Isle of Wight Council

Health contributions

Draft Supplementary Planning Document (SPD)

in partnership with

NHS
Hampshire and Isle of Wight

Document information

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Version 1	**19.10.23**	**First draft (JB)**
Version 2	**21.11.23**	**Second draft (JB)**
Version 3	**18.4.24**	**Final draft (JB)**

Contents

1.0 Introduction

1.1 To better integrate planning and health across the island and to help plan efficiently for health infrastructure, the Isle of Wight Council is working in partnership with the NHS Hampshire & Isle of Wight Integrated Care Board (ICB) to facilitate the collection of financial contributions towards primary care infrastructure from qualifying development, where necessary.

1.2 In May 2023, NHS England published their **'Delivery plan for recovering access to primary care'**[1] which included the following measure to assist building capacity so that GP practices can offer more appointments from more staff than ever before:

> 'Change local authority planning guidance this year to raise the priority of primary care facilities when considering how funds from new housing developments are allocated.'

1.3 A number of other areas in England, including Devon, Somerset and Hampshire, already collect contributions towards primary care infrastructure using the methodology set out within this SPD and the NHS Hampshire & Isle of Wight ICB, working in partnership with Isle of Wight Council, now wishes to implement the same approach on the island.

1.4 Any approach to calculate and request financial contributions is required to be in accordance with Regulation 122 of the Community Infrastructure Regulations and paragraph 57 of the National Planning Policy Framework (NPPF). This ensures that any contributions are only sought where they meet the following tests:

- Necessary to make the development acceptable in planning terms;
- Directly related to the development; and
- Fairly and reasonably related in scale and kind to the development.

1.5 This Supplementary Planning Document (SPD) sets out a robust, evidence-based methodology for deciding what the required health infrastructure improvements may be in a particular area of the island and then identifies how the level of developer contributions that would be required towards those improvements will be calculated.

[1] NHS England » Delivery plan for recovering access to primary care

1.6 In order to ensure that requests for health contributions on the island meet the tests set out above, the method of calculating contributions mirrors that which is used in the other counties referenced in paragraph 1.3 and has successfully been defended in appeal situations[2]. This will be achieved through using:

- Occupancy rates including the expected population increase;
- Current patient list sizes;
- Size and space standards; and
- Cost guidance.

1.7 The SPD outlines the reasoning for each area of evidence listed above being used to help identify where contributions are required and the method used to calculate them.

1.8 It is important to note that any contributions collected would be for healthcare infrastructure only (e.g. new or extensions to physical premises) and not services (e.g. more GPs).

1.9 The SPD was adopted on xx May 2024 following a decision by Cabinet on 9 May 2024. The SPD will be used as a material consideration in the determination of planning applications.

[2] Reference: APP/Q3305/W/22/3311900 (planninginspectorate.gov.uk)

2.0 Planning policy – national and local

National Planning Policy Framework (September 2023)

2.1 Paragraph 34 of the NPPF covers development contributions and requires Local Plans to set out the contributions expected from development. Health is listed as one of the 'other infrastructure' types where contributions may be needed.

Island Plan Core Strategy 2012

2.2 Policy DM22 of the Island Plan Core Strategy (adopted March 2012) outlines that '**the council will work in partnership with other public sector providers to ensure that development provides high quality infrastructure commensurate to the scale of development and the needs of different communities across the island.'**

2.3 The policy also states that the council will **'collect and use contributions from developers to support improvements in services and infrastructure that are required as a result of development'.**

2.4 Paragraphs 8.25 to 8.27 of the Core Strategy detail the various types of infrastructure that new development may be expected to contribute to and Table 8.3 clearly identifies healthcare infrastructure as one of the types that contributions may be collected for.

3.0 Evidence: Occupancy rates

3.1 The first stage of calculating an appropriate contribution is to calculate the expected increase in population to be generated by development. This can be achieved through using average occupancy rates taken from the ONS Household Projections data[3]. The most recent occupancy rates available for reference across Hampshire and the Isle of Wight are outlined in Table 1.

Table 1: Average occupancy rates (persons per household) across Hampshire and Isle of Wight (ONS Household projections 2023)

Area	Average occupancy rate
Basingstoke and Deane Borough Council	2.35
East Hampshire District Council	2.35
Eastleigh Borough Council	2.35
Fareham Borough Council	2.30
Gosport Borough Council	2.23
Hart District Council	2.48
Havant Borough Council	2.28
Isle of Wight Council	***2.09***
New Forest District Council	2.20
Portsmouth City Council	2.34
Southampton City Council	2.43
Test Valley Borough Council	2.38
Winchester City Council	2.37

[3] Household projections for England - Office for National Statistics

4.0 Evidence: Current patient list sizes

4.1 NHS England and Integrated Care Boards (ICBs) hold data on the locations of catchment areas and the capacity of and current patient list sizes of GP surgeries across the Isle of Wight. At the point of consultation with healthcare providers during the planning application process, the Hampshire & Isle of Wight ICB will be able to provide the surgery capacity and patient list sizes for the catchment(s) within which proposed development is located.

4.2 Contributions will be sought only where the population generated by the proposed development is unable to be accommodated within the existing surgery capacities.

4.3 It is important to be clear that contributions will not be sought to address existing over-capacity issues that may be identified.

4.4 Any proposed changes to the number of GP practices across the island are carefully considered by the ICB and notwithstanding the dynamic nature of primary care (with specific reference to practice mergers and closures), any contributions will be proportionally related to the identified development relative to the practice(s) catchment area(s).

5.0 Evidence: Size and space standards

5.1 NHS England use widely accepted 'size and space standards' which set out the appropriate size of GP premises (m2 Gross Internal Area) in relation to the number of patients to be accommodated at the premises. These standards are given in Table 2. The table also shows the corresponding Gross Internal Area per patient (in m2).

5.2 Although existing GP surgeries may not comply with the space standards set out, as the most recent guidance[4] was published in 2013 when many existing surgeries had already been developed, the evidence-based standards are used within this methodology to determine the Gross Internal Area (dependent on the number of existing patients and the number of patients to be generated) to which developments will be required to contribute.

Table 2: NHS size and space standards

Number of patients	Gross Internal Area (GIA)	GIA per patient
0 - 2,000	199m2	0.1m2
2,001 - 4,000	333m2	0.08m2
4,001 – 6,000	500m2	0.08m2
6,001 – 8,000	667m2	0.08m2
8,001 – 10,000	833m2	0.08m2
10,001 – 12,000	916m2	0.08m2
12,001 – 14,000	1000m2	0.07m2
14,001 – 16,000	1083m2	0.07m2
16,001 – 18,000	1167m2	0.06m2
18,001 or over	1250m2	0.06m2

[4] The size standards have been produced by the NHS as part of a document entitled 'Premises Principles of Best Practice Part 1 – Procurement and Development'. The space standards are used with Health Building Note 11-01 which is used within this methodology to determine costs.

6.0 Evidence: Cost guidance

6.1 When calculating the cost of providing new healthcare premises, historically the Healthcare Premises Cost Guide (HPCG) that was published by the Department of Health (2010)[5] provided a cost per square metre for building and engineering services for different healthcare premises based on real, built schemes based on overall gross internal area.

6.2 Table 3 below identifies the 2010 HPCG costs per m^2 for 'Facilities for primary and community care services' (as covered by Health Building Note 11-01). Costs are based on new-build, two-storey premises operating independently on a greenfield site. These costs were based on a MIPS Index (Median Index Of Public Sector) score of 480 at the time. The MIPS Index was used for many years in the capital planning of health projects by the Department of Health.

Table 3: Healthcare premises costs

Type	2010 HPCG (based on MIPS index of 480) per m2			
	Public space	Staff space	Clinical space	Overall space
Primary care	**£2,060**	**£1,820**	**£2,160**	**£2,040**
Extended Primary Care	**£1,870**	**£1,650**	**£2,210**	**£1,990**
Community Hospital	**£1,840**	**£1,620**	**£2,440**	**£2,200**

6.3 The MIPS index upon which these figures were reported is no longer published. In lieu of this, it is recommended by the Department for Business Innovation and Skills (now the Department for Business, Energy and Industrial Strategy) that the PUBSEC *(Public Sector Non-Residential)* Index should be used as an alternative. The conversion factor[6] from MIPS to PUBSEC is 2.778.

6.4 The latest 2023 BCIS published PUBSEC Index level is 303 which is a 75.4% increase from the 2010 index level. Updated costs per m2 adjusted from the HPCG 2010 figures and using the PUBSEC index are therefore presented in Table 4 overleaf.

[5] Healthcare_premises_cost_guides.pdf (publishing.service.gov.uk)
[6] Microsoft Word - TPINotesforBIS.doc (publishing.service.gov.uk)

Table 4: Adjusted healthcare premises costs

Type	Adjusted HPCG (based on PUBSEC index of 303) per m2			
	Public space	Staff space	Clinical space	Overall space
Primary care	**£3,612**	**£3,192**	**£3,788**	**£3,577**
Extended Primary Care	**£3,279**	**£2,893**	**£3,875**	**£3,490**
Community Hospital	**£3,227**	**£2,841**	**£4,279**	**£3,858**

6.5 GP surgeries are included within the HPCG under the 'Primary Care' category. Although the HPCG identifies between different types of specific spaces (i.e. public, staff and clinical), it is unlikely that, at the time of requesting contributions prior to the development securing planning permission, any detail will be known as to how the space required would need to be split between these types. Therefore, it is considered most appropriate for calculations to be based upon the 'Overall Space' cost as highlighted in orange in Table 4.

6.6 The overall space costs per m2 will be reviewed and if necessary, updated annually based on the most recently available and published PUBSEC index level.

7.0 How will contributions be calculated?

7.1 As set out in the previous sections, evidence relating to occupancy rates, current patient list sizes, size and space standards and cost guidance will be used to calculate whether contributions are required, and if so how much, using the following methodology. Table 5 overleaf demonstrates how each step of the methodology works using a simple worked example.

7.2 Taking each step in turn, **Step 1** is to determine the expected increase in population to be generated by a development, so the number of dwellings proposed should be multiplied by the average occupancy rate identified in Table 1.

7.3 Once the expected population increase has been identified, **Step 2** is to add this to the relevant current GP patient list to give an overall expected patient size list post development. In the case of a single standalone application for development, if the expected post development patient list size is within the existing capacity of the relevant surgery, then a contribution will not be sought.

7.4 In cases where an application forms part of a wider allocated site, existing capacity will be shared proportionately, and contributions may be sought to reflect this – see 'Table 6 Worked example 2' for further information on such situations. Similarly, if a development is located within the catchments of more than one surgery, the patient list sizes will be considered as a whole, and any contributions, should they be required, will be apportioned by the NHS ICB.

7.5 For **Step 3**, using the expected patient size list, the appropriate space requirement per new patient can be identified from the data within Table 2. The space requirement per new patient can then be multiplied by the expected population increase to give the total space (m^2) required.

7.6 Finally, for **Step 4** the total space (m^2) required can then be multiplied by the premises cost identified from the data in Table 4 to give the final developer contribution calculation.

Table 5: Worked example 1

Example 1: A residential development on the Isle of Wight of 33 dwellings, within the catchment of a GP surgery which has a total capacity for 3,363 patients and a current patient list size of 6,545. The surgery is therefore already over capacity by 3,182 patients (197% of capacity)	
Step 1	***Calculate the increased population from this development:*** No. of dwellings (33) x Average occupancy rate (2.09) = population increase of **69**
Step 2	***Calculate the new GP List size:*** Current GP patient list (6,545) + Population increase (69) = expected patient list size **6,614** If expected patient list size (6,614) is less than the existing capacity (3,363) a contribution is not required otherwise continue to step 3. ***Continue to step 3***
Step 3	***Calculate the additional GP space required to support this development:*** The expected m2 per patient for this size practice = 0.08m2 Population increase (69) x space requirement per patient (0.08m2) = total space (m2) required = **5.52m2**
Step 4	***Calculate the total contribution required:*** Total space required (5.52m2) x premises cost (£3,577 – see Table 4) = financial contribution **£19,745.04 (equivalent to £598.34 per dwelling)**

7.7 In more complex cases where an allocation is likely to come forward in multiple applications across a period of time, or where multiple allocations are located within a single catchment, spare capacity (frozen at the point of receipt of the first application for the relevant allocation(s)) will be shared proportionately between applications to reflect the number of additional dwellings within each application or across each allocation.

7.8 For example, if an allocation were to come forward over three separate applications for equal numbers of dwellings, each application would receive one third of the existing spare capacity upon receipt of the first application. The developer(s) would be expected to pay contributions for any additional patients generated above this irrespective of the order or timings of the applications. Capacity will be considered and accounted for upon receipt of a planning application (or, in the case of multiple consents making up an allocation, receipt of the first application). Table 6 overleaf provides a worked example of such a situation.

Table 6: Worked example 2

Example: A residential development of 500 dwellings as part of an overall allocation or site of 1,500 dwellings. The existing GP surgery has capacity for 5,000 patients and the current patient list size is 4,400. The surgery has spare capacity for 600 patients.	
The allocation is expected to be covered by two planning applications: one for 1,000 dwellings (A) and one for 500 dwellings ((B)	
Step 1	***Calculate the increased population from this development:*** No. of dwellings x Average occupancy = population increase **A: 1,000 x 2.09 = 2,090** **B: 500 x 2.09 = 1,045** **Total: 3,135**
Step 2	***Calculate the new GP List size:*** Current GP patient list (4,400) + Population increase (3,135) = **expected patient list size 7,535 (2,535 over capacity)**
Step 3	Share the existing spare capacity (frozen at the point of receipt of the first application for the allocation/site) proportionately between the applications: **Spare capacity: 600 patients** **A: 1,000 dwellings = two thirds of allocation/site: two thirds of spare capacity = 400 patients** **B: 500 dwellings = one third of allocation/site: one third of spare capacity = 200 patients**
Step 4	Deduct the proportion of spare capacity from the population increase for each application: **A: 2,400 – 400 = 2,000** **B: 1,200 – 200 = 1,000**
Step 5	***Calculate the additional GP space required to support each application:*** The expected m2 per patient for this size practice = 0.08m2 **A: Population increase (2,000) x space requirement per patient (0.08m2) = total space (m2) required = 160m2** **B: Population increase (1,000) x space requirement per patient (0.08m2) = total space (m2) required = 80m2**

Step 6	***Calculate the total contribution required:*** **A:** Total space required (160m2) x premises cost (£3,577 – see Table 4) = financial contribution **£572,320 (£572.32 per dwelling)** **B:** Total space required (80m2) x premises cost (£3,577 – see Table 4) = financial contribution **£286,160 (£572.32 per dwelling)**

8.0 Requesting contributions

When?

8.1 **Contributions will be sought on all qualifying applications from the date of adoption onwards** in accordance with the evidence and calculations contained within this document.

What development qualifies?

8.2 The threshold for considering a request for a contribution towards health provision on the island has initially been set at **all proposals for a net increase of 20 dwellings or more**. This will be kept under review post adoption of the SPD and in advance of the Draft Island Planning Strategy moving to submission and examination stages.

What if a site can accommodate a new healthcare facility?

8.3 The SPD and requirement for contributions looks solely at the expansion of existing GP surgeries in areas where capacity is needed and does not account for situations where the provision of an entire new surgery is required, or where provision will be included within the development of a building for wider community use.

8.4 In such instances where on site provision or expansion is to be provided, negotiations will need to be take place between the Hampshire & Isle of Wight ICB, the Local Planning Authority and the developer.

Questions

8.5 Any questions or queries over the content of this SPD should be directed to:

planning.policy@iow.gov.uk