



Valuation of medical centres and surgery premises

UK

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RICS standards framework

RICS' standards setting is governed and overseen by the Standards and Regulation Board (SRB). The SRB's aims are to operate in the public interest, and to develop the technical and ethical competence of the profession and its ability to deliver ethical practice to high standards globally.

The [RICS Rules of Conduct](#) set high-level professional requirements for the global chartered surveying profession. These are supported by more detailed standards and information relating to professional conduct and technical competency.

The SRB focuses on the conduct and competence of RICS members, to set standards that are proportionate, in the public interest and based on risk. Its approach is to foster a supportive atmosphere that encourages a strong, diverse, inclusive, effective and sustainable surveying profession.

As well as developing its own standards, RICS works collaboratively with other bodies at a national and international level to develop documents relevant to professional practice, such as cross-sector guidance, codes and standards. The application of these collaborative documents by RICS members will be defined either within the document itself or in associated RICS-published documents.

Document definitions

Document type	Definition
RICS professional standards	Set requirements or expectations for RICS members and regulated firms about how they provide services or the outcomes of their actions. RICS professional standards are principles-based and focused on outcomes and good practice. Any requirements included set a baseline expectation for competent delivery or ethical behaviour. They include practices and behaviours intended to protect clients and other stakeholders, as well as ensuring their reasonable expectations of ethics, integrity, technical competence and diligence are met. Members must comply with an RICS professional standard. They may include: • mandatory requirements, which use the word ‘must’ and must be complied with, and/or • recommended best practice, which uses the word ‘should’. It is recognised that there may be acceptable alternatives to best practice that achieve the same or a better outcome. In regulatory or disciplinary proceedings, RICS will take into account relevant professional standards when deciding whether an RICS member or regulated firm acted appropriately and with reasonable competence. It is also likely that during any legal proceedings a judge, adjudicator or equivalent will take RICS professional standards into account.
RICS practice information	Information to support the practice, knowledge and performance of RICS members and regulated firms, and the demand for professional services. Practice information includes definitions, processes, toolkits, checklists, insights, research and technical information or advice. It also includes documents that aim to provide common benchmarks or approaches across a sector to help build efficient and consistent practice. This information is not mandatory and does not set requirements for RICS members or make explicit recommendations.

Glossary of terms

Acronym	Definition
3PD	Third-party developer
APMS	Alternative Provider Medical Services
CHP	Community Health Partnership
CMR	Current market rent (as defined in the Directions)
District Valuer	a the District Valuer Services of the Valuation Office Agency or b such other valuer as the NHS may appoint.
GMS	General medical services
GPC	General Practitioners' Committee
LIFT	Local Improvement Finance Trust
LPA	Lease Plus Agreement
NWSSP-SES	NHS Wales Shared Services Partnership – Specialist Estate Services
PCO	Primary care organisation (ICB, HB or LHB as appropriate)
PMS	Personal medical services

1 Introduction

1.1 Application and scope

This professional standard concerns the valuation of medical centres and surgery premises occupied by doctors and other similar practitioners for medical or health services. It does not apply to valuations carried out under statutory provisions or to private healthcare properties, such as nursing or residential care homes. However, some of the considerations covered may be relevant to such properties.

This document applies to RICS members and RICS-regulated firms in the UK when valuing medical centres and surgery premises. In this document, references to the 'valuer' or 'valuers' relate to an RICS member and/or RICS-regulated firm accepting responsibility for the valuation. It is also aimed at valuation professionals and other industry stakeholders, including the National Health Service (NHS), investors, developers, lenders, legal experts and other professionals with an interest in the primary care health sector.

While the geographic scope of this standard is the UK, many of the principles are globally applicable and may support RICS members in other jurisdictions. This professional standard has been written specifically regarding the position in England. The valuation approach is similar in Wales, Scotland and Northern Ireland but differences are noted where they occur.

The NHS in Wales, Scotland and Northern Ireland have their own frameworks regarding the provision of general medical services and the relevant details are summarised in Appendices B, C and D respectively.

This professional standard supersedes the RICS guidance note *Valuation of medical centres and surgery premises*, 2nd edition, 2010.

Valuers are reminded that the [RICS Valuation – Global Standards \(Red Book Global Standards\)](#) and the accompanying [RICS Valuation – Global Standards: UK national supplement](#) apply to valuations for this purpose.

In this professional standard, the relevant Cost Directions are:

- [The National Health Service \(General Medical Services – Premises Costs\) \(England\) Directions 2024](#)
- [The National Health Service \(General Medical Services – Premises Costs\) \(Wales\) Directions 2015](#)
- [Primary Medical Services \(Premises Development Grants, Improvement Grants and Premises Costs\) Directions 2004](#)
- [The Health and Personal Social Services \(General Medical Services Contracts\) Regulations \(Northern Ireland\) 2004.](#)

1.2 Effective date

This professional standard is effective from 1 August 2025.

2 NHS framework

2.1 Introduction

This section outlines the NHS structure in England for primary care premises.

Appendices B, C and D outline the NHS frameworks in Wales, Scotland and Northern Ireland respectively.

To appreciate the role of the general practitioner (GP), it is necessary to understand the framework for the NHS.

2.2 NHS framework

2.2.1 GP contractors

Primary care services are mainly provided by independent contractors to the NHS. GPs (typically structured as a partnership) through either general medical services (GMS) or standard personal medical services (PMS) agreement contracts. The former is a nationally agreed contract between the Department of Health and the General Practitioners Committee of the British Medical Association; the latter is a contract agreed locally between primary care organisations (PCO) and GP practices based on nationally agreed template contracts but with elements that may be locally negotiated.

In England, a third contract exists – alternative provider medical services (APMS), which is agreed between a PCO and an alternative provider that may be a private company or a coalition of GPs who provide services not covered by a GMS or PMS contract and may be time limited.

The main difference is the contract term:

- a GMS contract is not time limited and is held in perpetuity
- a PMS/APMS contract may be time limited.

No new GMS contracts can be issued, but existing contracts can be merged and varied according to the guidance. GP practices also group together to form primary care networks, enabling collaboration to focus on local patient care and can hold specific contracts for this work.

2.2.2 Non-GP services

PCOs also commission community services such as podiatry, community nursing and physiotherapy in community settings as well as acute surgical or medical treatments from

NHS Trusts. It is increasingly Department of Health and Social Care policy to move some ambulatory services from acute settings to primary or community care settings to deliver care closer to home and in more appropriate environments. The prevailing policy should be considered.

In addition to services commissioned from NHS organisations, independent or private contractors are increasingly being used to expand the capacity available to the NHS and contracts are regularly awarded to both profit and not-for-profit organisations. The building typology, location and specification requirements of these occupiers are driven by the type of services being offered, be that broader primary care services, elective care or diagnostics, for example. For these premises, where appropriate, the standards and compliance stated in subsection 2.2.3 of this document would therefore still be considered to be a benchmark.

2.2.3 Primary care premises

Delivery of primary care services should ideally be from modern, safe and accessible buildings of appropriate design, meeting at least the minimum standards as set out in [The National Health Service \(General Medical Services – Premises Costs\) Directions 2024](#) (the Directions). The NHS Health Building Notes and Health Technical Memoranda give best practice guidance on the design, planning and specification of new healthcare buildings and on the adaptation/extension of existing facilities. [HBN 11-01: Facilities for primary and community care services](#) is particularly relevant and should be applied (this is currently under review). Design standards for such buildings are considered further in section 11 of this professional standard.

2.2.4 New, extended or refurbished premises

Under the Directions, the District Valuer provides advice on value for money to PCOs for new, extended or refurbished premises. Applications must be made by GP contractors to the commissioning body to seek approval for any proposals in line with the Directions. Applications should meet local commissioning needs and will be subject to PCO review and approval. Where NHS capital is proposed to be invested in the scheme, further approval from NHS England and/or the Department of Health and Social Care may be required, depending on the value of the investment and/or the funding source.

2.3 Guidance on Department of Health and Social Care primary care policy

The underlying principle of the Department of Health and Social Care primary care policy is to provide integrated, safe and secure services in fit-for-purpose premises that are readily accessible for patients and users. The creation of [integrated care systems](#) provides partnerships between primary care commissioners, providers and other organisations such as local authorities and NHS Trusts, to plan and deliver joined-up health and care services.

The NHS framework allows for different methods of premises procurement including practice-led schemes for owner occupation, third-party developments (3PD) leased to GPs or NHS bodies, and in limited instances, Local Improvement Finance Trust (England only). NHS England and PCOs issue advice on primary care property development proposals. Any new lease or lease renewal requires PCO approval.

2.4 NHS LIFT

NHS Local Improvement Finance Trust (LIFT) was one of the routes whereby primary healthcare premises were procured. Announcements by the Chancellor in the 2018 Budget Statement saw the formal withdrawal of private-finance and private-public partnerships, including LIFT. Although LIFT is a past form of procurement, several Lease Plus Agreements (LPAs) remain in place, with a significant portfolio of accommodation built across the country still operational and providing medical accommodation.

The LIFT concept was to promote partnerships, enabling community care models to be developed, such as incorporating diagnostic, social services, Sure Start, mental health services, pharmacy and voluntary agencies, in one building.

The strategic partnering agreement was a 20-year agreement for LIFTCo (the joint venture company created to deliver healthcare facilities under the LIFT programme) to develop proposals for new projects to meet local needs, and for the private sector to provide services that complemented those of the public sector in the locality.

The LIFT programme has designed, built, funded and operated 350 community-based healthcare buildings. LIFT companies are public-private partnerships with 40% public and 60% private ownership. Community Health Partnerships (CHP) is the 40% shareholder on all but seven LIFT companies, where ten local authorities are also shareholders.

The LPA financial structure is complex with shared ownership between Community Health Partnerships (clinical and administrative) across the LIFT estates. It is flexible and is regularly altered to respond to commissioning plans and tenants' needs through variations, extensions and refurbishments. CHP works with LIFT companies to deliver these for the health system.

In practice, due to the complex financial structures, LIFTCo shareholders ultimately became specialist infrastructure funds. They were, however, competitively selected and each building needed to provide the NHS with good value for money. The LIFTCo entities and the properties they own do not tend to trade in the wider market.

See section 9 of this professional standard for further guidance on the valuation of LIFT schemes.

2.5 NHS (General Medical Services – Premises Costs) Directions

General medical services (GMS) contractor premises costs are reimbursed by PCOs. This includes rent reimbursement as well as other costs or fees as stated in the Directions (to include business rates, water and clinical waste alongside the ability to apply for non-recurrent revenue and capital funding). The arrangements for these payments are set out in [The National Health Service \(General Medical Services - Premises Costs\) Directions 2024](#). Where reimbursement started prior to 2013, the previous Directions may be applicable, including any transitional arrangement that would entail approaching the valuation as if being valued under previous Directions. All payments to contractors will now legally be made under the 2024 Premises Costs Directions (PCDs) as the previous PCDs are revoked, however, Direction 58 allows for transitional arrangements between the 2013 PCDs and the 2024 PCDs.

Minimum standards

The PCO will expect all premises, where payments are made, to comply with published minimum standards as per the Directions as well as all statutory requirements. A breach can lead to the abatement of rent reimbursement, and would have financial implications for the occupier.

2.6 Other NHS controls over rent reimbursement

Premises costs disputes

[The National Health Service \(General Medical Services Contracts\) Regulations 2015](#) addresses dispute resolution where GPs have a disagreement on any point of their contract. The regulations encourage local mediation and require that the PCOs make every reasonable effort to settle any matters, including disputes over the level of current market rent (CMR), at a local level. In this respect, many PCOs have put in place individual procedures as well as adopting the NHS Resolution, local dispute resolution protocol (LDRP).

If local resolution fails then GP contractors can, under the NHS dispute resolution procedure, submit their case in writing to the NHS Resolution, an arm's-length body of the Department of Health and Social Care. They have the ability to appoint an independent adviser to report their findings and there is a scheme running whereby the [RICS Dispute Resolution Service](#) administers such appointments.

As GP contractors hold different types of contracts and may or may not be an NHS body, dispute resolution processes and routes may be different. Referral to the NHS contract is required to determine the correct route of appeal.

3 British Medical Association guidance

The General Practitioners Committee (GPC) of the British Medical Association (BMA) considers various matters relating to practice premises that could affect the valuation of GP premises and issues guidance to GPs on a regular basis. Valuers undertaking assessments of surgery premises occupied by GPs should keep abreast of BMA practice premises guidance.

Note that the BMA are intending to update their guidance to align with the 2024 NHS Directions. The [BMA website](#) contains practical guidance on premises matters for its members.

The GPC's publications set out the opinion of the GPC. However, as the considered opinion of such a prominent association, valuers should be aware of any publications as the content will influence GPs, which could ultimately impact on surgery values.

4 Sustainability and ESG

Sustainability and environmental, social and governance (ESG) requirements have a growing importance in the property industry and influence investment decisions.

Requirements for ESG are applied throughout the investment cycle, from ESG screening criteria for investment opportunities, monitoring ESG performance through investment period via sets of key performance measures, to retrofitting and investing at the end of the investment cycle.

Debt providers may also prefer assets with strong ESG credentials by either offering a discounted borrowing rate to 'green' assets or establishing a fund with a focus to lend for buildings with strong sustainability credentials. This is increasingly linked to lenders' own net-zero carbon commitments and expectations that they can influence the decarbonisation of buildings.

Rent negotiations may reflect a preference for properties that demonstrate robust ESG credentials, manifesting in divergent rental level and growth trajectories for assets of varying ESG quality.

[RICS Valuation – Global Standards \(Red Book Global Standards\)](#) set out the mandatory requirements for valuers regarding sustainability and ESG (see Red Book Global Standards, VPS 1 (Terms of engagement), VPS 6 (Valuation reports), and VPS 4 (Inspection, investigations and records)). The IVS 104 data and inputs appendix should also be considered. ESG material relevant to the respective valuation purpose is incorporated into Red Book Global Standards, VPGA 1 (Valuations for financial reporting), and VPGA 2 (Valuations for secured lending). ESG guidance in VPGA 8 (Valuation of real property interests) should also be considered. The current edition of RICS' [Sustainability and ESG in commercial property valuation and strategic advice](#) provides the guidance applicable for valuing commercial property and should be carefully referenced and applied when valuing medical centres and surgery premises.

RICS' [Commercial secured lending ESG and sustainability framework](#) provides a list of considerations to fulfil ESG obligations for UK commercial real estate for secured lending. Considerations including Minimum Energy Efficiency Standards (MEES), 'green' certification and leases and flooding are relevant to medical centre and surgery valuations for all purposes and should be considered and applied where appropriate.

Environmental aspects of medical centre estates can affect prospects for rental and capital growth, obsolescence and capital expenditure requirements. The current edition of RICS' [Sustainability and ESG in commercial property valuation and strategic advice](#) suggests that when performing a valuation, the discounted cash flow model 'has the advantage of clearly depicting the cash flow cost and income assumptions over time, and is the preference of some market participants for taking account of ESG and sustainability factors'.

Properties used as medical centres have a strong social benefit by delivering essential services to communities and attracting investors pursuing positive ESG outcomes. The added social impact created, albeit difficult to quantify, could be considered when valuing medical centre and surgery premises and when making comparisons to other property sectors. This added impact often enables longer term and more secure income streams.

NHS England published [Delivering a 'Net Zero' National Health Service](#) in July 2022, which laid out the NHS trajectory to achieve net zero. Section 3.1.2 of the report illustrated different interventions to reduce emissions from the primary care estate. Valuers should consider the implications on medical centre and surgery valuations under this governance.

In addition, in February 2023, the [NHS Net Zero Building Standard](#) was published, creating a reference point for all health care buildings. Where buildings meet the standard and the requirements for energy and carbon performance improvement over time, this should be considered by valuers.

The *National Health Service (General Medical Services – Premises Costs) Directions 2024* came into effect in May 2024. A salient amendment pertains to the enhanced capacity and flexibility afforded to commissioners in making substantial investments in GP practices. Of note is the revision to Direction 9(g), which now empowers NHS England to allocate premises improvement grants specifically for enhancements designed to mitigate the environmental impact of healthcare facilities. This provision is contingent on the demonstration of a net financial benefit to the NHS in its entirety. Valuers engaged in the assessment of medical premises should give due consideration to this.

5 Basis of value, approach and assumptions

Most valuations to which this professional standard applies will be undertaken for the determination of market value and/or market rent for partnership or transaction purposes, for investment or development and/or in connection with loan security.

The appropriate basis is usually market value as defined in [RICS Valuation – Global Standards](#), VPS 2. The valuer may have regard to the likelihood of continued use considering the profile of the medical practice and its service delivery as a surgery in the short, medium and long term and, while having regard to the potential availability of rent reimbursement through the NHS, no account should be taken of any actual Cost Rent or, without due consideration, actual current market rent (CMR) reimbursements from the NHS. These are individual contractual arrangements that might be terminated in the event of a sale or subject to abatement due to capital grants/supplements due to capital investment or amended in the event of significant changes in the occupying medical practice or its mortgage arrangements.

There may be circumstances where the valuer is asked to provide a valuation subject to special assumptions, in which case the Red Book Global Standards, VPS 2 will apply (for example, those assumptions as set out in a Partnership Agreement). If a special assumption valuation is to be provided, then it may be appropriate to comment on market value.

Many medical centres are occupied by GP partnerships or provider companies, PCOs and community care providers as tenants rather than as owner-occupiers. Primary care as an asset class is recognised in the investment sector. Surgery investments are normally valued based on market value.

5.1 Compliance with design guidance

Valuers **must** be aware of and understand the Department of Health and Social Care's design guidance, which differs between England, Scotland and Wales (see section 11 of this professional standard). The impact on value from the changes in design guidance, as it has been developed over the years to ensure premises meet the requirements of the time, should be recognised. Compliance, as well as non-compliance with current and previous Department of Health and Social Care design guidance, has a strong influence on the medical premises 'valuation hierarchy'.

Valuers should consider both the actual specification of the property in relation to its original compliance and, at the time of valuation, consider improvements and refurbishments undertaken during the life of the asset.

5.2 Obsolescence

Obsolescence is an important issue in the sector. Valuers are expected to comment on the design of buildings, their flexibility, potential for expansion, impact of population change and planning, and proximity of other surgeries in the locality. The valuer should establish how the premises align with the estates strategy of their PCO.

In considering obsolescence, the valuer should be aware of the minimum standards set out in the Directions and how these are interpreted by the local PCO (see section 10).

Except in circumstances where the premises fully meet current NHS design standards, are of an appropriate size for the expected catchment population and are supported in the estates strategy of the local PCO and the relevant Sustainability and Transformation Plan, the valuer should consider whether the premises are likely to continue in current use over the medium to long term; the extent to which capital expenditure may be necessary to upgrade the premises and the potential for change of use. Where appropriate, the valuer should consider adopting a 'term and reversion' approach.

5.3 Comparable rental evidence

In England, most lease rents on newly developed primary care centres for GP occupation are agreed by the landlord and tenant in the knowledge of an estimate of the CMR, which is provided by the District Valuer after discussion with the parties. In the case of PCO leases, the rent and lease terms will be agreed by the landlord and tenant following recommendations by the District Valuer. In both cases, rents are agreed before construction and are intended to reflect market rents having regard to the proposed lease terms. In accordance with the Directions, the NHS, for their own requirements, will review the development to establish whether or not 'value for money' is satisfied.

In Wales, for all newly developed NHS medical centres, the District Valuer enters into negotiations with the landlord to agree the rent to be paid and reimbursed by the Health Board. Any agreement is subject to funding approval by the Minister of Health in the Welsh government.

In England, CMRs for existing premises are also agreed with the District Valuer. The basis of value should be established as set out earlier in section 5 of this professional standard. Furthermore, CMRs can be subject to abatement if there has been a contribution of NHS capital (Direction 44) or supplement (Direction 45) if there have been improvements that would otherwise not be reflected in the reimbursement. Direction 34(4) applies in circumstances where the current market rent had been shown to be too low to justify the required capital investment in the premises (see subsection 5.3.1).

In Wales, all CMRs (with the exception of new developments) are negotiated by NWSSP – Specialist Estate Services, abated rents and supplements provisions are detailed in [The National Health Service \(General Medical Services – Premises Costs\) \(Wales\) Directions 2015](#) – see Appendix B of this professional standard.

In searching for and analysing comparable evidence, the valuer should obtain several comparables including those found in the wider commercial market as appropriate, so that the market rent in the locality can be ascertained. In the market, rents can vary from the general level of market rent particularly if they are based on indexed reviews, agreed without the benefit of specialist advice, or resulted from a development appraisal where there were significantly abnormal costs or subsidies associated with the development, or where rental levels have been influenced by the potential alternative use of the site or property. The circumstances pertaining to the assessment of rent for each of the comparables should be investigated.

The devaluation of income streams from LIFT and PFI schemes are not direct comparables for valuing conventional medical centres given the income is derived from a financial model.

See the current edition of RICS' [Comparable evidence in real estate valuation](#) for advice relating to comparables.

5.3.1 Top up supplements

A top up supplement may have been considered appropriate by the NHS Direction 34(4) of the *Premises Costs Directions* 2024 (or Direction 33 if agreed under the 2004 or 2013 Directions) where the current market rent had been shown to be insufficient to justify sufficient returns or support. The Directions state that the top up supplement must reduce in line with any increases in the current market rent until such time as the supplement is extinguished. However, to allow for any variations in the application of a supplement, where Direction 33 or 34 is not applicable or has not been applied, the valuer **must** establish the background to any reimbursement or lease rent where some form of supplement may exist.

5.3.2 Capital input and legal charges

Where the NHS or other funder has made a substantial capital input, there may be a legal charge on the property and a potential abatement to the rent. Consequently, valuers should investigate the title to the property and ascertain any conditions found in the Charges Register.

5.3.3 Restrictions on use

Valuers should have regard to any restrictions on use of the premises, whether imposed by way of conditions in planning consent, restrictive covenants on freehold title or user clauses in leases.

6 Valuations for partnership purposes

This section applies primarily to surgeries occupied by GPs. However, this section may also be of assistance in valuing, for partnership purposes, medical centres occupied by others providing medical or health services.

It is common for surgery premises to be valued to quantify the value of the property assets when a GP is leaving or joining the partnership. The valuer should clearly agree whether the partnership or an individual partner (or prospective partner) is the client.

The valuer should scrutinise the wording of the partnership deed in case it affects the appropriate basis of value to be determined. Difficulties can arise in interpreting clauses in partnership deeds, or there may be a complete absence of any reference to the basis of value to be adopted. In such cases, it is recommended that the matter is discussed with the client before the valuation is prepared at the terms of engagement stage (see [RICS Valuation – Global Standards](#), VPS 1).

In respect of owner-occupied premises where no detailed instruction to the valuer is provided in the partnership deed, market value with vacant possession should be assumed for those areas under GP occupation. Where the occupying GPs are under an NHS contract, they are likely to receive rent reimbursement as provided by the Directions.

While the occupying GPs are a 'special purchaser', they could still be considered as one of the potential purchasers. This means that the valuer may consider the current level of notional rent reimbursement as an income stream until the next triennial review when the notional rent will be reassessed. In considering the reassessed notional rent, consideration should be given to the valuer's opinion of the current market rent. If GPs have previously taken a capital grant towards development or improvement, it is possible that the passing notional rent has been abated. On abatements to the rent, unless the capital grant is repaid (which may not have been on the valuation date) then the NHS would look to continue the abatement for both the subject or any acquiring practice. The valuer should establish the exact situation and consider the effect of such abatements.

When undertaking a partnership valuation for owner-occupied practice premises, valuers should not assume a lease is either in place or could be put in place on the surgery. All leases and the terms of those leases, including the lease length, must be approved not only by the occupying GPs but also by the PCO on advice from the District Valuer and possibly the mortgagee. In many cases a practice may not be willing or able to enter into a lease and approval by the PCO or mortgagee may not be obtained. Thus, when looking at any lease potential the valuer **must** carefully consider any lease terms that may be agreed having

regard to such matters as the lifespan of the premises as a compliant medical centre and its position in the estate strategy of the PCO.

Furthermore, where there is any adjustment to the market value, valuers should gain the agreement of the partners and clearly state such adjustment(s) in the report. Care should be taken in valuing older premises with a limited life expectancy (as a GP surgery) because a valuation assuming an alternative use may differ from the value for the existing surgery use.

It is unlawful for GPs to sell the goodwill, or any part thereof, of their medical practice (section 54 of and Schedule 10 to the *National Health Service Act 1977*) and the valuer should confirm that the goodwill of the practice is not included in the valuation of GP premises. If there is any doubt as to whether a sale of an interest in GP practice premises might constitute a breach of these provisions, the GP can (but is not obliged to) apply to the GPC for a certificate confirming that there has been no breach of section 54 and Schedule 10.

It is open to partners of a medical practice to agree in their partnership documentation the basis of valuation to be adopted on partnership change. The historic GPC recommendations (*Valuing surgery premises* (revised November 2007)) suggested the following clause as being suitable for partnership agreements:

‘The freehold/leasehold assets of the practice shall be valued by a Chartered Surveyor appointed by the partners (in default of such nomination to be appointed by the President for the time being of the Royal Institution of Chartered Surveyors) having regard to the (open) market value as defined by the Royal Institution of Chartered Surveyors of the premises having regard to both the existing use of the premises and the benefits of any income or rent reimbursement (whether real or notional) paid in respect of the premises but disregarding any element of personal goodwill which may attach to them as a result of the occupation of them by the partners or any of them or by any deceased or retiring partner immediately prior to the death or retirement of that partner’.

There are many variations that should be treated as special assumptions and be addressed by the valuer, for example:

- Market value qualified to have regard to the rent reimbursement in the form of CMR or Cost Rent. In cases where the parties wish to reflect the level of rent reimbursement, the valuer should have regard to the amount by which such reimbursement differs from the market rental value of the premises, the potential for future income growth and the period for which such reimbursement will continue. Neither CMR nor Cost Rent is transferable to another property. Should the premises be vacated any rent reimbursement will cease.
- Market value of the premises as a doctor’s surgery (or other similar wording), excluding any value attributable to alternative use.

Where the valuation has regard to a special assumption, this should be specifically referred to in the report and expressly agreed and confirmed in writing to the client in the terms of engagement and before the report is issued (see [RICS Valuation – Global Standards](#), VPS 2).

7 Valuations for loan security purposes

[RICS Valuation – Global Standards \(Red Book Global Standards\)](#), VPGA 2, contains information on valuations for commercial secured lending. Depending on whether the property is owner-occupied or an investment, the specific relevant sections of this professional standard should also be considered together with the instructions of the lender.

The valuer should clarify to the lender that market value does not consider any Cost Rent or, without due consideration, adopt CMR reimbursements (see section 5). The valuer should consider any income from third-party lettings (including, for example, pharmacies or dentists) and the terms of their occupancy.

The valuer should establish, through direct contact with the PCO or by consulting the practice, the basis (if any) of rent reimbursement currently applicable to the premises and, in the case of borrowing cost or Cost Rent, whether the reimbursement is on a fixed or variable rate. This should be compared with the valuer's own assessment of CMR. The lender should be advised of any significant discrepancy between the current rent reimbursement and the valuer's opinion of the appropriate level of CMR. Most surgeries will be subject to CMR rather than borrowing cost or Cost Rent.

The valuer should identify any areas shared with a GP practice that might not otherwise be classified as provided for GMS or PMS, as these areas may not benefit from rent reimbursement. This is becoming increasingly common where the PCOs involve the private sector in the provision of some services, or where another NHS Trust, such as community services or mental health, occupy accommodation under a separate lease, or in some cases under a licence or a less formal agreement.

Some lenders may require several different valuation scenarios. Many lenders may require a market value and an exit value, the latter being subject to special assumptions that may include the continuation of surgery use or on the basis of the alternative use. For LIFT premises, the exit (or reversionary) value may be more relevant for loan consideration (see section 2.4 of this professional standard). Each of these valuation scenarios could reflect a special assumption. To comply with Red Book Global Standards, such a special assumption **must** be included in the terms of engagement or service level agreement and referred to in the report (see Red Book Global Standards, VPS 1 and 6).

The valuer should consider and investigate any grant funding (for example, improvement grants, deanery grants, section 106 or Community Infrastructure Levy (CIL) contributions), which may have an impact on CMR or notional rent by way of any abatement applied to the rent reimbursement and the period of the abatement, including any other adjustments impacting the amount of notional rent/CMR. The valuer should also investigate if there is any

clawback of any grant funding and whether there is a legal charge over the property and any effect this may have on the valuation.

8 Valuation of investment properties

The basis of value will be determined by the purpose of the valuation. In most cases, this is likely to be market value having regard to the leases but for financial reporting purposes, it is more likely to be fair value. The valuer should establish, through contact with the PCO or the occupier, the amount of any rent reimbursement currently applicable to any GP surgery element. It does not always follow that the rent included in the lease will be the level of reimbursement.

The lease terms for areas occupied by GPs and PCOs may vary, however, there is usually reference to the Directions and the process via which GPs are contractually able to secure reimbursement of premises costs.

While some leases are traditional in nature, committing the tenant to full repairing and insuring liabilities (FRI), it is not uncommon for medical leases to remove the tenant's insuring liability and limit the tenant's repairing obligations to the interior only (TIR) or limit the tenant's repairing obligations while retaining a tenant liability to reimburse the cost of insurance (IRI). In addition, modern TIR leases may exclude the tenant's liability for the replacement of major plant (while retaining the tenant liability for general maintenance) and in some cases extending the landlord liability to include the maintenance of external areas and landscaping. The valuer should fully understand the exact liabilities and include them in their report with the appropriate deductions being made from the gross rents to reflect the net operating income (FRI equivalent).

Rent review clauses will also vary and should be carefully considered. Where there are GP practices in occupation receiving CMR for reimbursement purposes, rent review provisions may require close adherence to the Directions and this should be carefully considered. There may be provisions for rents to be reviewed downwards as well as upwards.

In connection with alienation provisions, the valuer should check these where there are GPs in occupation. The leases will normally allow for GPs to leave and retire from a practice without any ongoing obligations, so long as there is a minimum number of GPs as signatories to the lease. Authorised guarantee agreements are not normally required on an assignment to another GP practice or NHS body. To maximise the covenant strength, the retention of a tenant with the right to receive rent reimbursement is greater than retaining a retiring GP tenant.

User clauses should be considered in any leases and their potential impact on value. It is common with medical centres for the user clauses to be specific to medical services being provided in the NHS. While the potential of these strict user clauses to adversely affect rental value should be considered, the reason for them is to protect the rent reimbursement

that is being received by the GP practice in occupation, and ensure any valuation takes due consideration of the use of the property as providing medical services in the NHS. It also prevents the assignment of the lease to a weaker covenant that may adversely affect the investment value.

It should not be assumed that occupation by the primary care tenant will continue at the end of the lease. This should be considered together with the potential reversionary use/value especially in respect of short-term leases, as well as a consideration of the primary care landscape and estate strategy.

It is possible some investors may require a discounted cash flow (DCF) method to be used. Application of DCFs in such circumstances should refer to the current edition of RICS' [Discounted cash flow valuations](#).

9 Valuation of LIFT schemes

Valuers should study the Lease Plus Agreement (LPA) in detail and fully understand the landlord's obligations under the terms of the Agreement. The valuer should also obtain details of the financial model and detailed breakdown of the LPA as this will include landlord's costs including building maintenance, life cycle costs, facilities management and payment reductions, to non-availability of facilities.

The signatory to the LPA will often have a pre-emption right during the term of the Agreement and/or an option to purchase at the end of the term. Valuers should familiarise themselves with this and the effects of any supplementary underleases.

As LIFT has some similarities to PFI and Scottish Hub, valuers should obtain clear instructions from any lender and investor(s) as to the method of valuation required. It is possible that some clients may require a discounted cash flow method to be used.

The LPA payments are subject to annual RPI increases. The gross internal floor area of the building, rather than the net internal floor area (see section 10 of this professional standard), is used for calculating the LPA. There is often third-party income (from pharmacies and other occupiers), and the terms of their occupation need to be checked. Many of these occupiers are subject to conventional leases.

NHS LIFT buildings are specialist, which means that the market value for alternative use can often be materially lower than the investment value, particularly as they tend to be in low value, deprived areas. Rental structures are generally in excess of market rents in the sector. This is partly because the lease structure provides for a day one rent to be inflated year-on-year to the increase in the Retail Price Index. Furthermore, for non-LIFT health centre premises, rents under LPA tend to be high as they include facilities management and life cycle functions, so rents require careful analysis.

In using LIFT property as a comparator, the valuer should strip out the additional services that are provided as part of the LPA charge. The net rent can only be established when facilities management, life cycle functions and any other specific contractual requirements are stripped out. The valuer should also be mindful of Retail Price Index-related rental increases from day one. Some rents agreed within LIFT buildings for new lettings are more comparable as the transaction will be current and open market as the buildings evolve and new tenancies are agreed.

At the end of the term the tenant has an option to purchase the building based on a prescribed formula, to continue to occupy or vacate the premises. This can create uncertainty for lenders, investors and operators and requires careful consideration.

See section 2.4 of this professional standard for more information on LIFT. Valuers should possess a comprehensive understanding of and have suitable experience of LIFT-related valuations.

10 Measurement and inspection

10.1 Measurement

Although it contains no specific reference to surgery premises, valuers should have regard to the current edition of RICS' [Code of measuring practice](#) when undertaking the measurement of property for valuation purposes.

This is a departure from the generally recommended adoption of [IPMS: All Buildings](#), but reflects that RICS' *Code of measuring practice* is the main basis of measurement applied to all medical centres and surgery premises. *IPMS: All buildings* should be adopted where appropriate and any departure from IPMS should be stated with the reason documented. The core definitions provided in RICS' *Code of measuring practice* include Gross Internal Area (GIA) and Net Internal Area (NIA).

GIA is the usual method of measurement for calculating building costs (for example, with reference to BCIS data) and valuing industrial and some residential property, but is often used by PCOs in England in determining the size that may be eligible for rent reimbursement as a guideline to the acceptability of premises and in the analysis of NHS LIFT payments.

NIA is the usual basis of measurement for the valuation and marketing of most non-industrial business premises. See application 9 of RICS' [Code of measuring practice](#).

In contrast to office premises and many other types of commercial property, surgeries contain specialist facilities and have different requirements for space utilisation. These include, among other matters, the provision of additional WC accommodation (to provide separate facilities for patients and staff) and additional cleaning accommodation to help manage infection control.

Therefore, in applying RICS' *Code of measuring practice*, certain areas additional to the facilities referred to in items 3.1 to 3.10 of the Code's core definitions should be included in the calculation of NIA. These would include:

- Changing Places rooms, baby changing facilities and other ancillary accommodation provided specifically for the benefit of patients.
- Additional protected areas provided because of the more stringent means of escape and fire regulations as applied to surgery premises.
- Additional WC accommodation provided exclusively for patients. In determining what constitutes additional WC provision, the valuer should have regard to the number of WCs required under current legislation for commercial premises in respect of the number of WCs required for staff.

- Facilities for the secure storage of clinical waste.
- Additional cleaners' rooms required for the management of infection control.
- Shower and locker rooms.
- Shared circulation/corridor space. Health buildings are often occupied by several healthcare bodies providing the required medical facility with shared circulation/corridor space. Where such space is shared, and where this space would form part of the NIA were the building to be in sole occupation, this circulation/corridor space should be apportioned and included in the NIA of the occupiers sharing the space. The apportionment may be done in the ratio of the exclusive NIA each occupier bears to the sum of the exclusive NIA. This approach has the advantage of transparency, although specific lease provisions may preclude this approach.

Floor plans showing examples of this are included in Appendix A but do not take precedence over the text of this professional standard.

It is for the valuer, when attributing value to such areas, to judge in each case whether these facilities have been over- or under-provided and the relative value to be attributed to them, and to explain their reasons in the rationale section of the report. The NIA should be measured in line with the plans in Appendix A, corridors bounded by structural walls being excluded from NIA, but the valuer will then consider whether any property attributes, not specifically included within NIA, attract additional value, having analysed the comparable evidence.

10.2 Inspection

During inspection, the valuer should note and record the value significant attributes of the premises. To do so competently, a working knowledge of NHS HBN 11-01 will be required.

Elements to be noted often include the following.

- Number and type of car parking spaces.
- An ambulance bay (when located within the demise).
- Access to and around the building and general compliance with the *Equality Act 2010*.
- Fixtures and fittings intended to be included in the valuation and referred to in the report. Where appropriate, these **must** be checked against those detailed in the lease.
- Aspects including room sizes and compliance of clinical wash basins, infection control measures, door and corridor widths, provision of patient confidentiality and staff security.
- Permanent circulation areas – these are to be excluded in accordance with RICS' [Code of measuring practice](#). For example, in surgery premises adapted from former, often older, residential property, internal dividing walls often support the structural integrity of the building or other walls directly above. As such, these walls cannot be regarded as removable to allow a greater flexibility of floor layout, without substantial, disruptive and costly works being carried out to support the structure. By contrast, more modern

methods of construction generally benefit from a greater flexibility of the internal cellular layout through the adoption of structural techniques (e.g. steel framed) that support the building with beams, columns, piers, etc., allowing internal dividing walls to be removed and relocated at relatively low cost. Consequently, the presumption is that internal structural walls within the envelope of such older properties may generally be taken to be immovable economically and such permanent circulation areas excluded from NIA, unless shared.

- Link corridors – those provided purely to enable enclosed and covered access between parts of the premises are to be excluded from NIA as permanent circulation areas.
- The degree of flexibility offered and the potential for future expansion.
- Passenger, stretcher and platform lifts, including the specification and number of lifts.
- Record details relating to sustainability and ESG (refer to section 4 of this professional standard and relevant sections of [RICS Valuation – Global Standards](#)).

11 Design and specification – the impact of legislation and NHS policy

The existing legislation together with NHS Directions, historic and current guidance regarding design and specification are important factors in determining the quality of a surgery and will impact on value.

11.1 Guidance in England

11.1.1 Historic guidance

Historically, the *Statement of Fees and Allowances* (paragraph 51), *Medical Practice Premises* (commentary 1999 and 2002) and *Primary and social care premises: planning and design guidance* (2004), applied.

11.1.2 Equality Act 2010

Due to the nature of the use, the *Equality Act* 2010 has a greater impact on medical premises than other types of property and greater impact on upper or lower floor accommodation than that provided at ground floor level. The Act requires that service providers take reasonable steps to remove, alter or provide reasonable means of avoiding physical features that make it impossible or unreasonably difficult for disabled people to use the service. Access to services for disabled patients is also a consideration of The Care Quality Commission (CQC) in rating the quality of services delivered by a GP practice. Much of the existing stock of surgery premises fails to comply with NHS disability standards and, in considering the value of individual surgery premises, the valuer should exercise judgement as to:

- the adaptability of the premises to meet NHS expectations
- whether such adaptation is reasonable in the context of service provision in that locality and
- the order of priority in which any necessary adaptations may need to be carried out.

Compulsory inclusion of Changing Places toilets in new public buildings in 2020 has seen facilities being included in the designs of larger new medical and primary care centres.

11.1.3 Department of Health's Health Building Notes (HBNs) and Health Technical Memoranda (HTMs)

[HBN 11-01](#) is the overarching document relating to best practice on the design and layout for primary and community care premises and community hospitals. The document is currently being updated and future design will expect to include provision of 'hot' and 'cold' hubs to allow buildings to remain open during future pandemics. Additionally, the COVID-19 pandemic has led to a reduction in face-to-face appointments, which may affect the size of premises in the future. The CQC also takes guidance in the HBNs and HTMs into consideration in its inspection of practices. At the time of writing, several of the HBNs and HTMs are out of date and are expected to be updated once HBN 11-01 is released.

HBN 11 has been written with the provision of new build facilities in mind. The principles described apply equally to the refurbishment and extension of existing buildings. HBN 11 shows the valuer what is required by the NHS for compliance and thus forms a guide to quality. Emphasis is placed on design to manage infection control.

11.1.4 The Premises Costs Directions 2024

Schedule 1 of [The National Health Service \(General Medical Services – Premises Costs\) Directions 2024](#) attends to the minimum statutory and contractual standards required for primary care premises in relation to:

- compliance under the *Equality Act*
- facilities for the elderly and young including WC facilities, baby changing/feeding facilities and infection control
- properly equipped and sized treatment rooms and adequate arrangements for instrument decontamination
- properly equipped consulting rooms
- convenient access and proper arrangements for storage of clinical waste
- wash hand basins with hot and cold water
- adequately sized waiting rooms with confidentiality provisions
- adequate lighting, heating and ventilation together with fire and security provisions and
- decontamination and infection control.

11.1.5 Energy sustainability requirements

The NHS has made a commitment to energy sustainability and the valuer should be aware of their requirements, notably in respect of:

- Building Regulations, Approved Document L.
- Building Research Establishment and Environmental Assessment Method (BREEAM). This is an environmental assessment tool that was introduced on 1 July 2008 where the NHS

in England requires an 'Excellent' rating for new buildings and a 'Very Good' rating for refurbishments.

- Display Energy Certificates (DEC).
- Energy Performance Certificates (EPCs) and the impact of Minimum Energy Efficiency Standards (MEES), particularly those buildings that may need to be upgraded before new minimum standards are introduced, currently anticipated in 2027.

11.1.6 Building Regulations

In line with the UK government's target to achieve net zero, Part L *Conservation of fuel and power* was amended in 2022 with the intention of reducing carbon emissions from non-domestic buildings by 27%. Valuers should have regard to age and obsolescence factors in buildings.

11.2 Guidance in Wales

Health in Wales is devolved to [the Welsh Government](#).

The design and specification of primary care buildings in Wales is influenced by current legislation, policy and guidance. There are several documents for reference and use in Wales including a suite of Welsh Health Building Notes (WHBN) and Welsh Health Technical Memoranda (WHTM). Current documents, and an archive, can be accessed via the [NHS Wales Shared Service Partnership](#).

The principal documents include:

- WHC 2018 043 *NHS Wales infrastructure investment guidance*
- WHBN 36 *General medical practice premises in Wales* 2017
- *Future Generations Act* 2015
- *NHS Wales decarbonisation strategic delivery plan* 2021
- *A healthier Wales: our plan for health and social care* 2018
- *NHS Wales Planning Framework 2022 to 2025*
- *The National Health Service (General Medical Services – Premises Costs) (Wales) Directions* 2015
- NHS Net Zero Building Standards – HTM 07-02: Parts A and B *Making energy work in healthcare* and HTM 07-07: *Sustainable health and social care buildings*
- WHBN 00-01: *General design guidance for healthcare buildings*. Plus: 00-02; 00-03; 00-04; 00-09; 00-10 (Parts A, B, C and D).
- WHBN 14-02: *Medicines storage in clinical areas*
- WHTM 01-05: *Decontamination in primary care dental practices and community dental services*
- WHTM 05-01: *Managing healthcare and fire safety*
- WHTM 05-02: *Fire safety in the design of healthcare premises*

- WHTM 05-03: *Firecode Part J*
- WHTM 07-01: *Safe and sustainable management of healthcare waste*
- WHTM 07-04: *Water management and water efficiency.*

11.3 Guidance in Scotland

Design guidance for primary care premises in Scotland is currently provided in *Scottish Health Planning Note 36 Part 1: General Medical Practice Premises in Scotland*.

This document provides advice on the design and specification requirements for primary healthcare premises in Scotland and is the first in a series of three Health Planning Notes. The other two being *Part 2: NHS Dental Premises in Scotland* and *Part 3: Community Pharmacy Premises in Scotland*.

All three documents are available on the [National Services Scotland website](#).

These documents provide the source for spatial and dimensional standards for premises in respect of which health boards may consider financial support to be appropriate. Part 1 is aimed at GPs considering a new build option, however, it also provides design teams with a set of minimum standards and can be used by NHS bodies and boards commissioning new premises for general medical practices. Although aimed at new build premises, the document also provides useful guidance for the refurbishment of existing buildings. The Health Planning Note shows the valuer what is required by the NHS for compliance and forms a guide to quality.

12 Co-located pharmacies

This section looks at pharmacies co-located in medical centre premises. Any valuer operating in this specialist sub-sector should be fully aware of the legislative background and nuances compared to high street pharmacies and medical centres.

12.1 Guidance in England

Pharmacies are sometimes incorporated into new medical centre developments and may be present at existing medical centres.

The provision of NHS pharmacy licences, including relocations and change of ownership, is controlled by the NHS under the *National Health Service (Pharmaceutical Services) Regulations 2013* – it is a regulated market.

Valuers should proceed with caution when evaluating the rents associated with new lettings, lease re-gears and renewals. Available rental evidence should be treated with caution as the amount of rent paid can be influenced by the working relationship and compulsions of either party.

Pharmacy licences are regulated and full details behind each transaction should be established before they can be relied on. Therefore, the rental evidence should be treated with caution, with new lettings not necessarily providing sufficient and reliable evidence.

Co-located pharmacies are normally let on commercial terms with additional clauses linked to the business of the adjacent medical centre. The primary commercial terms, and particularly the market rent, can be influenced by several physical and non-physical factors that may be interrelated to a greater or lesser extent. For example, these could include:

- the unit's size and how it may impact on service delivery to patients
- the unit's physical relationship to the GP surgery
- local competition – the presence and convenience of other pharmacy licences and operators can influence patient choice and unit desirability. Competition also arises from online prescription services.
- patient list size – appropriate knowledge should be applied when evaluating prescribing versus dispensing lists and in the valuer's differentiation of group practice lists (the valuer should consider that the existence of branch surgeries will affect the benefit to a pharmacist of a practice list size)
- GP item numbers – the number of items prescribed by the surgery, compared to national trends and other physical and non-physical factors, which can affect the capture rate
- the item capture rate – the number of items a particular pharmacy licence processes from a particular GP. Capture rate can be influenced by such factors including degree of

co-location with the surgery, impact of electronic prescribing, size of the pharmacy unit, and the ability to deliver services under the pharmacy contract in addition to dispensing medicines.

Note that two comparables may look similar, however, the market rent figures could vary between the two because of physical and non-physical factors. A valuer operating in this asset class should possess a comprehensive understanding of and have suitable experience of co-located pharmacies.

In addition, valuers should be fully aware of the changing market in the world of co-located pharmacies. The change in the way GP surgeries operate, the impact of electronic prescribing over recent years, local taxation, NHS Drug Tariffs, pharmacy contract revisions and means of additional funding have altered the pharmacy landscape. Many GP surgeries offer telephone and online consulting which, depending on how the surgery operates, may have influenced the number of patients visiting surgeries and medical centres. These factors can impact the appeal of premises situated wholly within a medical centre environment, although factors such as location, competition and the social economic/age profile of the immediate population should also be considered. At the time of writing, the mode of operation of practices within health centres and the operation of pharmacies is still in flux. Despite the changing market in co-located pharmacies, co-location can offer benefits. The valuer should consider the revisions to the pharmacy contract and the means of additional funding that facilitate the widening of healthcare services that pharmacists are now able to offer. The valuer, therefore, **must** be aware of all such factors and of how they affect the subject property.

12.2 Guidance in Wales

Professionals wishing to provide pharmaceutical services must apply to the local health board who determines the application in accordance with criteria set out in *The National Health Service (Pharmaceutical Services) (Wales) Regulations 2020*.

12.3 Guidance in Scotland

Professionals wishing to provide pharmaceutical services must apply to the appropriate NHS board who determines the application in accordance with criteria set out in *The National Health Service (Pharmaceutical Services) (Scotland) Regulations 2009*.

12.4 Guidance in Northern Ireland

Professionals wishing to provide pharmaceutical services must be registered with the Pharmaceutical Society of Northern Ireland. Applications for new premises are made through the Pharmaceutical Society of Northern Ireland, who pass the application and plans to the Medicines Regulatory Group (in the Department of Health) for inspection and recommendation.

Appendix A: Floor plan examples showing NIA calculation

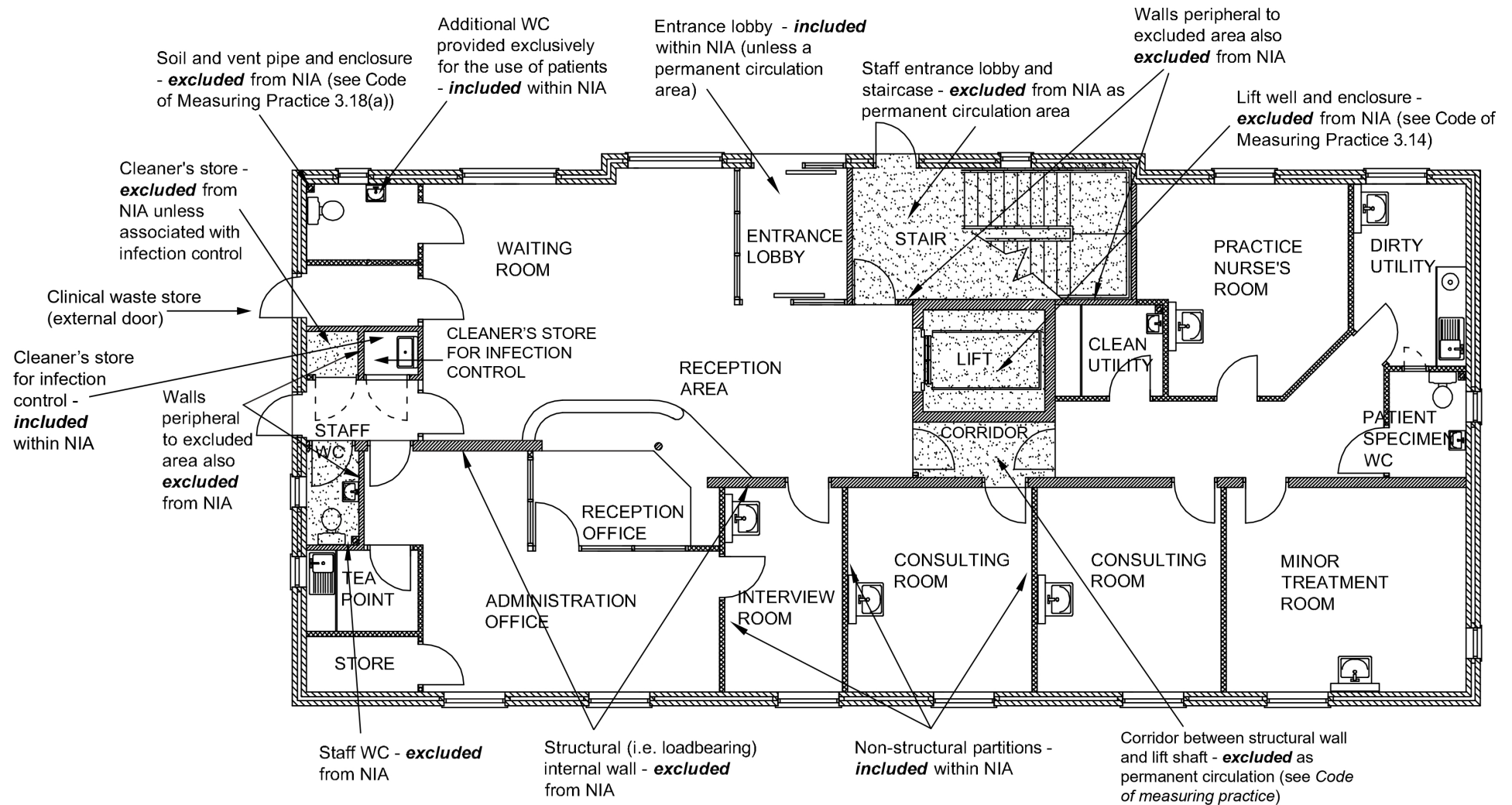


Figure 1: Ground floor plan of a purpose-built surgery

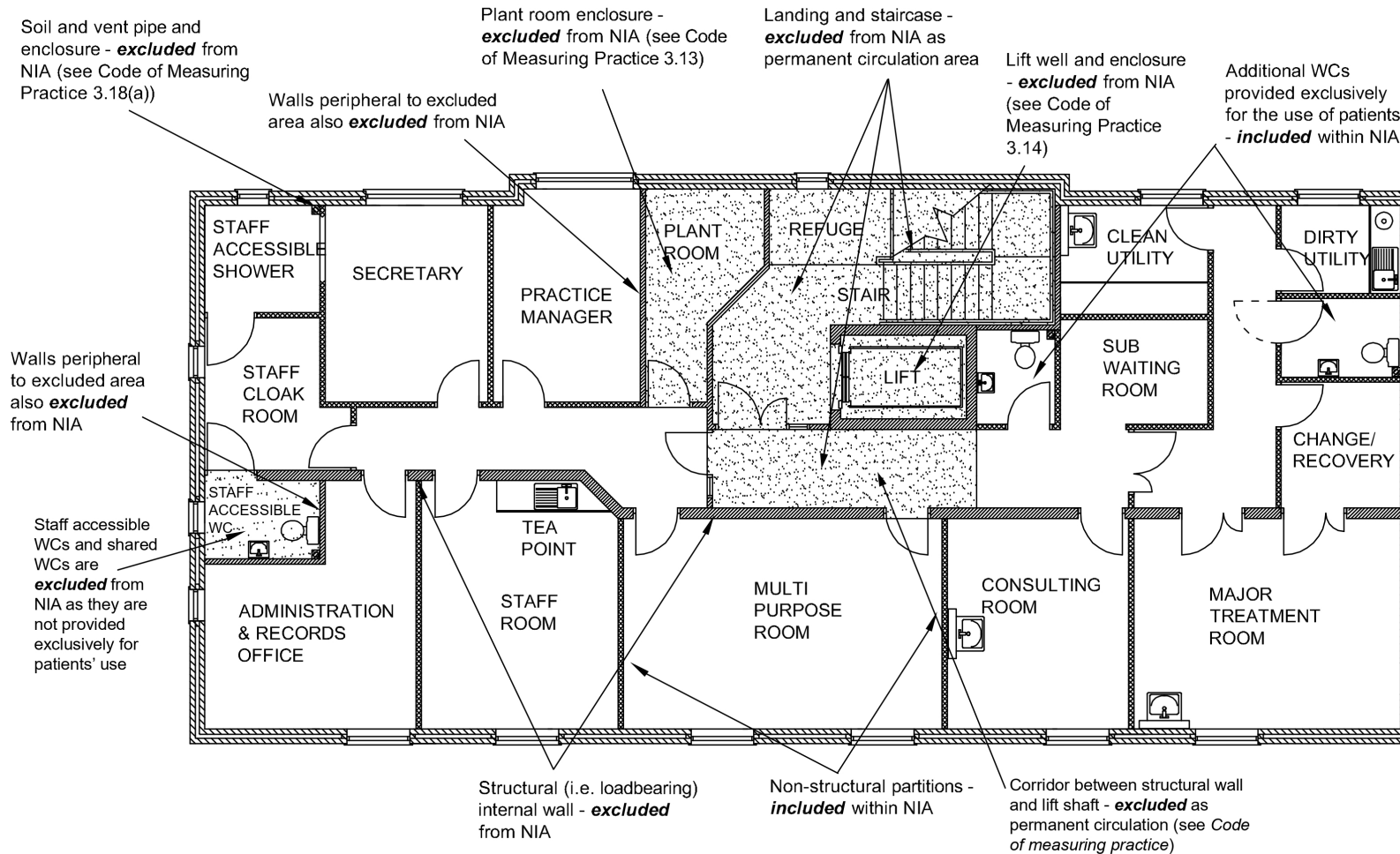


Figure 2: First floor plan of purpose-built surgery

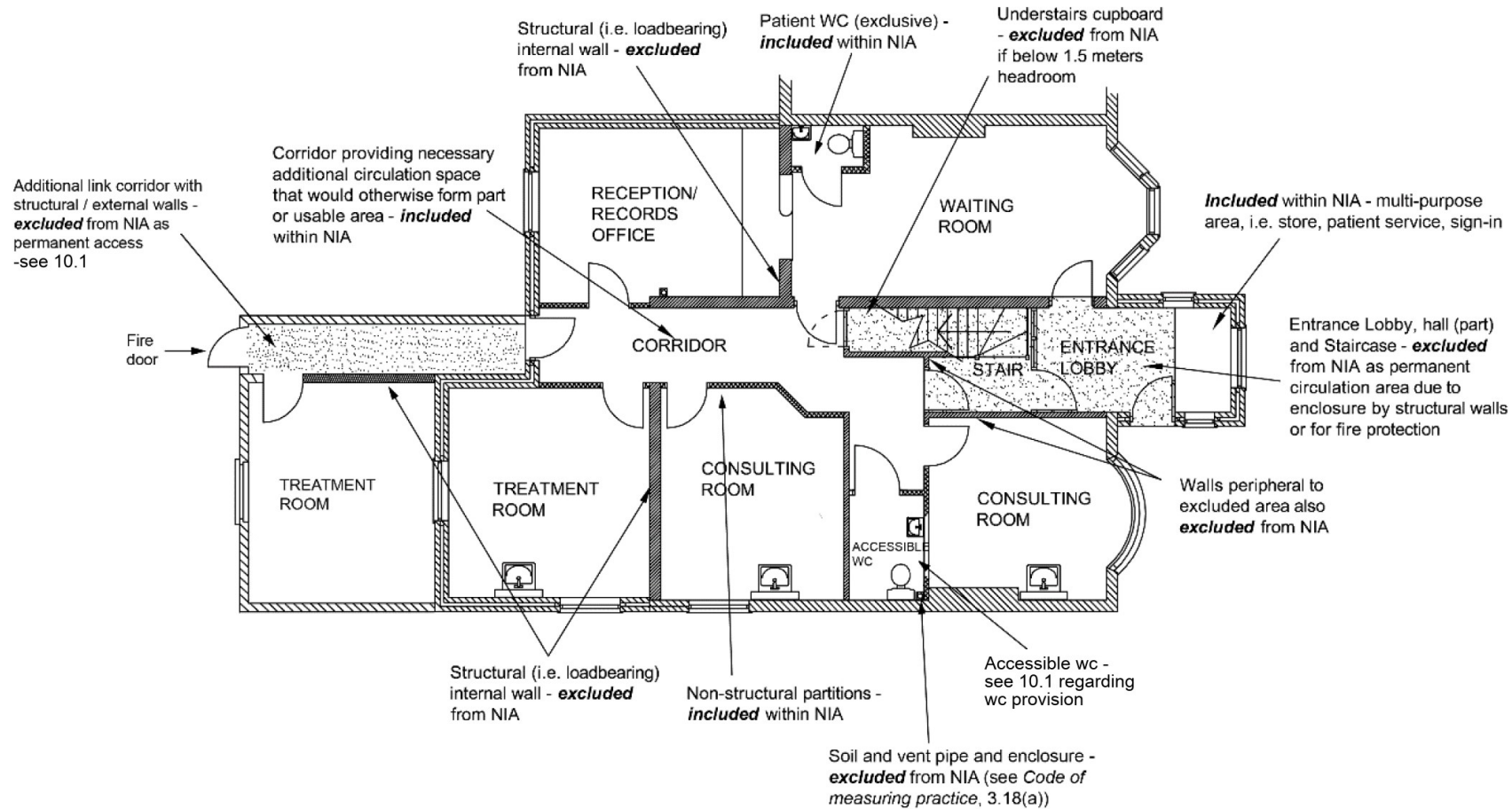


Figure 3.1: Ground floor plan of a two-storey surgery converted from a residential dwelling, with purpose-built additions

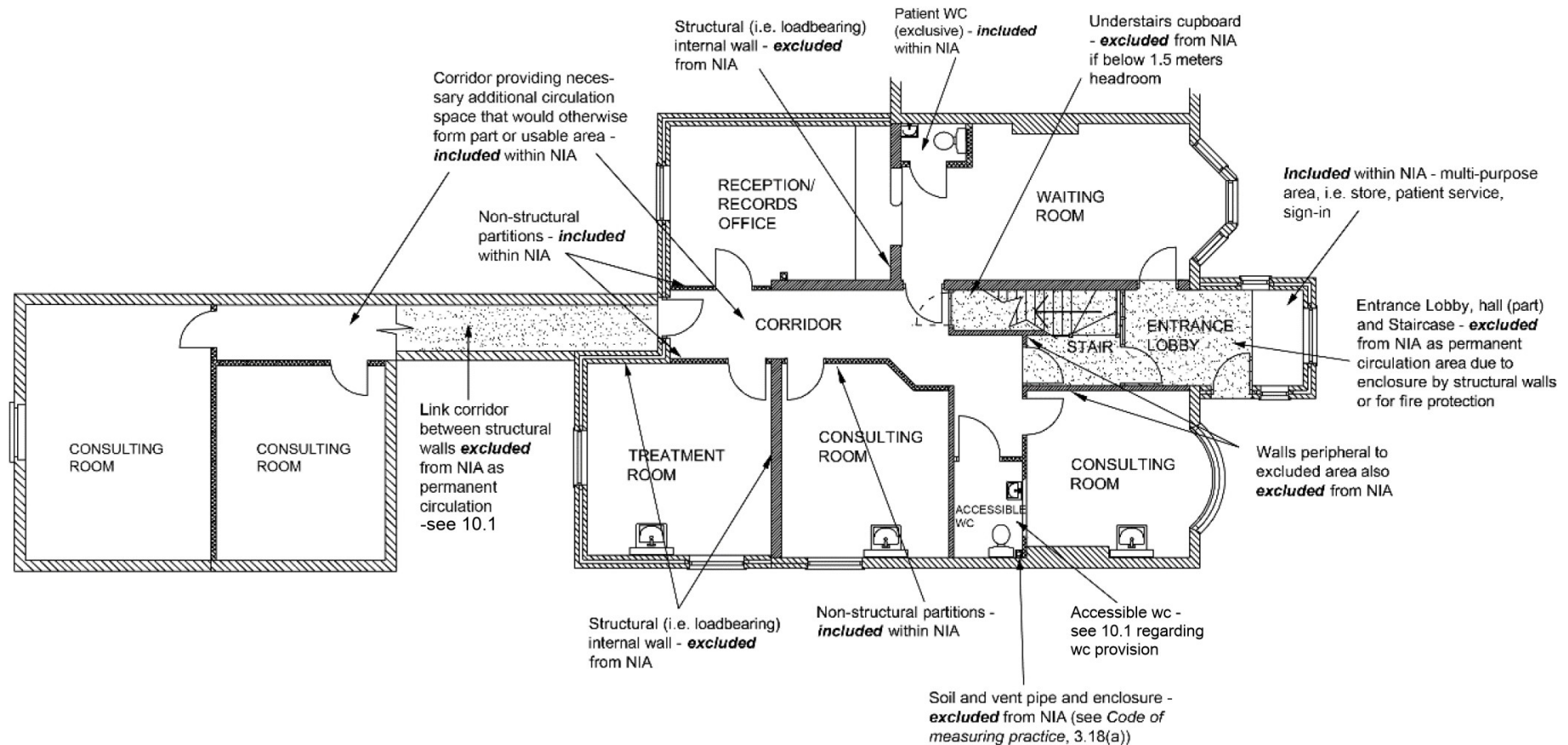


Figure 3.2: Ground floor plan of a two-storey surgery converted from a residential dwelling, with purpose-built additions

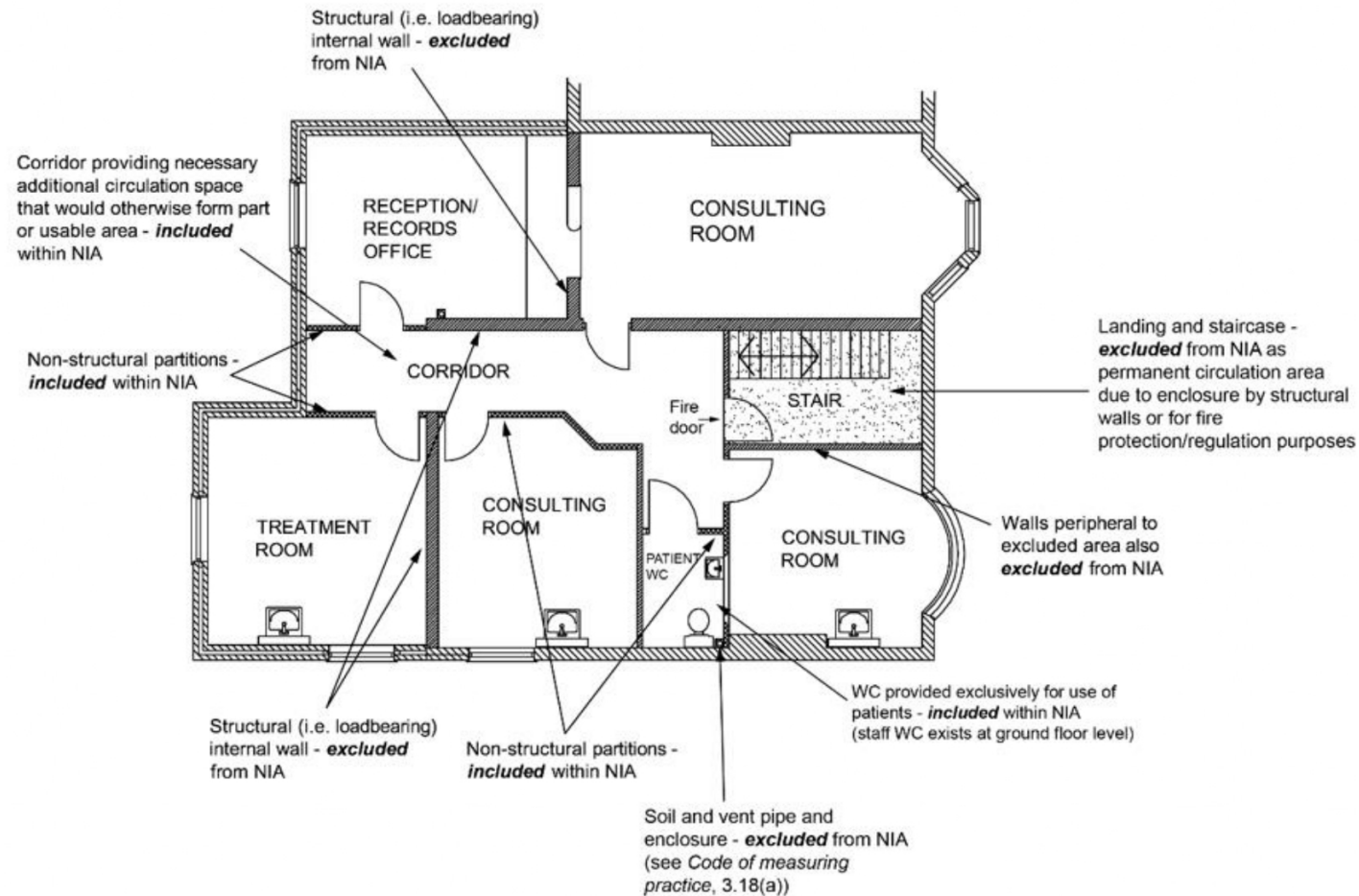


Figure 4: First floor plan of a two-storey surgery converted from a residential dwelling, with purpose-built additions

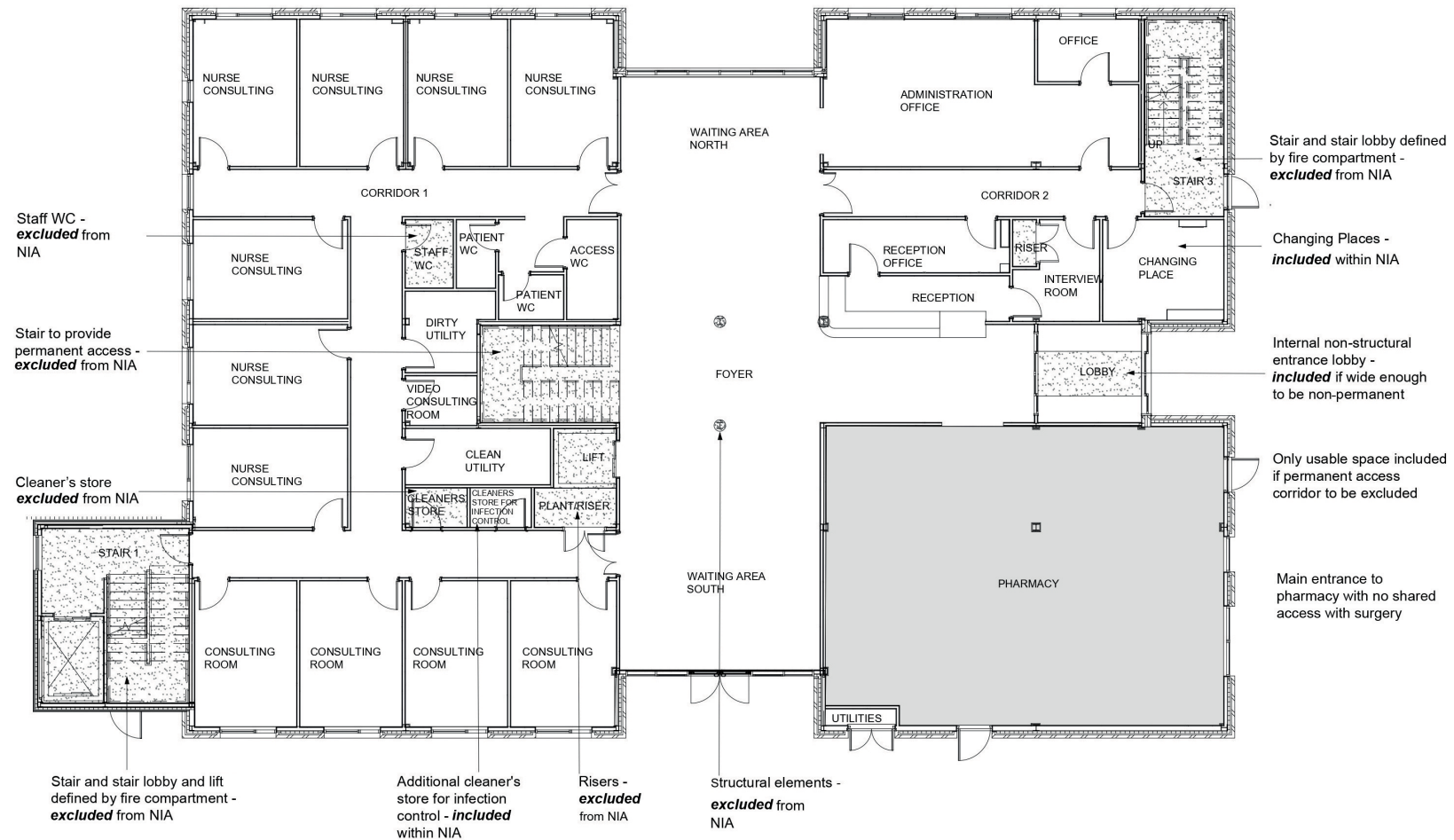


Figure 5: Ground floor purpose-built health hub

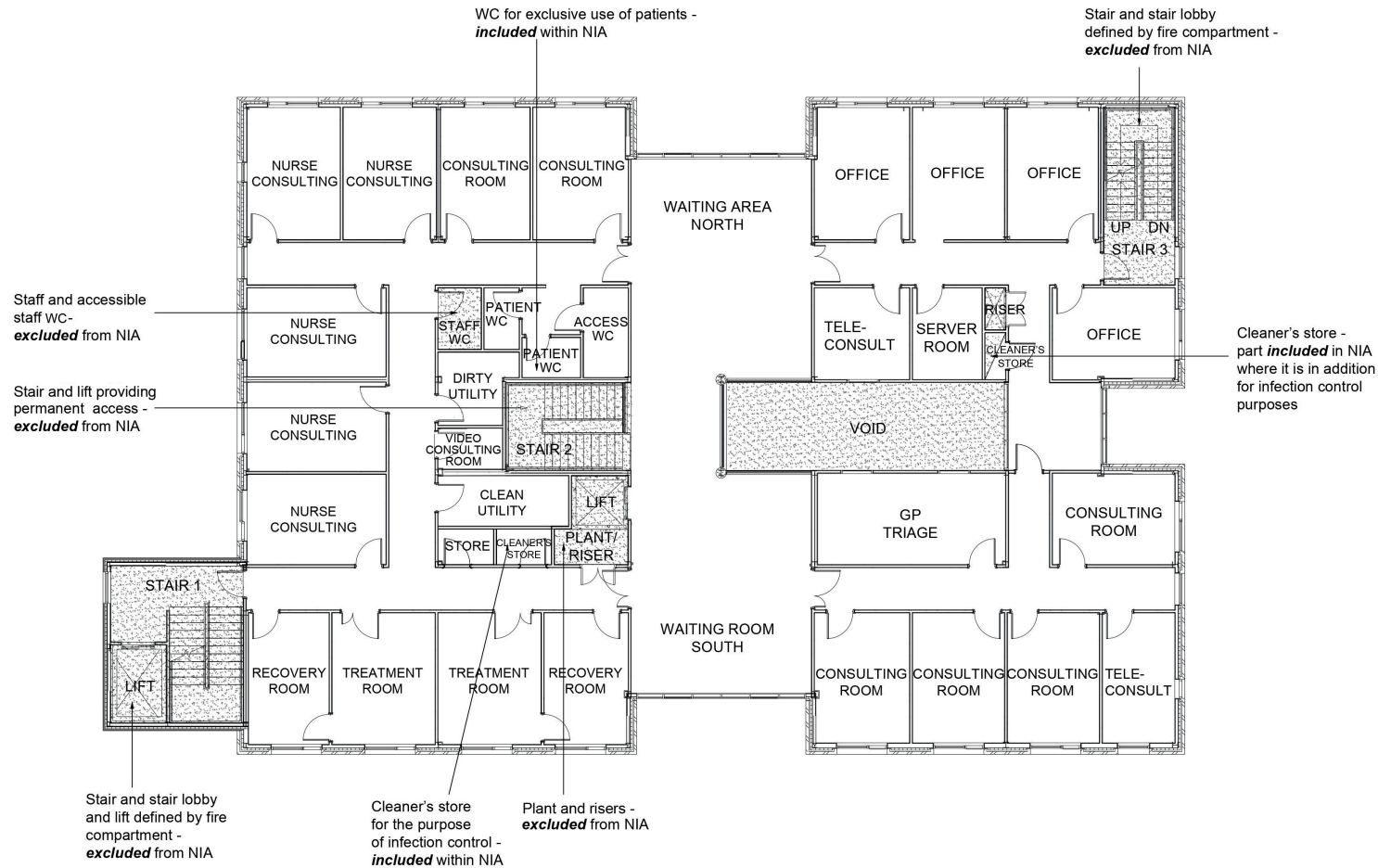


Figure 6: First floor purpose-built health hub

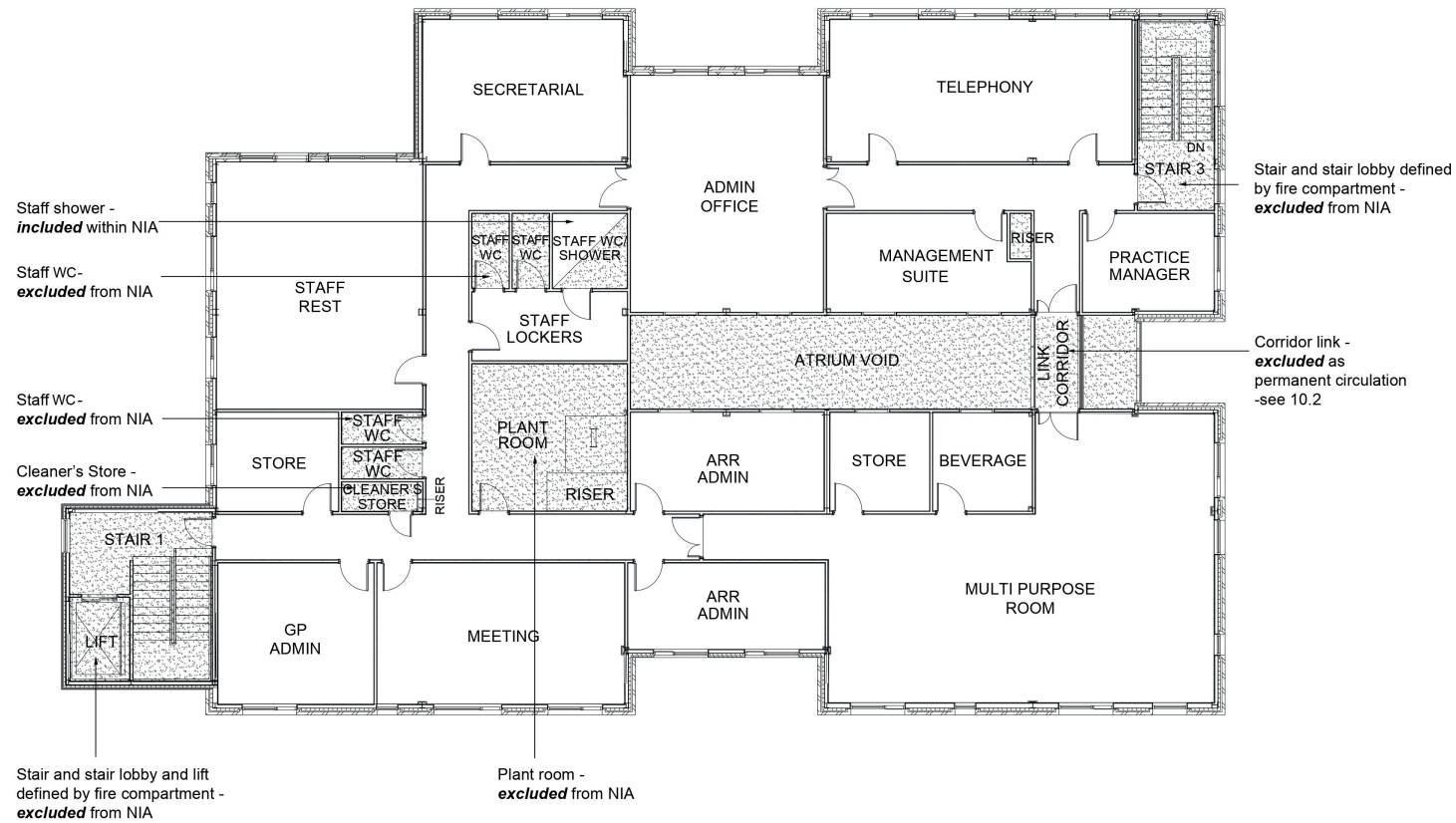


Figure 7: Second floor purpose-built health hub

Appendix B: Provision of general medical services in Wales

Introduction

In the UK, valuation principles relating to medical centres and surgery premises are the same no matter the jurisdiction in which they are being applied, but as the procedures and directions differ within the countries of the UK, Appendix B outlines some of the pertinent points that valuers should be fully acquainted with when valuing these properties in Wales.

B1 General medical services

Health services are provided by GPs as independent contractors. The GMS contract is a nationally agreed contract between the Welsh government, NHS Wales and the General Practitioners Committee (GPC Wales), with individual contracts agreed locally between NHS Wales (Health Boards) and GP practices.

The relevant legislation is *The National Health Service (General Medical Services Contracts) (Wales) Regulations 2023*.

B2 Non-GMS services

Health boards also provide community services such as health visiting, district nursing, midwifery, physiotherapy and wider therapies in community settings. Where possible these services are co-located in integrated primary care facilities specifically designed and developed for service delivery. There are significant benefits in moving appropriate services to community settings, from acute to the primary care setting.

B3 The Premises Cost Directions

Recurring GMS contractor premises costs are reimbursed by Health Boards in Wales. The relevant legislation is [The National Health Service \(General Medical Services – Premises Costs\) \(Wales\) Directions 2015](#). England, Scotland and Northern Ireland have their own versions of the Directions and, while the content is similar, there are differences that valuers should familiarise themselves with.

The purpose of the Welsh Directions is to ensure clarity and consistency of approach, parity of reimbursement, reasonable cost and value for money for the public purse.

GMS budgets are held and administered by individual Health Boards. New development and premises improvement are usually supported by Health Boards through Welsh government revenue funding allocation.

The Welsh Directions make provision for additional payments to GPs for new premises development or improvements and support for some related relocation costs, such as mortgage deficit support and legal/professional fees. All such payments are considered in line with Health Board budgetary targets.

Health Boards consider all applications for financial assistance in the context of their estate strategies, a prioritisation process and value for money assessment.

Examples of funding assistance include the following.

- Premises improvements grants of between 33% and 66% of the works and fees. Valuers should note that where such grants are used, the Health Board/Welsh government can claw back a proportion of the grant should the premises cease to be used for NHS purposes within a set period. This usually aligns to the period of any rental abatement.
- Reimbursement of rent, business rates and trade and clinical waste removal. Rental payments for reimbursement, whether notional leased or other, must be prior approved by the Health Board having taken advice from their professional advisers (NWSSP-SES).

Where an improvement grant has been provided towards the costs of building an extension or refurbishing the existing premises, the rent will be abated in accordance with Schedule 2 and 3 of the Welsh Directions.

Where a GP is to relocate from an existing premises to a new premises, various forms of support assistance can be provided, such as:

- mortgage deficit grant and mortgage redemption fees
- guaranteed minimum sale price
- support towards the cost of surrendering or assigning the lease of the existing premises
- paying Land Transaction Tax (LTT) on the lease of the new premises.

Minimum standards for practice premises are set out in Schedule 1 of the Welsh Directions. It is the contractor's responsibility to familiarise themselves with current relevant statutory requirements and ensure compliance. Health Boards can issue remedial notices for breach under Direction 48.

The National Health Service (General Medical Services Contracts) (Wales) Regulations 2023 came into force on 1 October 2023, replacing *The National Health Service (General Medical Services Contracts) (Wales) Regulations 2004*. These attend to the matter of dispute resolution where GPs have a disagreement on any point of their contract. The regulations encourage local mediation and require that the Health Boards make every reasonable effort to settle any matters, including disputes over the level of rent at a local level. If local resolution fails then GP contractors can, under the NHS dispute resolution procedure, apply for third-party

determination. In relation to disputes on rent, any third-party determination becomes the reimbursed rent under Direction 32(2).

B4 New premises procurement

The NHS framework supports different procurement routes, including GP-led schemes for owner occupation (known as DIY schemes), third-party development (3PD) and NHS capital schemes. All proposals must align with each Health Board's strategic plan and be progressed to approval.

DIY schemes: GPs can raise capital for the purchase of land, payment of consultant's fees and construction costs for a new primary care building. GPs are eligible for notional rent reimbursement, or a reimbursement based on a percentage of the borrowing costs subject to prior approval of the Health Board and value for money approval.

3PD schemes: specialist commercial development/investment companies can be procured to work at risk to deliver a new primary care scheme in collaboration with all stakeholders, including the occupiers and the Health Board. Once funding is approved, the occupiers will enter into an agreement for a lease on standard Welsh exemplar lease terms. The rent and CMR are reviewed prior by the District Valuer in order to confirm 'value for money' has been achieved.

NHS capital: The Welsh government supports the development of strategic projects via the All-Wales capital funding programme and the health and social care integration and rebalancing capital fund for integrated opportunities. Most capital cases are progressed on the five-case business model.

B5 Premises

Services should be delivered from fully compliant primary care premises of appropriate design and layout that allows access for all.

The [NWSSP-SES website](#) provides guidance and technical memorandum for Wales. This applies to new and existing practice premises considering improvement.

NWSSP-SES has a team of primary care property surveyors and estate advisers who provide advice and support to Health Boards on the development and improvement of all primary care premises.

Acting on behalf of the Health Boards, NWSSP-SES undertakes all notional and leased rent assessments and rent reviews on primary care premises for reimbursement purposes. The District Valuer provides advice for new premises development and the value for money report, which accompanies a funding bid.

In accordance with Welsh Language Standards that apply to public bodies, some documents are available in Welsh.

Appendix C: Provision of general medical services in Scotland

Introduction

In the UK, valuation principles relating to medical centres and surgery premises are the same no matter the jurisdiction in which they are being applied, but as the procedures and directions differ within the countries of the UK, Appendix C outlines some of the pertinent points that valuers should be fully acquainted with when valuing these properties in Scotland.

C1 General medical services

In common with England and Wales, family health services are in the main provided by GPs through GMS contracts. [The 2018 General Medical Services Contract in Scotland](#) was developed by the Scottish General Practitioners Committee (SGPC) and the Scottish government to improve general practice and to restore its core values. It aims to create a dynamic and positive career for doctors and ensure that patients continue to have accessible, high quality general medical services.

Health and social care partnerships (HSCP) are used as delivery agents of Integration Authorities, responsible for the planning and commissioning of primary care services.

Sustainability loans support general practice and will allow partners to release capital without destabilising their practice, reduce the upfront cost of becoming a GP partner and make general practice more financially rewarding. The loans encourage GPs to become partners in practices that own their premises. [The National Code of Practice for GP Premises](#) provides examples of how sustainability loans work.

The Code also covers the treatment of:

- GP-owned premises
- premises leased from private landlords and
- Health Board's powers to relocate GP contractors.

GP contractors who provide their own accommodation are eligible to receive rent reimbursements under the Scottish Directions. Before a GP contractor agrees to a new lease with a private landlord, it should consult its Health Board on the terms of the proposed lease.

C2 Premises Costs Directions

GMS contractor premises costs are reimbursed by Health Boards in Scotland in accordance with directions set out in the [Primary Medical Services \(Premises Development Grants, Improvement Grants and Premises Costs\) Directions 2004](#). These Directions are due to be updated, and the latest version will apply.

The bulk of the content of the Scottish Directions and the underlying principles mirror that of the English equivalent.

In broad terms, [The National Code of Practice for GP Premises](#) sets the strategy and principles for the future of GP premises in Scotland. [The 2018 General Medical Services Contract in Scotland](#) sets out the joint statement of policy that underpins a distinctively Scottish general medical services contract.

C3 New premises procurement

The 'hub Programme' is an initiative of the Scottish Futures Trust (SFT), a government-owned company with the objective of improving public infrastructure investment and procurement. Other methods of new premises procurement include GP DIY schemes and third-party development schemes.

Details can be found on the [SFT hub website](#) and at [Infrastructure Investment Plan 2021–22 to 2025–26](#). Scottish hub has some similarities to LIFT and PFI.

The Scotland-wide hub Programme is based on a partnership between the public and private sectors to deliver new community facilities, and runs throughout Scotland

To deliver community facilities, public bodies (such as NHS Boards, local authorities and blue light services) in each of those areas have teamed up with a private sector development partner to form a joint venture company known as a hub Company (hubCo).

The public and private sectors jointly own the hubCos, which oversee collaboration with their public sector clients to identify their needs before hiring contractors, cost managers, engineers and designers to provide the necessary infrastructure.

As the Programme manager, the SFT hub team oversees the Programme and provides oversight, direction, assurance and guidance.

The Programme is structured to deliver both revenue and capital funded projects. To date, a significant amount of revenue from health and care facilities has been delivered by the Programme. These range from GP surgeries through to health and care centres, procured on behalf of health and social care partnerships. Being revenue funded, a special purpose vehicle (DBFMCo) is responsible for the hard facilities management and life cycle maintenance of the facilities, these costs being included in the unitary charge, which is established at the outset of the project.

C4 Premises

Full details of the requirements are contained in *Primary Medical Services (Premises Development Grants, Improvement Grants and Premises Costs) Directions 2004*. As previously noted, these are due to be updated, and the latest version will apply.

In general terms:

- All GP contractors must ensure their premises are suitable for the delivery of the services they provide and that they are sufficient to meet the reasonable needs of their patients.
- Any GP contractor who receives payments for recurring premises costs under the Scottish Directions must comply with the minimum standards set out in Schedule 1 of the Scottish Directions. Those standards include a requirement for GP contractors to maintain the premises, fittings and furniture in good repair.

Therefore, all GP contractors who receive assistance with rental costs, notional rent or borrowing cost payments have agreed to maintain their premises in good repair as a condition of that assistance.

Appendix D: Provision of general medical services in Northern Ireland

Introduction

In the UK, valuation principals relating to medical centres and surgery premises are the same no matter the jurisdiction in which they are being applied, but as the procedures and directions differ within the countries of the UK, Appendix D outlines some of the pertinent points that valuers should be fully acquainted with when valuing these properties in Northern Ireland.

D1 General medical services

The provision of family health services in Northern Ireland generally follows the same process as in England, Wales and Scotland, being provided in the main by independent GPs through GMS contracts. The core terms of the contract are set out in [The Health and Personal Social Services \(General Medical Services Contracts\) Regulations \(Northern Ireland\) 2004](#). Individual contracts are agreed between GPs and the Strategic Planning and Performance Group of the Department of Health (SPPG), formerly regional Health and Social Care Boards.

Other healthcare professionals such as district nurses, health visitors and social workers are employed by regional Health and Social Care Trusts. These services are often provided alongside GP care, in existing primary care centres and allow for sharing of some facilities. The occupation of the Trusts in GP-owned premises is usually subject to a lease agreement, whereby the relevant Trust pays the contractor market rent for their demise.

D2 The Premises Cost Directions

The Strategic Planning and Performance Group of the Department of Health (SPPG) in Northern Ireland, may provide funding to GMS contractors for premises improvements in accordance with *The Health and Personal Social Services (General Medical Services – Premises Costs Directions) (NI) 2015* (the NI Directions). The NI Directions provide for payments to be made by SPPG to GPs for funding for improvements or recurring premises costs to provide general medical services. The NI Directions generally mirror the content of England's *The National Health Service (General Medical Services – Premises Costs) Directions 2013*, referred to in the main body of this professional standard.

The NI Directions came into effect in Northern Ireland in April 2015, although the previous (2004) Directions continue to apply where the GMS contractor was in receipt of reimbursement prior to 16 April 2015.

Key differences between the 2004 and 2015 NI Directions include:

- an assumption restricting the use of premises to 'practice purposes only' when assessing a notional rent
- a disregard of improvements relating to improvements that reduce the environmental impact of buildings, when assessing current market rent
- amendments to the provision for abatement of notional rent reimbursements
- the removal of the direction whereby GPs could have previously had their reimbursement abated if more than 10% of income was from 'associated private work'.

The local dispute resolution procedure in Northern Ireland is contained in *The Health and Personal Social Services (General Medical Services Contracts) Regulations (Northern Ireland) 2004*. These regulations state that before referral for determination, 'the contractor and the Board (now SPPG) must make every reasonable effort to communicate and cooperate with each other with a view to resolving the dispute, before referring the dispute for determination in accordance with the dispute resolution procedure (or, where applicable, before commencing court proceedings)'.

If agreement on a valuation issue is not possible, it is open to either SPPG or the GMS contractor to refer the matter for adjudication by the Department of Health. The request must be sent within a period of three years beginning with and including the date on which the matter giving rise to the dispute happened or should reasonably have come to the attention of the party wishing to refer the dispute.

To adjudicate on a determination of value based on all the information available, the Department may request that RICS select and appoint an expert adviser to provide professional advice and a recommendation.

D3 New premises procurement

Several options are available to GPs for the procurement of new premises, including the following.

- GPs enter into a lease with the relevant Health Trust to occupy space in a publicly procured new building, which may accommodate GPs and other Trust services (i.e. hub developments).
- The acquisition of a lease on a property by GPs subject to agreed terms and rent with a third-party landlord. Lease terms and rent are subject to prior assessment by SPPG on value for money and reasonableness.
- Third-party development is a growing sector in Northern Ireland, with an investor financing development of the premises subject to a future return by way of a lease

agreement with the prospective GP tenant. It is common practice for developers, GPs and SPPG to seek agreement on the estimated current market rent prior to commencing new development to minimise risk. This may run in parallel with the developer landlord's lease negotiations with the prospective tenant GP.

- Owner-occupation (by way of GP-led development). In this scenario, the GP contractor would acquire funding for the purchase of land, construction of a surgery, and associated costs and apply to SPPG for reimbursement via the Contractor Borrowing Scheme.

D4 Premises

The design of GP premises in Northern Ireland is principally reliant on UK guidance, such as Health Building Note 11-01: *Facilities for primary and community care* and Welsh Health Planning Note 36: *General Medical Practice Premises in Wales*, Revision 1, 2017. These are read in conjunction with the Northern Ireland Department of Health recommended schedules of accommodation for GP surgeries, and are primarily aimed at new build projects, but are also recommended for use on refurbishment and extension of existing premises (insofar as can be reasonably adopted within existing building constraints).

In addition, Schedule 1 of the NI Directions sets out minimum standards that must be met to receive recurring premises costs (i.e. rent and rates). For example, in relation to access and usability, the GP must meet obligations under the *Health and Safety at Work (Northern Ireland) Order 1978* and the *Disability Discrimination Act 1995*. Further requirements include ensuring good repair of fittings and furniture, arrangements for decontamination, storage and disposal and fire precautions, among others.

GMS contractors can access funding support through the SPPG's primary care infrastructure development programme, which aims to improve access to suitable accommodation for GP services to meet current and future needs.

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