

Establishment of two group practice centres by conversion of existing houses

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SUMMARY. A practice of five (later six) doctors established their own group practice centre by purchase and conversion of an existing house. Later a second, smaller centre was established in the same way to replace an existing branch surgery.

The planning, financing, and execution of these projects is described.

Introduction

WE have been unable to find any reports since the early 1960s of conversions of an existing house to a group practice centre, although there have been many descriptions of new buildings. In the present financial climate the possibility of conversion is worth considering and our experience of two such conversions may be helpful.

The practice initially consisted of five doctors and about 12,000 patients. It is in a semirural, predominantly residential area. Most patients live in an area of about six by two miles, with the main town and shopping centres of Beaconsfield near one end. Some patients are scattered over a wider rural area. The area is served by three district hospitals, each about five miles distant. District nurses, health visitors, and midwives are attached to the practice.

Originally the five doctors worked from five separate surgeries. Two doctors shared two lock-up premises, one in the town and the other at the far end of the practice; the other three had surgeries attached to their own homes, all in Beaconsfield. Consequently, the five doctors were working virtually single-handed with off-duty cover and some joint administration. Day-to-day collaboration was, therefore, extremely difficult. Ancillary staff were even more isolated, each working in

different premises, and satisfactory appointment systems could not be organized.

During 1973 an approach was made by the local authority to build a health centre in the town. This proposal was greeted unenthusiastically by five independently-minded doctors used to working from their own premises. The authority, challenged to find a suitable site, discussed two, neither of which was suitable. Moreover, it was apparent that a health centre would take several years to complete. The partners therefore decided to improve their own practice arrangements. It was agreed that the four surgeries in the town should be amalgamated in one group practice centre, retaining only the one lock-up surgery at the far end of the practice.

Method

Initial planning decisions

Initially a number of decisions were taken which it was thought would influence the design of the premises. A local firm of architects was involved in our planning from an early stage. They had much experience in conversions, but none in health or group practice centres. None of the partners wanted separate examination rooms. It was decided that all surgeries would have a couch with a curtain hung from the ceiling for screening. Plans should include treatment rooms with accommodation for community nurses, a room for health visitors, provision for eventual conversion to A4 notes, and the accommodation would be such that the practice could apply to become a training practice.

Some decisions on the way it was proposed to run the joint practice were taken at an early stage as it was thought that these could have a bearing on the design of the reception area and internal communications system. The decisions were that each doctor should retain his own list of patients, with records colour-coded and filed separately. Appointments would be made by the doctor's personal secretary, not by a single appointments clerk.

Purchasing the property

Any commercial property available in the town was

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either unsuitable or too expensive, so it was decided to search for a private house which could be converted. This was the first big problem, as no-one was willing to commit himself to the purchase of a property without planning permission. Obtaining such permission takes time and all too easily the property may be sold to another purchaser. This happened with the first property which was considered. Soon afterwards, however, another house came on the market, owned by a colleague who was in no hurry to sell. Because it was in a residential area, a great deal of preliminary work and lobbying was needed to obtain planning permission. The support of the family practitioner committee and the area health authority was obtained and representatives from both wrote to the planning authority. They and the regional medical officer gave us unfailing help and advice throughout.

After purchasing the property each partner was given special responsibilities for different aspects of the detailed planning, such as finance, telephones, and security. One partner's wife planned and organized internal furnishing and the décor.

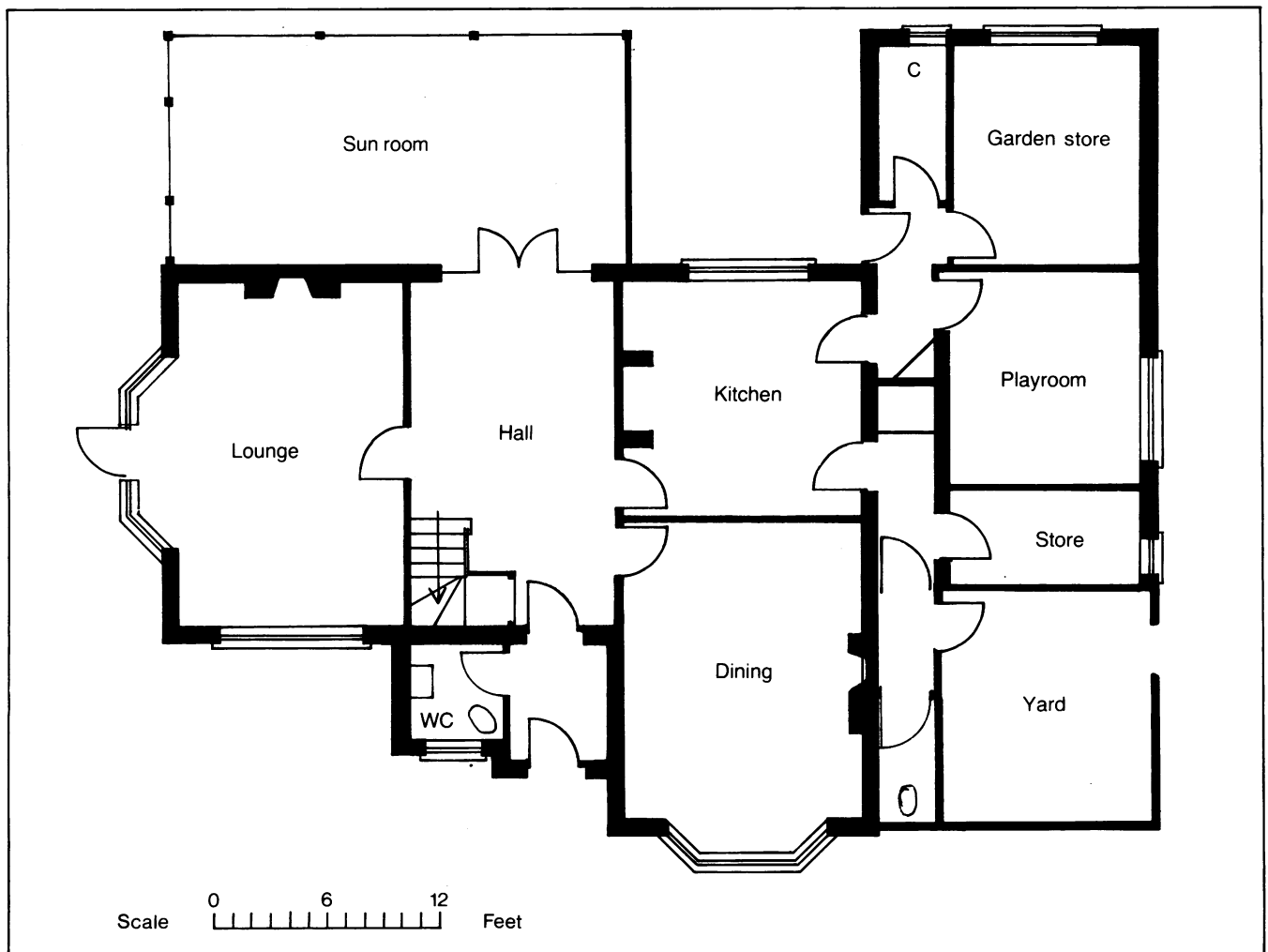
Finance

Initially it was agreed that the five partners would own

equal shares in the property; this may not always be the case so therefore it was agreed that any rent rebate received would be divided between the partners in proportion to their share of the ownership of the property, rather than being distributed as part of the practice profits. It was important to establish this principle as the rent rebate received represents interest on the capital invested by each partner in the enterprise.

The operation was financed by a mortgage from the General Practice Finance Corporation. These mortgages cover a hundred per cent of the cost of building and conversion, including most incidental expenses, and are granted for a fixed term at a fixed rate of interest, which is usually quite high. This need not be a deterrent since, provided 'cost rent' assessment is agreed, the percentage of capital cost paid as rent rebate is the same as that charged by the GPFC on the mortgage. Mortgage repayments are made quarterly by the family practitioner committee to the GPFC and shown as deductions on the quarterly statement. There is no need for all partners to take out mortgages for the same period. Where mortgage repayments are not the same for all partners, some adjustment will be necessary in any share-out of profits. Advances on the GPFC mortgage may be made in instalments as the work proceeds.

Figure 1a. Floor plan of ground floor before conversion.



Cost rent is normally paid for new, purpose-built premises. However, the Department of Health will authorize payment for conversion, provided it can be shown that no suitable site for a new building is available in the district, or that building a new centre would be prohibitively expensive. Unfortunately, final written agreement cannot be obtained until detailed plans have been submitted to the Department of Health. At the time the property was purchased the partners had only strong hints about cost rent, and final confirmation was received by telephone from the Department of Health only a few days before contracts for conversion were signed.

During the period that the building is owned but not occupied by the partners, they start paying mortgage premiums. It is important, therefore, that this period

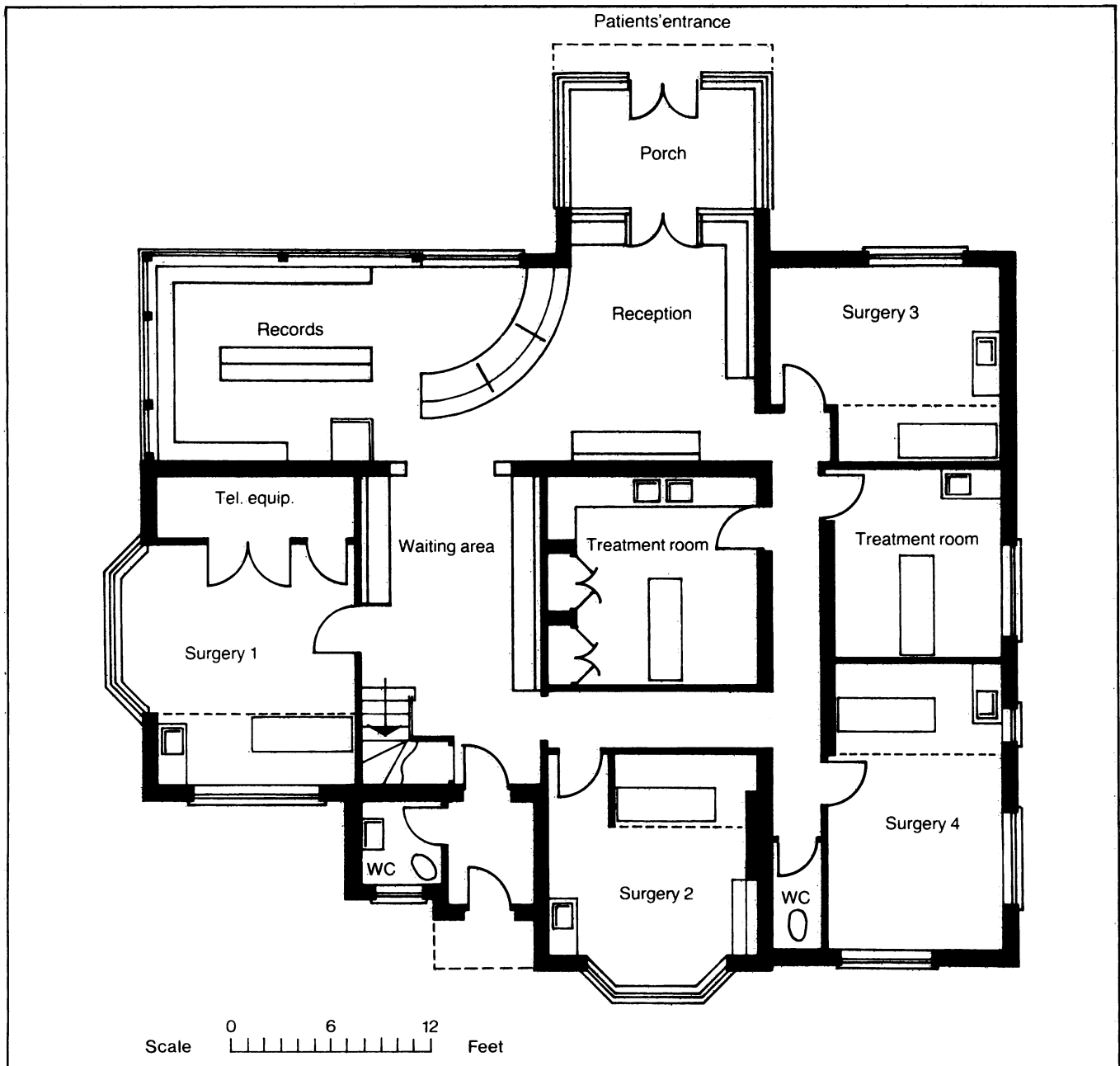
should be as short as possible. Once occupied, the interest charged on the unoccupied building up to the date of occupation may be added to the capital sum used in calculation of cost rent.

The conversion and furnishing

The local architect met the partners to discuss the general philosophy of the practice. Detailed plans were discussed at further meetings and, when finally agreed, specifications were prepared and sent out to tender. This takes some time and it was over four months before work started on this conversion.

Floor plans before and after conversion are shown in Figures 1 and 2. The open-plan, central ground-floor area is divided into two sections by a curved reception desk with stations for three secretaries, each with a full

Figure 1b. Floor plan of ground floor after conversion.



view of the waiting areas. The telephone desk, which overlooks the reception area, so that the telephonist can see which secretaries are available, is surrounded by a glass screen for sound-proofing. Records are filed laterally on shelves behind the reception desks. Of the four ground-floor surgeries and two treatment rooms, all but one open off a corridor. This, combined with stout walls and doors, provides effective sound-proofing. The call system is designed to attract reception staff and patients alike; it has a colour-coded light with a short 'pinging' device. Individual doctors use it differently—some rely on the receptionist, others on the patients.

On the first floor there is a further surgery, a staff room with provision for making tea and coffee, three secretaries' offices with space for four secretaries, a health visitor's room, and a small interview room. It is an interesting comment on the regulations that, owing to the number of people working in the building, separate male and female lavatories are required for the staff, but patients of both sexes are permitted to use the same toilets. On the ground floor a special long lavatory pan is provided for collection of midstream specimens of urine by women patients. There is a fair-sized car

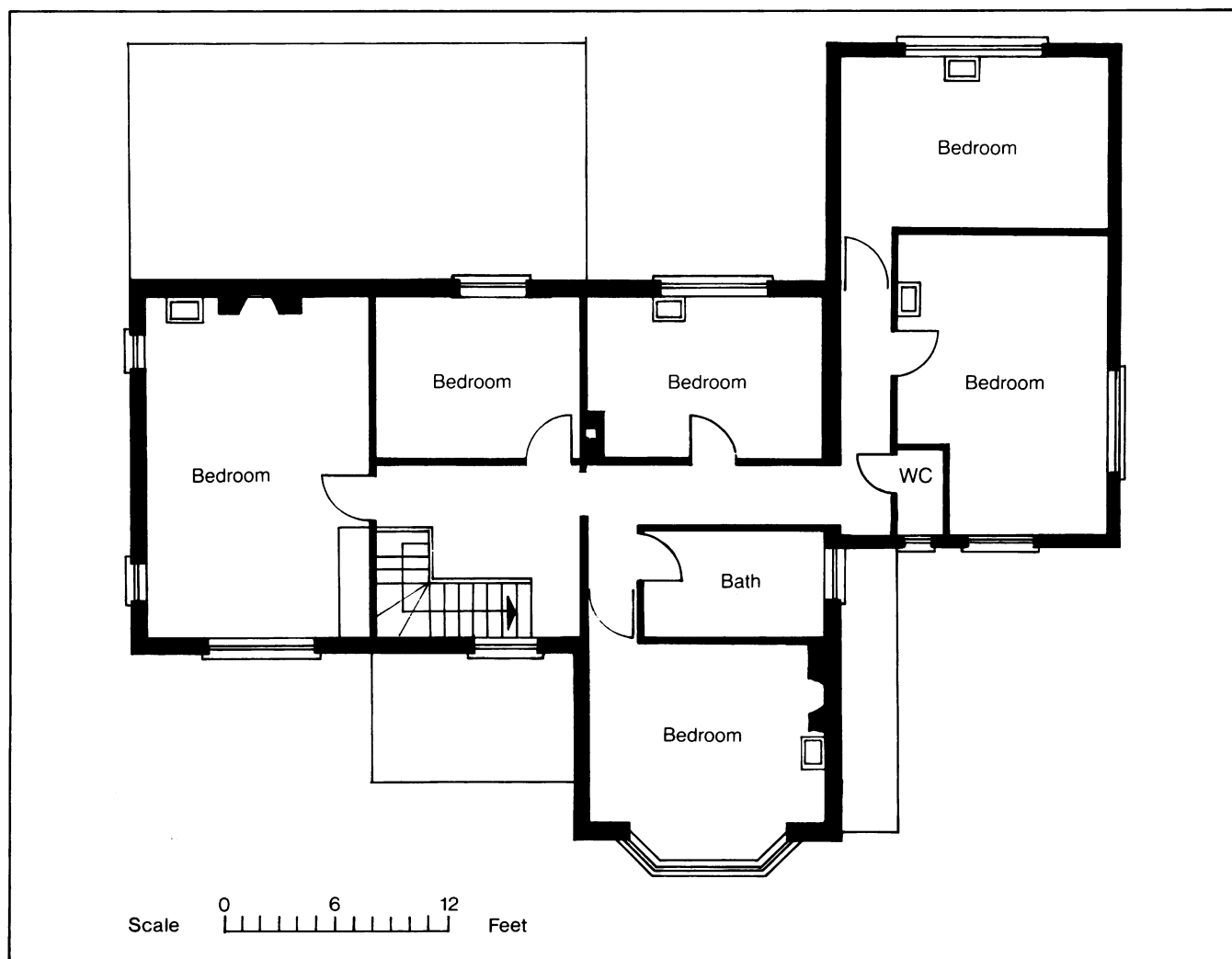
park built to local authority regulations, which was very expensive (about 20 per cent of the conversion cost).

Central heating with a natural gas burner is controlled by an outside temperature sensor and is both effective and economical. Most of the lighting is fluorescent. There are anglepoise lamps over the couches in the surgeries, except over one where a special anglepoise is suspended from the ceiling. One partner brought his own ceiling fitting, double fluorescent light, and still claims that this is the most satisfactory lighting.

Refuse disposal is provided by wastepaper baskets and sani-bins in each surgery. A new plastic liner is inserted into each sani-bin daily and when full these are transferred to thick paper bags provided by the local authority for refuse collection. For disposal of sharps, empty beer cans are better than the cardboard boxes used at first. The local authority refuse collection service has accepted these arrangements.

Floor-covering downstairs is by Heuga carpet tiles, which can be rotated to spread wear. Cleaning by the manufacturers, although expensive, has been worthwhile during two years of use. There is vinyl flooring in the treatment rooms, and upstairs the rooms are carpeted. Each surgery is individually furnished and decorated.

Figure 2a. Floor plan of first floor before conversion.



Internal communications

A PABX telephone system has been installed connected by landlines to the branch surgery. As a result there is only one telephone number for patients to remember. An 'Ansafone' operates at nights and weekends, giving the name and telephone number of the duty doctor. The increase in rent for this system over the original estimates can be described only as hyperinflation. Nevertheless, the system works well and it would be difficult to manage with anything less expensive.

With so many people working in the building the dissemination of routine information is a problem and here one simple innovation has proved extremely useful. Each week an information sheet is circulated to all staff. This contains such information as holiday dates, changes in clinic times or the nurses' duty rota, and

details of all births and deaths which have occurred among the practice population.

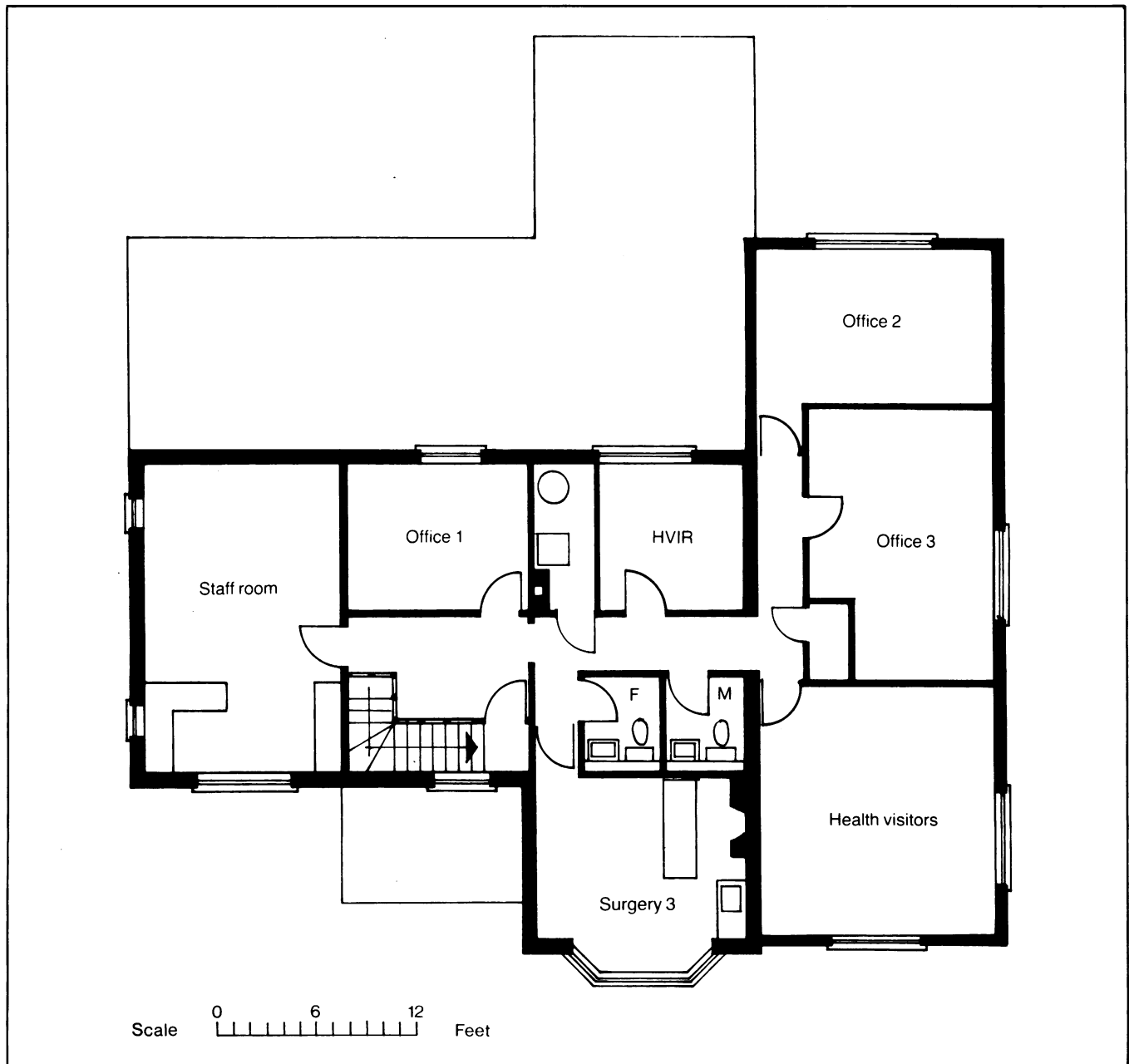
A big problem is how best to circulate internal mail to the partners themselves. Whatever scheme is devised, inevitably some document will get held up in someone's tray.

Assessment

The partners are pleased with the result. They are happy working in the centre and no-one wishes to return to the old system.

The internal design of the centre is satisfactory; little space is wasted. An essential feature is the staff room, which has become the social and administrative centre. The accommodation for secretaries is fully used and it would be difficult to manage with less. A separate office

Figure 2b. Floor plan of first floor after conversion.



for each doctor/secretary is one of the solutions suggested by others (Cammock, 1973) and we can recommend this as a very satisfactory working system.

The reception area is pleasant and open, but it fails to provide privacy for patients talking to secretaries. Moreover, a secretary may often be engaged on the telephone while a patient is waiting to speak to her. There have been no complaints about this, and it could not be overcome without a system of booths. The lack of waiting space for the upstairs surgery is a nuisance as it is difficult to keep patients downstairs when they know they are going upstairs.

The method of making appointments enables each doctor's secretary to know her own part of the practice and provides her with more interesting and varied work.

The initial idea of having two treatment rooms, one dirty and one clean, has not worked well, though both rooms are fully used. There was at first much traffic through one treatment room as the refrigerator and pathology facilities, including a small incubator, were in this room. These have now been transferred to the small interview room upstairs, which has been converted into a pathology laboratory. The anglepoise on the ceiling is unsatisfactory.

The biggest omission was lack of storage space. Initially the house appeared to have plenty of cupboards, but many disappeared during conversion and most items have to be stored where space can be found. Fortunately, the second centre described below has adequate storage space for the bulky supplies needed by the nurses. A room devoted solely to storage would be an advantage in a centre of this size.

The second centre

A year after moving into the main centre, the partners, now six in number, became dissatisfied with the cramped conditions and poor facilities in the branch surgery. It was decided to embark on a similar but smaller project in that area. Using the experience of the first centre this was a much easier exercise. Both architects and doctors now knew what they expected of each other. Once again, the first property bid failed. Soon afterwards another and fortunately more suitable

property came on the market with the owner in no hurry to sell. As it had been used commercially, there was little difficulty in obtaining planning permission for conversion to surgery premises. In this district an extensive investigation had been undertaken some years previously with the object of finding a site for building a small health centre, but at that time no such site could be found and this helped with the 'cost rent' application. This centre now has, on the ground floor, waiting, reception, and filing areas, two surgeries and a treatment room, and on the upper floor a further surgery, health visitor's room, and health visitor's waiting room. In addition there is adequate storage accommodation in a well-built outhouse.

The first centre took ten and a half months from the date of purchase to the date of first use, and the second centre nine and a half months. It appears unlikely that any such operation could take less than nine months.

The cost

In inflationary times exact figures have little meaning and vary considerably throughout the country, but it is worth recording that the conversion costs of the second, small centre in 1976, involving no additional building and little expenditure on the car park, amounted to three fifths of the more extensive operation two years previously (Tables 1 and 2). Three questions should be considered: first, how does the cost of purchase and conversion compare with that of new building? The answer depends on the cost of building land. Anyone able to buy a vacant site at a reasonable cost might be well advised to build. This was certainly not the case in the practice described, where a suitable site would have cost nearly as much as the whole property.

Secondly, what is the cost to the partners in terms of lost income while the work is in progress? As well as mortgage interest there are inevitably minor expenses and costs for furniture and equipment. These depend on how much the practice already owns or has purchased from individual partners. A rough estimate here is that the loss of after-tax income for each partner in the first operation was £300 to £400 and this was recouped by eligibility for group practice allowance. For the second operation the figure was rather less, and was compen-

Table 1. Analysis of conversion costs of Centre 1.

Date of tender	— November 1973
Commencement on site	— January 1974
Completion	— July 1974
Final total cost of building work (including external works)	£32,721.82
Floor area of building	3,440 sq. ft
Cost per square foot	£9.51
Approximate cost of building at that time	£12.00 per sq. ft
Approximate total cost	£75,000.00

Table 2. Analysis of conversion costs of Centre 2.

Date of tender	— December 1975
Commencement on site	— January 1976
Completion	— June 1976
Approximate overall cost of building work (including external works)	£16,109.00
Floor area of building	1,600 sq. ft
Cost per square foot	£10.06
Approximate cost of building	£15.00 per sq. ft
Approximate total cost	£45,000.00

sated for by the increased rent rebate on the premises as compared with the old branch surgery.

Thirdly, how are future changes in the partnership and property ownership to be arranged? The answer should be considered in two parts. The first consideration is the arrangement for retirement of a partner (or break-up of the practice). Legal advice is necessary, and the most likely agreement will provide for the share of retiring partners to be purchased by the remaining partners at an agreed valuation. Full details of the procedure are laid down, designed to safeguard the interests of all partners.

The second point concerns the position of a new partner who may wish to purchase a share in the property, immediately or after an interval. In advance of the event it is impossible to lay down a precise procedure. In principle the incoming partner will finance his purchase from a mortgage or the bank, and the interest payable on his borrowing should be covered by his share of rent rebate.

The benefits

Apart from the now well recognized benefit to the doctors in working in a group, there has been a considerable financial advantage to the doctors who have obtained, at no capital cost, two substantial properties. The Government have obtained two centres at less cost than two purpose-built centres. Another benefit to the partners is that they have a stake in their own future. The advantage, of course, is that the Government has no control.

Recommendations

In the light of these experiences, we wish to make two recommendations:

1. That family practitioner committees and area health authorities should be prepared to help doctors who approach them in obtaining planning permission for surgery premises, and in particular to impress on the planning authorities the need for speed in reaching a decision.
2. That the Department of Health should be prepared to give a commitment in principle for a cost rent assessment, subject to eventual approval of detailed plans. Regional medical officers might help with this.

Reference

Cammock, R. M. (1973). *Health Centres: Reception, Waiting and Patient Call*. London: HMSO.



COLLEGE ACCOMMODATION

Charges for college accommodation are reduced for members (i.e. fellows, members and associates). Members of overseas colleges are welcome when rooms are available. All charges for accommodation include breakfast and are subject to VAT. A service charge of 12½ per cent is added. Members are reminded that children under the age of 12 years cannot be admitted and dogs are not allowed. Residents are asked to arrive before 18.30 hours to take up their reservations.

From 1 January 1977, charges are:

	Members	Others
Single room	£5	£9
Double room	£9	£14
Flat 1	£11 (£70 per week)	£14 (£90 per week)
Flat 3	£12 (£75 per week)	£15 (£95 per week)

Charges are also reduced for members hiring reception rooms compared with outside organisations which apply to hold meetings at the College. All hirings are subject to approval and VAT is added.

	Members	Others
Long room	£30	£40
Damask room	£20	£30
Common room and terrace	£20	£30
Kitchen	—	£10
Dining room	£10	£10

Enquiries should be addressed to:

**The Accommodation Secretary,
The Royal College of General Practitioners,
14 Princes Gate, Hyde Park,
London SW7 1PU.**

Tel: 01-584 6262

Whenever possible bookings should be made well in advance and in writing. Telephone bookings can be accepted only between 9.30 hours and 17.30 hours on Mondays to Fridays. Outside these hours, an Autophone service is available.