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Date: 1<sup>st</sup> September 2023

Dear Sir/Madam,

**With Reference To:**

**Planning Application Ref:** F/23/93194

**Applicant Name:** Land & Development Advisory Ltd and RB Sports & Leisure Holdings Ltd

**Description:** Full planning application for the erection of 186 dwellings, a 71-bedroom care home (Use Class C2), a 142-bedroom hotel (Use Class C1), a well-being centre (Use Class E / F2), improvements to existing stadium, new vehicular access, car parking, pedestrian circulation, together with associated tree planting, landscaping, SuDS and biodiversity enhancements (Amended description)

**Address:** The Ageas Bowl, Marshall Drive, West End, Southampton, SO30 3XH

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 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 **186** dwellings and this will create an estimated population of **437** new residents within the development based on an average household size of **2.35**.
3. The GP surgeries with a contractual catchment that includes the proposed development are:

| GP Surgery                                 | Address                                                              |
|--------------------------------------------|----------------------------------------------------------------------|
| Hedge End Medical Centre                   | 24-28 Lower Northam Road, Hedge End Southampton, Hampshire, SO30 4FQ |
| St Lukes Surgery (Living Well Partnership) | St Lukes Close, Hedge End Southampton, Hampshire, SO30 2US           |
| West End Surgery (Living Well Partnership) | Moorgreen Road, West End Southampton, Hampshire, SO30 3PY            |

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 £588 based on a per dwelling calculation. The total contribution request for 186 dwellings is **£109,445**. 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 as described above, which can be drawn down once a project is viable, deliverable and affordable to the practices.

6. The contribution will be pooled to increase patient infrastructure capacity at the Hedge End Medical Centre or The Living Well Partnership's West End Surgery. This may be done through reconfiguration of either surgery, or the contribution may be pooled towards a future Hedge End Health Hub which may also include wider community services.
7. 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.
8. 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.
9. 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.
10. 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):**

11. 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):**

12. 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 needs<sup>1</sup>. 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.<sup>2</sup>

### **Commissioning Health Care Services/Facilities Through NHS Funding:**

13. 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.
14. 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.
15. 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).
16. The projected ICB allocations by NHS England makes an allowance for growth in the number of people registered with GP practices. This population

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<sup>1</sup> s. 116A of the 2007 Act and the Health and Social Care Act 2012

<sup>2</sup> S116B of the Health and Care Act 2022

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:**

17. **NHS England does not routinely allocate any additional funding to the ICB in the form of capital or revenue towards infrastructure projects to cater 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.
18. 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.
19. 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<sup>3</sup>. 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:**

20. 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

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

21. 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 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**

22. 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.

23. 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:**

#### **Extracts from:**

##### **Eastleigh Borough Local Plan (2016-2036)**

##### **Adopted April 2022**

*5.175 This plan proposes a variety of new developments and in addition, it is recognised that further development will continue to take place within existing built up areas. The Council will seek to secure funding from development for the provision of new or improved infrastructure, services, facilities and amenities made*

*necessary by the proposed development. The policy set out below will therefore apply to all proposals for development within the Borough.*

*5.176 Prospective developers are advised to seek the Council's advice on the nature and scale of the contributions that are likely to be sought before purchasing land or property for development. The Council intends to revise its Planning Obligations Supplementary Planning Document as soon as possible. This will provide guidance on the contributions that the Council will seek to negotiate to support new development*

## **Planning Obligations SPD (Adopted July 2008)**

### **3.9 Health Facilities**

*New development can place additional pressures on the existing health and wellbeing infrastructure and an aim of the Eastleigh Borough Community Plan is to improve access to health care and services. New developments should make a fair and reasonable contribution towards mitigating their impacts where there is not capacity to meet the additional needs generated. Government advice supports this requirement, which would be assessed on a site by site basis for major residential developments. The Council will require the relevant Primary Care Trust and developer to demonstrate how new proposals relate to existing health facilities. Where necessary, developers may be required to make provision for improved healthcare either through the enabling of new facilities or the extension of existing facilities. Land and/or financial contributions may be required.*

*Additional planning obligations for community facilities may be used for the provision of health facilities, should this be a priority for the community.*

## **5. Appendices**

### **5.1 Summary Table/Standard Charges and Worked Examples**

*The following summary table provides details of planning obligations currently sought at a starting point in any negotiations. The levels of contribution sought are based upon the Council's experience of current costs associated with the provision of infrastructure and will be reviewed annually.*

### **Health Provision**

#### **Applicability:**

*Major residential applications of 10 or more units  
assessed on a site by site basis.*

#### **Requirement:**

*Provision of land and/or contribution towards the provision of health facilities to meet the demands arising from new development.*

## **National Planning Policy Framework (NPPF):**

24. 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.<sup>4</sup>

25. 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.<sup>5</sup>

26. 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.

27. 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.

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<sup>5</sup> Please also see paragraph 3 above.



Martyn Rogers  
Deputy Director of Primary Care  
(Southwest Hampshire)  
**NHS Hampshire and the Isle of Wight  
Integrated Care Board (ICB)**



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 F/22/91394

1. Residential development of 186 **dwelling**s.

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

|                                            |                                                                         |
|--------------------------------------------|-------------------------------------------------------------------------|
| Hedge End Medical Centre                   | 24-28 Lower Northam Road, Hedge End<br>Southampton, Hampshire, SO30 4FQ |
| St Lukes Surgery (Living Well Partnership) | St Lukes Surgery (Living Well Partnership)                              |
| West End Surgery (Living Well Partnership) | West End Surgery (Living Well Partnership)                              |

which has a **total capacity** for 15,443 patients.

3. The **current patient list** size is 25,771 which is already **over capacity** by **10,328** patients (at 167% of capacity).

4. The **increased population** from this development = 437

- a. No of dwellings x Average occupancy rate = population increase
- b.  $186 \times 2.35 = 437$

5. The **new GP List size** will be 26,208 which is **over capacity** by 10,765

- a. Current GP patient list + Population increase = Expected patient list size
- b.  $25,771 + 437 = 26,208$  (10,765 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 = 30.60 m<sup>2</sup>

- a. The expected m<sup>2</sup> per patient, for this size practice = 0.07 m<sup>2</sup>
- b. Population increase x space requirement per patient = total space (m<sup>2</sup>) required
- c.  $437 \times 0.07 = 30.60\text{m}^2$

7. **Total contribution required** = £109,445

- a. Total space (m<sup>2</sup>) required x premises cost = final contribution calculation  
 $30.60\text{ m}^2 \times £3,577 = £109,445$  (£588 per dwelling).