Can sale and leaseback deals ease the primary care premises crisis?

By Nick Bostock

‘We need to start talking about surgeries,’ says Dr Peter Holden, premises lead for the BMA’s GP committee. ‘Premises are one of the biggest limiting factors not only in moving care out of hospitals, but in delivering the services patients need.’

The two main organisations representing GPs in England, the Royal College of GPs and the BMA, have been warning for some time that the profession is in crisis.

But premises have remained something of a footnote in the wider debate on the state of general practice.

Discussion has focused instead on the fact that the share of the NHS budget spent on UK primary care dipped sharply from 10.3% in 2004/5 to just 8.4% in 2011/12 and continues to fall.

GP leaders say practice profits have now dipped below the level they were at in 2004, with successive pay freezes steadily eroding the funding uplift that came with the new contract implemented that year.

Many in the profession report intolerable workloads, long working hours, recruitment problems, and despite a government pledge to funnel more medical students into general practice, uptake of training posts is in decline.

For Dr Holden, premises are right at the heart of the crisis in general practice.

A new generation of GPs is less willing to invest in premises as part of joining a partnership. Primary care buildings, meanwhile, are crumbling, with funding for development, expansion and refurbishment in short supply.

A BMA poll published on 10 July found facilities were inadequate for patient care at 40% of GP premises, and that more than half of practices in England have had no investment in premises for more than a decade.

So what are some of the potential solutions? Can different financial approaches to premises ownership help attract GPs into partnerships, and potentially bring the kind of investment that could enable practices to take on work moved out of hospital?

A plethora of companies are currently offering practices ‘sale and leaseback’ deals that some experts believe can ease pressure on GPs – both those already in partnerships and those considering joining one.

Simon Gould, development manager at Assura, says this type of deal is the ‘number one reason we get enquiries from GPs’.

‘The overriding message is that they have traditionally been very happy with the owner-occupation model, that notional or cost rent has covered premises costs and everything has been fine,’ says Mr Gould. But he adds: ‘The problem in more recent times has been attracting new partners into the practice who are reluctant to buy into bricks and mortar, and perhaps take out a large loan to do so.’

Tim Walker-Arnott, property director with Nexus, the outsourced management organisation for Primary Health Properties (PHP) plc, agrees that interest in sale and leaseback is growing.

He cites three key factors behind the trend. ‘The size of the buildings we deal with has gone up considerably – so the financial burden and debt that goes with that is significant.’

Secondly, practices are struggling to recruit partners, with many GPs more interested in salaried posts, he says.

The final factor is demographic - shortly before the demise of PCTs, 11 out of 152 had more than 35% of GPs aged over 55. This older cohort is likely to be wary of major investment in property, and the impact of this has been compounded by a trend towards part-time, portfolio

careers. The fact that women now outnumber their male counterparts in general practice is often blamed for this, but men too are increasingly steering clear of the responsibility of full-time partnership roles.
Medium-sized or larger practices tend to approach property investors - such as Assura, Primary Health Properties plc or Medicx - when one partner retires.
The departing GP is likely to want their share of any equity in the premises released, and partnership agreements often require remaining partners to buy them out or find a replacement partner to do so.
'It's an extra burden on the other partners – taking out loans at a time in their life when they hope to get rid of loans,' says Mr Gould. 'That's when they come to us.'
Mr Gould says anecdotal evidence suggests younger GPs are more attracted to practices that have made the switch to a sale and leaseback deal.
'The number one attraction about sale and leaseback, apart from equity release, is the flexibility it provides them.
'Under a lease arrangement it is easier for partners to leave or a new partner to come in and be a signatory to the lease.
'It's a straightforward process, as long as there is a minimum number of partners – usually two – on the lease.
'For new partners coming in, it means they don't have to take out huge loans.'
For smaller practices, attracting an investor willing to enter a sale and leaseback deal may prove tougher.
Mr Walker-Arnott says: 'As an investment company, fewer, larger assets are easier to manage. You don't want to be dealing with single-handers – there's a greater risk with that sort of size. We tend to look for three at least on the lease, so it tends to be for larger properties.'
But there is hope even for these practices – if they are willing to co-locate with other practices, or potentially other businesses. 'Where historically companies like ours have helped single-handers is moving them out of terraced houses into modern premises – we have created mergers and partnerships,'says Mr Walker-Arnott.
A further potential advantage of sale and leaseback deals is that the new landlord is likely to look for opportunities to invest in improving the premises, to increase their value.
'It is in the landlord's interest to have fit for purpose and quality premises,' says Mr Gould. 'We might invest in an extension, refurbishment, or to meet Care Quality Commission standards – and we would seek to have that recovered in the long term by an uplift in the rent.'
This is a sticking point, however. Mr Gould admits that 'the reality is there is no specific budget' within the NHS for higher rent reimbursement.
He says organisations like Assura will work with NHS England's local area teams to try to secure agreements for higher rent to pay for investment, but this is generally no easy task.
At the root of the slowdown in NHS premises funding over the past decade – in addition to a general climate of austerity in recent years – was the decision in 2004 to raid a recurrent primary care premises budget to help top up practices' core funding. The formula behind the 2004 GMS contract left more than 90% of practices worse off than the previous deal, so the premises piggy bank was raided to part-fund the 'minimum practice income guarantee', a top up that will be fully abolished only from 2021.
The way that money is now being redistributed among practices means it will never return to the premises pot.
But Dr Holden says it is vital that new funding is found for premises, and soon.
The lack of investment has cut financial incentives for GP partners to invest in bricks and mortar – and this has been a hammer blow to the profession, he warns.

‘The real truth is that there are no rewards for the responsibilities of partnership anymore,’ says Dr Holden.

The risks of joining a partnership are substantial. Because GPs cannot establish limited liability partnerships, they are at risk of bankruptcy if they are unable to service mortgage payments on premises.

‘You may have to mortgage or sell your house,’ warns Dr Holden. He adds: ‘Partners do more than just clinical work and they have to be rewarded for the liabilities they shoulder. For years no one has done that.’

Premises are not the ‘government cash cow’ that some people may regard them as, he says, but GPs investing in premises have to be able to expect a reasonable return on their investment.

At present many partners earn little more than their salaried counterparts and increasingly are asking themselves whether they are in the wrong game, Dr Holden warns.

Resuscitating interest in partnership depends heavily on making sure it is financially worthwhile for partners to invest in premises – not only through making premises funding available, but also by ending the wider pay freeze on the profession, he says.

Options such as sale and leaseback deals may be worth considering for GPs, he says, but are not a panacea.

Becoming a leaseholder, Dr Holden points out, doesn’t change the fundamental risk that as a partner you could be the ‘last man standing’. If your partners retire, whether you are the one stuck with a property or with a long-term lease could make little difference.

In fact, owning the property could mean you have more control because you may be able to sell it for development for purposes other than primary care, such as housing.

‘The best option depends on the surgery – the value of the surgery just as building land, the amount of equity you have. ‘You may want to bulldoze the premises and sell to a developer.’

Head of healthcare banking services at Lloyds Bank, Ian Crompton, says the most important issue for GP practices is to plan ahead.

‘Practices need to plan and take advice,’ he says. ‘Go through the options and don’t be pushed into anything.’

Seeking expert advice - from a specialist surveyor, accountant and/or solicitor - is an essential step for practices weighing up what to do about their premises. There is no one-size-fits-all solution, and independent advisors can consider options including sale and leaseback deals that best fit the needs of individual GPs or groups of partners.

The worst case scenario is that partners ‘fall into retirement’ and become landlords by default because they have failed to plan what to do with their premises, says Mr Crompton.

Interestingly, he says Lloyds and other banks are extremely keen to lend to GPs – Lloyds will offer 100% finance on investment in practices.

Despite ‘double-digit’ growth in GP lending over the past four years or so, however, many of the bank’s staff who are trained to lend to GPs are ‘doing other things’.

Rent reimbursement available from the NHS struggles to cover bank loans, and recurrent funding is simply not there to cover major new investment in premises, he warns.

Banks’ willingness to lend means the upfront funding required to bring primary care to the point where it can take on a growing share of work currently delivered in hospital and begin to make it a more attractive prospect for young doctors is simply waiting to be unleashed.

Organisations such as the NHS Alliance have long called for recurrent premises budgets to be held by CCGs that could identify suitable practices locally to develop, and add to premises investment with savings from hospital spending.

With the new NHS chief executive Simon Stevens moving swiftly to hand CCGs ‘co-commissioning’ powers that would give them control of primary care funding – including the

premises purse strings – the flow of money that could open the door to bank lending could grow beyond the current trickle.

If CCGs can begin to unlock premises investment, GPs will have to hope that they are not abolished after a 2015 general election.

Uncertainty, in today's NHS, is the single biggest factor undermining primary care. While doubts over the future of different contracts, ways of working and NHS systems persist, partners won't come in, trainees won't choose primary care, lenders won't lend and potential borrowers won't borrow.

As Dr Holden says: 'What we need more than anything else is a period of stability.'

Until that comes, any financial solutions on offer will simply amount to tinkering at the margins.

Nick Bostock is news editor of GP magazine and a contributor to Medeconomics.co.uk