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NHS Hampshire and Isle of Wight
Local Planning Engagement Team
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Date: 11th July 2024

Dear Sir/Madam,

With Reference To:

Planning Application Ref: 23/01700/FULLS

Applicant Name: Churchill Retirement Living

Description: Redevelopment for retirement living accommodation comprising 47 retirement apartments including communal facilities, access, car parking and landscaping

Address: Edwina Mountbatten House Broadwater Road Romsey Hampshire SO51 8GH

The above-named application has now been reviewed from a primary care perspective and the following comments are provided by NHS Hampshire and Isle of Wight Integrated Care Board (ICB) as their response to this application.

Introduction:

1. This document provides a summary of the impacts of new housing developments on primary care's capacity to provide health services, as well as a calculation of the contribution sought to mitigate the impact of the development on the local primary care infrastructure. It explains:
 - The impact created by the proposed development;
 - How the impact on the capacity to provide primary healthcare services can be mitigated by way of developer contribution and S106 Compliance.
 - How GP facilities are funded;

- The role and responsibility of Integrated Care Boards (ICBs) and Health and Wellbeing Boards;
- The planning policy context and decision-making process;

The Impact Created by the Proposed Development:

2. The proposed development is for **47** dwellings and this will create an estimated of population of **61** new residents within the development based an average household size of **1.3**.
3. The GP surgeries with a contractual catchment that includes the proposed development are:

GP Surgery	Address
Abbeywell Surgery	The Abbey, Romsey, Hampshire, SO51 8EN
Abbeywell Surgery: Nightingale Surgery	Great Well Drive, Cupernham Lane Romsey, Hampshire, SO51 7QN
Alma Road Surgery: Romsey	Alma Road, Romsey, Hampshire, SO51 8ED

It is envisaged that the vast majority of the residents of the proposed development will register as patients with [this/these] practice[s], though occasionally GP surgeries will allow registrations from outside of their catchment if the registration of the new population from a development is too significant for one practice to manage. In relation to the above GP surgeries, it is important to note:

4. The current combined medical centres providing primary care are up to their capacity and will not be able to absorb the increased patients arising from the proposed development. We have consulted with these practices as part of drafting this response, and they are supportive of our response to you.
5. The only way to mitigate the impact is to increase the physical capacity of the existing surgeries. The ICB has carefully calculated the space needed to mitigate the impact, drawing upon the document “*Health Contributions Approach: GP Provision document*” which was agreed by NHS England. The detailed calculation is attached to this document as Appendix 1. In this, we are requesting a contribution of £358 based on a per dwelling calculation. The calculation is directly linked to the proposed development and is fairly and reasonably related in scale and kind to the development. This funding on its own will not be enough to undertake an expansion project, so the ICB requests that the contribution is ringfenced for a future expansion project relating to

Romsey & North Baddesley PCN's practices, which can be drawn down once a project is viable, deliverable and affordable to the practices.

6. The contribution requested is necessary. Without the contribution to increase the physical capacity, the proposed development will put too much strain on the said health infrastructure, which may result in practices no longer being able to support registering new patients on safety and sustainability grounds. This would result in patients needing to register further away to access services, resulting in waiting times increasing and access to local health services declining. Such an outcome is not sustainable as it will have a detrimental socio-economic impact.
7. In addition, having no or limited access to the primary care will have a knock-on effect on secondary healthcare, in particular on A&E services, as those people who cannot access their primary care usually will present themselves at the A&E adding additional pressure on the already stretched secondary care.
8. Appropriate estates infrastructure is just one of the underpinning tools required by primary care to provide safe and sustainable services. In addition to this, General Practice colleagues and the NHS generally are experiencing significant difficulties with a reduced and fatigued workforce, an ageing population with more complex conditions and increasing comorbidities, and higher expectations regarding health service delivery from the public. Activity levels within primary care have not reduced to pre-Covid levels, and recent challenges facing the sector are not expected to diminish in the short to medium term. Whilst important to note the challenges impacting on primary care, contractors within general practice are responsible for ensuring safe and appropriate staffing levels, and any estates projects that come forward would have appropriate workforce plans in place to support such growth.
9. The development directly affects the ability to provide the health service required to those who live in the development and the community at large. Without securing such contributions, the ICB would be unable to support the proposals and would object to the application because the direct and adverse impact that the development will have on the delivery of primary health care.

Integrated Care Board (ICB):

10. The ICB plans and commissions health care services from providers and has delegated responsibility for commissioning primary health care services. ICBs exist to maintain and improve the health of their registered population and are, therefore, concerned with preventing as well as treating ill-health.

Integrated Care Partnership (ICP):

11. Hampshire County Council, together with the ICB, have an obligation to prepare joint strategic needs assessments. These strategies then inform joint health and

wellbeing strategies to meet the assessed needs¹. Both the needs assessments and wellbeing strategies **must** then be taken into account when an ICB and the responsible Local Authority exercise **any** of their functions.²

Commissioning Health Care Services/Facilities Through NHS Funding:

12. In a given year, central government through the Comprehensive Spending Review process sets the level of NHS funding. The process estimates how much funding the NHS will receive from central sources. The NHS receives about 80% of the health budget, which is allocated in England to NHS England/Improvement (NHSE/I), the governing body of the NHS in England. In turn, NHSE/I allocate funds to Integrated Care Boards (ICBs) which are clinically-led, statutory NHS bodies.
13. NHS-funded primary care services are delivered by independent contractors, usually GP partnerships, through General Medical Services (GMS), Alternative Provider of Medical Services (APMS) or Personal Medical Services (PMS) Contracts. GMS and PMS contracts are in perpetuity whereas APMS are a fixed-term, generally 5-10 years.
14. General Practices are funded using a weighted capitation formula based on existing registered patients which is updated quarterly in arrears. In addition, practices get income from achieving quality indicators as part of the Quality Outcomes Framework (QOF) and participating in nationally commissioned Direct Enhanced Services (DES) and ICB commissioned Locally Commissioned Services (LCS).
15. The projected ICB allocations by NHS England makes an allowance for growth in the number of people registered with GP practices. This population growth is based on mid-year estimates from the ONS age-sex specific population projections. Local housing projections, local housing land supply or existing planning permissions are not taken into consideration. The population projections only consider natural trends based upon births, deaths and natural migration and make a number of assumptions about future levels of fertility; mortality and migration based previously observed levels. The funding for ICB is reactive and the funding received from the Central Government is limited. In the case of patient movement, the funding does not follow the patient in any given year.

Infrastructure Facilities Funding:

16. **NHS England does not routinely allocate any additional funding to the ICB in the form of capital or revenue towards infrastructure projects to cater**

¹ s. 116A of the 2007 Act and the Health and Social Care Act 2012

² S116B of the Health and Care Act 2022

for the impact from new residential developments. As noted in the GP Recovery Plan, published by NHS England on 9 May 2023, greater developer contributions towards primary care infrastructure is being consulted on at present, and the ICB may become a statutory consultee in relation to health provision, putting us on equal footing with access to education.

17. Within the service contracts between the ICB and GP practices, practices are required to provide premises which are suitable for the delivery of primary care services and meet the reasonable needs of patients within their catchment area.
18. The Regulations governing GP contracts require ICBs to reimburse the practices for their premises through rents payable for lease property or pay a “notional rent” (a market rent assessed by the District Valuer on the assumption of a “notional” 15-year lease) in respect of a GP-owned building³. For new builds or extensions, the ICB needs to agree the additional rent from a limited revenue budget. If the ICB has no ability to reimburse then the project to increase the capacity by way of alteration extension, or building a new facility, will be at risk.

Premises Development in Primary Care:

19. Delivering GP services in a new location represents a challenge for the ICB as no new GMS service contracts are now available. Therefore, for the new location to operate, either:
 - the existing GMS service providers will have to relocate/expand; or
 - a new (APMS or PMS) contract will need to be created and procured for the new premises’ location
20. At the moment the ICB does not hold capital and does not own buildings, the procurement of new premises is either by:
 - a Third-Party development (where a third-party developer funds the capital to build a new building, owns it and charges a commercial rent via a normally 25-year lease that represents the developer’s return on capital, with the ICB reimbursing that rent); or
 - a GP owner-occupied scheme (where the GPs own and develop but receive a notional rent, as described above), to fund the cost of the build.

Either way, such developments are most likely to occur for occupiers who hold an existing GMS or PMS contract, as APMS contract holders will not have a sufficient

³ <https://www.kingsfund.org.uk/publications/gp-funding-and-contracts-explained>

contract term to either enter a 25-year lease or invest in a new GP premises development.

The Decision-Making Process and Planning Policy Context:

Decision-Making

21. The starting point for the determination of planning applications is the development plan. Section 70(1) of the Town and Country Planning Act 1990 ("TCPA 1990") provides that a Local Planning Authority (LPA) may grant planning permission unconditionally or subject to such conditions as it thinks fit. Section 70(2) of the TCPA 1990 provides that in determining an application for planning permission, the LPA; "shall have regard to the provisions of the development plan, so far as material to the application, and to any other material consideration. Section 38(6) Planning Compulsory Purchase Act 2004 states that applications for planning permission should be determined in accordance with the Development Plan unless material considerations indicate otherwise.

22. Whether or not a particular factor is capable of being a material consideration is a matter of law albeit that its factual context and weight are matters for the decision-maker. The health of communities has been a key element of government policy for many years and is reflected in adopted development plan.

Development Plan Policy:

Adopted Local Plan 2011-2029

Policy COM15: Infrastructure

Development will be permitted provided that the appropriate investment has been secured either in the form of works and/or financial contributions to mitigate the impact on existing infrastructure.

5.142 *Investment in a range of infrastructure and services is often necessary for development to proceed. Examples include water supplies, waste water, schools, community facilities, **health**, green infrastructure, telecommunication (including broadband) and transport....*

5.144 *New provision or improvements to existing infrastructure may be required to ensure a development is acceptable. This can take the **form of contributions or physical improvements**. The type, scale and location and impact of the development will determine the necessary contribution. Developers will be expected to provide information, and if necessary negotiate with, the Council, or the relevant provider, on the infrastructure necessary to make the proposal acceptable....*

National Planning Policy Framework (NPPF):

23. Paragraph 2 of the NPPF states:

The National Planning Policy Framework (NPPF) must be considered in preparing the development plan, and is a material consideration in planning decisions. Planning policies and decisions must also reflect relevant international obligations and statutory requirements.⁴

24. The ICB is delivering primary care services at the point of demand through General Practice under the statutory requirement. Paragraph 2 of the NPPF contains an imperative upon the decision makers to reflect statutory obligations.⁵

25. In addition, the health of communities has been a key element of government policy for many years and is, as stated above, reflected in adopted development plans. Please see NPPF Section 2 paragraph 8, Section 8 paragraphs 91 and 93.

26. The developer contributions are only sought from new development applications proposals where the contribution requested complies with the Community Infrastructure Levy (CIL) Regulation 122 tests:

(1) This regulation applies where a relevant determination is made which results in planning permission being granted for development.

(2) A planning obligation may only constitute a reason for granting planning permission for the development if the obligation 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.

(3) In this regulation—

“planning obligation” means a planning obligation under section 106 of TCPA 1990 and includes a proposed planning obligation.

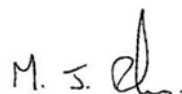
Could you please acknowledge NHS Hampshire and Isle of Wight’s request for an S106 contribution towards the cost mitigation of the pressures on the local healthcare facility [and that it will form part of any future S106 Agreement with the Developers].

Thanking you for your consideration on this matter.

⁵ Please also see paragraph 3 above.



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Malcolm Dicken
Head of LPA Engagement
On behalf of NHS Hampshire and Isle of
Wight Integrated Care Board (ICB)

Appendix 1: Mitigation Methodology Calculation

Methodology for Application 23/01700/FULLS

1. Residential development of 47 **dwelling**s.

2. This development is in **the catchment of**:

Abbeywell Surgery
Abbeywell Surgery: Nightingale Surgery
Alma Road Surgery: Romsey

which has a **total capacity** for 20,714 patients.

3. The **current patient list** size is 34,104 which is already **over capacity** by **13,390** patients (at 165% of capacity).

4. The **increased population** from this development = 61

- a. No of dwellings x Average occupancy rate = population increase
- b. $47 \times 1.3 = 61$

5. The **new GP List size** will be 34,165 which is **over capacity** by 13,451

- a. Current GP patient list + Population increase = Expected patient list size
- b. $34,104 + 61 = 34,165$ (*13,451 over capacity*)
- c. *If expected patient list size is within the existing capacity, a contribution is not required, otherwise continue to step 6*

6. **Additional GP space required** to support this development = 4.70 m²

- a. The expected m² per patient, for this size practice = 0.077 m²
- b. Population increase x space requirement per patient = total space (m²) required
- c. $61 \times 0.077 = 4.7m^2$

7. **Total contribution required** = £16,829

- a. Total space (m²) required x premises cost = final contribution calculation $4.7 m^2 \times £3,577 = £16,829$ (*£358 per dwelling*).