Strategic Growth, Section 106/CIL and Primary Care Estate Planning

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The Local Plan Process

- Call for Sites
- Suitability assessed and shared with infrastructure providers
- Infrastructure needs assessed and understood by all (most appropriate funding mechanism identified)
- Master-planning for growth
- Consultation on draft Local Plan
- Changes made as needed / submitted for Examination
- Examination in Public
- Formally Adopted Local Plan

S106

- A Legal Agreement between Local Authorities and Landowners/Developers detailing obligations required as a result of a planning application. A charge against land.
- S106 Planning obligations must meet requirements laid down in the Community Infrastructure Regulations. (Regulation 122).
- To be CIL Compliant the request must be:
  - Necessary to make the development acceptable in planning terms
  - Directly related to the development
  - Fairly and reasonably related in scale and kind to the development

Community Infrastructure Levy (CIL)

- A tax on net new floor space set locally and paid to the Determining Authority (District/Borough Council).
- Schemes need to go through a formal examination process
- LPA can top slice 5% towards costs of administering the scheme
- 15-25% of CIL collected will be made available to the appropraite neighbourhood. (Town or Parish council)
- Remainder available through bidding process.
- Not compulsory for LPAs to adopt CIL
- Currently only Stratford District and Warwick District have adopted CIL.

S106

Pros

- Income identified for something specific.
- Income collected by the LPA or WCC as appropriate.
- Some degree of certainty about income receipt.
- Protected by indexation.
- Can now seek admin / monitoring contribution.

Cons

- CIL compliance test
- Flexibility
- Viability Challenges
- Not always supported by LPAs
- Time taken to negotiate and then to secure funds in line with agreement triggers
- Income does not cover the actual costs now faced due to time lag and rapid cost increases/interest rates

CIL

Pros

- Not restricted by development proximity
- Possible additional funding
- Tax – has to be paid
- CIL paid early in Development.

Cons

- No control for WCC or ICB
- No certainty of receipt
- Bidding process
- Difficult to plan
- Viability could see S106 being reduced or removed

Infrastructure Levy

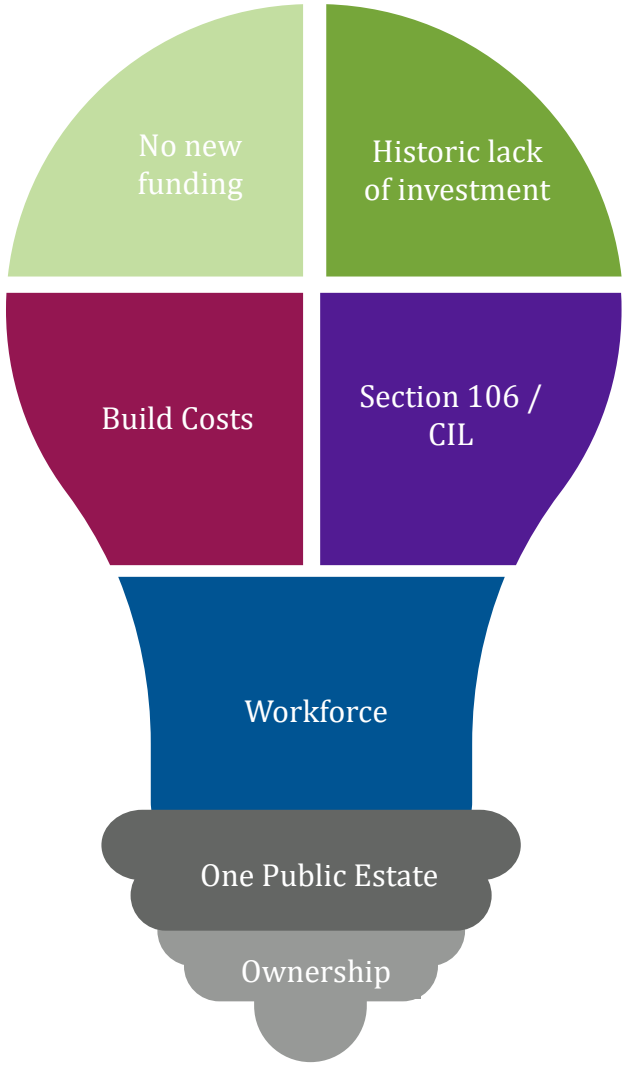
- Proposal to introduce a new mandatory Infrastructure Levy, set locally (similar to CIL) - would be based on the assessed uplift value of the land as a result of development
- CIL would go in all areas except London.
- Move away from S106.
- Payable to the determining Authority – District or Borough Council. Risk for primary care is that the authority does not pass on.
- LPA can borrow against future IL receipt.
- Needn't be used for infrastructure – could be used to support service delivery.
- Strong challenge at consultation ……..

Primary Care Estate Context

NHS Coventry and Warwickshire

- 3 legacy CCGs took different approaches to supporting PC Estate.
- General Practice are hugely frustrated and there is a need for a coproduced approach with the ICB.
- This needs to follow a systematic process and have a clear methodology for prioritisation.
- Need to be aware of limited funding position and impact of increased build costs and interest rates.
- Need to recognise significant strategic growth sites across the ICS e.g. Gaydon Lighthorne.
- Stakeholders and system leaders need to be sighted on the issues, implications and service delivery impact, if we do not progress solutions.

Primary Care Estate Environment



No new funding

No additional allocations to support rent for new builds/extensions. Additional funding must be found from within existing budgets.

Historic lack of Investment

Decades of under investment means we have significant estate that requires updating, improving or extending, this cost alone is prohibitive.

Section 106/Community Infrastructure Levy

S106/CIL allocations do not cover the funding needed to build a new surgery. Developers may support, but through land or a building with a market rent charge, leaving a capital or revenue shortfall.

Build Costs

Cost of new builds has risen significantly - £2500m2 to £4000m2, interest rate impact is worsening this position. Developer contributions are even less of a proportion of actual cost. DVs are not taking additional costs into consideration; rent values do not cover loan repayments.

Workforce

ARRs roles have increased staff numbers not originally included in estate planning. Space is at a premium and holding us back from further ARRS or wider workforce uptake. Training numbers, both medical and clinical, are being hampered by lack of space to support (funding routes e.g. SIFT and MADEL are no longer available).

One Public Estate

The One Public Estate process has not worked as well as envisaged. Other organisations are willing to allow use of space, but often require significant rental, which is prohibitive.

Ownership

The mixed ownership model can be a complication - GP owner occupation can be a challenge where GPs retiring want to sell on their share of the building and replacement partners do not necessarily wish to “buy in”.

Current Picture – understanding of ICB position

NHS Coventry and Warwickshire

- Baseline position
- GBP PCN profiles
- Existing estate portfolio (location, services, providers, condition and statutory compliance, legal, clinical capacity, etc).
- Existing wider health estates portfolio, service distribution and identification of interdependencies and opportunities.
- Impact analysis of digital strategy and emerging technology on the future service delivery models and its effect on the existing portfolio.

Current Picture – understanding of ICB position

NHS Coventry and Warwickshire

- Current registered population is 1,072,607, which is forecast to rise to 1,290,721 by 2032, an increase of 22%.
- The estate consists of 153 practice sites, set across 120 practices (GMS and APMS contracts) and 19 PCNs.
- 48% of estate is GP owned, 14% owned by developers and 20% by the public sector. 18% is not currently confirmed.
- There are approximately 1,400 patient facing rooms available in the estate, approximately 1,300 of these are clinical. This is below the expected capacity required by 2032.

Growth Areas and Priorities for further work

- Upper Lighthorne (Stratford)
  - Approx 3,000 new homes
  - Land and / or money
  - Link with a new Village Centre
- Southwest Rugby (Rugby)
  - Approx 5,000 new homes
  - New provision
  - Link to SPD and Framework S106
- Houlton (Rugby)
  - Approx 6,000 new homes
  - Land
  - Link to SPD and S106
- Polesworth / Dordon (North Warwickshire)
  - Approx 3,500 new homes
  - New provision
  - Inform masterplan
- Weddington (Nuneaton and Bedworth)
  - Approx 4,000 new homes
  - New provision Churchfield
- Southeast Nuneaton (Nuneaton and Bedworth)
  - Approx 3,500 new homes
  - Improvement works off site
- Atherstone (North Warwickshire)
  - Approx 2,500 new homes
  - Improvement works off site
- Long Marston Airfield (Stratford)
  - Approx 3,500 new homes
  - Delays on full planning submission
  - Road infrastructure
- Stratford Town Centre (Stratford)
  - Approx 1,000 new homes
  - Limited S106 availability
- Warwick/Leamington (Warwick)
  - Approx 5,000 new homes
  - Numerous developers and S106 agreements
  - Needs consolidation and understanding re triggers – expansion/new
- Kenilworth (Warwick)
  - Approx 2,000 new homes
  - Consolidation of agreements - expansion/new
- Kingshill (Warwick)
  - Approx 2,500-4,000 new homes
  - Uncertainty regarding how development plans come forward
  - Cross boundary considerations with Coventry

Opportunities

- Review existing S106 agreements.
- Explore CIL funding.
- Review of existing Local Plans.
- South Warwickshire Local Plan.
- One Public Estate Principles.
- Look to work more collaboratively.