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GPC

General Practitioners
Committee

The future of GP practice premises

Guidance for GPs

BMA 

The future of GP practice premises

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1. Introduction

Although GPs have traditionally assumed responsibility for the ownership of their practice premises, different approaches are becoming increasingly common. This guidance reviews the factors driving this change and the various models of premises provision currently available, and includes case studies suggesting how common problems may be overcome. It also addresses wider strategic issues which GPs will want to consider collectively within Local Medical Committees and Primary Care Organisations (PCOs).

The guidance summarises the risks and benefits for GPs associated with different models, and concludes that **GPs should continue to have the option of investing in their premises although some may find other models more suited to their needs**. It is not intended as a substitute for independent expert professional advice, and GPs considering any change in their circumstances are strongly advised to seek such advice before entering into any commitment.

This guidance is applicable throughout the UK, but readers in Scotland, Wales and Northern Ireland may wish to contact their national offices for further specific information.

2. The drivers of change

2.1 Market forces

Investment in premises using the facilities afforded by the cost and notional rent arrangements has, until recently, been regarded as a low risk high return capital investment for GPs. However, with the fall in property values in the late 1980s and early 1990s, it became a source of concern for many, raising the potential threats of reductions in notional rent and lower or negative capital returns. Confidence in the property market has not fully recovered in some areas, and remains subject to fluctuations in interest rates (although these are currently at an all time low and therefore present a much lower risk than at other times).

Meanwhile, commercial property investors and developers are increasingly keen to move into the primary care premises market, and so represent an external force for change.

2.2 Changing attitudes amongst GPs

It is a fairly common problem in most professions at present that some younger people who would naturally progress to partnership do not find the long hours and hard work attractive whatever the reward. There is therefore a move towards lower aspirations and less willingness to bear risk. In general practice there has been a marked trend towards greater professional and geographical flexibility, leading to increased part-time working, and unwillingness to invest capital in the practice and enter into property ownership. Findings from the BMA's cohort study of recent graduates confirm this general reluctance to take on the responsibilities associated with principal status and to invest in premises. It is not yet clear whether this represents a permanent change in attitude or simply an aversion to making long term commitments in the early years of their career, and the BMA will continue to research this aspect. However, with women making up half of all entrants to general practice, the demand for part-time working, career breaks and mobility is likely to increase.

These factors may make premises ownership unattractive to some GPs, although for some, the reluctance to invest may simply be due to a lack of understanding of the reimbursement system and how much this protects them from risk. For others the antipathy to risk is so great that the potential for a tax efficient

low risk investment is still not attractive, and other types of schemes are perceived, not always accurately, to present lower levels of risk. However, these attitudes may not be shared by the next generation of medical students and it would be premature to make wholesale changes which may be regretted in the future.

2.3 Government policy priorities and organisational change

The establishment of primary care trusts (PCTs) is part of an increasingly ‘corporate’ approach to delivering primary care, in the sense that GPs’ ability to practice as individuals is circumscribed by the need to function and take decisions as part of a larger group with common objectives. The extent to which GPs are able and willing to collaborate at this level will largely determine their ability to influence premises developments. This highlights the need for LMCs to be closely involved in the development of the PCT’s service strategy.

PCOs are becoming the focus of policy and strategy development for primary care, driving the expansion of service delivery into areas such as intermediate care, minor injuries and multi-disciplinary services, all with specific facilities requirements. Changes in skill mix and the emphasis on offering a wide range of ‘integrated’ services within one centre imply a multi-disciplinary primary care team within which GPs may no longer be in the majority, and a scale of development and cost that many GPs could find daunting.

Premises provision is thus inextricably linked with this wider issue of service strategy, and PCTs have explicit responsibilities to prepare a general statement of need for premises and a strategy for property management¹. Some may use this opportunity to exert greater control over premises provision, thereby reducing the control of the GPs. If the area is characterised by, for example, a cohort of GPs occupying unsuitable premises and nearing retirement, the PCT may be prompted to plan for a smaller number of larger, purpose-built premises. They may need to select opportunities for new development before knowing who the occupiers will be, and may have to act as developers, particularly in the short term. They may also need to sanction some investment before GPs are recruited, in order to support recruitment.

Many PCTs face an urgent need to develop the estates expertise necessary to fulfil this role. Nevertheless, **GPs in England will have to take into account their local PCT policy on premises development, which will almost certainly restrict their options in the future. The role of LMCs will be vital**, both in asserting the rights of existing GPs and helping to ensure the interests of GPs are protected in the future. For example, some provision for GPs to hold a stake in their premises should be maintained, even though this may not initially be taken up.

The growth of a salaried service implies that those GPs who choose this career path (even if this is only temporarily) will have no responsibility for, and correspondingly little opportunity to influence, premises provision.

All existing practice premises had to be compliant with the Disability Discrimination Act (DDA) by October 2003. This may have entailed significant alterations and the costs of these can be reimbursed, or partially reimbursed under the premises costs directions in the four countries, although this depends on the PCO's budgetary priorities. However, there will be many cases in which alterations to the building would simply not be viable or cost effective, and GPs should consider other ways of providing a full and comparable service to disabled people, for example by providing services in ground floor rooms on demand. It is difficult to foresee how strictly the requirements of the Act would be interpreted should a case ever come to court. **All new build premises are already subject to the DDA,** and GPs considering building new premises are strongly advised to seek appropriate professional advice to ensure compliance in this respect. Further GPC guidance on the DDA is attached at **appendix 1.**

2.4 Wider problems in primary care

Some areas face a range of interconnected problems which might include any or all of deprivation, property values which are too low to justify development, a high number of inadequate or unsuitable premises, a lack of suitable alternative sites for development, a cohort of GPs nearing retirement, a dispirited GP workforce and recruitment difficulties. Although these have significance beyond the provision of premises, they result in the unfortunate fact that **it is hardest to develop in areas where the need is greatest.** To add to the problem, these may also be the areas in which local expertise in property development is particularly weak.

Although there are many successful examples of GPs taking the lead on, and owning, new premises, this model may be neither practicable nor advisable in these circumstances. To some extent, the introduction of personal medical services, "golden hellos", premises flexibilities and NHS Lift have all been attempts to address some of these problems. **The tendency for PCTs to take an interest in premises provision, envisaging a future of third party development with GPs as tenants, can also be seen as a response to the problem overall.**

2.5 The New GMS Contract

The introduction of the new GMS contract from 1 April 2004 is already radically changing the premises landscape and has far-reaching implications for their future. The main changes are outlined in sections 4.49 to 4.59 and 5.37 to 5.46 of the first new contract document (New GMS contract: investing in general practice). The section of the Statement of Fees and Allowances which dealt with rent and rates has been completely replaced by the General Medical Services Contracts (Premises Costs) Directions 2004. These directions are summarised in a separate GPC guidance note, *Focus on Premises Costs*, which is attached as appendix 2 to this document.

It is too early to assess the full impact of the new GMS on premises, and many developments in this area were already in train but have been accelerated or brought into sharper focus by the contract negotiations. One of the most important questions for GPs is whether practice-level surgery development has any future. This has been brought into question by premises funding problems that came with implementation of the new contract, which will be considered first.

2.5.1 Funding

Under the old GMS contract, GPs received premises payments through two main streams; notional and actual rents from the **central non cash-limited GMS funds** and cost rents, improvement grants and grants to surrender leases from PCOs' **cash-limited unified budgets.**

Towards the end of 2003, the Department of Health announced that premises funding would henceforth be divided into three elements;

- € a baseline of existing premises spend
- € an additional element to meet the cost of new agreed premises developments (ie those ready for occupation, under construction and others contractually agreed between the practice and the provider) contractually agreed before 30 September 2003
- € a further element weighted to take account of premises inflation to meet costs of, for example, use of flexibilities and new premises developments which are agreed after 30 September

This created great uncertainty about the implementation of the premises flexibilities and about new developments that had not been agreed by 30 September, as there was no information about the quantity of nor method of distributing the third element of funding, from which these would have to be met. A subsequent allocation to PCTs for this third element was completely inadequate and this heightened the uncertainty.

Concerns were allayed to some extent by a further announcement of £108 million of new premises funding, which was over and above these three elements. However, the Department of Health conditioned use of this money on its expenditure on third party capital grants only. This meant that the money could not be used for recurrent expenditure and so could not be spent on cost or notional rents. This last point is key to the future of practice-level surgery development and appears to signal a drift away from this form of premises development.

Existing cost and notional rents continue to be paid under the first element of funding, and the concepts of cost and notional rent are preserved in the new directions (albeit with rather different terminology, cost rent being referred to as “borrowing costs”). However, new applications for borrowing costs or notional rent for new developments will be entirely conditional on availability of new funding, and the new £108 million cannot be spent in this way, as it is capital rather than revenue funding. This creates serious doubts about whether the Department of Health remains committed to support development by GPs.

It also remains unclear how new actual rents will be funded, i.e. whether they will be incorporated into the first element of funding – the “baseline”. Even if fewer practices develop their own premises in the traditional manner for lack of cost or notional rent funding, new revenue funding will still be needed to reimburse rent on leased premises. The success of LIFT projects and other third party developer new builds will depend on assurances of adequate reimbursement of actual rents, and there is currently a great uncertainty in the private surgery development market over the vagueness of recent funding announcements.

2.5.2 Flexibilities

The new set of flexibilities that were announced in a joint letter from John Hutton and John Chisholm in 2002 were transferred from the old contract, where they had been implemented through amendments to the SFA, to the new contract as part of the premises costs directions. They are essentially payment provisions that were designed to remove some long-standing barriers to GPs moving to new more modern premises and are covered in more detail on the GPC guidance note “Focus on Premises Costs”, which is attached at appendix 2 to this guidance.

Again, it is too early to gauge the success of these flexibilities, which will depend entirely on availability of adequate funding. Flexibilities costs were to be met from the third element of funding and so current

levels may be inadequate to have a significant impact. As more GPs relocate from substandard premises to modern leasehold premises, the need for many of these flexibilities should grow smaller. However, this will be a long process and so adequate flexibilities funding will be necessary for the foreseeable future. Indeed, it is essential if the Government's vision for primary care premises is to be realised.

3. Who should develop?

Development could be led by one of the following parties:

- € GPs, using private finance covered by rent reimbursement
- € Third party developers, using private or in house finance covered by the lease rent, which in turn is covered by rent reimbursement
- € PCTs, using private or in house finance covered by the lease rent, which in turn is covered by rent reimbursement
- € GPs or PCTs, via private finance initiative (PFI) schemes or NHS Lift.

3.1 Development covered by rent reimbursement under the Premises Costs Directions

Where there is a demand for new medical property the open market rental value of that property should justify the creation of new or refurbished premises. Based on this approach to valuation, district valuers (DVs) are now prepared to look at the costs of the project as part of the valuation. As a result, in recent years **many schemes have been implemented purely by using current market rent (CMR) reimbursement levels**, converted into an actual lease rent where a scheme is undertaken by a third party developer (3PD) or a notional rent where the doctors undertake their own project. The market has resulted in a fair amount of success and there are now some 20 specialist 3PDs and examples of schemes throughout the UK. However, the majority of cases tend to be in areas where expertise is readily available (from the district valuer, the health authority, independent advisers and third party developers) and often where property values are fairly strong.

The problems have tended to be in more outlying low value areas which also tend to have far less expertise available locally. Although this has in part been countered by the set up of the primary health care adviser team within the district valuers, their level of experience and expertise varies and they are swamped with potential schemes. They therefore tend to be reactive rather than proactive. To get a new scheme underway, especially in the more vibrant market of today, requires a proactive project leader, and in some of the most successful schemes the developer or the GP hires specialist consultants to undertake this role (some third party developers now employ their own project co-ordinators or managers).

The disadvantage for GPs wishing to undertake a new project on an owner/occupier basis is that they will need to either put a great deal of time into it or employ a project co-ordinator (architect, surveyor or valuer) to lead the scheme. It is likely that full appraisals will be needed each time a site is found to see if it is economically viable and this may also require some sketch drawings. During the recession it was possible for GPs to get an element of this undertaken at no cost, but unfortunately the same is not now true. Thus GPs are often faced with funding initial searches and appraisals which may cost a few thousand pounds, or going to a specialist third party developer who will agree to undertake all such work at no additional cost (although many now include a requirement for their costs to be reimbursed if the GPs pull out of their own accord). **The best solution is for PCTs to recognise the need for professional initial searches and appraisals and help cover the resultant cost.**

The team of primary health care advisers in England set up by the DVs to advise health authorities and PCTs, and specialist valuers in Scotland, must be a benefit but should not be seen as the only way to move forward. Furthermore, experienced surveyors and valuers must be involved and the NHS should consider bringing on board external specialists to work alongside the DVs (and possibly Capitec, the former estates department of the NHS) in managing and advising on some of the larger and/or urgent schemes. Their employment should of course be vetted by or undertaken through the DVs office to ensure that there is true expertise and that costs are reasonable.

3.2 Multi - property leases to PCTs

PCTs can take the head lease on premises owned by third party developers, subletting to individual GPs. This option could be beneficial for both GPs (who could potentially take on more flexible and short-term leases) and developers (who generally perceive numerous individual tenants as presenting a higher risk than a PCT).

The basic principles for letting multiple properties to one PCT as opposed to individually letting each property to GPs is the same. However, the investment value (which will determine the monies that the developer will be prepared to spend on the project) is not a simple standard multiplier of the rent. The multiplier used is a reflection of the yield or return an investor would require on his capital outlay, and would tend to increase as the number of tenants reduces. **This factor could mean that the letting of multiple properties to one PCT would increase the level of private finance available.**

For example, for letting to a four GP practice on full repairing and insuring terms and for a period of 25 years, investors require a return of about 8%, which means that a multiplier of about 12.5 would be applicable to the net rent. The return increases (and therefore the multiplier decreases) as the investor perceives that the risk for management costs would increase. Thus for the same size building, but let on a tenant internal repairing basis for 10 years with the lease split between two GPs, a dentist and private psychotherapist the yield required is likely to be over 9%, resulting in a multiplier of less than 11.1. This reduces the capital value or in the case of any new projects, reduces the money that an investor (whether a third party developer or the GPs themselves) would put into a scheme. Alternatively, bringing a number of properties together and letting them overall to a trust is likely to reduce the yield required to below 8% and increase the multiplier to over 12.5.

Consequently, if a PCT were aiming to create six new primary health care centres with a total rent role of say £250,000, the difference in capital that private investment would be likely to put into the scheme if the tenant were a single PCT, as opposed to multiple GPs and other tenants, could be as much as £250,000. **By creating a higher value for the property, the overall cost to the NHS is lower.**

However, there could be disadvantages to the PCT in having a dominant third party landlord. It would be prudent to split the PCT's property package into two, each with different landlords, a factor which would have little effect on value and ensure healthy competition for future projects. Alternatively, the PCT could consider using a consortium consisting of two or more developers together with the funder.

3.4 The private finance initiative (PFI)

Under the private finance initiative, private sector consortia are invited to bid for a contract to build premises for the public sector client (for example, an NHS trust). The successful bidder finances the building and owns it on completion. The trust pays an annual charge to lease the building for a period of usually 25 or 30 years. The consortium retains responsibility for maintenance and repair, and usually for providing facilities management and associated services such as cleaning and catering. Depending on the agreement reached, the consortium retains ownership at the end of the lease period.

The use of PFI as a means of designing, building, financing and operating new facilities now has an established track record in secondary care and it now the main procurement route for new build in the NHS.

The benefits of PFI to the NHS are generally argued to be risk transfer (as the contractor rather than the NHS bears risks such as construction overruns) and a payment mechanism that offers flexibility (in the sense that services can be added to the deal at a later date, and there is flexibility in use of other resources) and non-ownership of freehold. It is worth noting that most primary care premises are in private ownership (owned by GPs or 3PDs rather than by the NHS), which means that the individual GP already bears some of these risks and the NHS already pays for premises as revenue rather than through capital charges.

The PFI consortia that have been formed to bid for health building schemes are, for the most part, building contractor led and are focused on larger building schemes. Contractors do not tend to be positively disposed towards PFI procurement for smaller schemes, mainly due to the cost of bidding, there being no correlation between size of scheme and bid costs. The burden to both GPs and bidding consortia of transaction and legal costs is likely to prove prohibitive (at £500,000 plus even on the smallest of schemes) and, when rolled into the lease costs, would make PFI extremely unattractive compared to conventional means of development.

Thus for PFI to work in primary care a number of issues would need to be addressed to develop a procurement route which is both affordable to the private sector and acceptable to individual GPs and PCG/Ts. Some of these issues are explored below:

Is 'true PFI' likely to take off in primary care?

Amalgamating or 'bundling' schemes allows transaction costs to be spread across a number of developments, thus increasing the affordability of each individual scheme. However, a more fundamental solution is to seek to make primary care PFI more efficient by streamlining its processes. Evidence from major hospital PFI projects suggests that streamlining processes has delivered significant efficiencies in terms of transaction costs and reduced timescales, compared to early PFI schemes. The standard form of contract and standard payment mechanism have reduced advisory fees for legal and corporate finance for both the NHS and the bidding consortia.

Streamlining PFI in primary care should deliver similar benefits. **By developing a standard form of legal contract for procuring premises and standard payment mechanisms, GPs and PCOs will incur costs more in line with traditional procurement.**

In a true PFI scheme, the developer would also have responsibility for facilities management, covering the costs of such items as internal repair and cleaning, the employment of general receptionists, maintenance personnel etc. The additional cost would be added on to the 'rent'. **This might seem attractive to some GPs but would be a very large step towards losing their self-employed status for tax purposes and indeed to becoming a salaried service.**

Whilst GPs retain liability for such matters as internal repair, servicing of lifts and employment of general staff they also maintain the control of those elements and can minimise costs if they wish. With facilities management they would not, and they would need to spend time producing a specification for the service and monitoring it on an ongoing basis. Risk transfer may increase the cost, and the GPs would still bear some risk of service failure by the facilities management provider, which could be costly and time consuming to put right.

The benefits of using a facilities management service are that expenditure is controlled and predictable, requirements can be clearly specified, and the risks of wages and material costs increasing are transferred to the provider. The practice would not bear the overheads and health and safety responsibility of being an employer, and would not need to recruit and retain facilities management staff (which can be difficult in areas of high employment). If GPs are leasing the premises, this does not change the way they work and leaves them to run their clinical practice. However, if they have no control over their premises and their staff, it would be very hard for them to implement any changes in their practice and influence the way in which clinical care is provided. Transferring these risks would of course be reflected in the facilities management fee.

Sale and leaseback within PFI

Where a PFI deal involves the disposal of existing assets for the consortia to develop, the greater their value the greater the amount that is netted against the development and build cost, and therefore the lower the lease/PFI tariff cost. **This relationship would seem to favour deals involving sale of surplus assets in areas with high property and land values, thus introducing inequity into the system by disadvantaging areas with low values.** Indeed, there is evidence of strong competition from PFI consortia in high value areas because of the development opportunity.

However, deals in low value areas could be made to work through the specification process for schemes. This is because the impact of existing assets on lease or PFI tariffs is determined by margins more than by absolute land and property values. A deal involving release of assets in a high value area may benefit from the sale (or inclusion in the PFI deal) of those assets but will be negatively affected by the high costs of new land and build costs. The margin achieved may be just as great in a low value area because land and new build cost are lower. Thus **what is important in low value areas is to produce an efficient specification which manages down the area requirements and new build costs so that the margin from any sale/development can be maximised.**

The above applies to PFI where existing assets are put into the deal for the consortia to develop. The position is different for pure sale and leaseback schemes. Such schemes will certainly favour areas with high land values as the residual value of the property at the end of the lease period will be greater, which will positively impact on lease costs.

In conclusion, **PFI deals can be made to work in low value areas and should prove to be a more effective procurement route than sale of existing property and leasing back.** It is reasonable to assume that this is in line with developing policy to improve primary care premises in inner city areas through the provision of new purpose built facilities.

3.5 NHS Lift (Local Improvement Finance Trust)

Essentially, **NHS Lift is a new means of attracting private sector finance and management expertise into premises development. It assumes a PCT-wide strategic approach to premises development,** as opposed to the current approach which is seen as piecemeal and uncoordinated. Key features are:

- € It operates in areas of high deprivation, where sub-standard premises have been identified as a problem.
- € The NHS and Partnerships UK (a public-private partnership set up to develop the PPP market) established a new company, Partnerships for Health, to take forward the Lift initiative. Each

contributes funding that is used to support the establishment of a local Lift and to invest in the local schemes.

- € The public funding is devolved to local Lift companies (comprising representatives of the national Lift, local health economy stakeholders and a private sector partner) which were set up in each area involved to seek funding from local private sector bodies and take forward specific projects.
- € The NHS plan set a target of investment in primary care facilities of £1 billion. NHS Lift is expected to be a major contributor to meeting this target, although the exact proportions being delivered by different investment vehicles are not known.
- € Lift companies look at opportunities to bring together different services within one location. This may extend to including commercial or retail space which, particularly in areas of low land values, could help to ensure the financial viability of schemes.
- € Local health and social care stakeholders, such as PCTs, local authorities and individual practitioners will hold a minority stake in the local Lift, as will Partnerships for Health. **Thus, GPs are able to invest equity in their local Lift** and, if they opt to do so, they will own a share in all the properties owned by the company rather than owning the freehold of their own premises.
- € There will be opportunities for the NHS and PUK shares in Partnerships for Health to be bought out at a later date. Similarly, Partnerships for Health will be able to sell its shares in local Lift companies. There is therefore a possibility that premises in some areas will be entirely owned by private sector shareholders in the future, although they will still be subject to long-term partnering agreements between the Lift company and the PCT and other stakeholders.
- € The existing rent reimbursement mechanisms continue to apply even where a Lift is established, so that GP tenants of a Lift will receive rent reimbursement in exactly the same way as they do now.

Individual GPs will want to consider carefully the attractiveness of NHS Lift as an investment opportunity, regardless of whether or not they choose to be part of specific schemes to provide new and improved premises. There is no obligation on individual GPs to invest in a Lift, although they will have an opportunity to do so. In considering the merits of Lift as an investment opportunity, GPs should bear in mind the following:

- € To be an attractive investment opportunity, the shares would need to be fully marketable, and it is not at all clear where the market would be for these shares.
- € When GPs own their own premises, they benefit from the business taper relief for capital gains tax purposes, reducing the potential tax charge to just 10%. This would not apply on shares in a property investment company such as Lift, and GPs would therefore pay the full rate of capital gains tax applying to investments.
- € The Lift will be expected to invest in, and develop, groups of premises in batches across a locality. The batches to be developed will be commissioned and agreed by the local stakeholders, such as PCTs and local authorities, in consultation with the GPs concerned. It is hoped that such

'bundling' of schemes will help to ensure that premises that would otherwise be unattractive as an investment opportunity are deliverable under Lift schemes.

- € GPs thinking of investing in a Lift should take independent professional advice about their rights as shareholders. They may also benefit from the controls placed over the activities of the Lift by its partnering relationship with the local health stakeholders.

4. Ownership and leasing - the risks and benefits

The risks of premises ownership and of long-term leases, although very different in nature, are roughly similar in degree. In both instances the property is financed by rent reimbursement and the risk of maintaining the patient list size and number of GP partners (thus maintaining the recognised GMS area) lies with the GP owners/tenants.

In both categories, GPs who accept additional responsibility for a greater amount of space than that for which they will receive notional rent or current market rent take on the additional risk of finding suitable tenants who are able to pay the rent on the non-reimbursed areas. This will be required either to fund their mortgage outgoings (in the case of the owned property) or to pay rent to the landlord (in the case of the leased property).

Accordingly, **whilst it is not possible to avoid any element of risk altogether, it is for each GP to weigh up in his/her mind which type of risk he/she feels most able to live with.** GPs' concerns about the type of risk they are willing to bear will be the key factor in deciding between ownership and leasing. Those who undertake their own project are bearing the full risk of any other investor. If they take a lease on the property, the longer the term the greater the risk of being tied in and of meeting a larger dilapidations claim, although a shorter lease gives less long term security. Short-term occupation from PCOs almost completely removes the risk.

4.1 Owning premises

GPs who own their premises are, in essence, taking on the role of investor and developer and thus take on board the same risk as any other investor. That risk is that **returns can go down as well as up. Notional rent can be reduced on review, leading to a shortfall on mortgage payments, and property values can fall, resulting in negative equity. The benefit is that the returns are potentially high.** Over the long term, property values are generally expected to rise. The problem for individual GPs is that it is difficult if not impossible to predict the cycle of the market when they wish to retire.

Partnership disputes or splits can lead to additional complications. Maintenance costs are often high and, although the GP retains control over the premises and their location and has the opportunity of an improved working environment, the running costs of a new surgery in particular may reduce income. It should be noted however that these costs can also be high for leasehold premises, as many leases are on a full repairing basis. In either case it is advisable to have a fund for renovations.

Surgery ownership should not be seen as an unjustifiably high risk. To use an analogy, domestic property ownership could be described as high risk as property prices can go down, divorce can lead to a forced sale at an inopportune time and maintenance costs can be high. In reality, home ownership has provided considerable tax free gains over the last 20 years, with the value of domestic property rising 50% in the last 4 years. It is only people who bought at the peak of the market in 1988 who suffered a loss if they had to sell before the market recovered in the mid 1990s.

GPs are fortunate in being the only group of self-employed people whose business property is subsidised by effective reimbursements of the total loan interest cost, which can go on to subsidise the capital repayments as notional rent reimbursement continues indefinitely. Cost or notional rent reimbursement minimises the risk for GPs, which is why GPs are able to obtain lower interest rates on their loans as they are seen as low risk by the banks. They still benefit from the favourable capital gains tax (CGT) business tapering relief reducing the CGT on their ultimate gain to only 10% for a 40% taxpayer. **This makes investment in their surgery premises far more attractive than any alternative property investment opportunity.**

However, any property investment needs to be seen as relatively long term in order to produce a reliable prospect of a gain, and any GP who might only stay with a practice for a few years should not become involved in property ownership. It is interesting to note that in other professions a prospective partner with no commitment to the business would not be regarded as suitable for partnership at all.

Good advice can minimise the risk element (but unfortunately never dismiss it). GPs owning their premises would therefore be very prudent to employ a valuer to look at the future investment value of the premises and, if necessary, consider the adaptability and alternate use of the property in years to come. Flexibility is an essential element and one that is undoubtedly better where doctors own their own premises. For example, it is far easier and more cost effective to extend or refurbish an owner occupied property than one held under a leasehold interest.

However, **undertaking refurbishment and extension will have major financial implications for the GP owners.** Whether it is viable will depend principally on whether the additional cost of improving or extending the premises can be met through the additional rent, together with any other financial assistance such as an improvement grant. Except in the case of a cost rent scheme, the additional rent will be based upon the ultimate value as opposed to the cost, which may well be greater. For owner occupied property, an improvement grant may be sufficient to offset the extra cost. Indeed many GPs successfully turn round a property from being in negative equity to being financially viable by adding an extension funded by a two thirds improvement grant. The GPs will only have had to incur one third of the cost of the extension but it will have increased the overall value of the property enabling them to switch from cost to notional rent. The main problem with major development of existing premises is the possibility that preservation of equity in the existing buildings may be lost if the development cannot be fully financed by the methods discussed above.

4.2 Leasing premises from a third party developer (3PD)

Some GPs see leasing as the panacea for all their property worries as it removes the concerns about encouraging new part-time GPs to the practice and yet they consider that they still have some control over the design of their new surgery. It certainly takes away part of the responsibility and a substantial part of the cost in relation to the initial development, and of course there is no future capital to repay. In reality of course the developer is investing in surgery premises as an attractive business investment, and will ensure that the rent they will receive will fully cover the cost of the premises, including the financing costs, over the lease period of 20 to 25 years. They will therefore not allow extra costs which are not totally self financing.

Depending upon the terms of the lease, **risks include the possibility of a shortfall on rent review,** leaving the partners to make up the difference. **New partners may not wish to take on the liability of the tenant, thus making it difficult for partners to escape liability on retirement.** The risks of entering into a lease may, to a limited extent, be reduced if the landlord is prepared to accept more moderate terms in the lease, as recommended by NHS Estates and adopted by the vast majority of the specialist medical developers and investors. However, this cannot be guaranteed and **even in the most**

moderate form of lease, will still leave the GP exposed to some element of risk (but without any possibility of making any capital gain or loss). **Appendix 2** provides an introduction to leasehold law and some guidelines for GPs entering such an agreement.

Sale and leaseback is a useful option for GPs who wish to remain in their current premises but no longer wish to take on the risks and responsibilities of ownership. Many developers are looking to expand their portfolio of GP surgeries, and the sale price will be determined by a wide variety of factors including alternative use value, whether the premises are purpose built, the state of repair, any intended refurbishment or extension, the notional rent level and timing of rent reviews, the length of the new lease and rates of interest on any fixed rate loans. **GPs would be well advised to shop around before agreeing a sale price and to consider employing an adviser who could help them to secure the best deal.** If the GPs are to move to new premises, some developers will agree to purchase the existing premises at no loss to the GPs. If the GPs have endowment policies which are intended to be used as repayment vehicles, these should where possible be redirected to other uses. If it is decided to surrender the policy, advice should be taken as to the best available price on the second hand policy market, which can be up to 25% higher than the surrender value.

Maintenance costs could be high, particularly in the case of a full repairing (FRI) lease. The level of rent reimbursement should be in excess of the lease rent to reflect the repair and insurance element (usually between 5% and 7½%). However, the actual cost of repair may well exceed this and the risk rests with the GPs. **It is essential that the additional monies are used to form a sinking fund for future repairs and to pay the cost of building insurance.** An internal repairing lease offers the comparative benefit that the GPs have no responsibility for the maintenance of the structure and exterior. However, there is still the responsibility for the internal elements of the property and, as with FRI leases, if such responsibilities are not undertaken there is the prospect of dilapidation liability at the end of the lease. With internal repairing leases the additional rental element to help cover the costs of building insurance and external repair and decoration will be included within the rent to the landlord or developer. Reputable companies will ensure that this is put into a fund to ensure a proper ongoing management scheme attending to all repairs and undertaking redecoration on a regular basis, thus hopefully resulting in an improved working environment. Indeed, on large schemes the landlord/developer may extend the management of repairs to include outside elements such as car parking and landscaping, and the internal elements of any shared common accommodation, shared entrances, shared lifts and stairways. Management of these would undoubtedly be beneficial to the building but it must be borne in mind that in an FRI lease the total cost would be passed back to the tenant and on an internal repairing lease, part will be passed back to the tenant (such as repairs, maintenance and cleaning to common areas). To the GP tenants this is likely to be considerably more costly than managing the premises themselves.

Undertaking refurbishment and extension during the term is often more difficult in leasehold properties, and GPs are likely to face exactly the same problems with premises leased from developers as with premises rented from health authorities with regard to updating the premises in the future. There may be restrictions under the lease preventing development or alterations of the premises. There is also a risk that the landlord will require reinstatement of the alterations at the end of the term.

In conclusion, although leasing takes away the risk of investment, the tenant must get full professional advice from their lawyer and surveyor, not only on the lease but also the actual property and the build specification. Many disaster stories about leasehold properties are the result of incorrect or insufficient advice, and some problems can be ironed out if advice is sought in good time. Short term licences may be attractive to GPs with no long term commitment to the partnership, and leases may appeal to those who do not want to get involved in the initial costs and risks of property ownership, but for GPs expecting to stay in the practice long term it is passing an attractive investment opportunity over to a third party. It should be appreciated that if a developer can make the scheme viable, then so too could the GPs.

4.3 Leasing premises from the health authority or trust

Health authority or PCO-owned premises have historically suffered from a combination of immense under-funding and a total lack of property management (in itself, a result of under-funding). Proper management schemes were never put in place and proper leases to tenants were rarely granted. There is now an increasing trend, however, for trusts to require occupation of such premises to be put on a proper footing and the requirement for a formal lease to be entered into. GPs are strongly advised however not to sign up until a proper agreement has been put into place concerning the upgrading of existing accommodation to remedy the defects resulting from the lack of management in the past.

Looking to the future, the potential risks and degree of security and control over the premises will depend upon the terms of the lease, which will also determine the extent to which the GPs have responsibility for maintenance. Less responsibility could be seen as an advantage in some cases but for GPs who see themselves as independent contractors it can be very frustrating, particularly as the premises age and become unsuitable for the delivery of modern primary care, thus thwarting their clinical plans for the practice. Conversely, there may be good access to other patient related services, particularly where PCTs are embracing the government agenda of providing a range of integrated services within a single site.

GPs who wish to be salaried employees of a PMS pilot run by the PCT should not assume any role in premises provision, which should be the responsibility of the PCT. However, PCTs are likely to take a stronger lead not only in the development of PMS schemes but also in providing GMS in areas where there are no strongly established practices, or where the PCT is seeking to bring together disparate practices and a range of services. One way for this model to be delivered is for the PCT to lease a portfolio of premises from a third party developer, and this option is discussed further in section 3.3 above. To solve the problem of disrepair, the leases should be structured so as to pass the external repair liability onto the landlord or developer, who should be required to ensure that a proper management system is put in place.

4.4 Premises occupied by unofficial licence

In one sense occupying premises pursuant to a licence is the 'least risk' basis of occupation, in that the GP bears no financial responsibility and their risk relates only to liability for internal redecoration and minor repairs (although the running costs of a new surgery may, as elsewhere, reduce income). However, it leaves the GP exposed in another way in that he/she will have absolutely no security of tenure and may be evicted from the surgery. A written licence may provide for a minimum period of notice, generally of six months. However, if there is no written licence, then under the common law the occupier will be entitled only to a reasonable period of notice, which may only be a few months.

GPs occupying their premises under a licence are generally either in a health centre where the health authority has not arranged a formal lease, or are non property owning partners. The latter could be particularly vulnerable in the event of a partnership dispute. The former tend to be practices not wanting a long term commitment, and would be better advised to consult their solicitor and take a short term sub-lease. Whilst a third party developer will not be able to offer such an option, if the PCT takes the head lease it will be able to offer short-term leases to GPs. The main difference between a short-term lease and a licence is that the former gives the GPs some security and clearly sets out responsibilities as to maintenance, repair and other liabilities.

5. Multiple occupation

5.1 The GP as landlord

Many owner-occupier GPs are interested in letting extra space to other tenants (for example, a dentist or physiotherapist). The GPs retain control over the property but need to ensure the agreement with the tenant does not undermine this. In this case, they face the same risks and benefits as above, but will have the potential for additional income through enhancing the availability of additional services to patients. It is also worth noting that separate funding streams exist for teaching undergraduate and training GP registrars.

The degree of risk presented by letting extra space will vary depending on the proportion of the total building in this category and the length of leases granted. As long as the leases are relatively long, ideally matching the term of the loan, the risk diminishes considerably. **Such a development would need to be viewed as a long term investment and may not suit GPs who plan only to stay with the practice for a few years or who are totally risk averse**, as can sometimes be the case with part-time GPs. However, for GPs who have a long term commitment this can be a very attractive proposition with relatively low capital gains tax charges on disposal as a result of the business taper relief rates applying to the part of the building used by the GPs themselves. This reduces the capital gains tax to an effective rate of 10% after 4 years ownership on any gain on the surgery premises portion (a proposal to reduce this period to 2 years is likely to be implemented shortly). The part of the premises rented out to tenants will be treated as an investment asset and the capital gains tax rate on this part would reduce to 24% after 10 years ownership (under present CGT rules).

It is inadvisable to let space from GMS approved areas as the GP's rent reimbursement will be reduced by the same amount as the rent received from their tenants. In valuation terms smaller areas of accommodation (such as a few rooms) will generally have a higher rate per sq. metre than larger areas and thus the aforementioned scenario can be a positive detriment to the GPs. **A better solution is to have the area that they wish to let taken out of GMS and excluded from the reimbursement** and then let that at hopefully a slightly higher rate than they achieve via the CMR or notional rent. Another benefit of this arrangement is that, on the assumption that leases to tenants would contain upwards only rent review clauses, this rental income could serve as a buffer in the event of a downwards valuation of notional rent in the future.

Introducing too many tenants could create occupation and management problems, and can therefore be a detriment to the capital value of the property. However, provided the lease terms and management of all such lettings are properly implemented, the detriment can be limited.

This type of investment is at present only favoured by some of the most entrepreneurial GPs who want to have control over the overall services available to their patients and who see ownership of the primary care centre as a means of both delivering innovative services and providing themselves with an attractive, tax efficient investment opportunity.

5.2 The GP as head tenant

GPs who lease their premises but then sublet spare space to other tenants face the same risks and benefits as other leaseholders but, in common with owner-occupiers renting out spare space, have **the additional**

risk of finding suitable tenants and of potential management problems, and the additional benefits of potentially enhanced income ('profit rent') and enhanced services for patients.

However, **the possibility of getting any profit rent is extremely limited**, as landlords would look to recapture this during future rent reviews. Any increase in value relates to the property and will eventually be due to the landlord, even if such a benefit was realised by the tenants. The potential for profits from service charges to sub-tenants is also relatively small, particularly if they are other NHS bodies. NHS Estates' guidance on leasehold premises strongly advises GPs to only lease the part of the premises that they will occupy and not take any additional risk burden. A possible exception would be the pharmacy, where the rental value will be intrinsically linked to the number of GPs and patients and thus where the GP "head tenants" may secure an initial premium.

5.3 Partnerships between owners and tenants

It is quite possible that, within a partnership, some partners will wish to own a share in the property and others will not. **Legally, there is no reason why a partnership could not include a mixture of owners, tenants and licensees.** This approach is becoming increasingly common and may help to attract young incoming partners. The rent reimbursement would go to the practice, as providers of the accommodation, and there should be a proper lease drawn up between the landlord (those GPs who own the property) and the practice which clearly defines the responsibilities and liabilities of each. It may be helpful for a surveyor/agent to be appointed to negotiate on matters such as the level of rent reimbursement on behalf of the practice.

However, any partnership can only really be successful if the partners are like-minded in their work ethos and ideally their attitude to risk. Discussion within the partnership is essential, but if the partners have totally contrasting views then it will be very difficult for the practice to agree on a solution. This will either lead to stagnation in that it is impossible to agree to move forwards and ultimately to some partners leaving due to the frustration this causes, or to the possible dissolution of the partnership. In a large partnership this is less likely, as there can be room for compromise with one or two partners not initially joining in the property development. However in a small partnership of say three partners this would be difficult.

A partnership agreement should specify whether a majority or a unanimous decision is required for major issues such as this. In the case of a new development a unanimous decision, with all partners willing to proceed, is likely to be required. Partnership is always a difficult vehicle through which to run a business and major decisions such as property issues are likely to test the partners if they are not of a similar viewpoint.

5.4 Sharing premises with other GP practices

The presence of neighbouring practices requiring new premises at the same time could, depending upon the attitude of the GPs and the location, **point to a joint development**, either led by the developer or PCT for leasing back to the GPs or led by owner occupier GPs. The trend towards providing a greater range of services in primary care reinforces the incentive for joint developments.

However, the fact that neighbouring practices need to have new premises does not necessarily mean that they will work in harmony under the same roof (**regardless of whether it is owned or leased**). **Although some PCTs may be tempted to relocate a number of GPs in the same premises, they would be most unwise to do so without regard to the sensitivities of the GPs involved.**

CASE STUDY: neighbouring practices join forces to develop GP-owned centre

This example challenges the perceived wisdom that GPs are increasingly risk averse and that large developments must inevitably be led by the PCT or a third party rather than GPs. Two GPs nearing retirement, foreseeing the return of the 'cottage hospital' and the transfer of services from secondary to primary care, were the driving force behind the development of the Cheltenham Family Health Care Centre. All other GP practices in the area were invited to join the project, and roughly half opted to do so.

The centre houses five multiple partner practices, each with their own reception areas, surgeries and offices, a range of shared specialist services and units for other health care professionals including a chiropractic clinic, a pharmacy, an optometrist, community dentistry, chiropody and podiatry services, and complementary therapists. It has encouraged GPs to work together, sharing skills and resources, whilst maintaining the individual doctor-patient relationship.

The 30 GPs occupying the centre are shareholders in a limited company, which owns the premises and leases surgeries back to the practices, with collective leases for common areas. This mechanism helps facilitate transfer of ownership in the event of partnership changes, with partners selling their shares back to the practice if they leave. The practice then decides on matters such as whether to accept non-property-owning partners and the period over which new partners will be able to buy into the premises.

The company built up a strong professional team of accountants and commercial solicitors, and had agreed leases with the main tenants before construction began. The lender agreed to finance the project on the strength of the leases to near 'blue chip' tenants rather than the building itself, with a fixed rate loan which protects the GPs from interest rate rises. The company employed agents to monitor the construction and ensure it fulfilled their requirements, and negotiated a fixed price and fixed term contract with penalties if the developer failed to deliver on a set date. Although some of the initial work was done on spec, all the subsequent professional costs of the project were rolled into the loan. The five existing surgery premises were traded into the project (similar to a PFI sale and leaseback scheme), which avoided potential problems in disposing of them, provided some flexibility in the valuation and ensured there were no difficulties in the timing of the move.

The centre was built within the Red Book guidelines as a cost rent scheme, although the trust rents some of the additional space on a 25 year lease, and this and other rental income helps to reduce the risk for the GPs. The leases specify upwards only rent reviews, which ensures the rent received will always be greater than the loan repayments. Tenants pay additional service charges, in return for which the company provides all facilities management services.

A similar approach could work on a smaller scale if a centralised pattern of service is inappropriate.

5.5 Sharing premises with other providers

Where a new scheme is planned, the presence of other commercial users will benefit the development and increase the investment value. It is therefore likely to make the scheme viable using rent reimbursement or notional rent. **This will however depend upon all parties being committed to that location for some time** and thus being prepared to take on a term lease of at least 20 to 25 years or a 25 year mortgage. If in the same scenario the GPs are unsure of their future (in a deprived area from which they may want to move away) or there are GP recruitment difficulties, social services could not commit to the long term viability and voluntary providers only want short term accommodation, the scheme would only

be viable if the PCT, for example, was prepared to take a long term over-riding lease and then sub-let back to the various occupiers.

Where there is an opportunity for a new surgery in a health centre developed by the PCT, bringing together all primary care and social services, **this may seem attractive to many GPs**. It would provide them with a nil cost and very easy option, enabling them to deliver a modern NHS service to their patients. Obviously the PCT would only do this if it saw an overall long term use of the building that fell in line with its long term plans. However, the concept of sharing premises with other providers is a key element of NHS Estates policy and all PCTs are being encouraged to pursue it.

For GPs who value their independence or the ability to invest in their premises this is a less attractive development which presents a considerable dilemma for partnerships in which the GPs are of different opinions regarding risk and reward. The key is for GPs to get involved as early as possible in any new scheme to help direct the PCT as to eventual ownership.

There are other potential disadvantages to sharing premises. Generally, the greater the number of parties involved, the longer and more complex the negotiations will become. Furthermore, it may prove more difficult to find a site large enough to accommodate all such parties. Ironically, it can also prove difficult to bring such parties together as a viable economic unit when they are each seeking to protect their own positions and in particular, to satisfy the ‘value for money’ requirements under which they each operate.

6. Factors influencing choice of ownership and procurement route

6.1 Land values and availability of new sites

Land value is a factor of property value and thus high value areas will have high value land, high value property and high returns. Conversely, low land value will probably indicate low value property and lower (or no) returns. Thus, whether a scheme is undertaken by the third party developer, GPs or the PCT, the same problems will occur.

In low value areas the land may be easy to identify but it could be difficult to make a project economically viable, hence the need in some instances for the HAZ flexibilities or other funding solutions.

CASE STUDY: development in area of low land values and high deprivation.

In this example, the economic basis for the community served by the practice had all but vanished. The population was dwindling and ageing, with morbidity rates and consultation rates above average and rising. The three-strong group practice had inherited a purpose-built 1940s surgery, which was overdue for replacement. The GPs were determined to stick with the area and to build a strong practice. Much younger than the surrounding practices, they expected to absorb the list of one or two nearby single-handers who were nearing retirement.

A well-located site had been found nearby, but banks were reluctant to lend, as local property values were declining and the cost of a new building would be far greater than its value as loan collateral. The health authority and PCT had decided that the deficit and risk would eat up a disproportionate amount of their limited funds for capital development. An investment company had looked at the area but was unwilling to accept the risk without substantial assistance and guarantees, and the practice found the company's

outline design proposals well below the standards they sought both in space and specification.

The GPs managed to convince the PCT and health authority that action was needed if they were to keep the practice in the area. They wanted a stake in the building and to maintain and manage it but not to carry the whole project. After about three years of discussion, a package was agreed dividing the total cost into four roughly equal parts:

- € working closely with the local authority, the health authority received promises of grant aid from a consolidated regeneration fund for the area.
- € the investment company took a long lease on the shell of the building, with continuing responsibilities for structural repairs and underground services only. The shell would be rented to the practice and an advance valuation was made to assess the future rent they would receive.
- € the practice took out a bank loan to pay for fitting-out the shell, and were to receive a notional rent on such value as their input added to the shell.
- € the PCT and health authority made up the remainder of the total costs, including loose furniture, the telephone and computer systems, professional fees and interest costs incurred whilst the building was under construction

The health authority and PCT made a service agreement with the practice a condition of NHS funding. Similar to a PMS agreement, this confirmed a range and availability of services from the practice for three years, and provided for a negotiated follow-on package 'at an equivalent level' for a further three years. The content of the agreement was ambitious and a nearby GP who wanted an equally large grant to improve his premises was deterred by the requirement to introduce a range of new services.

The PCT purchased the site and held it during construction, but the NHS regional office asked for this holding to be relinquished within two years of completion. An arrangement was made with the local housing association, which had recently taken over the adjoining council estate. Two years after completion the freehold of the site will be transferred to the housing association for one pound. There is no ground rent and there are no management responsibilities, and reversion of the buildings is to the association after 99 years. The leases require the site to be used to provide primary health care services to the local community and the association agreed to enforce the leases if requested by the health authority, at the authority's expense.

The outcome of the package of agreements was that the new surgery was built, to a high standard, with the full approval of the NHS and local council. It is of great local benefit and the practice has achieved its aim of running its own premises. The risk of further decline in property values is shared with the investment company. The company is cushioned by its risk premium and the practice is consoled by the inclusion of items in the grant-aided project which normally fall on practice gross income.

Had NHS capital been more readily available, the project structure could have been simpler and the cost to the public less in the long term. The project relied on the persistence of the GPs and the ability of the NHS and local authority to co-operate through a joint venture.

In high value areas the high demand for land will make it difficult and expensive to acquire. During the recession other forms of non-medical development were more limited and the competition for such sites was reduced. However, in the current market, sites and opportunities are snapped up very quickly and **if GPs or their third party developers are to compete with other users, the system of NHS**

approval and finance must become much faster and more efficient. While some of the ideas relating to the various forms of financing new NHS projects appear useful, the biggest concern of virtually all third party developers and many PCTs is that excessive red tape, the lack of specialists and knowledge, will prevent many projects even getting over the first fence.

6.2 Recruitment difficulties in declining or deprived areas

As noted above, the ease of recruitment for new GPs in an area is a key element of any decision making, as GPs are hardly likely to want to invest large sums of their own money in a project where there are problems with recruiting. Equally a GP is unlikely to want to go into a 25 year lease because the risk that they could remain liable for their interest in the premises on retirement will increase should they not be able to recruit a successor. **In such areas it will generally be vital to ensure that the finance comes from the third party developer, with the head lease to the PCT and sub-leases to GPs and other healthcare users.**

If a practice is confident that owning their own surgery represents a good investment opportunity then this may help them to attract a new partner who would want to stay with the practice on a long term basis. However, this is likely to be the exception rather than the rule.

6.3 GPs nearing retirement

Whether owning or leasing, GPs nearing retirement need to consider the relationship between the value of their property and its cost. This is particularly important in the case of single handed GPs who may not be able to secure the continuity of their practice and therefore the ability for someone else to take over their interest in the premises (be they owned or leased) upon succession.

In the case of partnerships, it may be simpler for partners who own and develop their premises to cater for the position of a partner who is shortly to reach retirement, for example by agreeing to buy him/her out at a value equal to the cost he/she has borne with regard to the premises, thus putting him/her into a cash neutral situation. **GPs approaching retirement will be naturally cautious about financial involvement in a new surgery development,** and should not be expected to share in the ownership unless their partners can guarantee that they will not suffer any financial loss.

If the premises are self-financing, in that the cost or notional rent matches the loan interest, then there is no need for any partner approaching retirement to be involved as the other partners are not suffering any reduction in their profit, and hence their drawings, as a result of the new surgery ownership. However, this can cause a dilemma for any younger partner planning to leave the practice in the relatively short term who has not announced his/her intentions to their partners.

If the partner has become a tenant under a lease, the lease may not allow for an immediate escape route at the time of retirement, particularly in older and non specialist leases. This would act as a significant deterrent to a partner considering development of premises shortly before retirement. **However, a specialist primary medical centre lease should include a clause allowing existing partners to assign to a similar number of new NHS GPs** (for example, excluding the retiring partner but including the incoming partner, following the successful completion of any probationary period) providing they are eligible for rent reimbursement. The key element is that this form of assignment should be allowed without the need to provide an authorised guarantee agreements (AGA) thus letting the retiring partner relinquish responsibility without any risk of ongoing liability.

Problems occur particularly in specific localities served by a dominant cohort of GPs due to retire soon. These localities also tend to have a high proportion of single-handed practices, and of surgeries based in

converted residential properties, which PCGs may not wish to be used by incoming GPs. They are often in deprived areas where there may be recruitment difficulties, which will be compounded by the lack of high quality premises able to house the group practice environment favoured by new GPs. The failure to recruit a new partner (rather than an assistant or salaried GP) would mean that, in a leasehold property, the liability for the retiring partner would continue. In this situation, the PCG/PCT must work strategically with LMCs to achieve a satisfactory long term solution which respects the rights of existing GPs.

6.4 Inadequate or unsuitable premises

New GPs should of course be discouraged from agreeing to buy into, or become a tenant on a lease of premises which are already unsuitable at the date of their admission into the partnership. However, this will in itself add to the recruitment difficulties and increasing pressure to relocate that many GPs occupying inadequate or unsuitable premises are facing.

Such GPs are often persuaded against their better judgement to develop their existing premises in an attempt to make them 'adequate and suitable', simply *because of* their existing location, when **moving to an alternative site would provide a better and more cost effective solution to the problem**. They may also be pushed towards the lease option if insufficient partners are willing to invest and the need for new premises is pressing.

If the current premises are in a poor location they are likely to be hard to dispose of and may need the assistance of the premises flexibilities. In the past, an alternate route has been to require a third party developer to take on board the risk of disposing of the premises. Whilst this may appear beneficial, any investor is looking at the end investment value and from this all costs will be taken. Thus, **if the developer has to cover an element of risk on old premises it will simply come out of the monies available for the rest of the project.**

Health centres are often in need of refurbishment and repair and both the GP tenants and the health authority or PCT may see moving to an alternative site as the only solution. However, **the potential for refurbishment accompanied by a fresh look at working practices and the management of the premises may be worth exploring.**

Case study: health centre refurbishment

The building had been badly maintained. It had incorporated several experimental construction features, some of which did not work out, and several essential components were due for replacement. The layout and the amount of space taken by different activities owed more to original 'turf' rights than current needs. Privacy at the reception counter was impossible and patients knew which door off the reception area led to the STD clinic. Practice nurses had very little space but the last partner to use the separate examination room regularly had retired some time before. Attitudes were stale, with little communication between the GPs and the community health services. The community trust as landlord provided a minimal and slow maintenance service.

The GP practice of four partners had no interest in the premises and were in no hurry to review the service charges, which had been negotiated seven years ago. Recruiting new partners was proving difficult. The area was not attractive to new doctors and surrounding practices were not keen to take any of the list. Two partners planned to remain. They did not see themselves as property entrepreneurs but had accepted that things could not stay the same.

The PCT agreed that the health centre should be refurbished and up-dated, and that a new formula for its development and operation should be established which could be better expected to keep it up to date and ensure flexibility of use. The PCT established a steering group chaired by the GP member of the PCT executive and including the GPs based at the health centre, the works manager of the PCT, a patient representative and a community services manager. The GP lease was extended to include 50% of the building. The GPs agreed to continue with joint arrangements for cleaning and incidental maintenance but insisted these were contracted-out, the contract to be managed jointly and reviewed regularly.

The costs of the refurbishment and alterations were divided equally, although one side of the building needed more attention than the other. Similarly, although the lease delineated some of the building in two parts, much of it was designated as 'common parts', usable by either community health services or the GP practice. The cost totals were increased to allow for a new telephone exchange and system, a new computer system and fixed and loose furniture, both to be used and maintained jointly.

The practice agreed to continue to pay rent for their increased share of the building, reimbursable as a 'passing rent' and indexed to local property values for the future. The GPs would receive notional rent for half the value added by the improvements and this would vary with local property values. The PCT paid for half of the costs as an NHS capital scheme. The practice paid for part of their costs through a loan and obtained an improvement grant and an IT grant from the PCT's GMS discretionary budget for the remainder. The ratio of grant to loan was set by agreement, to make the interest charges on the loan equal to the notional rent the practice expected in respect of the improvements. Aware that the service charge would rise, the PCT agreed with the practice to allow payment to continue at the present level until their notional rent exceeded their loan charges and the addition to the service charge. This was achieved three years later, following the first review of notional rent.

To ensure the potential benefits of the project were realised, the PCT set up a two-part house committee as a condition of their support for the scheme, one part concerned with the upkeep of the property, its use and renewal, and the other with co-operation in service delivery. Membership was drawn from the practice partners and staff, the community health services and officers of the trust, chaired by a GP member of the PCT. Although the formula for the improvements was complex, the greater challenge was to maintain the cultural shift needed to ensure continuing co-operation and flexibility.

6.5 Personal Medical Services

There is little real difference between GMS and PMS in terms of property ownership and other premises issues. The premises provisions of the new GMS contract have been applied equally to PMS, including the flexibilities contained in the costs directions. The guidance document "Sustaining Innovation Through New PMS Arrangements", which was published in March 2004 and explains the impact of the new GMS contract on PMS, states (in section 3.22) that

"Additional premises payment mechanisms (also referred to as premises flexibilities) were developed and introduced on 18 September 2003. PCTs are able to use these arrangements to address estate problems that are common to both GMS and PMS practices. In this respect, PCTs will need to agree funding and support arrangements based on prioritisation of need regardless of the nature of the contract with practices. Once agreed at Board level and use made of the flexibilities, the new allocation and funding arrangements will be in place."

6.6 Established owner-occupiers

GPs currently owning their premises are generally best advised to continue to do so, as long as the premises are not judged to be inadequate and unsuitable. Over time, the current market value of the property will generally exceed the historic cost and the GPs will see a return on their investment. Most practices are now once again seeing a profit on their investment, which becomes evident as partners retire.

Where historic cost is significantly greater than current market value, GPs face the specific problem of negative equity. Most GP premises have now returned to at least their 1988 value so negative equity only remains for a few practices who made a poor investment, either by paying an excessive cost or by incurring expensive development problems. Unfortunately, **GPs suffering from this problem are unlikely to benefit by simply moving from owner occupation to a lease from a third party**, as investors will not pay more than the market value. In some instances, the 'sale and leaseback' route has been successful but this is inevitably because the investor is prepared to look into the future rather than at the short term. For example, the GPs may believe that the current value is less than the cost because they have relied solely on the district valuer's assessment (or the advice of a non-specialist valuer or surveyor). An investor coming onto the scheme (who will often employ their own surveyor or valuer) will look in depth at the level of current rent, make their own assessment as to how the current rent might be negotiated up with the district valuer, at how future rent reviews may react and finally what additional expense or work they can put into the project to create an even greater growth in rent. **It is only by uncovering such possibilities that the investor can, in essence, appear to create a higher value. In truth, of course, such higher value was the real value all along and applied as much to the GPs as it did any investor.**

PCTs have compulsory purchase powers and this has led to fears that GPs may be forced to sell their premises to the PCT. In reality, this risk is virtually non-existent. Compulsory purchase is designed to be used as a last resort when it is absolutely essential that a certain element of land be acquired, where it cannot be acquired by any other means, and where there is no other alternative. We have received assurances from NHS Estates that it is not the intention that these powers would be exercised to buy up primary care centres around the country as the cost of doing so would be prohibitive. It would inevitably mean paying more than open market value as, in addition to the purchase the owner must be compensated for moving, and would also lead to the payment of additional capital charges. Health authorities have had such powers for numerous years but have almost certainly never used them. To even investigate using such powers, the PCT would need to call on the expertise of Capitec or the district valuer's office to guide them through the very difficult procedures necessary.

6.7 Rural areas

Consolidating several practices within a single centre which can then offer a wider range of services may be an attractive option in densely populated urban areas. However, in rural areas it is unlikely to be feasible. Indeed, **even the closure of branch surgeries and single-handed practices in small villages could severely reduce patients' ability to access services within a reasonable distance. However, a variety of pressures threaten the closure of small surgeries** (particularly branch surgeries):

- € The PCO may be concerned at the standard of accommodation but no-one wishes to invest in it.
- € Conversely, a branch surgery may have acquired a high property value, giving the practice an incentive to sell it and consolidate at their main base.
- € When single-handers retire, their list may be absorbed by a neighbouring practice.

€ Practices may choose to merge, for a variety of reasons.

€ The practice may be concerned at the risks and inefficiencies of running a branch surgery.

The closure is likely to be seen by local people as in line with the closure of their public library, bank, shops, school, and bus service.

Any solution has to demonstrate quality and efficiency as well as accessibility. **The best route may be to establish a surgery as a part of a multi-purpose building**, particularly when the population served is small and the usage relatively light. The partners to such a development would depend on local needs, plans and resources, but might include the public library, a pharmacy, a church, local authority offices, a social services centre, the day-room of a sheltered housing scheme, or a new housing development. Privacy and quiet will be important factors, which may rule out the village community centre or nursery school as close partners.

Economies of scale can be achieved by making the surgery a self-contained part of a larger building, sharing some outdoor space, or even by the joint development of separate buildings on a single site, sharing a car-park and entrance. Indoor space could also be included, such as waiting areas, toilets and rooms for group activities. Shared space demands extra features, goodwill and good management. Negotiations on the development and ownership of the site can be complex and, if more than two parties are involved, it will probably be useful to identify a lead party which organises the overall development.

The concept of defining explicit standards for provision of and access to community services in rural areas is emphasised in the rural white paper⁴, and could usefully be adopted by health authorities in respect of GP surgeries. As a result of this white paper local authorities are expected to draw up ‘village and town plans’, whilst ‘quality parish’ models of good practice are being drawn up by DETR, the local government association and the national association of local councils. It is important that these include models for the preservation and development of primary health care in rural areas.

The key to making developments in rural areas financially viable may be to draw upon other sources of public funding. For example, the rural development agency provides grants for the conversion of farm buildings for alternative uses which employ people, provided a working farmer retains ownership. The same body also makes grants for the re-use of redundant buildings more generally in selected rural areas. The countryside agency’s community service is for the development or restoration of community services for rural areas. It does not act as a substitute for normal NHS-plus-private funding, but in some circumstances can help to get a project together.

The success of a branch surgery will also depend on resolving operational issues, such as effective use of IT systems, advanced telephone systems and portable miniaturised equipment. If the branch surgery has functional limits, the practice will need to seek patients’ understanding and support for the functional split between surgeries. Nurse-only sessions can help extend the opening hours of a branch surgery for specific clinics and follow-up attendances. Practices should expect to co-operate with community health services in sharing premises. Accommodation will be limited and delineating rooms, other than consulting rooms, on an us-and-them basis would usually be inefficient.

6.8 The health authority or PCO attitude to investment

The attitude of the health authority or PCO is a key element in the success or failure of different types of schemes. **There is a marked trend at present towards health authorities favouring private investment with GPs as tenants rather than owners**, bringing third party developers and GPs together

and not providing any finance for GPs wishing to undertake their own initial searches and appraisals. **Unfortunately, some GPs are led to believe that funding will only be available under this model** and are therefore drawn towards it without exploring the option of developing and owning the premises themselves. As the cost to the health authority or PCT should be the same regardless of whether the premises are developed by the GPs or a third party this trend is difficult to understand. **GPs are effectively the original PFI model in the NHS as, in owning their premises, they have provided the capital funding, and the health authority has borne an annual funding cost in exactly the same way as it would in funding the rent to a developer.**

In other areas health authorities have encouraged GPs and, in some instances, helped fund GPs to implement their own search and appraisal. Others have done nothing. Some PCOs have been lucky enough to retain estates expertise and others have sub-contracted specialist consultants but, **unfortunately, many PCOs lack the property knowledge and experience to help GPs in any way, and this may explain their preference for the third party developer route. The NHS must recognise and act upon the need for expertise to be available to support GP-led projects.**

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References

- ¹ *Primary care trusts: a guide to estates and facilities matters.* Department of Health. <http://tap.ccta.gov.uk/doh/point.nsf/Publications?ReadForm>
- ² For example, the final report of the Practice Premises Working Group (February 2001), representing the National Assembly for Wales, GPC (Wales), health authorities and local health groups, which reviews arrangements for the provision of primary care premises in Wales.
- ³ *Healthcare funding review: Annex 7: advantages and disadvantages of the private finance initiative.* BMA, 2001. <http://ww.bma.org.uk/public/polsreps.nsf/htmlpagesvw/hcfund>
- ⁴ *Our countryside: the future, a fair deal for rural England.* DETR, November 2000. www.wildlife-countryside.detr.gov.uk/ruralwp/index.htm. DETR's news release 731 lists a fund of £100m for the development of one hundred one-stop primary health care centres or mobile units in one hundred rural communities.

FOCUS ON PREMISES COSTS

INTRODUCTION

The long, and often confusing, sections of the Statement and Fees and Allowances relating to practice premises costs will from 1 April 2004 be replaced in England by the **National Health Service (General Medical Services – Premises Costs) Directions 2004**. These are currently available at

<http://www.dh.gov.uk/PolicyAndGuidance/HumanResourcesAndTraining/ModernisingPay/GPContracts/fs/en>

The corresponding Scottish directions are the **Primary Medical Services (Premises Development Grants, Improvement Grants and Premises Costs (Directions) 2004**. There are available at

http://www.show.scot.nhs.uk/gpweb/7/PDFs/PremDir_2004.pdf

This guidance note gives GPs, practice staff and LMCs a brief and readable overview of the Directions. Readers are strongly advised also to refer to the Directions themselves when investigating specific issues, as this note does not replicate the Directions in full.

Readers may note the repeated use of the phrase “PCTs must consider applications for financial assistance towards...”. This must be seen in the context of the new premises funding arrangements, whereby all new developments and projects are prioritised on the basis of need. The goal of PCT’s estate strategies is to deliver year on year improvements in the quality of primary care estates. This is an NHS plan obligation, and so funding will follow the projects considered most urgent. The funding for new projects and developments will be held by a lead PCT in each Strategic Health Authority area.

The new premises funding arrangements are explained in full in the Department of Health briefing paper “*New GMS contract and changes to the GP premises funding arrangements*”, which is at **Appendix A** to this guidance note, and in the joint Department of Health/National Primary and Care Trusts Development Programme guidance “*Future funding for Primary Care Premises: A guide to the role of lead PCTs and SHAs*”. The latter is available at

<http://www.dh.gov.uk/PolicyAndGuidance/HumanResourcesAndTraining/ModernisingPay/GPContracts/fs/en>

1. STRUCTURE OF THE DIRECTIONS

The Directions simplify the SFA premises sections but retain most core concepts. They incorporate the premises flexibilities, which were first agreed between the GPC and the DoH in 2002.

There are six **parts** to the directions. **Part 1** is a general introduction. **Part 6** relates to transitional provisions. The remaining **parts 1 to 5** divide premises payments into four categories within which the flexibilities are subsumed.

€ **premises developments and improvements - Part 2**

€ **professional fees and related costs incurred in occupying new or refurbished premises - Part 3**

- € **relocation payments - Part 4** (mortgage redemption or deficit grants, guaranteed minimum sale price, grants towards reconversion of former residential property, grants towards surrendering or assigning leases, stamp duty land tax)
- € **recurring premises costs – Part 5** (notional rent, cost rent, which is now referred to as “borrowing costs”, equipment lease costs, running costs, service charges)

There are also three **schedules relating to previous parts of the Directions**

- € **Schedule 1 – Minimum Standards for Practice Premises**
- € **Schedule 2 – Current Market Rents and Notional Rent Abatements**

This schedule sets out some general District Valuer assumptions in assessing current market rents and additions and reductions to be made.

- € **Schedule 3 – Notional Rent Abatement and Notional Rent Supplements**

This schedule explains how to calculate notional rent abatements where NHS funds have contributed to the cost of building or refurbishing and notional rent supplements.

There now follows a more detailed commentary on the four categories of premises payment (see section 5.4 below).

2. PREMISES DEVELOPMENTS AND IMPROVEMENTS (PARAGRAPHS 7 – 12 OF THE DIRECTIONS)

2.1 Eligible and ineligible improvements

The Directions give eight examples of the types of improvements that may be funded by an improvement grant, including extensions, alterations to comply with the Disability Discrimination Act, car parking, accommodation to meet the needs of children or elderly or infirm people (para 8)

Improvements started without the prior agreement of the PCT will not be eligible for a grant. Nor will the acquisition of land, existing or new buildings, repairs, restoration work, any work on domestic quarters in residential accommodation or extensions not attached to the main building by a covered passageway at least. (para 9)

2.2 Proposals for improvement grants: the PCTs’ obligations

- € **consult LMCs** on improvement or development proposals
- € **be satisfied** that proposals are necessary to support the delivery of services under its GMS contract and represent value for money
- € **have regard to** the standards set out in “Primary and Social Care Premises – Planning and Design Guidance which can be found at www.primarycare.nhsestates.gov.uk.

2.3 Proposals for improvement grants: the contractor’s obligations

- € **provide** architects’ or surveyors’ plans (if appropriate)
- € **provide** evidence of competitive tendering process for building work, including three written quotes
- € **provide** planning and building regulations consents

€ if premises are leasehold, **provide** copy of the landlord's or licensor's written consent to the development/improvement.

2.4 Project plans and conditions for payment

If a PCT decides that a proposal from a contractor is a priority project for inclusion in its estates strategy, it must aim to finalise a **project plan** with that contractor. It may only pay an improvement grant of between 33% and 66% of the cost of the improvement.

The project plan must include project specifications and a **payment schedule**. The payment schedule must specify that payments are conditional on the project specifications included in the plan being met. If the improvement/development is for premises held on a lease or a licence, the payments must be conditional on the contractor guaranteeing that the premises will remain in use for

- € at least five years for projects up to £100,000 plus VAT
- € at least ten years for projects costing over £100,000 plus VAT

If those premises cease to be used for NHS services before the 5 or 10 year period is up, the contractor will have to repay the relevant proportion of the grant (paragraph 12. b. iv).

3. PROFESSIONAL FEES AND RELATED COSTS INCURRED IN OCCUPYING NEW OR SIGNIFICANTLY REFURBISHED PREMISES (PARAGRAPHS 13-15 OF THE DIRECTIONS)

Under the Directions PCTs must consider applications for financial assistance towards **legal and professional fees incurred in occupying new or significantly refurbished premises**.

Where **notional rent payments** are being made for **newly built or refurbished premises**, these costs may be reasonable surveyors' or architects' fees and legal costs arising from the purchase of the site and the construction or refurbishment work. In the case of **leasehold premises**, the costs may be any **reasonable** costs of engaging a project manager and reasonable legal costs incurred in agreeing the lease. Agreed payments by the PCT to the contractor to cover these costs must cover VAT.

4. RELOCATION GRANTS (PART 4, PARAGRAPHS 16 – 30)

4.1 Mortgage redemption or deficit grants

Contractors may make a written application to the PCT for a grant to cover mortgage redemption or deficit grants in the following circumstances;

- € if the practice agrees to relocate to modern leasehold, PCT-approved premises
- € if the practice has a mortgage deficit due to the market value of the premises being too low to pay off the outstanding mortgage
- € if the practice must pay mortgage redemption fees as a result of selling the premises
- € if the practice includes all reasonable information that the PCT requires to decide on the application.

In order for a grant to be approved, the practice must be able to show that it has made every attempt to solve the problem by other means. This includes negotiating with the lender, exploring options for **alternative use** of the property, making a thorough attempt to identify a third party developer and site for the new leasehold premises and carrying out active marketing of the premises to achieve the **best sale price**.

If a grant is approved, the contractor must agree for it to be sent directly to the lender and must provide the PCT with enough details for it to do so. It must also provide enough detail for the PCT to establish whether there is any **endowment policy cover** linked to the mortgage and, if so its **surrender value**. This is because the PCT is required to deduct the surrender value from any grant it pays.

The same terms apply to contractors that have taken out a loan to cover mortgage deficits or redemption penalties (paragraphs 20-22).

4.2 Guaranteed minimum sale price payments

If a contractor has agreed **to move to PCT-approved modern leasehold premises** it can agree a **guaranteed minimum sale price** for the previous premises with the PCT. The PCT may then, on request, provide financial assistance towards the difference between that minimum price and the sale price for the previous premises. The following conditions, amongst others (see paragraph 24) must be met:

- € the PCT must be convinced that the relocation will improve the range and quality of services
- € the previous premises must have been placed on the open market and every effort made to achieve a maximum sale price
- € the PCT must receive professional advice on the market value of the property and be satisfied that this maximum is the highest achievable sale price
- € the sale is not to one of the persons mentioned in paragraph 24, (f).

4.3 Grants towards reconversion of former residential property

PCTs must consider applications for financial assistance towards reconverting former residential property back to residential use if

- € the contractor has agreed to move from premises no longer thought suitable for providing GP services to more suitable premises
- € the contractor has agreed to rent out the reconverted premises, through a registered social landlord or through its own arrangements, for a minimum period of time to be set by the PCT.
- € the tenant or social landlord is not one of the persons mentioned in paragraph 27 (a).

4.4 Grants towards the cost of surrendering or assigning leases¹ or to meet vacated leasehold premises costs

PCTs must consider applications for financial assistance towards these costs if the contractor is moving to more suitable premises from leasehold premises no longer considered suitable for providing GP services. Meeting the costs of assigning a lease is only possible where surrender is not an option.

¹ Surrender of a lease is where a lessee (tenant) gives up the lease altogether. Assignment of a lease is where the lessor (landlord) or lessee (tenant) assigns their interest in the lease to another person, subject to the terms of the lease.

These grants are not payable if the previous leasehold premises are owned by or leased from an NHS body, or are wholly or partly owned by or leased from the contractor or any of the persons set out in paragraph 29 (c).

4.5 Stamp duty land tax

PCTs must consider applications for financial assistance towards the payment of stamp duty land tax where the contractor has agreed to move to **modern leasehold practice premises approved by the PCT**.

The obligation of a contractor to pay stamp duty land tax is not conditional on whether or not the contractor is an NHS body.

5. RECURRING PREMISES COSTS (PARAGRAPHS 31 – 49)

This section of the directions allows for the payment of what was previously known as **cost rent – here referred to as owner-occupier borrowing costs – actual leasehold rent, current market rents and notional rents, notional rent supplements, abated notional rent, running costs and equipment lease costs**. It simplifies the corresponding premises paragraphs of the Statement of Fees and Allowances.

5.1 Leasehold rent

PCTs must consider applications for financial assistance towards a contractor's rental costs. If it grants the application, the amount it must pay is the current market rent or the actual lease rent plus VAT, whichever is the lowest.

In some areas of deprivation, where prevailing rents are too low to provide sufficient returns on new capital investment or to meet the minimum standards set out in Schedule 1 of the Directions, PCTs may supplement the current market rent payable. The uplift factor will be provided by the Valuation Office Agency.

5.2 Owner-occupier borrowing costs (“cost rent”)

PCTs must consider applications for financial assistance from owner-occupiers who have incurred borrowing costs from purchasing, building or significantly refurbishing its premises. Contractors who have financed the project with their own resources may also make such applications.

The contractor must have obtained three written quotes for the building work and must agree with the PCT which one represents best value for money. Applications may cover the following cost elements:

- € site purchase and reasonable associated legal costs
- € building works
- € reasonable surveyor' and architects' fees
- € rolled-up interest incurred on loans taken out to purchase the premises
- € local authority and planning application fees
- € costs to adequately fit-out and equip the new premises
- € VAT and stamp duty land tax

When calculating the amount applied for, a **prescribed percentage** must be applied to the necessary level of loan taken out to cover these costs. NHS Estates will no longer issue revised prescribed percentages as they do now. Instead, PCTs will calculate the percentages themselves.

The prescribed percentages will be

- € for **fixed rate loans**, the 20 high year gilt rate issued by the Bank of England, plus 1.5%
- € for **variable rate loans**, the Bank of England Interest Rate plus 1%

€ for **projects financed wholly or mainly by the contractor**, the percentage which the PCT considers best value for money.

If an application is granted, the PCT will pay the contractor monthly payments, based on an agreed annual amount, to cover the agreed borrowing costs. These will be payable on the last day of the month. They will end if the loan is paid off or if the contractor opts to switch to notional rent payments.

If a contractor changes lender or renegotiates lower loan costs, the PCT will recalculate the payments using the prevailing prescribed percentage (i.e. that in force at the time the loan or lender was changed).

If a contractor has a variable rate loan, the annual amounts from which the monthly payments are calculated will, at the end of every twelve months since the previous calculation, be recalculated using the prevailing Bank of England Base Interest Rate plus 1%.

If a contractor is receiving borrowing cost payments resulting from a fixed interest loan, it **must** inform the PCT of any change of lender or reduction in the level of interest it is being charged.

5.3 Notional rent

A contractor may have repaid its loans or may prefer to receive a notional rent instead of borrowing costs payments. In such cases it may apply to the PCT for notional rent payments. PCTs **must** grant the application if the contractor chooses to switch from borrowing cost payments to notional rent.

The amount must be reviewed every three years. The review will be brought forward if there is a change to the purpose for which the premises are used or if there is further capital investment in the premises which will be reflected in the payments the contractor is receiving under its contract.

5.4 Notional rent abatement and supplements

Notional rent payments will be **abated** (i.e. reduced in value) where improvements have been made to the premises and NHS capital has contributed to the cost of the building or refurbishment work (but only after 18 September 2003). The formula given in Part 1 of Schedule 3 of the Directions will be used to calculate the abatement.

Notional rent supplements are designed to ensure that contractors may **benefit financially** from enhancements to the value of the premises resulting from improvements that they themselves fund.

PCTs **must** grant applications for notional rent supplements if

a) a contractor receiving actual lease rent payments makes further capital investments in its premises that had the prior approval of the PCT

or b) a owner-occupying contractor receiving borrowing costs makes further capital investment in the premises that had the prior approval of the PCT but which does not raise the current market rent above the level of borrowing cost payments.

The value of the supplement is calculated in accordance with Schedule 2, Part 2 of Schedule 3 of the Directions.

5.5 Running costs

If contractors are receiving payments from the PCT for lease rental costs, notional rent or borrowing costs it **must grant** applications for financial assistance towards the following, provided they are not receiving payments for these costs under other Directions.

€ business rates

€ water and sewage charges or

€ in the case of modern practice premises, a **service charge** if this covers

- € fuel and electricity charges
- € insurance costs
- € costs of internal or external repairs
- € building and grounds maintenance

There may be circumstances where service charges are already rolled up in the lease or other payments, and so the PCT is already providing financial assistance towards service charges. To avoid double payment when payments are made under this Direction, the PCT must deduct from the other, possibly hidden, service charge payment either

- € an average amount that the contractor paid for the four service charge items listed above (the average amount must be calculated from the previous year's costs) or
- € 40% of the amount otherwise payable.

5.6 Equipment lease costs in modern leasehold premises

The PCT must consider, and if appropriate grant, an application for financial assistance towards equipment lease costs if the costs were agreed with the PCT before the equipment lease agreement was made.

5.7 Minimum standards

All the payments under **part 4** of the Directions – those listed in this section – are subject to the **minimum standards** set out in Schedule 1 of the Directions, which is replicated in full at Appendix B to this guidance note.

If the minimum standards are breached, but capable of remedy by refurbishing the premises, the PCT and contractor should revert to a plan as described in paragraph 18(3) of the GMS regulations below.

(3) Where, on the date on which the contract is signed, the Primary Care Trust is not satisfied that all or any of the premises specified in accordance with paragraph (1)(b) meet the requirements set out in paragraph 1 of Schedule 6, the contract must include a plan, drawn up jointly by the Primary Care Trust and the contractor, which specifies -

- (a) the steps to be taken by the contractor to bring the premises up to the relevant standard;*
- (b) any financial support that may be available from the Primary Care Trust; and*
- (c) the timescale on which the steps referred to in sub-paragraph (a) will be taken.*

If the timescale mentioned in (c) has not yet elapsed, the PCT should not issue a remedial notice. If it has elapsed and the PCT wish to issue a remedial notice, it must **consult the LMC** first.

5.8 Abatements for private income and commercial contracts

Any recurring notional rent or borrowing cost payments may be reduced by an abatement percentage (see the table in paragraph 49 of the Directions) if any part of the premises are used for or associated with the provision of medical services to private patients or under arrangements with any personal who is not a public authority. The value of any payments in kind will be taken into account in the calculation of private income percentages.

There is a threshold of 10% private income below which no abatement will be made.

6. TRANSITIONAL ARRANGEMENTS

The PCT must continue to provide financial assistance if it was making payments to a practitioners under the SFA immediately prior to 1 April 2004 for any of the recurring costs mentioned in section 5 of this guidance note. Those practitioners must either be a contractor, or partner or shareholder in a contractor and must own or be part owner of the leasehold or freehold interest in practice premises. From 1 April, the payments must be made to the contractor rather than the practitioner, unless the practitioner is a contractor. The PCT may simply continue with the existing payment levels without considering a new application.

APPENDIX A DEPARTMENT OF HEALTH BRIEFING NOTE – RELEASED NOVEMBER 2003

New GMS Contract & Changes to the GP Premises Funding Arrangements

The new general medical services contract introduces new arrangements for premises funding. This note, prepared by the Department of Health, explains the process for cash limiting GP premises spending. It is our intention to ensure that sufficient funding is available to cover all existing developments, planned LIFT developments and any other developments approved through the new arrangements in order of priority.

Premises allocations will take account of existing spend, existing commitments and funds for growth. The cut-off point for the baseline of commitments contractually entered into is the end of September 2003. It is intended that allocations will be made in the New Year.

The funds available for growth will need to be prioritised and allocated locally. It is from within this element that costs of new schemes not committed by the end of September 2003 would need to be identified. We do not anticipate known projects failing to proceed due to lack of growth monies, although of course there may be other reasons for non-completion.

This note addresses the concerns that are currently being raised about the new funding arrangements. This will also be posted on the NHS Estates website primary care section¹ and then into the New GMS Contract Guidance and will also be included in an electronic Newsletter for SHA new contract leads being produced to report developments under the new Contract.

What are the changes?

When the new Contract is introduced there will be a single unified funding stream to meet all general practice costs, including payments in respect of GP premises.

How will PCTs Access this New Funding Stream?

¹ http://www.nhsestates.gov.uk/primary_care/index.asp

From April 2004, for new GMS Contract practices, PCTs allocations will include three elements in respect of GP premises costs:

- € a baseline of existing premises spend
- € an additional element to meet the cost of new agreed premises developments (ie those ready for occupation, under construction and others contractually agreed between the practice and the provider) contractually agreed before 30 September 2003
- € a further element weighted to take account of premises inflation to meet costs of, for example, use of flexibilities and new premises developments which are agreed after 30 September

The first two elements will be allocated direct to individual PCTs. The third element will be allocated using a modified weighted capitation formula, which includes a premises market forces factor, to lead-PCTs for onward cascade to support premises new initiatives agreed with the Strategic Health Authority.

For PMS practices, baseline funding is already in PCT allocations which will be topped-up as described above for the other two elements.

What Guarantees of Sufficient Funding?

Work is being completed on how the new arrangements will operate and the detail of individual allocations is not yet available. The aim is to allocate as much as possible of the funding for the new contract at the same time. The date for announcing the allocations is not yet known, but we are aiming for this to be some time in the New Year. However, significant new funding was secured as part of the 2002 Spending Review. As described above, this will be added to baselines and matched against planned premises programmes.

The 'further allocations' described under the third bullet point will take into account government priorities and initiatives which are supported by SHAs through approved SSDPs and are at advanced stages of delivery.

Baseline and commitment information is being collected by the Department from a number of sources. We are currently asking PCTs to confirm their existing GMS premises spend and anticipate full validation to be completed by 12 December. A separate exercise will also be conducted to verify the Valuation Office Agency records of those new developments which reached contractual agreement by 30th September. This will be done under cover of an Allocation Working Paper expected to be released w/c 17 November.

Will PCTs be Able to Add to Their Premises Fund?

Yes, they will be able to vire-in from other elements of their allocations.

What is the role of the Lead-PCT and how are they to be Identified by SHA?

There will be two main roles. First, to act as the conduit on behalf of the SHA for new premises funding to pass to other PCTs and hold funds yet to re/allocated. Second, to advise SHAs on primary care estate procurement, management and disposal.

Identifying a single PCT to effect the first role should be relatively straightforward but SHAs will wish to ensure that the PCT is sufficiently resourced. For the second role, SHAs may have one PCT with the necessary experience and expertise to advise on primary care estate matters. Alternatively, the SHA could consider bringing together those skills from more than one PCT.

APPENDIX B

EXTRACT (SCHEDULE 1) OF THE NATIONAL HEALTH SERVICE (GENERAL MEDICAL SERVICES – PREMISES COSTS) (ENGLAND) DIRECTIONS 2004

MINIMUM STANDARDS FOR PRACTICE PREMISES

1. As regards the design or construction of the premises, or of the approach or access to the premises, to which the payments relate, the contractor must comply with any obligations it has to its own members (where applicable), staff, contractors and to persons to whom it provides primary medical services under the Health and Safety at Work Act 1974 (and legislation under that Act) and the Disability Discrimination Act 1995. The requirements of the 1995 Act include taking such steps as are reasonable to—
 - (a) provide for ease of access to the premises and ease of movement within the premises for all users of the premises (including wheelchair users);
 - (b) provide adequate sound and visual systems for the hearing and visually impaired; and
 - (c) remove barriers to the employment of disabled people.
2. Adequate facilities should also be provided for the elderly and young children, including nappy-changing and feeding facilities. There should also be adequate lavatory and hand washing facilities which meet current infection control standards.
3. If the premises has a treatment room, this should be properly equipped (an additional treatment room may be required where enhanced minor injury services are provided).
4. The premises should have a properly equipped consulting room for use by the practitioners with adequate arrangements to ensure the privacy of consultations and the right of patients to personal privacy when dressing or undressing, either in a separate examination room or in a screened-off area around an examination couch within the treatment room or the consulting room. However, in the case of branch surgeries, this standard need not be fully met if the contractor provides outlying consultation facilities using premises usually used for other purposes, and these meet with the approval of the PCT,
5. The access arrangements for the building should be convenient for all users.
6. There should be washbasins connected to running hot and cold water (possibly distributed through mixer taps) in consulting rooms and treatment areas or, if this is not possible, then in an immediately adjacent room.
7. There should be adequate internal waiting areas with—
 - (a) enough seating to meet all normal requirements, either in the reception area or elsewhere; and
 - (b) the facility for patients to communicate confidentially with reception staff, including by telephone.
8. There should be with adequate standards of lighting, heating and ventilation.

9. The premises, fittings and furniture should be in good repair and (when being used for the provision of primary medical services) clean.
10. There should be adequate arrangements for the storage and disposal of clinical waste.
11. There should be adequate fire precautions, including provision for safe exit from the premises, designed in accordance with the Building Regulations agreed with the local fire authority.
12. There should be adequate security for drugs, records, prescription pads and pads of doctors' statements.
13. If the premises are to be used for minor surgery or the treatment of minor injuries, there should be a room suitably equipped for the procedures to be carried out.

**THE DISABILITY DISCRIMINATION ACT
OBLIGATIONS OF GPs TO MAKE PHYSICAL ADJUSTMENTS TO PREMISES**

1. INTRODUCTION

On 1 October 2004, Part III of the Disability Discrimination Act will come fully into force. This section of the Act requires providers of goods, facilities and services, which includes GP practices, to make physical adjustments to their premises to enable disabled people to use their services. This applies not only to patients using the premises, but also to staff employed by practices which employ 15 staff or more, whether full or part time. The exemption of employers with under 15 staff will be removed in October 2004. Employment issues are handled briefly in this guidance, but will be addressed in more detail in separate future guidance. This main purpose of this note is to give a general introduction to what the physical adjustments to surgery premises might be and how to approach the problem.

Unfortunately, neither the GPC nor other organisations can give GPs definitive guidance on what adjustments will protect them against any discrimination claims under the act. The general principle is that a service provider has a duty to take reasonable steps to change either the practice or procedure or physical characteristic of a building that makes it difficult for a disabled person to use the service. However, it will be for the courts to decide whether or not a service provider has taken reasonable steps to remove or adjust the feature that has given rise to a claim. The concept of reasonableness will therefore be open to interpretation on the basis of the circumstances of the case. The authoritative document to guide the courts will be the *Disability Discrimination Act - New Code of Practice* (see appendix 2 - further reading).

Practices are strongly advised to start planning and making their adjustments ahead of the 1 October 2004 deadline. The adjustments that need to be made will often be simple ones, such as the installation of a handrail or the removal of an obstruction. Often it will be possible to avoid making an adjustment by finding an alternative way of providing the service or re-locating the point of service.

Other possible adjustments will be more expensive and complex, such as the installation of an induction loop at the reception desk or a stair lift. However, you are encouraged to think creatively about how to avoid the need for expensive changes, particularly if there is at first sight no funding available from the PCO or HA. Relocating a service to an accessible ground floor level, for example, would obviate the need for a stair lift. Ensuring a reception area is quiet and well lit enough to allow lip reading **may** be an acceptable substitute for an induction loop. It all comes down to the concept of reasonableness, and it is likely that the courts would take prohibitive costs into account when deciding if the steps you have taken are reasonable.

Practices are also encouraged to involve PCOs at an early stage. There is more information about this in the following sections.

It would be advisable to record any discussions and decisions taken at practice meetings about complying with the DDA. This would provide evidence that the practice has taken its obligations under the Act seriously and considered how best to implement the necessary changes.

2. BACKGROUND - THE DISABILITY DISCRIMINATION ACT 1995

The Disability Discrimination Act 1995 aims to end the discrimination that many disabled people face and aims to give them equal rights in terms of employment, access to goods facilities and services, and buying or renting property or land.

Part I of the Act deals mainly with the definition of disability. It defines a disabled person as someone with "a physical or mental impairment which has a substantial and long-term adverse effect on his ability to carry out normal day-to-day activities". It is worth noting the following exclusions from the definition:

- € addiction to or dependency on alcohol, nicotine, or any other substance (other than in consequence of the substance being medically prescribed);
- € the condition known as seasonal allergic rhinitis (e.g. hayfever), except where it aggravates the effect of another condition;
- € tendency to physical or sexual abuse of other persons.

Part II of the Act deals with the duties of employers and trade organisations towards their disabled employees and members.

The relevant section of the Act for the purpose of this guidance is Part III – Access to Goods and Services. Its provisions are being introduced in three stages.

- € since 2 December 1996 it has been unlawful for service providers to treat disabled people less favourably for a reason related to their disability;
- € since 1 October 1999 service providers have had to make ‘reasonable adjustments’ for disabled people, such as providing extra help or making changes to the way they provide their services; and
- € **from 1 October 2004** service providers may have to make other ‘reasonable adjustments’ in relation to the physical features of their premises to overcome physical barriers to access.

The requirement to make physical adjustments to premises is contained in paragraph 21 (2).

“Where a physical feature (for example, one arising from the design or construction of a building or the approach or access to premises) makes it impossible or unreasonably difficult for disabled persons to make use of such a service, it is the duty of the provider of that service to take such steps as it is reasonable, in all the circumstances of the case, for him to have to take in order to-

- (a) remove the feature;*
- (b) alter it so that it no longer has that effect;*
- (c) provide a reasonable means of avoiding the feature; or*
- (d) provide a reasonable alternative method of making the service in question available to disabled persons.”*

3. WHAT COUNTS AS A PHYSICAL FEATURE?

The DDA defines a physical feature as

“anything on the premises arising from a building’s design or construction or the approach to, exit from or access to such a building: fixtures, fittings, furnishings, equipment or materials and any other physical element or quality of land in the premises....whether temporary or permanent”.

Physical features will therefore include

€ steps and stairways	€ lighting and ventilation
€ kerbs	€ lifts and escalators
€ exterior surfaces and paving	€ floor coverings
€ parking areas	€ signs
€ building entrances and exits (including emergency escape routes)	€ furniture
€ internal and external doors, gates	€ temporary or movable items (such as equipment and display racks).
€ toilet and washing facilities	€ public facilities (such as telephones, counters or service desks)

4. WHAT CONSTITUTES “REASONABLE STEPS”?

The Disability Rights Commission suggests that the following factors will have a bearing on whether a change is a reasonable one for service providers to have to make:

- € whether taking any particular measures would be effective in overcoming the difficulty that disabled people face in accessing the services in question
- € the extent to which it is practicable for the service provider to take the measures
- € the financial and other costs of making the adjustment
- € the extent of any disruption which taking the measures would cause
- € the extent of the service provider’s financial and other resources
- € the amount of any resources already spent on making adjustments
- € the availability of financial or other assistance.

Affordability and feasibility are therefore key factors in deciding what is reasonable. The level of resources available to make the changes is likely to be taken into account, as are other calls on resources. If it can be shown that a major adjustment could divert resources from patient care, this would be a good argument in favour of the practice. However, it would not relieve the practice of the duty to consider the problem altogether. You may well need to show that you have considered and made reasonable alternative adjustments or alternative ways of providing the service to disabled people.

5. WHAT HAPPENS IF PRACTICES PREMISES DO NOT COMPLY WITH THE NEED TO MAKE REASONABLE ADJUSTMENTS BY 1 OCTOBER 2004?

If a practice does not comply with the need to make reasonable adjustments by 1 October 2004 and cannot justify its failure to do so, a disabled person will be able to bring civil proceedings against the practice in the County Court. If successful, the claimant would be awarded compensation (on which there is no upper limit) for any financial loss suffered, including injury to feelings. The disabled person may also seek an injunction to prevent the practice repeating any discriminatory act in the future. The court may make a declaration as to the rights and responsibilities of the parties involved but it cannot order the practice to make some physical changes to its premises.

The Disability Rights Commission has established an independent conciliation service for disputes arising under Part III of the Act, with a view to settling the same without resorting to court action. Court action must be brought within six months of the alleged discrimination but this time limit is extended by a further two months when a person is referred to the conciliation service by the Commission.

6. CHECKING COMPLIANCE WITH THE DDA

A short checklist is provided in appendix 1. This is intended to help you start the process of making your premises compliant. It is not as comprehensive as a full **access audit**. An access audit assesses how easy your premises make it for disabled people to access and use your services. They are usually divided into two stages: gathering information and making recommendations. A practice might want to do the first of these itself, with the help of the Department of Health’s audit checklist². However, the recommendations would need specialist technical advice.

Some PCTs are offering practices full audits. GPs should encourage this, as it is a good opportunity to have premises assessed at no cost and draws the funding problems to the attention of the PCT in a manner they cannot ignore. Employing an access consultant will be expensive and carrying out such a survey yourself will be time-consuming. That the audit may reveal the need for improvements should not be considered a threat. It is far more risky in the long term to avoid making these improvements, as this could result in a claim against the practice and possibly the award of damages to the complainant after 1 October 2004. These would fall to the practice, not the PCT.

² Access to Health Service Premises: Audit Checklist (available at <http://www.doh.gov.uk/pub/docs/doh/nhspremises.pdf>)

Acceptance of a PCT audit cannot indemnify the practice against claims, but it could strengthen its case greatly in the event of any claim, as it demonstrates the practice's intent to comply with the Act. It would also be a good opportunity to make a case for PCT reimbursement for the necessary adjustments. Unfortunately, the Department of Health has so far refused to release funding for adjustments, and so PCT funding is entirely discretionary. That a practice has made an application for funding, even if this was refused, would help it to demonstrate that it has taken reasonable steps to comply with the Act.

7. DDA CHECKLIST

A suggested initial checklist for DDA adjustments is provided in appendix 1.

As the introduction states, **this checklist is no substitute for a full access audit** and is only intended to give you an initial idea of the scale of necessary physical adjustments.

9. LOCAL ISSUES

Funding for DDA adjustments is a problematic area. The Department of Health has offered no ring-fenced, central funding for compliance with what is a legal, but not an NHS obligation.

For new-builds, DDA compliance should be built into the building costs and included in the planning of the premises, site and funding arrangements. This should not usually be an issue.

However for most of the NHS primary care estate, conversion of old premises is likely to be necessary, with attendant planning and funding problems. Under the Act, the provider of the premises is responsible for making the necessary changes. GPs and LMCs should strongly encourage PCOs to approve maximum levels of Improvement Grants to fund the necessary changes.

In the interests of providing a high quality service, PCTs will be unwilling to see non-compliant premises in their area. They will also be unwilling to see practices threatened with actions as a result of a complaint brought under the Act, as this would reflect badly on local healthcare provision.

It is therefore in practices' interests to encourage PCTs at an early stage to participate in joint solutions, by suggesting that they fund an access audit, for example. Access audits and the resulting cost estimates should form part of early planning for the PCT budget round with the assistance and involvement of the LMC.

In the event of discrimination claims, all this could lend weight to the practice's argument that it has taken all reasonable steps to raise premises to the level of compliance with the Act with the resources available.

10 STAFF ISSUES

10.1 Employers' obligations towards disabled staff

If you employ 15 people or more (full or part-time) you have obligations under the DDA towards those employees. This will be extended to all employers, regardless of the number of employees, on 1 October 2004. It is unlawful to treat any employees with disabilities, or applicants for jobs with disabilities, less favourably for a reason related to those disabilities. This applies to recruitment, doing the work (including career development and promotion) and redundancy and dismissal. An employee may make a complaint against you, which could be referred to an employment tribunal, which may award them compensation for financial loss or injury to feelings.

As employers, you need to consider whether any employment arrangements or physical features of the workplace are disadvantaging disabled employees in any way, and then make reasonable adjustments to remove these disadvantages.

The Disability Rights Commission suggests the following specific types of adjustments:

- € **Making adjustments to the premises.** This is covered elsewhere in this guidance, but obviously need to be extended to staff areas.
- € **Reallocation of minor duties** to another employee
- € **Offering flexible working hours**, to avoid rush hours, for example.
- € **Allowing absences during working hours**, for rehabilitation, assessment or treatment.
- € **Assigning or transferring a job or an employee** to a place of work more suited to their needs. For example, moving a workstation to a more accessible location.
- € **Making instructions and manuals more accessible;** for example, providing a Braille version for a blind person.
- € **Providing appropriate or additional training.**

It is important to ensure that recruitment procedures do not discriminate against applicants with disabilities. The job specification, applications forms, selection process, assessment technique and terms of employment offered all need to be designed so as not to disadvantage disabled people.

10.2 Staff Training

In view of the role of staff in facilitating disabled patients' access to services, it would be advisable for practices to include in the staff training programme a basic grounding in the DDA, equal opportunities legislation and recruitment policies. Once again, the demonstration by the practice that it has taken this step could be very helpful in the event of discrimination claims.

Employers are held to be vicariously liable for their employees' actions under the DDA 1995 (and under the Sex Discrimination and Race Discrimination Acts). The argument that the employer had no knowledge of their employer's actions is therefore not an adequate defence under the Act.

11. LEASED PREMISES

Under the DDA, it is the service provider, not the owner of the premises, who has to make physical adjustments to the premises if such adjustments are justified. However, where service providers rent premises they will be obliged under their leases to ask the landlord's permission before making any changes to the premises. The DDA allows for this and states that where an adjustment is reasonable, the service provider must merely write to their landlord informing them that they wish to make changes to the premises under the DDA. It is then up to the landlord to agree or disagree to these changes. If the landlord withholds their consent then the service provider's obligations under the DDA have ended. They should for their own protection obtain the landlord's response in writing and keep it on file.

As it is up to the service provider to make the relevant changes to premises under the DDA, they must bear the cost. Where a number of practices share leased premises, they should share the costs of any work required.

APPENDIX 1 – BASIC DDA CHECKLIST

As the introduction states, **this checklist is no substitute for a full access audit** and is only intended to give you an initial idea of the scale of necessary physical adjustments.

€ **GROUNDS, PUBLIC OR COMMON AREAS**

Even if the grounds around your premises are not practice-owned, you will need to ensure that there are no obstacles or impairments to people using sticks, crutches and wheelchairs and people with visual impairments.

€ **Is the pavement outside the premises free of potholes, uneven paving surfaces, etc?**

If not, you may need to get in touch with the local authority roads department to request repairs.

€ **Is all vegetation cut back from paths leading up to the entrance?**

€ **Is the route to the building kept free of leaves, snow and ice?**

€ **If the route is not level, is there a slip-resistant ramp with handrails available?**

€ **Are all paths free of obstacles, such as litter bins?**

€ **Are all surgery signs clearly visible?**

Signs should be as visible and possible. Lettering needs to be large to help people with visual impairments.

€ **Is external lighting good enough to help people find their way to the premises?**

€ **If you have a parking area, is there a reserved, wider bay for disabled people?**

€ **ACCESS TO MAIN ENTRANCE**

€ **Do you have alternative access, or a ramp, for people in wheelchairs?**

If the main entrance is not level, or is inaccessible and hard to change in some other way, is there a rear or side entrance where level access is possible?

€ **Do the steps have a clearly visible handrail?**

€ **Are the steps themselves clearly visible?**

Painting steps a different colour to the surrounding surfaces can make them easier for visually impaired people to see.

€ **Is the entrance well lit?**

€ **Is there an accessible bell, or entryphone system, for people to use if they are having difficulties getting in?**

This would be particularly desirable if access is not ideal.

€ **DOORWAYS**

€ **Is the door opening wide enough for all users?**

Wheelchair users generally need at least 750mm clear opening width (the space available between the door frame and the door in the open position).

If doorways do not meet this specification, you may need to have the doorway widened if there is no alternative way in.

€ **Is the door-handle low enough for a wheelchair user to reach easily?**

The recommended height is 1000 mm.

€ **Are entrance mats flush with the floor so that the surface is even?**

€ **If a door closer is fitted, does it have a delayed, or slow-action closure mechanism?**

€ **GETTING AROUND INSIDE THE PREMISES**

€ **Are there enough signs?**

€ **Are signs simple, short and easy to read, and located at convenient levels for wheelchair users?**

Signs can be made clearer by using pictorial symbols and visual clues.

€ **Are aisles, corridors and areas near doors free of obstacles and wide enough for wheelchairs to manoeuvre?**

€ **If there is a change of level, is there a platform lift available? If not, is there a permanent ramp that is wide enough for wheelchairs?**

€ **Are internal steps, and other potential hazards, clearly marked and fitted with a handrail and ramp?**

€ **Are all floor surfaces as level as possible, without the need for major adjustments? For example, are mats and joins between different floors, etc flush with the floor and each other?**

€ **RECEPTION/WAITING AREAS**

€ **Does your reception desk have an induction loop?**

This is an expensive adjustment but may be necessary, particularly at a glass counter.

€ **Is the reception area reasonably quiet and located away from any noisy machinery?**

€ **Is seating suitable for people with mobility impairments?**

€ **Is there waiting space for wheelchair user?**

€ **Might it be possible to create a lowered section of the reception desk?**

If not, it would be advisable to provide some means of allowing wheelchair users to sign forms, etc, such as a lower writing shelf, or simply a clipboard. Staff could be encouraged to come out from behind high reception counters, when a wheelchair user approaches.

- € **Are people standing behind reception well lit from the front, to make lip-reading easier?**

TOILETS

- € **Are the toilets accessible, both in terms of getting to and using them?**

If there is sufficient space available, the toilet may need to be modified to full wheelchair accessible standards. You will need technical advice on this.

The following practical suggestions should also be helpful

- € fit grabrails to help people with limited movement, balance or grip
- € ensure floor surfaces are non-slip
- € install outward opening doors
- € avoid shiny ceramic tiles and floors, which may cause reflection and glare

- € **EASE OF COMMUNICATION WITH STAFF**

Your premises should make it as easy as possible for disabled people to communicate with your staff.

Practice staff should show awareness of the needs and sensitivities of people with hearing impairments. For example in situations where it is not reasonable to install an induction loop, staff should make the effort to communicate in other ways, such as exchanging written notes. Staff could be encouraged not to cover their mouths when speaking to patients in order to help people who lip-read. Allow extra time, and repeating back to the customer to check accuracy can also help, as even partially deaf people may lip-read.

Even if few physical adjustments can be made, the attitude and awareness of everyone who deals with patients is key. A clear willingness to anticipate needs and look for alternative solutions could go a long way to avoid any complaints or legal action against the practice. A disabled patient minded to make a complaint will only be encouraged to do so if they encounter unreasonable, indifferent or insensitive attitudes. Clearly, these problems can be ameliorated if your staff are aware of the Act and trained appropriately. Staff training in disability awareness is therefore advisable and demonstrates the practice's clear commitment to take reasonable steps to comply with the Act.

APPENDIX 2 - FURTHER READING

The Disability Discrimination Act 1995: new requirements to make goods, facilities, services and premises more accessible to disabled people from 2004. New Code of Practice.

Available at <http://www.drc-gb.org/drc/InformationAndLegislation/Page331a.asp>

or from The Stationery Office (£13.95).

€ to directly place an order with The Stationery Office: Tel 0870 600 5522 Fax 0870 600 5533

€ to place an order online go to www.thestationeryoffice.com

€ or visit a local TSO shop (in London, Birmingham, Bristol, Manchester, Belfast, Cardiff and Edinburgh)

Disability Discrimination Act: Access to Goods, Services and Facilities.

Regulatory Impact Assessment - The Government's assessment of the costs and benefits of introducing the later rights in Part III of the Disability Discrimination Act 1995 (DDA)

Available on the internet at www.disability.gov.uk/dda/ria_part3.html

The Disability Discrimination Act 1995

Available on the internet at www.legislation.hmsso.gov.uk/acts/acts1995/1995050.htm

Or from The Stationery Office

Employing disabled people: a good practice guide for employers and managers

Available on the internet at <http://www.drc.gov.uk/drc/Documents/DLE7.doc>

What should GPs know about leasehold law

Agreement for lease

This is a contract between the future landlord/developer and tenant/GP occupier which should provide for the following:-

1. That the developer will provide new surgery premises
 - 1.1 To an agreed plan
 - 1.2 To an agreed specification
 - 1.3 Within a set timescale
 - 1.4 With collateral warranties (which will give the GP a claim against any contractor involved in the construction of the surgery premises)
2. In return for which the GP agrees to:-
 - 2.1 Enter into a lease in a prescribed format (to be attached to the agreement)
 - 2.2 At a rent to be determined by the DV (if possible at the time of completion of the project).

In addition, there should be provision for the GPs to appoint a monitoring surveyor to protect their own interests (as opposed to those of the developer) and whose observations should be taken into account by the developer throughout the development phase and prior to the issue of a certificate of practical completion

Lease (further guidance on lease terms is given in the NHS estates guide)

1. A lease is a contract between the landlord and the tenant and may not be varied without the agreement of both parties at the same time.
2. It prescribes a fixed term of years which may not be varied and accordingly, the tenant will not be able to bring the term to an end prior to the termination of the fixed term. (NHS estates recommend 15-20 years, but developers often seek a longer term of 25 years, which may or may not be acceptable to the GPs).
3. There should be provision for “alienation” (ie assignment and underletting) but the GP should be aware that even after assignment, he may not be “completely off the hook” in that he may be pursued under an “authorised guarantee agreement” for payment of rent and any other monies due under the lease. Most modern leases provided by specialist developers/investors cater for this and will not require “authorised guarantee agreements” where the premises are being assigned to the same number of other GPs receiving rent reimbursement. It is very important for GPs to ensure that such a provision is allowed for in a surgery lease.
4. Rent: There will be provisions for review of the rent (every three or five years). It is essential that the tenant seeks to negotiate a clause that the rent, at any given time, is no more than the rent

reimbursed by the health authority excluding if appropriate, any additional rent payable pursuant to paragraph 2(ii)(g) of paragraph 51 schedule 4 of the Red Book (paragraph 2(b) of paragraph 51 schedule 3 in Scotland). Advice from a specialist solicitor and specialist surveyor is essential to ensure that the lease is put together in a way that will achieve the required match between lease rent and reimbursement.

5. Repairing obligations: Are these full repairing and insuring (FRI), internal repairing and insuring (IRI), or just internal repairing (IR)? If the former, the tenant could be exposed to serious costs of maintenance, although they should be receiving reimbursement as a contribution towards the cost of building insurance and external repair. The uplift in reimbursement is not a fixed 5% or 7% but an amount that must be negotiated with the district valuer.
6. Schedule of dilapidations: This will, in any event, be served at the end of the term, but the extent of the tenants' liability in this respect will turn on whether the lease is FRI or IRI, and whether the tenant has complied with those liabilities strictly.
7. Alterations: The tenant may not be permitted to make any alterations and even if permitted to do so, it is questionable as to whether it is financially viable to do so given that:-
 - 7.1 The tenant has no capital gain in the property and
 - 7.2 There may be a liability to reinstate the alterations at the end of the term (at the tenants expense)
8. Use: There are likely to be certain restrictions on use but if these are too onerous, it may prove impossible for the tenant to dispose of the lease to any other party.

This summarises the key points of which the tenants should be aware but there are many other additional points, too numerous to mention, to be considered and the GP Tenant is strongly urged to seek expert legal advice before signing any documentation.

December 2001

