GP PREMISES POLICY REVIEW – Initial Thoughts on Solutions from the Primary Care Premises Forum (PCPF).

The Primary Care Premises Forum is an association of a number of organisations and individuals from the private sector with extensive specialist knowledge of the provision of primary care premises throughout the UK. Its members include investors, developers, bankers, surveyors, lawyers and other professionals with a range of public sector guest members. It has been established to promote best practice within its area of expertise.

PCPF Initial Proposals;

1. **Outline**;
    a. The fundamental change over recent years giving rise to the worry and concern of GPs over taking ownership or committing to long term leases is the uncertainty of their NHS contract and long term NHS commitment to their practice.
    b. Added to this other services that at one time came under the umbrella of the old PCT's (and thus where their accommodation within premises was often provided within the rent reimbursement scheme) are now divided into numerous groups and unable to sign long term leases due to their short term contracts.
    c. However developed or initially financed the current GP Estate requires GP Partners to give a long term commitment by way of a 20/25 year mortgage (GP Owner Occupied) or for GP Partners (and or other Service Providers) entering into a 20/25 year lease (3PD, NHS PS or CHP developed and owned). This is in direct conflict with the short term contracts and flexibility demanded by the CCGs and NHSE. Thus there is a need for a body or structure to divide the long term requirement and holding of Primary Care Premises and the potential flexibility of short term contracts. The NHS potentially via the CCGs (or a new NHS guarantee body) need either to take Long Term Heads Leases (which will required a resolution to current accounting procedures under CDEL) or give a binding and recognised Legal Commitment (over and above the current "Letters of Comfort") for the NHS Funding & Use of the Premises for the period of the Mortgage or Long Term Lease. If the NHS Guarantee Body were able to take leases from GPs it is not suggested that this should be automatic. It just needs to be there in case of partnership/tenant difficulties in relation to premises required in the estate strategy. For owner occupied premises, leases could be created to coordinate with the estate strategy. Such reassurance would give GP partners the confidence to enter into long term leases. This has similarities to, but is not a copy of, the new Scottish Model.
    d. The process and procedures for approval of new funding (particularly ETTF) are overly bureaucratic and complicated with layers of PID, OBC, FBC with no clear decision making and lack of transparency as to liability. Issues around the new Premises Directions and conditionality of grants (legal charge and claw back arrangements) including Abatements requires immediate attention and resolution to unblock the system.
    e. Service Charges are causing major problems both in the initial agreement of terms and in operation. Better understanding and guidance is required and on the larger

multi let building more use of the ability to assist GPs/tenants with the cost (as allowed in the PCD) should be engaged.

f. The current review of the Partnership model by Nigel Watson feeds into the process. GPs historically have been the champions of new premises innovation and development and have been willing to take the commercial risk alongside sufficient and robust support from the NHS and the relevant statutory and contractual safeguards. Such support would come from the NHS Guarantee Body or the NHS Legal Commitment.

2. Addressing the Issues;

See notes in red below.

3. Support of Innovation & Flexibility;

a. With the NHS Guarantee Body holding the Head Lease full co-ordination would be required with the CCG/STP to facilities occupation by both GPs and other service providers.

4. Benefits & Added Value;

a. The standard 20-25 year lease needs to be more flexible and aligned with the NHS commitment noted in 1c above. For large and important multi use integrated care centres where the NHS use is envisaged for the next 35 years then a 35 year commitment/lease should be considered. This creates a better investment requiring a reduced investor return and thus can be made viable at a rent based on a lower rate per square metre. The reverse applies and for smaller surgeries one could look at reduced term leases although this would create a need for a rent based on an increased rate per square metre.

b. Rental payments direct from NHS Guarantee Body to Landlord would reduce borrowing and save cost.

5. **Cost/Additional Funding, Efficiency Implications & Time Scale**;

a. In 2017 a consortium of PCPF members including Assura, PHP and Octopus Healthcare made a Primary Care Premises pledge to invest £3.3bn in primary care premises over 5 years to deliver 750 state of the art medical centres. Such an investment would result in significant efficiencies through the provision of modern, multifunctional and sustainable premises reducing the non-urgent use of A&E departments, reducing pressure on walk-in centres and increasing GP care of the elderly. The introduction of the NHS Guarantee Body would help facilitate and expand this pledge.

6. Who will be most affected;

a. Added confidence for GPs and other Service Providers and removal of the “last man standing” problem for GPs thus enabling them to take leases or own property.

b. CCG who would now have greater control over who occupies key Primary Care Premises.
c. Other Service Providers now able to take short term under leases from the NHS Guarantee Body.

7. **Risk & Unintended Consequences**;
   a. CDEL/Balance sheet problems.

8. **Supporting Evidence**;

   a. To be provided.

Statement from NHS England;

- We need an Efficient & Flexible Model for the GP Estate which meets the demands of an Integrated Care Model with a focus on Services closer to Patients Homes and which supports sustainable General Practice.
- The system pre Lansley and the Health and Social Care Act worked with the majority of developments (including LIFT) occurring in this era.
- The Premises Cost Directions (PCD) provide the Policy Framework. Need to look at the Issues and Challenges presented by the PCD, the risk of Property Ownership within the GP Partnership Model.
  Major problems caused by the delays in the publication of the new PCD rendering the ETTF a damp squib only suitable for existing premises improvement. Whilst agreed between the BMA and NHSE the draft was not made available to any non NHS Bodies for comment and thus lacks potentially valuable input from specialist funders, investors, lawyers, surveyors and other independent professionals.
- Strategic Appraisal and Potential Fundamental Change to ensure Estate can be delivered within the Resources Available.
  The funding of healthcare is divided and unlinked. NHS PS or NHS Trusts can sell land but they retain capital, many Social Services are Local Authority funded. The basis of the PCD funding is revenue reimbursement, topped up by limited capital grants from NHSE or the CCGs. The NHS PS and NHS Trust capital receipts need in part to be diversified and used in part for revenue reimbursement.

Barriers Identified by NHS England;

- GP Partners Liability in both Ownership or Lease (and fear of "The Last Man Standing).
  Resolved by the NHS Guarantee Body or the NHS binding and recognised Legal Commitment noted in 1c above.
- The Perceived Unattractiveness of Estate Ownership.
  Resolved by the NHS Guarantee Body or the NHS binding and recognised Legal Commitment noted in 1c above.
- Concerns over signing Long Leases.
  Resolved by the NHS Guarantee Body or NHS binding and recognised Legal Commitment noted in 1c above. The current structure of rent review in leases to GPs and the

corresponding procedure in the PCD are slow and clumbersome taking too long and costing all concerned (Landlord, Tenant and the NHS) too much. Updating the procedures in the PCD to allow direct negotiations between the Landlord and the valuer acting for the NHS would solve this (in essence reverting to the procedures in the 2004 PCD).

- Sub Optimal Utilisation.
  Resolved by the NHS binding and recognised Legal Commitment noted in 1c above. With such a commitment the landlord/investor would be more able to allow multi short term leases. Even stronger would be a situation where the NHS Guarantee Body took the Head Lease and underlet to the Service Providers. This also gives the CCG full control as to who can take such under leases thus allowing alignment with the commissioning of services and awarding of contracts.

- Difficulties in Achieving Mixed Use particularly in New Builds due to Balance of Liability across Different Parties.
  As above plus the coordination and simplification of the Business Case approval process (at present repetitive cases are required for each occupier).
- Revenue Implications of GP Estate Preventing Development.
  Neither the NHS binding and recognised Legal Commitment nor NHS Guarantee Body would in themselves remedy the lack of Funding but alteration to the silo form of funding and the better distribution of capital would. In addition longer term business plans for major primary care centres and thus the potential 35+ year leases (noted in 4a) would allow a better use of revenue available.

Potential Solutions noted by NHS England

1. **Current Ownership Models**;

- GP Partnership Developed & Owned.
- NHS PS or CHP Developed & Owned (LIFT Co's) with Lease to GPs and Other Service Providers.
- Third Party Developer/Investor (3PD) Developed & Owned with Lease to GPs and Other Service Providers.
- Third Party Developer/Investor (3PD) Developed & Owned with Lease to NHS PS or NHS Trust and Sub Lease to GPs and Other Service Providers.
- ACPS – Acute Trusts novating GP partnerships into a Social Enterprise vehicle guaranteed by the local Foundation Trust.

2. **Funding & Contracting**;

- Complex & Ridged format of the PCD, need to look at other ways to Fund the Cost in Existing Premises from funds available. To include how to support New Models of Care which are increasingly focused on Multidiscipline Teams, Co-location of Services and Integration.

3. **Sub-Optimal Use of Space**;

- Identification of Capacity by the CCG and Infrastructure to support separate providers working across Primary, Community & Social Care, Third Sector and Mental Health Services. Encouragement of Co-Location & Shared Use.