PROVISION OF NEW PURPOSE BUILT LEASEHOLD PREMISES FOR GP OCCUPATION IN SCOTLAND – A ROADMAP FOR GPs, PRIMARY CARE TRUSTS AND HEALTH BOARDS

Introduction

This ‘roadmap’ has been produced to assist Scottish GPs, Primary Care Trusts, and Health Boards seeking to arrange the provision by third parties of new purpose built Primary Care premises for lease by GPs and others.

Partnership

Optimal solutions to Primary Care premises used mainly for the delivery of GMS are most likely to be achieved where all interested parties – GP Practices, Primary Care Trusts, Health Boards, LHCCs developers and other government agencies work together in partnership. Primary Care Trusts and Health Boards should ensure that project arrangements are such as to achieve this.

Nothing herein however precludes the need for all parties to take independent advice to cover their respective interests.

Property Strategies

Primary Care Trusts (PCTs)/Island Health Boards (IHBs) are obliged to have in place Property Strategies that are integrated in terms of Primary Care premises that are both publicly or privately owned [reference NHS MEL(1999)44 Annex A Requirement 5]. This is further emphasised by the requirement at paragraph 51.3b of the Statement of Fees and Allowances for GPs in Scotland] for a plan agreed in consultation with local GP representatives to be in place to make overall provision for general medical services to meet future needs.

These arrangements should enable clear development priorities in respect of GP occupied premises to be established. Accordingly, PCTs/IHBs should normally only consider as eligible for reimbursement under the rent and rates scheme [SFA paragraph 51] and the improvement grants scheme [SFA paragraph 56] new build and improvement projects which have been identified as priorities within published plans.

New build development options include:

(a) New purpose built premises for public ownership with space leased to GPs and others.
(b) New purpose built premises for third party ownership with reimbursement through current market rent.
(c) New purpose built premises for GP ownership with reimbursement through notional rent.
(d) New purpose built premises for GP ownership with reimbursement on cost-rent basis.
New purpose built premises for third party ownership with reimbursement on cost-rent basis.

The number of developments which may proceed under (a) above will be limited by the availability of capital. Trusts should ensure that scarce capital is directed towards projects which are both priorities and for which an injection of public capital represents the only practical way forward.

For all other projects new build development options must be considered in the order listed above. Options to redevelop existing premises should of course be considered where this represents a more cost effective way forward.

**Business Case**

A business case must be prepared in respect of all new GP premises development projects funded through the GP Rent and Rates scheme [Circular PCA(M)(1999)3 para 8.1.a.ii]. This should be prepared on behalf of the GP practice as client in co-operation with or by the PCT/IHB drawing on the wider resources of the PCT/IHB and must be approved by them. In the light of the likely size of these projects Trusts may wish to consider a process derived from that concerning a Criteria Submission detailed in Circular NHS MEL(1998)46. It is important that these business cases properly assess the financial options available and their implications.

**Role of Advisers**

The District Valuer has a formal role to play in Rent and Rates scheme valuations. In respect of potential development under third party cost rent scheme pilots and/or current market rent, he should be involved in the project at an early date.

GP practices are likely to need help in accessing good quality independent advice around the development options open to them and the key factors to be considered when considering new premises. PCTs/IHBs should therefore be prepared to share with GP practices considering new build developments professional advice of a general nature which is relevant and where issues of confidentiality or propriety do not arise. PCTs/IHBs may also have, in addition to in-house expertise their own ad hoc GP and/or other professional premises advisers who can provide a valuable professional overview of GP premises development projects. It is important that professional advice to GPs from PCTs/IHBs is consistent and channelled through a nominated adviser.

The fees of a GP’s Client’s Agent may now be reimbursed within certain limits at the discretion of the Trust.[Circular PCA(M)(1999)3 para 8b]. It must be paid directly to the GPs and is intended to assure a quality outcome for the benefit of both the GPs and the NHSiS. It may **not** be rolled up in the cost-rent reimbursable to the developers.
**Batching of Schemes**

Trusts and GPs should recognise that individual premises projects may be less viable to potential developers, and the resulting costs to the NHSiS may be higher than where a number of projects (across Trust boundaries if necessary) can be batched together. Batching of schemes should therefore always be considered before potential developers are approached.

**Formal Selection of Developer**

Experience has shown that a formal process, which should normally be competitive, for the selection of a developer is essential if both value for money for the GP practice and consequently the NHSiS as a whole is to be achieved. Even, therefore, where the direct utilisation by the PCT/IHB of the new facility is limited or non-existent, PCTs/IHBs must ensure that an appropriate formal process is followed by the GP practice, for all schemes where Rent and Rates scheme monies will be applied and should facilitate the process as far as possible, in partnership with the practice(s) concerned.

Advertising the project invites competition within the private sector and assists in the process of assessing value for money.

Public sector projects which have a current value of over 5 million ECU (this threshold is subject to regular review) need to be advertised in OJEC. Most Primary Care projects fall below these limits but a competitive process is recommended unless there are strong reasons for going ahead with an individual tender. In such cases the Trust should record these reasons.

In practice, an early competition based on a clear output specification is likely to attract a wide range of interest and ensure commitment from the selected partner, and will ensure that value for money and probity can be demonstrated.

The invitation to tender should specify the nature of the project and key criteria which will be used in evaluating bids.

In identifying a suitable developer partner, GPs & PCTs/IHBs should consider the following factors:

- **Track Records:** this should include quality of design solutions achieved and references.
- **Financial Status of developer:**
- **Understanding of Project:** different developers are able to bring into play different experiences of other Primary Care or similar projects, and to apply this to specific requirements.
- **Likelihood of being a Long-Term Partner:** experience over the last 15 years has shown that Primary Care premises needs can change radically over comparatively short time...
scales. Many developers are as a consequence now recognising the importance of being long-term partners for the NHSiS. PCTs/IHBs and practices should assess how appropriate a long term relationship might be in individual cases, and how likely a particular developer is to maintain this.

- **Special Skills**: developers may be able to offer special skills, not readily available to GPs or even from within the NHSiS locally, i.e. in terms of ability to identify suitable sites, and/or by optimising development opportunities to involve other complementary activities, which benefit patients and/or the wider community.

- **Willingness to consider development under current market rent.**

  The third party cost-rent pilot is intended for use only where all other options are unsuitable. Developers should therefore always be initially invited to indicate whether they would be willing to initiate a development under current market rent.

- **Willingness to negotiate on CR1/CR2 rates (3rd party pilot schemes only)**. In third party cost-rent pilot projects the prescribed percentage will normally be the CR1 rate, but in exceptional cases may be the CR2 rate [Circular PCA(M)(1999)3 para 8.2 b. & c.]. Particular projects—or batches of projects—may however be sufficiently attractive to enable the developer to accept less demanding levels of reimbursement and the developer should be invited to indicate where this might apply and/or whether he would be willing to forego the security of the revisionary rate CR2 [Circular PCA(M)(1999)3 para 8.2 e & f iii]. Where a developer agrees to accept a lower starting rate than CR1, he should also be invited to accept a lower revisionary CR2 rate [Circular PCA(M)(1999)3 para 8.2 e].

- **Whether a development fee is justified. (3rd party pilot schemes only)** As indicated above, a developer may be able to bring valuable project management or service development skills to a project. A fee may, at the discretion of the PCT/IHB, be paid for this service for third party cost rent pilot schemes. [Circular PCA(M)(1999)3 para 8.2 f ii].

  The developer should always be expected in advance to identify whether he would consider this to be appropriate and to identify the service for which this would be paid. This should not simply be regarded as a way of inflating the developer’s potential profit without added value being provided. Any fee may be paid as a cost-rent at the discretion of the Trust, or as a single payment at the start of the project. Roll up should not however be automatic as this will usually be a more attractive option for the developer than for the NHSiS.

- **Reimbursement of other fees (3rd party pilot schemes only)**. The pilot allows PCTs/IHBs to consider reimbursement of certain qualifying expenses [Circular PCA(M)(1999)3 para 8.2 f]. Developers should always be invited to identify in advance those costs they
consider appropriate. PCTs/IHBs will wish to exercise discretion over the costs they consider appropriate for reimbursement [Circular PCA(M)(1999)3 para 8.2 f iii] and those where they consider the risk should properly lie with the developer, for example costs as described at SFA para 51.58.4 k iv.

- Risk & Negotiation: It should always be recognised that selection and contracting with the chosen developer is a negotiating process. The ultimate solution should ensure that the appropriate level of benefits are realised by PCTs/IHBs and GPs on behalf of the NHSiS, in return for the reimbursement allowed to the developer. Likewise the developer should be expected to shoulder an appropriate and significant share of the risk of the project particularly where the 3rd party cost rent pilot option is used.

- Openness: The third party cost-rent pilot arrangements have been introduced to bring clarity to the process of new third party GP leaseholder developments and to provide a viable option in circumstances which existing approaches are unsuitable. Potential partners under this scheme must be willing to share all relevant cost information relating to projects, to enable parties to reach informed decisions and to facilitate ongoing audit of the wider pilot. PCTs/IHBs should ensure that NHS MEL(1999)80 is followed. This places a requirement on PCTs/IHBs to make publicly available Outline Business Cases, Full Business Cases and addendums for schemes in excess of £10m.

- Involvement of other Interested Parties: New build projects offer a one-off opportunity to significantly influence service delivery arrangements in any area. These may well impact on more than one practice, go wider than GMS alone and may involve the wider Primary Care Team including for example dentists, community care and/or outreach services, the voluntary sector, other LA services, i.e. housing etc. Developers have a key role here but the prime responsibility for maximising the opportunities presented by new build projects to the NHSiS lies with the Trust and the LHCC. It should also be borne in mind that additional commercial development beyond provision of core GP premises may also significantly improve the profitability to the developer of the initial scheme and may affect the return he needs for the GP element of the scheme. The developer should be invited to clarify his wider plans/proposals.

Where a competitive process is involved evaluation should be made under the following headings in a structured and systematic way:

- Meeting service requirements
- Appropriate design and quality
- Technical feasibility
- Financial analysis
- Facilities management proposals
- Legal and Contractual aspects
- Value for money (financial and non-financial)
- Environmental impact study

Written proposals should normally be supplemented by presentations from shortlisted parties, to permit elaboration of proposals and fair evaluations against agreed evaluation criteria.

Where a project proceeds without a competitive process being used to identify the developer, the PCTs/IHBs should record the reasons for doing so.

**Transitional arrangements**

Where negotiations with a particular developer were already ongoing at 9 April 1999 (the date of issue of Circular PCA(M)(1999)3) Trusts must ensure that equivalent steps to achieve value for money as those outlined above are taken before negotiations are finalised.

**Project Scope**

- What is covered under GMS? The cost-rent space schedules [SFA para 51 Schedules 1 & 2] specify what floor area may be reimbursed under either the cost-rent or current market rent routes as eligible for GMS. This includes a limited Health Service development/management facility. Beyond this alternative non GMS funding streams have to be identified.

- ‘General Medical Practice Premises in Scotland A commentary’, published by The Scottish Office Department of Health- Management Executive in 1997, provides advice on issues to consider in developing high quality premises for the delivery of general medical services.

- ‘Long Life Loose fit’: This concept should, within constraints such as the cost-rent space schedules referred to above, guide developments. Great care has to be taken that over ambitious projects are not allowed to proceed at the risk of the NHSiS. In this respect it is also important that longer term constraints around the site, nature of building/redevelopment proposed and willingness of the developer- or his successor as landlord- to be a potential ‘long-term’ partner should be tested. Larger developments can however increase disproportionately the profitability to the developer.

**Value for Money**

The following factors should be particularly borne in mind for those projects which are not purely based on public sector capital.
(a) **Scale**

The scale of the project – and for cost rent schemes the cost- must be within the cost-rent schedules for all developments to be funded under the Rent and Rate Scheme in respect of the GMS element.

(b) **Actual Rent**

For schemes proceeding under the Current Market Rent (CMR) this should be determined by the DV in accordance with the specification in the SFA [SFA Paragraph 51 Schedule 3].

(c) **Cost Rent**

Where the alternative cost-rent route is chosen,

i. the cost must be within published schedules;

ii. a minimum of 3 competitive quotes should be obtained in respect of building work;

iii. the prescribed rate will be either that prescribed or a lower rate if so negotiated with the developer.

(d) **Expenditure avoided elsewhere**

The timely development of new purpose built premises can prevent expenditure on improvements which do not represent value for money beyond a very short time scale. Also expenditure benefits can accrue as a result of rationalisation of existing NHS estates. These potential cost benefits should be assessed in the business case.

**Leases**

GPs should take their own professional advice on the type of lease appropriate for their circumstances and be clear on the level of reimbursement available under the Rent and Rates Scheme [SFA Paragraph 51.13 a & Schedule 3] - in particular where the developer is seeking a full repairing and insuring type (FRI) lease, and the project is to be funded as a 3rd party cost rent pilot project. Care should also be taken to agree an appropriate term for the lease. Within the context of ‘Long life loose fit’ GP practices – PCTs/IHBs may conclude that 15-20 years may be represent the optimum lease length where circumstances may change significantly in coming years. 15 years is also the term included in the basis for assessment for the CMR used by the District Valuer. [SFA Paragraph 51 Schedule 3]. Developers may however seek longer leases to improve the security of their
investment and may be willing to reflect this by being willing to accept a lower return. GPs may also be comfortable with the perceived security to them offered by a longer lease. GPs should however carefully consider, in conjunction with their Trust, the long-term implications for GP practices in agreeing to longer terms and the term should not normally exceed 25 years. PCTs/IHBs may wish to consider routinely reviewing the terms of any long term leases to be entered into between GPs and developers.

- Where a development includes significant non GMS element careful thought needs to be given to leasing arrangements which best meet the needs of both the Trust if they are the (non GP) occupier(s) and the developer. Independent advice should be called upon as necessary. CLO may be in a position to provide advice to Health Service Bodies building on that gained in other similar circumstances. Special considerations apply where a development may include a pharmacy. Any pharmacy contractor who wishes to relocate his premises or open a new outlet must obtain approval from the local Pharmaceutical Practice Committee. Consideration may also be given to pharmacy occupation on a consortium basis if appropriate.

**Redevelopment of existing publicly owned premises**

There may be occasions where the third party development scheme is considered appropriate for developing or replacing on the same site as an existing publicly owned facility such as a Medical Centre or clinic. Advice is provided in the Property Transactions Handbook (PTH) about such circumstances [Part C Section 6]. Careful consideration should be given to the terms of any sale of property from the PCT/IHB to the developer to achieve the best balance between the need to obtain best value on disposal of premises which are unsuitable for ongoing NHSiS use, and the need to ensure the viability of the redevelopment. For instance where it is agreed that the best way forward for NHSiS interests is demolition and rebuild, the existing property site may be disposed of to the developer on a cleared site basis, at open market value subject to stated special assumptions.

In specific cases like this PCTs/IHBs must consider carefully whether in accordance with the guidance in the PTH any special clawback/ pre-emption condition would be appropriate.

**Projects with Part Capital Injection**

It is expected that in some cases new GP premises development will act as a focus for larger scale Health Service developments. In some cases an injection of public sector capital may be appropriate to fund non GMS space use, i.e. for community health.
These cases will require tailored solutions to provide optimal legal and management arrangements. CLO and/or other advisers should be involved early in the process to achieve this.

These projects are likely to raise particularly challenging issues for instance with respect to leasing arrangements. The prize is however very significantly improved practice in terms both of co-location of services to patients and the general public and of joint working.

**Capital Charges**

Leases do not count towards capital charges regardless of whether they are finance or operating leases [section 7 of the Capital asset accounting manual].

**On/Off balance sheet issues**

Trusts will need to investigate any balance sheet issues which may arise as a consequence of their involvement in such projects where this extends beyond straightforward reimbursement under the Rent and Rates scheme.

**Audit of projects**

The ME is committed to an audit of all projects which proceed under the third party cost-rent arrangements. Detailed arrangements will be announced in due course.

**Working Examples**

Trusts are encouraged to develop in conjunction with the GPs concerned templates derived from completed 3rd party projects to outline the key steps followed and the lessons learned, as a guide for future projects.

Directorate of Primary Care
February 2000
Version 1