Chapter 22: Healthcare

Introduction

22.1 Health provision is an integral component of sustainable development – access to essential healthcare services promotes good health outcomes and supports the overall social and economic wellbeing of an area. The Council will work with the Cambridgeshire & Peterborough Integrated Care System (ICS) to assess the need for additional health infrastructure and ensure that all residents have easy access to the care they need when they need it.

22.2 The delivery of new and improved health infrastructure is resource intensive. The majority of existing health infrastructure is at or nearing capacity, particularly primary care infrastructure, and the level of housing growth planned for Greater Cambridge will place additional pressure on existing health and social care provision. To cope with the additional demand generated by new development, health infrastructure will require improvement, and in some cases the provision of new infrastructure will be required.

22.3 Where the assessment of impact on local health provision identifies there is insufficient health infrastructure capacity to meet the needs generated by a development proposal, planning obligations will be required to mitigate the impact of the development and secure the required additional health infrastructure provision.

Policy Context

Cambridge

22.4 Cambridge Local Plan 2018 Policy 75 Healthcare facilities identify health infrastructure as necessary to support new development, and that the Council will work with the relevant health organisations to provide high quality and convenient local health services in all parts of Cambridge, but particularly in areas of population growth. Policy 85: Infrastructure delivery, planning obligations and the Community Infrastructure Levy includes healthcare amongst its requirements.

South Cambridgeshire

22.5 South Cambridgeshire Local Plan (Policy SC/4) requires all housing developments to include or contribute to the provision of the services and facilities necessary to meet the needs of the development, including health infrastructure

22.6 In addition to these district wide policies, both Local Plans include a range of site-specific policies. Where site specific policies have requirements for health facilities these will need to be considered by individual development proposals.

Development types from which Obligations will be sought

22.7 Residential development (self-contained and non-self-contained) of all tenures.

22.8 Assessment of impact on local health infrastructure, prepared in consultation with Cambridgeshire & Peterborough Integrated Care System (ICS) and other health stakeholders as appropriate.

Form in which contributions should be made

Health Infrastructure in the Greater Cambridge Area

22.9 Integrated Care Systems (ICS), established in 2022, introduced a new structure to enable closer working between organisations in the health and care system. ICSs cover the whole of England and bring together different partners including NHS providers, commissioners, local authorities, and the voluntary are community sector. The boundary of each ICS is covered by an Integrated Care Board who are responsible for commissioning the primary and secondary health services required to meet the requirement of the population registered with a GP in their area. ICBs have replaced Clinical Commissioning Groups (CCGs) and there are now 42 ICBs across England.

22.10 The Cambridgeshire & Peterborough ICS (C&P ICS) covers a geographical area with a population of around 1.3 million. The ICS has formed two place-based care partnerships to split the larger area it covers: North Cambridgeshire and Peterborough (focusing on Peterborough, Fenland and Huntingdonshire) and Cambridgeshire South (focusing on East and South Cambridgeshire and Cambridge City). Greater Cambridgeshire falls within the South Care Partnership, which has a population of around 468,000 and includes a range of NHS service providers:

- 39 GP practices organised into nine Primary Care Networks (PCNs) – Cambridge Northern Villages PCN, Cambridge City PCN, Cambridge City 4 PCN, Cam Medical PCN, Granta PCN, Median PCN, Cantab PCN, Ely North PCN and Ely South PCN. (For clarity, some PCNs expand beyond defined local authority boundaries. In this case, Ely North PCN and Ely South PCN fall within the overall South Care Partnership, but both fall outside the Greater Cambridgeshire local authority boundary – further advice on this matter can be provided on a site-specific basis).

To note, there are two surgeries within the Greater Cambridgeshire boundary which do not fall within the Cambridgeshire & Peterborough ICS:

- Bassingbourn Surgery – branch surgery of the Ashwell Surgery which falls under Hertfordshire and West Essex ICS
- Gamlingay Surgery – branch surgery of Greensand Medical Practice which falls under Bedfordshire, Luton and Milton Keynes ICS
- Two Hospitals (Cambridge University Hospitals, Royal Papworth Hospital)
- Cambridgeshire Community Services NHS Trust (community provider)
- Cambridgeshire and Peterborough NHS Foundation Trust (community and mental health provider)
- East of England Ambulance Service Trust

22.11 The integrated neighbourhood teams comprise a range of staff alongside medical professionals, including community services, social care and the voluntary, community and social enterprise sector. There are also local Medical, Dental, Pharmaceutical and Optical Committees, and at the ICS level a Children's and Maternity Partnership Mental Health, Learning Disabilities and Autism Partnership.

22.12 At the neighbourhood level, the development of PCNs is a key aspect of the NHS Long Term Plan in providing primary care services and delivering a set of service requirements specific to the needs for a defined patient population (a PCN will generally have a population of between 30,000 – 50,000 people). This model of care is based on providing extra resource in general practice so people can easily see the best primary care professional for their need or concern. The introduction of PCNs has set a new way of working within GP practices, enabling them to more effectively coordinate primary care services for populations at the PCN level.

22.13 This is a significant shift away from GP practices' previous way of working independently and having limited service offerings. Expanded multidisciplinary teams in PCNs comprise a range of staff in addition to GPs, including speciality and associate specialist doctors, pharmacists, district nurses,

community geriatricians, dementia workers and allied health professionals such as physiotherapists and podiatrists/ chiropodists. To address the pressure acute services are under, there is a focus on moving some intermediate health care services (for example, screening and testing) out of hospitals and into primary care facilities.

22.14 Because PCNs are made up of a group of GP practices which are closely working together and are aligned to other health and social care staff and organisations, this enables the closer integration of existing local services. Members of the PCN may also include other organisations such as community pharmacies, community service providers, mental health providers and voluntary sector organisations. This allows PCNs to collaboratively plan and organise the delivery of health and care services in each of their distinct geographical areas and means people can access the full range of primary care services that they need closer to home.

22.15 As identified in the Cambridgeshire & Peterborough ICS Joint Forward Plan (2024), a key issue for meeting the health needs of the existing and future population is the condition of the primary care estate. It is identified as being or is soon to become no longer fit for purpose and will not have the capacity to absorb additional patients in light of the identified pressures from a growing and aging population. Over recent years, the population has steadily increased and has already caused many GP practices to reach capacity, with a few facing difficulties in accepting additional patients and closing their lists to new patients.

22.16 Ensuring that everyone has access to the care they need when they need it means providing care in the right buildings, with the right staff and resources. The projected growth within the Greater Cambridgeshire area will further increase pressure upon existing facilities. In addition to significant housing growth, the increase in population will not be evenly distributed across the local area. This will also need to be factored into determining future primary care infrastructure needs to ensure healthcare inequalities are addressed and prevented.

22.17 From an estate perspective, delivering the NHS Long Term Plan means a shift away from smaller GP premises to larger scale, modernised integrated primary and community care hubs that accommodate a wider range of healthcare services built around the needs of the local population. The need to support a wider range of services in one location places pressure on healthcare infrastructure designed to accommodate traditional models of general practice. Successfully transforming the way services are delivered, and redesigning patient care requires making more efficient use of the existing

estate alongside ensuring that any new health infrastructure provided supports this new model of primary care provision.

Requirements for Assessing Impact on Local Health Infrastructure

22.18 New residential development will be required to mitigate its impact on health infrastructure. The type of provision and associated financial contribution(s) required will be determined based on the needs generated by the development and the existing capacity of impacted health infrastructure. Where a need is identified planning obligations may be sought including:

- Financial contributions towards improvement/expansion of existing health facilities
- Financial contributions toward construction of a new health facility
- Provision of land and a financial contribution for construction of a new health facility
- On-site health facility delivered by the developer
- Financial contributions towards costs related to any interim/temporary provision that may be required prior to the completion of new permanent facilities
- New facility required to compensate for the loss of an existing facility caused by the development

22.19 All major residential developments will be required to assess their impact on primary health infrastructure within the healthcare catchment of the proposed development following the process set out in the table below. For strategic-scale proposals, there may be additional requirements for health infrastructure related to acute, mental health, and/or community health provision. This will be determined on a case-by-case basis through the master planning process for the individual development.

22.20 Pre-application engagement with the ICS is encouraged for all scales of schemes and expected for sites that propose 200 or more residential units. Early and on-going engagement with the ICS and other relevant health stakeholders is particularly important for schemes with the potential for on-site health provision, such as those within areas of major change/new settlements and large residential-led site allocations.

22.21 To properly determine planning obligation requirements, it is important that needs assessments reflect the most up-to-date ICS standards of health infrastructure provision for planning purposes as set out in this SPD. The NHS are the only authority responsible for determining required health infrastructure across the county, and the ICS is responsible for commissioning the range of health services that local people rely on. Approaches to

assessing impacts on health infrastructure that do not accord with ICS strategies and standards will not be accepted.

Submission Requirements and Standard S106 Provisions

22.22 Where a Health Impact Assessment (HIA) is required, the assessment of impact on local health infrastructure should normally be included in the HIA with appropriate planning obligations summarised in the Planning Statement. Where an HIA is not required, the assessment can be provided as an appendix to the Planning Statement.

22.23 Where a planning obligation is likely to be required, the applicant should indicate this in any draft s106 Heads of Teams proposed. For applications where financial contributions towards primary care are required, the following standard wording will generally be used:

'Health Contribution: means the sum of £x (index linked) to be applied by the Cambridgeshire & Peterborough Integrated Care Board (ICB) or subsequent successor body towards the provision of additional primary care led capacity through the extension and/or remodelling of [insert name of facility], or through the extension or remodelling of other facilities within the local primary care networks (PCNs) – or subsequent successor - in which the development is located, or through the extension and/or remodelling of other facilities that would specifically provide services to serve the development Expenditure of planning obligations related to primary care facilities will normally be area-based on facilities within the local PCN(s) serving the development. In limited circumstances expenditure may be directed at a wider scale where this is deemed necessary to support service delivery objectives.'

22.24 For smaller schemes, to enable the required additional capacity to be in place in a timely manner the financial contribution will be due prior to commencement of the development. On larger, phased schemes trigger points for payment will be agreed in consultation with the ICS.

22.25 For proposals where other forms of contributions are required – for example, delivery of on- site facilities or contributions towards other forms of health infrastructure (acute, mental health) – the detailed wording of the s106 obligation will need to be agreed in consultation with the ICS. All financial contributions to health infrastructure will be indexed linked to the Build Cost Information Service (BCIS) All-In Tender Price Index.

22.26 Where facilities are delivered on-site, measures to ensure that they are fit for purpose and affordable will be applied including consideration of input from the District Valuer. Given the long timescales and uncertainties involved in

large developments, the requirement for an in- kind on-site facility may change over time. In these circumstances, the s106 agreement will include a cascade mechanism to secure a financial contribution in-lieu of the on-site provision where the facility is not required or able to be delivered. The s106 financial obligation will be used to contribute towards alternative provision in the area to mitigate the site-specific impact of the development.

Methodology for Calculating Primary Care Infrastructure Need

22.27 New housing developments increase the total number of patients that need primary care in a localised area. From a service planning perspective, to adequately provide for the needs of the population within the area the ICS must consider the total population that will live in the newly built homes and how services within the impacted Primary Care Network(s) (PCN) can be best provided to serve this additional population.

22.28 If the baseline position is that the existing primary care infrastructure does have capacity to accommodation the additional population growth caused by the development, a contribution will be required. To determine if a planning obligation is required and the appropriate form of contribution, a four-step process will be followed as set out in the table below.

Overview of Methodology for Calculating Primary Care Infrastructure Needs

- **Step 1:** Assess level of primary care infrastructure need proposal generates
    - Average household size applied to total number of residential units
    - ICS floorspace requirement for growth 150sqm GIA per 1,750 patients

- **Step 2:** Review capacity of existing primary care infrastructure
    - Existing practices likely to be impacted identified by ICS
    - ICS benchmark for existing capacity 120sqm NIA per 1,750 patients

- **Step 3:** Consider appropriate additional capacity solutions and approaches
    - Potential for expansion of existing facilities or new provision

- **Step 4:** Identify appropriate form of developer contributions
    - ICS 2024 build cost benchmarks (will be updated annually) of:
        - £5,179/sqm (South Cambridgeshire) and £5,324/sqm (Cambridge) for mitigation in the form of refurbishment/extension
        - £6,700/sqm (South Cambridgeshire) and £6,893/sqm (Cambridge) for mitigation in the form of new build

Example calculation for 250 unit scheme mitigated by expansion of existing facilities

[(250 residential units x 2.4 persons/house)/1,750 patients]*150sqm = 51sqm floorspace requirement

Where the 51sqm primary care floorspace is for a refurbishment or extension project then the total section 106 would equate to £271,524 in Cambridge and £264,129 in South Cambridgeshire. Where the 51sqm primary care floorspace is delivered as an entirely new facility then the total section 106 would equate to £351,543 in Cambridge and £341,700 in South Cambridgeshire.

Impact of development on Registered Patient Population

22.29 The residential population generated by the proposed development is used to estimate the direct impact on local primary care services by providing the number of GP registrations linked to the additional population.

- For self-contained (C3) dwellings the average household size of 2.4 as identified by 2021 Census will be used applied to all units.
- For non-self-contained dwellings such as student accommodation or purpose-built HMOs the standard assumption will be one person per bedspace.
- For older people's housing the most appropriate approach to determining population gain will need to be agreed on a case-by-case basis with the Council.

22.30 Alternate household size assumptions will only be considered by the ICS if justified by the applicant and agreed by the Council.

Primary Care Infrastructure Needs Arising from Development

22.31 Department of Health best practice guidance for primary care facilities is provided in Health Building Note 11:01: Facilities for Primary and Community Care (HBN 11-01). Health Building Notes provide guidance on the design and planning of new healthcare buildings, as well as the refurbishment and extension of existing facilities. HBN11-01 describes the way to quantify the types of spaces needed for primary and community care facilities to support the briefing and design processes for individual projects in the NHS building programme.

22.32 For planning purposes, the ICS uses a standard floorspace requirement of 150sqm Gross Internal Area (GIA) per 1,750 patients which is aligned to HBN11-01 guidance. This provides an appropriate benchmark for the early-

stage planning of new facilities, to identify the scale of additional infrastructure required to provide primary care services to a modern standard of care for residents of new housing in efficient, flexible, and user-friendly environments. This floorspace standard is kept under review by the ICS to ensure it reflects the most up-to-date best practice guidance and may be revised accordingly.

Capacity of Existing Primary Care Infrastructure

22.33 The ICS will identify the individual primary care premises likely to be impacted by new development based on existing GP catchments, predominant patterns of patient access in the local area and ICB objectives relating to primary care accessibility. This means that not all practices whose catchments cover the development site will necessarily be included in the assessment of existing capacity – for example while some GPs have very large catchments, the ICS does not consider it appropriate to expect patients to travel significant distances to access primary care facilities when there are closer options.

22.34 Early engagement with the ICS will ensure that baseline capacity assessment includes the correct premises. The ICS uses a standard floorspace requirement of 120sqm Net Internal Area (NIA) per 1,750 patients to assess the capacity of existing premises, aligned to HBN11-01. Where available, weighted patient list size should be used for the assessment. This results in a more accurate understanding of current infrastructure capacity because weighting for patient demographics reflects that certain types of patients place a higher demand on practices than others (e.g. older patients, very young patients).

22.35 In limited circumstances there may be existing capacity within the estate, or funded primary care estates projects with certainty around delivery that will deliver additional capacity in future. In such cases, it will be necessary to determine if the capacity will still be available at the time the proposed development is occupied – for example, improvement projects may have been identified in response to population growth associated with housing development that has already been approved but not yet implemented.

Additional Capacity Solutions and Approaches

22.36 Developer contributions towards health infrastructure should contribute to the delivery of effective and efficient primary care services that meet the strategic needs of the impacted PCN(s) and the ICS. The ICB will identify capacity solutions to deliver the required additional floorspace based on either:

- Refurbishment and/or extension of existing premises – this will depend on if existing premises are in the right location, have the potential for refurbishment, reconfiguration and/or extension, and alignment with ICS Infrastructure Strategy.
- New build health facilities – this may either on-site or off-site depending on the scale/location of the development and alignment with ICS Infrastructure Strategy.

22.37 In context of the significant transformation taking place within primary care, the most effective means of expanding primary care to serve the needs of a specific new development may not be focusing investment on the facility closest to the development site. Planning obligations will be linked to delivering additional capacity within the relevant PCN area(s). This flexibility is necessary to enable the ICS to deliver the required additional capacity in the location that most effectively serves residents of the new development at the time it comes forward, which may differ from the preferred mitigation project(s) identified at the time of permission.

22.38 At the masterplanning stage, development proposals in growth locations and areas of major change will generally need to provide flexibility to accommodate necessary health facilities on site. As a benchmark this will typically apply to developments over 1500 dwellings, but a number of factors will be considered when determining whether a particular development (including below that size) should include on-site provision of a primary care facility including:

- The ability of local facilities to expand sufficiently and impact of a new facility on them
- Cumulative impact with other residential development proposals and the needs of the existing community
- The viability of the development and the cost of a new primary care facility against other potential solutions
- The viability of a new facility, particularly in the early years of a large, phased scheme
- How the location and configuration of the development, including co-location with other services, would align with wider system objectives relating to service delivery
- Where floorspace requirements from a single development are not large enough the ICS may seek to work with developer to agree delivery of a larger facility

Form of Developer Contribution

22.39 Once the appropriate form of mitigation has been identified by the ICS, the capital cost of creating the additional primary care floorspace to the required standard will be determined based on the relevant build cost benchmark. The 2024 benchmark costs to be used in the calculation of the required contribution amount are:

- £5,179/sqm (South Cambridgeshire) and £5,324/sqm (Cambridge) for mitigation in the form of refurbishment/extension
- £6,700/sqm (South Cambridgeshire) and £6,893/sqm (Cambridge) for mitigation in the form of new build

22.40 ICS build cost benchmarks for primary care facilities are prepared by independent quantity surveyors with a healthcare specialism to ensure accordance with HBN11-01. The capital costs of additional provision, whether for upgrades to existing facilities or construction of new facilities, are based on providing spaces that specified to be ready for occupation, as opposed to shell and core condition. This reflects the full costs of delivering health infrastructure projects and therefore incorporate a range of allowances including (but not limited to) fit out, professional fees, externals and contingency. However, they do not include the cost of land acquisition.

22.41 Build cost benchmarks will be updated annually by the ICS to reflect current market conditions in the locality. Updated benchmarks will be published on the Greater Cambridge Shared Planning Service website. In cases where the ICS has identified potential priority projects in the locality of the development, for example in their Infrastructure Strategy, as part of developing the contribution requests these projects may be explored in more detail to refine the request.

22.42 Where the scale of the proposals requires on-site provision of a new facility, mitigation will take the form of either:

- In-kind provision by the developer in the form of a turnkey, fully fitted out facility transferred to the NHS at no cost; or
- The provision of a service plot of land at no cost, and a financial contribution to equivalent to the full capital cost of a new build facility of the required size.

22.43 The final design of the health facility should meet the most up to date model of health care provision standards. This will be secured in the s106 agreement by a requirement for the health facility specification to be agreed by the ICS and (if relevant) healthcare provider(s). The s106 will also include mechanisms to ensure that the delivery of any in-kind facility is financially and operationally viable for the needed services, for example lease terms.

Guidance for New Primary Care Facilities

22.44 The condition of the estate has a direct impact on patient care. A core ambition of the Cambridgeshire & Peterborough ICS is to support a primary care estate that is fit for the future and supports primary care teams to provide effective services that patients can easily access. This means providing place-based healthcare solutions that meet patient needs at the same time as supporting health professionals to effectively deliver services.

22.45 Where new primary care-led facilities are provided as part of new developments, these need to be designed to meet ICS health floorspace requirements as well as wider ICS objectives relating to the sustainability and operational viability of health infrastructure. The following requirements should be fulfilled when new on-site health facilities are proposed:

- On-site provision should be within a single building with a planned mix of compatible uses in proximity. Provision split across multiple sites does not accord with the ICS strategy of development of integrated hubs.
- The location of the facility should be easily accessible by public transport, easily visible from a public highway, have accessible parking for those with mobility issues and have easy access for emergency vehicles
- The site must be sized to incorporate the building as well as operational requirements related to parking, servicing and access. Where feasible, space should also be provided to allow for provision of mobile diagnostic services.
- The site should be flat and free from any ground contamination or constraints, fully serviced, and free of any abnormal development costs or restrictions
- There should be provision for soft landscaped areas around the health centre to provide areas for wellbeing and to deliver opportunities for social prescribing.
- Building design must ensure natural light is provided to consultation rooms, bookable space and multi-use spaces.
- Adherence to Delivering a Net Zero NHS requirements

22.46 Co-location of front-line staff from primary, community, social and VCSE sector providers all caring for the same local people around a defined neighbourhood geography including Family Hubs, is embedded within ICS priorities to support an increase in delivering more care closer to home and a reduction in inequalities. Where there is potential for co-location of the primary care services required by a new development with other complementary

services, this will need to be explored early in the master planning process to make sure that the specific clinical design requirements or primary care can be satisfied.

Exemptions

22.47 No specific exemptions.

Further guidance

Health & Wellbeing Integrated Care Strategy | CPICS Website (Cambridge & Peterborough ICS - Health and Wellbeing Integrated Care Strategy (2022))

Estates Strategy | CPICS Website (Cambridge & Peterborough ICS - Estates Strategy Summary 2023-2033 (The full version of which will be made available)). This includes clarification of PCN and Place areas.

Health Impact Assessment SPD - South Cambs District Council (scambs.gov.uk) (South Cambridgeshire - Health Impact Assessment SPD (2011)). NB – This SPD is proposed to be replaced by a new Health Impact Assessment SPD for Greater Cambridge in 2025.

Cambridgeshire & Peterborough Insight – Joint Strategic Needs Assessment (JSNA) – Published Joint Strategic Needs Assessments (cambridgeshireinsight.org.uk) (Healthy Places Joint Strategic Needs Assessment for Cambridgeshire and Peterborough 2024)

Any subsequent guidance documents which will be published.