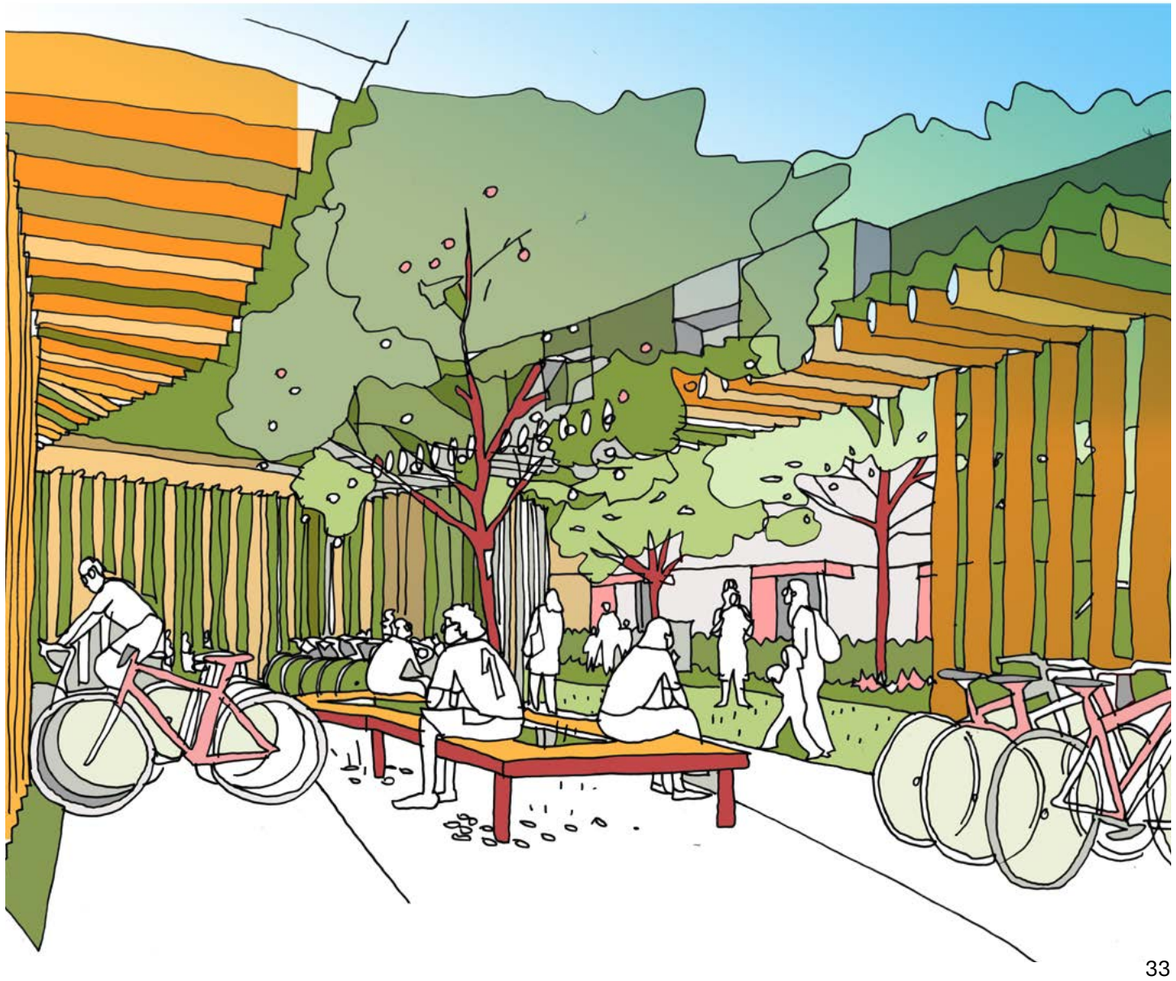
7.4. As discussed in the previous section, achieving success and viability is sensitive to the key components of build costs, land value, finance costs and net rental income (net of maintenance and management costs).

7.5. Without the underwriting of voids by Trusts or ICB, finance costs for schemes and, consequently, viability overall will depend heavily on funders' views of long-term demand risk. Key Worker homes for NHS people at discounts to market rent (in a way that is proportionate to NHS salary bands) have a low risk of voids, particularly if they are well designed with the potential for rental in the open market should the healthcare demand cease or reduce.

7.6. Demand assessment allocated to specific trusts is a source of difficulty for potential partners. Their ability to access the right data to inform demand forecasts and, ultimately, risk assessment on voids is hampered by their position on the outside prior to being appointed as preferred bidder. Where trusts have good-quality demand and 'Voice of the Customer' data, potential funders are able to quantify the risk and offer more informed costs of finance.

7.7. Where a Partner's required return and/or financing costs are lower, viability will improve. In this regard, an option to explore further involves the Partner in an NHS Homes scheme being an institutional investor who, along with financing, integrates the offering with design, build and operational aspects of the scheme. Early discussions have taken place with capital backing pensions that have their own development arms and would be able to offer all the required services to deliver and operate the asset. These conversations have elicited positive responses. The potential benefits are that a comprehensive delivery partner could combine returns from different elements of delivery and therefore potentially reduce the overall Internal Rate of Return (IRR) requirements.

7.8. Equally, the length of contract required by a Partner will be determined by its requisite level of returns. It is considered that the contract between Trust and Partner will be a minimum of 30 years but could extend up to 60 years, depending on the individual requirements of the Partner. The head lease term may be longer than the outsourcing arrangement itself where the investor Partner requires this to satisfy its risk exposure.



8. State Capital Support Schemes

8.1. Securing funding to bridge viability gaps needs suitable consideration from HM Government in an NHS Key Worker Homes context. The Government already operates successful schemes for other 'sub-market' sectors that otherwise deliver a broader benefit, such as the Affordable Housing programme for delivering homes across the UK to meet demand. Equally, sector-specific schemes exist, such as the BEIS/HNIP[14] programme that supplies capital grants for energy infrastructure investments to encourage a take-up of decarbonised district heating networks and thus decarbonise new and existing housing stock.

8.2. The NHS Homes programme should acquire its own dedicated sector status in the same way.

8.3. A policy could either be very simple or link to a standard viability model that would flex capital support based on scheme specifics and market conditions around a benchmark IRR and a competitive market process.

8.4. In terms of process, the grant would be awarded on a stage payment basis to the delivery partner – i.e., de-risking the scheme as it goes from concept through planning to financial close and then the build phase. More grant (up to the limit of each award) is awarded as pre determined milestones are reached, and the timing of these can be set within the award regime.

8.5. By way of example, the ability to deliver Model 1 – "NHS: New Homes Solution" in the market will depend on the viability of the individual schemes, and therefore its attractiveness to potential partners. For those schemes where the rental income received over the lifetime of the arrangement is insufficient to recover the capital and operational costs of the scheme and deliver the required level of return for a Partner, the 'gap funding' approach above would be sought from HM Government to reduce the size of the capital requirement and finance costs of the Partner, thereby improving viability. Approaches to HM Government could be made on an individual, scheme-by-scheme basis but would more efficient under an established grant framework accessible to Trusts for their individual NHS Key Worker housing schemes.

8.6. Where viability can be achieved on schemes or addressed by a gap funding regime from HM Government, securing funding at scale to tackle the NHS Homes programme requires broader consideration to drive efficiency.

8.7. As set out earlier in this paper, the Naylor Report from 2017 indicated potential land holdings capable of delivering up to 26,000 homes, and while likely out of date in 2023, there remains an opportunity to deliver a significant volume of housing on NHS land. Given the magnitude of this prospect, it warrants exploration of pooling a syndicate of institutional investors into a dedicated procured fund that could be drawn from as required. A pooled funding approach could deliver the following benefits:

- Delivery of NHS Homes at scale.
- Possibility of obtaining a preferential borrowing rate.
- An efficient process.
- Pipeline effect – viability considered at total pipeline level, with the viable schemes generating the returns required to meet some or all of the viability gaps on the more challenging schemes.

8.8. This approach is reliant on returns generated from more profitable schemes filling the viability gaps on those that are more challenging. The profitable schemes could therefore be adversely impacted by this approach. This would need to be considered carefully when exploring the possibility of a pooled private fund. If it proved not to be beneficial for all schemes to be included, then a pipeline of the remaining schemes could be considered. In this situation, the approach to gap funding from HM Government would be required, alongside the financing provided by the institutional lenders to address the viability gap.

9. Further Considerations to Manage Finance Costs and Secure Funding

9.1. Consultation with the funding market in producing this paper has revealed appetite for investment and concern over viability and robustness of returns. In a programme that contains no underwrite from HM Government so as to manage the NHS appetite to mitigate financial risk, the market is being asked to invest at risk. However, that same consultation accepts that the void risk is lower than in traditional end user markets, as NHS housing demand far outstrips supply.

To that end, the market recognises the need for a change in its approach to risk where NHS Homes can be ring fenced within a dedicated sector with support from the Government. Consultation has indicated that change can be either to:

9.1.1. Create sector-specific equity capital for injetion into the NHS Homes programme and deploy that capital to schemes akin to Model 1 or 2 in this document; or

9.1.2. Reshape investment regulations for its traditional annuity-linked investments to recognise the soundness of demand for NHS Homes and reduced demand risk thereon.

9.2. For 9.1.2., there is merit in exploring a public/private shared underwrite proposition for schemes, resulting in two key benefits:

- Where HM Government shares some of the demand underwrite, investment can be apportioned to the annuity business and attract lower costs of finance overall.
- Recognising the supply/demand ratio and, given the remoteness of a demand underwrite crystallising, accounting regulations may permit the Government to recognise its potential obligations under the shared agreement outside of the CDEL regime.

10. State Revenue Support Schemes

10.1. In recognition of the need to secure institutional investment against robust returns via rental income, viability concerns are more a function of affordability pressures than occupancy demand in itself. There is no doubt that demand for homes for NHS workers outstrips supply: rent increases over time based on inflation compared to a rigid salary regime remain the key risk factor for investors.

10.2. There is a growing difference in the existing and future housing market between rental rate indexation and NHS salary indexation. Equally, NHS salaries are, broadly, geographically resistant to variation. The housing market is not. The investor market recognises this, and consequently finance costs inflate to reflect that.

10.3. The mechanism for rental growth and the extent of any cap or collar on the level of inflationary increases will impact on the yield required by investors. Equally, the perceived void risk and associated cost of capital will decrease as the target rent discount to market value increases.

10.4. One option is to strengthen the cap and collar limiting rental increases in peak inflation periods while maintaining rental growth in line with NHS salary growth in lower inflation times. This would potentially impact the initial cost of capital and crystallise the viability gap at the point of construction. This gap could then be funded by capital grant, potentially at a much lower lifetime cost than revenue funding.

10.5. Equally, a tight cap and collar removing the long-term alignment between rental growth and inflation may exclude some potential sources of low-cost capital, particularly annuity funds. The Task Force should explore these issues in more detail with institutional capital providers.

10.6. An alternative is to explore the possibility of a HM Government-sponsored revenue fund for Key Worker homes that addresses the salary/rental market indexation delta. Where HM Government can introduce a scheme to top up salaries to cover the rental indexation delta commensurate with individual salary bands and geographical location, it will provide investors with further comfort, lower finance costs and improve viability. Equally, and returning to the genesis of the programme, it will allow NHS workers the opportunity to work where they live rather than having to move somewhere else in the UK just to be able to remain in the workforce.

11. Provision of land

11.1. Availability of land is a key factor in facilitating the delivery of homes. It is challenging to compete for land with open market rent and other grant-funded social rent and shared ownership developers. Using NHS-owned land, including that owned by NHS Property Services, provides a helpful starting point for the delivery of NHS Homes. The model could be applied to other public sector land, including that owned by Integrated Care System partners, and the provision of homes for other Key Workers such as teachers, police and firefighters.

11.2. NHS long-term clinical and estates strategies evolve over time, and so require the retention of control on sites for long-term flexibility. Equally, there may be opposition from Trust stakeholders to the sale of NHS land for one-off capital receipts.

11.3. Under the NHS Estate Code, Best Value requirements for the disposal of surplus land are interpreted as the Market Value for the capital transaction. The capital receipt from using land for NHS Homes will not compete with the capital sum received for open market housing. However, open market land value is a fundamentally different metric from the value of land on which Key Worker homes are built. The value to 'UK plc' of land on which well-built, high quality health and social care homes are built contains a breadth of environmental, economic and societal benefits. HM Treasury's own Value for Money benefits evaluation framework for infrastructure business cases contains robust, monetisable benefits in cash flow terms in the context of wellbeing uplift, efficient workforce and treatment improvements, air quality benefits, reduced recruitment costs, and accelerated skills escalation.

In this way, the approach to NHS Key Worker homes is not a land deal exercise; it is an exercise in maximising the broader output of the NHS through the use of its available land. The value of that output in economic terms is far greater than the land value in of itself. Therefore, where land is released for staff accommodation, the NHS Estate Code should be updated to enable land to be released on this basis, ensuring that the value of the transaction does not conflict with the current metrics of Best Value.

11.4. Many surplus sites, notably the case for Community Health Trusts, will be small, making it difficult to access lower-cost capital from pension schemes and other sources of long-term capital. A pooled approach may remove this barrier.

11.5. The NHS Homes approach advocated in this paper provides solutions to these challenges:

- Using medium-term lease structures ensures NHS control of sites, providing long-term flexibility and reassurance for the public and local authorities.
- Strong demand analysis by Trusts and ICBs, clear messaging, and consistent high-level engagement with the Local Planning Authority can deliver public support.
- An NHS framework with pro-forma documentation and site-specific terms can provide access to long-term institutional finance for smaller sites as part of a wider pipeline.
- ICBs have a role to play in coordinating sites and providing the option of homes close to, but not on, an individual's place of work.
- The approach could be extended to other public sector sites, creating further flexibility and the potential to widen provision to other Key Workers, including teachers, police and firefighters.
- Where development on NHS sites is not viable, grant funding to support viability would allow Key Worker uses to compete with open market, social rent and shared ownership.

12. Procurement

12.1. NHS Trusts are bound by public sector procurement rules and the extensive NHS business case process, which often have undefined timescales. These combined complexities can create delay that kills deals and increases cost. Where a Trust or ICB becomes involved in the specification of NHS Homes (e.g., family homes, cluster flats) to support the Trust's People Strategy or places obligations on a partner to deliver them, this can bring an arrangement with procurement rules requiring a Formal Procurement Process (formerly OJEU).

12.2. Procurement Challenges for a People-Driven Approach

12.2.1. A bespoke Formal Procurement Process is time-consuming, potentially adding 12 months to the project and costing up to 50% more than a private sector procurement, deterring many potential bidders, including long-term finance providers.

12.2.2. A Formal Procurement Process typically seeks a single contracting partner, or consortium with a guarantor, that can bring a complex package of funding and services, inhibiting market disruption and often preventing the selection of best in class for finance, developer, owner and operator options for a specific project.

12.2.3. Individual Trust procurement lacks the scale needed to unlock long-term, low-cost finance solutions where minimum deal sizes are typically circa £100m to allow for transaction costs.

12.2.4. The disposal of land on a freehold or leasehold basis must satisfy best value criteria linked to an RICS (Royal Institute of Chartered Surveyors) Red Book Valuation. Typically, these calculations focus solely on the capital sum received as opposed to the total value including revenue impact, wider social value, economic impact, future flexibility and reversionary land value.

12.2.5. The NHS business case process requires a Strategic Outline Case (SOC), an Outline Business Case and a Final Business Case. Capital schemes with an investment value exceeding £15m require NHSE and Department of Health and Social Care approval, contributing to delay, additional cost and uncertainty, further deterring private sector engagement. Any scheme of sufficient scale will exceed the £15m threshold.

12.2.6. Trust resources and bandwidth are stretched, making it challenging to maintain focus on NHS Homes against competing clinical priorities, further impacting on the decision-making timelines.

12.2.7. Using the NHS Estate Code to dispose of freehold or leasehold land without bringing the transaction within public sector procurement removes the ability to specify the type or mix of housing for a people-focused solution, and limits the ability to specify build and operational quality.

12.2.8. Some degree of collaboration with other public sector bodies such as a Housing Association may be permissible outside of the procurement rules, enabling the use of their pre-procured developers and funders. However, this can be challenging to maintain over the life of the project, and limits the potential for market disruption to deliver lower cost of capital and development profits.

12.3. Procurement Solutions to Secure a People-Driven Approach

12.3.1. An efficient, flexible, cost-effective suite of procurement models that are robust, agile and capable of delivering a people driven approach is required. Solutions include:

12.3.2. Creation of an NHS Homes procurement framework based on a Formal Procurement Process for pilot schemes supported by a working group with private sector and cross departmental expertise to shape the viability model, finance, lease and operating structures. The framework would provide scale and efficiency of transaction through standard process and documentation, attracting long-term, low-cost capital. Albeit the framework must include some flexibility to deliver bespoke/site-specific requirements for Trusts, and may be better delivered under the incoming procurement regulations.

12.3.3. An NHS Homes Centre of Excellence that supports Trusts to deliver at pace. The Centre would use the NHS Homes framework, non-procurement models or bespoke procurement, a toolkit of pro-forma documents, and a model process potentially underpinned by a revolving loan fund for initial feasibility work, project management resource and procurement. Trusts receiving loan funding would commit to an accelerated decision-making process, maintaining momentum. The framework fees, or consultancy charges for non-framework support, would fund the Centre of Excellence and contribute over time to the revolving loan fund.

12.3.4. NHSE, Department of Health and Social Care, HM Treasury approval of a single Strategic Outline Case for NHS Homes, incorporating a range of delivery models to support individual Trust and ICB circumstances. Outline Business Case and Final Business Case approval, if required, would be delegated to Trust Boards or ICB, with support from the NHS Homes Centre of Excellence.

12.3.5. An NHSE-approved benefits appraisal framework for Best Value calculations, including social value, revenue impact for the Trust or ICB Income and Expenditure account, and the benefits for the local economy.

12.3.6. Working with NHS Local Infrastructure Finance Trust Companies (LIFTCos) and Strategic Estates Partnerships (SEPs), where available, to test finance and legal structures and deliver schemes while the framework is being developed.

12.3.7. Partnering with hospital charities where the charity has the appropriate scale, skillset, financial resource and risk appetite, disposing of land interest to the charity, with procurement led by the charity outside the public procurement process. However, the Trust would still have no control over the land, and would not be in a position to be the decision-maker on the type of homes being delivered.

12.3.8. There is the potential to expand the application of the solutions to provide affordable key worker homes across the public sector.

Successfully navigating the complexities of the planning process is a key factor in managing risk, timelines, cost and therefore deliverability of NHS Homes.

13. Planning

13.1. Successfully navigating the complexities of the planning process is a key factor in managing risk, timelines, cost and therefore deliverability of NHS Homes. Extended timeframes of two years or more mean construction and finance markets change by the time consent is secured, resulting in a loss of momentum, risk of personnel change and, potentially, schemes that are no longer viable.

13.2. The planning challenge for NHS Key Worker Homes is illustrated by the recent case of R (Arthur) v London Borough of Barnet, where the Rt Hon Lord Justice Coulson commented in his Court of Appeal Judgement:

Ground 2: Affordable Housing Policies

... On this point it is also appropriate to refer to the wider merits. This is an application for 130 units of affordable accommodation for NHS workers for which, according to the evidence before the judge, there is a very pressing need. The lack of such affordable housing for NHS workers is a major difficulty for the NHS, which explains both the involvement of the Interested Party and the support of the application from NHS Trusts in North London. In those circumstances, criticism of the decision by reference to affordable housing policies is misconceived.

13.3. There is no National Planning Policy Framework (NPPF), Planning Guidance or definitions for Key Worker housing or the use of the NHS Estate for employer-related housing. As a result, each scheme would require bespoke negotiations with the Local Planning Authority, which would typically cover:

- Change of use for the NHS Estate from healthcare provision.
- Whether affordable housing policies apply in addition to the provision of discounted market rent NHS Homes.
- The level of s106, CIL, highways contributions.

13.4. Resource constraints in Local Authority planning departments could further impact the timelines for consent, particularly where complex bespoke negotiations are required. This uncertainty, and the impact on viability, could be a first hurdle to considering whether or not homes can be delivered at all.

13.5. There are a number of options to address the concerns over the change of use from healthcare:

- Expand healthcare use definition to cover employer-related housing, including for those providing outsourced services.
- Exclude homes on the NHS Estate from Right to Buy and enfranchisement to protect healthcare land use flexibility long term.
- Use medium-term leases with the NHS as freeholder to preserve flexibility for future healthcare use.

13.6. The creation of an NHS Key Worker Homes planning use class would provide a standard approach to reducing delivery risk, including:

- Maximum average rental level set as a discount to market rent, including energy costs (e.g., 80%). This would satisfy planning concerns on the delivery of 'affordable' housing while providing flexibility for the Trust or ICB to set rents at a lower level linked to salary bands. Using average rents would allow for rental growth overtime to align with an individual's career/wage progression. Additional rental income would be used to provide lower rental price points within the scheme for other salary bands.
- Expand the NHS Key Worker definition to cover those delivering health and social services though outsourced arrangements – e.g. social care workers, porters, domestic services, opticians or dentists. Many of those in this broader definition may work for the Local Authority or other care providers as well as the NHS, thus supporting Local Authority housing provision for Local Authority workers.
- Exempt NHS Key Worker housing from affordable housing policies, s106, CIL, and for car light schemes/highways improvements.
- Should homes not be required for NHS people within the ICB or adjoining ICBs, have a cascade of nomination rights in order of priority to include other Key Workers, Local Authority housing list and open market rent.

13.7. There are a number of delivery mechanisms for the solutions set out above that can support implementation in the short, medium, and long term:

- Establish a Local Development Order (LDO) that can apply for NHS sites across the country. This would effectively grant a planning consent in principle, offering a more dynamic planning tool that can adapt through market fluctuations and respond to changing needs over time. An LDO should be accompanied by a design code that can steer the architecture and landscape design, giving the NHS and the local planning authority some reassurance that the design ambition for the sites will be met while being mindful of the viability and potential associated grant funding requirements. The design code could be tailored for different degrees of density and be specific enough to capture the key principles for NHS housing schemes while leaving sufficient flexibility for local adaptations.
- Establish a Local Development Procedure Order with the ICB as a statutory consultee to support the LDO.
- Create a special workstream at the Planning Inspectorate to resource and expedite the consideration of NHS Key Worker Homes supported by Local Planning Authority managing statutory consultees.
- Issue Planning Guidance on NHS Key Worker Homes and healthcare use. • Establish a time-limited expansion of Crown Development Rights.
- Update the National Planning Policy Framework on NHS Key Worker Homes and healthcare use.

14. Design

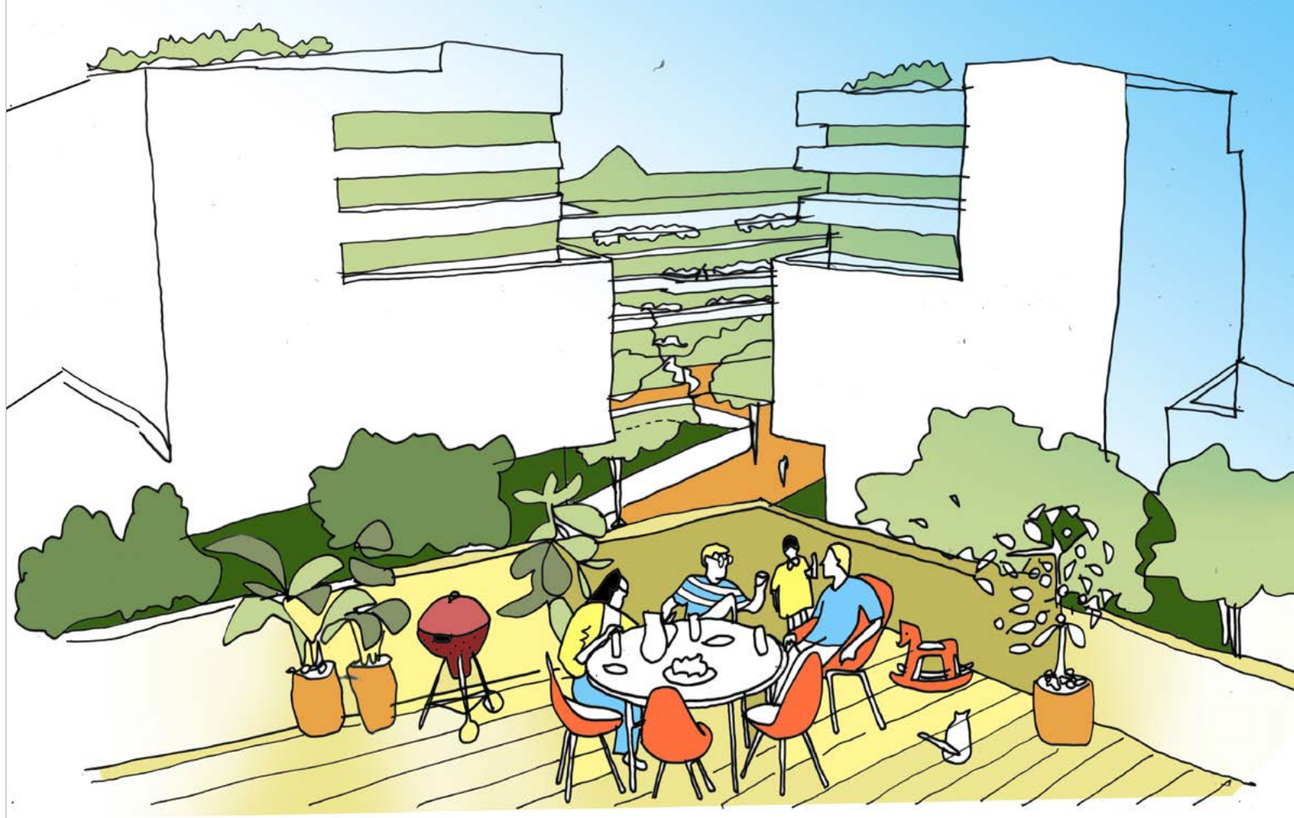
14.1. The design and architecture of the new developments should be of the highest quality, prioritising a people-centric layout and human-scaled density of homes, from compact low-rise to mixed-use medium and high-rise. This should include, where possible, dual-aspect units meeting the National Space Standards and light-filled homes with access to private and communal green space. The acoustic treatment of apartments is also very important in relation to staff who have different shift patterns, assisting rest during daylight hours by minimising noise through the structure of the building. The approach will vary depending on the site and the context, ensuring the new neighbourhoods seamlessly blend in and are considerate of their local environment. Where medium and tall buildings are constructed, heights should gradually step down to meet the massing of adjacent built fabric.

14.2. Key to successful design is the creation of an appropriate development brief based on a design code for NHS Homes and specific Trust or ICB requirements and demand data. Provision of pro-forma sample briefs as part of the toolkit, together with support from the Centre of Excellence, including the option of design review panels, will help deliver places that attract and retain NHS people in the long-term.

14.3. An extrovert housing approach and ground level design are critical to create a place that feels active and lived in. Front doors that face onto streets and windows that overlook public spaces, for example, create a homely environment with the presence of people. Defensible garden spaces allow residents to populate the edges of the public realm, talk to neighbours and passers-by while providing a buffer between the street and the home. The ground level of commercial and communal facilities should be glazed and transparent, with active uses, offering opportunities to spill out onto sidewalks and squares.

14.4. A variety of homes can be provided to suit different needs, from family-sized apartments and houses to smaller apartments and terraced housing. Apartment blocks in larger schemes have the capacity to incorporate a mix of uses at ground and lower levels, including education and childcare, that can serve NHS workers and the community more widely, not just the residents of the development.

14.5. Cluster living options can meet the needs of shorter-term stays, whether this is for visiting or more transient staff, such as researchers or graduates on work placements, or to provide a more affordable option for younger staff in search of a sociable lifestyle. This typology functions as a blend between aparthotel and co-living, with the potential to integrate different in-house services such as concierge, gym, event spaces and co-working spaces, as well as communal dining and living areas.



14.6. Car parking should ideally be located at the entrance points of sites to reduce car dominance and unlock the interior of the new developments for pedestrians and cyclists. Underground car parking is often very expensive to build, but utilising topography that allows for more cost effective ‘undercroft’ or podium-style accommodation can minimise the dominance of cars in the public realm. The public realm should be designed to inspire social interaction, weaving in squares and open spaces, natural play areas, and green and growing areas. By replacing ornamental trees and planting with edible varieties, children and people of all ages can learn about local food production, a means of encouraging more sustainable food habits. Integrated cycle tracks, walking routes and running circuits can help residents lead more active and healthy lifestyles.

14.7. High-quality materials and well-considered design solutions can help future-proof the development, ensuring durability and reducing maintenance, thus minimising labour requirements and operational costs in the longer run. By using local materials, the new architecture can blend with the local vernacular while helping to sustain local economies. Native plants should be prioritised, as they are well adapted to the UK climate, which means they are more resilient, lower-maintenance and use fewer resources.

High-quality materials and well- considered design solutions can help future-proof the development, ensuring durability and reducing maintenance.

15. Modern Methods of Construction

15.1. Modern methods of construction (MMC) that use modular and panellised off-site production would be well suited to the delivery of NHS Homes. MMC projects have many sustainability benefits, can speed up construction time, reduce costs, improve quality and precision, reduce waste, save energy, and minimise deliveries and their associated noise and pollution impacts. This method also enables standardisation across projects, which can streamline the design and development process to save time and money while maintaining the required level of quality.

15.2. The level of demand for housing that is affordable to NHS Key Workers means that rapid occupation is likely realising significant cash flow benefits from the shorter construction programme provided by MMC. A model procurement process, particularly if combined with a suite of standard living space ‘chassis’, could turbo charge the UK MMC industry, potentially driving expansion of capacity. The standard chassis can be finished with a range of facades and approaches to articulation to provide quality homes that speak to the local vernacular.

15.3. MMC can delivery multi-storey, multi-tenant buildings. Quality can be ensured through NHBC and BOPAS accreditation. Using a range of systems would mitigate concerns about systemic design failure. Including MMC development finance options on the NHS Homes framework would further support the use of MMC for the sector.

16. Maintenance and operations

16.1. The NHS has a poor track record of maintaining staff accommodation due to a lack of funds and resources, with rent contribution often directed to other services. This results in a decline in quality over time and a downward spiral of occupancy, rental level and further maintenance funding pressures, turning an asset for retention and recruitment into an embarrassment in many instances. This is further exacerbated by poor and aged design with little thought given to amenities that improve quality of life for NHS people.

16.2. Where buildings are operated by third parties, there has been limited active management of maintenance provisions.

16.3. There is a risk that homes and future flexibility of land use could be impacted by Right to Buy or enfranchisement by tenants or long leaseholders.

16.4. To ensure NHS Homes deliver the ambition of attracting and retaining NHS people in the long term, there needs to be:

16.4.1. A direct relationship between the operator and the tenant supporting a customer-focused service approach that aligns tenant, operator and leaseholder interests in delivering a well-managed and maintained building to maintain occupancy.

16.4.2. A pro-forma operating agreement with quality customer service agreements, maintenance and sinking fund provisions with the ability for the leaseholder, and ultimately the NHS freeholder, to change the operator if required.

16.4.3. Selection of quality long-term investors as leaseholders with a track record of caring for and maintaining their assets as part of a dedicated ESG agenda.

16.4.4. Ability for Trusts to select a best-in-class operator as part of the procurement based on local circumstances, including both professional Build-To-Rent operators and Registered Social Landlords.

16.4.5. Controls under the lease or concession arrangement to allow the building to be taken back for poor performance by the leaseholder in the first instance, and ultimately the freeholder.

16.4.6. Sufficient sinking funds built into the viability model to ensure long-term maintenance capability.

16.4.7. Active long-term NHS management of the relationships, likely at ICS level, with the skills and corporate memory to use legal mechanisms appropriately.

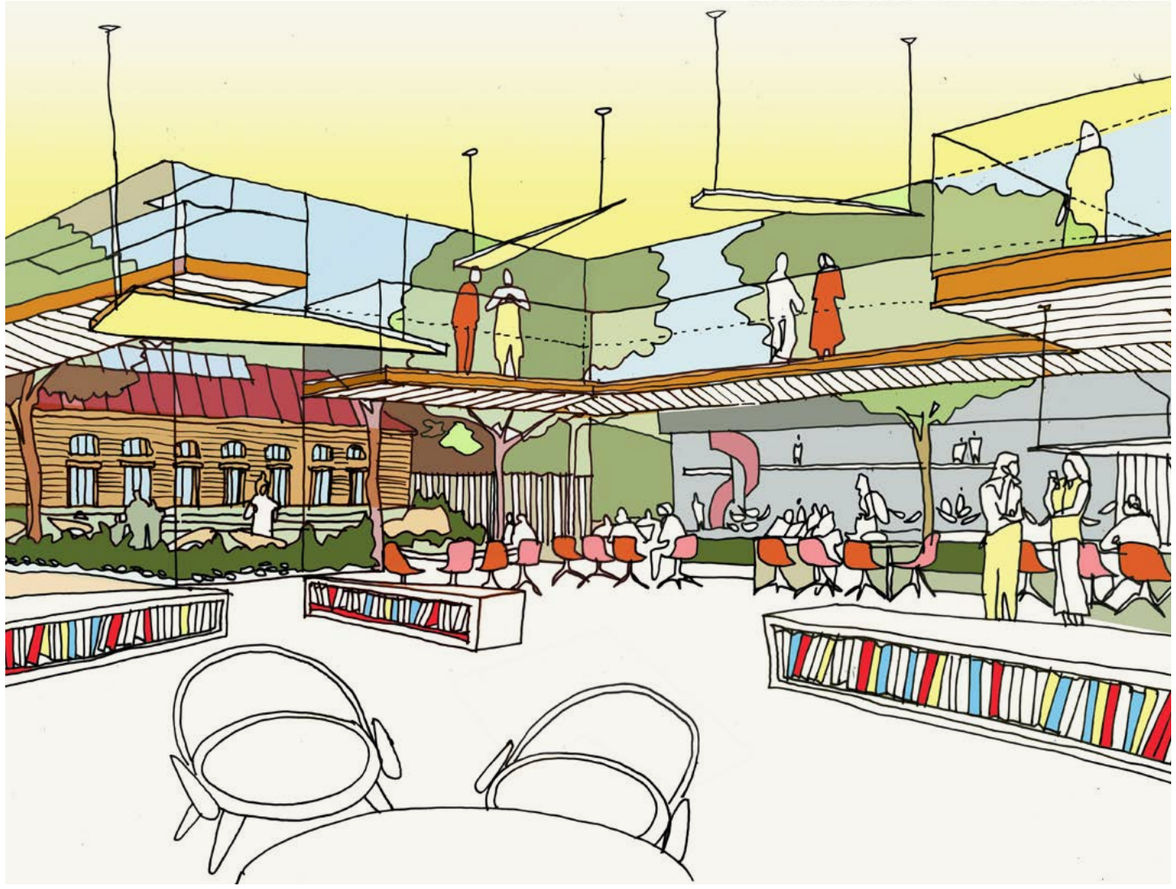
16.4.8. Thought given to the rental structures and what happens when an individual moves to a different Trust, works elsewhere in the care system or leaves altogether, ensuring that appropriate forms of tenancy are used to retain homes for NHS people.

16.4.9. An appropriate mechanism for adjusting rental discount as household income increases through career progression, with incremental rental income over the anticipated base level used to further discount rents in other homes within the scheme or returned to the freeholder via a turnover linked ground rent.

16.4.10. Exemption from enfranchisement in line with Shared Ownership.

16.4.11. An opt out from Right to Buy legislation in line with the rural exemption scheme for Shared Ownership.

16.5. Where a Formal Procurement Process is not used, only some of this list would be achievable.



Appendix

Appendix 1 - Potential Models

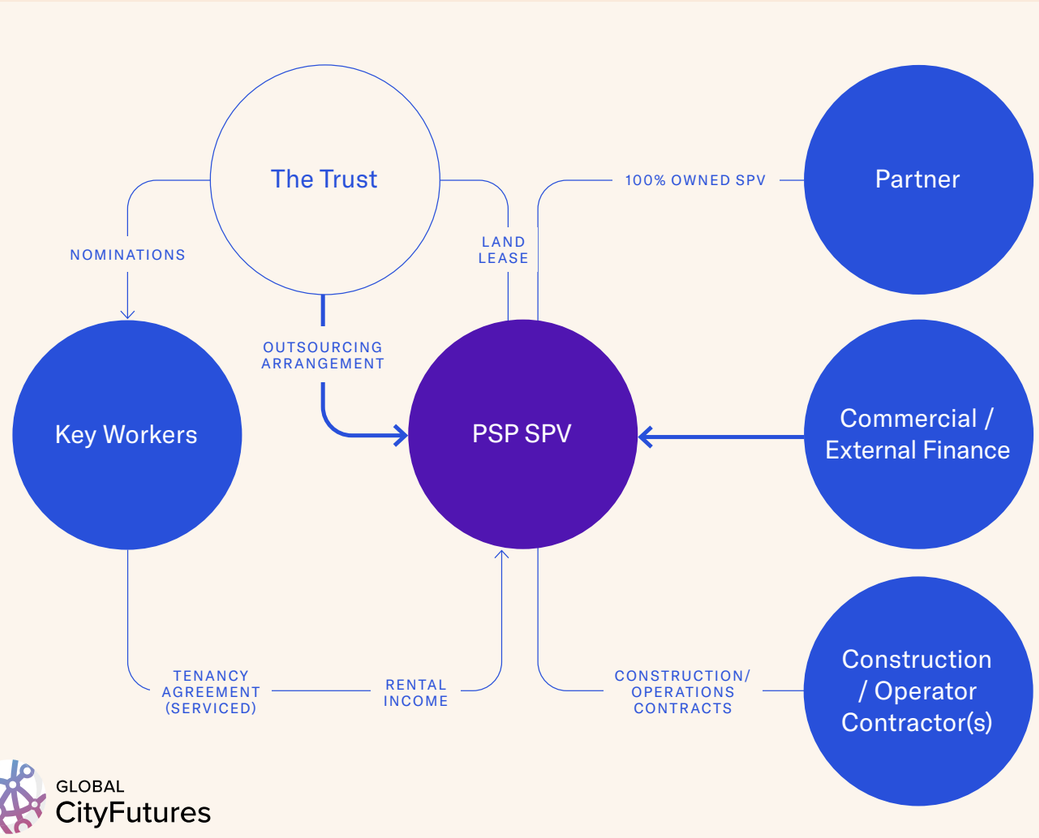
Five models have been developed. These have varying strengths and weaknesses in terms of control, procurement, capital departmental expenditure limit (CDEL), finance, cost and viability.

Model 1 – "NHS: New Homes Solution" – Developed by Global City Futures (GCF)

The proposed commercial structure is represented in the diagram below in Figure 1. The base case model involves a third-party partner (the "Partner") providing high-quality staff accommodation through an outsourced arrangement within a single contract between the Trust and its Partner where construction, availability, demand and void risks are passed to the Partner. The Trust takes on no financial risk.

The Partner finances and carries out the construction work in accordance with a specification developed by the Trust via the preferred option in its Business Case. The Partner would be responsible for maintaining and operating the accommodation to standards set by the Trust for an agreed term. The Partner would also be responsible for the management of the accommodation, including managing lettings, rent collection and marketing to potential occupants. At the end of the arrangement, the accommodation would return to the Trust for nil consideration.

Figure 1 NHS: New Homes Solution



NHS: New Homes Solution – Key Features

- The Trust would grant access to the Partner ("PSP SPV" in Figure 1 above) to occupy the Trust land under a head lease arrangement.
- The Trust would enter into a long-term (e.g., for 30–60 years) outsourcing arrangement with the Partner.
- The head lease term may be longer than the outsourcing arrangement itself, where the investor Partner requires this to satisfy its risk exposure.
- The Partner finances, builds and operates an accommodation facility to an agreed output specification, based on the Trust's business case, for the duration of the arrangement.
- The Partner's returns would be derived from the rent collected directly from tenants. The Partner would be expected to take occupancy risk of the tenants.
- The Trust has nomination rights such that its Key Workers have first refusal to the accommodation, followed by a cascade of further nominations, such as other Trust staff and, where agreed at a system level (ICB), other Key Workers in the local public sector. Following the cascade arrangement, the Partner can offer tenancies in the private rental market if there are any remaining vacant units.
- The Trust will not be required to make payments for the works or maintenance of the accommodation, and the Trust will not guarantee any obligations of the Partner to its funder or underwrite demand for the accommodation.
- Shorter-term occupancy commitments may be given by the Trust, with an annual nominations process rolling throughout the year to provide flexible tenancy start dates to meet staff demand.
- The Trust will 'set' the rental price regime for the accommodation for Key Workers via the contractual arrangement with the Partner, including, for example, indexation assumptions, with the potential to offer means-tested, discounted rents for Trust staff.
- The rental price regime further down the cascade will be agreed in the contract, where, for example, the Partner can set its own price at the end of the cascade for units offered on the open market.
- At the end of the arrangement, the accommodation, rental income streams and maintenance liabilities will revert to the Trust's ownership and control for £nil consideration, and the remaining term of the head lease falls away.

Scoring against CDEL: Accounting and Budgeting Solutions

NHS Trusts prepare their own financial statements under International Financial Reporting Standards for financial accounting purposes. However, for budgetary purposes the public sector and the NHS prepare a separate set of accounts, which are consolidated into the UK National Accounts. The method in preparing these accounts differs from the Trust's single-entity financial statements, and are used to determine the upstream treatment of financial transactions for the purposes of preparing the UK's National RDEL (resource spending) and CDEL budgets. These are later allocated downstream to ICBs and then to single entities such as NHS Trusts.

Accounting for the purposes of preparing those UK budgets follows the Manual of Government Deficit and Debt ("MGDD").[15] Equally, UK ICBs themselves, which can determine the allocation of RDEL and CDEL budgets into Trusts, NHS Property services and other NHS entities, have their own specific accounting manual: "Department of Health and Social Care Group accounting manual 2021 to 2022" published on 23 April 2022.[16]

Typically, the basis of preparation for the UK budgetary accounts in the MGDD and in the CCG Accounting Manual follows International Financial Reporting Standards. However, some differences do exist, in particular with reference to outsourcing-style arrangements, which many residential accommodation contracts resemble. Under the MGDD, the budgeting classification generally focuses on allocation of the risks and rewards of assets under an outsourcing arrangement between the public and private sector. In order to determine allocation, the MGDD establishes three primary risk factors against which an arrangement should be assessed. Where the private sector holds (a) construction risk and one or both of either (b) demand and (c) availability risk, the assets are not considered to be on the public sector balance sheet for the purposes of National Accounts, and the contract would require no CDEL cover.

Equally, the CCG Accounting Manual itself has a specific budgetary treatment relating to outsourcing style arrangements, stating:

- "4.462 – Assets are recorded 'off-balance sheet' if both of the following conditions are met:
- the private partner bears the construction risk, and
- the private partner bears at least one of either availability or demand risk, as designed in the contract."

To that end, CDEL-compliant solutions for residential accommodation schemes can exist under an outsourcing-style arrangement.

How the Model Supports the Delivery of NHS Homes

In deploying the NHS: New Homes Solution model to that opportunity and vision, the model considers the following relevant factors:

- Control: Where land is owned and ringfenced for on-site housing by NHS Trusts, and where commercial terms with a Partner can be agreed, the model provides those Trusts with robust control of the accommodation facilities. The nominations cascade arrangement offers exclusivity to Trust staff and, latterly, ICB Key Workers. Equally, the arrangement contains output-specified construction design and maintenance obligations commensurate with local and Trust and ICB-specific demand profiling gleaned from Voice of the Customer surveys and its Preferred Option in the Business Case process. This ensures, for example, that design can be built sustainably and future-proofed for the longer-term net zero targets.

- CDEL: The model has accounting and budgeting opinions confirming CDEL compliance, provided by external, qualified specialists in the field. The model also has recent written confirmation of CDEL compliance from the NHSE/I Accounting and Consolidation team.

- Procurement: The model assumes outsourcing of construction works and services to a third party. In this way, selection of an appropriate partner requires a procurement process, for which there are broadly two approaches currently being adopted by Trusts under this model:

1. Formal Procurement Process (formerly OJEU) process to select the Partner, or PSP SPV

2. Non-OJEU selection of a Housing Association

Should an appropriate framework be developed, this model could also be procured under than framework.

Current Projects Using this Model:

- Royal Devon University Hospitals NHS Foundation Trust, North Bristol Trust, Great Western Hospitals NHS Foundation Trust and East Kent University Hospitals NHS Foundation Trust are currently working with financial consultants, Global City Finance, and wider consultant teams (design, legal and planning) to deliver NHS Homes on the basis of the New Homes Solution commercial model. Each of these Trusts is currently within the business case lifecycle process, their Executive Boards having released revenue funding to progress their business cases and procure the projects.

- Unit numbers in this group range from circa 700 down to circa 100 units, depending on each Trust's objectives, approaches to its specific staffing considerations, and available Trust-owned land parcels.

- Each Trust has similar objectives, albeit with some variations on the golden thread of staff retention. Focus on retention in this group ranges from the nursing and student nursing cohort through to the junior doctor cohort. This results in differing approaches to design and rental value expectations. Equally, with these projects serving a wide geography as a group, sensitivity around differing land values and market rents is evident. To that end, this project group delivers a helpful spread of test cases with which to apply the commercial model in respect of housing density, local land values and the reality of localised market rent pricing.

- Work completed to date includes Standards of Business Conduct approval, Outline Business Case production, soft market testing and procurement activity where, in the case of Royal Devon UH and following soft market testing, prospective bidders have now committed their resources to prepare outline viability assessments to the Trust's deadline.

Model 2 - Medium-Term Lease with Discounted Asset Value Offset by Small Lease Premium

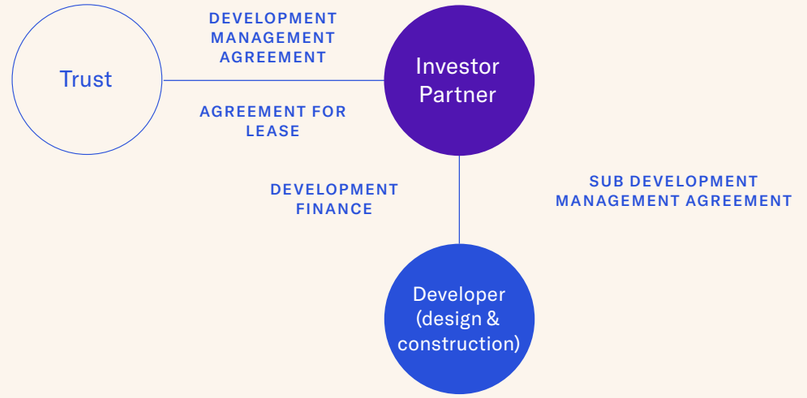
The proposed commercial structure is represented in the diagram below, in Figure 2. Model 2 has similar outputs to Model 1 but uses a different legal framework. The appetite of potential finance partners for the different structures should be explored through a Key Worker Homes Task Force working group.

The base case model involves a third-party partner or partners (the "Partner") providing high-quality staff accommodation through a development agreement, agreement for lease and a mid-term lease. As in Model 1 construction, availability, demand and void risks are passed to the Partner. The Trust takes on no financial risk. The Partner finances and carries out the construction work in accordance with a specification developed by the Trust via the preferred option in its Business Case.

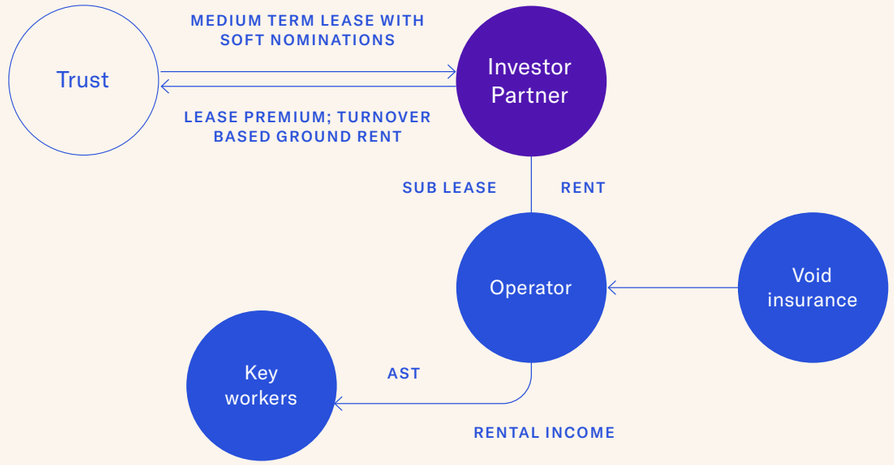
The Partner would be responsible for maintaining and operating the accommodation to standards set by the Trust for the length of the lease. The Partner would also be responsible for the management of the accommodation, including managing lettings, rent collection and marketing to potential occupants. At the end of the arrangement, the accommodation would return to the Trust for £nil consideration.

Figure 2 Medium term lease and premium

Design & construction phase



Operational phase



Model 2 – Key Features

- The Trust would grant access to the Partner ("PSP SPV" in Figure 3 above) to construct the homes on Trust land under a Development Agreement and Agreement for Lease setting out the terms of the future lease.

- The Partner would enter into a Sub-Development and Finance Agreement with a developer to design, secure planning and deliver homes.

- On practical completion of the homes, the Trust would grant the Partner the Medium-Term Lease in accordance with the Agreement for Lease. The Partner would pay the lease premium to the Trust.

- The Medium-Term Lease would include a soft nominations agreement, rental price regime, maintenance and operating provisions. Failure to remedy a serious breach of the lease would result in forfeiture of the building.

- The Partner would appoint an Operator for the buildings in line with the provisions in the lease.

- The Operator would receive the rents, take the occupancy risk of the tenants, and maintain the homes on behalf of the Partner. There is the potential to insure the occupancy risk.

- The Partner would receive a rental income from the Operator for the building sufficient to pay off the cost of the investment in the building and the required return over the length of the lease.

- Should the Operator fail to perform, the Partner would have the ability to replace the Operator.

- Under the Lease, the Trust has nomination rights such that its Key Workers have first refusal to the accommodation, followed by a cascade of further nominations such as other Trust staff and, where agreed at a system level (ICB), other Key Workers in the local public sector. Following the cascade arrangement, the Partner can offer tenancies in the private rental market if there are any remaining vacant units.

- Should rents be above the base level anticipated in the lease, the profit would be split between the Partner and the Trust as a turnover-based ground rent.

- The Trust will not be required to make payments for the works or maintenance of the accommodation, and the Trust will not guarantee any obligations of the Partner to its funder or underwrite demand for the accommodation.

- Shorter-term occupancy commitments may be given by the Trust, with an annual nominations process rolling throughout the year to provide flexible tenancy start dates to meet staff demand.

- At the end of the arrangement, the accommodation, rental income streams and maintenance liabilities will revert to the Trust's ownership and control for £nil consideration, and the remaining terms of the head lease falls away.

Model 2: Accounting and Budgeting Solutions

The use of development leases to deliver NHS Key Worker Homes would not only increase the development and land value retained by the NHS in the long-term, but also potentially be outside of Capital Departmental Expenditure Limits (CDEL) based on the steps below:

1. Reclassify land as investment property – IS40
Land can be reclassified as investment property under IS40 when operational use ceases. The signing of a development agreement and an agreement for lease provide evidence that the land is an investment property.

2. Grant a medium-term lease on the completion of development
A medium-term lease is granted in accordance with the agreement for lease on the practical completion of the homes. The land is then revalued upwards just prior to disposal maximising the valuation. The revaluation is a credit to the Income & Expenditure account.

The execution of the lease is a disposal, creating a credit to CDEL equivalent to the value of the lease disposed of. The lease disposal value is the lease premium – see below lease premium calculation.

3. Value of the land and homes reversion is booked at time of lease disposal
The value of the homes and the land at the end of the medium-term lease is the value of the reversion. The reversion is discounted by around 5%, as set out in the Sportelli Valuation case[17] to present value. The present value of the reversion is booked on the balance sheet, creating a debit to CDEL.

Setting the lease premium at the same level as the value of the reversion creates a neutral CDEL position, with the credit from the lease premium offsetting the debit from the building reversionary value.

4. Value of the reversion increases over time
As time passes and the end of the lease is closer, the level of discount applied to the reversionary value of the buildings unwinds. As the property is accounted for as an investment property, the unwind of the discount is not treated as CDEL.

5. Public Dividend Capital (PDC) on leasehold reversion
The Department of Health and Social Care charges PDC at 3.5% on assets. This charge is not mandated by HM Treasury but would be a drain on Trust resources. It is recommended that Key Worker housing be treated as outside of PDC.

Alternatively, there may need for an increasing ground rent at the tail end of the lease to offset the rising value of the reversion and associated PDC. This could be funded through as longer term on the lease.

Model 2 – How the Model Supports the Delivery of NHS Homes

- Control: Where land is owned and ringfenced for on-site housing by NHS Trusts, and where commercial terms with a Partner can be agreed, the model provides those Trusts with robust control of the accommodation facilities. The nominations cascade arrangement offers exclusivity to Trust staff and, latterly, ICB Key Workers. Equally, the arrangement contains output-specified construction design and maintenance obligations commensurate with local and Trust-specific demand profiling gleaned from Voice of the Customer surveys and its Preferred Option in the Business Case process. This ensures, for example, that design can be built sustainably and future-proofed for the longer-term net zero targets.

- The use of a lease structure provides a robust mechanism for enforcing the maintenance and operation conditions, with the ability to revoke the lease and take the building back as the ultimate sanction for non-compliance.

- CDEL: The model requires further testing by the proposed Task Force in terms of the CDEL treatment of the unwinding of the discount on the reversion over time to confirm that it is outside of the CDEL envelope.

- Procurement: The focus on specifying the outcomes based on the people needs of the Trust and the requirement for control to ensure that these are delivered over the life of the scheme brings the model within the public sector procurement rules.

The model requires the procurement of a partner or partners for finance, delivery and operations. The ability to procure these elements individually may enable disruption in the market, bringing in the existing Build-To-Rent investment sector at substantially lower cost of capital, thus transforming viability.

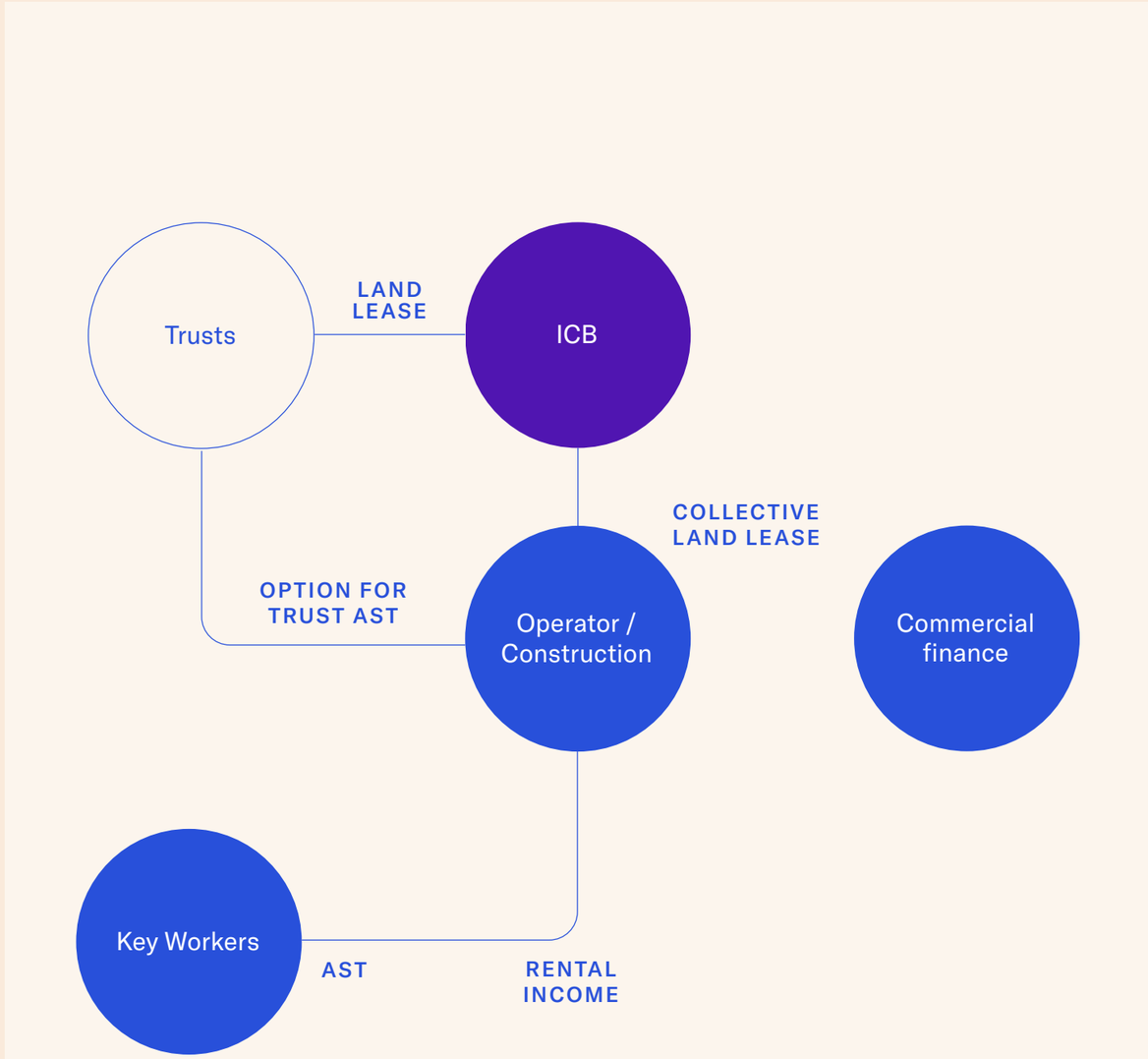
The potential approaches for procurement include:

1. Full OJEU process to select the Partner, or PSP SPV.

2. Non-OJEU selection of a Housing Association.

3. Development of an appropriate framework including all key elements – finance, delivery, operations with the ability to mix and match best in class for each solution for the specific scheme.

Figure 3 ICB Estate Code Solution



Model 3 – "ICB Estate Code Solution"

The proposed commercial structure is represented in the diagram in Figure 3.

The base case model involves the ICB and Trusts identifying possible housing sites. The ICB markets sites collectively to Build-to-Rent operators/investors to create scale. Marketing information includes a due diligence pack, expected lease terms, and a requirement to offer units to Key Workers at a discounted price as part of a nominations cascade.

Operators test core requirements, including the number of units, rents, demand from health occupiers and demand from other key workers. The operator determines the potential housing numbers/mix and commercial terms.

Design, planning, construction, availability, demand and void risks are passed to the Operator. The Trust and ICB take no financial risk. There is no nominations agreement from the Trust.

The Operator finances and carries out the construction work in accordance with a specification developed by the Operator based on its market analysis. The Trust provides oversight on its own site.

Prior to completion, Trusts can secure a number of units on Assured Shorthold Tenancy. The Operator markets units through the cascade routes, and occupation is through standard Assured Shorthold Tenancy. Where voids exist, the Operator markets them on the open market. At the end of the year, there is a profit share on open market rents, returning value to the ICB or Trusts.

The Operator would be responsible for maintaining and operating the accommodation through the course of the lease term.

At the end of the arrangement, the accommodation would return to the Trust for a peppercorn consideration.

ICB Estate Code – Key Features

- The Trust would grant access to the ICB to occupy the Trust land under a head lease arrangement.
- The ICB would enter into a back-to-back mid-term collective sub-lease with the Partner. • The Operator designs, finances, builds and operates an accommodation facility based on its view of the market need.
- The Operator's returns would be derived from the rent collected directly from tenants. The Operator would be expected to take occupancy risk of the tenants.
- The Operator markets the units through the cascade routes.
- The ICB will not be required to make payments for the works or maintenance of the accommodation, and the Trust will not guarantee any obligations of the Operator to its funder or underwrite demand for the accommodation.
- Individual Trusts may secure a number of units on Assured Shorthold Tenancy agreements. • Shorter-term occupancy commitments may be given by the Trust, with an annual nominations process rolling throughout the year to provide flexible tenancy start dates to meet staff demand.
- The ICB sets the requirement to offer units at a discounted price under the lease. • The rental price regime further down the cascade will be for the Partner to determine based on the market. Any 'excess' rent over and above the standard discounted rent will be shared with the ICB.
- At the end of the arrangement, the accommodation, rental income streams and maintenance liabilities will revert to the Trust's ownership and control a peppercorn sum, and the remaining term of the head lease falls away.

ICB Estate Code – How the Model Supports the Delivery of NHS Homes

- Control: The model is based on the Partner market testing core requirements in terms of units, rents and demand. The Partner determines the potential housing numbers/mix and commercial terms. The market incentive is for the most profitable units (e.g., cluster flats), as opposed to identifying the most urgent people need for an individual Trust.

There is a requirement to offer to Key Workers in the occupation cascade under the lease, but there is no nominations agreement in place. Design, planning and construction all sit with the Partner based on its assessment of the market. There is no requirement for sustainability or future-proofing for the longer-term net zero NHS targets.

- CDEL: There is no control or guarantee on the rents, therefore no CDEL implication on the grant of the lease. However, this needs to be confirmed with Central Government. The accounting treatment reflects those normally found with land leases where the asset is not in the ownership/ control of the NHS.
- Procurement: The model assumes that the specification and rents are entirely determined by the market, and as such under the NHS Estate Code this model falls outside of the procurement regulations.

ICB Estate Code – Current Projects Using this Model:

- NHSE Southwest is currently exploring this model with a number of Trusts.

Model 4 - Hard Nominations with Housing Associations of S106

16.6. This model considers situations where Trusts have either very limited surplus land to offer for Key Worker housing or no surplus land at all.
16.7. The following potential options present themselves:

- Working with a nominated Housing Association to take up a proportion of existing stock or stock under development specifically for NHS Homes, based on nominations from the Trust.

- Working with developers of housing that are in negotiation with Local Planning Authorities on planning consent and s106 agreements, where any affordable or social housing component could be the subject of specific hard nomination for NHS Homes by the Trust or ICB.

- Working with providers of student accommodation to assess level of appetite for diversification into a new asset class. Many of these organisations are backed by major funds already interested in the potential this market offers, and they have the infrastructure in place to develop and manage large residential portfolios.

16.7.1. Contractual Arrangements

- The Trust enters into an agreement with the Housing Association to guarantee to provide tenants for a specific number of homes of size and type to be agreed. • Tenancy arrangements are a direct relationship between the Trust employee and the Housing Association.

- Where a housing developer in negotiation with the Local Planning Authority looks to support from a Trust to demonstrate a NHS Homes need to gain support for planning consent, a development agreement should document the respective duties and obligations of the parties to secure properties for NHS Key Workers, together with how ongoing ownership and management is to be addressed.

- If there is appetite from student accommodation providers to diversify into this market, the contractual arrangements will be as per those with the Housing Association.

16.7.2. The Details

16.7.2.1. The Trust enters into a development agreement with the Housing Association/Developer to nominate a specific number of employees as occupiers of what will be described as NHS Key Worker Housing. A legal definition of this term needs to be made. In return, the developer will build and offer to the nominated parties the housing described in the development agreement.

16.7.2.2. The Housing Association will own and manage the property, having a direct contractual arrangement with the Key Worker.

16.7.2.3. The Residential Developer will, as part of the development agreement, work with the Trust to find a buyer for the Key Worker Housing of appropriate standing and with a track record of competent estate management.

16.7.3. CDEL Implications

16.7.3.1. Where a hard nominations agreement is inclusive of a Trust guarantee over voids, this option will potentially result in a CDEL implication for Trusts. In the absence of such a guarantee, the CDEL implication is potentially minimal.

Model 5 – Corporate Joint Venture

Model 5 represents a different approach whereby the public sector shares risk with the private sector through an investment joint venture. The public sector retains an appropriate degree of control through the joint venture by participating side by side with a private sector co-investor. This approach enables an open tender exercise to be used to facilitate the public sector assessing how value can be maximised, while still ensuring that the land is developed to house NHS Key Workers and there is a degree of retained control over key decisions and ongoing proper use and maintenance of the property estate.

An example of this type of joint venture is provided by Transport for London in its joint venture with Grainger, Connected Living. The public sector contributes the value of the land, and the private sector partner matches this and sources the additional finance required, potentially by way of debt to the joint venture, to develop the land for Build-to-Rent residential. The joint venture holds the land, benefitting from the income flow, or potentially sells it. The initial land value is tested and protected, either through the tender process or independent valuation, to ensure Best Value requirements are met. The adjoining ongoing operational assets (here the relevant NHS facilities) can be protected, if necessary, through the use of asset protection agreements.

The public sector retains overall control of land use and ensuring it is looked after through the property being a long leasehold interest in which it retains certain controls as freeholder. However, the lease in this arrangement is likely to be a 'virtual freehold'/long leasehold and demised for at least 250 years. There is also likely to be a right for the leaseholder to extend the lease under normal residential principles such as enfranchisement.

The public sector will be a shareholder in the joint venture, which potentially (subject to various adjustments for public sector balance sheet and other issues) enables it to participate in key decisions made by the joint venture. The joint venture accepts development and letting risk; this is then shared between the public and private sectors in accordance with their respective interests.

The approach capitalises on current investor appetite for residential assets, but would be looked at on a case-by-case basis by the investment market to consider the value and attractiveness of each asset. An important consideration, however, will be the potential for the public sector to contribute additional capital alongside the private sector and the terms for that contribution.

Example Application/Structure

- Under this approach in a Key Worker Homes context, the Trust will potentially take an influencing share of a joint venture, between 1% and 49%. Note that the Trust's share of the JV can be only up to 49% of the JV. Any greater share would, potentially, automatically trigger a CDEL implication, since any project funded by public capital at 50% or more is deemed as public sector-owned and controlled for balance sheet and CDEL purposes under the Manual for Government Deficit and Debt.

- The majority stake will be held by the delivery partner. The Trust will transfer its land, via a long lease, into the partnership vehicle in exchange for its equity stake. The delivery partner will match this with cash in exchange for equity commensurate with its own stake.

- In this structure the separate entity partnership, or JV, is capitalised by a mixture of land value from the Trust, cash from the delivery partner and commercial borrowing.

- The Trust provides the land on a 250-year-plus long head lease.

- The JV vehicle designs, builds, finances and operates the Key Worker accommodation facility. • There are no minimum lease payments to be made by the Trust. Rather, units are rented directly to key worker tenants, with the JV collecting rents and taking on demand and credit risk.

- The JV is also responsible for maintaining the facility and making it available for rental, thereby adopting availability risk.

- The Trust has nomination rights for the units such that it is able to nominate its own NHS staff as primary tenants. Thereafter, the Trust can nominate other key workers, and where there is availability beyond that, the scheme could market the units freely.

- The rental price is set by the outsourcing contract,

- The JV will also provide placemaking amenities and open spaces, all of which are maintained and operated by the JV and/or the Trust, which collects subscriptions and revenues at market rates.

Unlike other public sector bodies, NHS Trusts are currently prohibited from using JV Structures by NHSE.

Appendix 2: Model Comparison Table

	1. NEW HOMES SOLUTION	2. MEDIUM TERM LEASE	3. ICB ESTATE CODE	4. HARD NOMINATIONS SOLUTION	5. Corporate Joint venture
LAND SOURCE	Trust surplus	Trust surplus	Trust surplus	S106 / open market landowner	Trust Surplus
LAND	Mid-term lease	Mid-term lease	Mid-term lease	N/a	Mid term Lease
LEASE PREMIUM	Driven by viability	Required to offset discounted asset value of building reversion for neutral CDEL	Driven by viability	N/a	Driven by viability and equity in JV
SCALE	Individual trusts	Individual trusts - scale via framework	Trust demand consolidated at icb level	Individual trusts	Individual Trusts
SPECIFICATION AND MIX	Set by trust based on people needs and business case	Set by trust based on people needs and business case	Determined by partner based on market	Set by trust based on people needs and business case	Set by Trust based on people needs and business case
CONSTRUCTION; AVAILABILITY; DEMAND AND VOID RISK	With partner	With partner	With partner	Demand and void risk with trust	with JV
CONSTRUCTION QUALITY AND CONTROL FRAMEWORK	Outsourcing contract	Development agreement and agreement for lease	Lease	With landowner	Outsourcing contract
LETTINGS; RENT COLLECTION; MARKETING	Partner	Operator	Partner	Trust	JV
NOMINATIONS	Soft nomination - trust keyworkers first refusal 15/03/2023 Cascade to other trust staff Other key workers in local public sector Private rental market depending on planning permission	Soft nomination - trust key workers first refusal Cascade to other trust staff Other key workers in local public sector Private rental market Excess rent subject to profit share ground rent	No Trust nomination right Key Worker under terms of lease Cascade to other Key Workers; then private rental depending on planning permission Excess rent subject to profit share ground rent	Hard nomination - trust key workers first refusal Cascade to other trust staff Other key workers in local public sector Private rental market	Soft nomination - trust keyworkers first refusal 15/03/2023 Cascade to other trust staff Other key workers in local public sector Private rental market depending on planning permission
VOID RISK	Partner	Partner	Partner	Trust	JV
RENT	Set via outsourcing contract – indexation, potential means tested discounted rents for Trust stafff	Set via long lease – indexation, potential means-tested discounted rents for Trust staff	Set by market with requirement for discount under lease	Trust control through Hard Nominations Agreement	Set via outsourcing contract – indexation, potential means tested discounted rents for Trust staff
OPERATION AND MAINTENANCE RESPONSIBILITY AND RISK	Partner	Partner	Partner	Partner	JV
OPERATION AND MAINTENANCE QUALITY SPECIFICATION	SLA in outsourced contract	Maintenance clauses via head lease sla via sub leasure operation agreement	Not specified	Nomination agreement	SLA in outsourced contract
OPERATION AND MAINTENANCE CONTROL FRAMEWORK	Outsourcing contract	Long lease - user cluase; gervis v harris maintenance clause	No icb control	Nomination agreement	Outsourcing contract
END OF LEASE	Accommodation, rental income stream, maintenance liabilities never to trust ownership and control for £nil consideration	Accommodation, rental income stream, maintenance liabilities never to trust ownership and control for £nil consideration	Accommodation to nhs for peppercorn	Reverts to landowner with potential loss of access for nhs	Accommodation, rental income stream, maintenance liabilities never to trust ownership and control for £nil consideration
CDEL IMPLICATIONS	CDEL complicance from budgeting and accounting perspective confirmed by specialists and dNHSE/I accounting team	Discounted value of reversion debit to cdel Offset by small lease premium on grant of lease Unwind of reversion is outside of cdel	Not on balance sheet as no requirement to purchase at the end of the lease	Hard nominations commitment is a debit to CDEL	CDEL complicance from budgeting and accounting perspective confirmed by specialists and dNHSE/I accounting team (subject to JV approvals in of themselves)
PROCUREMENT	OJEU, Housing Associaton or Framework	OJEU, Housing Association or Framework	Outside procurement regulations	Varies	OJEU, Housing Associaton or Framework

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