NHS Property Services

Quality Healthcare Environments

The NHS, S106 and CIL

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NHS
Property Services

Property strategies and solutions.
Estate and facilities management.
Safety. Efficiency. Sustainability.
Specialist knowledge, skills and advice.

NHS Re-organisation …

- **patients**, commissioners and providers
- patients – us!
- commissioners – NHS England and CCG
- providers – GPs, NHS Trusts, social enterprises, private sector, voluntary
- public health
- for an alternative view, see the King's Fund video at:

http://www.youtube.com/watch?v=8CSp6HsQVtw

Healthcare provision – the property owners …

- our homes and the community;
- NHS Trusts (c. 90% of the NHS estate) – mostly acute and mental health;
- NHS Property Services Ltd (c. 10% of the NHS estate – 3+m square metres) mostly primary care and community services – c. 100 community hospitals and 2,000+ “health centres”;
- PFI and NHS LIFT;
- “private” providers:
  - social enterprises;
  - GPs – mostly primary care;
  - Assura, Brackley Investments, BUPA …

Town and Country Planning and the NHS

- why is it important for us?

  - accommodating planned growth;
  - funding for planned growth;
  - premises accessibility and sustainable communities;
  - impact on property investment and disinvestment;
  - health and wellbeing.

The implications of growth:

- 90% of patient interaction is with primary care services;
- c. 8,000 GP premises in England and c. 80% GP/privately owned;
- c. 35k GPs in England with a population of c. 53m;
- average of 1,800 people per FTE GP
- premises requirements?
- costs:
  - assume only capital cost of building?
  - equipment?
  - revenue funding?

The tools:

- development plan documents – “policy”;
  - Local Plan/Core Strategy;
  - Area Action Plan/Site Allocations Documents/other DPD;
  - Neighbourhood Plan;
- evidence - Infrastructure Development Plans (IDP);
- language – population and household growth is different;
- viability;
- site allocations and financial contributions (s106/CIL).

The NHS and local government:

- public health and social care
- Health and Wellbeing Boards – where we all come together?
- Joint Strategic Needs Assessments – the evidence
- Joint Health and Wellbeing Strategies – the response:
  - needs an estate link?
  - CCG estate strategies?
- statutory guidance at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/223842/Statutory-Guidance-on-Joint-Strategic-Needs-Assessments-and-Joint-Health-and-Wellbeing-Strategies-March-2013.pdf
- "*JSNAs can also be informed by … wider issues that affect health such as … transport, planning or housing.*"
- *"health and wellbeing boards will need to consider:*
  - *wider social, environmental and economic factors that impact on health and wellbeing such as access to green space, the impact of climate change, air quality, housing, community safety, transport, economic circumstances, employment; …"*
- *"Health and wellbeing boards should also work closely with other local partners such as … local planning authorities …"*
- local authority duty to have regard to JSNA and JHWS

Population Change - National

- 1952 – 255 100th birthday telegrams
- 2011 – 9,736 100th birthdays telegrams
- 2001 – 4.5% of people over 65 were resident in communal establishments
- in 2010, the expected years lived in poor health from age 65 onwards was 7.7 years for men and 8.7 years for women
- support ratio projected to change from 3.14 to 2.61 (no of people of working age to no. of people of pensionable age)
- no. of people aged 65 and over is projected to increase 23 per cent from 10.3 million in 2010 to 12.7 million in 2018. Growth in this age group is projected to continue for the foreseeable future, with the 65+ population expected to reach 16.9 million by 2035

JSNA and JHWS

- the older population is expected to grow to 28% by 2033, with a 5% reduction in the working age group
- the population in Essex aged over 75 years is expected to increase significantly over the next 20 years and if the need for **supported housing units** follows this trend it is estimated there will be a potential deficit of over 22000 units by 2030
- a 5 year strategy? Core Strategies to 2021 and beyond …

ill health or following injury	trauma, improving recovery from stroke.
Ensuring that people have a positive experience of care	Improving access to primary care services.
Ensuring that people have a positive	The proportion of people who use services

Where do we want to be?

- promote policies that allocate sites for new healthcare where they are required;
- s106 agreements that really deliver;
- health infrastructure on a par with schools – it is “essential”;
- access to the CIL pot via LPA (75%) and Parish/Neighbourhood (15-25%);
- avoid policies that restrict the development of our premises;
- promote policies that allow for the flexible development of our estate.

Education:

- straightforward household multipliers
- DfE capital cost per pupil
- S106/CIL funding was “straightforward”
- but LEA owned and controlled premises now becoming independent academies …
- increasing number of providers?

Model for health s106/CIL funding route?

- basis for predicting need?
- what premises do we want/need and can we afford, and where do we want them?
  - extensions to GP premises?
  - new build premises?
  - shared premises?
  - better use of existing premises?
  - longer hours?
- NHS England to co-ordinate GP commissioning alongside CCG?
- NHS England and CCG not property holders
- funding to transfer to NHS England?
- NHS England to use funding via NHS Property Services?

How do we get where we want to be? The evidence base:

- need for housing and other development;
- understand population growth planning (via JSNA and JHWS or a service delivery plan?);
- consider infrastructure implications;
- input requirements through the Infrastructure Development Plan and realise them on the Regulation 123 list;
- ensure site specific allocations with major growth proposals;
- respond to major planning application consultations?

Some local challenges …

- many major sites already have permissions;
- proposals for growth may be spread across a wide area without a clear focus for new healthcare facilities;
- Assets of Community Value and site marketing/disposals;

Chelmsford example …housing land supply …

- 66,000 existing homes in 2001;
- 14,000 new homes planned from 2001 to 2021;
- but 4,000+ had been completed by 2007 and 3,800+ “commitments” existed …
- and 1 house does not equal 2.3/2.4 new people;
- no reference to planned population growth in Core Strategy, but evidence base documents suggest 157,500 to 165,700:
    - 14,000 new homes to be built;
    - for 8,200 “new” people;
    - so occupancy is only 1.7 people per household;
- but 2010 mid year population estimate suggested population of 169,500 (12,200 increase since 2001) after 5,926 dwelling completions;
    - occupancy therefore 2.1 people per household;
- and housing delivery fluctuates!
    - .

Chelmsford

- *NHSNE have identified that there will be an overall capacity deficit in GP surgeries of 16,860 patients which accounts for 17,750 sq m. of GP Surgery floorspace which will either comprise extensions to existing surgeries. The NHSNE estimate that the cost of this provision will total £2.27m. At present there is no other funding committed or held for this provision, therefore the funding gap for primary healthcare totals £2.27m.*

Community Infrastructure Levy - Funding Gap with Infrastructure Projects >£0.5m							
Infrastructure Projects	Development Plan Evidence Base*	Cost (£m)	Developer Funding secured or proposed (£m)	Non-Developer Funding (£m)	Sources of non-Developer Funding	Net Funding Gap (£m)	Delivery Body
Healthcare							
Primary Healthcare	CS, NCAAP	£2.27	£0	£0.0		£2.27	NHS North Essex (NHSNE)
Health Sub Total		**£2.27**	**£0.0**	**£0.0**		**£2.27**	

And now to real life …

- the NHS engages successfully with the development plan system;
- a site is allocated in a Local Plan:

- the planning application is submitted;
- the NHS is not consulted, but a site for healthcare is secured through the s106 agreement;
- time moves on …
- the NHS decides that the site secured through the agreement is not big enough and there is not, in any case, funding for a new facility;
- the developer applies to lift the requirement to provide a health facility;

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Some lessons for us:

- early engagement is crucial;
- ongoing engagement is equally crucial;
- develop planning needs alongside NHS business cases;
- base planning requirements on an estate strategy?
- align JHWS with Core Strategy?
- get out the crystal ball!

Some end of process practicalities …

- who will take the s106/CIL funds?
- who will own the premises?
- will we be happy with third party developments?
- do we have the funds to acquire sites at “market value”?

Conclusions …

- period of much change (legislation and policy);
- circumstances change – healthcare practice, funding, policy, legislation …
- resource intensive process - needs to be worthwhile and review lessons learned from success stories aswell as failures;
- political;
- rewards may take time to realise;
- BUT it is worthwhile!