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INSTITUTE FOR GOVERNMENT

INSIGHT | JUNE 2024

Delivering a general practice estate that is fit for purpose

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Introduction

General practice is changing. In its 2019 *Long Term Plan*, NHS England outlined a "new service model for the 21st century", which included the introduction of primary care networks and a wider range of professionals working alongside GPs.[1] This was followed by the 2019 Conservative Party manifesto, which pledged to hire 6,000 more GPs and 26,000 other direct patient care staff,[*,2] a substantial expansion of the general practice and wider primary care workforce. The government has set other ambitious goals for general practice. It wants to see greater integration with community care and adult social care, and for GPs to divert more patients away from specialist secondary care.[3] The government has had success in some of these ambitions. It has grown the number of direct patient care staff, though the number of fully qualified GPs has fallen since 2019.[4] But there has been limited focus on how the estate can support these plans and new models. Close to a quarter of the current primary care estate was built before the NHS was even established. This has left GPs and the rest of the general practice workforce working in buildings that are often too cramped, too old and too inflexible for a modern health service.

It is arguable that the NHS does not allocate sufficient money to general practice capital investment. But there are also issues with how the NHS manages the estate, spends the existing budget, relies on GP partners to direct capital investment and handles potential investment from the private sector. All of these factors prevent the NHS from providing a general practice estate that is fit for purpose, and undermines the delivery of high-quality care.

This report summarises a private roundtable discussion and interviews on this topic held with senior representatives from central government, the NHS, the private sector and elsewhere.

How does the general practice estate operate currently?

The estate in general practice is unlike most other parts of the NHS. The provision and maintenance of premises is typically the responsibility of GP partners, who themselves effectively operate as small private businesses that provide services to the NHS. For those services, the NHS pays GP partners through the GP contract.

When it comes to the estate, GP partners either rent their premises or buy the buildings outright. In either case, the NHS reimburses partners for the specific cost of operating in the property (either the rent on the property or the mortgage cost) in addition to funding for other services in the GP contract.[5] That reimbursement does not, however, cover any maintenance or repairs that the GP partner may need to carry out on the building. Instead, funding for maintenance comes out of any surplus from the GP contract, after covering other expenses.

[*] Referred to as "primary care professionals" in the manifesto, this includes staff groups such as pharmacists, care co-ordinators and social prescribing link workers.

This structure creates some unique challenges for the NHS and the government. The NHS does not have direct control over the general practice estate in the same way that it does in hospitals. According to the *Fuller Stocktake Report* from 2022, only 14% of GP premises are owned by NHS Property Services, with 49% owned by GPs and 35% by a third party.[6] This means that the NHS largely relies on individual partners to invest in their practices. GP partners find this difficult to do when baseline funding from the GP contract has not risen in line with inflation and wage pressures since at least 2019.[7]

The system is also highly fragmented. As of April 2024, there were just over 6,300 practices operating in England, run by over 16,000 GP partners. This means that, for example, an increase in funding for the GP contract will lead to a wide range of responses from partners. Some may choose to invest more in the estate, but many may instead invest in pay uplifts to retain experienced staff.

These characteristics make it difficult for the NHS to meet objectives (discussed in more detail below), many of which require a high-quality primary care estate.

What estate does general practice need?

The current general practice estate is not fit for purpose. More and more people want to access general practice but buildings are now relatively small and are poorly maintained. The government has grown the non-GP workforce but not provided an estate that is either large enough or tailored to the work that they need to do. The government and NHS England plan to better integrate primary care, community care and adult social care. But again this is difficult to achieve if there is no physical space in which these services can co-locate. These changes demand an estate that is both larger and more flexible. The estate will also need to contend with patients who expect to access care on the day they contact their GP practice – as has been promised to them by the government.[8] As it stands, the estate is not equipped to deal with these changes. This section examines the trends and policies that will influence the needs of a future primary care estate.

There is evidence that the estate is not fit for purpose, but the NHS should publish more data

It is difficult to quantify the state of the general practice estate, as the NHS does not publish relevant data. Instead, we can piece together a picture from a combination of surveys, one-off reports and anecdotes. As of 2022, there were 8,911 premises in general practice.[*,9] Of those, 22% were built before the establishment of the NHS in 1948. GPs reported that 2,000 (22.4% of the premises) were not fit for purpose.[10] There is also often insufficient room in practices for GPs to work effectively. In a recent survey of GPs, 88% of respondents claimed that they do not have sufficient consulting rooms.[11]

This view was supported by roundtable attendees. There was near consensus that the estate was nowhere near adequate for the role that NHS England and the government expects it to play. The conclusion of attendees was not simply that there needs to be an extensive building programme, but that general practice and newly expanded

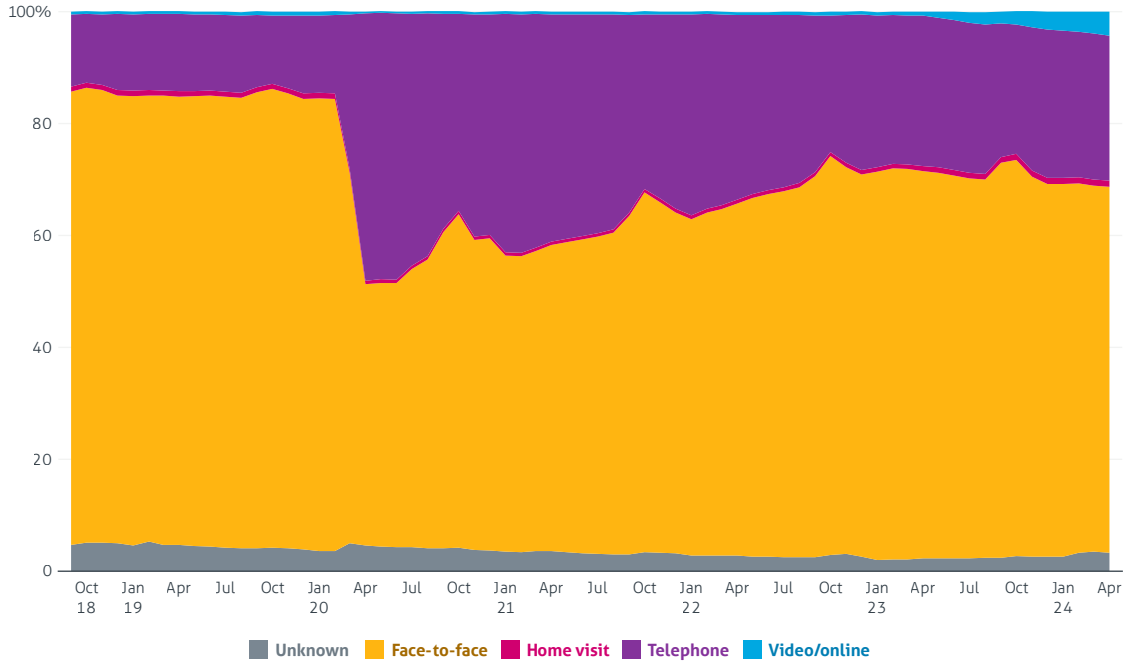
[*] There are more premises than practices because a practice can operate across multiple premises.

multi-disciplinary teams (MDTs) needed access to appropriate space. This could be through new buildings, but it could also come from better utilisation of existing space within primary, community and secondary care or from retrofitting buildings that were designed for other purposes.

Persistent demand for face-to-face appointments means general practice cannot reduce its footprint

Social distancing requirements during the pandemic meant that GP practices shifted to delivering a far greater proportion of their appointments remotely.* The change was rapid and stark: in 2019, GPs delivered 80.7% of appointments face-to-face. In 2021, only 57.6% of appointments were delivered that way.

Figure 1 **GP appointments by mode of delivery, September 2018 to April 2024**



Source: Institute for Government analysis of NHS England, 'Appointments in General Practice, April 2024' ('Table 1a').
Note: Data was first published in 2018/19.

This remarkable change sparked hope among some in health policy circles that there would be a permanent shift to more appointments being delivered remotely, which would in turn reduce the need for physical space in primary care, as GPs would be able to carry out appointments either from home or from smaller premises, as the need for examination space fell.

But that revolution in appointment delivery has only partially transpired. Since 2021, there has been a gradual increase in the proportion of appointments delivered face-to-face. In 2023, this had risen back to 69.0% of all appointments, compared to 80.7% in 2019. This is partly because patients often prefer to have face-to-face appointments, but also because many consultations require physical examinations. Or digital exclusion of some groups (including older and disabled people) may mean that face-to-face appointments remain the most appropriate mode of consultation.

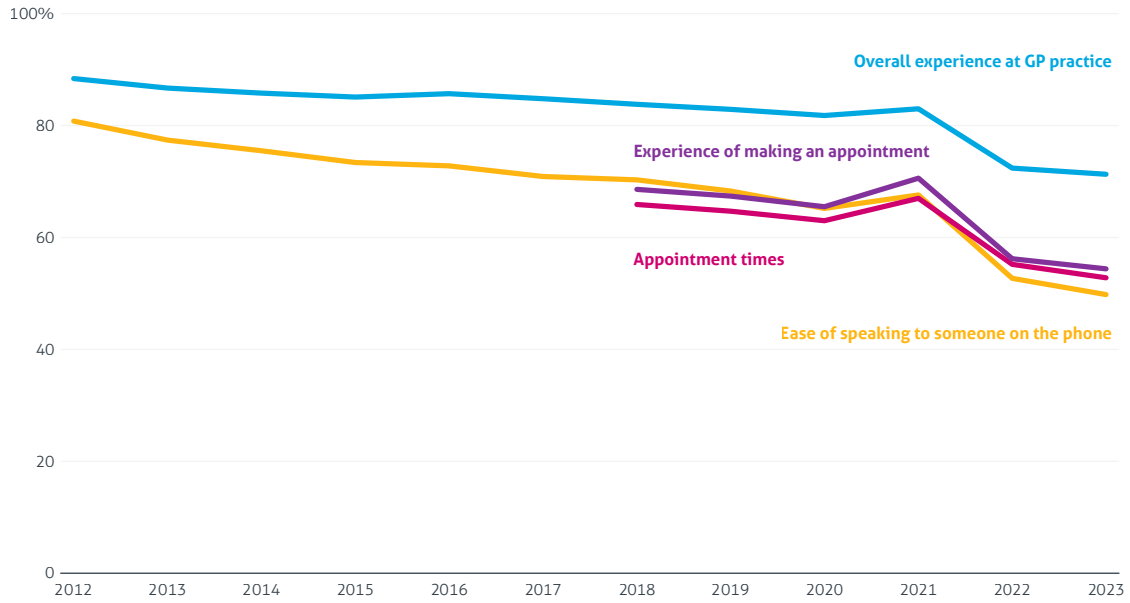
* By which we mean by telephone, by video or online.

Since the middle of 2022, the proportion of appointments delivered face-to-face has seemingly levelled off, potentially signalling a new, post-pandemic equilibrium. This, however, only tells half the story. The large increase in total appointments since the pandemic means that there were only slightly fewer appointments actually delivered face-to-face in 2023 than in 2019: 240.0 million in 2023 compared to 242.0 million in 2019, a fall of only 0.9%.

Patients are already finding it difficult to access general practice

It appears that patients are finding it increasingly difficult to secure appointments. This is hard to quantify exactly, but it is visible in declining patient satisfaction with the service. Only 52.8% of patients were satisfied with their appointment times in 2023, down from 64.7% in 2019. This trend is mirrored in overall satisfaction with general practice.

Figure 2 **Patient satisfaction with general practice, 2012–2023**



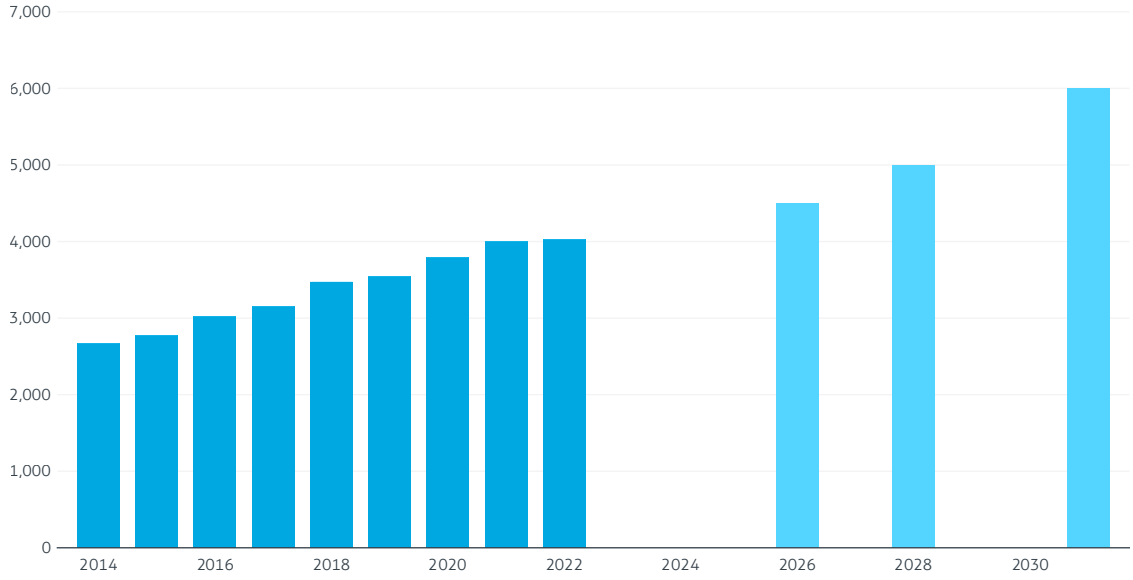
Source: Institute for Government analysis of NHS, GP Patient Survey 2023, supported by CIPFA. Notes: This chart shows responses to questions 1, 6, 21 and 32 in the survey. The numbers shown in the chart indicate what proportion of respondents gave the two most positive responses. For example, for the overall experience question, this shows those who responded "Fairly good" or "Very good". Each time series starts from the first year the question was asked.

Access problems are likely to get worse. Demand has risen in part due to a backlog of people who could not access care during the pandemic, and because many cannot access the care they need due to long waiting times in secondary care.[12] But it is also partly due to a growing and ageing population: the population in England is due to grow by 4.6% between 2020 and 2030, with the over-65 population growing by 21.5%. The number of people living with a major illness is expected to increase by more than a third by 2040.[13] The combination of a larger, older and sicker population will further increase the need for physical examination space.

The estate should facilitate planned growth in the GP workforce

This government aimed to grow the GP workforce by 6,000 before the next election. Though it failed in that ambition, there is still a need to expand the number of fully qualified GPs. This is recognised in the *NHS Long Term Workforce Plan*, which sets out a target to grow the number of GP trainees by 50%: from 4,000 in 2022 to 6,000 by 2031/32.[14] This is a worthy goal. But – putting aside other barriers to achieving the ambition, such as the lack of GP trainers – the estate is not designed to accommodate such a large increase in trainees, or the rise in fully qualified GPs that the government hopes will follow.

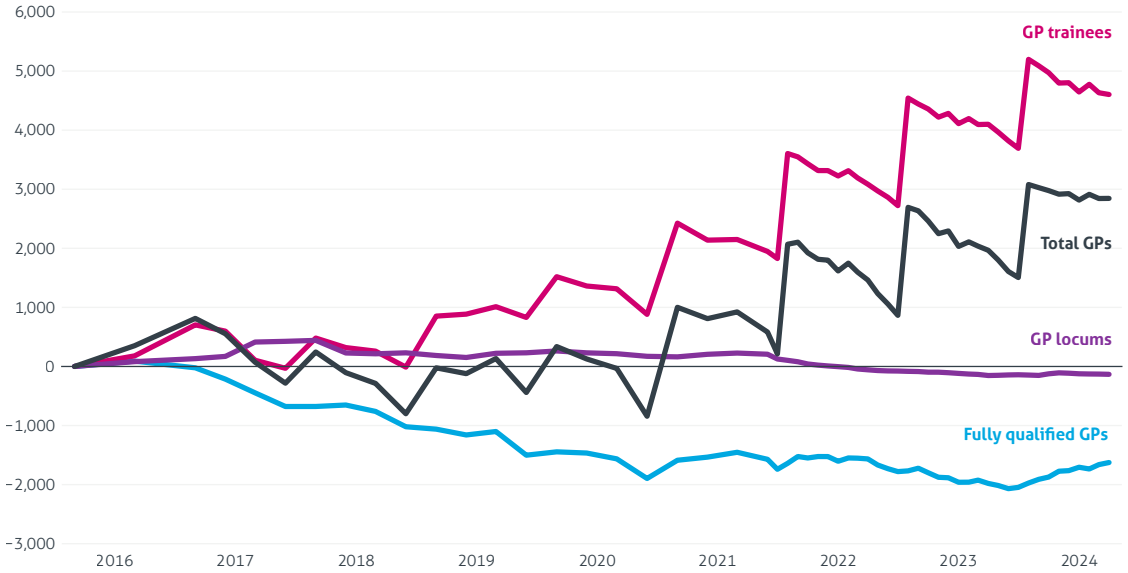
Figure 3 **GP trainees, actual and planned, 2014–2031**



Source: Institute for Government analysis of Health Education England, 'GP trainee recruitment data', 2022 and NHS England, 'NHS Long Term Workforce Plan', 2023.

While there has been a decline in the number of fully qualified GPs in recent years, this has been more than offset by rising numbers of GP trainees. There were 37,235 total GPs (a sum of fully qualified GPs, locum GPs and GP trainees) in March 2024, up from 34,744 in March 2016 – an increase of 7.2%, driven entirely by a rising number of GP trainees. GP trainees require a room in which to work.[15] Despite that, they do not add to the capacity of the practice, as they are supernumerary. This effectively means that as the GP trainee workforce expands, practices will either have to reallocate space that is being used by existing staff (leaving them with nowhere to work), expand, or make better use of currently underutilised space. But this will need to happen without expanding the services they offer.

Figure 4 **Net change in the number of GPs, by type of GP, September 2015 to April 2024**



Source: Institute for Government analysis of NHS Digital, 'General Practice Workforce, England, Bulletin Tables December 2015 – April 2024' (table '1a'). Notes: 'Total GPs' is the sum of the other three staff groups.

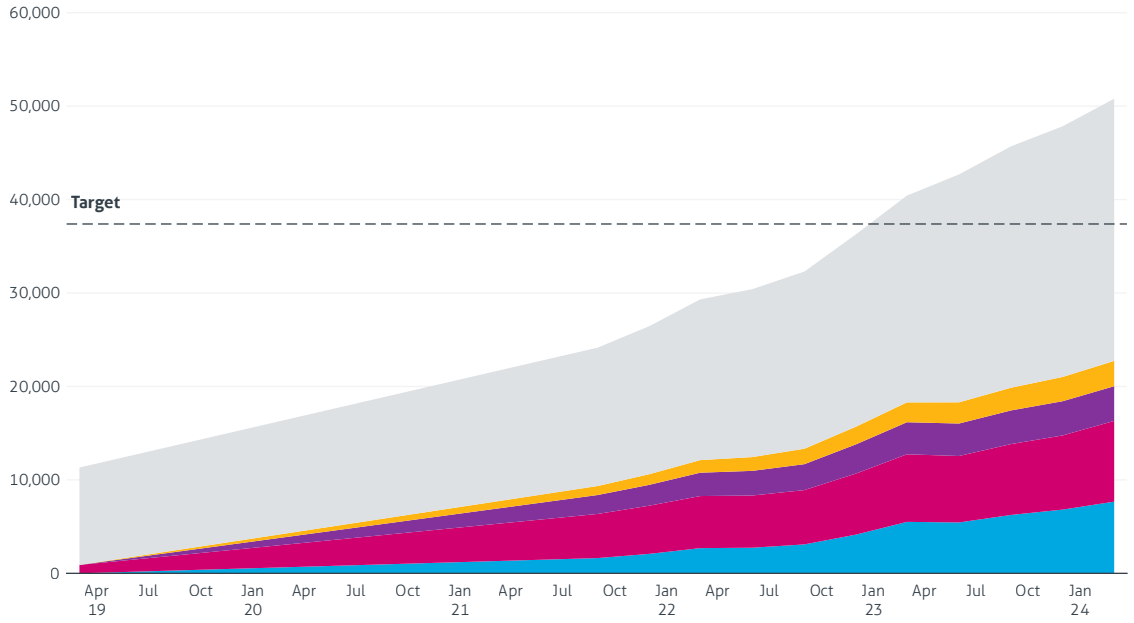
While the increase in GP trainees has not thus far translated into a substantial rise in the number of fully qualified GPs, that is ultimately the hope. When that does start to happen, there will be even more pressure on the estate, as a larger fully qualified workforce works alongside an expanded number of GP trainees.

Without substantial increases in the amount of space available to accommodate these extra GP trainees, it seems unlikely that the NHS will be able to achieve its current ambition. Indeed, it already seems as though the estate is reaching its limit in this regard; when surveyed, three quarters of GP respondents said that they did not have sufficient space to take on additional GP trainees.[16]

The estate should support increased multi-disciplinary team working

It is not just GPs who struggle to operate effectively in the current estate, but also the wider primary care workforce. This is particularly relevant because of the recent large expansion in direct patient care (DPC) staff – for example, pharmacists, care co-ordinators, and social prescribing link workers. At the end of March 2024, there were 39,472 more DPC staff working in primary care than in March 2019, exceeding the government target of 26,000. Not all of these will require space in the general practice estate. For example, some pharmacists may be in a separate building. But many will be working closely with GPs. Despite the fact that the DPC workforce has more than quadrupled in less than five years, the estate has not kept pace.

Figure 5 **Direct patient care staff employed in primary care networks, by staff group, March 2019 to March 2024**



Source: Institute for Government analysis of NHS Digital, 'Primary Care Workforce Quarterly Update' ('1b' table), March 2024.

The increase in DPC staff has been implemented with the express intent of expanding primary care capacity and improving services for patients.[17] The expansion of multi-disciplinary teams (MDTs) – either formal or informal groups of staff that are led by GPs and who have shared objectives, work closely together and who meet regularly[18] – within general practice has implications for both the amount and type of space needed. These staff offer either new services or take on work that GPs have historically done. For example, the government has developed policy that will allow the newly expanded clinical pharmacist workforce to prescribe medication for a select number of conditions without a GP appointment and also to carry out blood pressure checks.[19]

But there is evidence that, so far, those new staff are being under-utilised due to insufficient and inadequate estate space. Traditionally, GPs conduct one-on-one consultations in examination rooms that sit within a practice premises. But MDTs work in different ways. Physiotherapists, for example, generally need more space to work with patients.[20] MDTs may also work with groups of patients as well as individuals. MDTs also need space to meet each other, co-ordinate care and collaborate.[21] The current estate is not designed to facilitate those ways of working.

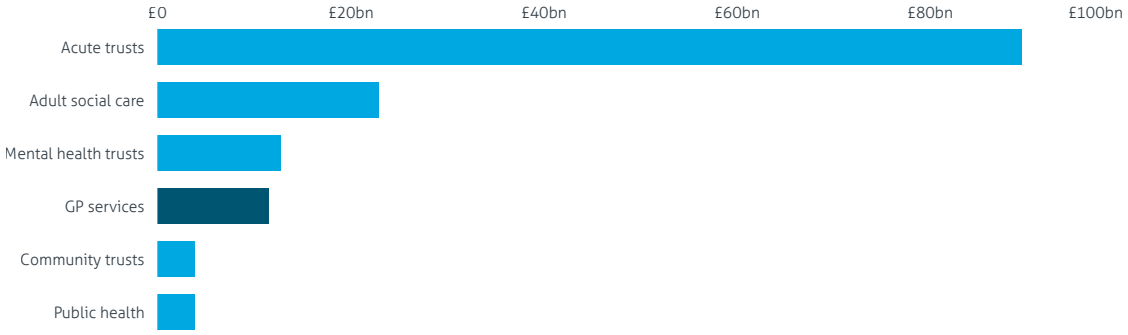
If designing a general practice estate that is fit for purpose, the government and the NHS should consider the needs of a wide range of different staff groups and how they use the estate.

Physical space should support NHS goals

The NHS disproportionately funds acute hospitals, despite wanting to move care closer to home

The government has professed a desire to move more NHS care out of hospitals and into communities for decades. Expanding the supply of care in general practice is a crucial part of this puzzle and yet the NHS has made little progress in rebalancing funding towards non-hospital parts of the system. In 2022/23, the NHS spent roughly one eighth as much on general practice as on acute hospital trusts (£11.5 billion on the former and £89.5bn on the latter). This is despite the majority of daily NHS activity taking place in primary care.[22]

Figure 6 **Spending on the health and social care system, by type of service, 2022/23**



Source: Institute for Government analysis of NHS England, 'Annual report and accounts' ('Operating expenses' table), 2022/23, NHS England, 'Consolidated NHS provider accounts' ('Analysis by type of trust' table), DLUHC, 'Local authority revenue outturns: RO3', 2022/23 and NHS Digital, 'Adult Social Care Activity and Finance Report, England 2022-23' ('Appendix B, Table 5'). Notes: "GP services" comes from p. 162 of NHS England's annual report 2022/23.

It will be impossible, however, to shift care into the community without an expansion in capacity, which will in turn need a modernised and expanded estate that will facilitate the working of an expanded GP workforce and new MDTs.

Integration of care is made difficult by the current estate

The government also wants to better integrate community, primary and social care. The current estate makes this difficult. Partly this is because practices do not have appropriate space for a reimagined workforce. But it is also because the size and placement of practices is largely inappropriate for integrated care. There needs to be larger spaces that facilitate co-location of primary care, community care, social care and other parts of the health and care system that the government expects to collaborate in an integrated system.[23] At the same time, to truly understand and address the needs of communities, there should be a range of smaller sites that are closer to the people who use their services.[24]

Attendees at the roundtable also argued that a model that required a number of large centres with co-located services combined with smaller, more localised practices could have wider benefits for the service. They claimed that this would enable GPs to work more closely with and therefore become accustomed to a community. This would lead to better understanding of what that community needed, while also potentially improving GP retention as they became attached to their community.

General practice has a vital role to play in shifting to prevention

The government also clearly believes that GPs have a role to play in shifting towards a more preventative model of health care. The Impact Investment Fund (IIF) – a scheme wherein the NHS financially rewards GPs for carrying out certain types of activity – includes targets in relation to improving preventative care (largely through increased vaccination coverage) and tackling health inequalities.[25] Despite that, the balance of spending and provision continues to tilt towards acute secondary care.

There are many reasons for the lack of progress towards a shift to prevention,[26] but an estate that does not support an expanded workforce that would be needed to make it happen is certainly one reason.

The quality of the estate, as well as the size, is important for improving care

If general practice is the front door of the NHS, it is currently a door that is hanging off its hinges, is too narrow for many to enter, and makes many of those who do pass through it feel undervalued. The estate and spaces in which public services operate are never purely functional. They are also a symbol of the importance that the government places on those services and the people who work within them.

The quality of the estate impacts staff morale. There is evidence that staff who work in newer buildings are more satisfied and less likely to leave the service.[27] This makes sense. Working in an environment that is old, cramped and not suited to their needs would make most people feel under-appreciated. At a time when there is a retention crisis in primary care,[28] this has arguably never been more important.

The quality of the estate also affects patients, with newer and higher quality buildings across health and social care associated with improved patient outcomes. One study showed that "the likelihood of patients dying within 30 days of admission was 14% lower in hospitals with better care environments than in hospitals with poor care environments".[29] Newer hospitals were also associated with shorter lengths of stay for patients.[30] Residents of newer care homes are also less likely to fall and are more likely to receive harm-free care than those in older buildings.[31] The same is likely to apply in general practice: a modernised, expanded and more up to date estate will generate better outcomes for patients.

Finally, there is evidence that if designed well, the estate can facilitate the integration of services. The King's Fund has published a report that shows that co-location of primary and community services led to better communication between disparate staff groups, and consequently improved understanding of others' roles and the needs of the community.[32] However, the same work also stresses that a well-designed estate is not a sufficient condition to improving integration.

How can the government support delivery of the required estate?

The cause of underinvestment in the general practice estate is multifaceted. GP partners – the GPs that the NHS contracts to provide services in a specific area, and who effectively act as small business owners alongside their clinical work[33] – are responsible for providing an adequate estate. But their ability to do so has been undermined by the terms of the GP contract and other systemic issues.

Attendees at our roundtable suggested several steps that government could take to encourage further investment in the system.

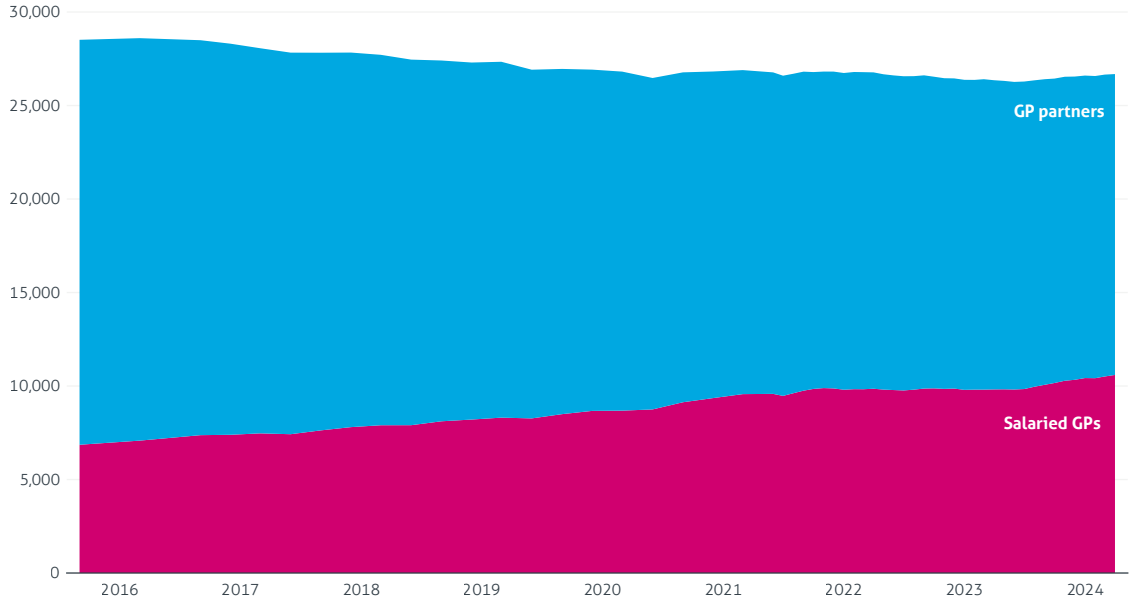
Tailor the ownership model to encourage investment

There was near consensus at the roundtable that the partnership model of general practice often discouraged appropriate investment in the estate. The NHS expects GP partners to appropriately maintain the estate, using money from the GP contract. But that funding is in direct competition with other costs to practices, such as staff salaries and utilities costs. That creates ambiguity about where responsibility for investment lies.

There is also a huge perverse incentive against investing in the estate for GP partners. Most GP partnerships operate under the unlimited liability model, meaning that GP partners can be held personally liable for their partnership's liabilities. This means that they could risk losing their personal assets in the event of having to close a practice. One of the largest liabilities for any practice is the premises. This can be for the mortgage (if the partnership purchased its property) or for the lease (if the partnership is renting premises).[34] When a number of partners leave a partnership, they can shift the entire burden of the partnership's liabilities on to the remaining partners or partner. The last partner standing may therefore end up being personally liable for a significant amount of money. The greater the investment made, the greater the potential personal liability.

The government's 2019 review of the GP partnership model identified the unlimited liability arrangements as a key disincentive to GPs entering into partnership. This is one of the reasons for the steadily declining number of GP partners: the number of partners fell by more than a quarter (25.7%) between September 2015 and April 2024. The proportion of the GP workforce that are partners has fallen from 75% to 60.3% over the same period. The problem is even more severe in the younger cohorts of GPs; among GPs aged 35–39 the proportion that are GP partners has declined from 62.2% in March 2016 to 39.2% in March 2023.[35] But in a system that relies on the existence of partners to take on new premises, maintain the existing estate, and tailor premises to meet the needs of their workforce, a declining number of GP partners poses a substantial risk to the NHS's ability to provide an estate that is fit for purpose.

Figure 7 **GP partners and salaried GPs, September 2015 to April 2024**



Source: Institute for Government analysis of NHS Digital, 'General Practice Workforce, England, Bulletin Tables December 2015 – January 2024' '1' table). Notes: This is shown in FTEs. Data was not published before September 2015.

Roundtable attendees told us that there is an increasing trend of hospital services funding investment in primary and community care buildings, effectively circumventing the GP partnership model. This has even involved the 'vertical integration' of hospital trusts and some GP practices.[36] In this case, the trust takes on responsibility for practices that are at risk of failing. The NHS might have to explore making approaches like this a more central part of its primary care estates strategy if the number of GP partners continues to decline, unless property ownership is decoupled from partnership. This does, however, have implications for the NHS's capital budget, as is discussed in more detail below.

There are some ways that the government could make partnership more attractive. One option could be moving away from an unlimited liability model of partnership. In his review of the GP partnership model, Dr Nigel Watson recommended that the government should allow partners to operate under a limited liability or mutual model.[37] This would prevent GPs' individual liability from becoming too large and disincentivising them from entering partnership and subsequently investing in their estate. The same report recommends that the NHS should potentially take on the liability for a lease under certain circumstances if a partner wanted to leave the practice.[38]

The Scottish government has taken a more radical approach to the same issue. It has, first of all, offered interest-free loans to Scottish GPs to allow them to release equity in their property when a partner leaves, without having to sell the building or loading up the remaining partners with unsustainable levels of debt.[39] The government then intends to gradually purchase GPs' premises, with the goal that no GP will own their practice by 2043.[40] In 2019, the NHS estimated that it would cost "a minimum of

£5–6bn" to buy out the GP-owned estate in England.[41] It calls this amount "prohibitively expensive",[42] though if following the Scotland example, there would be no need to incur the full expense at once, but rather take on ownership as GP partners retire.

Removing the ownership of premises from the GP partnership model would have a couple of benefits. First, it may arrest the declining number of GP partners. While not directly generating more investment in the estate, it would be beneficial to a service that relies on GPs entering partnership for the delivery of services. Second, it would remove the current ambiguity around responsibility for investing in the estate. At the moment, NHSE says that there is insufficient investment because GP partners are not allocating enough of their income to that end. For their part, GP partners argue that the GP contract does not provide enough funding to make sufficient investment. This leads to an impasse in which very little investment is made. If, in contrast, the NHS owned the entire primary care estate, it would be clear that responsibility for investment lay with them, not GP partners.

An even more radical approach – and one that would not be welcomed by many in the service – could be to move away from a partnership model of general practice towards having most, if not all, GPs employed as salaried GPs. On estates, this would remove the need to work through GP partners entirely, thus giving NHSE more direct control over premises. But this approach would have much wider implications for the workforce and arguably the effectiveness of the service; the government's 2019 review of the GP partnership model identified a range of benefits, including the freedom to innovate, being embedded in and accountable to a community, and providing value for money.[43] It would likely also come with substantial cost for the government as it may be forced to buy GP partners out of their practices.

Make better use of the existing estate

There is a strange paradox in the general practice estate. On one hand, GPs and others report that there is not enough space for them to work effectively. On the other, there are multiple reports of large amounts of void space in the NHS estate as a whole – in other words, space that exists in buildings that is vacant or not used for clinical purposes. It is difficult to quantify how much void space there is, but roundtable attendees agreed that, if used effectively, it could address some of the issues described above. One said that the NHS had successfully reduced the proportion of the secondary care estate that was used for non-clinical purposes from 45% to 30% and that similar improvements in utilisation could be made in primary care.

One major impediment that roundtable attendees described to us is the NHS's requirement that primary and community care providers charge market rent for the use of void space, even if the new occupier is another part of the NHS. While understandable in theory – the NHS should be achieving value for money from its assets – it leads to incoherent outcomes. Many community and primary care providers are not able to afford the market rents. At the same time, there are very few potential occupiers from the private sector who would want to take a lease out on space within a GP practice. The

result is that void space remains unused, even while many providers struggle to fit their operations into the existing available estate. While there may also be a cost associated with using space,* it would make sense if the NHS relaxed its rules around the rates at which it requires providers to rent out void space to other parts of the NHS.

This is an easy and obvious step for the government to take, but there is a danger that its benefit can be overstated. While there is a lot of void space, even utilising all of it will likely not meet the requirements of a modernised primary care estate. The expansion of MDTs in the primary care workforce also means that an expanded estate will more than likely need different types of space; there is no guarantee that void space will meet this requirement. By definition, void space is also in the existing estate, which means that there is little flexibility about expanding the estate into new geographical areas. This will make it more difficult to embed primary and community care further into neighbourhoods, as described above.

General practice needs support co-ordinating estates planning and investment

Historically, the NHS has relied on GP partners to lead and manage investment in the primary care estate. This approach makes sense in an NHS where GP premises are the principal locations in which patients access primary care. But as discussed, the government and the NHS aim to move towards a wider range of services in a more integrated model of primary and community care. To achieve that ambition it is likely that there will need to be more co-ordination of estates planning and implementation between GP practices, community care and other parts of the NHS.

It is difficult for GP partners to lead this co-ordination effort. They manage a budget that is designed for, at most, a handful of premises. The scale of funding that any practice has access to is insufficient to support a substantial shift towards a modernised, integrated estate. It might therefore make sense for other parts of the health system to take a more proactive role in co-ordinating estates planning and implementation across primary and community care.

NHS England is one option for co-ordinating capital spending

One choice could be NHS England (NHSE). As the public body that co-ordinates policy across the entire service in England, it could make better decisions where to direct money. But NHSE would likely not solve many of these issues because its attention is frequently focused elsewhere in the system, most often on hospitals. This makes it hard for primary and community care to attract the kind of consideration and planning that is needed. In some ways, this is understandable. The hospitals estate is also in dire need of investment and there is substantial public concern about poor hospital performance.

High political salience leads to ministers focusing on hospitals, with NHSE required to prioritise accordingly, and limiting the extent to which it can most effectively allocate capital spending. A prime example is the New Hospital Programme (NHP) – a political project from the Johnson administration to deliver "40 new hospitals".** This project has

* GP partners would be required to make the space good for use, including decorating it and fitting it out with equipment. Once it is operational, it will also then require maintenance, adding more pressure to contract funding.

** Though as the NAO has pointed out, there are not 40 hospitals and nor are the majority of them new.

ended up being very centralised, with decision making happening in the Department of Health and Social Care (DHSC) and NHSE, with little latitude for decision making at a local or regional level about where to build those hospitals, or if new hospitals were even the best use of the additional funding.

But even if NHSE focused more on primary and community care than it currently does, it is still not well placed to understand the need that local areas have for primary and community care estate.

Integrated care boards (ICBs) could improve allocation at a regional level

One way that NHSE could help is by removing some of the barriers to better investment at a local level. Capital funding is often fragmented. The NHS provides a capital budget to general practice through the GP contract. It allocates another part to ICBs through a funding formula that estimates the need for maintenance spending. Other projects – for example the NHP – are decided centrally, with funding then funnelled through ICBs. NHSE could provide local areas with more flexibility by removing some of the separation between these budgets, reducing the conditions attached to funding and allowing local areas to choose how to allocate spending, if that was within a framework of national objectives. ICBs are well placed for this because they have an area-wide view of the health and care system and can therefore identify where the current estate is not fit for purpose. This view is supported by an upcoming Institute for Government report that recommends that the NHS should by default allocate capital budgets to ICBs to spend how they see fit.

There are a few reasons, however, why ICBs may not be the best channel through which the NHS plans general practice estate investment. Attendees at our roundtable identified ICB capability as a limiting factor for this type of work. Some attendees said that there is often poor understanding of general practice within ICBs and even less about the complexities of investing in the estate. They may be well versed in the requirements of capital spending in other parts of the NHS, but this does not necessarily translate into good decision making capacity for general practice. Since the establishment of ICBs, there have also been concerns that they tend to favour the viewpoints of the hospital sector over other parts of the health and care system. Given the need for capital investment in hospitals, an allocation system that in some ways depends on who has the most powerful 'voice' in an ICB could lead to a disproportionate amount of capital funding directed towards hospitals.

Primary care networks (PCNs) offer the most localised view of capital needs

An alternative forum for capital spending co-ordination might be primary care networks (PCNs). They were established with the express intention of better integrating primary and community care.[44] They cover a smaller geography than ICSs (there are 42 ICSs in England, compared to 1,250 PCNs)[45], meaning that they might be better placed to make decisions about the needs of neighbourhoods. But PCNs are still imperfect vehicles for this type of decision making. PCNs typically lack the capability, both in terms of funding and expertise,[46] to carry out this kind of work. Their geographies might also be too small for them to make the level of investment needed for larger primary and community care hubs.

There is likely to be some blended approach between these three levels of geography that would be optimal for planning capital spending. Given the system-wide view that they have, ICBs may well be the most appropriate place for capital spending decisions to sit. What is clear is that expecting GP partnerships to make investment decisions that benefit the wider system is not working and resulting in poor outcomes.

Remove financial and accounting barriers to further investment

There are a number of ways that the NHS can expand the general practice estate. GP partnerships can purchase or rent existing property and convert it into a practice. Alternatively, the NHS can construct buildings designed specifically for its needs. In this latter case, funding for the building can either come from the NHS itself, or from private companies who then lease the property to the provider.

Given the need for an estate that provides space for integrated care and MDTs, it seems logical that the NHS will have to increasingly rely on buildings specifically designed for their purposes, rather than existing properties. This means that the NHS will need to finance the building of more properties itself or else rely on third-party developers.

Budgets are tight across the entire NHS. In general practice, the government's decision not to uplift the GP contract in line with inflation since 2022 means that there is substantial pressure on GP funding.[47] Putting aside funding for specific expenses, GP partners effectively have one 'pot' of money that they can use to cover their other expenses, including things such as staff wages and utility costs – both of which have risen much faster than funding since 2022. When competing with those more immediate pressures, capital investment can seem a lower priority. The updated Premises Costs Directions (published in May 2024) allows commissioners to fund up to 100% of a premises improvement project, up from 66% in the last set of directions.[48] This is a welcome change, but still relies on commissioners having sufficient budget to fund improvements.

It is difficult to invest in the general practice estate when there are substantial pressures on the wider NHS capital budget. There is a record maintenance backlog in hospitals. The government is funding the New Hospital Programme. It has also prioritised the expansion of diagnostic capacity, among other things. It therefore seems unlikely that there will be much NHS money available for investment in the general practice estate. That means that the NHS will need to rely more heavily on third-party developers.

This model has typically been less intensive on the NHS's capital budget. This is because the NHS does not incur upfront capital spending. Rather, the developer makes the initial investment and then generates a return by leasing the property to GP partnerships, typically for periods of 20–25 years. The NHS reimburses partnerships for that cost and the expense counts against the NHS's day-to-day (or revenue) spending. This is what is known as 'off-balance sheet' financing; in other words the money for the investment does not count against the NHS's capital budget and is instead paid for over the course of the lease. This allows the NHS to expand the estate without having to commit large amounts of its capital budget to the cause.

Of course, this model would still require the NHS to commit to revenue spending over the course of the lease. But this source of spending has typically been more protected than capital budgets, which are continuously raided to fund day-to-day spending. It may also be easier for a policy maker to commit to revenue spending over the course of decades, rather than the immediate fiscal hit of capital investment.

Off-balance sheet investment has, however, run into a problem in general practice. While it has traditionally been GP partnerships that have commissioned new buildings and taken on the lease, roundtable attendees told us that there has been an increasing trend of NHS trusts and integrated care boards (ICBs) playing this role. ICBs have done this done because, first, the declining number of GP partners means that there is often not enough capacity within general practice to expand the estate in line with need. Second, the NHS increasingly requires more integrated estate space. In these instances, it doesn't make any sense to put the entire burden of co-ordination and funding on to GP partnerships.

But roundtable attendees told us that this approach can prevent investment. Whereas rent paid through a partnership can be classified as revenue spending, when an NHS trust or ICB takes on a similar lease, it is required to capitalise the entire cost of the lease in the first year, in line with an international accounting standard (known as IFRS 16) that was introduced into NHS accounting practices in 2020.[49] As a simplified example, if a trust takes on a lease to pay a provider £100,000 per year for 20 years, it will be forced to record the entire value of this lease (£2 million) as capital spending in the year that the lease is signed. That in turn counts towards the trust and the NHS's capital spending limit (technically known as CDEL) for the year. The NHS is not legally allowed to breach this amount. To prevent an illegal breach of the CDEL limit, trusts are forced to pause the construction of new buildings, even when developers are conducting and financing the work.

In the 2021 spending review, the Treasury provided DHSC with an additional £1.4bn per year of funding for 2022/23 to 2024/25 to account for the increased cost of the accounting change.[50] But interviewees report that DHSC is underspending its allocation for IFRS 16. One reason could be that while the funding is sufficient at a national level, there could be misallocations to subnational levels, meaning that some areas underspend their allocation while others use all of theirs. It could also be that the amount the Treasury has allocated is an underestimate, and that this limits the NHS's ability to take on additional large projects, which in turn means the allocation is not spent. Whatever the cause, those we spoke to said that the IFRS accounting change is preventing sufficient capital investment.

This is a cause of frustration among both those in general practice and developers. One company told us that 23 projects worth £172m had been paused for a number of reasons, including CDEL limits. This means that there is a need for premises – as revealed by the NHS contracting these companies to carry out the work – the capacity for these companies to fulfil the contract, and willingness to commit to long-term leases.

But despite this, the work is not carried out because it would lead to more CDEL spending. The government denies that this is a major issue, claiming that "most general practice premises are directly owned or leased by GPs [...] and therefore IFRS 16 has a minimal impact on the funding of GP premises improvements".[51] While this may have a minimal impact on premises improvement (by definition changes to the existing estate) it does still prevent expansion of the estate with new buildings.

There is little that the NHS or the government can do to circumvent IFRS 16; it is an international accounting standard with which they have to comply. But there are ways that they can make the same investment within the rules. The most obvious would be to change the composition of spending settlements to reflect the need for high capital spending and lower resource spending. The government provided additional funding in the 2021 spending review in an attempt to do this, but that funding has not resolved the problem. Forthcoming Institute for Government work shows that hospitals (the focus of that report) still feel constrained by IFRS 16, despite additional funding. The Treasury should work closely with DHSC to ensure that the allocation made in the next spending review is sufficient to address the impact of IFRS 16. The NHS and government could also do more to support the expansion of GP partnerships so that they could take on leases and treat the lease liability as revenue expenditure.

Provide private investors with increased certainty

Another factor that influences private developers' decisions to invest in the general practice estate is the level of certainty that they have over future income. This is because they often fund the building of premises through borrowing. Companies make this investment with the expectation that they will be able to cover their interest repayments and also generate a profit. But companies told us both at the roundtable and in interviews that uncertainty over the level of return meant that they had a reduced incentive to invest, particularly in an environment of higher than anticipated interest rates.

They identified a couple of sources of uncertainty. First, they argued that uncertainty over future rents made it less likely that they would be willing to borrow to invest. The primary source of income for companies in this situation is rents from GP practices or ICBs. The level of rent that GPs pay to owners of a property is based on the current market rental (CMR) value of the property.[52] There is, however, difficulty in accurately assessing this value. There is no 'market' to speak of for GP practices; while there are a handful of private GP practices, the vast majority of funding comes from the NHS. The job of determining the CMR therefore falls to the District Valuer Services (DVS).[53] This process has worked well during periods of relative stability. But attendees at our roundtable said that current fluctuations in inflation, interest rates and property values mean that valuations are lagging substantially behind market interest rates, which have risen steeply in recent years and make the borrowing needed to build properties much more expensive. One attendee claimed that there is a two-year backlog in valuations that the DVS needs to work through. Meanwhile, the same provider has seen its cost of borrowing soar, meaning that it no longer knows if it is going to generate sufficient return on its investment.

There were counterpoints to this position, however. Some attendees argued that while many developers seek a reasonable return, there are some who exhibit overly aggressive and commercialised behaviour. And that this way of working made it very difficult to reach agreement on rental levels. This could take the form of pricing aggressively when they know that the NHS has few other options. In some ways, this is unsurprising; private companies have an incentive to maximise the return on their investment. In this case, the return comes from rents paid by the NHS. There is therefore always an inherent tension between private providers' desire for high returns and the NHS's need to deliver value for money.

Second, attendees at the roundtable argued that policy uncertainty reduces the attractiveness of investing in the sector. They pointed to the trend of approval for capital spending coming so late in the year (often just weeks before the end of March) as an example – largely because the NHS rushes to allocate underspent capital budgets at the end of a financial year. This kind of late approval makes it very hard for GPs, ICBs and developers to plan their own projects and creates a sudden rush of activity to spend money when it becomes available. Similarly, private providers have to plan their own construction schedules and, consequently, their expenditure. This is very difficult to do if confirmation of a contract only comes at the end of the year. This trend is not unique to general practice but rather characterises policy making across much of the health and care sector.[54] Upcoming Institute for Government work on the topic of capital spending in public services will address some of these issues in more depth and provide recommendations on how the government can deliver more certainty around capital spending.

Another major issue that attendees and interviewees raised was around the use of what is known as section 106 funding. When a landowner wants to develop their property, the planning authority often requires them to make a financial contribution to mitigate the impact of the development on demand for local services. This money is generally used to either fund affordable housing or infrastructure.[55] Some of this funding is often earmarked for investment in general practice capacity, including by expanding the estate.

Ostensibly, this is welcome news for the NHS and third-party developers. This is a source of funding for the general practice estate that does not come from the government and therefore does not count against CDEL. But the NHS is not currently making the best use of this money. Section 106 funding is agreed in a negotiation between the developer and the planning authority. Part of that negotiation includes an agreement about the amount of time for which the funding is available. If the funding is not used in that time, it is returned to the developer. Attendees described their frustration that delayed decisions within the NHS about how to spend the money often results in the section 106 funding being returned to the developer. This is an absurd situation for a system that is routinely scrabbling for additional funding. Funding is also often tied to milestones in the development process; for example, funding may only be released when all the houses in a development are completed. But if those milestones are not reached, for any reason, then the developer is no longer liable for the funding.

Some of these issues may be solved by the introduction of the government's new Infrastructure Levy.[56] This policy will replace section 106 funding and the Community Infrastructure Levy (CIL) – another source of funding. The Infrastructure Levy will limit the extent to which developers can negotiate down the amount that they pay, though there is no information about whether the Infrastructure Levy will remain available to spend for a longer period than section 106 funding. There is also a risk that the Infrastructure Levy will lead to less money being available for the general practice estate. Attendees at the roundtable claimed that because local authorities have more control over CIL funding, they are less likely to direct it towards the NHS, which councils perceive as being relatively well funded. If local authorities have as much control over the Infrastructure Levy as they do over CIL, then the shift to the former risks exacerbating the trend of insufficient funding finding its way to general practice. This is especially true as it will trigger the abolition of section 106, which currently limits the extent to which local authorities can divert funding away from the NHS. It is unclear what will happen to the Infrastructure Levy reforms after the July 2024 general election. But whoever forms the next government should think carefully about how developer contributions flow to general practice.

Conclusion

General practice is going through a period of immense change. More people than ever are employed in the service, even as the number of GP partners – arguably the staff group on which the service most relies – rapidly declines. Both political parties have committed to shifting care closer to home, better integrating general practice with the wider system, and making a shift towards prevention. But the current estate is a drag on those ambitions. There was consensus in our roundtable that urgent action is needed. And while there is no silver bullet, this paper proposes a number of options that the government could helpfully pursue: decouple partnership from either leasing or owning property; encourage co-ordination of spending at an ICB and PCN level; and provide all parts of the system with greater certainty around spending plans.

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Our thanks to **Assura** for its help in producing this report.

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June 2024