

RICS Practice Standards, UK

Valuation of medical centre and surgery premises

2nd edition, guidance note



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Valuation of medical centre and surgery premises

RICS guidance note

2nd edition (GN 60/2010)

Published by the Royal Institution of Chartered Surveyors (RICS)

Surveyor Court

Westwood Business Park

Coventry CV4 8JE

UK

www.ricsbooks.com

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Produced by the Valuation Professional Group of the Royal Institution of Chartered Surveyors.

1st edition published 2003 as Valuation Information Paper No. 4: *Valuation of surgery premises used for medical or health services*.

ISBN 978 1 84219 599 4

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Cover image photo © Medicx Ltd 2010

Typeset in Great Britain by Columns Design Ltd, Reading, Berks

Printed in Great Britain by Annodata Print Services, Dunstable, Beds

Contents

RICS Valuation standards (the ‘Red Book’)		iv
RICS guidance notes		1
1	Introduction	2
2	The NHS framework	3
3	British Medical Association (BMA) guidance	7
4	Basis of valuation, general assumptions and considerations	8
5	Valuation for partnership purposes	10
6	Valuation for loan security purposes	11
7	Valuation of investment properties	12
8	Valuation of LIFT schemes	13
9	Inspection and measurement	14
10	Design and specification – the impact of legislation and NHS policy	15
11	Pharmacies within healthcare developments	17
Appendices		
1	Floor plan examples showing NIA calculation	18
2	Provision of general medical services in Wales	21
3	Provision of general medical services in Scotland	23
4	Glossary of terms	25

RICS Valuation Standards (the ‘Red Book’)

RICS (Royal Institution of Chartered Surveyors) is the leading organisation of its kind in the world for professionals in property, land, construction and related environmental issues. As part of our role we help to set, maintain and regulate standards – as well as providing impartial advice to governments and policymakers.

To ensure that our members are able to provide the quality of advice and level of integrity required by the market, RICS qualifications are only awarded to individuals who meet the most rigorous requirements for both education and experience and who are prepared to maintain high standards in the public interest.

Members who qualify as valuers are entitled to use the designation ‘Chartered Valuation Surveyor’ and, in addition to compliance with the general Rules of Conduct applicable to all members, must also comply with the RICS *Valuation Standards*, generally referred to as the ‘Red Book’.

This guidance note describes the standard of work that is expected of a reasonable, competent valuer experienced in the subject to which this note relates.

RICS has in place a regulatory framework. Where a valuer undertakes work that has to comply with the Red Book that valuer is also required to register with RICS. Registration enables RICS to monitor compliance with the valuation standards and take appropriate action where breaches of those standards have been identified.

Acknowledgments

This guidance was produced by the Surgery and Primary Care Premises working party within the Valuation Professional Group. RICS would like to express thanks to the chair of the working group, John Hearle, FRICS, MCI Arb, Aitchison Raffety and the group members:

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RICS guidance notes

This is a guidance note. It provides advice to RICS members on aspects of their practice. Where procedures are recommended for specific professional tasks, these are intended to embody 'best practice', i.e. procedures which in the opinion of RICS meet a high standard of professional competence

Members are not required to follow the advice and recommendations contained in the note. They should, however, note the following points.

When an allegation of professional negligence is made against a surveyor, the court is likely to take account of the contents of any relevant guidance notes published by RICS in deciding whether or not the surveyor had acted with reasonable competence.

In the opinion of RICS, a member conforming to the practices recommended in this note should have at least a partial defence to an allegation of negligence by virtue of having followed those practices. However, members have the responsibility of deciding when it is inappropriate to follow the guidance.

On the other hand, it does not follow that members will be adjudged negligent if they have not followed the practices recommended in this note. It is for each surveyor to decide on the appropriate procedure to follow in any professional task. However, where members depart from the practice recommended in this note, they should do so only for a good reason. In the event of litigation, the court may require them to explain why they decided not to adopt the recommended practice. Also, if you have not followed this guidance, and your actions are called into question in a RICS disciplinary case, you will be asked to justify the steps you did take and this may be taken into account.

In addition, guidance notes are relevant to professional competence in that each surveyor should be up-to-date and should have informed him- or herself of guidance notes within a reasonable time of their promulgation.



1 Introduction

1.1 This guidance note is concerned with the valuation of surgery premises, including all medical centres and surgeries 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.

1.2 This guidance note has been written specifically with regard to the position in England. The valuation approach is essentially the same in Wales, and Scotland, but where there are differences they are noted where they occur.

1.3 The National Health Service (NHS) in Wales and Scotland have their own framework with regard to the provision of general medical services and the

relevant details are summarised in Appendices 2 and 3 respectively. Although the details vary in Northern Ireland, the principles are similar and should be capable of adaptation to local circumstances.

1.4 Valuers are reminded that the RICS *Valuation Standards* (the 'Red Book') apply to valuations for this purpose.

1.5 The terms used in this guidance are defined in Appendix 4.

1.6 In July 2010 the government issued a White Paper 'Equity and Excellence Liberating the NHS'. This announced the intention to abolish Primary Care Trusts and Strategic Health Authorities, in England, from 2013. This guidance note will be revised when the detailed proposals are published.

2 The NHS framework

2.1 The following paragraphs, 2.3 to 2.6 outline the NHS structure in England. Appendices 2 and 3 outline the NHS framework in Wales and Scotland respectively.

2.2 To appreciate the role of the (General (Medical) Practitioner (GP)) it is necessary to understand the framework of the NHS. The elements of most relevance are:

- The NHS framework;
- NHS Local Improvement Finance Trusts (LIFTs) in England;
- NHS (GMS-Premises Cost) Directions 2004;
- Controls over NHS Reimbursement.

2.3 The NHS framework

The following information has been provided by the Department of Health in England.

Primary Medical Care Contractors (PMCC) Services

2.3.1 Family Health Services are in the main provided by GPs through either GMS or Personal Medical Services (PMS) Contracts (GMS only in Wales). The former is a nationally agreed contract between Department of Health (DH) and the General Practitioners Committee of the BMA; the latter is a contract agreed locally between PCOs and GP practices. Which contract is entered into is a matter of choice for the GP practice. Both contracts refer to service providers as PMCCs. In England, a third contract exists – APMS which is one agreed between a PCO and an Alternative Provider which may be private company or a coalition of GPs who provide services not covered by a GMS or PMS Contract.

Non-PMCC services

2.3.2 PCOs also commission community services such as midwifery and physiotherapy provided in community settings. In addition PCOs commission services from NHS and Foundation Trust Hospitals such as surgical or medical treatments provided in acute settings. It is increasingly DH policy to move

appropriate services from acute settings to primary care settings. (For the purposes of this paper, Primary Care is defined as *PMCC, Community and any other non-acute based services.*)

PMCC premises

2.3.3 Delivery of PMCC services should ideally be from modern safe and secure buildings of appropriate design that allows good access to the building. Design standards for such buildings are considered further in section 10.

The design elements of the *Primary and Social Care Premises – Planning and Design Guidance* have been replaced in England in 2009 by a new *Health Building Note for Primary Care and Community Hospital premises* known as HBN11.

New, extended or refurbished premises

2.3.4 Guidance on planning and funding of new, extended or refurbished premises, including Business Case arrangements, can be found at www.pcc.nhs.uk/planning-and-design-guidance.php.

Under the Premises Directions, the DV (or the PCO's Appointed Valuer) provides advice on value for money to PCOs for new, extended or refurbished premises. The DV is a recognised source of expertise on value for money and valuation matters for PMCC premises.

Guidance on DH Primary Care Policy

2.3.5 The underlying principle of DH Primary Care Policy is to provide safe and secure services in safe and secure premises that provide good local access for patients and users. Initiatives to achieve this include the NHS Next Stage Review (Darzi Reports), World Class Commissioning, Practice Based Commissioning and Transforming Community Services (TCS). Details of these and other initiatives can be found on the DH web site (www.dh.gov.uk).

2.3.6 The NHS framework allows for different methods of procurement including doctor led schemes for owner occupation, third party developments (3PD) leased to GPs or Primary care Trusts (PCOs), LIFT (England only) and private finance initiative (PFI) schemes.

2.4 NHS LIFT

2.4.1 LIFT, as detailed below, is one of the routes whereby new Primary Healthcare Premises are procured.

2.4.2 LIFT is the established name for the Department of Health's Local Improvement Finance Trust initiative. It is a major Government Public Private Partnership (PPP) initiative designed to stimulate investment in primary and social care facilities. The joint venture company (LIFTCo) is established with the following shareholding; 60% private sector partner, 20% PCO and 20% Community Health Partnerships. The formation of a local PPP and the establishment of a long term partnering agreement between it and a range of local public sector organisations is expected to facilitate the delivery of the service strategy laid down in the PCO's Strategic Service Development Plan. The LIFT concept is 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, within one building.

2.4.3 The Strategic Partnering Agreement (SPA) is a 20 year agreement for the LIFTCo to develop proposals for new projects to meet local needs and for the private sector to provide services that complement those of the public sector in the locality. The Shareholders Agreement prescribes procedures and processes for the management and operation of the LIFTCo to meet the requirements of all the shareholders. Normally public sector occupiers (including PCOs and GPs) within a LIFT building will enter into a Lease Plus Agreement (LPA), based on a commercial lease with additional provisions to benefit the public sector (or GP) tenant. These include a duty to provide premises suitable for specified use(s), building maintenance and facilities management for the term of the lease, a guaranteed right to buy at the end of the term and a facility for making rent reductions for non-availability of specified facilities. The rental payment

under the LPA is retail price index (RPI) linked. Other private sector occupiers normally enter into a standard commercial lease.

2.4.4 There have been four separate waves of LIFT projects (46 now operational) generating £1500m in investment to develop more than 210 new integrated community facilities mostly across deprived urban areas.

2.4.5 In the Autumn of 2008 the government launched Express LIFT to assist those PCOs without access to a LIFT company. The idea behind Express LIFT is to speed up the procurement of new primary care facilities. The framework is to be based on LIFT. The Express LIFT model will generate a list of approved private sector partners, each of whom will have demonstrated a track record of delivering the services required of a successful LIFT company. Under the initiative, between six and ten companies will join a national partnering framework. PCOs that are not currently in a LIFT Co will be invited to select joint venture partners from a pre-approved panel to set up their own LIFT Co. The Express LIFT process will be heavily centralised with standard financial and technical details arranged through the frameworks leaving PCOs to concentrate on their service requirements.

2.4.6 In Scotland, an initiative known as HUB which is similar to LIFT is being introduced. However, this is not a PPP but rather uses public funding via the Scottish Futures Trust.

2.5 NHS (GMS-Premises Costs) Directions 2004

2.5.1 GMS contractor premises costs are reimbursed by PCOs in addition to the service contract price. The arrangements for these payments are set out in the *NHS (GMS – Premises Costs) (England) Directions 2004*. The Directions may be found on the DH web site at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_4078585.

Payments are made from PCOs' financial allocations and the purpose of the Directions is to provide the means to recognise reasonable cost, value for money to the public purse and parity of treatment for General Medical services (GMS) contractors. For PMS/Alternative Provider Medical

services (APMS) contractors, whilst not obligatory, PCOs may agree to use the Directions in respect of their premises costs.

2.5.2 The Directions allow PCOs to make payment to GPs for premises development or improvements plus related professional fees and relocation costs plus recurring premises costs (although all such payments are tempered in that they must be in line with the budgetary targets of the PCOs). The Directions came into force on 1 April 2004.

2.5.3 In exceptional circumstances the PCO can allow the rent reimbursement to be increased over and above the market rent where the market rent is deemed insufficient:

- to support new capital investment in practice premises
- to support existing premises being brought up to minimum standards.

The level of any increase must be approved by the DV in accordance with the Directions. In England and Wales such additions are reserved for areas of deprivation and in Wales increases are further limited to 20% of the market rent. The situation is more common in certain areas of Scotland where the rental agreed prior to construction of new GMS premises is actually an economic or augmented rent that has been agreed with the DV utilising an appraisal based approach and representing a significant premium to current market rental levels in the locality. For leasehold premise such above market rents will affect the ability to increase rents at review and in owner occupied premises uplifts may be personal to the GPs. Such deprivation uplifts or augmented rents do not reflect current market rental levels. In such circumstances the valuer needs to ascertain full details of to whom and for how long any above market rent applies.

2.5.4 The forms of financial assistance the PCOs may offer are unlimited in the case of an emergency, but generally revolve around proposals within the PCOs' Estates Strategy that can be shown as representing value for money, normally of the following format:

- Premises Improvements Grants between 33% and 66%. Valuers should note that where such grants are used, the PCO may reserve the right

to claim a proportion back should the premises cease to be used for GP purposes within a five to ten year period.

- Payments of professional fees in respect of occupying new or refurbished premises.
- Recurring premises costs. For owner occupied premises, the level will be the Current Market Rent (CMR) assessed by the District Valuer having regard to specified assumed lease terms. For leased premises, reimbursement will be the lower of the CMR or lease rent (subject to specified adjustments). For new owner occupied premises the PCOs can also reimburse the borrowing costs (similar to the historic Cost Rent Scheme) where a prescribed percentage is applied to the site purchase, building works, professional fees, rolled-up interest, statutory costs, fit-out costs, Value Added Tax (VAT) and Stamp Duty Land Tax (SDLT).

2.5.5 Valuers are advised that PCOs will abate the level of CMR reimbursed where a capital grant (under the Improvement Grant provisions in Wales) has been provided towards the costs of building or refurbishment. This highlights the need to fully investigate tenants' improvements and how they were funded. An abatement also applies where more than 10% of the Practice income relates to private patients.

2.5.6 Where a GP is to relocate to new/refurbished leasehold premises and the existing premises are not suitable, the PCO can assist GPs in respect of disposing of those existing premises by:

- Paying mortgage deficit or mortgage redemption fees;
- Guaranteeing the minimum sale price;
- Paying the cost of reconverting former residential property;
- Paying the cost of surrendering or assigning leasehold premises; and
- Paying SDLT on new premises.

Minimum standards

2.5.7 To all premises where payments are made as summarised above, the PCO will apply minimum

standards which, if breached, can lead to the abatement of rent reimbursement.

2.6 Other NHS Controls over Rent Reimbursement

The Darzi Report

2.6.1 The report by Lord Darzi, 'High Quality Care For All – NHS Next Stage Review Final Report' redefines the NHS and looks at the future of healthcare services which it seeks to bring into the community. As a guide to PCOs, it will affect the Strategic Estate Plans that every PCO should hold. For valuers, such information will assist in assessing the demand for medical premises in any particular location.

Premises costs disputes

2.6.2 The *NHS (GMS Contracts) Regulations 2004* attends 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 PCOs make every reasonable effort to settle any matters including disputes over the level of CMR at a local level. In this respect, many PCOs have put in place individual procedures. If local resolution fails then GP contractors can, under the NHS Dispute Resolution Procedure, put their case in writing to the Secretary of State. The regulations give the Secretary of State the right to appoint an adjudicator which, for CMR cases in England, will be Family Health Services Appeals Unit (FHSAU) within NHSLA. In turn, the FHSAU have the ability to appoint an independent expert advisor and there is a scheme running whereby the RICS Dispute Resolution Service administers such appointments. Adjudication in Scotland and Wales currently remains with the NHS although it may in the future follow the above. Procedures for dispute resolution in Scotland and Wales vary from the above although the principles are the same.

3 British Medical Association (BMA) guidance

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

The current key relevant BMA document is 'The future of GP practice premises – Guidance for GPs'. This was issued in December 2001 (revised January 2007). A further revision is planned. This guidance examines the current state and future of the various primary care premises development options, covers ownership and leasing, and describes the premises provisions of the new GMS contract. It incorporates GPC guidance on the premises costs directions (which provides a brief overview of The Directions and on the *Disability Discrimination Act*). The paper also provides commentary on NHS Lift and PFI schemes. In Wales and Scotland this document needs to be read within the context of their policies and procedures.

3.2 The Health Policy & Economic Research Unit of the BMA produced a 'Survey of GP practice premises' in May 2006. This was commissioned by the GPC to find out what issues practices are facing with respect to their premises and

discovering future problems they anticipate in their ability to deliver and develop further, high quality, general practice care to patients. Other guidance issued in 2006 included an update of 'Partnership Agreements'. This relates to practices in England and Wales and Northern Ireland and includes advice on the basic elements of a partnership, implications of the new GMS contract, contractual obligations, and types of partnership and related entities. An associated paper 'Valuing surgery premises' (revised November 2007) is aimed at owner occupiers to update them on the current principles applied to the valuation of surgery premises with particular regard to the drafting of relevant clauses within a partnership agreement.

3.3 The GPC's publications are very much papers of guidance and set out the opinion of the GPC. However, as the considered opinion of such a prominent association, valuers should be fully aware of these publications, as their content will influence GPs which, in turn, could ultimately impact on surgery values. The BMA website address is www.bma.org.uk. A limited number of documents on the website is available to non BMA members, but a number relating to practice premises is currently only available to BMA members. The BMA is considering allowing wider access to these documents.

4 Basis of value, general assumptions and considerations

4.1 The purpose of the valuation will determine the basis of value. The majority of valuations to which this guidance note 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.

4.2 The appropriate basis of value is usually Market Value (see *Red Book* PS 3.2). No account should be taken of any Cost Rent or, without due consideration, CMR reimbursements from the PCOs, as these are individual contractual arrangements that might be terminated in the event of a sale.

4.3 There may be circumstances where the valuer is asked to provide a valuation subject to special assumptions, in which case the *Red Book* PS 2.2, will apply.

4.4 An increasing number of medical centres are occupied by doctors and PCOs as tenants rather than as owner occupiers. This has become a recognised investment sector. Surgery investments should be valued on the basis of Market Value.

Compliance with design guidance

4.5 Valuers need to be aware of and understand the DH design guidance, which differs between England, Scotland and Wales (see Section 10 below). The impact on value of the changes in design guidance, as it has been developed over the years to ensure premises meet the requirements of the time, needs to be recognised. Compliance as well as non-compliance with current and previous DH design guidance has a strong influence on the medical premises 'valuation hierarchy'.

4.6 Obsolescence

Obsolescence is an important issue in the sector. Valuers are expected to comment upon the design

of buildings, flexibility, potential for expansion, impact of population change and planning and competition from other surgeries in the locality. The valuer is advised to establish how the premises fit with the estates strategy of the PCO.

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

4.7 Comparable rental evidence

4.7.1 In England the majority of lease rents on newly developed NHS medical centres for GP occupation are agreed by the landlord and tenant in the knowledge of an advance estimate of the CMR, which is provided by the DV after discussion with the parties. In the case of PCO leases, the rent will be agreed by landlord and tenant following recommendations by the DV (or the PCO's appointed valuer). In both cases rents are agreed before construction, and are intended to reflect Market Rents. Where possible, a development appraisal is used by DVs to test for value for money.

In Wales for all newly developed NHS medical centres the DV enters into negotiations with the landlord to agree the rent to be paid and reimbursed by the LHB. Any agreement is subject to funding approval by the Minister of Health within Welsh Assembly Government (WAG).

4.7.2 CMRs for existing premises are also agreed with the DV. Care should be taken to establish the basis of value for reasons established in 4.1 to 4.4 above. Furthermore, CMRs can be subject to Abatement if there has been a contribution of NHS capital (Direction 43) – see 2.5.5 above – or Supplement (Direction 44) if there have been improvements which would otherwise not be reflected in the reimbursement.

In Wales these provisions are detailed in Schedule 3 of the Welsh Premises Directions (see appendix 2).

4.7.3 In searching for and analysing comparable evidence, the valuer is recommended to obtain a number of comparables so that the Market Rent in the locality can be ascertained. Some lease rents and rent reimbursements can be above or below the general level of Market Rent particularly if they have 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 alternative use of the site or property. The circumstances of new developments need to be fully investigated.

4.7.4 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 2.4 and VIP 8 The analysis of commercial lease transactions)

5 Valuation for Partnership Purposes

5.1 These paragraphs apply primarily to surgeries occupied by GPs. However, many of the comments may also be of assistance in valuing, for partnership purposes, surgeries occupied by others in providing medical/health services.

5.2 It is common for valuers to be asked to value surgery premises in order to quantify the value of the property assets when a GP is leaving or joining the partnership. It should be clearly agreed whether the partnership or an individual partner (or prospective partner) is the client.

5.3 In respect of owner occupied premises, it is recommended that vacant possession should be assumed for those areas under GPs' occupation.

5.4 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 it is recommended that the valuer confirms that the goodwill of the practice is not included in the valuation of GP premises.

5.5 If there is any doubt as to whether a sale of an interest in GP practice premises might constitute a breach of the above 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.

5.6 It is open to partners of a medical practice to agree within their partnership documentation the basis of valuation to be adopted on partnership change. The current GPC recommendations (Valuing Surgery Premises (last revised November 2007)) suggest 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. These have to be treated as special assumptions and have to 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.

5.7 The actual wording of the partnership deed should be scrutinised 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, the matter should be discussed with the client before the valuation is prepared (see *Red Book* PS 2.1(f)).

5.8 In the absence of any specific instruction, agreement between the parties or reference in the partnership deed as to the basis of value, it will usually be appropriate for the valuer to recommend the basis of Market Value in accordance with the GPC recommendations.

5.9 Where the valuation has regard to a special assumption this should be specifically referred in the Report (See *Red Book* PS 6.4)

6 Valuation for Loan Security Purposes

6.1 The *Red Book*, Appendix 4.4, contains general guidance on valuations for commercial secured lending.

6.2 The valuer is advised to clarify to the lender that Market Value does not take into account any Cost Rent or, without due consideration, adopt CMR reimbursements (see 4.2) For owner occupied premises, a valuation assuming vacant possession is therefore recommended. Income from third party lettings (including for example, pharmacies or dentists) should be valued having regard to the terms of their occupancy.

6.3 The valuer is recommended to 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. The majority of surgeries will be subject to CMR rather than Borrowing Cost or Cost Rent.

6.4 Any areas shared with a GP practice that might not otherwise be classified as provided for GMS or PMS should be identified 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.

6.5 Some lenders may require a number of different valuation scenarios. For owner-occupied premises, the valuer may be asked to provide a separate valuation having regard to the Borrowing Cost, Cost Rent or CMR reimbursement. In relation to investment properties, 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 value) and for LIFT premises, the exit (or reversionary) value may be more relevant for loan consideration. Each of these valuation scenarios would reflect a special assumption. To comply with PS 2.2 such a special assumption must be included in the terms of engagement and referred to in the report (see PS 6.4).

7 Valuation of Investment Properties

7.1 The appropriate basis of value will be Market Value having regard to the leases. The valuer is recommended to 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.

7.2 The lease terms for areas occupied by GPs and PCOs may vary but are usually influenced by prior involvement of the DV (or the PCO's appointed valuer). Whilst some leases are more traditional in nature committing the tenant to full repairing and insuring liabilities, it is not uncommon for leases to limit tenant's repairing obligations to the interior only. In modern leases, the internal repairing liability may exclude the replacement of major plant. In addition, a landlord may be responsible for bearing the cost of the buildings insurance. Appropriate deductions should be made from the gross rents to reflect the FRI equivalent. This should be clearly identified in the valuation report.

7.3 Rent review clauses will also vary and should be carefully considered. Where there are GP practices in occupation, their rent reviews may intend the rent to be influenced by the DVs assessment of the CMR for reimbursement purposes. There may be provisions for rents to be

reviewed downwards as well as upwards. In connection with alienation provisions, the valuer should carefully check these where there are GPs in occupation. The leases will normally allow for doctors 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. Some alienation provisions may require the practice to maintain rent reimbursement. Authorised guarantee agreements are not normally required on an assignment to another GP practice or NHS body. Lease definitions should be checked carefully.

7.4 User clauses should be checked carefully. It is very common with medical centres for the user clauses to be specific to medical services being provided within the NHS. While the potential of these strict user clauses to adversely affect rental value has to be considered, the prime reason for them is to protect the rent reimbursement that is being received by the GP practice in occupation. It also prevents the assignment of the lease to a weaker covenant that may adversely affect the investment value.

7.5 It cannot be assumed that occupation by the primary care tenant will continue at the end of the lease. This needs to be considered together with the potential reversionary use/value especially in respect of short term leases.

8 Valuation of LIFT schemes

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

8.2 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.

8.3 As LIFT has some similarities to PFI, valuers should obtain clear instructions from any lender as to the method of valuation required. It is possible that some lenders may require a discounted cash flow method to be used.

8.4 The LPA Payments are subject to annual RPI increases. The gross internal floor area of the building rather than the net internal floor area is used for calculating the Lease Plus Payment. 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.

9 Inspection and measurement

9.1 Although it contains no specific reference to surgery premises, it is recommended that valuers have regard to the RICS *Code of measuring practice* when undertaking the measurement of property for valuation purposes. The core definitions provided in the code include:

Gross Internal Area (GIA). GIA is the usual method of measurement for calculating building costs (for example, with reference to BCIS data), 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;

Net Internal Area (NIA). NIA is the usual basis of measurement for the valuation and marketing of the majority of non-industrial business premises. (See application 9 in the core definitions: Net Internal Area of the Code of Measuring Practice.)

9.2 In contrast to office premises and many other types of commercial property, surgeries contain specialist facilities and generally have different requirements in terms of space utilisation. These include, amongst other matters, the provision of additional WC accommodation (in order to provide separate facilities for patients and staff), additional corridor/circulation space (necessary to enhance confidentiality for clinical rooms and reception areas) and additional cleaning accommodation to allow for infection control.

9.3 Therefore, in applying the RICS *Code of measuring practice*, certain areas additional to the facilities referred to in items 2.1 to 2.10 of the core definition should be included within the calculation of NIA. These would include:

- internal pram stores, baby changing facilities and other ancillary accommodation provided specifically for the benefit of patients;
- additional protected areas provided as a result of the more stringent means of escape and fire regulations as applied to surgery premises.
- additional WC accommodation provided exclusively for the use of patients;
- In determining what constitutes additional WC provision, the valuer will need to have regard to the number of WCs required under current legislation for the number of staff employed at the property including wheelchair accessible WCs required for staff under the Disability Discrimination Act (DDA); and only include within the NIA the additional WCs provided for patients;
- necessary additional circulation space;
- facilities for the secure storage of clinical waste;
- additional cleaners' rooms required for infection control; and
- shower rooms.

Examples of floor plans showing the above are included as Appendix 1.

9.4 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.

9.5 During the course of inspection, opportunity may be taken to record the 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.

10 Design and specification – the impact of legislation and NHS Policy

The existing legislation together with NHS Directions, historic and current Guidance in respect of design and specification, are important factors in determining the quality of a surgery.

10.1 Guidance in England

Historic Guidance

10.1.1 Historically, the Statement of Fees and Allowances Paragraph 51, Medical Practice Premises – The Commentary 1999 and 2002 and Primary & Social Premises Planning & Design Guidance 2004, applied.

The Disability Discrimination Act 1995 and 2005 (DDA)

10.1.2 Due to the nature of the use, disability legislation probably 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. 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 will need to exercise judgment as to:

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

DH Health Building Note 11 (HBN11)

10.1.3 This document provides best practice on the design and layout for primary and community care premises and community hospitals. The document is part of the already published suite of Health Building Notes to which the NHS has

access. HBN11 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. The HBN11 shows the valuer what is required by the NHS for compliance and thus forms a guide to quality.

The Directions

10.1.4 Within Schedule 1, the Directions attend to the minimum standards required for primary care premises in relation to:

- Compliance under the *Disability Discrimination 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; and
- Adequate lighting, heating and ventilation together with fire and security provisions.

Energy sustainability requirements

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

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 Certificate (DEC). From 1 October 2008 DEC's are required for all primary healthcare buildings in excess of 1,000m² GIA (due to be

reviewed in 2010). In line with other commercial property, Energy Performance Certificates (EPCs) are required for all new premises or those that are the subject of a sale or lease.

10.2 Guidance in Wales

The following guidance is available to assist in ensuring that primary care premises are fit for purpose:

- Welsh Health Estates (WHE) Primary Care Development: Design Guide;
- Welsh Health Circular (WHC) (2007) 64 Primary Care Estate Development and Bid Processes;
- WHC (2008) 55 Guidance on Accommodation Schedules for GMS Space in newbuild facilities;
- WHC (2008) 56 Attached Staff Funding of Costs Associated with Staff attached to Primary Care Teams;
- DVs Performance Specification for Building, Engineering Works for Primary care Developments.

Future guidance will be made available on the WHE primary care website.

10.3 Guidance in Scotland

10.3.1 Design guidance for Primary Care Premises in Scotland is currently provided within 'Scottish Health Planning Note 36 Part 1: General Medical Practice Premises in Scotland'. This document is free to download from the Health Facilities Scotland website at:

[www.hfs.scot.nhs.uk/online-services/publications/property/scottish health planning notes](http://www.hfs.scot.nhs.uk/online-services/publications/property/scottish%20health%20planning%20notes)

10.3.2 This document provides advice on the design and specification requirements for Primary Healthcare Premises in Scotland and is the first of 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.

10.3.3 Health Planning Note 36 draws from, and replaces, the GP Premises Directions – Guidance Note 2 publication 'GP Practice Premises in Scotland – A Commentary (June 2002)'. The new document provides updated guidance, as the source for spatial and dimensional standards, on

the nature of premises in respect of which Health Boards may consider financial support to be appropriate. The guidance is primarily aimed at General Practitioners 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 will also provide useful guidance for the refurbishment of existing buildings. The Health Planning Note shows the valuer what is required by the NHS for compliance and thus forms a guide to quality.

11 Pharmacies within healthcare developments

11.1 In England

11.1.1 Pharmacies are increasingly incorporated into new healthcare developments and the impact on value they have on the whole needs to be considered. The success of the pharmacy may well depend on the ultimate success of the health centre. Some GPs would be reluctant to commit to a new health centre unless it had the potential to have an integrated pharmacy.

11.1.2 In addition to pharmacy design and size, there are a number of other important factors that will determine the value of the premises.

11.1.3 The provision of pharmacy licences is tightly controlled by the NHS under the *National Health Service (Pharmaceutical Services) Regulations 2005*, the *National Health Service Act 2006* and the *National Health Service Act 2009*. In relation to the 2005 Regulations, the DH provides guidance to PCOs in the form of a document titled 'Information for Primary Care Trusts' – revised September 2009. Each PCO is now required to assess needs for pharmaceutical services within its area and publish a statement concerning such assessment.

11.1.4 Prospective pharmacy operators may apply to the local PCO for a new pharmacy licence which must be granted where necessary to meet an identified need or where the PCO is satisfied that the grant of a licence would secure improvements or better access to pharmaceutical services in its area. It is, however, more common for an existing pharmacy to relocate to a new development.

11.1.5 Typically, pharmacies are let to local or national pharmacy chains on commercial investment terms. The degree of competition for premises (and therefore the level of rent) is determined by a number of factors, including:

- the size and configuration of the pharmacy – whether possessing a consulting room or having appropriate storage.
- whether a new licence or a 'minor relocation' of an existing contract is required and, if a new licence, whether this is a '100 hours' contract

where operating costs are likely to be substantially higher than the average

- the likely number of 'scripts' (prescriptions) to be issued by the associated GP practice(s). In part, this is determined by the patient list size of the GPs and by the demographics of the practice list;
- the spatial relationship between the surgery and the pharmacy: to what extent does the pharmacy benefit from the surgery's 'pedestrian flow'?
- the extent to which electronic prescribing by the associated GP practice(s) is possible;
- the proposed lease terms and covenant strength of the operator;
- the nature of the planning consent and the extent to which retail sales are permitted. The opportunity for general retail sales may add value;
- whether an additional premium is paid at the outset of the lease. The impact of this at review (if any) will depend upon the terms of the lease.

11.2 In Wales

Those persons who wish to provide pharmaceutical services need to apply to the Local Health Board who determines the application in accordance with criteria set out in the *NHS (Pharmaceutical Services) Regulations 1992/662*; the *NHS (Pharmaceutical Services) (Amendment) Regulations 2009/1491*; and the *NHS (Pharmaceutical Services) (Amendment) Regulations 2005/1013*.

11.3 In Scotland

Those persons who wish to provide pharmaceutical services need to apply to the appropriate NHS Board who determine the application in accordance with criteria set out in the *NHS (Pharmaceutical Services) (Scotland) Regulations 2009*.

Appendix 1

Floor plan examples showing NIA calculation

Figure 1: Ground floor plan of a purpose built surgery

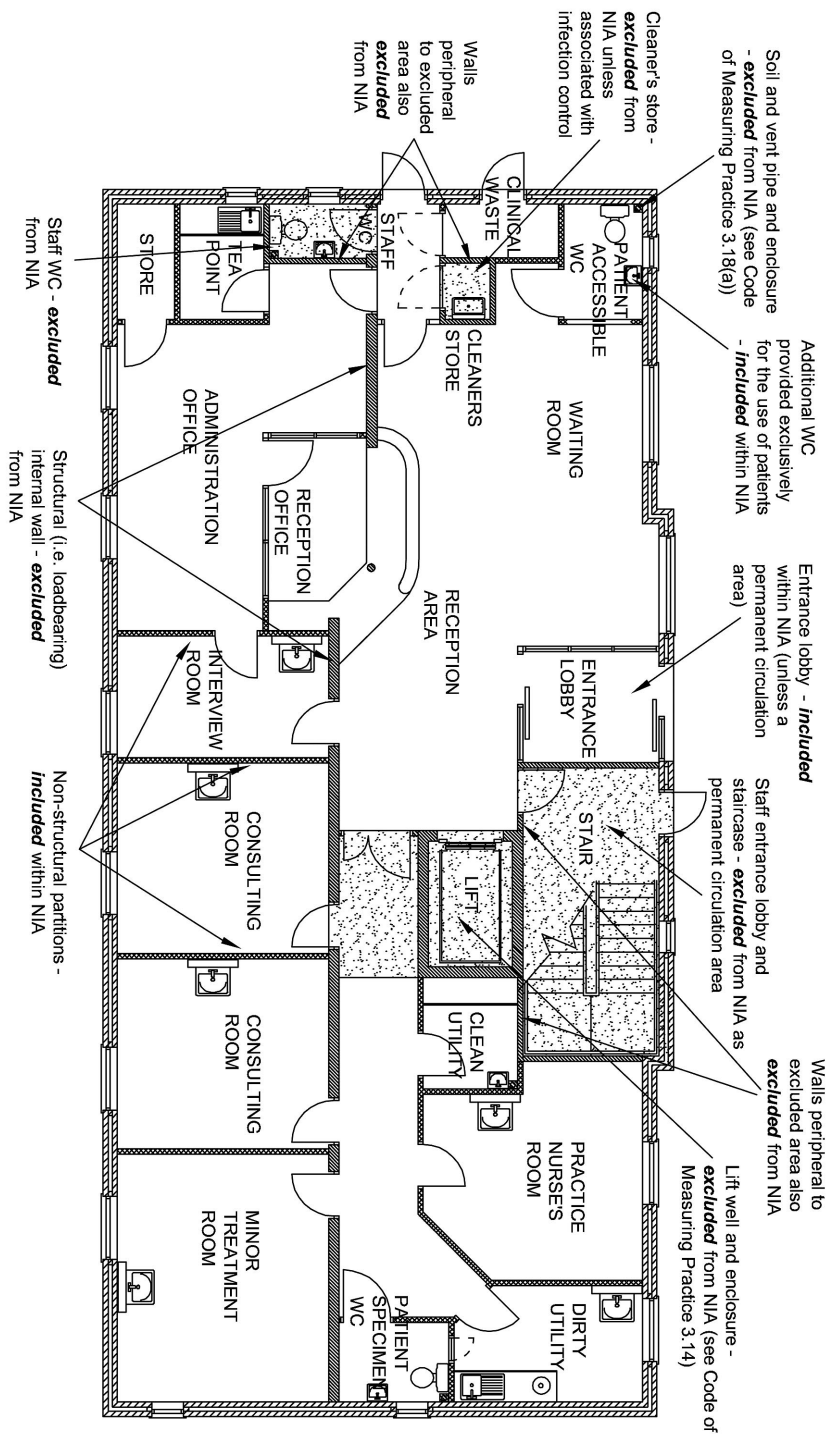


Figure 2: First floor plan of a purpose built surgery

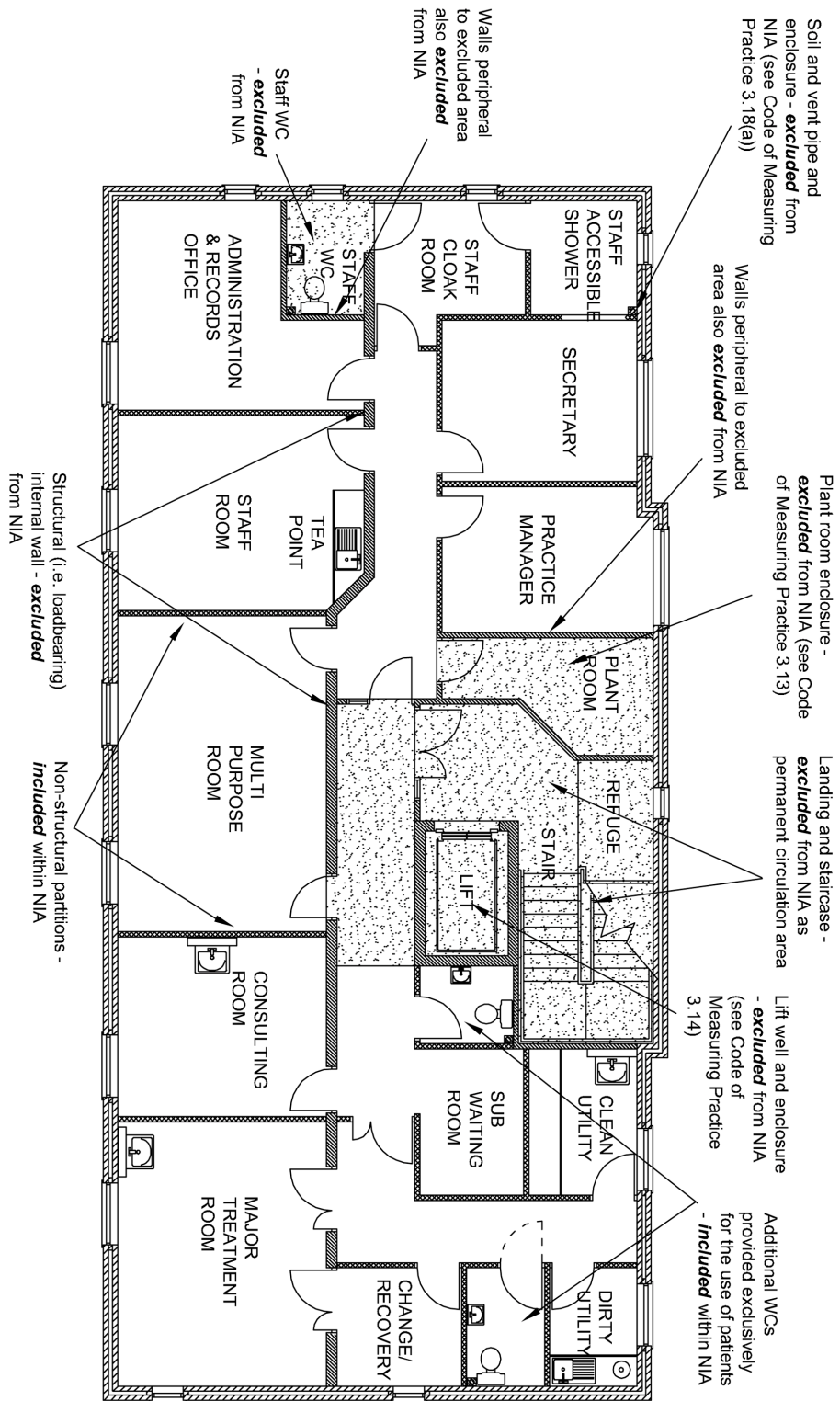
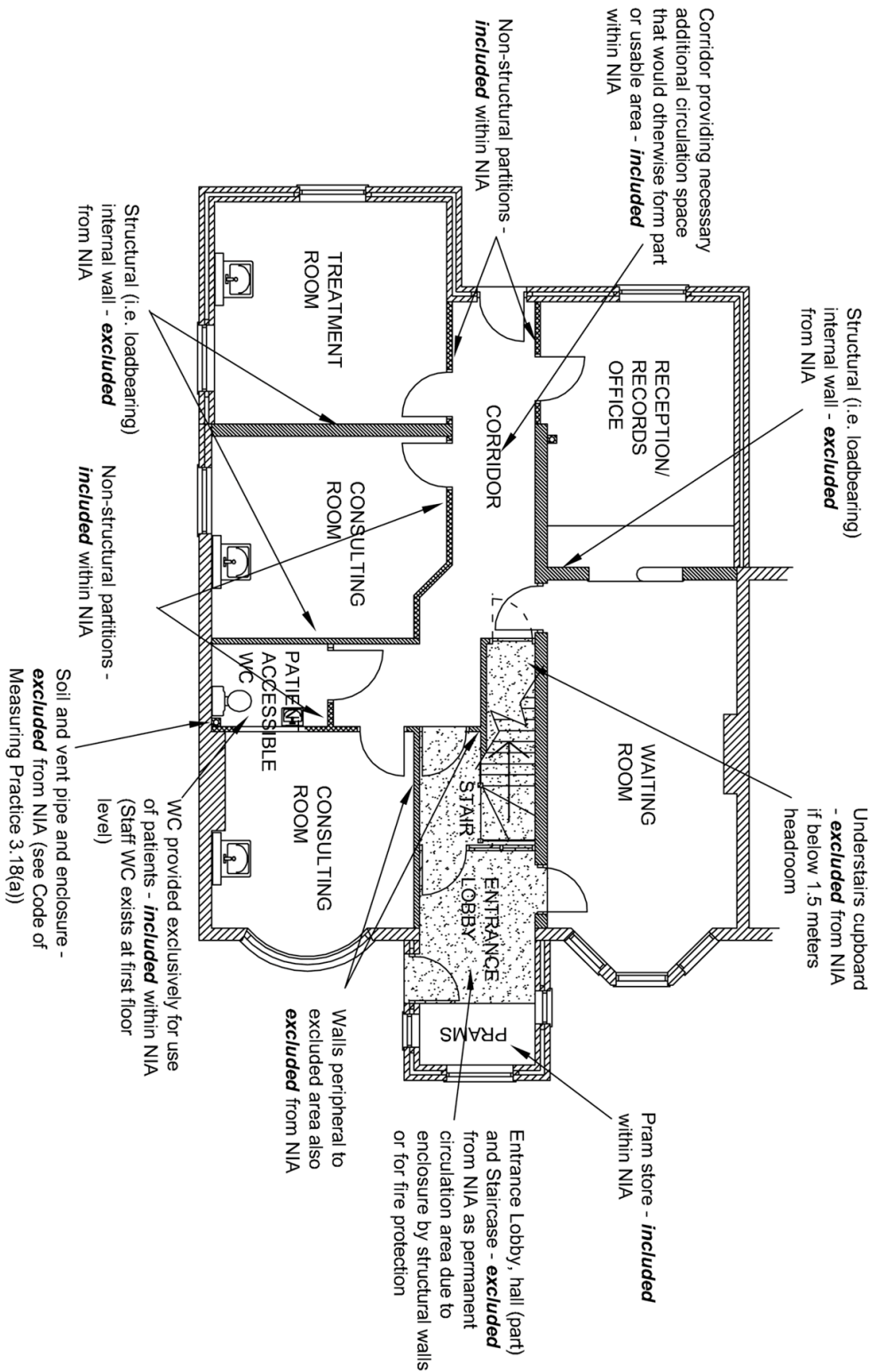


Figure 3: Ground floor plan of a two storey surgery converted from a residential dwelling, with purpose-built additions



Appendix 2

Provision of general medical services in Wales

1 General Medical Services

1.1 Family health services are in the main provided by GPs through GMS Contracts. The GMS contract is a nationally agreed contract between the Welsh Assembly Government and the General Practitioners Committee of the BMA with individual contracts agreed locally between Local Health Boards (LHBs) and GP practices.

2 Non-GMS Services

2.1 LHBs also provide community services such as health visiting, district nursing midwifery and physiotherapy in community settings and sometimes these services are co-located in primary care centres specifically designed and developed for GMS services. There are many benefits to moving appropriate services from acute settings to primary care settings and where possible the collocation of various health and social care services is encouraged.

3 Primary Care Premises

3.1 Delivery of primary care services should be from modern safe and secure buildings of appropriate design and which allow good access to and from the building. The Primary Care Development: Design Guide available on the WHE primary care website provides information on the design principles to be followed in new primary care premises in Wales.

3.2 Guidance on planning and funding of new, extended or refurbished premises, including funding bid documentation, can be found on WHE's primary care website. WHE's primary care estate advisors provide advice and support to LHBs on the development of all primary care premises.

3.3 The District Valuer (DV) provides advice on value for money to LHBs for new, extended or

refurbished premises and provides the Value for Money report which accompanies the funding bid for all premises development.

4 Procurement routes

4.1 The NHS framework allows for different methods of procurement including doctor led schemes for owner occupation (known as DIY schemes) , third party developments (3PD) schemes and NHS capital schemes.

DIY schemes

4.2 GPs can raise capital for the purchase of land, payment of consultants fees and construction costs of a primary care building. GPs are eligible for notional rental reimbursement or a reimbursement based on a percentage of the borrowing costs.

3PD schemes

4.3 Specialist commercial development companies will work at risk to purchase land, provide the necessary consultant activities relating to the planning, design and development of a scheme, in agreement with all the stakeholders including the occupiers and the LHB representatives. Once a funding bid is approved the occupiers will be required to enter into an agreement for lease with the 3PD and once handover of the constructed building has been achieved the occupiers will enter into a formal lease of 20 years in return for a rent prior agreed with the DV.

NHS capital

4.4 On occasion it may be appropriate for NHS capital to provide the funding for primary care buildings.

5 NHS (GMS-Premises Costs) (Wales) Directions 2004

5.1 GMS contractor premises costs are reimbursed by LHBs in Wales. The Directions may be found on the WHE intranet web site at:

www.wales.nhs.uk/sites3/Documents/254/401PremisesCostDirections.pdf.

England, Scotland, and Northern Ireland have their own versions of the Directions and, whilst the bulk of the content is similar, there are some fundamental differences, for example the exclusion of service charge reimbursement in Wales.

5.2 Payments are made from Assembly's GMS budget rather than from individually held LHB budgets although LHBs must submit funding bids on behalf of the GPs and all bids must be LHB Board approved. The purpose of the Directions is to provide the means to recognise reasonable cost, value for money to the public purse and parity of treatment for GMS contractors.

5.3 The Directions allow payments to GPs for premises development or improvements, related relocation costs plus recurring premises costs. All such payments are tempered in that they must be in line with the budgetary targets. The Directions came into force on 1 April 2004.

5.4 The forms of financial assistance available generally revolve around proposals within the LHBs' estates strategies that can be shown as having a high priority and representing value for money

5.5 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 LHB/Assembly will reserve the right to claim a proportion back should the premises cease to be used for GMS purposes within a five to ten year period.

Recurring premises costs. Where owner occupied premises receive reimbursement on the basis of the notional rent assessment, DVs will have regard to specified assumed lease terms. For leased premises, reimbursement will be the lower of the

rent assessed by the DV or the actual lease rent (subject to specified adjustments).

5.6 It should be noted that the notional rent reimbursed where an Improvement Grant has been provided towards the costs of building an extension or refurbishing the existing premises will attract an abatement subject to a formula detailed in Schedule 3 of the Premises Directions.

5.7 Where a GP is to relocate from unsuitable existing premises to new/refurbished premises, various forms of assistance can be provided to GPs in respect of disposing of those existing premises, such as:

- Paying a mortgage deficit grant including mortgage redemption fees;
- Guaranteeing a minimum sale price of the existing premises;
- Paying the cost of surrendering or assigning the lease of the existing premises;
- Paying Stamp Duty Land Tax on the lease of the new premises.

Minimum standards

5.8 LHBs apply minimum standards to all premises where payments are made as summarised above, which, if breached, can lead to the abatement of rent reimbursement.

Premises Costs Disputes

5.9 The *NHS (GMS Contracts) Regulations 2004* attends 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 LHBs 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, put their case in writing to the Assembly which determines the process to be followed.

Appendix 3

Provision of general medical services in Scotland

1 Hub Scotland

1.1 General medical services

In common with England and Wales, family health services are in the main provided by GP's through GMS contracts. The Scottish GMS contract is agreed between The Scottish Government and the Scottish General Practitioners Committee of the BMA. It is locally administered between Health Boards and GP practices.

1.2 The Hub Programme is a major initiative of the Scottish Futures Trust, a Government-owned company established in 2008 with the objective of improving public infrastructure investment and procurement. Details may be found on the Scottish Futures Trust Hub website www.scottishfuturestrust.org.uk/a.asp?a=22.

1.3 Hub is a procurement vehicle which is intended to improve the efficiency of community infrastructure delivery – with a particular emphasis on supporting the provision of more joint services across local authorities, NHS Health Boards and other community partners.

1.4 Across Scotland five separate Hub regions have been identified, with the two pilot regions being the North and the South East. For each region, a Hub Joint Venture, or Hub Co, will be formed between the public and private sector. The equity capital of the Hub Co will be split between the private and public participants and a Partnering Agreement will set out the rights and obligations of the parties, including the provision of partnering services by Hub Co and the exclusivity provisions from the public sector partners.

1.5 The focus of the Hub Co will be the planning, development and delivery of new infrastructure projects within the sphere of health and social care. However, the documentation will allow for the scope to be extended, at public sector discretion,

to include libraries, education facilities, police services, fire services and various other council and community facilities. The range of services will also be extendable to include estate management, service planning, property development and regeneration activities.

1.6 The ongoing provision of partnering services will be linked to the achievement of improvements in the way that community facilities are delivered, through improved designs, reductions in the cost of construction and buildings maintenance and faster delivery.

1.7 It is anticipated that the Hub Programme will deliver investment in the order of £300 million in respect of each of the two pilot regions over a ten year period. As at November 2009, Hub North initiated the procurement process for a private sector partner, with first phase submissions due in early 2010. Hub South East, meanwhile, had initiated the procurement process in July 2009 and have selected a short list of three private sector bidders, from a total of fifteen, and have appointed a private sector partner.

2 Premises Cost Directions

2.1 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. The Directions may be found on the Scottish Government Health Directorates website at: www.sehd.scot.nhs.uk/gpweb/7/PDFs/PremDir_2004.pdf

2.2 The bulk of the content of the Directions and the underlying principles mirror that of the English equivalent which has been covered in detail within the body of the guidance note. However, various minor differences exist at points throughout the

Directions and there are also two additional sections plus one additional schedule incorporated within the Scottish Directions that are not covered in the English version, namely:

- Part 1, Point 5 – Existing premises development and improvement commitments

Provides direction to Health Boards in respect of occasions where they had committed themselves prior to the current Directions coming into force, 01 April 2004, to provide financial assistance for premises development and improvement during the financial year 2004-05.

- Part 5, Point 35 – Health Centre Rents

- Schedule 4 – Health Centre Rents

Provides direction to Health Boards in respect of payment(s) due where a contractor is a tenant of a Health Centre.

2.3 The section considering residential property re-conversion grants and the occasions when the same will / will not be payable are also significantly different between the two versions, reflecting differences in practice and application between the two countries.

Appendix 4

Glossary of terms used

3PD	Third Party Developer
APMS	Alternative Provider Medical Services
BMA	British Medical Association
CMR	Current Market Rent (as defined in the Directions)
DDA	<i>Disability Discrimination Act</i> 1995 and 2005
The Directions	<i>The National Health Service (General Medical Services – Premises Costs) (England) Directions</i> 2004 <i>The National Health Service (General Medical Services – Premises Costs) (Wales) Directions</i> 2004 <i>The Primary Medical Services (Premises Development Grants, Improvement Grants and Costs) Directions</i> 2004
DH	Department of Health
DV	District Valuer
GMS	General Medical Services
GP	General (Medical) Practitioner
GPC	General Practitioners' Committee
HB	Health Board in Scotland
LHB	Local Health Board in Wales
LIFT	Local Improvement Finance Trust
NHS	National Health Service
PCO	Primary Care Organisation (PCT, HB or LHB as appropriate)
PMCC	Primary Medical Care Contractors
PMS	Personal Medical Services
Red Book	The RICS Valuation Standards, 6th Edition.
SDLT	Stamp Duty Land Tax
WAG	Welsh Assembly Government
WHC	Welsh Health Circular
WHE	Welsh Health Estates

Valuation of medical centre and surgery premises

2nd edition, guidance note

This guidance note provides valuation advice on surgery premises, including medical centres and surgeries occupied by doctors and other similar practitioners for medical or health services within the NHS.

The valuer will need to have an understanding of the NHS framework, the applicable Regulations and BMA guidance.

The guidance note aims to assist the valuer by dealing with the following topics:

- The NHS framework
- BMA guidance
- The approach to valuation for various purposes;
- Inspection and measurement
- Design and specification
- Floor plan example showing NIA calculation.

This guidance is applicable only to the United Kingdom.



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