



Healthcare Bulletin

Pause, Stop, Rewind for the Health & Social Care Bill



The clock is ticking for the Health & Social Care Bill

Following the announcement in April of a break in the progress of the Bill to 'pause, listen and reflect' an independent review group 'NHS Future Forum' was set up, taking representations from a broad spectrum of interested parties. The Forum reported their findings and recommendations

last June, which covered some of the issues raised in our previous Bulletin.

Following the report the government has undertaken a review and set out a number of amendments addressing concerns raised.

A principal concern was the fact that the NHS should be freed from day to day political interference but that the Secretary of State must remain ultimately accountable for the NHS and the Bill will make the accountability of the Secretary of State explicit. The Bill will further require the NHS commissioning board and clinical commissioning groups to take active steps to promote the NHS constitution which enshrines core principles and values of the NHS.

The Forum stated that the NHS belongs to the people and that there must be transparency about how money is spent and how and why decisions are made. Consequently the government will seek to strengthen the accountability of new organisations, including clinical commissioning groups, and ensure more joined up local services by strengthening requirements for close working between health and well-being boards and clinical commissioning groups.

Greater emphasis will be placed on patient care and public involvement and reflect better the principle of 'no decision about me without me'.

The Forum emphasised that competition should be used as a tool for supporting choice and improving quality and must not be pursued

as an end in itself. In this regard, Monitor's core duties will be focused on protecting and promoting patients' interests and not on promoting competition. The existing rules on cooperation and competition in the NHS will be retained and additional safeguards will be introduced to protect against cherry picking and price competition.

It is clear that the government has taken on board a number of the concerns that have been raised and is seeking to address these within the amendments to the Bill.

A further issue is that the current uncertainty is not helping those involved in the NHS. In this regard the government has indicated a time frame confirming that Primary Care Trusts will cease to exist in April 2013, although clinical commissioning groups will not be authorised to take on any part of the commissioning budget in their local area until they are ready and willing so to do. The NHS commissioning board will be established by October 2012 to begin authorising commissioning groups but will only take on responsibility from April 2013 and will act as the commissioning authority where authorised commissioning groups have not already been established. It is further anticipated that the remaining NHS trusts will be authorised as foundation trusts by April 2014, but this may be extended to 2016.

These amendments to the Bill are at the reporting stage before their third reading and changes may still be afoot but the Government has sought to dispel the implication of "privatisation" and tried to emphasise integrated patient healthcare.

From our perspective it is disappointing to note that the initial Bill and the Forum results do not feature premises or property and rent and it is still unclear as to what body the current NHS landed interests will transfer to. A senior party within the Department of Health has told us that such detail will now start to flow and that hopefully we should hear something in the coming months.

For further information contact Andrew Hues MRICS - 0207 518 3440 or email: andrew.hues@argroup.co.uk

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Notional Rent Trends

The continued demand by the NHS for quality primary health centres has resulted in our analysis of notional rent appeals and rent reviews, settled on behalf of our clients, continuing to show rental increases, although the rate of rental growth has slowed.

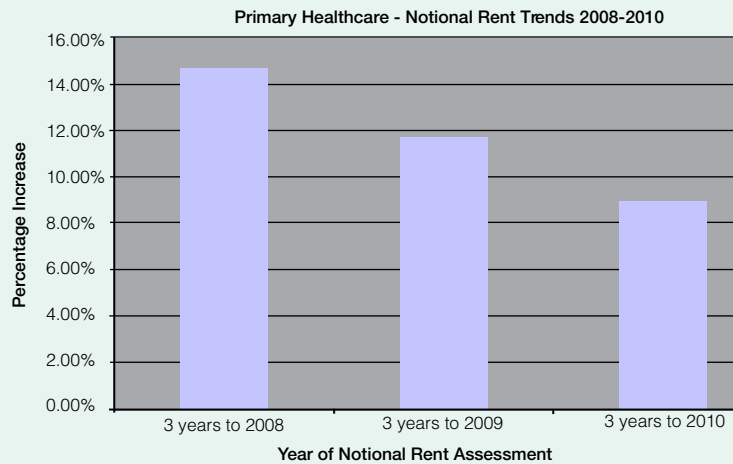
While rents for the three year period 2005-08 show an average increase on review of 14.37%, the rate of increase slowed to 11.52% for the period 2007-10 (four major firms of surveyors supporting the Primary Care Premises Forum reported an increase for the same period of 10.82%; our figures are therefore similar, although slightly ahead).*

One trend we are noticing is that Primary Care Trusts and District Valuers are becoming very prescriptive with PREM 1 forms, and ruling out areas not identified in these forms. This may lead to an increase in the number of surgeries with disparities between rent paid and rent reimbursed, but we are optimistic that PCT's will allow corrections to the forms to ensure accuracy and the right and fair assessment.

On a cautionary note, we are aware of GP's accepting notional rent assessments without professional advice, in low single figure percentages, and this is having an adverse

effect on other reviews. There is also the occasional suggestion from the DV/PCT of a zero percent increase, possibly resulting from the NHS need to save revenue. With the exception of very poor quality premises this is rarely justifiable, a fact supported by Third Party determinations. This re-enforces the importance of instructing a specialist healthcare surveyor to consider your notional rent assessment.

For further information contact Roger Chisnall BSc MRICS - Senior Healthcare Surveyor. 01727 844555 or email: roger.chisnall@argroup.co.uk



**An initial analysis of our rent review data until December 2010 shows an increase of 11.52%. However data includes four rent reviews over the period which were agreed unusually at increases over 20%, with one review where the previous rent was agreed by a council landlord who had not obtained specialist healthcare advice, showed a very substantial increase of 50.91%. We have adjusted our data to account for these variations, and this demonstrates an increase of 8.77%.*

Opportunities Still Exist For Investors

Demand continues to be high in the primary care investment market with investors ranging from small private individuals seeking assets for their pension funds through to specialist investor developers. Specialist developers are seeking larger lot sizes with good length lease terms remaining with modern purpose built premises the main attraction. Larger institutions are interested in moving into the market subject to buildings of an appropriate lot size being available. Meanwhile individual investors are favouring smaller lot sizes which are financially more attainable, the issues they consider important being more management-based with a preference for full repairing and insuring leases.

While the demand appears buoyant there has been a shortage of stock with many of the premises available being of an older nature or, where purpose built, the unexpired term of the occupational lease is generally between 10-15

years in length having been constructed in the late 1990's or early 2000's.

The fact that there is a shortage of stock and demand levels are high should indicate a strengthening of the market for assets, although the transactional evidence to date suggests little movement in yields since the beginning of the year. This is predominantly down to the quality of buildings available but also reflects finance and funding availability.

Current market conditions are providing opportunities for GP's owning their practices to realise capital through a sale and leaseback arrangement. Aitchison Raffety has considerable expertise in this field and can provide advice and assistance for the purchase or sale of primary healthcare assets.

For further information call 01727 844555

Imperfections in dentistry contract lead to new trial scheme



In the past few years we have witnessed significant changes in NHS dentistry. A new format of NHS/PCT contracts was introduced five years ago, bringing with it much consternation amongst practitioners. And this autumn a new scheme is being trialled in selected practices.

In 2006 the aim was to offer a better service to patients by offering a simplified pricing structure and an increase in preventative treatment whilst reducing the incentive for dentists to undertake unnecessary treatments. Under this new structure dental contracts are based upon UDA's (Units of Dental Activity) in return for an annual contract value. Thus, dentists essentially have a UDA target to meet each year as agreed in their contract.

This replaced the historic system whereby a practice received payment on a piecemeal, fee per service arrangement. Whilst there used to be over 400 different prices, under the revised contracts the pricing of treatment falls within one of only three different bands. This reduction in complexity is on the face of it a good thing from a patient point of view as you pay the same for three fillings as you do for one. But this does make the cost of one filling poor value for money.

Despite best intentions, the British Dental Association claims that under

the present contract system dentists are becoming increasingly disillusioned with their profession as a result of excessive administration with not enough time to provide patients with preventative dental care, rising costs and endless problems with their dental contracts.

The criticism of the 2006 contract is that dentists are paid according to how many treatments they carry out, with individual targets, resulting, in extreme cases, dentists having to stop seeing patients in January because the practice has filled its quota for the financial year. In other instances dentists have to refund money when they fall short of their target. Ironically many believe that the current system has led to a "drill and fill" mentality which is what the present contract policy was meant to prevent!

Another failing of the current system is that many patients are not registered with an individual practice. Research has shown that in the past two years one million people failed to see an NHS dentist. In addition, over the last 10 years there has been a 40% increase in emergency admissions due to dental problems. Indeed, around 25,000 people were treated in hospital for dental problems in 2009, up from 17,400 in 2000/1.

As part of the proposed NHS Reforms, the Coalition Government has announced

plans to trial new changes to the current dental contracts in 68 practices across the UK. It is hoped that this will improve the oral health of patients through the promotion of preventative treatment, with a particular emphasis in reducing tooth decay in children, by encouraging good habits early on.

A major criticism of the current contract system is that it leaves dentists concentrating on activity with no specific rewards for high quality care or for delivering prevention. Therefore under the pilot scheme dentists will be paid for the number of patients they care for and the health results, rather than the number of courses of treatment dentists perform. A capitation formula will be developed to recognise the differing dental needs of their population – i.e. elderly patients tend to require more restorative work than children who require more check-ups. Dentists will maintain a detailed record of their patients' oral health to monitor over time the improvements in their oral healthcare.

The introduction of the pilot schemes has been met with approval from the BDA and it will be interesting to follow the outcome of these trials and see how they might shape the future of NHS dentistry.

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The Care Quality Commission



Gareth Morgan,
Director

The independent Care Quality Commission was created to replace CSCI in April 2009, in order to service a rapidly expanding need to regulate and register those individuals and organisations providing healthcare services to the general public, including both state and private providers.

Much of this expansion resulted from the Health and Social Care Act 2008, which came into force in October 2010 creating a new set of essential standards of quality and safety relating to healthcare delivery. So what does this huge Quango actually do?

- It registers providers of healthcare and social care
- It monitors how providers comply with set standards
- It enforces requirements by recommendation, fines, public

- warnings and can also close units down
- It acts to protect patient rights
- It promotes improvements in services

There are further major changes in the immediate future. These include registering dental practitioners and practices for the first time (effective from April 2011) and recommending better standards such as the installation of decontamination rooms. For many patients, knowing your dentist and dental nurse have passed the Criminal Records Bureau checks before saying "Open Wide" is a comfort and reassurance, but the setting and enforcing of standards of treatment, accommodation and equipment are of primary importance.

For Care Homes (Nursing and Residential) changes in the register, abolition of the star ratings, greater self certification and fewer physical inspections mean a sea change in monitoring, administrating and indeed lending to such businesses.

For banks, owners and investors these are volatile times and understanding the complex changes and their effects upon businesses is difficult. We will be holding some workshop sessions when our highly experienced and knowledgeable experts will be on hand to guide you painlessly through the changes and consequences, making buying, lending and investing far safer and easier.

For further information contact Gareth Morgan FRICS FAVLP CEnv SSBV 01384455035 or email: gareth.morgan@argroup.co.uk

Keeping in line with current and new property legislation



Let Aitchison Raffety manage your property

Is your practice keeping up to date with statutory property legislation? Both tenants and property owners are now faced with a plethora of regulations to which they must legally adhere, from asbestos control registers, fire risk assessments, fixed wire electrical tests, water tank chlorination tests, lift equipment testing, plant equipment and gas safety tests, lightning protection tests and much, much more. Then there is the maze of health & safety legislation. Just keeping up to date with all this can be a full time job in itself!

At one northern based medical centre where we now provide management services, the practice manager was struggling to understand the technical details of how many service visits were required to ensure the safe operation of the building's air conditioning units, water pressure vessels, air handling units etc. Aitchison Raffety has taken away the headache of sourcing reputable plant maintenance contractors, tendering the annual contracts and providing a day to day repair and maintenance service for the centre which leaves the practice manager free to concentrate on the core business of the surgery in providing the medical services and administration required in providing such to patients.

Our team of professional RICS accredited managing agents has considerable experience in managing buildings throughout the country including those being used to provide healthcare services to the general public. For further information contact our property management team: 01908 608002 or email: irene.dymond@argroup.co.uk

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