Health & Adult Social Care Select Committee and Growth, Infrastructure & Housing Select Committee – Joint review into planning for future primary healthcare in Buckinghamshire

Contents

Introduction by the Joint Chairmen of the Review

Cllr Isobel Darby
Chalfont St Peter

Cllr Chris Poll
Ivinghoe

"Primary Care in Buckinghamshire is one of the most important pathways for our residents when accessing services to help them remain healthy, happy and prosperous. With significant housing growth expected within Buckinghamshire over the coming years, there is a real need to have a robust delivery plan for primary care estates which aligns with the predicted housing growth to ensure that the population's health needs are met. We recognise the significant challenges faced by the Buckinghamshire, Oxfordshire & Berkshire West Integrated Care Board, Primary Care Networks and GP surgeries in planning for future provision – short planning cycles, regular changes to NHS services and structures, lack of funding for GP estates and a complex property valuation mechanism to name a few. We hope that the key findings and areas of recommendation from this rapid review will provide a basis for improving cooperation and planning for primary care estates. We would like to extend our thanks to the Members of the review group and to all the contributors who gave their valuable time to attend the evidence gathering meetings."

Members on the Review Group

Cllr Qaser Chaudhry
Chesham
(Day one only)

Cllr Robin Stuchbury
Buckingham West

Cllr Nathan Thomas
Tylers Green & Loudwater

Cllr Alan Turner
The Risboroughs

Cllr Stuart Wilson
The Wooburns,
Bourne End & Hedsor

Aim of Rapid Review

The rapid review, undertaken jointly between the Health & Adult Social Care Select Committee and the Growth, Infrastructure & Housing Select Committee aimed to achieve the following:

- Clarity on where the responsibility around planning future primary care services lies and identify the key influencers and decisions-makers in this process.
- Review current mapping of primary care provision against planned housing growth and identify potential gaps in the process to lead to improved working practices.
- Achieve greater understanding of how primary care infrastructure is funded and the level of support provided to Primary Care Networks/GP surgeries in securing funding and support to deliver proposals.
- Clarity around current planning consultations (including the Local Plan) and the engagement by health partners in the process.
- Strengthen existing partnerships by ensuring there are opportunities for primary care development as part of the Local Plan for Buckinghamshire. Contributions for local health provision via Section 106 (S106) and Community Infrastructure Levy (CIL) agreements would also be examined.

Methodology

The review group gathered evidence as follows:

Desktop research – Members considered important documentation relevant to the review. This included, but were not limited to the following:

- Next steps for integrating primary care: Fuller stocktake report
- Buckinghamshire Joint Strategic Needs Assessment
- Pharmaceutical Needs Analysis
- Planning Documentation around CIL and S106 agreements
- A proforma produced to assist Buckinghamshire Healthcare Trust (BHT) applying for S106 contributions
- Case studies of healthcare developments in Buckinghamshire

Two days of evidence gathering took place:

- 29th September 2023 – meeting with Integrated Care Board (ICB) representatives (including Estates Team), Planning Officers, BHT representative and relevant Buckinghamshire Council Cabinet Members. This set the scene, discussed existing planning processes, including the Local Plans and decision making. ICB funding, planning and delivery of primary care services, engagement between Planning and the ICB, and S106 and CIL were also discussed.

- 9th October 2023 – meeting with ICB representatives (including estates team), Planning Officers, Primary Care Networks (PCN) Lead, BC Estates, and BC Cabinet Members, discussing needs analysis and mapping, relevant case studies, and gap analysis.

National Context

Integrated Care Boards (ICB) were introduced in July 2022 replacing Clinical Commissioning Groups (CCGs). The ICB is a statutory NHS organisation responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and commissioning the provision of primary care services in a geographical area. New ICBs tend to cover a larger area than the predecessor CCGs, to allow for enhanced cooperation and cost savings, although these large diverse geographical areas can also present a challenge for the ICB.

In July 2019, as part of the NHS Long-Term Plan (LTP), around 7,000 general practices across England came together to form more than 1,250 Primary Care Networks (PCNs), covering populations of approximately 30,000-50,000 patients. They aim to improve the ability of practices to recruit and retain staff, to manage financial and estate pressures, to provide a wider range of services to patients and to ease integration with the wider health and care system.

Local Authorities have a statutory duty to prepare a Local Plan for their area. This development plan sets out the location of future growth and is the starting point for determining planning applications. As part of this, the ICB are a statutory consultee (specific consultation body) and are responsible for the provision of primary healthcare. On the 26th October 2023, the Levelling Up and Regeneration Bill obtained royal assent. This aims to help speed up the planning system, hold developers to account and encourage infrastructure development like GP surgeries, schools and transport links.

Concerns have been expressed nationally regarding the provision of Primary Care. The shortage of GPs, and a perceived inability to get a timely appointment, as well as a lack of NHS Dentists have implied a crisis in Primary Care. The continuing rise in population, and expected housing growth across the country, will further compound the problem.

Local Context

Buckinghamshire Council has a statutory duty to prepare a new Local Plan for Buckinghamshire and adopt it by 2027. More importantly, the Plan provides a major opportunity to shape the growth of Buckinghamshire over the next 15 years and beyond.

Buckinghamshire currently has four Local Plans and two Core Strategy development plan documents adopted by its predecessor councils. These are the Vale of Aylesbury Local Plan (VALP), Chiltern, South Bucks and Wycombe Local Plans, and Core Strategies for Chiltern and South Bucks. Community Infrastructure Levy (CIL) has been adopted for all these plan areas with the exception of Aylesbury Vale. An ongoing review is assessing whether CIL will be implemented in Aylesbury Vale before the adoption of the Buckinghamshire Local Plan. It is notable that only the Wycombe Local Plan makes specific reference to providing CIL monies for primary care facilities under policy CP7.

During the formulation of the VALP, the most recently adopted Local Plan in Buckinghamshire, whilst there was engagement with Health partners, the quality of their input was variable. In retrospect, this was a missed opportunity, and the Council is keen to have more engagement with Health partners as the Buckinghamshire Local Plan moves forward.

Buckinghamshire is part of an Integrated Care System (ICS) with Oxfordshire and Berkshire West, which consists of five local authorities. As mentioned above, the NHS created Integrated Care Boards as the statutory body to commission health services across the ICS. As part of this, staff working for predecessor Clinical Commissioning Groups were TUPED into the new organisation, however the ICB is still recruiting to a number of posts across the organisation and has had a number of interims in place since its creation.

Since July 2023, Buckinghamshire has a General Practice Providers Alliance (GPPA), a collaborative alliance of the key General Practice leaders and stakeholders in Buckinghamshire. This is the united front for General Practice in Buckinghamshire, and is comprised of the PCNs, FedBucks and the Local Medical Committee (LMC). FedBucks is a federation of 47 GP practices covering a population of over 485,000 patients across Buckinghamshire, they work to develop opportunities to support resilience and sustainability in local general practice. The function of LMCs is to represent the interests of GPs and practices with the objective of optimising the terms and conditions, working environment and stability of all GPs both individually and at practice level.

Members of Buckinghamshire Council routinely hear from residents that their main concern around new housing growth relates to the associated infrastructure that is needed, including primary care provision, and there are growing concerns that delivery results to date have been mixed and far from ideal to meet future need. Financial contributions from developers can be used to deliver some of this infrastructure. However, there is also a need for developer contributions to support infrastructure linked to Council Services, such as education, highways and leisure. The Local Planning Authority therefore has to balance these competing priorities, taking into account site viability, when negotiating contributions with developers.

Summary of Recommendations

Please find below a summary of our recommendations. The full narrative which leads to these recommendations is set out in the body of the report.

Recommendation 1
Mindful of the emerging ICB Primary Care Strategy and ICS Infrastructure Strategy, the ICB, in conjunction with the GPPA and BHT, should create a shared vision for Primary Care in Buckinghamshire as a matter of urgency. The vision and process should encompass:
Development of an action plan and timeline for the delivery of a draft vision for Buckinghamshire within a year to include but not be limited to:

- **A comprehensive audit and mapping exercise of current GP and primary care facilities as detailed in the Fuller Report, to include a condition review and SWOT analysis of current GP and primary care facilities**
- **The mapping of this data against future growth identified in the emerging Buckinghamshire Local Plan**
- **Incorporation of Census 2021 data, Public Health data and additional research to aid the mapping of future growth and need**

Recommendation 2
The Cabinet Member for Health & Wellbeing, the ICB and the GPPA should write to the Secretary of State for Health to highlight the barriers and inadequacies of the current funding formula and request a fundamental review of the funding mechanisms for Primary Care Estates and the methods of procuring new Estates Developments, including how the District Valuer assesses rental values. A new and improved 'fit for purpose' process needs to be developed that aligns more fully with the developing national ICS landscape and aims.

Recommendation 3
Buckinghamshire Council should work with the ICB, the GPPA and BHT to identify the co-resourcing of a key role to assist in the creation of a vision for future healthcare planning, as detailed in recommendation 1.

Recommendation 4
Community Infrastructure Levy (CIL) guidance for Town and Parish councils should be updated to raise awareness of how they could use their CIL funding allocation to support healthcare initiatives serving their local areas by funding or part funding projects. These could be initiatives or projects brought forward by their GP Practices, Local Members, their Community Board or by local voluntary organisations.

Recommendation 5
The Health and Wellbeing Board, Director of Public Health and the ICB should benchmark against comparable authorities in order to assess development of the Buckinghamshire JSNA, identify gaps and improvements and improve the Buckinghamshire provision, and specifically explore the development of Buckinghamshire bitesize housing growth digests.

Recommendation 6
Buckinghamshire Council and the ICB need to work together to update annually the quality and consistency of data which is used to inform service and estates planning, such as the Joint Strategic Needs Assessment and the Pharmaceutical Needs Assessment. The JSNA should include the evidence base as a part of the new Local Plan and Public Health should work with Planning colleagues to produce bitesize summaries of housing growth across Buckinghamshire.

Recommendation 7
Public Health, the ICB and the Planning Policy team should review how the data contained within the latest Pharmaceutical Needs Assessment can be used to inform the next Local Plan. This would include looking at examples from other authorities to demonstrate how it has been achieved.

Recommendation 8
The GPPA Enabler Lead (Estates), once appointed, should be the key link to the ICB Primary Care Estates team and be included in all future discussions around Primary Care Estates in Buckinghamshire. This role should aim to convene a regular programme of estates assessment / future planning meetings of key stakeholders as an early priority, the first of which should take place within 3 months of their appointment.

Recommendation 9
The ICB should formally assess the feasibility of increasing staffing levels in their Primary Care Estates team and consider including Data Analysts, in order to facilitate the development and delivery of a Primary Care Estates Plan at place as well as at the strategic level.

Recommendation 10
Buckinghamshire Council should formally assess how key staff members from the Planning and Public Health teams might work collaboratively with the enhanced ICB team, mentioned above, in the short and medium term. This would support the development and delivery of the Primary Care Estates Plan for Buckinghamshire and ensure the sustainability of the Buckinghamshire Local Plan.

Recommendation 11
As a matter of urgency, further improvements need to be made to the toolkit to ensure the results can be used to inform future estates planning. The toolkit should be re-directed to individual GP practices for completion. This project needs to be prioritised and a formal progress report of findings be produced within six months and presented to the HASC Select Committee for scrutiny.

Recommendation 12
The Buckinghamshire Executive Partnership (BEP) should commission a working group drawn from the ICB and the Council's estates teams and the GPPA. The group should identify and highlight opportunities within all organisations existing property portfolios which could expediate the delivery of additional health facilities. The working group should report back to the BEP.

Primary Care Estates Planning

From the outset, we knew this review was going to be a complex piece of work due to the nature of what we were looking at and we heard a lot of evidence over the two days. For ease, we have divided the key findings and areas of recommendation under three main headings – Primary Care Estates Planning, Funding Primary Care Estates and Delivering Integrated Primary Care.

Buckinghamshire Council sets out in the introduction to its Corporate Plan - 'We are committed to making Buckinghamshire the best place to live, raise a family, work, and do business. We want our county to be a place everyone can be proud of, with excellent services, thriving businesses and outstanding public spaces for everyone. We want our residents, regardless of background, to live healthy, successful lives and age well with independence.'

After the pandemic, all public services are under pressure financially and resourcing remains a key focus for all our healthcare partners. There is a need to collaborate effectively with partner organisations in order to deliver more by working smarter and more creatively. For the purposes of this review Buckinghamshire Council is not just seen as the planning authority but also as an enabler and a 'place shaper'. The developing Buckinghamshire Plan is not simply about where in the county is best placed to absorb additional housing growth, but it is also an opportunity to think about the wider implications of that growth for all public services and businesses in Buckinghamshire.

Access to healthcare is a hot topic locally and nationally and the interdependence between primary care, acute hospital trusts and local authority social care is well-recognised. A lack of investment in primary care can lead to a significant increase in acute admissions and subsequent demand for social care. Therefore, it is important for Health and local authorities to work together more closely to enable a whole system approach to deliver more effective and integrated care for our residents. The decision to create ICBs nationally reflects the fact that the NHS cannot deliver in isolation and highlights the importance of a partnership approach.

Legal and governance framework

One of the aims of this review was to provide clarity around where the responsibility for planning future primary care services lies and to identify the key influencers and decision-makers in this process. This section of the report looks at the legal and governance structures currently in place as part of the Council's planning process and in relation to primary care estates planning and delivery, as well as looking at the current situation in relation to existing local plans and primary care estates planning.

As mentioned, the Council has a statutory duty to prepare a new Local Plan for Buckinghamshire and adopt it by 2027 which provides a major opportunity to shape the growth of Buckinghamshire over the next 15 years and beyond.

We heard about the rigorous statutory tests for seeking infrastructure through the planning process both in terms of onsite provision or financial contributions towards off site provision, which needs to take into account the complex NHS funding mechanisms amongst other matters, to ensure any mitigation is:

(a) necessary to make the development acceptable in planning terms;

(b) directly related to the development; and

(c) fairly and reasonably related in scale and kind to the development.

How this works in practice will be discussed later in the report, alongside the differences in funding options available for infrastructure projects through S106 agreements and the Community Infrastructure Levy.

In July 2022, Clinical Commissioning Groups were abolished and replaced by an Integrated Care Board. According to the NHS England website, an Integrated Care Board is "A statutory NHS organisation responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in the ICS area. Within each Integrated Care System, place-based partnerships will lead the detailed design and delivery of integrated services across their localities and neighbourhoods. The partnerships will involve the NHS, local councils, community and voluntary organisations, local residents, people who use services, their carers and representatives and other community partners with a role in supporting the health and wellbeing of the population."

Whilst the ICB is responsible for commissioning primary care services, it does not hold any capital to invest in primary care estates nor is it allowed to do so. There are no ICBs that currently own primary care estate and in order to do so, the ICB will need consent from the Department of Health and Social Care (DHSC), who in turn will require the ICB to pay for an annual "capital charge" to hold such estate.

A complex landscape of primary care estates ownership currently exists, which sits predominantly with corporate Landlords, NHS Property Services, individual GP practice owner-occupiers or "accidental" GP landlords (retired GPs who continue to own the building with current GPs occupying the premises).

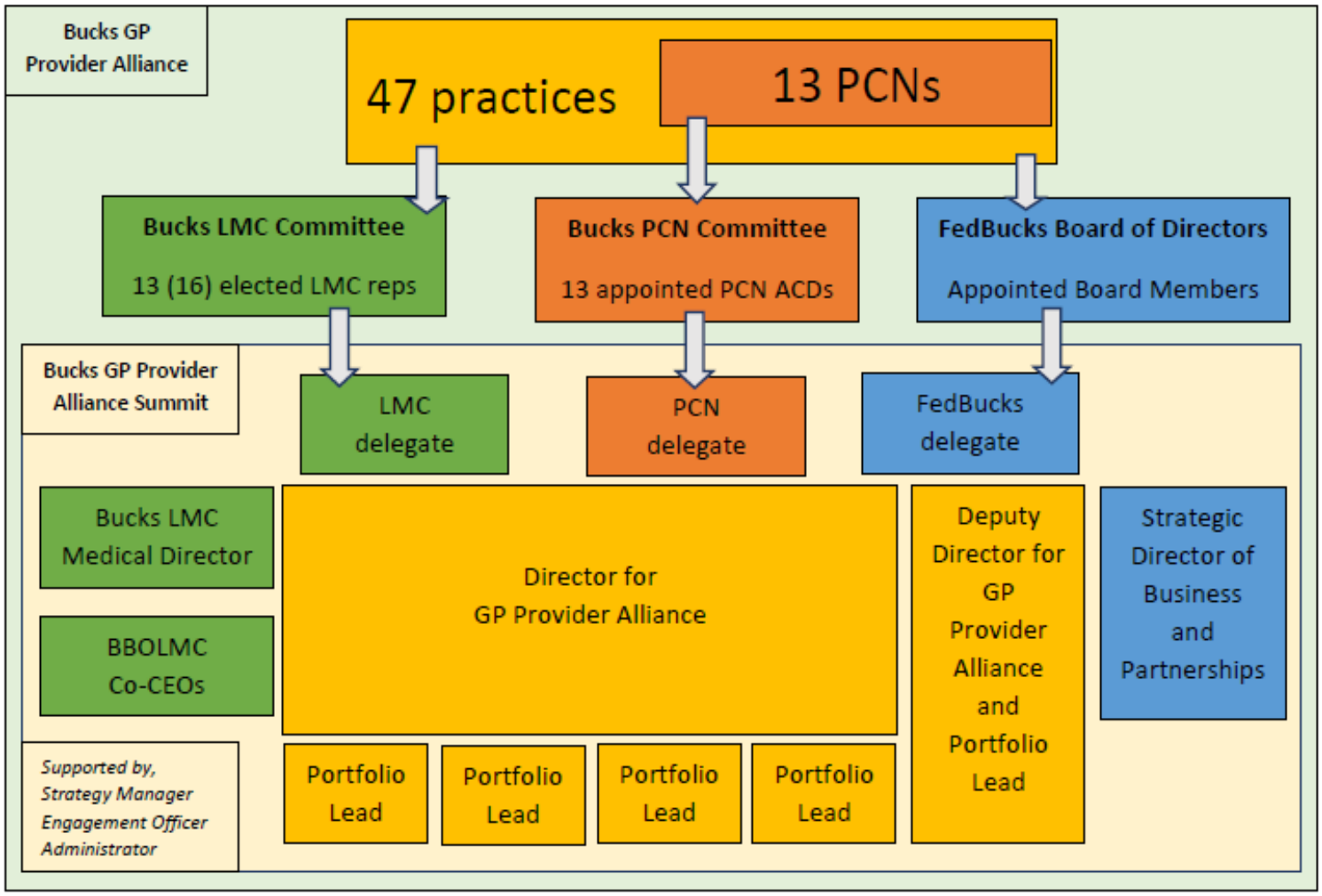
We understand that new primary care developments, whether brand-new buildings or extensions to existing premises, need to be GP-led. GPs would approach the ICB with plans around their existing estates (or to discuss any plans to expand) with a view to that Practice being willing to either take a new long-term lease from a Third-Party Developer (in the case of new premises or significant extension), or if the premises are owner-occupied, to find capital funding to pay for the proposed development. In each case, the ICB is responsible for the revenue-funding of such development (through rent reimbursement) and for working with the GP practice to develop those plans to deliver the project.

The Review Group was struck by a mismatch between the aspirations of the ICB and PCNs to deliver 'primary care at scale' and the fact that the starting point for any new GP estates development would be at the individual GP practice level. An individual GP practice would be asked to identify a need to expand their estate, secure funding for it, perhaps through liaison with the local planning authority to secure S106 or CIL, devise a project and then approach the ICB to provide more expertise or support. This appears to place a heavy burden on individual GPs who may not view property development as a top priority or have in-house expertise or funding to lead on such an endeavour. This also presents a 'Catch 22' whereby a GP cannot secure developer funding without a fully detailed and specific project plan, but the ICB is unlikely to support the development of such a plan without knowing that funding has been agreed.

Buckinghamshire General Practice Providers Alliance (GPPA) and Primary Care Networks (PCN)

We also heard about the newly created Buckinghamshire General Practice Providers Alliance (GPPA), which brings together the key General Practice leaders and stakeholders (see structure below). The GPPA will provide the united front for general practice in Buckinghamshire by directly working at System and Place with the ICS and local providers and supporting resilience within general practice.

In Buckinghamshire, there are 47 GP practices which make up the 13 Primary Care Networks.



Basic structure of the GPPA, June 2023

In 2022, the Health & Adult Social Care Select Committee (HASC) undertook an inquiry into the development of Primary Care Networks in Buckinghamshire.

For context purposes, as part of the NHS Long-Term Plan (LTP), around 7,000 general practices across England came together to form more than 1,250 Primary Care Networks, covering populations of approximately 30,000-50,000 patients. Bringing general practices together to work at scale has been a priority for some years for a range of reasons, including improving the ability of practices to recruit and retain staff, to manage financial and estate pressures, to provide a wider range of services to patients and to ease integration with the wider health and care system.

The new five-year framework for the GP contract published in January 2019, put a more formal structure around this way of working. To support PCNs, the Additional Roles Reimbursement Scheme (ARRS) provides funding for 20,000 additional roles to create bespoke multi-disciplinary teams, including pharmacists, physiotherapists, paramedics, physician associates and social prescribing support workers. Whilst the ARRS initiative has exceeded original expectations with over 26,000 additional staff successfully recruited, this funding is for a set time period and ICBs and PCNs are awaiting clarity from NHS England around whether the scheme and funding will be extended, discontinued or a new model brought forward.

Members on the HASC Select Committee inquiry heard that, whilst the additional roles were welcomed across the PCNs, these additional roles had created pressure on existing workspace. One of the recommendations in

the HASC inquiry was for the ICB to undertake a mapping exercise to align future primary care provision, based on fully developed PCNs across the county, with future housing growth at "Place and neighbourhood". The recommendation also stated that senior people should be involved in conversations between Buckinghamshire Council and health in relation to future planning of primary care.

"NHS England has significant ambitions for Primary Care Networks, with the expectation that they will be a key vehicle for delivering many of the commitments in the NHS Long-Term Plan and providing a wider range of services to patients."

King's Fund report, November 2020

Health and Wellbeing Board

We heard about the statutory role of Health and Wellbeing Boards to promote and improve integrated working among local providers of healthcare and social care so that patients and other service-users experience more joined-up care. We also heard from Public Health colleagues about the statutory duties associated in producing a Joint Strategic Needs Assessment (JSNA), the Pharmaceutical Needs Assessment (PNA) and the Joint Health & Wellbeing Strategy (JHWS). More on these later in the report.

Buckinghamshire Executive Partnership

We understand that the Buckinghamshire Executive Partnership (BEP) was established in April 2023 to support the delivery and transformation of health and care services in Buckinghamshire and to complement the work of the Health and Wellbeing Board. Its purpose is to bring together CEOs, statutory officers and senior executives across Buckinghamshire to:

- Accelerate progress on shared system priorities, as defined by the ICP and HWB;
- Ensure the right enablers are in place to deliver those priorities (such as infrastructure, workforce, and governance);
- Identify specific areas where system and partnership approaches can add value and drive improvements;
- Support and champion innovation and transformation through sharing best practice and risk; and
- Ensure strategic alignment, best use of resources and operational oversight of integrated care across the Buckinghamshire health and care system.

We understand that senior members of the GPPA are included on the Bucks Executive Partnership and they will also be invited to have a member on the Health and Wellbeing Board. We are pleased to hear that there will be continuity of GPPA membership on the HWB and the BEP to help improve information sharing across GPs and a more joined-up approach to delivering integrated primary care services.

Current situation

This section of the report outlines a summary of the adopted local plans for Buckinghamshire with identified areas of growth until 2033. We acknowledge that the Buckinghamshire Local Plan will look at housing growth until 2040 but these plans will be used as the basis of developing the Buckinghamshire Local Plan. This section will also look at the current situation in relation to planning primary care estates by the Integrated Care Board. It is important to recognize that the majority of new development will come from larger schemes that will trigger CIL and S106 contributions. However, a significant number of additional smaller windfall units of development will collectively add to pressure on services but will not trigger thresholds and developer contributions.

Vale of Aylesbury Local Plan

For the purposes of providing some context for this report, below is a summary of the key detail contained in the Aylesbury Vale Local Plan (VALP).

The VALP makes provision for 28,600 new dwellings for the period 2013 to 2033. It refers to the total population of the Aylesbury Vale area as 174,100 (2011 Census) and also states that there is an ONS forecast of population increase in the area to around 214,000 by 2033 (this did not take into account the impact of the VALP accommodating unmet need) including unmet housing need from the former legacy council areas of Chiltern, South Bucks and Wycombe (8,000 dwellings).

A number of sites contributing to the VALP housing target already have planning permission (since 2013) with 12,325 dwellings having been completed between 2013 and 2022. 11,127 homes have permission but are not built as at 31st March 2022. This equates to 82% of the total VALP housing provision (23,452 dwellings compared to 28,600 dwellings provided for within the plan).

The Local Plan housing target is equivalent to 1,430 dwellings p.a. which is taken from the published Five-Year Housing Land Supply Position Statement (2023).

There are relevant Local Plan policies to secure appropriate infrastructure linked to new development, including provision for GP practices. There are also policies relating to specific site allocations requiring healthcare infrastructure provision on site or financial contributions towards off site provision.

Below are the eight largest site allocations detailed in the Local Plan.

- D-AGT1 – South Aylesbury
- D-AGT2 –South West Aylesbury (Oxford Road and Lower Road)
- D-AGT3 – Aylesbury North of A41 (Woodlands[1], Manor Farm, Westonmead and College Farm)
- D-AGT4 – Aylesbury South of A41 (Hampden Fields, New Road and Aston Clinton Road)
- D-AGT5 – Berryfields, Aylesbury
- D-AGT6 – Kingsbrook, Aylesbury
- D-NLV001 – Land south of the A421 and east of Whaddon Road, Newton Longville (SW Milton Keynes)
- D-WHA001 – Shenley Park, south of Milton Keynes

[1] Note that the Woodlands site is not the entire area of AGT3

Wycombe Local Plan

The Wycombe Local Plan makes provision for 10,925 dwellings to 2033.

The annual Local Plan target is equivalent to 546.3 dwellings p.a. which is taken from the Council's Five-Year housing supply position statement.

There are relevant Local Plan policies to secure appropriate infrastructure linked to new development CP7 Delivering the Infrastructure to Support Growth which includes the provision of primary care facilities where required.

In terms of site allocations PR7 sets out the development requirements for the Princes Risborough expansion area which includes healthcare. Policy BE3 supports health facility development in the Bourne End and Wooburn area.

Below are the largest site allocations in the Local Plan.

- Policy HW5 – Abbey Barn South
- Policy HW6 – Gomm Valley and Ashwells
- Policy HW7 – Terriers Farm, High Wycombe – Development Brief
- Policy HW8 – Land off Amersham Road including Tralee Farm, Hazlemere
- Policy PR4 & PR7 - Princes Risborough Expansion – adopted SPD
- Policy BE1 – Slate Meadow Bourne End and Wooburn, Development Brief
- Policy BE2 – Hollands Farm Bourne End and Wooburn, Development Brief

In the Wycombe area, Community Infrastructure Levy (CIL) is in place since the adoption of the CIL charging schedule in November 2012.

Both Local Plans were supported by evidence of future housing and population needs in a joint study called The Buckinghamshire Housing and Economic Development Needs Assessment (HEDNA, dated December 2016, updated August 2017).

New information is being released from the 2021 Census which will feed into new household projections (usually published in 2 years' time). This will help inform the new Local Plan for Buckinghamshire.

Chiltern and South Bucks

The Chiltern Local Plan was adopted in 1997, and the South Bucks Local Plan adopted in 1999. Further Core Strategy documents were adopted in 2011 for both areas. A proposed Local Plan for both areas, the joint Chiltern and South Bucks Local Plan was withdrawn following agreement by Buckinghamshire Council, at its full Council meeting on 21st October 2020. Whilst the examination Planning Inspectors' initial findings on the duty to cooperate were not agreed and/or accepted, the likelihood was that this action might in any event be forced on the Council by the Inspectors. Therefore, to withdraw would have potentially saved significant abortive costs and would allow efforts and resources to be concentrated on the preparation of the new Local Plan for Buckinghamshire. Therefore, the Chiltern and South Bucks areas are more susceptible to speculative development without the protection of an up-to-date recent Local Plan and an inability to demonstrate a five-year housing land supply.

Against this backdrop of existing local plans, we heard that the Council's planning team has been in discussion with both the ICB, responsible for primary care and Buckinghamshire Healthcare NHS Trust (BHT), responsible for acute and community care. These discussions focused on how both organisations can positively engage in

the planning application process as well as engaging with the development of the new Local Plan to identify the impact of development on healthcare and identify their infrastructure requirements. The focus of the discussions has been on the Vale of Aylesbury Local Plan area where the CIL charging regime is not currently in place.

We heard how joint working between the planning team and Buckinghamshire Healthcare NHS Trust (BHT) intensified following the unsuccessful judicial review in 2021 brought by the Hampden Fields Action Group on Hampden Fields in relation to the provisions made for healthcare, with officers working collaboratively with both bodies. We heard that improvements in working practices have been made following this with BHT and planners working together to produce a proforma which is now used by BHT in the planning application stage. This has helped BHT to demonstrate the evidence required for S106 agreements more robustly.

It was good to hear that BHT and the planners have taken positive steps to improve their working practices and we heard that BHT has taken four of its services through the proforma planning process. We recognise that BHT is one organisation with its own legal and governance structures in place as opposed to GP practices, who are individual businesses each with their own business plans and who are also operating within Primary Care Networks to provide additional healthcare support within their locality. Decisions regarding primary care estates start with the individual GP practices and we acknowledge that GP practices operate differently, depending on their size, location and in-house expertise/skills. We also recognise that estates planning is not a core business for GP practices.

Primary Care Estates for Buckinghamshire

From speaking to ICB colleagues, it became apparent that there is no current Primary Care Estates Plan which identifies specific projects for investing in future estates which could then be linked to local housing development. Without this information, planners are unable to justify and secure developer contributions to mitigate against housing development which could then be used to meet the identified local healthcare needs.

We understand that KPMG has been commissioned by the ICB to develop a Primary Care Strategy which will cover the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System. They are in the process of conducting a public consultation designed to inform the new ICB Primary Care Strategy and a wider ICS Infrastructure Strategy, both of which we believe will feature elements relating to primary care estates. We welcome the development of these much-needed strategies, however it remains uncertain whether either will contain sufficient detail relating to primary care estate planning at place level in Buckinghamshire and how the future needs of the county will be identified, designed, funded and delivered. We are concerned that these will be high-level documents which will not address the fundamental issues around developing and delivering a local primary care estates plan which aligns with the local Buckinghamshire plan and the already identified areas of housing growth as outlined above in the VALP and newly identified areas emerging through the Local Plan process.

During the evidence gathering, we heard that the planning cycle for the NHS is far shorter than the planning cycle for the council planners, which looks to 2040 and beyond. This immediately highlighted the challenges around aligning the key elements from both planning processes. However, a starting point should be the already developed local plans which detail where housing growth will be over the next 10 years.

As part of the request for background information for this review, ICB colleagues provided us with a copy of the Fuller report, “Next steps for integrating primary care: Fuller Stocktake report”. This report was commissioned by NHS England and NHS Improvement and was published in May 2022.

The Fuller report states that a detailed review of the space available in the system, service by service, needs to be undertaken in order to inform the ICS estates infrastructure strategy.

The Fuller report also states that PCNs have been more successful than had hoped in hiring staff in new roles with the latest data as of Q4 2021/22 showing over 18,000 FTEs were in post by the end of March 2022 – significantly ahead of the trajectory towards the 26,000 March 2024 target. The report provides details of integrated neighbourhood “teams of teams” which need to evolve from PCNs and require a shared, system-wide approach to estates, including NHS Trust participation in system estate reviews, with organisations co-locating teams in neighbourhoods and places.

During the evidence gathering, we heard that primary care also includes Pharmacy, Optometry and Dentistry (POD). These services have recently become part of the ICB’s commissioning responsibility. For the purposes of this review, the focus is on future planning around GP provision but we are mindful of the need for the ICB to have wider discussions with other primary care providers to ensure future needs are met across all services.

We would like to have heard more evidence of joint working between those commissioning and delivering primary care and BHT, who are responsible for community services. We are increasingly concerned at the apparent lack of integrated planning across all healthcare providers and with increased financial pressures there is even more need for integrated planning of healthcare services and smarter ways of working.

There is direction from the NHS to create integrated neighbourhood teams and discussions are already taking place around community diagnostic centres, as well as BHT’s ambition for delivering care closer to home through the development of community hubs. Delivery of pilot projects in Marlow and Thame, which have been

discussed by the HASC Select Committee for several years, have extended far longer than originally planned and there is no clear indication that these initial hubs will be developed further or provide a model for further sites and delivery of community-based services in the future. A final decision about the feasibility and scope of the Marlow and Thame community hubs, whether they provide a model that will be rolled out to other sites across Buckinghamshire and an indication of potential locations would be very welcome.

There needs to be a clear vision for integrated primary care in Buckinghamshire which describes the ambition for primary care over a defined timeframe (at least the next 10 to 15 years). From this overall vision, a local delivery plan can be developed which can be aligned to the identified areas of growth in the local plan to ensure funding opportunities are maximized and future local healthcare needs are met. It was clear from our evidence gathering that this lack of a coherent strategy made it incredibly difficult for the Council's planning team to secure developer contributions towards primary care estate. Whilst developer contributions alone cannot fix existing problems within the primary care estate or plug all the gaps in terms of meeting additional health needs arising from new housing developments, a more proactive approach from the ICB and a deliverable Primary Care Estates Plan would provide an evidence base to enable more robust applications to secure funding.

Recommendation 1

Mindful of the emerging ICB Primary Care Strategy and ICS Infrastructure Strategy, the ICB, in conjunction with the GPPA and BHT, should create a shared vision for Primary Care in Buckinghamshire as a matter of urgency. The vision and process should encompass:
Development of an action plan and timeline for the delivery of a draft vision for Buckinghamshire within a year to include but not be limited to:

- **A comprehensive audit and mapping exercise of current GP and primary care facilities as detailed in the Fuller Report, to include a condition review and SWOT analysis of current GP and primary care facilities**
- **The mapping of this data against future growth identified in the emerging Buckinghamshire Local Plan**
- **Incorporation of Census 2021 data, Public Health data and additional research to aid the mapping of future growth and need**

Funding Primary Care Estates

NHS funding for primary estates

As mentioned earlier, the ICB does not hold capital to invest in primary care estates, nor is it allowed to do so. The Fuller report states that there are 8,911 premises in England, 22% of which are pre-1948 and 49% of which are owned by GPs, 35% by third party and 14% owned by NHS Property Services. Around 2,000 premises have been identified by GPs as not being fit for purpose.

We heard about the current rent arrangements for GP practices and how NHS England reimburses GP practices for rent and business rates on leased properties. We also heard about the role of the District Valuer Service (DVS) to assess whether the rent/lease terms for any new premises represent value for money, given that the NHS reimburse that rent. The DVS advises the NHS whether the proposed terms of a new or changed lease represent value for money, based on a specific approach to calculate the rental value. The DVS will generally calculate an appropriate rent by multiplying the net internal area of a premises by their opinion of an appropriate rent per square metre (gathered only from other assessments of nearby GP premises) to provide their assessment of a value for money rent. Where developments are proposed to be part-funded by developer contributions (S106 or CIL), the DVS will also calculate an abatement of that rent to reflect those contributions. It is necessary to have this approval from NHS England (or occasionally an agreed departure from it) before a new lease is signed. During the evidence gathering, we heard that there is a significant disconnect between the DVS's rental valuations and the rent that commercial property developers require, given the current economic

environment in which we are working in, as detailed below.

With the uptick in interest rates and increased costs in building materials, developers have seen a reduction in commercial estate values. To compensate for this, developers see an increase in rent as the only way to match the price with the cost of building. The DVS therefore do not find that the proposed rent value represents value for money. This is stopping GP's from acquiring new properties via lease/rent agreement.

As outlined earlier, when looking to develop GP estates in response to housing growth, developer contributions from the housing developments is only a small part of the funding solution. The complexities around securing funding for primary care estates were highlighted through a number of examples which were discussed during the evidence gathering. Specific examples are detailed below and in Appendix 1.

We heard that a GP practice in North Buckinghamshire spent over 7 years trying to deliver a primary care estates project. Significant delays in the process meant that opportunities were lost but ultimately the district valuer's value for money assessment for the rental contributions over a 35-year lease agreement were not considered viable, leading to more project delays whilst possible alternatives are considered. It is fair to say that this appears to be a common theme in the other examples which were discussed, with the District Valuer Value for Money Assessment being the common factor in proposed primary care estate developments not being viable.

We heard examples where NHS England had funded, through its Estates and Technology Transformation Fund (ETTF) and Sustainability and Transformation Plan (STP) Grant funding infrastructure, projects across the county in Beaconsfield, Berryfields and Chalfont St Peter. We also heard that in Winslow, NHS Property Services have funded another major refurbishment. Chalfont and Winslow were largely expansion of existing premises with Beaconsfield and Berryfields being the development of new sites.

From what we heard, the complexities around the funding and investment opportunities in primary care estates are a barrier to delivering existing primary care estates, let alone being able to plan for future estates. We feel that understanding the current primary care estate is key to understanding what investment is needed to meet the future ambitions around primary care estates and ultimately how it will then be funded.

Section 106 and CIL funding, which we will consider next, is only one part of the solution and it is recognised that it is unlikely to raise the substantial sums needed to adequately finance future primary care estate needs. However, it could play a role in resourcing necessary enabling and feasibility work and needs to be viewed in conjunction with all other funding options when considering primary care estates. A joined-up and integrated approach by key stakeholders will ensure all potential opportunities can be reviewed as a whole and funding opportunities can be maximised to achieve successful outcomes.

What is clear is that a fundamental review of the funding mechanisms available to invest in primary care estates needs to be undertaken nationally. It needs to look at ownership models and a thorough reassessment of the role of the DVS is long overdue, including the assessment model/formula used by the DVS. This will ensure future funding of primary care estates can be delivered in a more commercial, financially viable and joined-up way.

Recommendation 2

The Cabinet Member for Health and Wellbeing, the ICB and the GPPA should write to the Secretary of State for Health to highlight the barriers and inadequacies of the current funding formula and request a fundamental review of the funding mechanisms for Primary Care Estates and the methods of procuring new Estates Developments, including how the District Valuer assesses rental values. A new and improved 'fit for purpose' process needs to be developed that aligns more fully with the developing national ICS landscape and aims.

Section 106 and Community Infrastructure Levy

During the evidence gathering, we received a short presentation on the differences between S106 developer contributions and Community Infrastructure Levy. These schemes currently operate in very different ways when it comes to funding health infrastructure through developer contributions.

To briefly summarise what we heard, S106 monies are contributions from developers secured by a legal agreement usually accompanying a planning permission, to make developments acceptable which would otherwise be unacceptable in planning terms. We understand that S106 money can only be secured if there is a costed, identified project which can be linked to the specific development. We heard from health colleagues about the challenges in the timescale for accessing the money and the longevity of the available funds (as set out in the agreement). Health providers, like other infrastructure providers for education and highways, are unable to forward fund so they may have to wait for the delivery of a certain number of homes on a development before any monies can be released.

The Community Infrastructure Levy (CIL) is a fixed charge levied on new development to fund infrastructure. CIL is not negotiable (unlike S106 contributions). Up to 5% may be retained by the Council towards the cost of administering CIL. A proportion of CIL (15% rising to 25% where a Neighbourhood Plan is adopted) collected from development is passed to the Town or Parish Council within which the development was situated.

Unlike S106 funding, CIL can be used to fund an infrastructure project which is not specifically linked to the development so it could be used for improved transport links, roads or schools in the wider locality, for example. How CIL money is allocated is a decision for the councils who receive it. We understand that Buckinghamshire Council is currently reviewing whether it should take a county wide approach to CIL.

Historically, Wycombe District Council allocated 20% of its CIL to fund social infrastructure with 5% on healthcare but we heard that CIL is not currently being used to fund any healthcare facilities.

During the evidence gathering, we heard examples of healthcare projects in the Aylesbury Vale area where S106 agreements had been drawn up to include funding for healthcare facilities. Without an agreed Buckinghamshire Primary Care Estates Strategy to refer to, there have been examples where S106 agreements have specified the provision of land parcels or funding for healthcare facilities but delivery of these facilities is no longer part of the ICB and local GPs plans and therefore managing local expectations becomes very challenging.

The HASC Select Committee have been advised of an evolving issue in the settlement of Long Crendon in north Buckinghamshire as part of their duty to review substantial service changes. A new development proposal allocated a specific parcel of land for a healthcare facility as part of the agreed S106 provision in a final site planning permission. However, no one designated contact in either the planning or healthcare teams took ownership of formalising a delivery plan and residents and the parish council only became aware of the land allocation when the Long Crendon GP surgery was designated as ‘unfit’ and marked for closure due to the age and constraints of the building during the Covid crisis. Patients were informed they would be reallocated to the surgery in the neighbouring settlement of Brill where the CCG planned to bring health professionals together under one roof. The local community rejected this proposal on logistical grounds and on the basis of significant housing growth within the settlement increasing the need for improved services in Long Crendon. They lobbied stakeholders including their MP and the HASC Select Committee and have spent two years trying to bring forward a viable business plan to facilitate the building of a new surgery, dispensing and community service facility with no success due significantly to the obstacles and failings within the current funding process and model of value assessment.

Please see a further case study demonstrating the misalignment of Local Plans and Primary Care in Bourne End and Wooburn in Appendix 1.

We heard that proposals for mitigation schemes that comply with planning policy and are considered affordable and deliverable, are more likely to result in contributions being secured. Mitigation can only be sought where it is necessary, directly related and proportionate to development proposals.

It is important to recognise that developer contributions, whether from S106 agreements or CIL cannot fix existing shortcomings in the primary care estate. They can only be used to mitigate an increased need for healthcare arising from the new development. However, when there is very little funding available to support the expansion of the primary care estate it is incumbent on the ICB, the Council, BHT and the GPPA to try and maximise this potential funding stream. This is why a more strategic approach is vital.

There have been examples in Buckinghamshire where developer contributions have had to be 'retrofitted' because the original plans haven't been deliverable and with a more robust strategy in place this could be avoided. We also acknowledge that there are competing priorities for developer contributions – they can also be used to fund new schools, affordable housing, roads and leisure facilities.

However, as we alluded to earlier, the Council has a role to play as an enabler and a 'place shaper' and if health facilities are a priority for residents of Buckinghamshire, then this should be reflected in the effective use of CIL monies. In addition, if primary care can focus more on a preventative agenda and residents can be seen quickly by a GP or other professionals, this could save money down the line across the wider health and care system. This is a fundamental element of the Council's Live Well, Age Well approach in the Buckinghamshire Joint Local Health & Wellbeing Strategy 2022 to 2025.

Recommendation 3
Buckinghamshire Council should work with the ICB, the GPPA and BHT to identify the co-resourcing of a key role to assist in the creation of a vision for future healthcare planning, as detailed in recommendation 1.

Recommendation 4
Community Infrastructure Levy (CIL) guidance for Town and Parish councils should be updated to raise awareness of how they could use their CIL funding allocation to support healthcare initiatives serving their local areas by funding or part funding projects. These could be initiatives or projects brought forward by their GP Practices, Local Members, their Community Board or by local voluntary organisations.

Delivering Integrated Primary Care

Earlier in the report, we highlighted the need for a clear vision of what future primary care will look like as well as a recommendation to lobby Government to undertake a wholesale review of how primary care estates are funded, with more focus on providing funding for primary care. We feel that proper investment in primary care will, ultimately, take the pressure off other parts of the health and care system and strengthen the ambition for providing care closer to home and avoiding hospital admissions.

The Fuller report outlines 3 key enablers to help support the delivery of integrated primary care – Data, Workforce and Estates. During the evidence gathering meetings, we examined these areas in more detail to assess the current situation in Buckinghamshire.

Data

"Unlocking" the power of data across local authorities and the NHS will provide place-based leaders with the information to put in place new innovative services to tackle the problems facing their communities. A more joined-up approach will bring public health and NHS services much closer together to maximise the chances for health gain at every opportunity. Each ICS will implement a population health platform with care co-ordination functionality that uses joined-up data to support planning, pro-active population health management and precision public health by 2025.

Joining up care for people, places and populations,
The Government's proposals for health and care integration - published February 2022

Whilst acknowledging that different data sets (both qualitative and quantitative) exist across the health and care system and data is interpreted in different ways depending on what is being looked at, there is still a fundamental need for accessible, good quality, meaningful data which can be used with confidence as part of key decision-making.

NHS Digital merged with NHS England on 1st February 2023 and NHS Digital's responsibilities for designing and operating national data infrastructure and digital systems now resides with NHS England. Aiming to reduce duplication and bring the NHS' national data and technology expertise together into one organisation, the new configuration is now working to enable closer links between the collection and analysis of data and the delivery of service improvements as a result of that insight. However, during the evidence gathering, we were concerned to hear about gaps in existing data which directly impact on how services are currently delivered and future planning decisions, particularly around demand for services.

We understand that a new ICB Data and Digital Strategy was approved by the ICB Board in May 2023 with an ambitious implementation programme detailed within it. We look forward to seeing what the implications will be for Buckinghamshire and its residents.

NHS Opt-Out

In terms of health data, we heard about patient record opt-out which, according to the NHS Digital website, the national data opt-out allows a patient to choose if they do not want their confidential patient information to be used for purposes beyond their individual care and treatment - for research and planning.

We heard that a local GP practice has chosen to opt-out all its patient records whilst in other cases, individual patients have chosen to opt out of national data collection. This means that the patient's record is not available across the health and social care system and will not be included as part of any data sets which could be used to help with planning future demand. There is also another unknown factor which relates to the number of people

who have not registered with a GP. Both of these issues raise concerns about the unknown impact on demand and therefore the associated challenges in planning for the future.

Further clarity is needed from NHS England and the Department of Health to understand whether there will be changes to national legislation to facilitate the anonymised use of data for research and planning processes.

Joint Strategic Needs Assessment and Joint Health & Wellbeing Strategy

We heard from Public Health colleagues about the Joint Strategic Needs Assessment (JSNA) and the Joint Health and Wellbeing Strategy (JHWS).

According to the Department of Health paper entitled "Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies", local authorities and Clinical Commissioning Groups (CCGs) – now the Integrated Care Board - have equal and joint duties to prepare JSNAs and Joint Health and Wellbeing Strategies, through the health and wellbeing board.

The paper goes on to say that the responsibility falls on the health and wellbeing board as a whole and so success will depend upon all members working together throughout the process. Success will not be achieved if a few members of the board assume ownership, or conversely do not bring their area of expertise and knowledge to the process.

Buckinghamshire Council's website states that the Joint Strategic Needs Assessment is a continuous process to assess the current and future health, care and wellbeing needs of the local community to inform local decision making, using a variety of data sources. It also provides information on the population of Buckinghamshire and wider determinants of health. Wider determinants include a range of social, economic, and environmental factors – JSNA Buckinghamshire Council

From the evidence we heard and having reviewed the JSNA on the website, we have concerns about how the information is presented and identified some gaps. For example, the housing and homelessness section is coming soon.

We heard that the Clinical Commissioning Group (now the ICB) used to have in-house data analysts working on analysing and producing data sets which were used as part of the JSNA. We understand this function was outsourced but the ICB is now looking to bring some expertise back in-house. We welcome this decision as we feel there needs to be renewed effort by all organisations to work together to bring the JSNA up-to-date and to ensure it includes the evidence base as part of the new Local Plan so that it takes account of population changes associated with housing growth. We would like to see ownership and leadership by health colleagues and Public Health to drive forward data improvement.

We reviewed how other authorities have used the information contained within their JSNA to produce meaningful information and particularly liked Oxfordshire's bitesize population digests showing housing growth by area. Whilst acknowledging the pressure on resources, but also recognising the need to produce robust and good quality data, we feel that Buckinghamshire should produce JSNA bitesize digests showing housing growth by area. An example of these digests can be found on Oxfordshire's website - JSNA_Bitesize_Population_Mar23.pdf (oxfordshire.gov.uk).

Recommendation 5
The Health & Wellbeing Board, Director of Public Health and the ICB should benchmark against comparable authorities in order to assess development of the Buckinghamshire JSNA, identify gaps and improvements and improve the Buckinghamshire provision, and specifically explore the development of Buckinghamshire bitesize housing growth digests.

Pharmaceutical Needs Assessment

We also heard about the Pharmaceutical Needs Assessment (PNA) which is a comprehensive assessment of the current and future pharmaceutical needs of the local population and considers whether there are any gaps to service delivery in Buckinghamshire. Current national trends see major pharmacy groups including Boots and Lloyds rationalising sites and services with the potential loss of over 200 pharmacies by mid-2023. Live data relating to service provision needs to regularly inform the Buckinghamshire PNA.

Health and Wellbeing Boards (HWBs) have a legal duty to produce, consult and publish a PNA for their area every three years. The latest Buckinghamshire PNA was approved by the HWB in September 2022 and it showed that Buckinghamshire is well served in relation to the number and location of pharmacists. During the evidence gathering, it became apparent that the PNA is not well known or used by other parts of the system and is not an evidence base which is used in the planning process.

Recommendation 6
Buckinghamshire Council and the ICB need to work together to update annually the quality and consistency of data which is used to inform service and estates planning, such as the Joint Strategic Needs Assessment and the Pharmaceutical Needs Assessment. The JSNA should include the evidence base as a part of the new Local Plan and Public Health should work with Planning colleagues to produce bitesize summaries of housing growth across Buckinghamshire.

Recommendation 7
Public Health, the ICB and the Planning Policy team should review how the data contained within the latest Pharmaceutical Needs Assessment can be used to inform the next Local Plan. This would include looking at examples from other authorities to demonstrate how it has been achieved.

Workforce

GP workforce

Workforce challenges are well evidenced across the whole health and social care sector and the national shortage of GPs is well documented as part of these challenges. As mentioned earlier, one of the aims of creating Primary Care Networks (PCNs) was to enhance access to local primary care services, for example physiotherapists, pharmacists and social prescribers, to allow GPs to concentrate on patients with the most complex needs. Funding for these additional roles sits outside of the GP contract and funding is allocated on an annual basis, making it difficult to plan for the medium and longer term.

As mentioned earlier, the newly created GPPA is the united front for General Practice in Buckinghamshire. Whilst recognising that GPs core business is the provision of healthcare for their patients and estates planning is not part of their core business, we feel that more support needs to be given to GPs to help them with their estates planning and to work with the ICB and the council planners to align existing provision against planned future housing growth so that plans can be developed to meet the local population needs. We understand that there is a vacancy for a GPPA Enabler Lead (Estates) and would like the recruitment to this post to be given priority to ensure this important work can proceed at pace.

Recommendation 8
The GPPA Enabler Lead (Estates), once appointed, should be the key link to the ICB Primary Care Estates team and be included in all future discussions around Primary Care Estates in Buckinghamshire. This role should aim to convene a regular programme of estates assessment/future planning meetings of key stakeholders as an early priority, the first of which should take place within 3 months of their appointment.

Integrated Care Board Primary Care Estates

We heard that the current ICB Primary Care Estates "team" consists of one person who is covering the Buckinghamshire, Oxfordshire and Berkshire West ICS. We understand that a town planner will soon be joining who will provide much needed additional resource but we remain concerned about the lack of resource within the primary care estates team. This team covers the whole of the BOB ICS area so we are concerned about capacity to deliver across this wide geographical area and secondly, without a clear delivery plan for primary care estates, we feel the team will continue to be working against a very challenging and difficult backdrop.

As referenced earlier, quality of data and consistency of data usage has been highlighted, so we welcome the plans to strengthen data analysts within the ICB. We would like to see closer working between Public Health colleagues and the ICB data analysts.

Increased collaboration between ICB staff and planning colleagues will help to drive this agenda forward whilst also supporting the newly developed ICB Primary Care Strategy and positively impacting the Buckinghamshire Local Plan, which will need to demonstrate that infrastructure, such as healthcare facilities, can be delivered alongside housing growth, as part of its sustainability assessment.

Recommendation 9
The ICB should formally assess the feasibility of increasing staffing levels in their Primary Care Estates team and consider including Data Analysts, in order to facilitate the development and delivery of a Primary Care Estates Plan at place as well as at the strategic level.

Recommendation 10
Buckinghamshire Council should formally assess how key staff members from the Planning and Public Health teams might work collaboratively with the enhanced ICB team, mentioned above, in the short and medium term. This would support the development and delivery of the Primary Care Estates Plan for Buckinghamshire and ensure the sustainability of the Buckinghamshire Local Plan.

Estates

As detailed in the Fuller report, estates are much more than buildings and should be the catalyst for integration not a barrier. Creating the right environment needs to start with understanding what is currently available in terms of estates.

GP practice estates profiles

As mentioned earlier in the report, we feel that there needs to be a renewed effort in understanding the current primary care estates infrastructure. A thorough understanding of the status quo in terms of estates will then provide a 'springboard' or strong foundation to think about future needs and plan how they can be best met in terms of expanding existing GP practices or the creation of brand-new ones.

We understand that a "toolkit" was prepared by an external organisation and sent to Primary Care Networks to complete. We were not supplied with a copy of the toolkit but ICB colleagues expressed concerns about the quality of the results, particularly the deficiency in the data and felt that more work was needed before the information could be used as part of a meaningful discussion about future estates planning. We also heard that a potential shortcoming is that the toolkit is directed at PCNs whereas estate ownership is at individual GP practice level. We are concerned that this exercise has not been undertaken satisfactorily in advance of the development of the ICB Primary Care Strategy.

Recommendation 11
As a matter of urgency, further improvements need to be made to the toolkit to ensure the results can be used to inform future estates planning. The toolkit should be re-directed to individual GP practices for completion. This project needs to be prioritised and a formal progress report of findings be produced within six months and presented to the HASC Select Committee for scrutiny.

One Public Estate

During the evidence gathering, we heard about several factors which impact on current GP surgery space. The additional roles created within Primary Care Networks normally require longer patient consulting time than a GP (physiotherapists, for example), thereby creating more pressure on consulting room space. We also heard about the changes to training requirements for new GPs, which also impacts on consulting room space.

Buckinghamshire Council's corporate plan states that - "We are committed to partnership working, focusing on shared priorities, and encouraging collaboration, sharing intelligence, and driving change and tackling key issues in a more coordinated way".

We heard from the Council's property team about the One Public Estate (OPE). We are aware of a successful project which has been delivered in Milton Keynes, where a number of health partners now operate from one location, but we are not aware of any similar projects in Buckinghamshire that have been delivered or are currently in development. We understand the requirement for health partners to develop their estates plan first before opportunities can be identified within OPE.

We feel the Council needs to take a more pro-active approach in relation to its own property portfolio and should initiate discussions with health partners around opportunities for co-locating services. The HASC Select Committee is aware of a number of council property proposals that have been developed recently which could, potentially, have benefitted from a wider discussion with key partners to ensure opportunities were not lost. These have included sites at Tilehouse Lane in Denham and King George V House in Amersham.

We feel that the Council property team needs to work collaboratively with the ICB and work more closely with them to help align their primary care vision using appropriate existing property, whenever and wherever possible. We also recognise that there is increased pressure on public development and delivery funding and there is an increasing need to work with commercial partners to deliver new facilities.

Linked to this, the Council needs to be more ambitious in its approach to financially supporting the ICB. Whilst every effort should be made to influence national policy decisions to simplify and improve NHS estate ownership processes, the Council should actively investigate how they could act as a landlord for the ICB whilst they are unable to invest in property themselves.

Through the Buckinghamshire Executive Partnership there is an opportunity for senior leaders of all relevant stakeholders to work together to prioritise primary care estates planning and bring forward delivery plans for Buckinghamshire in order to ensure better facilities and health outcomes for its residents. Members would like to see the Buckinghamshire Executive Partnership commission a working group to drive this work forward as we have seen little evidence of successful projects being delivered by OPE.

Recommendation 12

The Buckinghamshire Executive Partnership should commission a working group drawn from the ICB and the Council's estates teams and the GPPA. The group should identify and highlight opportunities within all organisations existing property portfolios which could expediate the delivery of additional health facilities. The working group should report back to the Buckinghamshire Executive Partnership.

Conclusion

In bringing this report to its conclusion, the review group would like to reiterate a few overriding key messages which we heard during the evidence gathering meetings.

The current disconnect between planning and delivering future primary care estates and planned housing growth, through the Council's Local Plans, is leading to missed opportunities and real concerns about future proofing primary care estates to meet the needs of a growing population.

Complex models of GP estate ownership exist which create significant challenges when considering future estates planning. Estates planning is not a GPs core business, yet the onus is on individual surgeries to scope and provide a plan to the ICB for consideration of any investment in their future estate.

The role of the ICB is to commission primary care services, yet the ICB is not able to hold any funds to help and support estates delivery. A complicated and, at times, undeliverable funding mechanism exists, and developer contributions represent just one small part of this. Whilst acknowledging financial pressures, we feel strongly that there is not enough estates planning resource within the ICB to deliver across the wide geographical area of Buckinghamshire, Oxfordshire and Berkshire West.

Additional pressure on primary care estates has been created by the development of additional roles within Primary Care Networks and recent changes to GP training, both of which have led to a requirement for more consulting space.

The District Valuer assessment is complicated, difficult to navigate and not in line with increased commercial property costs, thereby leading to projects not being deemed financially viable by the NHS and thus not being progressed.

The discussions around the Joint Strategic Needs Assessment highlighted the need for more ownership and leadership to drive improvements in data collection and analysis. This would lead to more robust data being used as an evidence base to help inform decision-making.

Without a vision for primary care and the subsequent primary care estates plan there could again be missed opportunities in the emerging Local Plan for Buckinghamshire, which could be used to help support and meet local healthcare needs. Prioritising primary care estates, as a local health and care system, and developing a joined-up approach to delivering care closer to home, will alleviate pressure on acute services and social care and ensure a more balanced approach to delivering healthcare for residents.

Appendix 1 – Case Study – Bourne End and Wooburn

The Wycombe Local Plan (WLP), adopted in 2019, designated Bourne End and Wooburn as a settlement for up to 800 dwellings in its Spatial Strategy Policy CP3 – settlement strategy to meet its housing need assessment. To achieve the aims of the WLP, two major sites for development: in the Bourne End/Wooburn area were identified,

1. Policy BE1 : Slate Meadow indicative 150 dwellings
2. Policy BE2: Hollands Farm indicative 467 dwellings

Housing development is also taking place on small sites that are not identified in the plan but where housing development is acceptable in accordance with the general policies of the plan. Indeed, Policy CP3 of the local plan identifies Bourne End and Wooburn as a Tier 2 settlement (collectively called Market Towns and Other Major settlements).

Policy BE3 provides general support for proposals put forward by the local clinical commissioning Group or other promoters for a new heath care centre that come forward subject to normal planning criteria.

POLICY BE3 – HEALTH FACILITIES IN BOURNE END AND WOOBURN

1. **Proposals put forward by the local Clinical Commissioning Group or other promoters for a new health centre in Bourne End and Wooburn will be supported subject to transport assessment, parking arrangements and other relevant planning considerations being satisfactory.**

Policy BE3 was informed by commentary that noted the increased demand pressure on primary care provision from planned development through the Infrastructure Delivery Plan. The WLP noted that the Chiltern Clinical Commissioning Group had submitted practice plans to NHS England to develop a new build surgery to house both Hawthornden and Pound House practices (both part of Bourne End and Wooburn Green Medical Centre), including their branch surgeries in a modern, state of the art building with sufficient capacity to absorb expected population growth. It was acknowledged in the supporting text that a new health centre could be facilitated on the housing allocations at Slate Meadow (BE1) or Land at Hollands Farm (BE2) subject to agreement with landowners and consideration given to transport and parking matters. Existing employment sites in Bourne End may also be a suitable location.

Since the adoption of the local plan no formal submissions have been made which fall to be assessed under policy BE3.

The Local Planning Authority has granted planning permission for a housing development at Slate Meadow (Policy BE1), in considering this application no demonstrated justification was provided by the CCG (now ICB) or the local GP practice on health care grounds for mitigation measures whether in respect of health care facilities or financial contributions.

Policy BE2 at Hollands Farm is at outline planning consent stage (three applications). The developers who have promoted these applications have not identified any sites within their applications for health care facilities. The local plan does not require them to do so. Financial contributions towards health care building projects can be secured from such housing developments but subject to evidence being provided from the ICB that meets strict national planning rules. The ICB have submitted a representation for s106 funding to only one of the applications for increased demand amounting to £339,821 based on a formula agreed with the Local Planning

Authority. This ICB representation states that "BOB ICB would allocate resources gained to increase capacity within ARC BUCKS PCN and have identified a project opportunity for expansion of existing practice premises…Our project will be to [mitigate] the demand created by the new population. Additional capacity will be created by developing Bourne End and Wooburn Green Medical Centre (BEWGMC)." However, there is no project to expand develop the BEWGMC agreed with the practice nor is that feasible in the existing premises.

Elsewhere in its submission, the ICB states that it inherited a Primary Care Estates Strategy for 2020 -2025 from Buckinghamshire CCG that considered the areas where there are particular pressures which the CCG should prioritise in terms of Estates Development being Aylesbury (excluding Berryfields), Buckingham, Wycombe Town and Winslow. Clearly, this is inconsistent with the WLP Infrastructure Delivery Plan and policies which recognised additional pressures in Bourne End and Wooburn.

Separately, BEWGMC had been pursuing a plan to develop new state of the art healthcare facilities on a local employment site. This had progressed to an advanced stage but was rejected by the ICB in 2023 based on its priorities stated above, the perceived lack of demand growth and lack of developer contributions. Working independently, BEWGMC had only used housing growth from BE1 and BE2 in its calculations and had no engagement with the local planning authority or developers on potential funding to support the business case.

The actual housing growth for Bourne End and Wooburn will be in excess of 1000 dwellings with windfall from in-fill and substantial office to residential conversions. The employment site has subsequently been lost. Policy BE1 has made no provision for additional healthcare facilities as no demonstrated justification was provided by the CCG (now ICB) or the local GP practice. There is considerable risk that financial provision from the remaining Policy BE2 will be inadequate to deliver the aspirations for wider health care facilities which are supported in principle by Policy BE3.

Appendix 2 - Glossary of Terms

5YHLS	Five-Year Housing Land Supply
ARRS	Additional Roles Reimbursement Scheme
BEP	Buckinghamshire Executive Partnership
BHT	Buckinghamshire Healthcare Trust
BOB	Bedfordshire Oxfordshire & Berkshire West
CCG	Clinical Commissioning Group
CIL	Community Infrastructure Levy
DHSC	Department of Health and Social Care
DVS	District Valuer Service
ETTF	Estates and Technology Transformation Fund
FTE	Full Time Equivalent
GPPA	General Practice Providers Alliance
HASC	Health & Adult Social Care select committee
HEDNA	Housing & Economic Development Needs Assessment
HWB	Health and Wellbeing Boards
ICB	Integrated Care Board
ICP	Integrated Care Partnership
ICS	Integrated Care System
JHWS	Joint Health & Wellbeing Strategy
JSNA	Joint Strategic Needs Assessment
LMC	Local Medical Committee
LTP	Long-Term Plan
ONS	Office for National Statistics
OPE	One Public Estate
PCN	Primary Care Network
PNA	Pharmaceutical Needs Assessment
POD	Pharmacy Optometry & Dentistry
S106	Funding from developers towards the cost of community and social infrastructure
STP	Sustainability and Transformation Plan
VALP	Vale of Aylesbury Local Plan