

# General Practice Premises Policy Review

NHS England and NHS Improvement



# General Practice Premises Policy Review

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## Executive Summary

1. Recognising ongoing issues around general practice premises, NHS England launched and has led the General Practice Premises Policy Review, as agreed with the Department of Health and Social Care (DHSC) and the General Practitioners Committee of the British Medical Association (GPC England) following settlement of the 2018/2019 General Medical Services (GMS) contract.
2. In January 2019, the context for the Review developed further with the publication of both The NHS Long Term Plan<sup>1</sup> (LTP) and the Five-Year Framework for GP contract reform<sup>2</sup>. They establish the ambitions for the next ten years to improve the quality of patient care and health outcomes, and to deliver more co-ordinated and joined up primary and community care. The Five-Year Framework described the introduction of Primary Care Networks (PCNs) as the foundation of Integrated Care Systems (ICSs), delivered in part through the introduction of the new Network Contract Directed Enhanced Service (DES)<sup>3</sup>. These are the most significant developments in primary care in recent years, delivering:
  - i. Major investment into general practice. Funding for the core practice contract has been agreed and fixed for each of the next five years and by 2023/24 will increase by £978 million per year. By 2023/24, the new Network Contract DES will be worth up to £1.799 billion per year.
  - ii. Stability and expansion of the primary care workforce, including up to 20,000 additional posts in five specific different primary care roles. These five reimbursable roles are clinical pharmacists, social prescribing link workers, physician associates, physiotherapists and paramedics.
  - iii. A series of digital reforms, which will transform how primary care services are offered to patients, supported by an access review which will develop the offer that PCNs will make for both physical and digital services.
3. These developments clearly have implications for general practice and wider primary care estates, but in many places the development of functional primary care networks is just beginning, with the full implications likely to become clear as they develop in maturity. The findings of the Review set out a series of policy responses to the issues explored. Some will need further work before implementation begins, and where there are new financial commitments these will be dependent on the capital available. Where necessary, details will be subject to negotiation with GPC England. These policy conclusions are only one part of what is required to address the issues the Review describes. We

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<sup>1</sup> 'The NHS Long Term Plan'; available from:

<https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/>

<sup>2</sup> 'Investment and evolution: A five-year framework for GP contract reform to implement The NHS Long Term Plan'; available from:

<https://www.england.nhs.uk/wp-content/uploads/2019/01/gp-contract-2019.pdf>

<sup>3</sup> 'The Network Contract Directed Enhanced Service (DES) Specification 2019/20'; available from: <https://www.england.nhs.uk/gp/gpfv/investment/gp-contract/>

know that our primary care premises in many places are not fit for purpose, particularly in the future for implementation of the LTP; this is supported by GPC England's Premises Survey<sup>4</sup> which reports that 50% of respondents felt that their premises are not suitable for present needs. What must now follow is an implementation framework describing how NHS capital for estates will be deployed to support the LTP, developed alongside the forthcoming government spending review which will determine what resources are available. NHS England and GPC England will work together to describe the case for capital investment in primary care, jointly recognising the importance of this to the delivery of the LTP and the future development of general practice.

4. The key policy conclusions following the Review are to:

- assign existing practice leases to NHS bodies or other appropriate entities where they are of strategic importance, and where their length and liabilities prevent the healthy renewal of partnerships and the estate. The detail of which leases are of strategic importance will be subject to further detailed discussions with GPC England and within NHS England and Improvement during 2019. The Capital Departmental Expenditure Limit (CDEL) cover which would be required to enable this will be dependent on the outcome of the government's spending review, and a relative prioritisation process;
- support the availability of an ownership model which continues to make sense for GP practices, but over time we expect more practices to want to separate the decision to enter premises ownership from the operation of primary medical services. We will develop best practice guidance on this for all property-owning GPs. Future NHS capital investment would come with a requirement to demonstrate robust governance around property ownership;
- provide clearer guidance on the expectations of owners and occupiers around maintenance and standards, as part of professionalising property ownership and management;
- pilot alternative premises reimbursement arrangements at a network level, to give networks greater autonomy to manage and minimise their costs relating to estates across their premises;
- pilot a simpler model of premises provision in which the NHS directly bears the cost of premises in multi-use new build premises, removing the need for bureaucratic premises reimbursement systems, promoting integration of service delivery and optimal use of space;
- develop a package of support relating to primary care engagement in Sustainability and Transformation Partnerships' (STPs) and ICSs' capital strategies and the capital allocations process;
- encourage networks to start working out their future estates needs now, taking into account joint working and the estate of their community partners;

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<sup>4</sup> BMA GP Premises Survey Results 2018; available from: <https://www.bma.org.uk/advice/employment/gp-practices/premises/bma-gp-premises-survey-results-2018>

- focus our primary efforts on understanding what it would take to ensure we have premises that are fit for purpose, as part of the spending review;
- following the spending review, develop and publish a premises implementation framework.

# General Practice Premises Policy Review

## Overview

### Background

5. NHS England has led this Review, working in collaboration with a number of key stakeholders including DHSC, GPC England, the Royal College of General Practitioners (RCGP), the Strategic Estates Advisors (SEA) service, NHS Property Services (NHSPS), Community Health Partnerships (CHP), the Care Quality Commission, the District Valuers Services and NHS Clinical Commissioners. The Review also had links to the General Practice Partnership Review and NHS Property Board.

### Scope

6. The Review first sought to identify a number of barriers to effective service delivery which can occur in relation to general practice estate, which include:
  - The individual cases where partner liabilities associated with estate ownership or occupation make healthy renewal of the partnership very difficult or lead to individuals being ‘trapped’ (also known as ‘last partner standing’).
  - A perception that estate ownership is unattractive and may be a factor in declining interest in general practice partnership.
  - Concerns around signing leases with liabilities of considerable duration.
  - Making the best use of estate.
  - Difficulties in achieving mixed use, particularly of new builds, due to the balance of liability across the different parties involved.
  - Revenue implications of estate preventing developments.
7. The ongoing work of the Review takes place in the context of the Naylor Review “*NHS property and estates: why the estate matters for patients*”<sup>5</sup> which highlighted the lack of available and consistent data on primary care estate, despite its pivotal role in delivering the future objectives of the NHS, as well as the General Practice Partnership Review Final Report<sup>6</sup>, which called for action to mitigate the personal risk associated with being a lease holder or property owner and support and guidance for GP partnerships around property ownership.

### Approach

8. The Review held an open Call for Solutions collecting solutions to the specific issues identified, as well as views on wider questions about the system of

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<sup>5</sup> ‘NHS property and estates: why the estate matters for patients’; available from: <https://www.gov.uk/government/publications/nhs-property-and-estates-naylor-review>

<sup>6</sup> ‘GP Partnership Review Final Report’; available from: [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/770916/gp-partnership-review-final-report.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/770916/gp-partnership-review-final-report.pdf)

estates provision. Further details are at Annex A.

9. 106 proposals were received from a range of contributors, including GPs, patients, CCG representatives, Local Medical Committees (LMCs), pharmacists, practice managers, third party development companies, legal firms, NHS Foundation Trusts, regional and national NHS England employees, Local Improvement Finance Trust (LIFT) companies and NHS PS. No new barriers were identified beyond those outlined in the call.
10. Proposals were assessed using an agreed set of criteria including: feasibility, cost and value for money, impact, and risk before a subset was developed further from the basic concept. The Review group agreed a guiding principle that where NHS money is being committed, it should only be committed in the best interest of patients.
11. The Review also drew upon GPC England's Premises Survey<sup>7</sup> which was open to all GP practices in England during November 2018.
12. Many submissions to the Call for Solutions covered the same core issues, and proposals were grouped under themes:
  - i. Strategic estates planning (including decision making on NHS capital investment).
  - ii. Central estate ownership and buy out, including loans.
  - iii. Central function to hold or act as guarantor for leases.
  - iv. Separation of estates ownership and partnership model/service contract.
  - v. Simplification of Premises Costs Directions (PCDs).
13. A number of the submissions received highlighted the poor relationship between NHS PS and GP tenants. The Review was not the primary forum in which to address the issues raised, but the context is reflected in its conclusions.

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<sup>7</sup> BMA GP Premises Survey Results 2018; available from:  
<https://www.bma.org.uk/advice/employment/gp-practices/premises/bma-gp-premises-survey-results-2018>



## Areas considered by the Review

### De-risking leases in strategically important estate

**Outcome:** The assignment of leases to NHS bodies or other appropriate entities, where their length and liabilities prevent the healthy renewal of partnerships and the estate is of strategic importance. We need to reassure GP leaseholders occupying estate which is clearly part of future service provision and where the perceived risk associated with leases is impacting on estate transformation and general practice partner recruitment.

14. In line with the findings of the GP Partnership Review<sup>8</sup>, entering into long leases can be off-putting for GPs, and terms which were viable at the beginning of a lease may become less so over time. We know that lengthy lease periods can create significant difficulties where GPs are closer to retirement than the lease's duration, which can impact on moves into new premises, and can also be off-putting for prospective replacement partners.
15. To ensure that NHS funds are used in the best interests of patients, an offer by the NHS to stand behind leases would only be made for estate which has been identified as having ongoing importance for delivery of services, linked to the STP's or ICS's estates strategy. It would be offered as a last resort only, and at the request of NHS England an NHS body or other appropriate entity would take on the lease assignment where key criteria are met, including identifying the strategic importance of the premises.
16. There are clearly costs and risks associated with an NHS body or other appropriate entity taking on a lease from a practice which need to be considered in future budget-setting exercises. These could include legal fees, surveyor costs and Stamp Duty Land Tax for leases with over seven years remaining. In addition, accounting rules require that a provision would need to be made in the CDEL to account for the entire cost of the remaining lease term. Although lease assignment can occur now, without CDEL cover this can be difficult to achieve and therefore in order to implement this recommendation, a proportion of capital allocated to NHS estate would need to be directed to support the CDEL limit. This is therefore dependent on the outcome of the capital allocations process as part of the upcoming spending review. NHS England and GPC England will work together to describe the case for capital investment in primary care, jointly recognising the importance of this to the delivery of the LTP and the future development of general practice.
17. In situations where leases are assigned, a sub-lease (with a shorter term) would need to be agreed between the practices and relevant body. Participating practices would also be asked for undertakings in return. This may include the provision of data on the estate, ensuring the estate is appropriately maintained, and full engagement in the STP or ICS estates planning process.

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<sup>8</sup> 'GP Partnership Review Final Report'; available from:

[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/770916/gp-partnership-review-final-report.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/770916/gp-partnership-review-final-report.pdf)

Leaseholders may also wish to take decisions such as co-locating with other services or moving to improved premises. In these scenarios it is envisaged that decisions would be taken collaboratively, with practice tenants engaged in the conversation.

18. NHS PS could be the right entity to hold these leases on the system's behalf but NHS (Foundation) Trusts and Local Authorities might also wish to do so, perhaps making use of space themselves as part of local plans to deliver integrated services.
19. In that vein, NHS bodies or other appropriate entities could also take on the new lease commitment for new builds to better enable mixed use of new premises, with sub-leases or other suitable tenancy documentation in place for tenants. The Review heard that co-location of services in new builds is not always possible due to long leases and questions over who will ultimately hold liability for the asset.
20. The Review noted the ongoing challenge presented by the relationship between NHS PS and GP practice tenants raised via the Call for Solutions, GPC England's Premises Survey<sup>9</sup>, and stakeholders on the Review's Core Steering and Advisory Groups. To effectively operationalise this recommendation via NHS PS, a greater level of trust will need to exist between NHS PS and the GP community, supported by the current work to resolve the identified challenges.
21. Further discussions to agree and implement this recommendation are ongoing.

### Central estate ownership and state backed loans

**Outcome:** Not taken forward

22. The Call for Solutions yielded a series of proposals around state ownership or buy-out of estates and a model of state-backed loans to GPs. These proposals included calls for England to adopt a similar approach to premises as has been introduced in Scotland, where the government has agreed 'a long-term shift to gradually move general practice towards a service model that does not entail GPs owning their practice premises'.<sup>10</sup>
23. Review stakeholders were clear that they did not expect or wish to make such a move in England, preferring to retain flexibility for GP partners to choose their model of estates provision.

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<sup>9</sup> BMA GP Premises Survey Results 2018; available from:

<https://www.bma.org.uk/advice/employment/gp-practices/premises/bma-gp-premises-survey-results-2018>

<sup>10</sup> 'National Code of Practice for GP Premises'; available from:

<https://www.gov.scot/publications/national-code-practice-gp-premises/>

24. It was estimated that the indicative cost of buying out the GP owned estate in England would be a minimum of £5-6bn<sup>11</sup>. Not only is this prohibitively expensive, it would be at the expense of other capital requirements. The Review concluded that there was no convincing argument that this direction of travel would deliver a 'fix-all solution', as it would be impossible to justify taking this step for any premises other than those which are fit for purpose and of ongoing strategic importance.
25. The new premises model in Scotland is part of an agreed package of wider contract reform<sup>12</sup> which has not been replicated in England, and this element of the package could not successfully be 'cherry picked' for implementation without the support of general practice. The recently announced general practice contractual framework<sup>13</sup> sets the clear direction of travel for primary care in England over the next five years.
26. Insufficient evidence of a market failure was provided to suggest a state-backed system of loans would be a necessary and proportionate response to secure the ongoing delivery of primary medical services; neither would it be likely to be attractive to GPs, given the likely security and control requirements that would be necessary to safeguard taxpayer investment.
27. A complex, state-backed loan system would cement the current model of new partners taking on significant debt rather than support new, more flexible partnership models which are in line both with the call from the profession and the system. The Review therefore concluded that no recommendation should be made relating to state buy-out or state-backed loans. These proposals are not being taken forward as part of its ongoing work.

### Property ownership as part of the partnership model

**Outcome:** Where an ownership model continues to make sense for GP practices, it should continue to be available, but over time we expect and will encourage more often that practices separate the decision to enter premises ownership from the decision to enter into a general practice partnership and the operation of primary medical services. We will develop best practice guidance for all property-owning GPs. Future NHS capital investment would come with a requirement to demonstrate robust governance around property ownership.

28. A key message from the Call for Solutions process, and a finding of the General Practice Partnership Review is that risk, and the perception of risk, is one of the significant factors which can discourage GPs from becoming partners. While for some, property ownership has been highly effective and

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<sup>11</sup> NHS England internal analysis based on the Current Market Rent (CMR) of 1004 properties across England deemed suitable for long term use.

<sup>12</sup> 'GMS contract: 2018' (Scotland); available from:

<https://www.gov.scot/publications/gms-contract-scotland/>

<sup>13</sup> 'Investment and evolution: A five-year framework for GP contract reform to implement The NHS Long Term Plan'; available from:

<https://www.england.nhs.uk/wp-content/uploads/2019/01/gp-contract-2019.pdf>

should remain an option for practices to choose, tying estate ownership to the partnership's delivery of services via GMS/PMS/APMS contracts can create difficulties in the renewal of partnerships which can contribute to situations of negative equity and last partner standing.

29. A number of general practice partnerships have adopted a model where the choice to own premises is separated from that to become a partner in the service contract, something this Review considered could support the future development of the partnership model in general practice. We expect to see such arrangements grow in number over time and would support such a shift.
30. Where the NHS is investing capital in general practice premises owned by GPs, it should seek evidence that the practice has robust governance arrangements in place, ensuring that general practice partners who choose to own their estate understand the extent of their personal liability, that liability is limited appropriately, and that NHS investment would be protected from associated future risk. Separation of the premises-owning and partnership entities could be one way of demonstrating good governance.
31. The NHS will wish to seek assurance:
  - i. That the relationship between the estate owners and the partnership is formally documented (whether this is the same or multiple entities).
  - ii. That documentation is valid and up to date, reflecting current and former partners as appropriate.
  - iii. That practices seek professional advice in the matter to understand their liabilities and commitments to be made under the terms and conditions of investment.
  - iv. That the documented arrangements adequately record and protect NHS England's investment.
  - v. That all partners support the investment and understand the liabilities to which they will be committing.
32. To support partnerships in providing these assurances, best practice guidance will be produced; existing partnerships will be able to determine the extent of their current risk exposure.

### **Professionalisation of property ownership and management**

**Outcome:** Clearer guidance on the expectations of owners and occupiers around maintenance and standards, as part of professionalising property ownership and management.

33. We know that we want to promote a consistent and professional approach to property ownership, and this should also include how premises are managed. Through the Review it was identified that a lack of clarity or understanding around the responsibilities of all parties involved in estate ownership and occupancy can lead to these responsibilities not being fulfilled. These obligations apply to parties irrespective of whether the property is owned and

occupied by the same group, or whether there is a landlord/tenant arrangement in place.

34. Under the current rent reimbursement model, NHS England provides GPs with an amount of funding for maintenance. A maintenance backlog will reduce the financial value of a property, its value for future use and any proposal for investment.
35. The Review therefore recommends the production of guidance which clearly sets out the various roles in estate ownership and their associated responsibilities. Guidance should include what is reimbursed under the PCDs, and is therefore an owner/occupier or tenant responsibility, and what is not. This could include a breakdown of the different funding opportunities (e.g. rent reimbursement, business as usual capital and transformation funding) and their intended use.
36. The Review also recommends the production of a Customer Charter, for adoption by owner/occupiers, landlords and tenants of primary care estate. The Charter would set out core principles relating to how each practice premises will be managed, with each party's obligations clearly agreed.

### **New models and the Premises Costs Directions**

**Outcome:** Pilots for network level premises reimbursement arrangements, which will give networks greater autonomy to manage and minimise their costs relating to estates across their premises.

Pilots of a simpler model of premises provision in which the NHS directly bears the cost of premises in multi-use new build premises, removing the need for bureaucratic premises reimbursement systems, promoting integration of service delivery and optimal use of space.

37. A number of comments on the PCDs were received through the Call for Solutions process identifying that they are complicated and misunderstood; lack flexibility; create barriers in allowing mixed use of space; and do not fully reimburse for all costs incurred by practices. The complexity of the PCDs has hampered agreement on reform. Some of the key issues which the Review discussed in relation to the PCDs include:

- i. *Incentive to manage costs*

Reimbursement is offered for rent, business rates, water and clinical waste. The process for rent reimbursement is closely managed with external advice sought from the Valuation Office Agency. Business rates are reimbursed at face value in relation to approved GMS space, as is water and clinical waste. The table below sets out the annual recurrent spend on premises through the PCDs, which has been increasing year-on-year:

	£ thousands				
	2013/14	2014/15	2015/16	2016/17	2017/18
Premises	793,540	844,714	889,059	893,953	882,980

Although the NHS is responsible for reimbursing the costs, it is not able to directly influence cost incurred and there is no actual incentive within the system for GPs to drive costs down or seek cheaper alternatives where such costs are within their control.

ii. *Flexibility of use by other services*

The Review heard that the hosting of community or secondary care services within practice premises is restricted, with the PCDs setting out the terms under which services may be hosted and the associated impact of doing so, such as the abatement of notional rent or of recurring costs. There is a need to develop an acceptable and workable solution which fits the future model of service delivery.

iii. *Complicated reimbursement process*

The process of reimbursement claims requires time resource at a practice, CCG and national level as it continues to rely on manual checking and payment mechanisms.

38. The Review considered opportunities to amend the Directions and manage payments differently. The main proposal considered was to introduce a single payment to practices, which could be calculated based on historic spend with potential for revision should practices move premises.

39. Potential benefits of a single payment approach include:

- A simplified process, which would lead to practice staff and NHS staff spending less time processing claims.
- Release of system resource could allow support to be redirected towards other matters regarding the estate.
- Delivers an incentive for practices to manage their costs.
- Potential for increased flexibility through removal of the stipulation around use by NHS third parties.
- Could be supported by a 'model health centre', mirroring the 'model hospital' in the acute sector, which would enable a practice to understand a reasonable benchmark of costs.

40. Potential risks of a single payment approach include:

- Increased bureaucracy and impact on resource for GP practices in seeking alternative providers to manage costs within one payment.
- Potential for complex calculation required to inform single payment, including energy costs which may vary across the country.
- Would require flexibility and adjustment when practices want to move premises as rent may increase.



- Removal of stipulation around third party use may have a detrimental impact on use for GP services.
  - If a practice exceeds its single payment, financial risk is held with the practice.
41. Such a change was not supported for immediate implementation, and further work would be required to address the concerns raised during discussions. But the conclusion that the PCDs are simply not fit for purpose was clear, particularly for PCNs, which will need to plan how they will use their available estate across their Network and will have greater opportunity to manage their estates costs at scale. The Review therefore recommends that network-level arrangements are piloted to understand and evaluate the opportunities for more efficient estates management. This allows the benefits of a single payment model to be tested in circumstances that are future-facing.
42. Given the complexities outlined above, the PCDs are also unable to support effectively general practice housed in integrated care hubs or estate with multiple providers; they therefore hamper transformation and development. NHS England would prefer that the PCDs did not apply to practices housed in new NHS estate, such as integrated care hubs, and that they were replaced by a simple model of reimbursement where the NHS directly meets the costs associated with the hub and practices would be responsible for paying those which are currently non-reimbursable under the PCDs, removing the complicated process of charging and reimbursement which currently exists. A simple 'licence to occupy' agreement would be held between the practice and other primary care provider housed within the estate. The NHS would own the asset and practices would not be required to invest any funding in order to be housed in these premises. Such a model will also be developed, in the first instance for limited piloting and evaluation.

### **Developing greater support for community and primary medical care in local estates planning and in developing strong and future-facing ICS capital funding bids**

**Outcome:** A package of support relating to primary care engagement in STPs' and ICSs' capital strategies and the capital allocations process.

43. We do not have a complete picture of the current general practice or wider primary care estate, and this is a significant barrier to proper future estate planning. The Naylor Review reports that there is no national picture for GP estate but that anecdotally it mirrors the picture for overall NHS estate, 42% of which is over 35 years old and 62% of which is over 25 years old<sup>14</sup>. As a result, it is difficult to accurately assess how much of the existing estate is fit for current delivery or for future purposes. STPs and ICSs are required to work collaboratively within their areas to produce strategic estates plans and will

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<sup>14</sup> 'NHS property and estates: why the estate matters for patients'; available from: <https://www.gov.uk/government/publications/nhs-property-and-estates-naylor-review>

require a clear picture of their local estate to do this meaningfully.

44. In addition to other data held, the Review was able to access data collected by the DVS. Analysis of information held confirmed the lack of a full and coherent set of data at a national level. Through this work, the Review identified the need for a data collection project to develop a central dataset to support the general practice estate planning process.
45. The NHS Property Board has set up a Data Collection Project for Primary Care to undertake data collection, led by NHS England, during 2019/2020. It is recommended that this data collection include details on leases, utilisation and available space and condition. The data will be used to help drive strategic planning, inform investment, and deliver efficiencies utilising planning tools such as the Model Hospital, the Estates Return Information Collection (ERIC) and the Strategic Health Asset Planning and Evaluation (SHAPE). This will enable the system to plan and target areas more efficiently and strategically to help support Primary Care delivery under the LTP.
46. Through work undertaken with existing capital allocations processes, such as the Estates and Technology Transformation Fund (ETTF) and the Sustainability and Transformation Partnership Waves 1-4 funding programme, the Review heard that there is a perceived disparity between general practice estate and the rest of the system, in terms of ease of access to both capital funding and the relevant expertise to support bids. As above, the GPC Premises Survey<sup>15</sup> reports that 50% of respondents felt that their premises are not suitable for present needs, and that there are identified improvements which practices would like to make. However, nearly 60% of those who responded also confirmed that their practice had not applied for a grant from NHS England since 2015. It is understood from the GP Partnership Review<sup>16</sup> that reasons for applications not being made or being abandoned include a lack of expertise and concerns regarding bureaucracy.
47. Throughout the Review, concerns have been heard about the role and engagement of general practice within STPs and local estates planning, and the impact this can have on the perception of the capital allocations process and transformation. Additionally, the Review acknowledges that there was a loss of expertise in general practice estate with the abolition of Primary Care Trusts (PCTs).
48. The Review recognised that primary care needs access to support and expertise to ensure it is in a position to take advantage of opportunities to apply for capital funding. The Review concluded that, to support this ambition, the roles and responsibilities of all partners relating to estate within a local system

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<sup>15</sup> BMA GP Premises Survey Results 2018; available from:

<https://www.bma.org.uk/advice/employment/gp-practices/premises/bma-gp-premises-survey-results-2018>

<sup>16</sup> 'GP Partnership Review Final Report'; available from:

[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/770916/gp-partnership-review-final-report.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/770916/gp-partnership-review-final-report.pdf)



need to be agreed and clearly described, including the Strategic Estates Advisors (SEAs), to help ensure that STPs and ICSs are able to ensure robust engagement of all relevant parties and that they are using best practice. The package of guidance proposed by the Review could also help CCGs and local providers to collectively create the right level of expertise and collaboration.

49. Additionally, consolidating the available guidance and training on premises, including on the development of capital bids, will help to address this need. Central funding for a training budget has been secured to deliver a set of modules in 2019/20.
50. Finally, NHS England will continue work to ensure its capital allocations processes are set up in a way which enables and encourages high quality applications from primary care. The LTP confirmed that consideration is being given to reforms that will ensure funding is prioritised and allocated in a way which is effective and supports the transformation of services, as well as better enabling planning and control. Further information about these reforms will be set out alongside the spending review.

## Next steps

51. The outcomes of this Review will be taken forward to implementation stage.
52. As described in the introduction, they will help ensure that future investment is made in a more coherent and strategic way into a professionally managed estate. But capital is required both to bring up the standard of current estate and to transform primary care estates across England, to deliver what is required for the clinical and service vision of the LTP in purpose-built premises.
53. The work that follows this Review will create an implementation framework, informed by the government's future spending review timetable and outcome, to start the delivery of that transformation.

## Annex A

To support the open Call for Solutions a document was published which outlined the background and context to the Review and included a number of questions to help those responding to the call to structure their proposals:

What is the outline of your proposal: what is the change from the current system, how long would it take for this change to be implemented?

Which of the issues currently impacting on general practice estate will be addressed by your proposal and how?

How will this change support innovation and flexibility for the future, including accounting for the increased use of technology and digital opportunities, which may impact on the type and amount of estate required?

What are the intended benefits and added value of this proposal?

What are the cost and efficiency implications of this proposal, and over what timescale? If additional funding is required, how will this provide value for money for the tax payer? (Please note that no new funding should be assumed to be available.)

Who will be most affected by the change? Including all stakeholders who could be positively or negatively affected by the proposed change and with consideration given to the potential impact on health inequalities.

Are there any risks or unintended consequences which you can foresee? How could these risks be mitigated?

Is there evidence available to support your proposal? Please summarise and include links/references as appropriate.

## References

NHS England (2019) The NHS Long Term Plan. Available from:

<https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/>

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