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**Supplementary Planning  
Document**  
Draft Contributions to  
Health Facilities from  
development

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**JANUARY 2009**

## Executive summary

This draft Supplementary Planning Document (SPD) on Contributions to Health Facilities from Development has been prepared by the council working in partnership with Barnet Primary Care Trust.

The purpose of this draft SPD is to provide advice to developers on the council's approach to securing S106 contributions for health facilities.

The draft SPD supplements policies of Barnet's *Unitary Development Plan* (UDP), adopted in 2006, and the Mayor of London's *London Plan 2008 (Consolidated with Alterations since 2004)*, which together form the development plan for Barnet. The draft SPD does not introduce new policies. That is a role for Barnet's emerging Local Development Framework.

The council uses the HUDU Planning Contributions Model to calculate the potential planning contributions from residential developments in Barnet for the provision of health care facilities. It is proposed that the HUDU Model will be extended to incorporate a method to calculate the impact of new residential development on the provision of social care facilities. Following the successful extension of the HUDU Model the council will seek s106 contributions for social care facilities.

For large development schemes the council will assess the complex factors that must be taken into account in putting together a 'package' of Section 106 financial contributions, and the standard values used in the HUDU Model may be subject to variation.

For smaller schemes the draft SPD sets out required capital contributions by size for each net residential unit.

This draft SPD will be taken into account as a material planning consideration when planning applications are being considered.

## Foreword

Significant numbers of new homes are likely to be built in Barnet in coming years. The Mayor of London's *London Plan* (Consolidated with Alterations since 2004) sets a target of 20,550 additional homes to be created in the borough between 2007/08 and 2016/17, an annual target of 2,055 new homes. Demographic projections by the Greater London Authority estimate that by 2017 Barnet's population could be as high as 370,450. This represents an increase of over 44,000 new people on the population level of 2008 (326,300).

To accommodate these new homes whilst maintaining and improving the area as a successful city-suburb, and while achieving our commitments to a strong and healthy Barnet will require significant investment in our 'social infrastructure'. This will include the provision of health and social care facilities. The provision of adequate and accessible health and social care facilities is an essential part of community infrastructure.

This draft supplementary planning document (SPD) sets out in detail the council's expectations of how planning applicants for residential development will be able to contribute to the achievement of the council and the PCTs objectives and help to deliver better health in Barnet.

## 1.0 Introduction

- 1.1 This draft Supplementary Planning Document (SPD) on Contributions to Health Facilities from Development has been prepared to supplement the policies and proposals of Barnet's Unitary Development Plan, adopted in 2006, and the Mayor of London's *London Plan 2008 (Consolidated with Alterations since 2004)* which together form the development plan for Barnet. The draft SPD addresses the provision of health care infrastructure for the borough's population, and sets out the council's and Barnet Primary Care Trust's (PCT) approach to planning obligations for health care facilities. The draft SPD does not introduce new policies as that is a role for Barnet's emerging Local Development Framework (LDF). The LDF is made up of a 'folder' of separate documents that will together, in time, fully replace the Unitary Development Plan.
- 1.2 The purpose of this document is to provide advice and information to developers and the public about the levels of Section 106 contributions that will be required for the provision of health care facilities. Section 106 financial contributions will normally be required for health facilities from any development that generates new residential units.
- 1.3 Planning obligations (Section 106 agreements) are legal contracts between local planning authorities and developers that are drafted as part of the process of an applicant obtaining planning permission. Section 106 agreements are a means of ensuring that developers contribute financially to the cost of providing the infrastructure and public services that are needed as a result of their development activity.
- 1.4 The council will ensure reasonableness and fairness in levying Section 106 and that contributions to health and social care, and any other planning obligations, enhance the quality and sustainability of future development. It will address and overcome the negative impact of development enabling proposals to go ahead which might otherwise be turned down.
- 1.5 This draft SPD belongs to a suite of similar documents that will cover other areas of Barnet's Section 106 policy. Any contributions for health and social care provision will be independent from, and additional to, contributions for other community infrastructure, for example open space and education.
- 1.6 This draft SPD has been subject to a sustainability appraisal (SA) which sets out the likely significant social, environmental and economic effects of the measures it is seeking to implement. The SA has appraised the SPD and any reasonable alternatives to it, providing the 'baseline' against which the effects of the SPD can be considered. The SA is also subject to consultation.

## 2.0 Our objectives for health

- 2.1 Over the next two decades, Barnet will experience major changes. The council's five key corporate priorities set out in the Corporate Plan 2008/09 to 2011/12 [www.barnet.gov.uk](http://www.barnet.gov.uk) each have an impact on a healthier Barnet.
  - A Bright Future for Children and Young People
  - Clean, Green and Safe
  - Supporting the Vulnerable
  - Barnet - a Successful City-Suburb
  - Strong and Healthy

2.2 The PCT has an overall responsibility for ensuring the health and well - being of its local residents. In its widest context this relates to what is know as the ‘wider determinants of health’ meaning that factors such as income, education, housing, employment and living environment can impact on the health and well being of an individual. The PCT and the council have a common goal in addressing these issues for the population of Barnet.

2.3 The PCT Corporate objectives for 2008/9 include

- First things first: to maintain core standards if dignity, respect, privacy, cleanliness, evidence based practice and accessibility
- To improve health and ensure quality provision supporting people to support themselves
- To have accessible quality services for all the people of Barnet
- To have best outcomes from the best centres, to use PCT buildings to support the delivery of high quality health care to the people of Barnet
- Building resilience

2.4 The most significant impact for the council and the PCT arises from the priority to ensure a strong and healthy Barnet, where good services must be provided fairly to all, including new and emerging communities. Barnet has set itself challenging objectives for a healthier borough and the following provide the objectives for the draft SPD -

- **Creating a health supporting environment**

The council will work with key partners through our strategic plans and Local Area Agreement (LAA) to tackle the social and economic factors underpinning health inequalities in Barnet such as poor housing, limited access to transport and shops, unemployment and crime and disorder. This includes ensuring that new developments provide for a quality of life that facilitates healthier lifestyles and mitigates against adverse local and wider impacts on health.

- **Improving health and well-being**

The council believes that individuals and the community have a key role to play in improving their own health and it works to encourage and influence the rest of the community to do so. Community engagement and participation forms an integral part of the joint working with the Primary Care Trust on health improvement.

- **Bringing user experience to healthcare improvement**

The council is responsible for scrutinising the effectiveness of local health services in the borough; ensuring that residents have a good experience of healthcare. This includes ensuring that everyone who has contact with health services is treated with dignity and respect and that the services themselves are clean and safe.

2.5 **Sustainable Community Strategy for Barnet 2008 -2018**

One of the four key themes of the *Sustainable Community Strategy for Barnet 2008 - 2018*, which aims to bring together the partner agencies that work in the borough, is "healthier Barnet (including Older People)". The strategy states that:

*We want to add years to life and life to years of the people of Barnet. We aim to do this by continuing to build on the known and relevant success factors which lead to improved health outcomes but also by ensuring that health inequalities are addressed and an improved quality of life is secured for those experiencing multiple disadvantage.*

### 3.0 Barnet Council and Barnet Primary Care Trust - Partnership Working

- 3.1 By working with Barnet PCT, the council will ensure that local health services meet the current and future needs and preferences of Barnet's residents and are accessible to all members of the community. Through the newly established Local Involvement Network (LINKs) in Barnet, it will be easier for local people to have a say about health and social care services. The council is committed to ensuring that these views and the experience of users help to shape future developments in local health and social care services.
- 3.2 The council currently works with the PCT to deliver integrated and well-coordinated health and social care services for adults (maximising choice and promoting independence) and children (as part of Barnet's Children's and Young Peoples Plan).
- 3.3 Partnership working includes :
- The Health and Well-being Commissioning Framework for Barnet 2008/09 – 2011/12 provides the delivery framework for the 'Healthier Barnet' theme of the Sustainable Community Strategy. It also contributes to 'a successful city suburb' by ensuring that Barnet remains a place where people lead long, healthy and fulfilling lives
  - Local authorities and PCTs are required by the Local Government and Public Involvement in Health Act (2007) to undertake a Joint Strategic Needs Assessment (JSNA) . The JSNA sets out the current and future health, care and well-being needs of our population and the strategic direction of service delivery to meet those needs. A Health Profile for Barnet was produced in 2007 as the first step to a full JSNA.
  - Tackling obesity, by increasing levels of physical activity and promoting healthier eating, and to reduce smoking rates, in order to tackle the fatal diseases of cancer, heart disease and stroke.
  - Ensuring that the Barnet, Enfield and Haringey Clinical Strategy, takes account of and meets the needs of Barnet's growing population by providing care closer to patients homes in suitable clinical environments.
  - Ensuring the effective delivery of primary and secondary health care services through a series of scrutiny reviews.
  - The Planning and Health Engagement Agreement approved in December 2008 between the council as the local planning authority and the PCT provides the opportunity to create a formal partnership arrangement to strengthen the integration of local health and planning strategies (the LDF) and processes.
- 3.4 More detailed information on the joint projects between the council, PCT and voluntary sector are set out in the Health and Well-being Commissioning Framework, which was approved in October 2008.

### 4.0 Policy Framework

- 4.1 Barnet's *Unitary Development Plan*, adopted in May 2006, establishes the link between new housing development and the increased pressures on the existing health and social care infrastructure. The UDP makes specific reference to the requirement for contributions to fund facilities needed because of the likely demand arising from the development (see **Appendix A**). In 2007, the council adopted an overarching SPD on *Planning Obligations*, which further elaborates upon this policy.
- 4.2 The statutory basis for contributions from development towards the provision of community facilities is set out in Section 106 of the Town and Country Planning Act 1990 (as substituted by the Planning and Compensation Act 1991), and Circular 05/2005 – *Planning Obligations*. The circular explicitly identifies the potential for contributions to support new "community

infrastructure”, highlights the need to look at the impacts from development cumulatively and the potential for the pooling of contributions, and states that local authorities should lay out in their development plan documents (DPDs) and supplementary planning documents (SPDs) their generic and detailed policies.

- 4.3 The Mayor of London’s *London Plan 2008 (Consolidated with Alterations since 2004)* states that accessible and affordable community facilities are key to enabling the community to function. It highlights that local assessments of need will help to identify gaps in the provision of social infrastructure, which the development process can then seek to address. Relevant policies are highlighted in Appendix A.
- 4.4 Legislation permits health infrastructure to be secured as part of a development proposal where unacceptable burdens are imposed on existing services.
- 4.5 In November royal assent was given to the Planning Act 2008 which is expected to come into force in April 2009. The Act introduces the Community Infrastructure Levy (CIL) which will be used to increase investment in infrastructure to mitigate the impact of development and make growing communities sustainable. Local planning authorities, in preparing their LDFs will set out the broad quantum, type and location of development in their area. This will inform estimates of how much CIL is to be collected (the charging schedule), the phasing of development, funding sources and responsibility for delivery. Work on preparing the infrastructure requirements framework for the borough is underway as part of the emerging LDF Core Strategy. It is envisaged that the LDF Core Strategy and the CIL charging schedule will be examined by an independent planning inspector in 2010

## **5.0 Role of Barnet Primary Care Trust**

- 5.1 PCTs are responsible for the commissioning, planning and securing of health services for their local populations. The PCT must ensure there is sufficient primary care capacity to provide for the population it serves and that its health services are accessible to all patients.
- 5.2 Barnet PCT is the appointed responsible authority required to commission health services for the local population of Barnet. Everybody who is a permanent resident of the UK is entitled to the services of a NHS GP.
- 5.3 The Primary Care Trust commissions health services for residents in Barnet. This is set out in its five year commissioning plan - *Better Health in Barnet – A Strategy for Better Health for the People of Barnet (July 2007)*. The PCT has the following 5 ambitions
- Maintaining the core standards of dignity, respect, privacy, cleanliness, evidence-based practice, and accessibility
  - Improving health and offering long-term preventative support
  - Providing more services closer to people’s homes
  - Providing specialist care from recognised centres of excellence
  - Supporting patients to live independently in their homes and manage their own healthcare needs
- 5.4 Primary care is the provision of basic health care at the point where a person first makes contact with the health service outside of hospital. It is also the place where an ongoing relationship is developed with health care providers for the co-ordination and delivery of health care; in particular long term conditions, palliative care and routine regular screening. Primary care provides the common link between the patient, community care, secondary (hospital) care, mental health care and the local authority. General Practitioners (GPs) are seen as the “gatekeepers” of the NHS, ensuring people are seen by the most appropriate health care provider. A range of services that have traditionally been provided in hospitals

such as diagnostics and day surgery are provided at a primary care level by GPs, nurses, health visitors, therapists, pharmacists, dentists and optometrists.

- 5.5 The NHS Plan<sup>1</sup> identified the development of primary care as “key to the modernisation of the NHS”. Within this same document and elaborated further in the NHS Improvement Plan<sup>2</sup> were the priority areas for primary care development. These included access to primary care services; the delivery of services from high quality buildings, such as primary care centres.

#### **Existing Primary Care Delivery in Barnet**

- 5.6 The existing model of primary care delivery in Barnet is still, in the main, one of individual practices providing routine care and some urgent GP care to a defined population. GP services in Barnet are delivered from 77 premises which incorporate branch surgeries and practices co-located in shared buildings. Patients should enjoy the same levels of access to GP services wherever they live and Barnet is considered to have good provision of independent primary care contractors across the borough. More specifically there are:

- 74 GP contracts with 270 GPs in total. This includes 182 principals and 88 salaried and registrar GPs
- 78 Dental contracts
- 73 Opticians
- 79 Pharmacies

- 5.7 The quality of primary care facilities in Barnet varies from purpose built, modern premises to the ground floor of a semi-detached house. A significant proportion of primary care is delivered from small, converted residential properties. The PCT acknowledges that the quality of care in small practices can be equally as good as that provided in larger practices; a lack of space and facilities prevents these practices from expanding the range and complexity of services provided. It also prevents them from increasing their capacity to absorb the predicted population increases arising from future housing growth. The vast majority of these premises cannot be brought up to the required standards.

#### **Modern Primary Care Delivery in Barnet**

- 5.8 The White Paper Our Health, Our Care, Our Say, a new direction for community services 2006<sup>3</sup> set a clear direction for the development of primary and community services outside acute hospital settings and closer to patient’s homes. The Barnet Enfield and Haringey Clinical Strategy - Your Health Your Future: Safer Closer Better, 2007<sup>4</sup> sets out the local vision for change in the way healthcare is delivered to patients in Barnet. The Clinical Strategy states that;

- People should be helped to remain healthy and independent, have real choices and greater access in both health and social care
- Services should be integrated, built around the needs of individuals, promoting independence and choice.

- 5.9 The Health White Paper highlights that most people are best cared for by community services. In Barnet this requires a planned change to current infrastructure as part of a reallocation of services across hospital and community care. This requires investment in local healthcare premises to increase capacity and improve access for new and existing populations.

<sup>1</sup> The NHS Plan: A plan for investment. A plan for reform. DH, July 2000

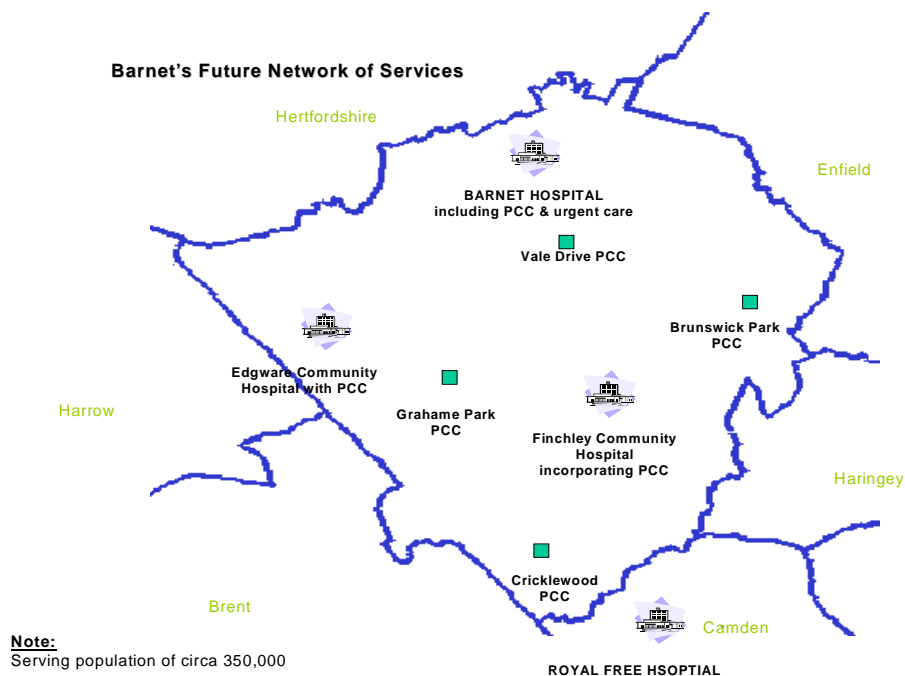
<sup>2</sup> The NHS Improvement Plan: Putting People at the Heart of Public Services. DH, June 2004

<sup>3</sup> Our Health, Our Care, Our Say; a new direction for community services, Department of Health, 2006

<sup>4</sup> Your Health, You future, Safer Closer Better, Barnet Enfield and Haringey PCTs, 2007

- 5.10 Locally, the Barnet, Enfield and Haringey clinical strategy, is consulting on options for change to the configuration of acute care services in North London. Options will lead to a significant movement of out patient and urgent care services to primary care. Alongside the increase in activity described above, there is an expected population increase of approximately 44,000 by 2017, much of which is linked to regeneration work in the borough.
- 5.11 Long term conditions currently account for 80% of GP consultations<sup>5</sup>. Professor Ari Darzi in Healthcare for London – A Framework for Action, 2007, which sets out a health strategy for London over the next 10 years, identified that significant percentages of people have undiagnosed, long term conditions such as diabetes and Chronic Obstructive Pulmonary Disease (COPD) and that the prevalence of such conditions will increase significantly in the future.
- 5.12 Investment in new primary care services will be targeted to the areas of greatest need. Primary care will use public health predictions on population trends and growth to identify areas of greatest needs both in terms of population size and health need.
- 5.13 The PCTs long term plans are to deliver primary care services based on a hub and spoke model that consists of Primary Care Centres (PCCs) serving a population of approximately 30,000 to 50,000. To qualify as a spoke, a practice or a group of practices will need to be located in premises that are at least as good as purpose built premises and / or serve a population of approximately 9,000 residents. Figure 1 identifies Barnet's future network of health services and reflects the long term plans of the PCT in identifying where new Primary Care Centres are expected to be located.

Figure 1 – Modern Primary Care Delivery in Barnet



<sup>5</sup> Chronic disease management: A compendium of information, Department of Health, May 2004

## Pharmacists and Primary Care Centres

- 5.14 The movement of GPs to PCCs will have an effect on pharmacy contractors as much of their business is dependent on prescriptions generated by GP practices located nearby. The PCT expects to utilise pharmacist expertise to deliver local, non-complex, routine and urgent care, thus creating capacity in general practice for more complex work and meeting population needs for access to local advice and services.

There are two potential models for pharmacy care relating to PCCs that the PCT will utilise.

- Co-location of a pharmacy in the PCC: This model may be utilised in areas where a new population is expected and pharmacy infrastructure is not already in place. This would include regeneration programmes such as that planned in Cricklewood.
- Dispensing service only within the PCC: This model may be utilised in PCCs where there is already good high street pharmacy provision in close proximity.

- 5.15 The PCT will work with local contractors and their representatives to explore models of pharmacy provision that ensure sufficient and robust local availability of pharmacy services is maintained as the service model above is implemented.

## 6.0 The level of contributions required

- 6.1 The PCT is required to commission primary health care and acute services for the population of Barnet. While acute services are generally commissioned from mainstream acute or community hospitals, the first point of patient contact with primary care is their GP practices. The national average recommended GP patient list size is 1800. It is the role of the PCT to ensure that there are appropriate facilities for patients enabling access and choice. Where the development of new housing is likely to increase the demand for these services, the council will seek, through the use of its planning powers, to require applicants to provide financial contributions (or otherwise help) to secure sufficient service provision to meet identified needs.
- 6.2 Contributions will be required where there is a net increase in units. Table 1 sets out the expected contributions for capital per unit by bedroom size from small developments of below 10 units<sup>6</sup>. Schemes of 10 units or more will be expected to make a contribution to health on the basis of the HUDU Planning Contributions Model.

**Table 1 – Capital Contributions to Health per Residential Unit for Minor Developments**

Number of Bedrooms				
	1 Bed	2 Bed	3 Bed	4+ Bed
<b><i>Expected Capital Contribution to Health</i></b>	<b>£802</b>	<b>£1184</b>	<b>£1682</b>	<b>£2016</b>

- 6.3 Contributions towards health care provision will normally be expected from all qualifying residential development proposals whether new build, change of use, conversions or extensions. There will be no minimum threshold at which Section 106 financial contributions

<sup>6</sup> The UDP Policy on Affordable Housing sets a unit threshold of 10 units. Schemes of 10 units or more will be required to make a contribution to the provision of affordable housing. The HUDU Model includes defaults on contributions to affordable housing.

for health will be incurred, i.e. for every development proposal; any increase in the net number of residential housing units will normally require a planning contribution.<sup>7</sup>

- 6.4 Contributions will be expected from all types of new residential accommodation. Specialist housing e.g. residential care homes and extra care accommodation will require an independent appraisal in order to establish a suitable contribution.

### **The HUDU Planning Contributions Model**

- 6.5 The NHS London Healthy Urban Development Unit (known as “HUDU”) was established in February 2004 to help the NHS engage and be proactive in relation to the health and planning strategy agenda for London. The principal role of HUDU is to support all of the 31 NHS Primary Health Care Trusts across London. HUDU was established as a result of research which found that early engagement in the planning process was required to enable the NHS to respond positively and proactively to the opportunities provided by growth in housing and employment in London.

- 6.6 Further guidance about the use of the HUDU Model is set out at Appendix B. Details of the HUDU methodology used in this SPD for calculating contributions for Barnet are available at [www.healthyurbandevelopment.nhs.uk](http://www.healthyurbandevelopment.nhs.uk)

On the basis of the numbers of proposed housing units expected to be built for each individual scheme and the population they will generate the Model calculates the :

- Amount of hospital beds or floor space required for the population generated by the development in terms of acute non-elective, intermediate care, mental health and primary care.
- The capital cost of providing the required health care space.
- The revenue costs of running the necessary services before mainstream NHS funding is available to serve the population.

- 6.7 The HUDU Planning Contributions Model was initially published as a Microsoft Excel model in 2005. In 2007 the web based model was introduced. The improved model relies on essential data on the delivery of development including the tenure, type and number of bedrooms. The Model contains a number of assumptions about population including household profiles and inward migration, health care and other variables such as the impact of inflation on build costs. In using the HUDU Model a choice can be made between the defaults and those assumptions which require more local knowledge.

- 6.8 The contributions expected from developers in Barnet will normally only cover the capital costs of development. In exceptional circumstances on the basis of robust evidence from the PCT and in order to deliver new services from new premises associated with development the council may require contributions to revenue costs in the absence of mainstream funding.

### **Major Developments and Affordable Housing Schemes**

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<sup>7</sup> Therefore, in the case of an application for the demolition of an existing residential unit and its replacement with a newly-built property, financial contributions will be required if there is any increase in the net number of units on the site – only if there is a one-for-one replacement of the number of units will no contribution be required. Where new units of mixed sizes are created, the net number of units will be calculated by excluding the largest first, e.g. if two units are demolished to be replaced with five one-bedroom and five two-bedroom units, the net number will be calculated as being five one-bedroom and three two-bedrooms units.

- 6.10 The council recognises the need to ensure that Section 106 financial contributions are directly related in scale and kind to proposed development and are reasonable in other respects. The council will therefore consider the specific circumstances of large development schemes and assess the complex factors that must be taken into account in putting together a package of Section 106 financial contributions. Barnet may accept variations in health care planning contributions where the proposed development is required to make significant financial contributions to, or investment in, other public infrastructure provision, affordable housing and/or other requirements which meet the council's wider planning and regeneration objectives. However, this does not mean that developers of large schemes should assume there will be any reduction in the per unit level of health care contributions.
- 6.11 In the case of large development schemes Section 106 health care contributions will be the subject of pre-application discussions, and negotiations during the planning application process, between the developer and the council. The negotiated route to determining Section 106 financial contributions will usually apply to large housing development proposals only, for example, those for which the developer is required to submit an environmental statement. Developers are strongly encouraged to approach the council at an early stage in the development process.
- 6.12 The HUDU model takes affordable housing into account as a key variable. In those cases where residential proposals for 100% affordable housing (as defined by PPS 3) come forward the council will assess the need to make contributions on a scheme by scheme basis.
- 6.13 The reason for levying Section 106 contributions for health care is that new development brings additional people into an area, i.e. creates a direct impact on services. However, in the case of social rented and other affordable housing, the council usually has 'nomination rights' to any such housing built in Barnet. This means that the tenants who will eventually occupy such affordable housing have moved within Barnet, and will already access healthcare in the borough through local GPs or dentists.
- 6.14 The recommended, standard practice in London's housing sector is that 75 per cent of nominations to family-size housing be given to the 'home' local authority in the location where the affordable housing is actually built (as outlined in the London Boroughs Association<sup>8</sup> publication *Partners in Meeting Housing Need*). All registered social landlords building new affordable homes in Barnet, for example, are required to sign-up to this standard as a minimum requirement. An operating assumption has therefore been made that 75 per cent of residents in affordable housing units will already be attending health and social care facilities in the borough. The council will review this approach if new policies and practices are introduced regarding nomination rights to affordable housing across London's housing sector.

## **7.0 Extension of the HUDU Planning Contributions Model to incorporate Social Care**

- 7.1 Health services and social care services are closely aligned, often supporting each other in providing care to the same individual. New population arriving in an area as a result of major housing developments coupled with an aging population can have a significant effect on local social care services. The potential impact of rising populations on social care is substantial and meeting their needs will result in services being stretched or effectively

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<sup>8</sup> The London Boroughs Association merged with the Association of London Authorities in 1995 to form the Association of London Government which in 2006 changed its name to London Councils.

reduced to both the existing and new populations. Mitigating these effects is a legitimate use of S106 contributions.

- 7.2 The costs of providing services are often shared between PCTs and local authorities. Early intervention through social care may avoid the need for more expensive and invasive health service interventions.
- 7.3 The extension to the HUDU Model is being led by EDAW following the publication in 2007 of their Social Care Scoping Report. Barnet Adult Social Services will form part of a working group to assess the extended model assumptions on the spatial requirements of social care facilities as well as appraise, advise and test the Model and its outputs. HUDU do not expect the social care element to be added to the Model until mid 2009. Upon the successful launch and operation of the extended Model the council will seek contributions to social care facilities in common with those for health facilities for every net addition to the housing stock in Barnet.

## **8.0 The use of planning contributions - Ensuring local control**

- 8.1 It is imperative that Barnet residents benefit from contributions secured through this SPD. In order to ensure that local control is retained over the use of S106 funding the council will have overall jurisdiction on how the S106 is allocated and that this allocation will be based on an understanding of the additional needs generated by individual developments specifically and the overall population growth more generally. Clear evidence will be required from Barnet PCT on how S106 monies will be allocated and spent to support any bids for S106 funding.
- 8.2 Section 106 contributions will be suitably expended by the council on capital investment for providing additional health care capacity in the borough. The contribution will cover the capital costs of development. In exceptional circumstances on the basis of robust evidence from the PCT and in order to deliver new services from new premises associated with development the council may require contributions to revenue costs in the absence of mainstream funding.
- 8.3 Planning contributions for health care might also be used as part of projects targeting the provision of multi-purpose facilities associated with health care use; or in areas where the cumulative impact of development will create additional demand for health care provision, contributions might be 'pooled' to meet needs.
- 8.4 Pooled contributions will be used to fund infrastructure in Barnet as identified by the PCT. With the exception of areas of major regeneration, it is unlikely that any one development will warrant a whole health facility. S106 pooled contributions will be used to fund the necessary infrastructure to support the healthcare needs of the increased local population, ensuring comprehensive cover of the borough.

## **9.0 Practical arrangements related to Section 106 contributions**

### **Timing of provision of financial contributions**

- 9.1 When developers enter into Section 106 contracts with the council, it will ensure that appropriate triggers are in place in the legal agreements to ensure that new health and social care provision is in place upon occupation of new housing units. Payments will therefore usually be required on the commencement of construction. On large development

schemes, the council might agree to monitoring and phasing arrangements to ensure the timely provision of health and social care facilities. All planning contributions will be subject to index linking.

- 9.2 If a developer is required to construct a new health or social care facility or transfer land for a health or social care facility to the PCT or council, it will be obliged to make such transfers at no charge to the PCT or council and free from financial ties. The land should have planning permission for health care use, must be fully serviced, and have access provided to the boundary (to a standard specified by the council).
- 9.3 It should be noted that in the furtherance of its duty to provide suitable access to health and social care, the council, in those circumstances where financial contributions do not meet the full cost of health and care demands, reserves the right to insert planning conditions to ensure that the occupation of the development is conditional on necessary health and social care provision being in place.

### **Project management and monitoring**

- 9.4 All Section 106 agreements will be logged and monitored and managed from the date of agreement until the full realisation of the funds owed.
- 9.5 Developers should also note that there will be an additional contribution that will be required for this project management aspect of planning contributions administration (as described in the council's adopted SPD on *Planning Obligations*).

## Appendix A – Legal and policy framework

### Key elements of Circular 05/2005 relevant to health care provision

The circular greatly strengthens local authorities' opportunities to argue for the provision of additional community facilities related to new developments. Paragraph B15 states:

If a proposed development would give rise to the need for additional or expanded community infrastructure, which is necessary in planning terms and not provided for in an application, it might be acceptable for contributions to be sought towards this additional provision through a planning obligation.

Where justified, payment for the maintenance costs of providing services are now acceptable as part of Section 106 funding. Paragraph B20 states:

...where contributions to the initial support ("pump priming") of new facilities are necessary, these should reflect the time lag between the provision of the new facility and its inclusion in public sector funding streams...Pump priming maintenance payments should be time limited and not be required in perpetuity by planning obligations.

Pooled contributions and the cumulative effect of a number of schemes can be taken into account. It is not just one-off, big developments that can have an effect on health and social care delivery – a number of smaller schemes, when taken together, can have a significant impact upon the delivery of various elements of health and social care services for all . Paragraph B22 states that:

...in some cases, individual developments will have some impact although insufficient to justify the need for a discrete piece of infrastructure. In these instances, local planning authorities may wish to consider whether it is appropriate to seek contributions to specific future provision...In these cases, spare capacity in existing infrastructure provision should not be credited to earlier developers.

### Barnet Council's *Unitary Development Plan - 2006*

#### **Policy IMP1 – Priorities for Planning Obligations**

The council's key priorities for planning obligations will be for the provision of:

- Residential Development:
  - » Improvements to public transport infrastructure, systems and services.
  - » Educational provision in areas with existing shortages of school places or where the development will create such a shortage.
  - » Affordable or special needs housing to meet identified local needs.
  - » Where appropriate; highway improvements (including benefits for pedestrians and cyclists), environmental improvements; the provision of open space; and other community facilities.

#### **Policy IMP2 – Use of Planning Obligations**

In order to secure the best use of land, the council will seek to ensure through the use of conditions or planning obligations attached to planning permissions, that new development provides for the infrastructure, facilities, amenities and other planning benefits which are necessary to support and serve it, and which are necessary to offset any consequential planning loss which may result from the development.

Policy CS13 expressly requires developers to meet the extra health and social care arising from

new development.

**Policy CS13 – Health and Social Care Facilities – Planning Obligations**

Where a proposed residential development creates a need for additional health and social care facilities, the council will seek to enter into planning obligations with developers to secure contributions to their provision.

The commentary to this policy explains:

New housing development may increase the population in a particular locality, and as a result could place increased pressure on health and social care facilities in an area. When new housing developments are proposed, the council, in partnership with the local health authorities and other relevant organisations, will assess the likely demand arising from such schemes, and whether existing health and social care facilities are adequate. Where a need for additional health and social care facilities can be demonstrated as a result of new housing development, the council will seek to enter into a Section 106 agreement with developers to secure contributions to help fund the facilities required.

**The Mayor’s London Plan (Consolidated with Alterations since 2004) 2008**

**Policy 3A.21 Locations for health care**

Policies in DPDs should support the provision of additional healthcare within the borough as identified by the strategic health authorities and primary care trusts. The preferred locations for hospitals, primary healthcare centres, GP practices and dentists should be identified in appropriate locations accessible by public transport and with particular reference to policies 3A.20, 3A.7 and 3D.1

The commentary to this policy explains:

Demographic trends, as well as policy shifts, determine the scale of healthcare need in particular locations, and adequate healthcare facilities may often be needed as part of large scale commercial and housing developments. The needs of older Londoners particularly, in respect of residential and nursing home provision, also need to be considered.

At the same time, there are existing geographical differences in access to primary care and the average list size of GPs across London. Planning can contribute towards addressing such disparities by ensuring the provision of primary care facilities as part of new residential and commercial developments (including through Section 106 agreements), encouraging additional provision in areas identified to be in need of additional primary care facilities and recognising locations such as town centres as appropriate areas for healthcare facilities.

## Appendix B - NHS London Healthy Urban Development Unit’s online standard planning contribution model for London.

This Model calculates the potential planning contributions for developers of residential developments, in respect of the provision of health care facilities and the associated health services.

This Model is intended to ensure that representatives from health organisations are equipped to engage in an informed dialogue with developers over the potential impact of proposed residential developments on local health demand and health provision. It offers a standardised and fully transparent approach, whilst at the same time allowing for the inclusion of some local assumptions to reflect potential differences across PCTs in their plans for delivering health care to their local communities. HUDU consider the model is fully compliant with Circular 05/05.

The Model relies on a number of assumptions about population, health care and other variables. These are built into the model as a series of defaults which allow it to calculate health care requirements with a minimum of data. It is very important that in using the model Primary Care Trusts or others satisfy themselves that the assumptions are valid for their situation. If so it is also important to share the assumptions with the local authority and the developer in each case. If the user does not wish to accept the assumptions and hence the defaults, the model is fully flexible to allow different assumptions to be entered. These too should be shared with the local authority and developer. The Guidance Notes show clearly where these decisions need to be taken.

In seeking financial contributions based on the outputs of the model PCTs must also be in a position to demonstrate the extent to which existing healthcare services and facilities can or cannot cope with the increased demand arising from the development proposal in question and how it intends to apply any contributions sought. (The HUDU Toolkit gives more guidance on the circumstances in which planning obligations are justified. See HUDU web site).

To run the default version of the Model the user requires a level of ‘Essential data’. If the decision is taken to alter the assumptions and hence the defaults then further information is required. This is set out below.

<p><b>Essential Data</b></p>	<ul style="list-style-type: none"> <li>• Planning application title (often the address of the application site), and the application reference number (as set by the Local Authority)</li> <li>• Location of application (by PCT and Local Authority)</li> <li>• Likely date of onsite build commencement.</li> <li>• The tenure (market or affordable), type (houses or flats) and number of bedrooms.</li> </ul> <p>See pages 17 of HUDU Model Guidance Notes for details of Essential data.</p>
<p><b>Optional data</b> (Model contains default data)</p>	<p>The model contains default assumptions for all inputs except those listed above. The assumptions can however be manually input.</p> <p>See pages 18-19 of HUDU Model Guidance Notes for details of optional data requirements.</p>

Access to the HUDU Model Website is available for use by members of the 31 London Primary Care Trusts, and any additional organisations specifically authorised by the website administrator.