THE NATIONAL HEALTH SERVICE (SCOTLAND) ACT 1978

THE PRIMARY MEDICAL SERVICES – (PREMISES DEVELOPMENT GRANTS, IMPROVEMENT GRANTS AND PREMISES COSTS) DIRECTIONS 2004

ARRANGEMENT OF DIRECTIONS

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SCHEDULES

Scottish Ministers, in exercise of the powers conferred by section 17E(3A), 17M and 105(7) of the National Health Service (Scotland)Act 1978(**a**), and of all other powers enabling them in that behalf, hereby give the following Directions.

PART 1

GENERAL

Citation, commencement and territorial application

(**a**) 1978 c.29; section 19 was amended by the Health Services Act 1980 (c.53) ("the 1980 Act"), section 7, by the Health and Social Services and Social Security Adjudications Act 1983 (c.41) ("the 1983 Act"), Schedule 7, paragraph 2, by the medical Act 1983 (c.54), Schedule 5, paragraph 17(a), by the National Health Service and Community Care Act 1990 (c.19), section 37, by the Medical (Professional Performance) Act 1995 (c.51), Schedule, paragraph 29(a), and by the National Health Service (Primary Care) Act 1997 (c.46), Schedule 2, Part I, paragraph 39 and Schedule 3, Part I, and is to be read with the Health and Medicines Act 1988 (c.49), section 17; section 105(7) which contains provisions relevant to the making of Regulations, was amended by the 1980 Act, Schedule 6, paragraph 5 and Schedule 7, by the 1983 Act, Schedule 9, Part I, paragraph 24 and by the Health Act 1999 (c.8), Schedule 4. paragraph 60; section 108(1) contains a definition of "regulations" relevant to the exercise of the statutory powers under which these Regulations are made. The functions of the Secretary of State were transferred to the Scottish Ministers by virtue of section 53 of the Scotland Act 1998 (c.46).

1. These Directions may be cited as the Primary Medical Services (Premises Development Grants, Improvement Grants and Premises Costs) Directions 2004 and shall come into force on 1st April 2004.

Interpretation

2. In these Directions–

"the 1978 Act" means the National Health Service (Scotland)Act 1978;

"contractor", unless the context otherwise requires, means a person entering into, or who has entered into, a GMS contract or s.17C arrangements with a Health Board;

"default contract" means a contract under section 7 (1) of the Primary Medical Services (Scotland) Act 2004(**b**);

"family member" means–

(a) spouses;

(b) lineal ancestors (which includes step-parents, adoptive parents and their ancestors) and lineal descendants (which includes step-children, adopted children and their descendants);

(c) brothers, sisters, aunts, uncles, nephews, nieces and first cousins (which includes their step or adoptive equivalents); and

(d) the spouse of any family member falling within sub-paragraph (b) or (c));

"GMS contract" means a general medical services contract under section 17J of the 1978 Act(**c**);

"Area Medical Committee" means a committee recognised under section 9 of the 1978 Act;

"Health Board" , in relation to a contractor, means the Health Board with which the contractor has entered into or is entering into a GMS contract or section 17C arrangements;

"Health Centre" means premises provided (either by Scottish Ministers or Health Boards) under section 36 of the 1978 Act;

"practice premises" means premises specified in a GMS contract as premises at which services are to be provided under the contract or under section 17C arrangements;

"spouse" includes husbands, wives, unmarried partners, partners of the same sex and former spouses;

"Statement of Fees and Allowances" means the statement determined and published by the Secretary of State under regulation 35 of the National Health Service (General Medical Services) Regulations (Scotland) 1995, as that statement had effect on 31st March 2004; and

(**b**) 2001 (asp 1).
(**c**) 1978 (c.29).

Payments in relation to which these Directions apply

3. These Directions are given to Health Boards and apply in relation to the payments made to contractors–

(a) in respect of premises developments or improvements;

(b) in respect of professional fees, and related costs, incurred in occupying new or significantly refurbished premises;

(c) relating to the relocation of the contractor; or

(d) in respect of recurring premises costs.

Payments in relation to which these Directions do not apply

4. However, the Directions indicated below do not apply in relation to payments made to contractors under a GMS contract or section 17C agreement–

(a) all Directions - in respect of a plan drawn up in accordance with regulation 18(3) of the National Health Service (General Medical Services Contracts(Scotland)) Regulations 2004**(d)** or regulation 18(3) of the National Health Service (Primary Medical Services Section 17C Agreements) (Scotland) Regulations 2004 ; or

(b) Directions 6-61- where payments in accordance with Direction 5 – Existing premises development and improvement commitments - are being made.

Existing premises development and improvement commitments

5. (a). Where Health Boards have already committed themselves, prior to 1st April 2004, to provide financial assistance in the financial year 2004 to 2005–

(i) towards the building of new premises to be used for providing medical services;

(ii) towards the purchase of premises to be used for providing medical services;

(iii) towards the development of premises which are used or are to be used for providing medical services; or

(iv) in the form of premises improvement grants,

in accordance with the arrangements for funding capital investment in premises set out in the Statement of Fees and Allowances, then subject to the provisions of this Direction, those commitments are to be met.

(d) SSI 2004 No 115 .

(b) As regards any such capital investment project, a Health Board must pay to a contractor under its GMS contract or section 17C arrangement any amount that the Health Board agreed before 1st April 2004 to pay to the contractor (or to the practice for which the contractor is now responsible) during the financial year 2004 to 2005, subject to the following conditions–

(i) the contractor must comply with any conditions to which the agreement to make the payment was subject. For these purposes, it shall be deemed that the specifications for the project which are set out in the project proposal, and any standards to be met during construction or development work which are set out in the project proposal, are all conditions of the agreement to make the payment; and

(ii) the project must not change significantly (in the Health Board's view) from the version of the project in respect of which the Health Board agreed to make the payments.

(c) If any of these conditions are breached, the Health Board may in appropriate circumstances withhold payment of any or any part of any payment that is otherwise payable under Direction 5.(b). If the breach arises because the project has changed significantly, and additional costs will be incurred as a consequence, any claim for PCT funding in respect of those additional costs is to be determined in accordance with the arrangements set out elsewhere in these Directions.

(d) If it was agreed before 1st April 2004 that the amount of payments payable in respect of the project plan would be reviewed in the financial year 2004 to 2005, the payments payable under this Section are subject to the outcome of that review and any revised amount agreed in accordance with that review becomes the amount payable under this Section. If a dispute as to the amounts payable arises as a result of that review, resolution of that dispute shall be resolved in accordance with–

(i) any dispute resolution procedure (for resolution of disputes between the Health Board and the contractor) agreed in respect of the project plan; or

(ii) if no such procedure was agreed, the NHS dispute resolution procedures – or by the courts (see Part 7 of Schedule 5 to the National Health Service (General Medical Services Contracts) (Scotland) Regulations 2004).

General duties of Health Boards under these Directions

6. Where pursuant to or as a consequence of these Directions a Health Board may or must make a payment to a contractor in specified circumstances–

(a) the Health Board must only make the payment to a contractor in the specified circumstances; and

(b) if the payment is to be made, the Health Board must vary the contractor's GMS contract so that the payment is made under the GMS contract and is subject to any specified conditions relating to that payment which are set out in these Directions.

Financial assistance in circumstances not contemplated in these Directions

7. However, these Directions do not prevent Health Boards from providing such financial assistance as they think fit in order to pay, or contribute towards, the premises costs of a contractor in circumstances that are not contemplated by the payment arrangements set out in these Directions, such as where–

(a) the contractor is providing services under a temporary GMS contract;

(b) an emergency need for financial assistance in respect of premises costs arises in circumstances that could not reasonably have been foreseen; or

(c) the contractor needs temporary accommodation (whether in the form of portable premises or an existing building) while new practice premises are being built or existing practice premises refurbished.

PART 2

PREMISES DEVELOPMENT AND IMPROVEMENT

Premises development proposals

8. Where a contractor has a proposal for–

(a) the building of new premises to be used for providing primary medical services;

(b) the purchase of premises to be used for providing primary medical services;

(c) the development of premises which are used or are to be used for providing primary medical services (or for significant changes to existing development proposals); or

(d) premises improvements, which are to be the subject of a premises improvement grant application,

and it puts that proposal to its Health Board as part of an application for financial assistance in respect of the proposal, the Health Board must consider that application.

Health Boards must have in place a plan for the development of premises to support the provision of Primary Medical Services. This plan must be approved in consultation with the local Area Medical Committee. This plan should be updated annually and be consistent with the Health Board's wider Property Strategy.

Projects that may be funded with premises improvement grants

9. The types of premises improvement projects that may be the subject of a premises improvement grant include–

(a) improvements to practice premises in the form of building an extension to the premises, bringing into use rooms not previously used to support delivery of primary medical services or the enlargement of existing rooms;

(b) improving physical access to and within practice premises, and alterations or additions for Disability Discrimination Act 1995 compliance;

(c) improving lighting, ventilation and heating installations (including replacement of other forms of heating by central heating) of practice premises;

(d) the reasonable extension to telephone facilities within practice premises (but not the initial purchase or replacement of telephone systems);

(e) the provision of car parking;

(f) the provision of suitable accommodation at the practice premises to meet the needs of children and elderly or infirm people;

(g) fabric improvements to practice premises such as double glazing, security systems and work required for fire precautions and other statutory building requirements; and

(h) refurbishment of a building not previously used for the provision of primary medical services but which are to be used as practice premises on a temporary basis.

Projects that may not be funded with premises improvement grants

10. Health Boards must not, however, agree to fund the following expenditure with a premises improvement grant–

(a) any project where a contract has been entered into, or work commenced, that has not been subject to prior agreement with the Health Board;

(b) any cost elements in respect of which a tax allowance is being claimed;

(c) the cost of acquiring land, existing buildings or new buildings;

(d) the repair or maintenance of premises, furniture, furnishings, floor covering and equipment;

(e) restoration work in respect of structural damage or deterioration;

(f) any work in connection with the domestic quarters or the residential accommodation of practitioners, caretakers or practice staff, whether or not it is a direct consequence of work on surgery accommodation; and

(g) any extension not attached to the main building by at least a covered passage way.

Initial consideration of premises development or improvement proposals

11. Before determining whether a proposal from a contractor for premises development or improvement of a type mentioned in direction 7 should be included in the Health Boards property strategy for investment prioritisation, the Health Board must–

(a) consult the Area Medical Committee for its area about the proposal;

(b) satisfy itself that the proposal is required to support, and will support, the delivery of the services that the contractor has agreed to provide under its GMS contract or section 17C agreement;

(c) satisfy itself, where appropriate in consultation with the District Valuer, that the proposal represents value for money;

(d) if the premises are held on a lease –

(i) satisfy itself that the contractor has adequate security of tenure (i.e. the premises should be either a health centre owned by a Health Board or held on a lease the unexpired portion of which is at least as long as the period of guaranteed use (see direction 13(b)(iii) and (iv) below)), and

(ii) satisfy itself that a contractor intends to occupy the premises for at least as long as the period of guaranteed use (see direction 13(b)(iii) and (iv) below); and

(e) have regard to the standards provided from time to time published by the Scottish Executive Health Department and NHS Scotland Property and Environment Forum If a contractor is proposing to depart from extant standards (for example, because the physical nature of the building or site does not allow for full compliance with the standards), the Health Board must satisfy itself that–

(i) the departure from the standards is reasonable in the circumstances, and

(ii) the premises will nevertheless comply with the minimum standards set out in Schedule 1.

Documentation required in respect of premises developments or improvements

12. The Health Board must refuse an application for financial assistance in respect of a premises development or improvement proposal from a contractor unless–

(a) if the nature of the work is such that, in the opinion of the Health Board, it requires architect's plans for the development or improvement to be drawn up, the contractor supplies the Health Board with such plans;

(b) if the nature of the work requires building work, the contractor–

(i) carries out a tendering process for a building contractor to undertake the work, resulting in at least three written quotes, and

(ii) agrees with the Health Board which of those written quotes represents best value for money;

(c) the contractor supplies to the Health Board copies of any necessary planning and building regulations consents; and

(d) if the premises development or improvement is to premises that are held on a lease, the contractor supplies the Health Board with a copy of the written consent to the development or improvement of the landlord.

Priority funding projects and conditions attached to payments

13. If the Health Board determines that a proposal from a contractor for premises development or improvement of a type mentioned in direction 8 is to be included in the Health Boards property strategy for investment prioritisation, and is to be one of its priority funding projects, the Health Board must seek to finalise a project plan with the contractor. If the financial assistance is by way of a premises improvement grant, the Health Board must not commit itself to covering less than 33% or more than 66% of the total cost of the premises improvement. The Health Board must only agree to a finalised project plan with the contractor if it includes–

(a) a payment schedule setting out the financial assistance to which the Health Board has committed itself in respect of the project (the Health Board must also ensure that this payment schedule is included in any payment schedule in the contractor's GMS contract or section 17C agreement); and

(b) the following conditions–

(i) a condition which has the effect of making payments to the contractor under that payment schedule subject to a requirement that the contractor adheres both to the specifications for the project which are set out in the finalised project plan and to any standards to be met during the development or improvement work which are set out in the finalised project plan,

(ii) a condition which has the effect of making payments to the contractor under that payment schedule subject to a requirement that the contractor, when carrying out the development or improvement work, does not depart significantly, in the Health Boards view, from the version of the project in the finalised project plan (which may be varied with the consent of both parties),

(iii) if the development or improvement work is in respect of premises held on a lease by the contractor, a condition (unless such a condition is unreasonable in the circumstances) that has the effect

of making the payments to the contractor under that payment schedule subject to a requirement that the contractor guarantees that the premises will, once the development or improvement work has been completed, remain in use for the delivery of NHS services–

(aa) for projects costing up to £100,000 plus Value Added Tax, for at least 5 years, and

(bb) for projects costing over £100,000 plus Value Added Tax, for at least 10 years, and

(iv) if the development or improvement work is in respect of premises held on a lease by the contractor, a condition (unless such a condition is unreasonable in the circumstances) that has the effect of committing the contractor to repaying a proportion of the grant should the premises cease to be used to provide NHS services before that 5 year or, as the case may be, 10 year period of guaranteed use has expired. The repayable amount is to be calculated by multiplying the amount the Health Board has paid by the fraction produced by dividing the amount of time (expressed in whole and part years) left before the 5 or 10 year period of guaranteed use has expired by 5 years or, as the case may be, 10 years.

PART 3

PROFESSIONAL FEES, AND RELATED COSTS, INCURRED IN OCCUPYING NEW OR SIGNIFICANTLY REFURBISHED PREMISES

Reimbursement of legal and other professional costs incurred in occupying new or significantly refurbished premises

14. Where–

(a) the Health Board determines that a proposal from a contractor for premises development or improvement of a type mentioned in direction 8 is to be included in the Health Board's property strategy, and is to be one of its priority funding projects, and the Health Board has agreed a project plan with the contractor;

(b) a contractor intends to procure or has procured newly built practice premises or intends to refurbish or has refurbished existing practice premises;

(c) actual or notional rent payments are to be paid to the contractor in respect of those premises by the Health Board pursuant to these Directions on completion of the building or refurbishment work; and

(d) the contractor makes an application to its Health Board for reimbursement in respect of the professional expenses referred to in direction 15,

the Health Board must consider that application for financial assistance and, in appropriate cases (having regard, amongst other matters, to the budgetary targets it has set for itself), grant that application.

Types of professional expenses that may be reimbursed

15. In the case where–

(a) notional rent payments are to be paid in respect of newly built or refurbished practice premises, the reimbursable professional expenses are–

(i) reasonable surveyors' and architects' fees, and

(ii) reasonable legal costs in connection with the purchase of a site (where applicable) and the construction or refurbishment work; and

(b) the practice premises are, or are to be, leasehold premises, the reimbursable professional expenses are–

(i) reasonable costs of engaging a client agent to oversee the interests of and give advice to the contractor, up to the maximum reimbursable amount, which is 1.5% of the total reasonable contract sum relating to the construction or refurbishment work, and

(ii) reasonable legal costs incurred by the contractor in connection with agreeing the lease or a contract for the lease.

Value Added Tax on professional expenses

16. Where–

(a) a Health Board decides to grant an application for reimbursement in respect of the professional expenses mentioned in direction 15; and

(b) Value Added Tax has been properly charged in respect of the amount that the Health Board has decided to reimburse,

the Health Board must provide the contractor with financial assistance, under its GMS contract or section 17C agreement, to cover the cost to the contractor of that Value Added Tax.

PART 4

GRANTS RELATING TO RELOCATION OF A CONTRACTOR

Mortgage redemption/deficit grants

17. Where a contractor–

(a) agrees to relocate to modern leasehold premises approved by its Health Board in its property strategy for investment prioritisation;

(b) makes an application in writing to its Health Board for a mortgage redemption/deficit grant to cover all or a proportion of the following–

(i) a mortgage deficit which arises, after owner-occupied practice premises are sold, because the actual sale price of the premises was not sufficient to clear the outstanding mortgage on the property, or

(ii) mortgage redemption fees that the contractor may incur as a result of the sale or re-mortgage of such premises; and

(c) includes in that application all reasonable information required of it by the Health Board to determine the application, including details of the amount of the outstanding mortgage that was used to build and improve the property,

the Health Board must consider that application for financial assistance and, in appropriate cases (having regard, amongst other matters, to the budgetary targets it has set itself), grant that application.

Costs that may not be funded with mortgage redemption/deficit grants

18. Health Boards must not agree to cover the following costs or liabilities of a contractor with a mortgage redemption/deficit grant–

(a) any proportion of a mortgage deficit that has arisen through–

(i) payment holidays, or

(ii) reduced loan repayments not reflected in the cost rent reimbursement; and

(b) any borrowings or redemption charges not connected with the original purchase of land, building works and subsequent improvements to the premises – for example, furnishings, fittings and equipment (including IT and telephone systems, etc.).

Matters that must be considered before determining mortgage redemption/deficit grant applications

19. Before determining an application for a mortgage redemption/deficit grant from a contractor, a Health Board must obtain professional advice and be satisfied that–

(a) negotiations with the lender have limited the extent of any deficit or redemption charges;

(b) options for change of use for the property have been considered and where appropriate, outline planning permission sought or obtained;

(c) a proper process has been undertaken to identify a suitable third party developer and a site for the new leasehold premises;

(d) the timing of the grant is appropriate to maximising the opportunity for a sale which will coincide with completion and occupation of the new leasehold premises; and

(e) the sale of the premises is adequately advertised and the best price obtained,

and the Health Board must deduct from any amount that it would otherwise be prepared to pay by way of a mortgage redemption/deficit grant the surrender value of any endowment policy cover linked to the mortgage on the premises.

Conditions attached to mortgage redemption/deficit grants

20. Although, for accounting purposes, a mortgage redemption/deficit grant is to be treated as a payment to the contractor, the Health Board must ensure that payment of the grant is made subject to the following conditions–

(a) the contractor must consent to the Health Board sending the grant directly to the lender;

(b) the contractor must provide the Health Board with sufficient details to enable it to do so;

(c) the contractor must provide the Health Board with the information it needs from the lender to determine whether any endowment policy cover is linked to the mortgage on the premises, and if so, its surrender value; and

(d) the contractor must not be in receipt of mortgage redemption/ deficit loan repayment payments in respect of the same mortgage.

Borrowing costs relating to mortgage deficit/redemption costs

21. Where a contractor, who is not in receipt of a mortgage deficit/redemption grant–

(a) agrees to relocate to modern leasehold premises approved by its Health Board in its property strategy for investment prioritisation;

(b) takes out a loan to cover–

(i) a mortgage deficit which arises, after owner-occupied practice premises are sold, because the actual sale price of the premises was not sufficient to clear the outstanding mortgage on the property, or

(ii) mortgage redemption fees that the contractor may incur as a result of the sale or re-mortgage of such premises,

or a third party takes out a loan to cover those costs or fees on its behalf and the contractor is obliged to meet the third party's liabilities in respect of the repayment of that loan; and

(c) makes an application in writing to its Health Board for financial assistance towards meeting its, or the third party's regular payments to repay the loan; and

(d) includes in that application all reasonable information required of it by the Health Board to determine the application, including details of the amount of the outstanding mortgage that was used to build or improve the property,

the Health Board must consider that application for financial assistance and, in appropriate cases (having regard, amongst other matters, to the budgetary targets it has set itself), grant that application.

Costs that may not be funded with mortgage redemption/deficit loan repayment payments

22. A Health Board must refuse an application of a type mentioned in direction 21 if the loan covers–

(a) any part of a mortgage deficit which has arisen through–

(i) payment holidays, or

(ii) reduced loan repayments not reflected in the cost rent reimbursement;

(b) any borrowings or redemption charges not connected with the original purchase of land, building works and subsequent improvements to the premises (for example, furnishings, fittings, equipment (including IT and telephone systems, etc.).

Matters that must be considered before determining applications of the type mentioned in direction 21

23. Before determining an application of the type mentioned in direction 21, a Health Board must obtain professional advice and be satisfied that–

(a) negotiations with the lender have limited the extent of any deficit or redemption charges;

(b) options for change of use for the property have been considered and where appropriate, outline planning permission sought or obtained;

(c) a proper process has been undertaken to identify a suitable third party developer and a site for the new leasehold premises;

(d) the timing of the loan is appropriate to maximising the opportunity for a sale which will coincide with completion and occupation of the new leasehold premises; and

(e) the sale of the premises is adequately advertised and the best price obtained,

and the Health Board must deduct from any regular payments that it would otherwise be prepared to pay, in granting the application, a regular and appropriate proportion of the surrender value of any endowment policy cover linked to the mortgage on the premises.

Conditions attached to mortgage redemption/deficit loan repayment payments

24. Although, for accounting purposes, regular payments that a Health Board makes on granting an application of the type mentioned in direction 21 are to be treated as a payment to the contractor, the Health Board must ensure that the payments are made subject to the following conditions–

(a) the contractor must consent to the Health Board sending the payments directly to the lender;

(b) the contractor must provide the Health Board with sufficient details to enable it to do so;

(c) the contractor must provide the Health Board with the information it needs from the lender to determine whether any endowment policy cover is linked to the mortgage on the premises, and if so, its surrender value; and

(d) the contractor must not be in receipt of a mortgage redemption/ deficit grant from its Health Board in respect of the same mortgage.

Guaranteed minimum sale price payments

25. Where–

(a) a contractor agrees with its Health Board to relocate to modern leasehold premises approved by the Health Board in the Health Boards property strategy for investment prioritisation;

(b) the relocation will, in the opinion of the Health Board, result in an improvement in the range and quality of services to be provided to patients by the contractor;

(c) the Health Board and the contractor have agreed a guaranteed minimum sale price for owner-occupied practice premises that are being sold ("the previous premises");

(d) the Health Board is satisfied that the previous premises were placed on the open market with active marketing to sell them at the maximum price achievable on a date to coincide with the contractor's move to new premises;

(e) the Health Board is satisfied, having taken professional advice, that an increased offer (i.e. an offer that was better than the one that was in fact accepted for the previous premises) could not reasonably have been achieved;

(f) the Health Board is satisfied that the previous premises have not been sold to–

(i) the contractor,

(ii) a present or former partner in, shareholder in or employee of the contractor,

(iii) a family member of a present or former partner in, shareholder in or employee of the contractor, or

(iv) the employer of a family member of a present or former partner in or shareholder in or employee of the contractor; and

(g) in appropriate circumstances (for example, if the future planning use of the property is unclear)–

(i) the agreement for sale of the previous premises includes a clawback arrangement, and

(ii) the contractor has agreed with the Health Board an enforceable undertaking in the form of a condition in its GMS contract or section 17C agreement that it will use any clawback monies to repay all or a proportionate part (as is appropriate) of any payment from the Health Board pursuant to this direction,

if the sale price for the previous premises is less than the agreed guaranteed minimum sale price for the premises, the Health Board must provide to the contractor under its GMS contract or section 17C arrangements financial assistance in the form of a payment equal to the difference between those two prices.

Agreement of a guaranteed minimum sale price

26. If a Health Board is considering agreeing a guaranteed minimum sale price with a contractor, it must–

(a) seek professional advice on the actual sale price of the premises to be sold; and

(b) only agree a guaranteed minimum sale price with the contractor–

(i) on the basis of the professional advice about the actual sale price of the property that it has received, and

(ii) having taken into account the options for change of use of the premises.

Grants relating to the cost of reconverting former residential property

27. Where a contractor has a proposal for reconverting practice premises which were previously the contractor's (or a partner in or a shareholder in the contractor's) owner occupied residential property back to residential use, and–

(a) the property is no longer suitable for the delivery of modern primary medical services, and

(b) the contractor has agreed to move to premises suitable for the delivery of modern primary medical services, and

(c) the contractor makes an application to its Health Board for a residential property re-conversion grant towards the cost of the re-conversion,

the Health Board must consider that application for financial assistance and, in appropriate cases (having regard, amongst other matters, to the budgetary targets that it has set for itself), grant that application.

Circumstances where residential property re-conversion grants are not payable

28. The Health Board must refuse an application of the type mentioned in direction 27 where the costs to which the application relates were incurred without the prior approval of the Health Board.

Grants towards the cost of surrendering or assigning leases or to meet vacated leasehold premises costs

29. Where a contractor which is moving or has moved to premises that are suitable for the delivery of modern primary medical services makes an application to its Health Board for a grant towards–

(a) the costs reasonably incurred (including reasonable legal costs) that relate to–

(i) surrendering a lease, or

(ii) assigning a lease where surrender of the lease was not realistically possible,

of leasehold premises that are or were practice premises but are not suitable for the delivery of modern primary medical services; or

(b) vacated leasehold premises costs that relate to the contractor's ongoing liabilities (or a partner in or shareholder in the contractor's ongoing liabilities) in respect of practice premises that are being or have been vacated because they are not suitable for the delivery of modern primary medical services,

the Health Board must consider that application for financial assistance and, in appropriate cases (having regard, amongst other matters, to the budgetary targets it has set itself), grant that application.

Circumstances where an application of the type mentioned in direction 29 must be refused

30. The Health Board must refuse an application of the type mentioned in direction 29 where–

(a) the costs to which the application relates were incurred without the prior approval of the Health Board;

(b) the leasehold premises are owned by or leased from an NHS body;

(c) the leasehold premises are wholly or partly owned by, or are leased from–

(i) the contractor,

(ii) a present or former partner in, shareholder in or employee of the contractor,

(iii) a family member of a present or former partner in, shareholder in or employee of the contractor, or

(iv) the employer of a family member of a present or former partner in, shareholder in or employee of the contractor;

(d) in the case of costs of assigning a lease, surrender could be agreed with the landlord, unless professional advice has been obtained and the conclusion of that advice is that surrender or assignment is not cost effective;

(e) in the case of vacated leasehold premises costs–

(i) surrender could be agreed with the landlord, or

(ii) assignment to a third party could be agreed with the landlord and is realistically possible,

unless professional advice has been obtained and the conclusion of that advice is that surrender or assignment is not cost effective; or

(f) in the case of vacated leasehold premises–

(i) the costs relating to liabilities in respect of the vacated leasehold premises have not been agreed with the landlord, or

(ii) the financial assistance is not subject to a condition to the effect that the contractor will continue to take all reasonable steps to surrender or assign the lease to a third party on reasonable terms.

Stamp Duty Land Tax payable on agreeing a new lease

31. Where–

(a) a contractor agrees with its Health Board to relocate to or additionally occupy modern leasehold practice premises approved by the Health Board in the Health Boards property strategy for investment prioritisation;

(b) the relocation or additional premises will, in the opinion of the Health Board, result in an improvement in the range and quality of services to be provided to patients by the contractor;

(c) the contractor makes an application to its Health Board for financial assistance to cover the cost of any Stamp Duty Land Tax incurred by the contractor as a consequence of signing a lease to occupy premises,

the Health Board must consider that application for financial assistance and, in appropriate circumstances (having regard, amongst other matters, to the budgetary targets it has set for itself), grant that application.

PART 5

RECURRING PREMISES COSTS

Leasehold rental costs

32. Subject to the following provisions of this Part, where–

(a) a contractor which rents its practice premises makes an application to its Health Board for financial assistance towards its rental costs; and–

(b) in the case of rental costs arising under a lease agreed or varied on or after 1st April 2004, the Health Board is satisfied (before the lease is agreed or varied), where appropriate in consultation with the District Valuer, that the terms on which the new or varied lease is to take effect represent value for money,

the Health Board must consider that application and, in appropriate cases (having regard, amongst other matters, to the budgetary targets it has set for itself), grant that application.

Amount of leasehold rental costs payable

33. If a Health Board does grant the application, subject to the following provisions of this Part, the amount that it must pay in respect of a contractor's rental costs for its practice premises is–

(a) the current market rent for the premises; or

(b) the actual lease rent for the premises, plus any Value Added Tax payable by the contractor if this is properly charged to the contractor by the landlord,

whichever is the lower amount.

Current market rents

34. The amount of the current market rent of leasehold premises is to be determined in accordance with Parts 1 and 2 of Schedule 2. However, having regard to the fact that current market rent levels in some areas may be too low to provide–

(a) sufficient returns to support new capital investment in practice premises; or

(b) sufficient support for existing premises that meet the minimum standards set out in Schedule 1,

Health Boards may in such circumstances increase the amount it would otherwise pay as the current market rent of practice premises by applying an appropriate uplift factor (as provided by the Valuation Office Agency in accordance with principles established by the Scottish Executive Health Department for such circumstances).

Health Centre rents

35 In respect of a contractor, who is a tenant in a Health Centre but where a formal lease is not in place, in place of the leasehold rent cost detailed in direction 33, the Health Board may consider an application for reimbursement of any Health Centre rent payable that is calculated in accordance with Schedule 4.

Premiums or grassum affecting the lower rent rate

36. If the actual lease rent for practice premises, plus any properly chargeable Value Added Tax, is only lower than the current market rent for those premises because, in the calculation of the current market rent for the premises, the Health Board includes the value of a premium or grassum paid by the tenant, the amount to be paid by the Health Board pursuant to direction 33 is the current market rent for the premises rather than the actual lease rent.

Equipment etc. lease costs for modern practice leasehold premises

37. Where–

(a) a contractor has entered into an agreement (whether as part of a practice premises lease agreement or otherwise) to lease or purchase equipment, furniture or furnishings;

(b) the nature and level of the costs of leasing or purchasing the equipment, furniture or furnishings (including any arrangements for increasing the amounts payable), together with the period of time for which any recurring costs are payable, were agreed by the contractor and its Health Board before the agreement was agreed, and–

(i) the period of time for recurring costs does not exceed the remaining term of the occupancy lease, and

(ii) the Health Board obtained professional advice before reaching agreement with the contractor; and

(c) the contractor makes an application to its Health Board for financial assistance towards those costs,

the Health Board must consider that application for financial assistance and, in appropriate circumstances (having regard, amongst other matters, to the budgetary targets it has set for itself), grant that application.

Owner-occupier borrowing costs

38. Subject to the following provisions of this Part, where a contractor that is an owner-occupier of its practice premises–

(a) incurs borrowing costs as a result of purchasing, building or significantly refurbishing its practice premises (or would have incurred such costs had the contractor not funded the project with its, or its partners' or shareholders', own resources); and

(b) makes an application to its Health Board for financial assistance towards meeting those costs,

the Health Board must consider that application and, in appropriate cases (having regard, amongst other matters, to the budgetary targets it has set for itself), grant that application.

Conditions to be met if applications for financial assistance in respect of borrowing costs are to be granted

39. If the contractor's borrowing costs relate to the building of new practice premises or the significant refurbishment of existing practice premises, a Health Board must only grant an application of the type mentioned in direction 38 if–

(a) in respect of the building work, the contractor–

(i) carries out or carried out a tendering process for a firm to undertake the work, resulting in at least three written quotes, and

(ii) agrees or agreed with the Health Board which of those written quotes represents or represented best value for money;

(b) the amount of financial assistance applied for has been calculated by applying the prescribed percentage to the necessary level of loan incurred (or that would have been incurred had the contractor not wholly or partly funded the project with its, or its partners' or shareholders', own resources), and agreed with the Health Board, to meet the aggregated cost elements to build, fit-out and equip the premises. For these purposes, the cost elements that may be aggregated include–

(i) site purchase,

(ii) building works,

(iii) reasonable surveyors' and architects' fees, and reasonable legal costs arising out of the purchase of the site (where applicable) and the building or refurbishment,

(iv) any rolled-up interest incurred on loans taken out to procure the premises,

(v) necessary local authority and planning application fees incurred,

(vi) purchase or lease costs to adequately fit-out and equip the new premises, and

(vii) Value Added Tax and Stamp Duty Land Tax, where properly charged in relation to the above; and

(c) the loan (i.e. any loan actually taken out by the contractor) is secured by the contractor.

The prescribed percentage

40. For the purposes of direction 39(b), the prescribed percentage is–

(a) if the loan is a fixed interest rate loan (for the duration of loan period), the 20 high year gilt rate issued by the Bank of England, plus 1.5%;

(b) if the loan is not a fixed interest rate loan (for the duration of the loan period), the Bank of England Base Interest Rate plus 1%; or

(c) if the contractor is financing the building or refurbishment scheme wholly or mainly from its (or its partners' or shareholders') own resources, that which the Health Board determines as representing best value for money.

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Amounts payable in respect of borrowing costs

41. Once a Health Board has decided to grant an application from a contractor for financial assistance in respect of borrowing costs pursuant to direction 38, and the Health Board has determined an annual amount in respect of the contractor's borrowing costs in accordance with directions 39 and 40, the Health Board must each month provide financial assistance to the contractor in respect of those borrowing costs, based on one twelfth that annual amount, until–

(a) the loan is paid off;

(b) in the case of a loan that is not a fixed interest rate loan (for the duration of the loan period) twelve months have elapsed since the annual amount was last established, at which point a new annual amount is to be established for the next twelve months, based on a re-determined prescribed percentage, which is the Bank of England Base Interest Rate at the time the annual amount is recalculated plus 1%, being applied to the agreed level of borrowing;

(c) alternative borrowing arrangements are entered into by the contractor. Where a contractor changes lender or re-negotiates lower loan costs, the amount payable by the Health Board shall be recalculated using the appropriate prescribed percentage in force at the time that the changed loan arrangements come into effect; or

(d) the contractor elects not to receive any further payments under these arrangements (for example, in order to receive notional rent payments),

and the monthly amount is to be paid on the last day of the month, unless alternative payment arrangements are agreed between the Health Board and the contractor.

Condition attached to payments in respect of borrowing costs based on a fixed interest rate loan

42. If a contractor is to receive payments in respect of borrowing costs under this Part, and those borrowing costs arise as a result of a fixed interest rate loan, the Health Board must ensure that the making of the payment is subject to a condition to the effect

that the contractor must advise the Health Board of any change of lender or any reduction in the level of interest charged to its loan.

Notional rent payments

43. Subject to the following provisions of this Part, where a contractor that is an owner-occupier of its practice premises–

(a) either–

(i) has repaid the loans secured on its practice premises, or

(ii) incurs borrowing costs as a result of purchasing, building or significantly refurbishing practice premises (or would have incurred such costs had the contractor not funded the project with its, or its partners' or shareholders', own resources) but elects not to receive any payments from its Health Board in respect of those borrowing costs; and

(b) makes an application to its Health Board for notional rent payments,

the Health Board must consider that application and, in appropriate cases (having regard, amongst other matters, to the budgetary targets it has set for itself), grant that application. If a contractor has been in receipt of payments in respect of its borrowing costs pursuant to direction 41, elects not to receive further payments pursuant to that direction and makes an application in accordance with this direction, its Health Board must grant that application and make notional rent payments to the contractor under its GMS contract or section 17C agreement at an appropriate level and frequency.

Amount of notional rent payments

44. Where a Health Board grants an application of the type mentioned in direction 43, subject to the following provisions of this Part, the amount that it must pay to a contractor in respect of notional rent is the current market rental value of its practice premises, as determined in accordance with Parts 1 and 3 of Schedule 2. The Health Board must review this amount as part of a three yearly review of the contractor's notional rent, although this review may be brought forward if–

(a) there is a change to the purposes for which the premises are used;

(b) there is further capital investment in the premises, and payments are to be made to the contractor in respect of that investment under its GMS contract or section 17C agreement.

Abatement of notional rent payments

45. Where–

(a) NHS capital has contributed to the cost of building or refurbishment work done in respect of the practice premises of a contractor; and

(b) that contribution of NHS capital was made after 18th September 2003,

on completion of the building or refurbishment work, the amount of the notional rent payable by a Health Board must be the abated notional rent for those premises, calculated in accordance with Part 1 of Schedule 3, rather than the full notional rent, determined in accordance with direction 44. However, after a period of 10 years the full notional rent again becomes payable.

Notional rent supplements

46. If a contractor–

(a) is an owner-occupier of its practice premises and is in receipt of payments in respect of its borrowing costs which are paid by a Health Board pursuant to direction 41, and–

(i) the contractor makes further capital investment in the practice premises and that investment (including the details of the finalised project plan) had the prior approval of its Health Board, but

(ii) the current market rent (and so the notional rent) for the practice premises remains lower than the repayments in respect of borrowing costs being made; or

(b) rents its practice premises, is in receipt of payments in respect of its actual lease rent which are paid by a Health Board pursuant to direction 34,

(i) and makes further capital investment in its practice premises, and

(ii) that investment (including the details of the finalised project plan) had the prior approval of its Health Board,

and the contractor makes an application to its Health Board for a notional rent supplement, the Health Board must grant that application and make notional rent supplement payments to the contractor under its GMS contract or section 17C agreement at an appropriate level and frequency.

Amount of notional rent supplements

47. Where a Health Board grants an application of the type mentioned in direction 46, the amount that it must pay to the contractor as a notional rent supplement is the value of the enhancement of the current market rent for the premises arising from the further capital investment, which is to be determined (and abated) in accordance with Schedule 2 and Part 2 of Schedule 3.

Payments in respect of running costs.

48. Where–

(a) a contractor is in receipt of payments pursuant to this Part in respect of leasehold rental costs, health centre rents or borrowing costs, or by way of notional rent payments;

(b) the contractor actually and properly incurs the costs which are or relate to–

(i) business rates,

(ii) water and sewage charges,

(iii) charges in respect of the collection and disposal of clinical waste, or

(iv) in the case of modern practice premises, a utilities and services charge (for example, a service charge under a lease or a charge levied under separate arrangements made by a contractor which is an owner-occupier), and the charge covers–

(aa) fuel and electricity charges,

(bb) building insurance costs,

(cc) costs of internal or external repairs, and

(dd) plant, building and grounds maintenance costs;

(d) these costs are not covered in the other payments that the contractor is receiving pursuant to these Directions; and

(e) the contractor makes an application to its Health Board for financial assistance towards meeting any or all of these costs,

subject to direction 49, the Health Board must consider that application and, in appropriate cases (having regard, amongst other matters, to the budgetary targets it has set for itself), grant that application.

Financial assistance towards service charges

49. A Health Board must deduct from any amount that it would otherwise be required to pay in respect of a service charge pursuant to an application of the type mentioned in direction 48–

(a) an average (calculated on the basis of the previous three years) amount that the contractor (or, prior to 1st April 2004, the antecedent practice) paid in respect of–

(i) fuel and electricity charges,

(ii) building insurance costs,

(iii) costs of internal or external repairs, and

(iv) plant, building and grounds maintenance costs,

calculated by reference to the same time period as the period in respect of which the service charge is payable; or

(b) if suitable and sufficient information is not (or does not become) available to calculate the average referred to in paragraph (a), 40% of the amount otherwise payable.

Abatement in respect of contributions towards recurring premises costs from third parties

50. Where a contractor's practice premises, or any part thereof, are or form part of premises that are owned or rented by any person other than the contractor, and that person –

(a) is required by any agreement (which includes a lease) to make or makes any contribution towards any recurring premises costs in respect of which the Health Board is providing financial assistance to the contractor in accordance with this Part; or

(b) is required by any agreement (which includes a lease) to pay or pays to the contractor any amount –

(i) by way of rent in respect of the practice premises or any part thereof, or

(ii) in respect of the running costs of the practice premises,

the Health Board must set off that contribution or that amount, equitably, against the payments made to the contractor pursuant to this Part.

Abatements in respect of income from private patients and commercial contracts

51. Where a contractor's practice premises, or any part thereof, are used for or associated with the provision of medical services –

(a) to private patients; or

(b) under arrangements with any person who is not a public authority (and for these purposes "public authority" includes NHS bodies, government departments, local authorities and the armed forces),

the Health Board must reduce the amount of any payment that it makes to the contractor pursuant to this Part by the appropriate abatement percentage. The appropriate abatement percentage is the percentage listed in column 1 of the table in this paragraph

opposite percentage band, in column 2 of the table, into which the contractor's private percentage income falls.

TABLE

Column 1 *Appropriate Abatement percentage*	*Column 2* *Private income percentage*
0%	Up to 10%
10%	Between 10% and 20%
20%	Between 20% and 30%
30%	Between 30% and 40%
40%	Between 40% and 50%
50%	Between 50% and 60%
60%	Between 60% and 70%
70%	Between 70% and 80%
80%	Between 80% and 90%
90%	Above 90%

Private income percentages

52. A contractor's private income percentage is –

(a) the average amount of income derived by the contractor, or members or employees of the contractor, from the provision of medical services, at or associated with its practice premises, to private patients or under any arrangements with a person other than a public authority; divided by

(b) the average total amount of the income of the contractor, or members or employees of the contractor, relating to the provision of medical services at or associated with the practice premises,

multiplied by 100. For these purposes, practice premises are associated with the provision of medical services if there is any connection or association between the provision of the medical services and the practice premises (for example, contact or billing arrangements), even if the medical services are provided elsewhere. The Health Board is to take all reasonable steps to agree with the contractor what are appropriate average amounts for the purposes of sub-paragraphs (a) and (b), and must duly justify the average it does determine.

Payments in kind

53. If a payment that is to be made pursuant to this Part would be abated, or abated by a greater amount, if instead of receiving money or obtaining a pecuniary advantage a contractor, or a member or employee of a contractor, receives a payment in kind, the value of the payment in kind is to be taken into account in determining amount of the payment to be made pursuant to this Part. The Health Board is to take all reasonable steps to agree with the contractor the value of the payment in kind and must duly justify the value it does determine.

Minimum standards condition attached to all payments under this Part

54. If a payment is to be made by a Health Board pursuant to this Part, the Health Board must ensure that the making of the payment is subject to a condition to the effect that the practice premises in respect of which the payment is made meet the minimum standards set out in Schedule 1. If this condition is breached but the breach is capable of remedy by refurbishment of the premises–

(a) a remedial notice should not be served in respect of the breach if, pursuant to a plan drawn up in accordance with regulation 18(3) of the National Health Service (General Medical Services Contracts (Scotland)) Regulations 2004 or Regulation 18(3) of the National Health Service (Primary Medical Services Section 17C Agreements) (Scotland) Regulations 2004 , action is already due to be taken which will remedy that breach and the timescale for taking that action under that plan has not yet elapsed;

(b) before serving a remedial notice in respect of the breach, the Health Board must consult the Area Medical Committee for its area; and

(c) if a remedial notice is served, the notice period must be at least six months, unless the breach was due to be remedied as a consequence of action taken under a plan drawn up in accordance with regulation 18(3) of the National Health Service (General Medical Services Contracts (Scotland)) Regulations 2004 or Regulation 18(3) of the National Health Service (Primary Medical Services Section 17C Agreements) (Scotland) Regulations 2004, but the timescale for taking that action under that plan has elapsed without the action being taken.

Accurate information condition attached to payments under this Part

55. Where a Health Board grants an application under this Part, it must ensure that the payment is made subject to conditions to the following effect–

(a) the contractor must make available to the Health Board any information which the Health Board does not have but needs, and the contractor either has or could reasonably be expected to obtain, in order for the Health Board to calculate the appropriate amount of financial assistance to be provided; and

(b) all information supplied by a contractor to its Health Board pursuant to or in accordance with the condition set out in paragraph (a) must be accurate.

PART 6

SUPPLEMENTARY PROVISIONS

Payments previously made to practitioners rather than contractors

56. If, immediately prior to 1st April 2004–

(a) a Health Board was making payments under the Statement of Fees and Allowances to a registered medical practitioner who–

(i) is either a contractor or a partner in or a shareholder in a contractor, and

(ii) owns or is a part owner of the leasehold or freehold interest in practice premises,

(b) those payments were with regard to any of the recurring premises costs in respect of which payments may or must be made pursuant to Part 5,

the Health Board must, subject to direction 57, continue to provide financial assistance in respect of those costs.

Conditions relating to cases of preserved rights to payments in respect of recurring premises costs

57. That financial assistance must be provided–

(a) to a contractor rather than an individual registered medical practitioner, unless the registered medical practitioner is himself a contractor;

(b) in accordance with Part 5 (except that, where it is reasonable to do so, the Health Board may simply continue with the existing payment levels without the need to consider a new application for financial assistance), and subject to any relevant condition relating to that type of financial assistance which are set out therein.

Payments under default contracts

58. Where–

(a) a registered medical practitioner or a partnership of registered medical practitioners agrees a default contract with a Health Board;

(b) that practitioner or a partner in that partnership was in receipt of payments under the Statement of Fees and Allowances with regard to any of the recurring premises costs in respect of which payments may be made pursuant to Part 5; and

(c) the Health Board must, by virtue of direction 56, make similar payments to the registered medical practitioner or the partnership when he or it agrees a GMS contract with the Health Board,

the Health Board must provide financial assistance to the potential contractor under his or its default contract in respect of those recurring premises costs, at an appropriate level and frequency having regard to the amount that the potential contractor is likely to be paid in respect of those costs under the GMS contract.

Direct payments to third parties

59. Where a contractor and its Health Board agree, the Health Board must pay any amount that is due to the contractor as financial assistance under these Directions to a third party instead of the contractor, subject to a condition that the contractor ensures that it treats the payment for accounting purposes as a payment to it. If –

(a) the payment from the Health Board to the third party is less than the amount that is due from the contractor to the third party; and

(b) the contractor is due other payments from the Health Board as financial assistance under these Directions which are greater than or equal to the amount of the shortfall,

where the contractor and the Health Board agree, the Health Board must pay all or part of those other payments to the third party instead of to the contractor, subject to a condition that the contractor ensures that it treats the payment for accounting purposes as a payment to it.

Time limitation for making applications

60. Health Boards must only consider or grant an application of the types mentioned in these Directions if the application is made within six years of the premises costs to which the application relates fall due.

Applications in respect of historic premises costs

61. Apart from an application of the type mentioned in direction 31 relating to Stamp Duty Land Tax which falls due on or after 1st December 2003, the Health Board must only consider or grant an application of the types mentioned in these Directions if the premises costs to which the application relates–

(a) fall due on or after 1st April 2004; and

(b) if they are recurring premises costs, are in respect of a period that starts on or after 1st April 2004.

H.Wilson

A member of the staff of the
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31 March 2004

SCHEDULE 1

MINIMUM STANDARDS FOR PRACTICE PREMISES

1. As regards the design or construction of the premises, or of the approach or access to the premises, to which the payments relate, the contractor must comply with any obligations it has to its own members (where applicable), staff, contractors and to persons to whom it provides primary medical services under the Health and Safety at Work Act 1974 (and legislation under that Act) and the Disability Discrimination Act 1995. The requirements of the 1995 Act include taking such steps as are reasonable to–

(a) provide for ease of access to the premises and ease of movement within the premises for all users of the premises (including wheelchair users);

(b) provide adequate sound and visual systems for the hearing and visually impaired; and

(c) remove barriers to the employment of disabled people.

2. Adequate facilities should also be provided for the elderly and young children, including nappy-changing and feeding facilities. There should also be adequate lavatory and hand hygiene facilities which meet current infection control standards.

3. If the premises has a treatment room, this should be properly equipped (an additional treatment room may be required where enhanced minor injury services are provided).

4. The arrangements for instrument decontamination comply with national guidelines as appropriate to primary care.

5. The premises should have a properly equipped consulting room for use by the practitioners with adequate arrangements to ensure the privacy of consultations and the right of patients to personal privacy when dressing or undressing, either in a separate examination room or in a screened-off area around an examination couch within the treatment room or the consulting room. However, in the case of branch surgeries, this standard need not be fully met if the contractor provides outlying consultation facilities using premises usually used for other purposes, and these meet with the approval of the Health Board,

6. The access arrangements for the building should be convenient for all users.

7. There should be washbasins connected to running hot and cold water (ideally distributed through elbow, knee or sensor operated taps) in consulting rooms and treatment areas or, if this is not possible, then in an immediately adjacent room.

8. There should be adequate internal waiting areas with–

(a) enough seating to meet all normal requirements, either in the reception area or elsewhere; and

(b) the facility for patients to communicate confidentially with reception staff, including by telephone.

9. There should be with adequate standards of lighting, heating and ventilation.

10. The premises, fittings and furniture should be in good repair and (when being used for the provision of primary medical services) clean and hygienic.

11. The arrangements for the storage and disposal of clinical waste comply with current legislative requirements and national guidance.

12. There should be adequate fire precautions, including provision for safe exit from the premises, designed in accordance with the Building Regulations agreed with the local fire authority.

13. There should be adequate security for drugs, records, prescription pads and pads of doctors' statements.

14. If the premises are to be used for minor surgery or the treatment of minor injuries, there should be a room suitably equipped for the procedures to be carried out.

SCHEDULE 2

CURRENT MARKET RENTS AND NOTIONAL RENT ABATEMENTS

PART 1

FACTORS COMMON TO ALL CURRENT MARKET RENT CALCULATIONS

1. Current market rent calculations for notional rent purposes differ from current market rent calculations for actual leasehold premises pursuant to direction 34.

2 However, in both cases, the valuer must consider what might reasonably be expected to be paid by a tenant for the premises at the valuation date. The aim will be to arrive at a rent which can be agreed between the contractor (or his or her representative) and a third party in willing negotiation. For these purposes, it must be assumed that neither party is seeking to take advantage of the fact that–

(a) the contractor's remuneration is so arranged that this rent and any VAT payable is reimbursed separately; and

(b) at any one time only one contractor is permitted to be in the market to use the premises for practice purposes.

3. In determining a figure for any current market rent, the following will also apply–

(a) where the practice accommodation forms part of an owner-occupied residence but does not include areas which are used regularly but not exclusively for practice purposes, the current market rent will be assessed for the practice accommodation only, but as part of the whole premises and not increased or reduced to reflect any advantage or disadvantage there may be in the fact that the practice accommodation is not in separate premises;

(b) where the practice accommodation forms part of a residence owned or rented by a person not connected with the contractor, the current market rent will be assessed in respect of the practice accommodation only and is to reflect any advantage or disadvantage there may be in the fact that it is not in separate premises;

(c) where the practice accommodation forms part of an owner-occupied residence and includes areas which are used regularly but not exclusively for practice purposes, the CMR will be assessed as at (a) above but with an agreed percentage added of the current market rental value of any area

used regularly but not exclusively for practice purposes having regard to the extent and such use and any modifications made to facilitate that use.

PART 2

FACTORS WHICH ONLY APPLY IN RELATION TO LEASEHOLD PREMISES

4. The valuer must first have regard to the actual terms of the lease. In the case of the payment provisions–

(a) the amounts payable must be adjusted to take account of appropriate deductions in respect of the following–

(i) any amount referable to residential accommodation, except where this is to be taken into account in accordance with paragraph 3,

(ii) other non-practice accommodation, unless the Health Board has specifically agreed that no deduction is to be made in respect of it,

(iii) furniture or moveable equipment included in the rent costs,

(iv) services or other facilities included in the rent costs,

(v) the value of any responsibility of the landlord in respect of internal repairs or decoration,

(vi) any amount referable to water rates, where the tenant is responsible for paying the landlord's share and recovers that share from the landlord;

(b) the amounts payable must be adjusted to take account of appropriate additions in respect of the following–

(i) the value of any responsibility of the tenant in respect of external repairs and maintenance, or for insurance of the building,

(ii) any premium paid by the tenant,

(iii) any Value Added Tax paid by the tenant where properly charged to the tenant by the landlord

(c) relating to reviewing rental payments, the Health Board must–

(i) review its assessment of the current market rent for the property when the landlord undertakes a rent review provided for in the lease, unless the landlord’s review does not result in a change to the level of rent charged (an assessment on the basis of vacant possession will not be appropriate on a rent review, unless the

terms of the lease so provide or the property market can be shown not to distinguish between vacant and tenanted premises), and

(ii) if the rent review is linked to an index (for example, the Retail Price Index, adjust the amount it pays in accordance with that index, provided it received a copy of the lease on offer before it was agreed and it agreed to the indexing arrangement, having taken professional advice as to its appropriateness.

(d) if the lease rent is inclusive of rates (including water rates), the current market rent must also be inclusive of the rates so included.

PART 3

FACTORS WHICH ONLY APPLY IN RELATION TO NOTIONAL RENT CASES

5. If the premises are owner-occupied premises, the following assumptions are to be made by the valuer about the nature of the notional lease upon which the notional rent payments are to be based. This notional lease–

(a) is to be for a term of 15 years, with upward only rent reviews every three years;

(b) includes a covenant that the tenant undertakes to bear the cost of internal repairs and decoration and the landlord undertakes to bear the cost of insuring the building and of carrying out external repairs and maintenance;

(c) does not include a service charge, or like payment for such items as upkeep, maintenance (including lift maintenance where appropriate), cleaning and heating of common parts;

(d) is for vacant possession (for the purposes of the initial assessment but not for the purposes of the notional rent review, unless the terms of the lease so provide or the property market can be shown not to distinguish between vacant and tenanted premises);

(e) is exclusive of rates;

(f) includes a right for the tenant to assign or sublet the whole premises, subject to landlords consent which is not to be unreasonably withheld;

(g) allows the premises to be used for practice purposes and for any other purpose for which planning permission has been granted, or might reasonably be expected.

SCHEDULE 3

NOTIONAL RENT ABATEMENTS AND NOTIONAL RENT SUPPLEMENTS

PART 1

NOTIONAL RENT ABATEMENTS

1. Where NHS funds have contributed to the cost of building or refurbishment work done in respect of practice premises, the notional rent payable in respect of those payments is to be abated (in proportion to the level of NHS contribution) as follows–

(a) determine the current market rent for the premises prior to improvement ***(P_u)***;

(b) determine the current market rent for the whole of the improved premises should also be assessed ***(P_i)***;

(c) subtract one from the other ***($P_i - P_u$)***, which will produce the current market rent value of the enhancement ***(I)***;

(d) determine the amount of the capital provided by the contractor as a proportion of the whole cost of the improvement, expressed as a percentage ***(A)***;

(e) ***(A)*** is then to be enhanced by adding 10% of ***(I)*** to cover normal landlord expenses, which is then applied to ***(I)*** and the resultant is added to ***(P_u).***

2. Accordingly, expressed as a formula, the post improvement notional rent is–

$$I \times (A+10)\% + P_u$$

PART 2
NOTIONAL RENT SUPPLEMENTS

3. Where a notional rent supplement is to be calculated, the amount of that supplement, expressed as a formula, is: $I \times (A+10)\%$.

SCHEDULE 4

HEALTH CENTRE RENT AND ASSOCIATED PAYMENTS

Where a contractor is a tenant of a Health Centre, in place of Current Market Rent, the maximum reimbursable rent may be calculated as that share of the original capital cost of the building attributed to occupation by the contractor concerned multiplied by a factor that represents the capital charge borne.

To this amount may be added amounts as advised by the District Valuer from time to time as appropriate where the tenant has accepted responsibility for external and/or internal maintenance and decoration of the building.