HEALTH APPRECIATION

INVESTING IN HEALTH FACILITIES FROM NEW DEVELOPMENT

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INTRODUCTION

London has a rapidly growing population, a trend that is set to continue for the foreseeable future. Not only does this create a growing demand for new homes, it also requires sufficient infrastructure to ensure that public services are not overwhelmed. In particular, given the growing pressures on health services, it is essential to ensure that local health provision is able to expand so that it can cope with these changes. In order to meet the extent of housing development that is expected in London, facilities for up to 550 new GPs may be needed in London over the next ten years.

At the same time, local authorities have the ability to use the planning system to fund new infrastructure. This can either be through planning agreements on specific applications (so-called 'Section 106' agreements) or more recently through a fixed tariff as part of a Community Infrastructure Levy (CIL). However, whilst this is widely used for provision such as affordable housing or transport, health opportunities are often overlooked or given a lower priority.

As demonstrated in this report, there is both a need and an opportunity for this situation to change. This will require an improved approach across the planning system in London to ensure that best practice in some London boroughs is shared by all. Planning policy, especially for developer contributions, needs to fully reflect the need for health and to set targets linked to new development, whilst there also needs to be clear and consistent monitoring of performance. This should all be undertaken in coordination with local health services. If this approach is adopted, it could help realise the potential for developers to fund the new health facilities that London needs.

DEMAND FOR HEALTH FACILITIES

There is increasing demand for local health facilities in London and the rest of country, particularly in primary care and especially for GPs. Across England, GPs now see 340 million patients per year, an increase of 40 million since 2008[1]. London has a population that is both growing and ageing, which is set to further stretch resources in the future. Already, at least 18% of patients in London find it difficult to get a GP appointment when they need one[2]. In addition, care is increasingly being transferred into the community in order to relieve pressure on hospitals, especially A&E departments. As noted in recent planning guidance by the Mayor, 'A great deal of attention is being paid to remodelling emergency and urgent care services to alleviate pressures on hospital A&E departments and reduce emergency admissions. This is likely to require an expansion in primary care.'[3]

According to the Local Government Association, in the 2013/14 financial year London had an average of 7.7 GPs per 10,000 people, slightly above the England average of 7.6. Within this, however, there is considerable variation across London boroughs, with Lambeth at 10.4 and Havering at 5.5[4]. 15 local authorities, including the City of London, are below the England average. The NHS recommends a maximum of 1,800 patients per GP[5], equal to around 5.6 GPs per 10,000 people, and a number of boroughs are already at or around this level.

1. *Royal College of General Practitioners*, January 2014
2. *Access to GP Care*, London Assembly, March 2015
3. *Social Infrastructure SPG*, GLA, May 2015, pp53-4
4. *Ratio of GPs per 10,000 population in England*, Local Government Association, accessed Nov 2015
5. Standard set by the NHS 's London Healthy Urban Development Unit (HUDU), quoted in various planning policy documents, for example *here*

Borough	GPs per 10,000 people
Lambeth	10.4
Tower Hamlets	9.9
Kingston upon Thames	9.8
Southwark	9.8
Lewisham	9.3
Wandsworth	9.1
Hackney	9.0
Richmond upon Thames	8.9
Camden	8.5
Croydon	8.4
Newham	8.3
Bromley	8.1
Islington	8.1
Greenwich	7.8
Merton	7.7
Barnet	7.6
Brent	7.6
Hammersmith and Fulham	7.6
England Average	**7.6**
Kensington and Chelsea	7.5
Waltham Forest	7.3
Sutton	7.2
Barking and Dagenham	6.9
Harrow	6.7
City	6.6
Haringey	6.6
Ealing	6.5
Redbridge	6.4
Enfield	6.1
Hillingdon	6.1
Bexley	5.9
Hounslow	5.7
NHS Guideline (min 1 GP per 1,800 people)	**5.6**
Westminster	5.6
Havering	5.5

In addition to this, the London Plan has set targets to build over 420,000 homes across London over the next ten years[6], and based on typical household sizes[7] this equates to a population increase of over 1 million people. Based on the NHS guideline above, this would suggest that up to 550 new GPs are needed across London over the next ten years in order to meet future demand.

6. Target to deliver 423,887 homes 2015-2025; *The London Plan*, GLA, March 2015, p110
7. Average London household size in 2011 was 2.48 people; *London Housing Strategy Evidence Base*, GLA, April 2014, p7

PLANNING CONTRIBUTIONS

This creates a pressing need to ensure that there is a sufficient contribution from the planning system, especially for new GP facilities, in order to mitigate the impact of this level of development. In some cases this can be achieved through consolidation of existing facilities into larger premises, but in many cases it will require new floor space to be provided. NHS guidance recommends an average of 165m^2 floor space per GP[8].

However, this can also be seen as an opportunity to increase the use of developer contributions to provide some much needed new investment in local health services, especially primary care. Whilst developer contributions are widely used for items such as affordable housing and transport, they are often overlooked as a source of funding for health facilities.

Contributions can be made to local infrastructure from new development in one of two ways. First, there is the 'Section 106' (S106) system, where contributions can be negotiated with developers on a site-by-site basis, either by physically providing a new facility or service on site, or by making a financial contribution. Secondly, there is the newer system of a Community Infrastructure Levy (CIL) – a fixed tariff that is levied automatically on all new developments of a certain type, and the local authority then directly spends this money on whatever local infrastructure it considers appropriate. Most boroughs now have a CIL arrangement in place, and increasingly this is becoming the main way in which local infrastructure is funded. As a fixed tariff system, not dependent on individual negotiations with developers, it has the potential to increase the amount of funding available.

The most recent version of the London Plan sets out a clear intention for boroughs to use development funding to support health and other infrastructure. Paragraph 3.10A states directly that 'New development should be supported by necessary and accessible health and social infrastructure. Planning obligations should be secured, and the Community Infrastructure Levy should be used as appropriate to ensure delivery of new facilities and services'. Policy 3.17 goes on to state that boroughs should 'regularly assess the need for health and social care facilities at the local and sub-regional levels' and 'secure sites and buildings for, or to contribute to, future provision'.[9]

Further to this, in May 2015 the Mayor published a dedicated Supplementary Planning Guidance document on social infrastructure. It states that 'the scale of physical development in London over the next 20-30 years presents a significant opportunity to regenerate deprived areas of the capital and create healthy communities by linking planning outcomes to health outcomes'[10]. Is also states specifically that 'there is a particularly important need to access funding and provision of in-kind primary care facilities via S106 and CIL.'[11]

PLANNING POLICY

In practice, however, an analysis of London boroughs' planning policy shows a wide variety of approaches towards health contributions from new development. Some boroughs have set specific policies to target planning contributions from each new development: Bexley,

8. Standard set by the NHS 's London Healthy Urban Development Unit (HUDU), quoted in various planning policy documents, for example *here*
9. *The London Plan*, GLA, March 2015
10. *Social Infrastructure SPG*, GLA, May 2015, p51
11. *Social Infrastructure SPG*, GLA, May 2015, p54

for example, requires specific contributions for health facilities for each new development over 5 units[12]. Others target numbers or ratios, such as Brent which has a policy of ensuring that there is 1 GP per 1,500 people[13]. Barnet has produced an entire Supplementary Planning Document dedicated to securing planning obligations for health facilities. Other boroughs prefer to operate on a case by case basis, or give very little policy guidance at all[14].

In addition, where boroughs have a CIL in place, in order to meet the regulations they have to provide a list of infrastructure that the money will be spent on (known as a 'Regulation 123 list'). Whilst health is included as an item on the vast majority of these lists, they are rarely specific as to the number and type of facility which should be provided to match the number of new homes. Given the increasing reliance on CIL to raise planning contributions from developers, this lack of detail is concerning.

MONITORING

Monitoring is a critical part of the planning system, and most local authorities produce annual monitoring reports. These measure performance against what the local authority wants to achieve in its planning policy, and crucially gives it the opportunity to make changes where necessary. Conversely, if there are areas where monitoring is not taking place, or not taking place sufficiently, it is difficult to ensure these objectives are reached. Another benefit of monitoring is that it puts this information into the public domain so that the local authority can be held to account for its performance.

When it comes to monitoring of health facilities, the situation is mixed across London, with boroughs reporting this in different ways and some not at all. Reporting can include the amount of health floor space delivered, the number of health facilities or GPs, the amount of money received through Section 106 planning agreements, or other measures such as lists of planning permissions that include health facilities. In total 24 London local authorities monitor health provision through the planning system in any form, whilst 9 do not. Of those that do monitor, 10 monitor floor space or the number of new GPs, whilst 16 monitor monies received or allocated to health through planning contributions; only 6 monitor both. Also, whilst the London Plan produces annual monitoring reports to measure growth across London, it does not include any indicators to measure health facilities[15].

Without clear and consistent monitoring across London, it is difficult to ensure that sufficient new facilities are being provided to match the increase in housing development. That is in contrast, for example, to the situation with affordable housing, where the number and type of new affordable homes are provided each year by each borough in a consistent way, ensuring that the performance in each borough can be compared and held to account. Health provision is no less important and there is no reason why it should not receive a similar level of focus and attention.

12. *Planning Obligations Guidance SPD*, London Borough of Bexley, 2008, pE5
13. *Annual Monitoring Report 2015-2015*, London Borough of Brent, p26
14. *Contributions to Health Facilities from Development SPD*, London Borough of Barnet, July 2009
15. See Appendix

THE WAY FORWARD

A change in approach is needed at all stages of the planning process, to ensure that the highest possible contribution is made towards new health facilities, especially for GPs, from new developments across London. By taking on board the following recommendations, London boroughs can ensure that this achieved.

Recommendation 1

All London boroughs should monitor and publish, annually at a minimum, the amount of GP floor space delivered through developer contributions through CIL or Section 106 contributions.

Recommendation 2

All London boroughs should update their CIL or Section 106 strategies to ensure that sufficient new GP floor space is delivered to support new housing development, and that there provision made for at least 1 GP per 1,800 new residents.

Recommendation 3

London boroughs should ensure that NHS bodies, such as the London Healthy Development Unit (HUDU) and local Clinical Commissioning Groups (CCGs), are fully involved in decisions on how CIL and Section 106 money is raised and spent, and that they are fully consulted on all major housing applications.

APPENDIX

Monitoring of health facilities through the planning system, by local authority, together with the number of GPs per 10,000 people

Borough	Monitoring of health facilities	Monitors S106/CIL contributions for health	Monitors number/ floor space of GPs or facilities	GPs per 10,000 people
Barking and Dagenham	✗	✗	✗	6.9
Barnet	✓	✗	✗	7.6
Bexley	✓	✓	✓	5.9
Brent	✓	✗	✓	7.6
Bromley	✓	✓	✗	8.1
Camden	✓	✓	✗	8.5
City	✓	✗	✗	6.6
Croydon	✓	✓	✗	8.4
Ealing	✓	✓	✗	6.5
Enfield	✓	✗	✗	6.1
Greenwich	✗	✗	✗	7.8
Hackney	✓	✓	✗	9.0
Hammersmith and Fulham	✗	✗	✗	7.6
Haringey	✗	✗	✗	6.6
Harrow	✓	✓	✓	6.7
Havering	✓	✗	✗	5.5
Hillingdon	✓	✓	✓	6.1
Hounslow	✓	✓	✗	5.7
Islington	✗	✗	✗	8.1
Kensington and Chelsea	✓	✓	✗	7.5
Kingston upon Thames	✗	✗	✗	9.8
Lambeth	✓	✓	✗	10.4
Lewisham	✗	✗	✗	9.3
Merton	✗	✗	✗	7.7
Newham	✓	✓	✗	8.3
Redbridge	✗	✗	✗	6.4
Richmond upon Thames	✓	✓	✗	8.9
Southwark	✓	✓	✓	9.8
Sutton	✓	✗	✓	7.2
Tower Hamlets	✓	✓	✓	9.9
Waltham Forest	✓	✗	✓	7.3
Wandsworth	✓	✗	✓	9.1
Westminster	✓	✓	✓	5.6

Monitoring data compiled from monitoring reports and other planning documents for all local authorities in London. GPs per 10,000 people are figures from 2013/14 compiled by the Local Government Association, available *here*.

FEEDBACK

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