NHS
Hampshire and Isle of Wight

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NHS Hampshire and Isle of Wight
Integrated Care Board
Hampshire Fire and Police Headquarters
Leigh Road
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Hampshire
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Date: 28 April 2023

Dear Sir/Madam,

With Reference To:

Planning Application Ref: P/OUT/2023/01166

Applicant Name: Dudsbury Homes (Southern) Ltd

Description: Mixed use development of up to 1,700 dwellings including affordable housing and care provision; 10,000sqm of employment space in the form of a business park; village centre with associated retail, commercial, community and health faculties; open space including the provision of suitable alternative natural green space (SANG); biodiversity enhancements; solar array, and new roads, access arrangements and associated infrastructure (Outline Application with all matters reserved apart from access off Hillbury Road)

Address: Land To The South Of Ringwood Road Alderholt

The above-named application has now been reviewed from an NHS primary care perspective and the following comments are provided by the 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 the new housing development on the NHS primary care infrastructure 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 role and responsibility of Integrated Care Boards (ICBs) and Integrated Care Partnerships (ICPs);

- How GP facilities are funded;
- The planning policy context and decision-making process;
- The Impact created by the proposed development and;
- How the impact on the capacity to provide primary healthcare services can be mitigated by way of developer contribution and Community Infrastructure Levy (CIL) compliance

Integrated Care Board (ICB):

2. The ICB plans and commissions health care services from providers and has delegated responsibility for commissioning primary 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):

3. The Local Authority 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 needs[1]. 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:

4. 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 (NHSE), the governing body of the NHS in England. In turn, NHSE allocate funds to Integrated Care Boards (ICBs) which are statutory NHS bodies.

5. 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 typically in perpetuity whereas APMS are a fixed-term, generally 5-10 years.

6. 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).

[1] s. 116A of the 2007 Act and the Health and Social Care Act 2012
[2] S116B of the Health and Care Act 2022

7. 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:

8. NHS England does not routinely allocate any additional funding to the ICB in the form of capital or revenue ringfenced for infrastructure projects to cater for the impact from new residential developments.

9. 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.

10. 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 building[3]. 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:

11. 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

12. Whilst an ICB can own buildings, currently NHS Hampshire and Isle of Wight ICB does not hold capital and does not own buildings, therefore historically the procurement of new premises is either by:

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

- 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 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

13. 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.

14. 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.

14. Policies and Proposals for Alderholt (Extract from East Dorset Local Plan)

14.21. There are no general pre-requisites for development in the Alderholt area. Housing development will be limited to infill and redevelopment within the defined village policy envelope. The level of growth which is expected to result will not require additional general infrastructure for the settlement.

Windfall Sites (Alderholt)

14.22. Whilst there are no specific proposals for further housing development in the village in the 'Bournemouth, Dorset and Poole Structure Plan', it is envisaged that development will also continue on 'windfall' sites within the built-up area during the Plan period, including infilling and redevelopment with conventional and other more

specialised forms of housing development. By their nature, the numbers of these sites arising are hard to forecast, depending as they do on the varied decisions of private landowners.

The village has already undergone substantial expansion in recent years and further extensions to the village would be unlikely to add significantly to the local facilities while it would increase the pressures on local infrastructure, including the road network. The area of the village within which further development or redevelopment of land for housing may be permitted under Policy HODEV1 (para 6.159) is shown on the Proposals Map. Development on windfall sites will be permitted subject to the policies set out in Chapter 6.

National Planning Policy Framework (NPPF):

15. 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]

16. 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]

17. 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.

18. 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

[5] Please also see paragraph 3 above.

(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.

The Impact Created by the Proposed Development:

19. The proposed development is for 1700 dwellings and this will create an estimated population of 4,080 new residents within the development based on an average household size of 2.4.

20. The rapid development of the village during the 1980s has led to a corresponding increase in population. By 1991 the population had risen to 2,880 from the previous census in 1981 which showed only 1,710 persons resident. Alderholt has a slightly smaller proportion of people who are over retirement age than the average for East Dorset District. The village has a population of 3,113 according to the 2001 Census, increasing along with the electoral ward of the same name to 3,171 at the 2011 Census.

21. It can be seen from the data above that this development will change the character and population of the village dramatically. The village will more than double in size and the infrastructure requirements will need a radical rethink.

22. The proposed site is a "windfall" site and as such has not been taken into consideration when planning the infrastructure requirements of the village. One of the unplanned infrastructure requirements is the primary healthcare facilities or GP practice. The existing facility, operated by The Fordingbridge Surgery is a small chalet bungalow used. This building, owned by the surgery, is in a poor condition with investment required. Currently there is no accessible WC and no space for wheelchair access or baby changing. There is a requirement for repair and redecoration. The building is currently only used for notes storage and in order to see patients it would require renovation in terms of walls, doors and flooring. There is a lack of sound proofing and no treatment room on site or adequate facilities for dispensing medicines.

23. The surgery is a branch of the Fordingbridge Surgery which is 2 1/2 miles to the north east of the village. The Fordingbridge surgery is in good condition. Some of the building is listed and the practice have extended up to their current footprint so there is no further space or opportunity to extend or reconfigure this current site.

24. Nearly 80% of Alderholt's existing resident population are registered with the Fordingbridge practice and it is envisaged that most if not all of the new residents of the proposed Alderholt Meadow's site will register with the practice.

25. The only acceptable mitigation to the increased population that would result from this proposed application would be a new purpose-built General Practice surgery that could be utilised to offer NHS primary healthcare access to all of Alderholt's citizens. As nearly all of the citizens are already registered with Fordingbridge Medical Practice and are known to the medical team there, it makes perfect sense for this new surgery to be a branch of the Fordingbridge practice.

26. An estimate of the size of this new surgery has been calculated using the Department of Health Building Notes HBN11-01[6]. The estimate is for a 600 sq metre building, fully fitted out to the required standards.

27. An initial surgery building size of 300sq meters will be required to meet the first tranche of the new population with the ability to grow the surgery to the eventual 600 sq metres during the phasing of the proposed development.

28. Initial discussions between the Land Agent/Developer and the ICB have been on the assumption that the health infrastructure deficit mitigation would be in the form of a new branch surgery built and fitted out to the required standards by the developer as part of the community facilities. The surgery would, at practical completion, then be transferred to the NHS to be used in perpetuity for the purpose of Health Care delivery. Should this not transpire, the ICB would seek equivalent funding from either a S106 contribution, CIL or a mixture of both.

29. Without the contribution to increase the physical capacity, the proposed development will put too much strain on the said health infrastructure, putting people at risk. Waiting times would increase and access to adequate health service would decline, resulting in poorer health outcomes and prolonged health problems. Such an outcome is not sustainable as it will have a detrimental socio-economic impact.

30. In addition, having no or limited access to primary care services will have a knock-on effect on secondary healthcare, in particular on A&E services, as those people who cannot access primary care usually present themselves at the A&E adding additional pressure on the already stretched secondary care.

31. The development directly affects the ability to provide the health services 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.

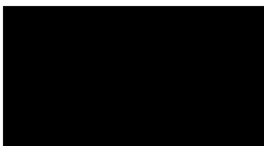
[6] https://www.england.nhs.uk/publication/facilities-for-primary-and-community-care-services-hbn-11-01/

Could you please acknowledge NHS Hampshire and the Isle of Wight ICB'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.

We would be grateful if you would contact Leenamari Aantaa-Collier at The Wilkes Partnership (Laantaa-collier@wilkes.co.uk; 07866 039931) who can assist your legal department in relation to the drafting of an adequate obligation which assures that the contribution delivers the mitigation requested.

Thanking you for your consideration on this matter.

Yours faithfully



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