Could Super Practices soon be commonplace?

With the NHS under increasing pressure to provide an ever improved level of service, there are plans for 7,500 existing GP practices in the UK to become 1,500 'Super Practices'. So what does the future hold for primary care services in the UK, and what issues need to be overcome from a logistical and estates standpoint? Adam Thompson, director at Primary Care Surveyors, specialists in the healthcare property market, investigates, and explains the issues with which the NHS and GPs will have to contend.

Under Government plans to expand opening times and drive transformation in the primary care sector, thousands of GP practices are destined for closure, with 7,500 surgeries envisaged to become 1,500 'Super Practices' within the next five years. This drive is part of a campaign to improve access to services, with more services being provided in the community, together with increased access to GPs at evenings and weekends, under a manifesto pledge to offer all patients appointments between 8.00 am and 8.00 pm, seven days a week – but that is not the whole story.

With cuts to budgets for social care, an ageing population (there are more than one million additional people over the age of 65 than five years ago), and a 'retirement bubble' in the GP sector that sees practitioners retiring and leaving the sector for good with no natural succession, the NHS is under pressure. Factor in urban regeneration, the Government's initiatives to sanction greenfield developments across the UK, increases in immigration over the last 20 years, and a shift for current GPs towards 'part-time' working, and it seems there is necessity for a change of practice.

Complex reasons

The overall reasons why the NHS is taking the 'Super Practice' route are very complex and multi-faceted. NHS bodies (including NHS Property Services) are the custodians of a great deal of property, which is not just poorly utilised, but some of which may not be suitable to meet the population's needs. The key role of the NHS should be to provide the best medical care possible, and as such the NHS may not be best-positioned to be a landlord managing a property portfolio.

What the healthcare sector needs is transformation of services, new vision, investment, and better property utilisation. The right infrastructure is required to enable transformation in healthcare services. In a nutshell, with its capacity for enabling working at scale, the new 'Super Practice' model may well be a viable solution. More than 550 GP surgeries have closed in England since 2012, with remaining surgeries expanding to take thousands more patients. The average list size has risen by 18 per cent in a decade. The 'Super Surgery' may herald a step change in primary healthcare, with larger surgeries able to scale up, and, in line with Government plans, not just to expand opening times, but also to provide better services to patients and the community by offering services now normally only found in hospitals.

Putting practices into 'hubs'

The current thinking is that by putting GP practices into hubs of 50,000 patients plus, those practices are then able to employ pharmacists and physiotherapists and provide more services at scale (e.g. diagnostics and specialist nursing teams dealing with long-term conditions) than they could as a single-handed GP, or as a practice of two or three GPs, which has historically been the norm.

Providing services where they are needed

Part of the intended outcome is to redirect patients to the appropriate healthcare practitioners best suited to provide the service or treatment those patients require. When we refer to a 'doctors' surgery', the patient's expectation is to see a doctor. However, a doctor may not be the most appropriate person for that patient's particular condition. Many minor conditions can be dealt with by practice nurses or clinical pharmacists. Moreover, many patients with long-term conditions will receive more appropriate care by seeing a specialist nurse dedicated to dealing with those particular conditions. This has often not been possible in the traditional GP practice due to the lack of sufficient critical mass of patients with that condition necessary to make having such specialist teams worthwhile or effective. However, within the Super Practice this becomes a reality, and in addition there will be opportunities to provide further services, such as diagnostics or mental health services.

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Addressing mental health issues

Depression, mental health issues, and even loneliness, are becoming topical issues that the medical profession is

struggling to deal with, and there is much that can be done in the community to assist with such conditions. In some of the proposed developments for new medical centres we are now seeing community areas being provided where patients will be encouraged to pop in for a chat and some support. There may well be talks or some other activity taking place, but even if not, a room will be available for providing community care, encouraging those who may be depressed or just lonely to stop by for some much-needed comfort.

These community support rooms may well be more accessible than traditional day centres, and will complement the increase in social prescribing, as well as potentially providing groups such as 'knit & natter' and 'men's sheds'. Sadly, this in turn will create funding challenges, since the revenue funding for primary care facilities has evolved around the core general medical service's activities. The provision of community space/mental health accommodation is not within the current definition of general medical services. This can cause conflict between the desired shift in healthcare services and what is allowed under current Regulations, notably the NHS Premises Directions 2013 (although these are due to be updated imminently).

Multiple occupancy practices

The occupancy of large medical centres has changed in recent years. Traditionally the property would be developed for a doctors' practice, with it then being occupied under a single lease, sometimes with or without a pharmacy being present. Now there are increasingly a number of occupiers within a single medical centre. Some occupants may be more informal, using rooms on a sessional or part-time basis, in addition to services being provided by other NHS bodies and sometimes by the voluntary sector. In other instances the use is more full-time; hence a formal lease arrangement will be required. Traditionally community services such as midwifery, health visitors, and district nurses, were treated as being part of the general medical services activity, and included within the revenue funding. In some instances NHS England local commissioning groups have deemed that such services are not part of general medical services, and are therefore excluded from revenue funding.

This then necessitates a lease to be put in place with the Community Trust to recover the reduction in notional rent/rent reimbursement that has been withdrawn. This does seem to be a backward step that is inconsistent with the general shift of putting more services into the community, and bringing about more collaborative working practices.

The range of occupiers within a single practice is increasing, with opportunities for pharmacists to locate alongside general medical as well as other healthcare services. In one recent case Primary Care Surveyors assisted a medical practice to directly contract with a physiotherapy provider for referral of patients, generating savings to the practice, as well as to the NHS, with other similar enquiries for the inclusion of renal dialysis and ophthalmology within the primary care premises.

The challenges of consolidation

The advent of the Super Practice is largely driven by the significant number of mergers that have taken place within GP practices in recent years, typically initiated by the number of retiring or soon-to-retire GPs. Primarily the purpose of a merger revolves around the consolidation of practices and patient numbers, rather than the consolidation of premises, but that is a clear direction of travel, as ultimately operational savings will be achieved by reducing the number of premises and being able to provide services at scale. Having said that, this does not work in all locations. Many practices may work on a 'hub and spoke' model, with branch surgeries being retained in rural areas. Then, the ultimate reduction in the number of GP premises may have an impact upon the access to healthcare within some rural areas, but this in turn may provide opportunities for community pharmacies to provide or accommodate other healthcare services.

In the current model, pharmacists are required to provide a consulting room, often little more than a vestibule, in which to see patients. If that consulting room were to be made larger, then it may be suitable for other healthcare practitioners – such as a visiting doctor or a community nurse – to consult in. This would mean, even on a part-time basis, that the community would have access to other healthcare services. These are examples of the different ways in which healthcare services can be provided, and of how the property can be used to bring about the transformation that is required in the community.

The rural economy

The conundrum of providing primary care services in rural locations may be affected by another set of circumstances. Ministers are poised to weaken protections to meet ambitious building targets, with the Government investing £3 billion to build 360,000 new homes on green belt land over the next year or so. With GP numbers declining through retirement, rural locations will suffer from a lack of existing primary medical clinics and GP

Case Study 1: Swindon Town Centre

The primary care provision in Swindon town centre showcases many of the issues affecting the way GPs deliver services. The town accommodates approximately 20 GP surgeries, which are a typical mix of some good quality, modern, purpose-built medical centres, and some modest house conversion-type surgeries. The latter have typically been 'one partnership per property' entities, but there have been many issues of succession, with it being difficult to recruit GP partners in the Swindon area. This in turn has led to many of the practices becoming vulnerable and at risk.

Some practices have been taken over by APMS (Alternative Providers of Medical Services) that provide services by way of a fixed term contract. Others have also been taken over by a commercial entity seeking to become a key provider of primary care services.

The competition from such corporate providers has spurred some of the other practices into considering other ways of restructuring, with a Super Practice model emerging. Should this come to fruition, it will mean that there will essentially be three service-providers providing the bulk of primary care within Swindon.

Case Study 2: Cheltenham

The town of Cheltenham has already seen the development of one large medical centre, which accommodates five individual GP practices alongside other healthcare services, including a chiropractor. There is now a proposal for there to be another large medical centre which will accommodate at least three of the other GP practices within Cheltenham.

Some other practices will remain in their existing premises, which are of differing quality. However, it is interesting to observe how the number of premises from which primary care is provided has reduced drastically over the last few years, or will certainly do in the future, should the new medical centre come to fruition.

Case Study 3: Wokingham

The new medical centre in Wokingham was completed in 2013, with the scheme undertaken by the partners of a GP practice who previously operated from two surgeries within the town centre, one being a Grade II listed building.

The practice already had a large base of over of 23,000 patients, and was able to serve those patients from one new medical centre, enabling transformation in the way health services are delivered. A specialist diabetes service was provided for high dependency diabetes patients, focusing on the dietary requirements of those patients, and thus encouraging change in their eating habits. This resulted in much weight loss for some patients, and a reduction in the number of prescription drugs, which in turn generates significant cash savings.

The Tudor House Practice in Wokingham.

surgeries. With 360,000 new homes planned, this will require substantial investment into medical facilities for those areas alone.

With house occupancy averaging at 2.3 residents per dwelling, this rural expansion would potentially accommodate over 828,000 'additional' inhabitants. Within the UK the ratio of patients to GPs varies across the country, from 1,500 to over 2,500 in certain cases. With a mean average of 2,000 patients registered to a single GP, this increase in population within the green belt alone would make a case for over 414 GPs to administer to that number of patients. Would the 'Super Surgery' work in this environment, and could the Section 106 contributions, which housebuilders pay councils to create community infrastructure, be used to pay for this new primary healthcare provision?

Property matters

One other significant factor for the emergence of the Super Practice is the matter of property or, more to the point, the capital value of property. With interest rates being at an all-time low, and without an increase looking imminent, it follows that investment yields are also low, which drives up the capital value of surgery premises. While this may appear to be beneficial for the retiring, or near-to-retiring GP, such high capital values are often a deterrent to young GPs looking to buy into an existing partnership. In addition, many GPs are concerned as to the future direction of their careers, with many now choosing between part-time and full-time work, but also having portfolio careers. In turn, there are issues regarding the long-term suitability of some individual properties, with GPs reluctant to take on a significant share of the equity within an existing building when partnerships consist of no more than a handful of partners.

With Super Practices sometimes having as many as 50 partners there is then a degree of safety in numbers, with reduced fractional risk per individual partner. Many Super Practices are currently exploring how property ownership will be dealt with – one potential solution being that all property be conveyed into the Super Practice, with other Super Practices considering leaving the property to the individual partners, as is currently the case.

Varying age profiles

The outcome for each Super Practice does appear to depend upon the age profile of each of the individual partners in question, together with details of the outstanding mortgages. Sometimes the existing mortgages may have many years to run, or were granted at high interest rates, resulting in there being high redemption charges to exit those mortgages, which may render the property illiquid.

Regarding leasehold premises, it remains the case that a partnership is not a single entity, and cannot take a lease in the partnership name. It is the individual partners of a partnership (no matter how

Case Study 4: Royal Arsenal Medical Centre, Woolwich

On a site previously owned by the Ministry of Defence in Woolwich, the ground floor area of a proposed new residential block was identified as providing potential opportunity for the delivery of a new medical centre.

Acting on behalf of H-Med, Primary Care Surveyors undertook negotiations with the principal developer, Berkeley Homes, to acquire a long leasehold interest of the shell and core of the ground floor accommodation. Simultaneously the company undertook negotiations with a nearby doctors' practice to relocate them from their existing surgery. These negotiations also required the involvement of the Primary Care Trust, who instructed the District Valuer to advise on rental values and lease terms.

All parties worked in cooperation to bring about the delivery of the medical centre to serve this significant new development, the Royal Arsenal Riverside development, prominently located adjacent to the River Thames, and the new medical centre opened in October 2012.

Royal Arsenal Medical Centre now provides 10 consulting rooms, five treatment rooms, and ancillary accommodation. The practice provides a wide range of services which, together with an adjacent pharmacy, have vastly improved the healthcare provision to the local population.

The accommodation has been leased to the GP practice for 25 years. The long leasehold interest was forward-sold to Medicx, who retain the investment proposition.

large that partnership may be) that are the tenants under a lease. Not all partners will need to be individually named (it is capped at six), but those named tenants should be no more liable than the other partners within the practice if the partnership agreement has been drafted properly to include joint and several liability. This is all part of the importance of ensuring that the partnership agreement has been professionally drafted.

'Last man standing'

An issue linked to this is that of the 'last man standing', which is often viewed as a grave concern. Many of the first generation of property developments by landlords and leased to practices are now coming towards the end of their first leases. Many of the original individual doctors have now retired, but it is surprising how many of them had not had their names removed from the lease before doing so. It is not uncommon for a GP to believe he is now the last man standing under the current lease, with it transpiring that the now-retired doctors have not had their names removed. Even if they tried, they would often not be allowed to, with most leases stipulating there are ultimately a minimum of three named individual tenants. It follows that those retired doctors will remain liable for obligations under the lease, including payment of rent and any dilapidations for wear and tear to the building.

It can be reassuring for the doctor who believes he was the last man standing to now find that he at least has shared liability with his former partners, rather than being solely liable.

With leases coming to an end, this does present further opportunities for many practices. Many of those premises are still suitable for the provision of healthcare, although a refurbishment may be long overdue. The granting of a new lease creates a significant improvement in the investment value for the landlord. It may also be the case that the landlord is required to undertake refurbishment of the premises in return for a new lease being granted, all at a rent commensurate with the refurbishment that has been undertaken.

Under the NHS Premises Directions 2013, it is essential that the 'contractor' seeks prior approval for any new contract (i.e. lease) before committing to the new lease. Without such prior approval there is a substantial risk that the practice will lose its entitlement to rent reimbursement.

There is certainly much to be considered, with the advent of Super Practices, to ensure that issues of property, albeit freehold or leasehold, are considered. Putting property to one side, there is fundamental reason for the Super Practice, which will ensure the delivery of improved healthcare services for the community. hej

About Primary Care Surveyors

Primary Care Surveyors (PCS) was established in 2009 by Adam Thompson to provide advice on all primary care property matters, including rent reviews, valuations, lease consultancy, development, and investment transactions. PCS offers a complete and integrated service to general practitioners, advising on and implementing rent reviews to maximise the value of the practice property. It looks creatively at ways to include other service-providers, thereby improving returns on the property asset. PCS also acts for many commercial landlords of such properties, and provides advice on asset management opportunities.