NHS
Morecambe Bay
Clinical Commissioning Group

Section 106 Monies & Community Infrastructure Levy Funding Policy for Health Facilities.

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Patient focused,
providing quality,
improving outcomes

Document Version Control

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Section 106 Monies & Community Infrastructure Levy for Health Facilities

1 Introduction

1.1 This paper gives an overview of Section 106 (S106) planning obligations and the Community Infrastructure Levy, highlights the importance of the CCG engaging with District/Borough Councils (as the Local Planning Authorities (LPA) to ensure health infrastructure needs are taken into account by fulfilling its responsibilities as a named body to be consulted in local plans and recommends criteria for the allocation of health infrastructure monies that come through both S106 and Community Infrastructure Levy (CIL) funding routes.

1.2 It is important to note that the S106/CIL responsibility and decision making sits with the LPA. The CCG will work with the LPA to secure and receive monies and ensure their expenditure in accordance with S106 agreements as set out in this policy; the CCG is a statutory consultee whose views, reflecting this policy, will be a material consideration in the decision making process.

2 Background

2.1 The link between planning and health is long established. The planning system has an important role in creating healthy communities; it provides a means both to address the wider determinants of health and to improve health services and infrastructure to meet changing healthcare needs. Consultation between Local Planning Authorities (LPAs), public health and health organisations is a crucial part of this process.

2.2 LPAs vary across England, in two-tier local authorities areas (such as Lancashire County Council area); the relevant LPA is the district or borough council, except for applications involving minerals and waste development which are made to the county council. Clinical Commissioning Groups (CCGs) and NHS England (NHS E) are named bodies to be consulted in Local Plans.

2.3 The power of a LPA to enter into a Planning Obligation with anyone having an interest in land in their area is contained in S106 of the Town and Country Planning Act 1990 (as amended by Section 12 of the Planning and Compensation Act 1991). A S106 also allows for a landowner to give the council a Unilateral Undertaking. The council isn't a party to the agreement but it does the same thing, and is enforceable by the council. The main service areas where monies are received through the use of S106 obligations:

- Local Economy,
- Community or Town Centre use,
- Highways/Traffic,
- Education,
- Health,
- Land,

- Affordable housing and
- Other (which records payments for any other contributions which do not fall into one of the above categories).

2.4 It is important to note that S106 monies may only be spent on facilities/infrastructure where the impact of a new development has, at least in part, contributed to the need for the facilities. S106 funding is available for capital projects only. Revenue funding towards on-going running costs is not available. It will be necessary, when requesting funding through S106, that existing permissions on other sites providing pooled contributions to the same piece of infrastructure are declared, to ensure transparency.

2.5 Following concerns that S106 obligations were not transparent, were ineffective in providing for major infrastructure, had a disproportionate effect on major developments, and that most development did not pay, The 2008 Planning Act - introduced the Community Infrastructure Levy (CIL), the purpose of which is to raise funds from developers who are undertaking new building projects, to help pay for infrastructure that is needed to support new development. CIL is an optional tariff based system of collecting money to pay for all or part of the cost of providing infrastructure to support development. Where adopted it will replace S106 planning obligations for many forms of infrastructure, although S106 agreements can still be used for site-specific mitigation measures and for affordable housing provision. LPAs will determine what infrastructure is required and can use the money to provide, improve or operate facilities. It can be used to fund a wide variety of infrastructure including:

- transport schemes
- flood defences
- schools, hospitals and other health and social care facilities
- parks, green spaces and leisure centres.

2.6 CIL is now becoming a method for collecting pooled developer contributions to fund infrastructure and it is a matter of choice for each LPA to move to CIL.

- The Councils within Morecambe Bay CCG Boundary have no adopted Community Infrastructure Levy and at the present time are not working on such a Policy

- The Borough Councils within Morecambe Bay have no CIL in place at present. Nothing further has happened with CIL since the consultation on the Preliminary Draft Charging Schedule in summer 2016 (the same time as the Publication Local Plan). The LDS states that it is intended to commence work on CIL after the adoption of the Local Plan and subject to the outcome of the Government's Review. There is no timetable at present.

3 Developing a Community Infrastructure Levy (CIL)

3.1 LPAs are allowed to raise funds from developers through a CIL to help to deliver infrastructure needed to support development requirements within their wider administrative areas;

- A CIL Charging Schedule must be prepared, and this sets out the types of development that will be liable to pay CIL and the methods by which it will be calculated. This could

apply to new NHS premises. This entire process is subject to public consultation and examination by an independent examiner;

- CIL is a standard charge on all liable new buildings and extensions that occur within a council's administrative area;
- LPAs must prepare a "regulation 123 list" which sets out the type of infrastructure that may be funded by CIL in an area (for example, health facilities and transport infrastructure). The Infrastructure Plan (or similar) sets out what infrastructure is required to serve the planned growth in an area, and this is where public health, CCGs and NHS E, in conjunction with Foundation Trusts and Trusts, need to engage with LPAs;
- There will be a high level of competing needs for infrastructure funding from a wide variety of projects. As CIL is intended to supplement other sources of funding for local infrastructure, not all projects will receive funding through this levy. The apportionment of CIL to projects will be determined by the LPA as the charging authority in relation to local infrastructure priorities.
- It is important that the CCG engages with its District/Borough Councils to ensure health infrastructure needs are taken into account in the development of CIL charging schedules by fulfilling its responsibilities as a named body to be consulted in local plans.

3.2 When the levy was introduced (and nationally from April 2015), the regulations restrict the use of pooled contributions towards items that may be funded via the levy (Regulation 123). At that point, no more may be collected in respect of a specific infrastructure project or a type of infrastructure through a S106 agreement, if 5 or more obligations for that project or type of infrastructure have already been entered into since 6 April 2010, and it is a type of infrastructure that is capable of being funded by the levy.

Where a S106 agreement makes provision for a number of staged payments as part of a planning obligation, these payments will collectively count as a single obligation in relation to the pooling restriction. The Government has recently announced its intentions (Response to Supporting Housing Delivery through Developer Contributions Oct 18) to lift the pooling restriction in all areas so as to incentivise the use of CIL by removing barriers to development.

4 Securing Section 106 and CIL Monies

4.1 In general terms, most S106 agreements allow the following improvements to health facilities:

- The reconfiguration or expansion of health premises to provide additional facilities and services to meet increased patient or user numbers;
- New health premises or services at the local level to provide additional facilities and services to meet increased patient or user numbers;
- Any new facility required to compensate for the loss of a health facility caused by the development.

4.2 Historically the processes for allocating S106 health funding was via the Primary Care Trust (PCT) who were responsible for maintaining an Estates Strategy and would manage any health allocation as a contribution to delivering against that strategy. The process for securing healthcare contributions was based on a simple formula applied to the number of

dwellings proposed in each planning application.

4.3 In April 2013, PCTs were disbanded and Clinical Commissioning Groups (CCG) were established, the responsibility for estate management for health provision was split. NHS England North as a regional body was made accountable for primary care whilst the CCGs retained responsibility for acute and community care. NHS Property Services (NHSPS) took over all PCTs and Strategic Health authorities estates interests. Where PCT properties were classed as "critical clinical infrastructure" and a Foundation Trust or another NHS provider was the majority occupier ownership was offered to those NHS bodies initially rather than NHSPS.

4.4 NHS Morecambe Bay Clinical Commissioning Group has delegated authority for the co-commissioning of primary medical services and it also inherited the responsibility to produce an Estates Strategy for its area. The Governing Body has approved both a Primary Care Development Strategy and a local Estates Strategy Framework. These areas were further developed through the CCG's 2030 Vision that was approved also by the Governing Body.

4.5 The CCG needs to be able to exercise its responsibility to make recommendations on the allocation of health related s106 and CIL monies in a way that is:

- strategic
- financially robust
- meeting need in a particular area
- Supported by the relevant Council, the CCG Members and relevant healthcare organisations in CCG area
- allows the CCG and district/borough councils to align their relevant investment strategies in order to enable the development of a holistic approach to investment in the broad healthcare estate

4.6 Best practice guidance for Primary and Community care services is contained within Health Building Note 11 – 01 Published in March 2013 from the Department of Health and Social Care. It describes the way to quantify spaces and has been written for new build, refurbishment and extension of existing buildings. (See in particular Section 4 pages 15 – 18). A worked example is shown at Appendix 3 and Appendix 5.

4.7 No S106 contributions will be sought for residential developments that are 10 units or less. There will be no distinction between the types of residential provision attracting a contribution. Residential park homes, affordable housing schemes, projects for specialist accommodation for the elderly/extra care/ assisted living will be subject to obligations. Such forms of housing generate a high percentage of dependent patients reliant upon NHS Services and places high demands on local clinical services where infrastructure needs to respond to such pressures.

4.8 The threshold of 10 units has been established through the following measures:

- Developments of less than 10 will have a marginal impact on local health infrastructure.
- It is unlikely that schemes of such scale would generate a mix of housing types such as affordable or specialist accommodation that generate high dependency patient numbers.

- Schemes of 10 or less can be financially unviable for developers and unlikely to be brought forward if S106 contributions apply.
- LPA's have set a threshold of 10 or more units as Major applications that can attract S106 contributions for such things as Public Open Space, Education Contributions and Affordable Housing. This threshold is in line with that requirement for similar contributions.
- NPPG also sets a threshold of 10 units for S106 contributions.
- There may be occasion where Morecambe Bay has work force pressures that would become necessary to address should multiple/cumulative applications of 10 units or more are brought forward.

4.9 Should a planning application not specify the unit sizes in the proposed development (for example in an outline planning application), the average occupancy of 2.4 persons (Office for National Statistics average household size 2017) will be used in the initial health calculation until such time as the size of the units are confirmed at which point the final costs/health calculation would be confirmed. For example if the proposal was for a 400 dwelling development the initial calculation would be – 2.4 persons x 400 units x £the agreed rate as per appendix 4 in relation to the project type (extension, alteration or new build) = £xxx contribution. If funds are to be secured through S106, an approach similar to that used for LCC Education Contributions would be appropriate. The S106 essentially confirms mutual agreement of the methodology that will be used to calculate the contribution once the details of the scheme are known e.g. new build, extension or internal alterations. It doesn't actually specify amounts at outline stage but clearly a guide contribution could be established. The calculation will be made upon the lodging of a reserved matters application.

4.10 To establish the number of clinical rooms to determine the core GMS (General Medical Services) space required for a practice patient population the Department of Health uses a space calculation in Health Building Note HBN11-01: Facilities for Primary and Community Care Services 2013. Details are set out in Appendix 3 and 5 as to how this works.

4.11 HBN11-01: Facilities for Primary and Community Care Services sets a standard size of 16 m^2 for a consulting/examination room. (See section 3). HBN 00-03 Clinical and Clinical Support Spaces provides a standard size for a treatment room of 18$m^{2.}$ Other support service spaces are also indicated e.g. utility rooms.

4.12 All consultations on planning applications received by the CCG will be routed through a single email inbox fwccg.enquiries@nhs.net that is now in operation. In addition; the CCG Estates Team will check the weekly list of planning applications for each of the local district/borough councils.

4.13 The CCG Estates Team has established a clear process for reviewing and responding to planning applications. This includes logging all information centrally that tracks the application from response to planning authority decision and where S106 contributions are received by the CCG, the CCG will need to be a party to the S106 obligation through to a business case being submitted and release of the funds.

4.14 In order to respond to planning applications the CCG will assess the impact on local practices whose catchment area is within a specific radius of the development. All GP practices have well established Practice Boundaries. Contributions received by the CCG will only be expended on facilities within that radius/boundary.
The CCG will also use local knowledge and intelligence regarding the 2030 Vision, premises conditions, and numbers of clinical rooms and ability to accommodate growth to inform the response. One or more general practices may be named as an expected recipient of the funding for alterations or extensions to existing premises and in some cases the CCG may also highlight the requirement for a strategic infrastructure solution. In response to a planning application consultation the CCG will clearly identify where extra capacity is required and determine exactly where the finances are to be directed towards a single "identified project". Such details will be set out within the planning obligation thereby clearly linking the obligation to the specified scheme. Such an "identified scheme" may involve more than one local practice in a settlement where capacity has to be met at more than one location. This will still be one project but implemented across two sites.

4.15 In responding to planning applications the CCG will also be mindful of the pooling restrictions referred to in section 3 above as no more than 5 obligations can be entered into for a specific practice premises project. (See section 3.2) However a large project can be broken down into smaller definable elements thus attracting 5 obligations for each element. The Government has recently announced its intentions (Response to Supporting Housing Delivery through Developer Contributions Oct 18) to lift the pooling restriction in all areas so as to incentivise the use CIL by removing barriers to development.

4.16 Requests for CIL funding will be made in line with the process of the LPA. CIL funding requests are not made linked to consultations on individual planning applications.

5 Allocating and drawing down Section 106 and CIL Monies

5.1 The Councils and Local Authorities within Morecambe Bay are at present not holding funds from any S106 agreements on behalf of another party but the CCG is committed to primary healthcare estate alterations to provide additional capacity for extra patients. The legal S106 agreement itself for a particular development will state where the funds should be spent and on the specific (or general) practice premises project to reflect the initial S106 request. The CCG needs to introduce a Policy that can be agreed with the LPA to secure S106 resources.

5.2 Most S106 agreements also include a time limit for spending or committing to spend the contribution, usually 5 years from when it has been received. If a contribution is not used for the intended purpose or not spent within the time specified in the agreement, the funds would then need to be returned to the developer with accrued interest.

5.3 Since taking on delegated co-commissioning the CCG has undertaken a large data collection and validation exercise in order to understand the historic S106 contributions secured and those where funds are with the local planning authorities.

5.4 It is important to note that S106 contributions are secured as part of the planning approval process. Depending on the timeline for further approvals (where required), the commencement of the development and the triggers for release of funding in the S106 agreement, the secured funding may not be available to the CCG until many months or even years following approval. It is important to note that some plans that are approved may not progress and therefore the contribution will not become available. For this reason secured S106 contributions cannot therefore be assumed as funding that will be received at a point in the future.

5.5 Each S106 agreement will detail the triggers when the contribution must be paid by the developer; this is often based on phases of a development or a level of occupancy. The CCG will monitor all applications and developments as they progress but will only progress development of a proposal, in line with the S106 agreement, when the funding is confirmed as being received by the CCG. The CCG will be responsible for monitoring trigger points and enforcing agreement where payment is not made or delayed.

5.6 In terms of allocating the S106 contributions for primary healthcare facilities, the CCG will review the specific S106 obligation requirements and determine the allocation (within the scope set out in the S106) to relevant practices, being specifically mindful of the pooling restrictions.

- As an example, the S106 agreement could detail up to four general practices where the healthcare contribution could be spent on improving or extending infrastructure but the CCG may determine, based on local knowledge and intelligence that the healthcare contribution be allocated to two of the four practices only. This may be due to specific works already having been completed at two of the practices or the other practices receiving funding from a different S106 agreement. The s106 should name a specific project.

- The S106 will identify the specific project contained in the S106 obligation and detail the exact works required to provide the infrastructure deficiency that the development creates.

- The CCG will detail the specific works required and the project details for inclusion in the S106 obligation.

5.7 In order to release the healthcare contribution (to the CCG) for each S106 agreement the CCG will need to submit to the Developer a proposal detailing the works to be undertaken with costs and timescales for implementation and incorporation into the planning obligation.

5.8 To enable submission to the CCG the CCG will request completion of a S106 proposal template by the relevant practice(s). Where one or more practices may receive funding from a specific S106 agreement the CCG will manage an open and transparent process through discussion with the practices to agree the projects to be supported through the available healthcare contribution. This will not usually involve 'bidding' for a share of the funding. There may be circumstances such as on large new strategic development sites where the development of a new practice or other models of care may be more appropriate. When such circumstances exist the CCG will conduct a thorough and transparent procurement process to work with new providers for the delivery of such a scenario.

5.9 S106 and CIL funding is made available on the same basis as Improvement Grants, typically up to 66%, in line with the Premises Cost Directions (2013) or any successive Directions. Practices will be expected to fund any elements not supported by the Premises Cost Directions and proposals will be expected to provide a clear break down of all elements of the project to ensure transparency.

5.10 Section 6 of the Premises Cost Directions (2013) state "The Directions do not prevent the Board from providing such financial assistance as it thinks fit in order to pay, or contribute towards, the premises costs of a contractor in circumstances that are not contemplated by the payment arrangements set out in these Directions". An exceptionality assessment can therefore take place under Section 6 and funding may be available for more than 66% of the project.

5.11 The exceptionality assessment <u>may</u> support funding above 66% funding in the following circumstances:

a) Emergency provision of infrastructure for GMS Services (e.g. temporary building)
b) Where there is a stipulation in the S106 legal agreement that the funding should be utilised for a specific practice meaning no other practice can utilise the funding and there is a risk of losing the funding. This may be subject to negotiations in line with local commissioning strategy (specifically Local Care Plan and General Practice Premises Development Policy).
c) Where not investing in infrastructure development will impact on the resilience of the practice's ability to continue to provide GMS services to the existing and growing population.
d) Where a case is made relating to a specific set of circumstances for a general practice

that are not covered by the above; this will be through consultation with NHSE where required.

5.12 In addition Practices will be expected to give a binding commitment, through the project agreement (contract variation), in line with the obligations under the S106 or CIL agreement and in line with the local commissioning strategy (specifically 2030 Vision and General Practice Premises Development Policy).

5.13 Where a practice receives S106 or CIL funding rent abatements will apply in line with Premises Cost Directions (2013).

5.14 The CCG Estates & Primary Care Team will review the proposals and submit to the Finance & Performance Committee (F & P) with an assessment against the criteria set out in Appendix 1. The F & P Committee will make a recommendation to the Governing Body for approval of the submission to the LPA to request release of the funding from the CCG to the provider.

Appendix 1 - Criteria for Assessment for securing S106 healthcare contributions

This table will be completed for each proposal and will be assessed by the Primary Care Committee. This will then be submitted to the Governing Body with a recommendation prior to any submission to the local planning authority.

	Criteria	**Rationale**
1.	When the CCG is formally consulted on planning applications it will consider **strategic fit** with strategic commissioning plans and the estates framework and recommend the funding is allocated in support of specific premises schemes or for specific practice developments.	*To ensure that the investment supports strategic commissioning plans and future commissioning intentions for Morecambe Bay and to enable the development of a holistic approach to investment in the broad healthcare estate*
2.	When the CCG is formally consulted on planning applications it will apply the **occupancy estimates** set out in paragraphs 4.8 and 4.9 above to reach a value of health need/sum requested from S106/CIL agreements	*To ensure there is a consistency and objectivity to calculations used across the Morecambe Bay area*
3.	For the purpose of S106/CIL funding allocations where a particular practice is cited as a potential recipient the **CCG interpretation** will be to allocate the monies for infrastructure to support services delivered in the particular practice or infrastructure for services that are provided outside of the practice but support the practices registered patient population	*To ensure that the investment supports delivery of the primary care development strategy, strategic commissioning plans and future commissioning intentions for Morecambe Bay and to enable the development of a holistic approach to investment in the broad healthcare estate*
4.	Any S106/CIL monies will be used for the **purpose** provided for in the relevant agreement.	*Spend needs to comply with the purpose outlined in the S106/CIL agreement or CCG will not be able to draw down funds*
5.	Any S106/CIL monies will be used in the **location** provided for in the relevant agreement	*Spend needs to be in the location outlined in the S106/CIL agreement or CCG will not be able to draw down funds*
6.	Any S106/CIL monies not spent within the **time limits** prescribed in those agreements, will be returned to the payee.	*Spend needs to be in the time period outlined in the S106/CIL agreement or CCG will not be able to draw down funds*
7.	The CCG will aim to **utilise 100%** of the S106/CIL funding available for primary healthcare facilities in its area.	*To maximise the S106/CIL resources available to the CCG*
8.	**Each proposed scheme will require a proposal** to be submitted (using CCG S106 template) which will highlight how the proposed schemes will improve access to healthcare for the local patients and meet the specific requirements of the S106 agreement.	*To ensure that the access to healthcare will be improved for patients in the affected locations and supports delivery of the 2030 Vision.*
9.	The CCG will not support any business case/proposal where a **contract has already been entered into, work has been commenced** or that contract or work has not been subject to prior agreement with the CCG.	*To ensure that the access to healthcare will be improved for patients in the affected locations and to ensure the proposed investment supports strategic commissioning plans and future commissioning intentions for Morecambe Bay.*

10.	S106 funding is made available on the same basis as Improvement grants, typically up to 66%, in line with Premises Costs Directions 2013, and any successive Directions, in particular sections 8 and 9 (see Appendix 2) as to projects that may or may not be funded. Practices will be expected to fund any elements not supported by the Premises Cost Directions and proposals will be expected to provide a clear break down of all elements of the project to ensure transparency.	*To ensure there is a consistency and objectivity in the application and use of S106 funding available for capital projects. Revenue funding towards on-going running costs is not available.* *All practices will be expected to give a binding commitment, through the project agreement (contract variation), in line with the obligations under the S106 or CIL agreement and in line with the local commissioning strategy (specifically Local Care Plan and General Practice Premises Development Policy)*.
11.	Under Section 6 of the Premises Cost Directions (2013) an exceptionality assessment has determined that more than 66% funding contribution should be made available.	*Section 6 of the Premises Cost Directions (2013) state "The Directions do not prevent the Board from providing such financial assistance as it thinks fit in order to pay, or contribute towards, the premises costs of a contractor in circumstances that are not contemplated by the payment arrangements set out in these Directions".* *Exceptional circumstances must be detailed to the CCG and assessed in line with section 5.11 of the policy.*
12.	The CCG will not support a business case for S106/CIL funding that would lead to the **space allocated for core GMS** exceeding the square meterage calculation that of the space required to deliver core GMS for the patient population under consideration (see paragraph 4.10 above)	*To ensure minimise the additional cost pressures that may arise for the CCG as a result of allocating S106/CIL capital monies*
13.	Where a practice receives S106/CIL monies that contributes to the cost of building/alterations and the capital was not borrowed by or provided by the contractor the notional rent payable in respect of those payments is to be **abated** in line with directions 43 and 45 and schedule 3 of the Premises Costs Directions (2013)	*To secure best value for money for the provision of GMS services through the named practice.*
14.	Each proposed scheme will be **assessed against these criteria by the** Primary Care Committee, with a recommendation made to the Governing Body prior to submission to the LPA in order for the monies to be released.[1]	*To ensure that the access to healthcare will be improved for patients in the affected locations and to ensure the proposed investment supports strategic commissioning plans and future commissioning intentions for Morecambe Bay.*

[1] To support decision making and to ensure maximum fairness the Primary Care Co-commissioning Committee will be provided with details of any other grants, administered by the CCG or NHS England, which the practice bidding for S106/CIL monies has received in the previous 12 months.

Appendix 2 - Extract from NHS Premises Costs Directions 2013

Projects that may be funded through planning obligations. Only certain elements would be eligible.

8. The types of premises improvement projects that may be the subject of a planning obligation would include-
   (a) improvements to practice premises in the form of building an extension to the premises, bringing into use rooms not previously used to support delivery of primary medical services or the enlargement of existing rooms;
   (b) the provision 'of car parking required for patient and staff use, subject to the number of parking spaces being agreed by the Board (access to and egress from each parking space must be undertaken without the need to move other vehicles); where extending in connection with an enlargement of the practice;
   (c) the provision ofsuitable accommodation at the practice premises to meet the needs of children and elderly or infirm people where extending in connection with an enlargement of the practice;
   (d) the internal alterations of premises to create additional clinical rooms;

Projects that must not be funded with premises improvement grants

9. The Board must not agree to fund the following expenditure with a premises improvement grant-

   (a) any cost elements in respect of which a tax allowance is being claimed;
   (b) the cost of acquiring land, existing buildings or constructing new buildings;
   (c) the repair or maintenance of premises, or the purchase, repair or maintenance of furniture, furnishings, floor covering (with the exception of the specialist floor covering referred to in direction 8j and equipment;
   (d) restoration work in respect of structural damage or deterioration;
   (e) any work in connection with the domestic quarters or the residential accommodation of practitioners, caretakers or practice staff, whether or not it is a direct consequence of work on surgery accommodation;
   (f) any extension not attached to the main building by at least a covered passage way;
   (g) improvements designed solely to reduce the environmental impact of premises, such as the installation of solar energy systems, air conditioning, or replacement windows, doors or facades; and
   (h) any work made necessary as a result of fair wear and tear.

APPENDIX 3 – SOMEWHERE MEDICAL CENTRE (Based on the Department of Health calculation in HBN11-01: Facilities for Primary and Community Care Services.)

1 Calculating the number of Consultation/Examination Rooms required for General Medical Services

Practice Population	11000						
Access rate	8037	per	1000	population			
Anticipated annual contacts	11	x	8037	:	88407		
Assume 100% patients use C/E room Patients accessing a C/E room	88407						
Assume open 50 weeks per year: Patients per week	88407	/	50	:	1768.14		
Appointment duration	10	minutes					
Patient appointment time per week	1768.14	x	10/60	:	294.69	hrs. per week	
Assume building operational	52.5	hours per week					
Assume room utilisation	80%						
Rooms available	42	hours per week					
Number of Consulting/Examination rooms required	294.69	/	42	:	**7.02**		

2 Calculating the number of Treatment Rooms required for General Medical Services

Practice Population	11000						
Access rate	5260	per	1000	population			
Anticipated annual contacts	11	x	5620	:	61820		
Assume 20% patients use a treatment room Patients accessing a treatment room	61820	x	20%	:	12364		
Assume open 50 weeks per year: Patients per week	12364	/	50	:	247.28		
Appointment duration	20	minutes					
Patient appointment time per week	247.28	x	20/60	:	82.42667		
Assume building operational	60	hours per week					
Assume room utilisation	60%						
Rooms available	36	hours per week					
Number of Treatment rooms required	82.42667	/	36	:	**2.29**		

APPENDIX 4 – COST ANALYSIS OF VARIOUS PROJECT TYPES The building costs have been established using the Building Cost Information Service (BCIS) of the Royal Institution of Chartered Surveyors (RICS) costs for healthcare premises depending upon the type of project undertaken.

	Gross Internal Floor Area (m^2)		
	<500	**500 – 1500**	**>1500**
	£/m^2	£/m^2	£/m^2
New Build excl land	£2,250.00	£2,064.00	£2,094.00
New Build incl land	£3,150.00	£2,964.00	£2,994.00
Extension (Clinical excl treatment rooms)	£1,782.00	N/A	N/A
Extension (Clinical incl treatment rooms)	£1,902.00	N/A	N/A
Extension (Admin areas only)	£1,662.00	N/A	N/A
Alterations (excludes replacement furniture)	£1,002.00	N/A	N/A
Alterations including replacement furniture	£1,044.00	N/A	N/A

General Qualifications

- Assumed Firm Price Design and Build Contract typically sort through selective competitive tenders
- Estimate at 4th Quarter 2018 prices
- Rates based on 2010 Building Regulations

General Assumptions
All above rates include:
Build Costs
Design Fees
Overheads and Profit
Employers Agent Fees
Project Management Fees
Legal Fees
Insurances
General ground conditions are suitable for a trench foundation
Allowance for general abnormals included
Land prices based on ACTUAL COST per acre plus VAT to be confirmed at project concept stage – Note VAT only payable on land if the vendor is VAT registered.

General Exclusions

Any asbestos removal/remediation
Rights of light matters and associated costs
Off-site infrastructure upgrades will not be required

New Build Clarifications

All new build rates above include for achieving a BREEAM "Excellent" rating under 2011

Extension and Refurbishment Calculations

No allowance for consequential improvements have been made – 10% of GIFA or >1000m2

APPENDIX 5 – COST ANALYSIS OF VARIOUS PROJECT TYPES

EXAMPLE

NHS England (Lancashire and South Cumbria Area)

Response to Wyre Borough Council

Up to 210 Dwellings at Forton and 270 Dwellings at Garstang

<table>
<tr>
<td>Impact of new development on GP practice</td>
<td>
The development is proposing up to 480 dwellings which based on the average household size in the UK (ONS 2017) of 2.4 per dwelling would result in an increased patient population of approx. 980

The calculation below shows the likely impact of the new population in terms of number of additional consultations per year. This is based on the Department of Health calculation in HBN11-01: Facilities for Primary and Community Care Services.

Consulting room requirements

<table>
<tr><td>Proposed population</td><td>980</td></tr>
<tr><td>Access rate</td><td>5260 per 1000 patients</td></tr>
<tr><td>Anticipated annual contacts</td><td>0.980 x 5260= 5154.80</td></tr>
<tr><td>Assume 100% patient use of room</td><td>5154.80</td></tr>
<tr><td>Assume surgery open 50 weeks per year</td><td>5154.80/50 = 103.09</td></tr>
<tr><td>Appointment duration</td><td>15 mins</td></tr>
<tr><td>Patient appointment time per week</td><td>103.09 x15/60 = 25.77 hrs per week</td></tr>
</table>

Treatment room requirements

<table>
<tr><td>Proposed population</td><td>980</td></tr>
<tr><td>Access rate</td><td>5260 x1000 patients</td></tr>
<tr><td>Anticipated annual contacts</td><td>0.980 X 5260 = 5154.80</td></tr>
<tr><td>Assume 20% patient use of room</td><td>5154.80 x20% = 1030.96</td></tr>
<tr><td>Assume surgery open 50 weeks per year</td><td>1030.96/50 = 20.61</td></tr>
<tr><td>Appointment duration</td><td>20 mins</td></tr>
<tr><td>Patient appointment time per week</td><td>20.61 x20/60 = 6.87 hrs per week</td></tr>
</table>
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</table>

GP practice most likely to be affected by growth and therefore directly related to the housing developments	The proposed site would be within the practice boundary of the GP practice in Garstang: Garstang Medical Practice
Necessary to make the development acceptable in planning terms. Plans to address capacity issues.	New residents in Forton & Garstang are likely to register with the GP practice within Garstang. The Garstang practice is at full capacity, with any current limited plans to expand surgery facilities focusing on meeting existing deficiencies. An assessment has been undertaken, of the GP surgery based on issues relating to standards, capacity and workload which would impact on the practices ability to manage increased numbers of patients. This has resulted in a rating of Red for the practice. The practice would be seeking to expand their facility accordingly through internal alterations.
Fairly and reasonably related in scale and kind to the development.	The building costs have been established using the Building Cost Information Service (BCIS) of the Royal Institution of Chartered Surveyors (RICS) costs for healthcare premises depending upon the type of project undertaken. For the Garstang practice to expand to meet their share of the population increase the total cost has been identified below.

Additional patients to be accommodated 980	x	Standard area m^2/person based on total typical list size of approx. 6000 = 0.11	x	Cost of build including fees £/m^2 £1902	=	Total cost 980 x 0.11 x £1902 = £205,035.60

Financial Contribution requested	£205,035.60
Definitions	• Access rate is determined by the number of visits per registered patient. See The Kings Fund – Understanding pressures in general practice 2016 in particular page 15. •

Number of patients	**Size GIA**	**Sqm per patient**
3500	587	0.16
5000	638	0.12
8500	1000	0.11
10000	1130	0.11
13700	1200	0.0875
16000	1428	0.0892
23000	2000	0.0869