

# Exploring Developer Contributions for NHS Infrastructure

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## Task and Finish Group

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## Executive Summary

This report sets out the findings of a task and finish group set up by the Systems Leadership Team of the 'Our Dorset' integrated health care system. The role of the group was to review the evidence and explore ways in which new development can contribute towards the additional pressure new homes place upon health care infrastructure.

The current method used by the Dorset Clinical Commissioning Group and Health Care Trusts is to make a request for contributions from a planning application. These are targeted at larger developments and omits to capture contributions from all development.

The HUDU model is a bespoke piece of software that was designed for use by the NHS in calculating contributions and is mainly used in London. However, the model can be programmed to use local Dorset costs and assumptions and local housing or population forecasts. The model generates a cost per dwelling or per person.

The model can calculate the cost for an individual development or a group of several developments. At a strategic scale it can apportion costs per home based on the Council's housing trajectory of forecast delivery or on the basis of population growth forecasts.

Using the model for individual developments is onerous due to the time involved in finding out the specific information for each planning application and inputting this into the model. The simplest and recommended approach of the Group is to use the housing trajectory approach. This only requires the parties to update the model once on annual basis with the latest forecasts of delivery and cost assumptions. This is far less onerous, and the output is a standard cost per home. Splitting Dorset into two areas corresponds with the hospital trust areas.

Based upon the Council's housing trajectories at April 2019, the cost per dwelling towards health care would be:

- £516 per home in the East Dorset area; and
- £722 per home in the West Dorset area.

With more homes are projected to be built in the East Dorset area, the projected contributions for 2020/21 are £1.6M for East Dorset and £1.11M in the West Dorset area. The table apportions the contributions to health care sectors. The proportions vary due to differing population characteristics and types of development in each area. Note that 2020/21 coincides with the Covid-19 pandemic which may see less homes built than forecast.

	East Dorset		West Dorset	
Forecast no of homes built	3,102		1,536	
Rate per home	£516		£722	
Total projected contributions	£1,600,632		£1,108,992	
Primary Care share	21%	£336,133	16%	£177,439
Acute Care share	57%	£912,360	62%	£687,575
Community/ Mental health share	22%	£352,139	22%	£243,978

The estimated total contributions would be £7.76m for East Dorset and £6.93m for West Dorset:

	2020/21	2021/22	2022/23	2023/24	2024/25	Total
East Dorset	£1,600,632	£1,756,464	£1,543,872	£1,490,724	£1,370,496	£7,762,188
West Dorset	£1,108,992	£1,329,202	£1,072,892	£1,222,346	£2,200,656	£6,934,088

The Group recommends that each year the Council's contribution is reported to the Systems Leadership Team and the ICS is invited to request the requisite amount of contributions for the development completed in the previous years. The contributions will mainly be collected through community infrastructure levy. The exception is the North Dorset part of Dorset Council where the community infrastructure levy isn't in place and Section 106 planning obligations will be collected instead.

The Councils will annually publish the contributions collected and how it was spent in the new Infrastructure Funding Statement. Dorset Clinical Commissioning Group and Health Care Trusts are also required to report their income and expenditure.

# Contents

<b>Executive Summary</b> .....	2
<b>1. Introduction</b> .....	5
The role of the task and finish group .....	5
<b>2. The Integrated Health Care Partnership</b> .....	6
<b>3. Legislative and Policy Background</b> .....	8
Development Plans.....	9
<b>4. Evidence</b> .....	10
NHS Infrastructure needs and its funding.....	10
Need for developer contributions .....	11
<b>5. Finding a robust methodology</b> .....	13
HUDU and NHS funding model in Dorset.....	13
Inputting housing assumptions into the model.....	14
Local data inputted into the HUDU model .....	16
<b>6. Options for calculating a developer contribution</b> .....	18
Testing the HUDU model approaches.....	18
Results of the Testing .....	20
Benchmarking.....	21
<b>7. Paying for the Mitigation Strategy</b> .....	22
<b>8. Monitoring and Implementation</b> .....	23
<b>9. Summary &amp; Recommendations</b> .....	24
<b>Appendix 1 – Primary Care - Known Infrastructure Projects</b> .....	25
<b>Appendix 2 – Acute Care Capital Plan Submission 29 May 2020 – East Dorset area</b> .....	26
<b>Appendix 3 – Acute Care Capital Plan Submission 29 May 2020 – West Dorset area</b> .....	27
<b>Appendix 4 Community and Mental Health Capital Plan Submission 29 May 2020 – East and West Dorset areas</b> .....	28
<b>Appendix 5 – Primary Care calculator</b> .....	29
<b>Appendix 6 – Acute care calculator</b> .....	30

# 1. Introduction

## The role of the task and finish group

- 1.1 In 2019 the Systems Leadership Team set up a task and finish group ('the Group') to explore the potential for new housing development to contribute towards health care infrastructure. The Group comprises representatives from:
  - Planning Policy, Dorset Council;
  - Planning Policy, Bournemouth Christchurch & Poole Council (BCP Council);
  - Dorset Clinical Commissioning Group (DCCG);
  - Public Health Dorset;
  - Dorset County Hospital NHS Foundation Trust;
  - The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust
  - Dorset HealthCare University NHS Foundation Trust
  - NHS England and Improvement
- 1.2 The Group was set the task of reviewing the evidence to ascertain whether developers could be asked to contribute towards health care infrastructure in order to mitigate the pressure of population growth.
- 1.3 Historically, the strategic planning of healthcare through the planning system has been inconsistent. Working with Dorset Clinical Commissioning Group, Dorset and BCP Councils have been able to secure some mitigation from proposed development towards primary care (doctor's surgeries). But there's increasing demand on a solution that deals with the needs of healthcare comprehensively.
- 1.4 The Group is therefore exploring a possible comprehensive contributions policy for the purposes of easily and robustly calculating the cost of mitigating the impact of future development on all forms of health care in Dorset, and the recovery of that cost through developer contribution tools including Community Infrastructure Levy and S106.
- 1.5 This report provides the recommendations of the Group to the Systems Leadership Team that will decide how to progress these recommendations into actions.

## 2. The Integrated Health Care Partnership

- 2.1 The [NHS Long Term Plan](#) (2019) sets out a 10 year plan for reform to create Integrated Health Care where the NHS and Councils work closer together to promote health and wellbeing, and break down barriers between health and social care. This would include the 'triple integration' of primary and specialist care, physical and mental health services, and health with social care. There are currently 14 Integrated Health Care that have formed across England, including Dorset.
- 2.2 ['Our Dorset'](#) is a partnership of the NHS, Public Health Dorset, Bournemouth Christchurch and Poole Council (BCP Council) and Dorset Council working together to deliver Integrated Care Systems. It is an important steppingstone towards a better integrated, continuously evolving health and care system for Dorset, putting us in the best position to jointly plan and prioritise our resources, meaning better experiences and outcomes for everyone.
- 2.3 The ambition of Our Dorset is for everyone to have the best possible health and care outcomes with everyone living healthier, longer and fulfilling lives. The vision is for everyone to have access to high quality, joined-up health and care services, available when and where they are needed. In short, it is about working together for people to have healthier, fulfilling lives supported by sustainable health and care services.
- 2.4 The partnership will work closely together to tackle all of the factors affecting health and wellbeing, including employment, housing and transport and ensure we invest our collective resources wisely for now and the future.
- 2.5 The emerging ['Our Dorset Looking Forward 2019-2024'](#) plan sets out an aspiration for communities to be active, social and engaged with the natural environment. Planning policy plays a key role in shaping the built and natural environments to help meet these aspirations by shaping communities that support physical activity (e.g. active travel), provide safe and affordable housing, enable social interaction and support mental wellbeing (e.g. provision of high quality, accessible greenspaces).

### The Dorset Vision

- 2.6 Rising demand on NHS services means that significant changes are needed to ensure the NHS can afford to provide high-quality safe care both now and in the future.
- 2.7 The outcome of the [Clinical Services Review](#) will transform hospital services for the people of Dorset. Poole Hospital will become the major planned care hospital for east Dorset and Royal Bournemouth Hospital the major emergency care hospital. The plans include securing £147 million of government funding to invest in both hospitals, and alongside this, the trusts are also planning to merge to become the University Hospitals Dorset NHS Foundation Trust.
- 2.8 Under the plans, Dorset County Hospital will continue to be an emergency and planned hospital for its communities. Planned investment will expand the Emergency Department and Intensive Care Unit as well as establish an Integrated Care Hub as part of a long-term project to deliver the recommendations of Dorset's Clinical Services Review. The programme of works identified in the Clinical Services Review is expected to be completed by 2026/2027.

### Partnership working

- 2.9 Our Dorset is a partnership of health and social care organisations working together to deliver Integrated Care Systems. The ambition of Our Dorset is for everyone to have the best possible health and care outcomes. Living healthier, longer and fulfilling lives. Our vision is for everyone to have access to high quality, joined-up health and care services, available when and where they are needed. In short, we are working together for people to have healthier, fulfilling lives supported by sustainable health and care services.
- 2.10 There are 3 NHS Foundation Hospital Trusts in Dorset:

- Dorset County Hospital NHS Foundation Trust
  - The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust/Poole Hospital NHS Trust merging to become University Hospitals Dorset NHS Foundation Trust (from 1 October 2020)
  - Dorset Healthcare NHS Foundation Trust
- 2.11 Poole Hospital is an acute general hospital based on the south coast of England and employs around 3,700 staff. The hospital has a 24-hour major accident and emergency department and is the designated trauma unit for east Dorset, serving a population of around 500,000 people. In addition, the hospital's flagship Dorset Cancer Centre provides medical and clinical oncology services for the whole of Dorset, serving a total population of over 750,000.
- 2.12 The Royal Bournemouth and Christchurch Hospital NHS Trust provides health care for the residents of Bournemouth, Christchurch, East Dorset and part of the New Forest with a total population of around 550,000, which rises during the summer months. Some specialist services cover a wider catchment area, including Poole, Purbeck and South Wiltshire.
- 2.13 Dorset County Hospital NHS Foundation Trust is a busy, modern hospital providing a full range of district general services, including an accident and emergency department, and links with satellite units in five community hospitals.
- 2.14 Dorset County Hospital is the main provider of acute hospital services to a population of around 250,000, living within Weymouth and Portland, West Dorset, North Dorset and Purbeck. they also provide renal services for patients throughout Dorset and South Somerset; a total population of 850,000. Some 3,000 staff work in GP surgeries, schools, residential homes and people's own homes as well as Dorset County Hospital and the community hospitals. Dorset County Hospital has approximately 400 beds, seven main theatres and two day theatres.
- 2.15 Dorset HealthCare is responsible for all mental health services and many physical health services in Dorset, delivering both hospital and community-based care. Dorset HealthCare is the biggest provider of healthcare in Dorset, and services continually evolve and develop to meet the needs of the local community. Dorset HealthCare serve a population of over 750,000 people and employ around 5,000 staff, covering a wide range of expertise and specialisms. Staff provide healthcare at over 300 sites, ranging from village halls and GP surgeries to mental health inpatient hospitals and community hospitals - as well as in people's homes. Dorset HealthCare's services include:
- Dorset's 12 community hospitals and minor injuries units
  - Adult and children's community health services (physical and mental)
  - Specialist learning disability services
  - Community brain injury services
- 2.16 Community health services encompass: district nurses, health visitors, school nursing, end of life care, sexual health promotion, safeguarding children, diabetes education, audiology, speech and language therapy, dermatology, podiatry, orthopaedic services, wheelchair services, anti-coagulation services, pulmonary rehab, early discharge stroke services, Parkinsons care, community oncology and breastfeeding support services.
- 2.17 Dorset Council and BCP Council are partners in the Integrated Care System. The councils have a key role in delivering services and support for adults and children. Working in partnership through the Integrated Care System (ICS) not only helps to deliver a range of services to local residents, but also helps embed health and wellbeing into strategic and local plans.

### 3. Legislative and Policy Background

- 3.1 **Clinical Commissioning Groups** (CCGs) were created following the Health and Social Care Act in 2012, and replaced Primary Care Trusts on 1 April 2013. They are clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area. As of 1 April 2019 there are 191 CCGs in England.
- 3.2 The National Health Service (General Medical Services Contracts) Regulations 2004 provides the legal requirements of general practice to provide care for their registered patient population.

#### Community Infrastructure Levy (CIL) and planning obligations (s106)

- 3.3 Planning obligations under Section 106 (S106) of the Town and Country Planning Act 1990 allows local authorities to enter into a legal agreement with a developer to secure financial or 'in kind' contributions to mitigate the impact of a development proposal. Developers may also contribute towards infrastructure by way of the Community Infrastructure Levy (CIL) which is a fixed charge levied on new developments to fund infrastructure and is intended to address the cumulative impact of developments in an area.
- 3.4 The Community Infrastructure Levy (Amendment) (England) (No. 2) Regulations 2019 came into force on 1 September 2019. The amended regulations make changes to how CIL is charged, collected and reported and seeks to clarify the relationship between CIL and S106 contributions. The Government have updated the national Planning Practice Guidance on Community Infrastructure Levy and Planning Obligations to reflect the amended regulations.
- 3.5 The guidance clearly distinguishes between the purpose of S106 obligations to mitigate site-specific impacts and CIL which can be used to address the cumulative impact of infrastructure in an area. Planning authorities can now use CIL and S106 obligations to contribute towards the same piece of infrastructure, subject to three planning tests (in [Regulation 122](#)) to ensure that S106 contributions are necessary, reasonable and directly related to the development.

#### *“Limitation on use of planning obligations*

- 122. (1) *This regulation applies where a relevant determination is made which results in planning permission being granted for development.*
- (2) *A planning obligation may only constitute a reason for granting planning permission for the development if the obligation is*
  - (a) *necessary to make the development acceptable in planning terms;*
  - (b) *directly related to the development; and*
  - (c) *fairly and reasonably related in scale and kind to the development.”*

- 3.6 Local planning authorities are also required to produce an infrastructure funding statement (under Regulation 121A) which identifies the infrastructure required to support development in an area and how it will be funded, using CIL, or S106 obligations, or a combination of both. It will also report on how CIL and S106 receipts have been spent. The first statement should be published by 31 December 2020 and will cover the financial year 2019/2020.

#### National Planning Policy Framework

- 3.7 The National Planning Policy Framework (NPPF) sets out the Government's planning policies for England and how these should be applied. It prepares a framework within which locally-prepared plans for housing and other development can be produced. Planning Practice Guidance (PPG) adds further context to the NPPF and it is intended that the two are read together. The Planning Practice Guidance brings together planning guidance on various topics into one place.
- 3.8 At the heart of the planning system is sustainable development. At a very high level, the objective of sustainable development can be summarised as meeting the needs of the present without



compromising the ability of future generations to meet their own needs. Achieving sustainable development means that the planning system has three overarching objectives, economic, social and environmental.

- 3.9 The social objective is to support strong, vibrant and healthy communities, by ensuring that a sufficient number and range of homes can be provided to meet the needs of present and future generations; and by fostering a well-designed and safe built environment, with accessible services and open spaces that reflect current and future needs and support communities' health, social and cultural well-being.
- 3.10 NHS bodies (including Healthy Urban Development Unit Planning Contributions Model) responded to recent changes to the NPPF – supporting changes to planning policies at the national level seeking a structured and equitable level of support for NHS organisations. The Government are currently working on preparing national guidance on developer contributions for health being drafted by NHS England and Improvement for the Department of Health and Social Care. The proposed approach in Dorset is consistent with the emerging guidance.

### Development Plans

- 3.11 The local authorities in Dorset have adopted Local Plans which contain policies that address health care:
- *Bournemouth Core Strategy (2012)*
  - *Christchurch and East Dorset Local Plan Part 1 (2014)*
  - *The Poole Local Plan (2018) - Policy PP32 Part (1)*
  - *The North Dorset Local Plan Part 1 (2016)*
  - *The Purbeck Local Plan Part 1 (2012) and Swanage Local Plan (2017) - A new Purbeck Local Plan is currently at examination and will replace the 2012 Plan*
  - *The West Dorset, Weymouth & Portland Local Plan (2015)*
- 3.12 Local plans across Dorset have been developed with the NPPF and the principle of sustainable development at their core. Following local government reorganisation in April 2019, the two new Councils have commenced preparation of the BCP Council Local Plan and the Dorset Council Local Plan. These two new local plans will replace the plans listed above when adopted. The process should be complete by 2022/23.
- 3.13 The local plans will be accompanied sustainability appraisals which identify and evaluate the impact of the plan and its policies on those three objectives. Health and equalities impact assessments may form part of these appraisals to closely evaluate health receptors.
- 3.14 In addition to the local plans, there may be relevant policies in neighbourhood plans.

## 4. Evidence

- 4.1 As new housing is developed in Dorset and Bournemouth Christchurch Poole (BCP) Council areas, and the population grows, so the demand on health services increases. Along with other publicly funded services, improvements to health infrastructure are needed to ensure services are sustainable.
- 4.2 The NHS requires physical infrastructure to meet health care needs in three elements of the NHS:
- Primary care– doctors surgeries
  - Secondary (Acute) care – acute hospitals
  - Community services, mental health services and children, young people and families services – within the community based in community hospitals and hubs
- 4.3 A list of known infrastructure projects is set out in Appendices 1-4. These are discussed below:

### NHS Infrastructure needs and its funding

- 4.4 NHS England is responsible for determining allocations of financial resources to CCGs. The allocations process uses a statistical formula to determine geographic distribution.

#### Primary care

- 4.5 General practices are responsible for their individual surgery buildings and must meet all the national health and safety and clinical standards set out either by national legislation or by the Care Quality Commission. Health Building Notes<sup>1</sup> () and Health Building Memorandas give best practice guidance on the design and planning of new healthcare buildings and on the adaptation or extension of existing facilities.
- 4.6 Principles of best practice for the design of primary medical care facilities can be found in Health Building Note 11-01: Facilities for primary and community care services and Health Building note 11-01 Supplement A. Resilience and emergency planning in primary and community care<sup>2</sup>.
- 4.7 A list of known projects is set out in Appendix 1. The projects involve new doctors surgery provision and total an estimated £42.5M.

#### Secondary (Acute) care

- 4.8 All acute NHS trusts in Dorset are funded through what is referred to as a Collaborative Agreement (a 'block contract' for the provision of services and detailed cost improvement plans) with Dorset CCG. This is calculated by submission of annual activity data by the local trusts, which is then used to forecast predicted activity in the coming 12 month period. This methodology is used for the majority of specialities across all 3 trusts (although specialist services are commissioned directly from NHS England).

#### Community care

- 4.9 Community buildings range from community hospitals that are subject to the complexities of the aforementioned Healthcare Technical Memorandums as they contain operating theatres and other similar treatment facilities, to office spaces with associated facilities for delivering community services. Clinics are held in locations around the County in designated rooms fitted out for a range of services from mental health sessions to chiropody. It is widely accepted that there is significant backlog maintenance in many of the Trust owned properties due to historic lack of availability of capital for investment. The funding for the services provided by the Trust follows the same model as suggested below in the Acute Care section via the CCG.

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<sup>1</sup> <https://www.gov.uk/government/collections/health-building-notes-core-elements>

<sup>2</sup> <https://www.gov.uk/government/publications/guidance-for-facilities-for-providing-primary-and-community-care-services/>

## Capital Plan - East Dorset acute hospital services

- 4.10 The two acute hospital trusts in East Dorset are the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust (RBCH) and Poole Hospital NHS Foundation Trust (PHT). Between them, the trusts provide acute hospital care to residents of East Dorset and beyond, to the local workforce, students, tourists and other visitors.
- 4.11 The two trusts are due to merge in 2021, and in collaboration with Bournemouth University, the new merged trust will have University Hospital status. In anticipation of merger, the trusts are already working collaboratively on the planning and delivery of a joint Capital Plan for the six year period from 2020/21 to 2025/26 (and on further capital investment plans for the period thereafter). This will be delivered within the framework of the Dorset Integrated Care System (ICS).
- 4.12 The strategic context for the Capital Plan is formed by the Clinical Service Review (CSR) completed by Dorset Clinical Commissioning Group (CCG) in 2017. The CSR considered the future provision of NHS services in Dorset recognising the population growth and associated demographic impacts.
- 4.13 Under CSR, acute hospital services in East Dorset are to be reconfigured to create an emergency hospital at Royal Bournemouth Hospital (RBH) and a planned care hospital at Poole Hospital Trust (PHT). In accordance with this plan, significant new build developments are required to create a new Women's Children's and Emergency Centre at RBH and a new Theatres facility at PHT. A range of further new build and refurbishment projects are also to be delivered in support of the strategy. In addition, investment will be made in IT infrastructure and medical equipment.
- 4.14 A new end-of-life care facility will be developed at Christchurch Hospital in collaboration with Macmillan Caring Locally. Meanwhile, ongoing investment will also be made in support of business-as-usual at all three hospitals through ongoing refurbishment and backlog maintenance.
- 4.15 The East Dorset Acute Hospitals planned capital developments are included within Appendix 2. This plan demonstrates a required capital investment of £526.2 million over the period 2020-28. Externally secured national capital funding into the Dorset Integrated Care System subject to any final approval process has been identified in Figure 1. These external capital funds described as Public Dividend Capital (PDC) exactly aligns to the Five Year NHS Capital Plan submission submitted on 29 May 2020.

## Capital Plan - West Dorset acute hospital services

- 4.16 Dorset County Hospital are hoping to expand the Emergency Department (ED) and Intensive Care Unit (ICU) as well as establish an Integrated Care Hub as part of a long-term project to deliver the recommendations of Dorset's Clinical Services Review.
- 4.17 The West Dorset Acute Hospitals planned capital developments are included within Appendix 3. This plan demonstrates a required capital investment of £85 million over the period 2020-28. Externally secured national capital funding into the Dorset Integrated Care System subject to any final approval process has been identified in Figure 1. These external capital funds described as Public Dividend Capital (PDC) exactly aligns to the Five Year NHS Capital Plan submission submitted on 29 May 2020.

## Dorset Healthcare Capital Plan

- 4.18 The Dorset Healthcare Capital plan is included in Appendix 4 and shows a capital investment requirement of £241.5M for the next 5 to 8 years. The plan is made up of Capital development schemes that contribute to the fulfilment of the Dorset Clinical Services Review as well as the Trust's Strategic Mental Health growth agenda. It also includes backlog maintenance requirements as well as capital replacements. As per the Acute Care Trusts above funding is provided via Public Dividend Capital, however it shall be insufficient to cover the overall capital requirements of the trust.

## Need for developer contributions

4.19 As set out above known capital costs are:

- Primary care £42.5m
- Acute care £611.2m (£526.2m for East and £85m for West Dorset)
- Community & mental health £241.5m

4.20 The Five Year NHS Capital Plan submission submitted on 29 May 2020 is set out in Figure 1.

*Figure 1: Dorset Five Year NHS Capital Plan submission 29 May 2020*

Funding source	Amount secured
One Dorset Reconfiguration Wave 1	£147,265,000
HIP 2 Seed Funding (Dorset ICS)	£3,700,000
LIMS - Pathology IT System (Dorset ICS)	£958,000
Blandford Primary and Community Hub Wave 4	£4,186,000
Mental Health Estates Development Wave 4	£5,932,000
Cyber Security	£14,000
Provider Digitisation	£2,957,000
<b>Total</b>	<b>£165,012,000</b>

4.21 As set out above the infrastructure needs to meet population growth in Dorset cannot be met from government funding alone. This currently leaves a significant funding gap. In this circumstance it is appropriate to seek funding from development to mitigate its impact upon the health care service, as there currently is a significant shortfall in funding this critical infrastructure. Other funding will be necessary as development will only fund a small proportion of this gap.

## 5. Finding a robust methodology

- 5.1 The previous section provided a justification that there is a funding gap between funding and the infrastructure needs to meet the requirements of a growing population. This section looks at methods of securing funding for health care from development.
- 5.2 The CCG and the Hospital Trusts currently request contributions from larger development on a site by site basis:
- (i) Primary care calculator – this approach establishes the cost of general practice space (doctor’s surgeries) as a result of new development. It is used on the floorspace needs of doctors surgeries local to the proposed housing development.
  - (ii) Acute care calculator – this approach the cost of the number of hospital visits generated by each new home in the first year of occupation. The developer contribution covers the gap funding of staffing cost in hospitals in that first year, as the Trusts costs are paid in arrears. the first 12 months.

Appendices 5 and 6 provides a full explanation of these approaches and worked examples.

- 5.3 These approaches have been used with varying degrees of success. Neither approach has the functionality to deal holistically with the needs of healthcare, something which this guidance seeks to overcome. The CCG approach requires a calculation for every development proposal and is sought on proposals over 40 dwellings only, see Appendix 5. Examples where this calculator has secured a financial contribution include Bank & Ridge Farms, Chickerell, and Littlemoor, Weymouth.
- 5.4 Government is preparing guidance to help local authorities determine a methodology. As this is yet to be published the Group has explored other options, principally the use of the Healthy Urban Development Unit Planning Contributions Model (the HUDU Model).

### HUDU and NHS funding model in Dorset

- 5.5 The Healthy Urban Development Unit Planning Contributions Model (HUDU)<sup>3</sup> has been developed to assist NHS organisations and local authorities in addressing the impact of new residential developments and population growth on healthcare services and infrastructure and help secure developer contributions. This model has been created by the NHS London Healthy Urban Development Unit.
- 5.6 The HUDU model was first created in 2005 and then updated and placed on a website in 2009. A third version of the model was introduced in 2016 and added new functionality and analysis options, notably the ability to analyse the impact of a group of developments (in addition to just a single development), and/or the impact of a housing trajectory or population projection profile over a set period. It also enabled data to be more easily and regularly updated.
- 5.7 The model is updated annually with the latest data, and functionality has been added to provide a new approach to assess primary healthcare impacts.
- 5.8 The HUDU model provides a standardised and transparent approach to help calculate potential developer contributions. The approach has been refined and used successfully by all London Boroughs and its application has withstood challenge.
- 5.9 The use of the HUDU model locally is encouraged and supported by Public Health Dorset. It can also assist both planners and NHS partners to provide evidence to support future healthcare provision and to make the case for the allocation and release of development contributions where new capacity is needed to mitigate the impacts of population growth resulting from new development.

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<sup>3</sup> <https://www.healthyurbandevlopment.nhs.uk/our-services/delivering-healthy-urban-development/hudu-model/> with user guidance notes

## Inputting housing assumptions into the model

5.10 The model has 4 analysis options:

- Population projections
- Housing trajectory
- Single development
- Grouped development

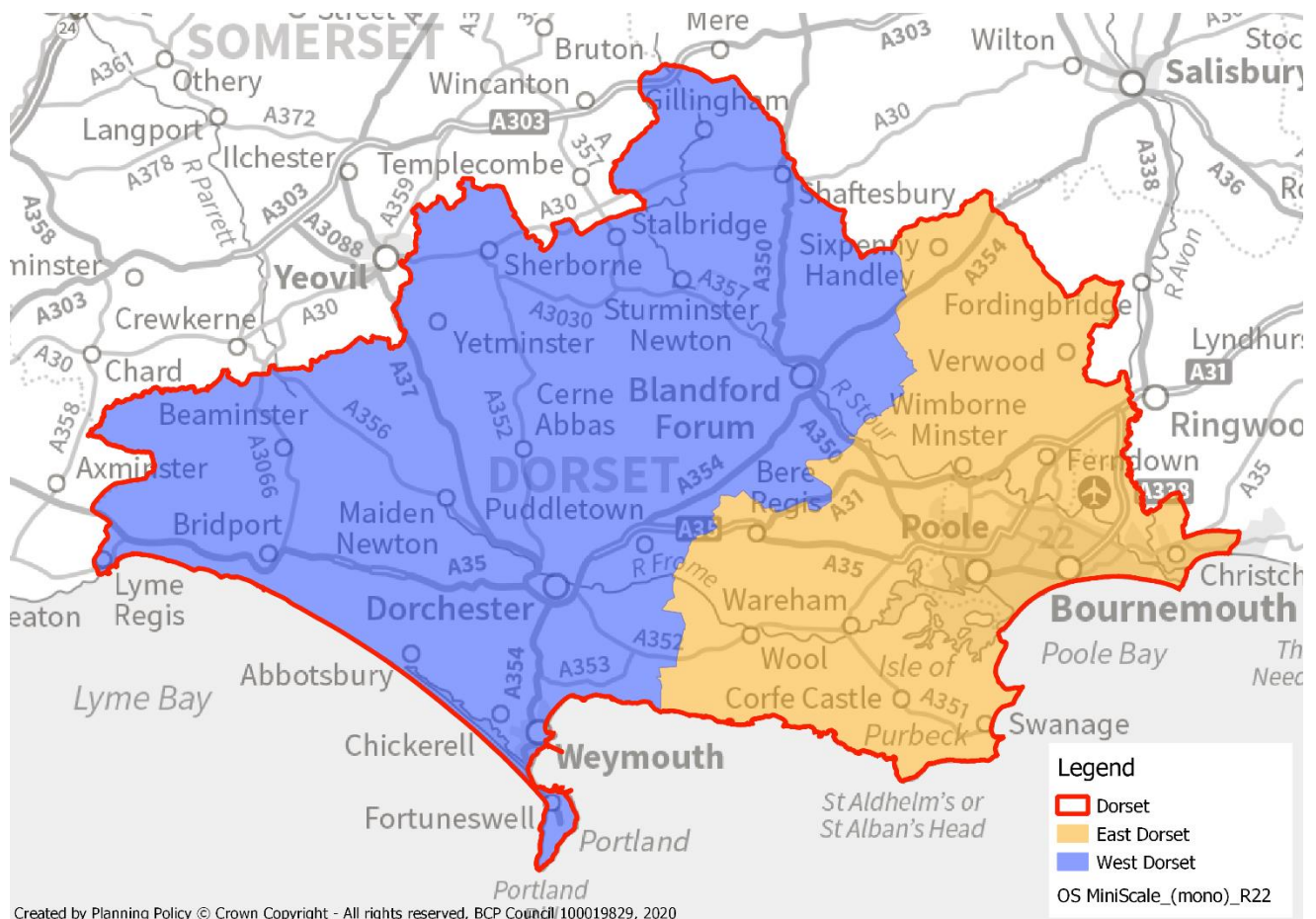
5.11 Using the housing trajectory and population projection analysis options, the model can be used as a forward planning tool to estimate future healthcare requirements and costs to support the preparation and review of borough infrastructure delivery plans. The model can also help NHS organisations plan for future healthcare provision and make the case for the allocation and release of developer funding where new capacity is needed to mitigate the impacts of population growth resulting from new developments.

5.12 The single and grouped development analysis option enables users to assess the impact of one or more developments based on a shared set of data assumptions. The user is only required to enter the new housing profile and build rates for each individual development. However, the shared default assumptions can be manually changed, and different baseline years can be selected for each individual development. The model generates a summary report for each individual development and a summary report for the group of developments.

5.13 The model uses a range of assumptions based on the most up to date information available. Although used primarily in London the model includes functionality to work outside of London by inputting locally derived data. Users can manually adjust or input new data or assumptions.

5.14 The geography of has been broadly split between East and West Dorset to accord with the hospital trusts as shown in Figure 2. The boundaries align roughly with the split of the BH and DT postcode areas.

Figure 2: The split of East and West Dorset



5.15 These roughly relate to the local plan areas as shown in Figure 3:

Figure 3: Geography of hospital trusts corresponding with local plans

Area	Hospital Trust	Local Plan
East Dorset	Royal Bournemouth & Christchurch	Bournemouth
		Christchurch and East Dorset
	Poole	Poole
		Purbeck
West Dorset	Dorchester	West Dorset and Weymouth
		North Dorset

### Standard assumptions in the HUDU model

5.16 Any reductions in average lengths of stay associated with Acute and Mental healthcare due to efficiency savings and proportion forecast to be re-provided in the intermediate care setting.

Proportion of A&M Length of Stay reduction:

- Efficiency savings 50%
- Re-provided as intermediate care beds 25%
- Re-provided as intermediate care day places 25%

5.17 Projected GP/ Nurse consultations uses the national (England) contact rates per age band per year are as follows:

- Ages 0-4 5.86 contacts per year
- Ages 5-14 2.16 contacts per year
- Ages 15-44 3.81 contacts per year
- Ages 45-64 5.21 contacts per year
- Ages 65-74 7.98 contacts per year
- Ages 75-84 11.12 contacts per year
- Ages 85+ 13.19 contacts per year

5.18 For instance, a child aged 6 is estimated to need a primary care appointment just over twice a year.

5.19 GP activity and premises usage assumptions are based on national default values:

- 15 minutes appointment duration
- 60 opening hours per week
- 60% Clinical room availability
- 20% use of clinical rooms for wider primary and community care use

5.20 Standard revenue costs are applied using the 2019/20 Clinical Commissioning Group Allocations per Head per Age Band as follows:

- Ages 0-4 £722
- Ages 5-14 £453
- Ages 15-44 £978
- Ages 45-64 £1,443
- Ages 65-74 £2,809
- Ages 75-84 £4,415
- Ages 85+ £7,051

5.21 Facilities for primary and community care are based on new standalone buildings. The model factors in annual build cost inflation which applies over the project timeline. The following standard costs are included:

- Professional fees at 15%
- Equipment costs (varies by healthcare type)
- A contingency of 7.5%

## Local data inputted into the HUDU model

5.22 The HUDU model enables the user to input local data. Where local data isn't available the model uses national data sets. The following local data was used for health care assumptions.

### Existing Admission Levels

5.23 A local input is the latest records of Acute and Mental Healthcare patient admissions which will then be compared against the population at 2018 to generate a Health Activity Rate, as shown in Figure 4.

Figure 4: Existing Admission Levels (patient numbers) by East or West Dorset area.

Age	Elective In-Patient		Non-Elective In-Patient		Day Case		Mental Health	
	East	West	East	West	East	West	East	West
0-4	65	45	5,006	2,564	210	215	0	0
5-14	107	92	2,459	1,303	619	448	9	0
15-44	1,343	778	16,596	7,536	10,055	4,673	644	351
45-64	2,871	1,901	11,491	6,180	17,712	10,893	299	158
65-74	2,307	1,899	7,940	5,145	12,821	9,898	105	63
75-84	1,789	1,525	10,084	6,579	10,772	8,468	84	59
85+	578	449	9,716	6,341	4,158	3,314	37	27
<b>Total</b>	<b>9,060</b>	<b>6,689</b>	<b>63,292</b>	<b>35,648</b>	<b>56,347</b>	<b>37,909</b>	<b>1,178</b>	<b>658</b>

Data source: Monthly acute SUS ([Secondary Uses Service](#)) data, national NHS England dataset which is standard methodology and format for all provider of NHS funded care.

### Existing Average Length of Stay and Average Occupancy Rates

5.24 A local input is the latest records of average lengths of stay and the latest records of occupancy associated with each type of admission. The same data is used for both East and West Dorset areas as shown in Figure 5.

Figure 5: Existing Average Length of Stay and Average Occupancy Rates

Occupancy	Elective In-Patient	Non Elective In-Patient	Mental Health
Existing Average Length of Stay	2.7	3.8	69.8
Existing Average Occupancy Rates	87%	87%	89.8%

Data source: Average length of stay is at patient level, data taken from SUS as highlighted above using the total length of stay (days from admissions to discharge) for each patient.

5.25 Standard default assumptions are applied to the local rates. The annual change in average lengths of stay per admission is -2.8% for elective in-patients, -3.1% for no-elective in-patients and -1.5% for mental health. There is no forecast change to occupancy rates. This is based on bed availability & occupancy – provider [KH03 quarterly](#) submissions, overnight bed usual submitted by all providers

### Floorspace Requirements and Build Costs for each Healthcare Facility

5.26 A local input is the floorspace requirements and capital cost of building associated with each type of healthcare facility space or bed. The same standard is used for both East Dorset and West Dorset areas as shown in Figure 6.



Figure 6: Floorspace Requirements and Build Costs for each Healthcare Facility

Type of health care facility	Floorspace requirement sq.m per bed/place	Build Cost £ sqm
Acute Beds (elective/ non elective/ day)	24 sq.m	4,604
Mental Health Beds	24 sq.m	4,586
Intermediate Care Beds	24 sq.m	3,853
Intermediate Care Places	24 sq.m	3,853
GP and Primary Care Service	16 sq.m	3,898

Data source: Health Building Notes (<https://www.gov.uk/government/collections/health-building-notes-core-elements>)

5.27 Once all of the information is inputted, the output of the HUDU model are calculations of:

- The net increase in population resulting from new development
- Health activity levels
- Primary healthcare needs (GP surgeries)
- Community health facilities (mental health & physical health community based facilities)
- Acute healthcare needs (hospital beds and floor space requirements)
- Other healthcare floor space
- Capital and revenue cost impacts

## 6. Options for calculating a developer contribution

- 6.1 To obtain the possible developer contributions the HUDU model was tested for the three scenarios:
- Population projections
  - Housing trajectory
  - Single development
- 6.2 Each of these scenarios is discussed below, and the outputs are summarised at the end of this section. Where there is specific local information this was used to populate the model. The health care assumptions are set out in the previous section. Local data inputs for housing growth are included below.
- 6.3 There is a fourth option of grouped developments, i.e. two or three developments in one area. This option was not tested as the other 3 options provide sufficient information. This option would only be needed for a specific area, e.g. a neighbourhood plan area.

### Testing the HUDU model approaches

#### Population projections

- 6.4 This approach generates a contribution per dwelling using the 2018 ONS mid year estimates and population projections. This data has been refined to the East and West Dorset areas. Both areas indicate the main increase will be in the over 65s as people are forecast to live longer. This older age group has higher health care requirements. Despite a fall in the 0-64 population, the increase in over 65s is far higher and leads to an increase in population, as shown in Figure 7.

*Figure 7: Population projections from 2018-2038 for the East and West Dorset areas*

Age Group	2018 existing population East Dorset	2018 existing population West Dorset	2038 forecast population change East Dorset	2038 Forecast population change West Dorset
0-4	26,575	10,567	-2,967	-1,114
5-14	57,129	25,484	-8,295	-3,798
15-44	182,934	68,613	-4,909	-4,167
45-64	137,904	70,001	-4,583	-5,237
65-74	64,966	36,414	+13,080	+9,094
75-84	40,967	21,398	+15,694	+12,114
85+	19,845	9,471	+10,218	+8,093
<b>Total:</b>	<b>530,320</b>	<b>241,948</b>	<b>+18,238</b>	<b>+14,985</b>

- 6.5 This approach is based on likely number of people, which provides accuracy in terms of pressures on health care. However, this approach does not take into account planned housing growth, which the other options do. It is also unlikely that government will accept the 2018 population projections as the basis for setting housing targets.

#### Housing Trajectory

- 6.6 Each year the Councils prepare a housing trajectory forecasting planned housing growth. The trajectory forecast at April 2019 is set out in Figures 8 and 9. These housing trajectories were used to populate the HUDU model and are based upon forecasted housing delivery through existing local plans in the East and West Dorset areas.

Figure 8: Housing trajectory by local plan area for East Dorset area (net)

Local Plan area	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28
East Dorset & Christchurch	961	989	868	746	708	702	732	602	541
Purbeck	160	180	185	225	275	230	230	230	180
Bournemouth	988	988	988	988	988	559	559	559	559
Poole	794	945	1363	1033	918	1165	1164	1124	1074
<b>TOTAL</b>	<b>2903</b>	<b>3102</b>	<b>3404</b>	<b>2992</b>	<b>2889</b>	<b>2656</b>	<b>2685</b>	<b>2515</b>	<b>2354</b>

Source- Council SHLAA/AMRs

Figure 9: Housing trajectory by local plan area for West Dorset area (net)

Local Plan area	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28
West Dorset and Weymouth	837	1253	1189	1115	1232	2097	1013	1006	831
North Dorset	182	283	652	371	461	951	664	450	371
<b>TOTAL</b>	<b>1019</b>	<b>1536</b>	<b>1841</b>	<b>1486</b>	<b>1693</b>	<b>3048</b>	<b>1677</b>	<b>1456</b>	<b>1202</b>

Source- Council SHLAA/AMRs

6.7 The trajectory approach uses the housing mix of past completions to determine population. Data for the 5 year period 2014/15-2018/19 was used for the East Dorset area and for the 2 year period 2016/17-2017/18 for the West Dorset area as set out in Figure 10. The figure shows that there is a higher proportion of flatted development in the East Dorset area as would be expected for an area dominated by the BCP conurbation.

Figure 10: Housing mix for East Dorset and West Dorset areas (gross)

Type	Flats	%	Houses	%
Market housing – East Dorset				
1 bed	2633	30.78%	103	1.20%
2 bed	1770	20.69%	726	8.49%
3 bed	278	3.25%	1149	13.43%
4 bed	242	2.83%	1022	11.95%
Affordable housing - East Dorset				
1 bed	108	1.26%	25	0.29%
2 bed	163	1.91%	161	1.88%
3 bed	2	0.02%	154	1.80%
4 bed	0	0.0%	17	0.20%

Type	Flats	%	Houses	%
Market housing – West Dorset				
1 bed	180	12.79%	65	4.62%
2 bed	224	15.92%	185	13.15%
3 bed	52	3.70%	260	18.48%
4 bed	0	0.00%	199	14.14%
Affordable housing - West Dorset				
1 bed	35	2.49%	9	0.64%
2 bed	42	2.99%	82	5.83%
3 bed	0	0.00%	68	4.83%
4 bed	0	0.00%	6	0.43%

Source- Council monitoring of housing completions

6.8 The housing trajectory provides a robust way of planning infrastructure to meet the needs of new growth. It is not yet possible to use the housing targets in the new local plans as the target has yet to be agreed. This approach could therefore be refined alongside the local plan process.

### Single Development

6.9 This approach looks at the specific proposals for an individual development. Three examples were used based on the housing mix put forward by the applicants. All three are within the East Dorset area:

#### East Dorset area

- North of Merley for 600 homes (mostly family houses)
- North of Bearwood for 695 homes (mostly family houses)
- Winter Gardens for 351 homes (all flats)

## West Dorset area

- Bank & Ridge for 292 homes (mostly family houses)
- Land south of Nottingham Lane 215 homes (mostly family houses)
- McCarthy & Stone, Dorchester 45 homes (retirement apartments)

6.10 This approach would be onerous for every development, so is best used for larger schemes.

## Results of the Testing

6.11 The figures above have been inputted into the HUDU model and the three different approaches produced the results shown in Figure 11. The population projection figure works out significantly higher. However as discussed above this approach is not proportionate as it doesn't take into account that a much higher number of homes will be built. Whereas, both the housing trajectory and testing of a number of known single developments provides a more proportionate and consistent approach.

Figure 11: Possible rates for East and West Dorset areas based on the different HUDU approaches

HUDU Approach	Example	East Dorset area	West Dorset area
Population Projection	ONS 2018 mid year estimates and population projections	£3,199 per house £2,181 per flat	£4,157 per house £2,846 per flat
Housing Trajectory	Each Council's housing trajectory with a base date of April 2019	£516 per home	£722 per home
Single Development	North of Merley (600 homes)	£495 per home	n/a
	North of Bearwood (695 homes)	£596 per home	n/a
	Winter Gardens (351 homes)	£319 per home	n/a
	Bank & Ridge (292 homes)	n/a	£722 per home
	Land south of Nottingham Lane (215 homes)	n/a	£609 per home
	McCarthy & Stone, London Road, Dorchester (45 homes)	n/a	£344 per home

6.12 The housing trajectory approach is the simplest to use as it requires one single calculation using the model. Providing calculations for every single development is onerous so is not preferred.

6.13 Therefore the preferred approach is to use the housing trajectory approach. For 2020/21 a tariff of £516 per home for the East Dorset area and £722 per home for the West Dorset area will be used. On this basis, the estimated contributions for 2020/21 would be £1.6m for East Dorset and £1.11m for West Dorset as shown in Figure 12.

6.14 The total contributions are then split out by each of the health care sectors. The percentage share for each sector is based on the output of the HUDU model and differ between East and West Dorset areas. Note that 2020/21 coincides with the Covid-19 pandemic which may see less homes built than forecast.

Figure 12: Estimation of possible contributions for the year 2020/21

	East Dorset		West Dorset	
Forecast no of homes built	3,102		1,536	
Rate per home	£516		£722	
Total projected contributions	£1,600,632		£1,108,992	
Primary Care share	21%	£336,133	16%	£177,439
Acute Care share	57%	£912,360	62%	£687,575
Community/ Mental health share	22%	£352,139	22%	£243,978

6.15 Figure 13 illustrates how contributions can be estimated for the next 5 years. This uses the same rates and housing projections referred to above. The estimated total contributions would be £7.76m for East Dorset area and £6.93m for West Dorset area.

Figure 13: Estimation of possible contributions for the years 2020/21-2024/25

	2020/21	2021/22	2022/23	2023/24	2024/25	Total
East Dorset	£1,600,632	£1,756,464	£1,543,872	£1,490,724	£1,370,496	£7,762,188
West Dorset	£1,108,992	£1,329,202	£1,072,892	£1,222,346	£2,200,656	£6,934,088

## Benchmarking

6.16 Advice was sought and provided by HUDU throughout the process. The HUDU based approach is largely used by London local authorities where the contribution per unit is typically between £1,400 - £1,800 per unit. The cost per unit will vary depending on whether the default or manual values are used.

6.17 Outside of London, Mid and South Essex use a standardised tariff based approach for primary care only which results in approximately £330 per unit. To enable comparison, applying the 21% share for primary care in East Dorset and 15% in West Dorset (Figure 14).

Figure 14: Comparison of Dorset rates with known rates elsewhere

	Elsewhere	East Dorset	West Dorset
Contribution per dwelling	£1400-£1800 in London	£516	£722
Contribution per dwelling for primary health care only	£330 in Mid and South Essex	£108	£108

6.18 This illustrates that the contributions per home are lower in Dorset than the sample authorities in the south east of England, which may be down to lower capital costs. The Council will continue to monitor how other local authorities set rates and how these compare with Dorset.

## 7. Paying for the Mitigation Strategy

- 7.1 This document has been prepared having regard to the tests set out in the Community Infrastructure Regulations 2010 and subsequent amendments, in particular Regulation 122 which sets out the three tests that the planning obligation should be necessary, directly related and fairly and reasonably related in scale and kind to the development.
- 7.2 Planning authorities can now use CIL and Section 106 obligations to contribute towards the same piece of infrastructure, subject to three planning tests (in Regulation 122). The councils can use different mechanisms dependent upon local circumstances with existing policies and procedures.
- 7.3 To provide certainty to those considering or making planning applications for residential development and to ensure transparency and accountability, this document sets a standard contribution of £722 per home to fund NHS healthcare in the West Dorset area and £516 per home in the East Dorset area. Both market and affordable housing development (unless benefitting from relief via CIL) will need to contribute to health care infrastructure.
- 7.4 BCP Council will recover the cost through the Community Infrastructure Levy. Where sites are zero rated from paying CIL, a contribution will be sought through S106 agreement using the standard contribution of £512 per home. Dorset Council will recover most of the cost through CIL (except in North Dorset area where there is no CIL charging schedule in place). In the former North Dorset area, a contribution will be sought on development proposals of 10 or more dwellings through S106 agreement using the standard contribution of £722 per home.
- 7.5 Some health infrastructure will be expected to be delivered directly by developers through on site provision. This may have a bearing on the value of the standard contribution.
- 7.6 The funding equipment and buildings is a major undertaking, the Councils will work the ICS to ensure that the developer funding collected through CIL and planning obligations will be spent in a timely manner ensuring that the developer contributions will go to each of the NHS organisations in Dorset. As public bodies (and not for profit) 100% of the contribution will be spent for the public benefit and accounts are publicly audited.

## 8. Monitoring and Implementation

- 8.1 Each Council will need to determine its spending priorities through Cabinet and Council committee meetings and this document will provide the basis for justifying a portion for health. The Councils may also choose to consult upon this document as a new interim strategy.
- 8.2 The Councils are required to report on the collection and spend of developer contributions through an Infrastructure Funding Statement which will be published in December each year.
- 8.3 These funding statements will also establish the housing completions for the preceding financial year. At the point of publication, the total healthcare cost for dwellings completed in that financial year will be reported to the Senior Leadership Team of the ICS. Following this, the CCG and Hospital Trusts will be invited to formally request the drawdown of CIL money from each Council. Each organisation will have to report its spending as per its own governance.
- 8.4 This report has been developed in the early stages of strategic planning for Dorset and BCP Councils. The group will review the evidence base through the development of local plans, in particular the housing delivery forecasts which are based on emerging housing targets.
- 8.5 Updates from HUDU are expected in time, which will also need to be considered by the group.

## 9. Summary & Recommendations

9.1 The report has tested a number of scenarios of the HUDU Planning Contributions Model.

9.2 On the 24<sup>th</sup> September 2020, the Systems Leadership Team approved the recommendations of this report, specifically:

- The geographical split between East and West Dorset, aligned to the Local Plan;
- The use of a housing trajectory led approach yielding a contribution per home in accordance with the outputs of the HUDU model;
- That the identified costs will be recovered through each Council's Community Infrastructure Levy, except for the area covered by the North Dorset Local Plan where Section 106 contributions will be used on applications of 10 or more dwellings;
- That the contributions paid to the CCG and Hospital Trusts by the end of each calendar year will be based upon the Council's annual monitoring of housing completions for the preceding financial year, commencing with the year 2020/21;
- The proportioning of health contributions between the primary, acute and community sectors in accordance with the outputs of the HUDU model;
- That the costs and assumptions contained in this report are monitored and reviewed as necessary alongside the development of local plans and other emerging strategies, including a regular assurance review in relation to the HUDU model data inputs and associated outputs;
- The CCG and Hospital Trusts cease submission of requests for contributions to planning applications and current 'live' requests are superseded by this new approach.

9.3 The next steps following the Systems Leadership Team approval are for Dorset Council and Bournemouth Christchurch and Poole Council to agree their own governance arrangements of how to take this forward with the aim to implement this strategy and approach in 2020/21.



## Appendix 1 – Primary Care - Known Infrastructure Projects

Infrastructure Project	Type	Cost (£)	Funding Secured	Funding Gap	Delivery Agency	Timescale Delivery
Parkstone Tower Practice: Merging of two GP facilities into one New build on a new site	Additional Surgery Provision	£5M (estimated)				up to 2021
Potential expansion to capacity of GP's at Hamworthy: To provide additional healthcare services to support growth	Additional Surgery Provision	£150,000	£0	£150,000	BCP/ Developers (s106/CIL)	up to 2033
Potential expansion to capacity of GP's at Merley and Bearwood: To provide additional healthcare services to support growth.	Additional Surgery Provision	£2M	£0	£2M	BCP/ Developers (s106/CIL)	Up to 2030
Relocation of Panton Surgery : New build on a new site.	Additional Surgery Provision	£5M (estimated)	£0	£5M		Up to 2022
Blandford : New surgery	Additional Surgery Provision	£5M (estimated)	£4.2M but also needed for Blandford Community Hospital reconfiguration			Up to 2022
Extension to Strouden Park Surgery	Additional Surgery Provision	£100,000	£0	£100,000		Up to 2022
Extension to Adam practice - Longfleet Road	Additional Surgery Provision	£250,000	£0	£250,000		Up to 2022
New Chickerell Surgery	Additional Surgery Provision	£5M (estimated)	£252,000			Up to 2022
Boscombe Town Regeneration	Additional Surgery Provision	£5M (estimated)				Up to 2023
Wareham Gateway/Community Hub	Additional Surgery Provision	£5M (estimated)	£0		Dorset Council	Up to 2025
North Bournemouth – new surgery with two practices working together	Additional Surgery Provision	£5M (estimated)			BCP Council	Up to 2025
Winton Surgery	Additional Surgery Provision	£5M (estimated)			BCP Council	Up to 2023
<b>Total</b>		<b>£42.5M</b>				

## Appendix 2 – Acute Care Capital Plan Submission 29 May 2020 – East Dorset area

Infrastructure Project	Type	Cost (£)	Delivery Agency	Timescale Delivery
St. Mary's Hospital: To share services between Poole and Bournemouth Hospitals			TBC	up to 2033
Women, Children & Emergency Centre New Build Development at RBH	Works	£154.3M	RBCH/PHT	2020-25
Theatres Development at PH	Works	£43.7	RBCH/PHT	2020-26
MacMillan Unit New Build at Christchurch Hospital	Works	£12.6M	RBCH/PHT	2020-23
Pathology Hub New Build on Wessex Fields	Works	£17.2M	RBCH/PHT	2020-22
Pathology Essential Services Lab and Urgent Treatment Centre at PH	Works	£2.4M	RBCH/PHT	2024/25
Linac Refit at Poole	Equipment & Works	£6.3M	RBCH/PHT	2020-22
Ward Refurbishments for CSR at RBH	Works	£32.5M	RBCH/PHT	2021-25
Infrastructure at RBH, including Road and Energy Centre developments	Works	£18.7M	RBCH/PHT	2020-26
Patients and Visitors Concourse at RBH	Works	£13.1M	RBCH/PHT	2020-25
Miscellaneous Decants	Works	£4.9M	RBCH/PHT	2020-25
Multi-Storey Car Park at RBH	Works	£15.6M	RBCH/PHT	2020-22
Estates Backlog	Works	£11.3M	RBCH/PHT	2020-26
IT Infrastructure	IT	£23.0M	RBCH/PHT	2020/26
LIMS (Pathology IT System)	IT	£1.4M	RBCH/PHT	2020-22
Electronic Prescribing and Medicines Administration System (EPMA)	Works	£18.7M	RBCH/PHT	2020-26
Medical Equipment	Equipment	£14.2M	RBCH/PHT	2020-22
Merger - Swipe Cards & Signage	Other	£0.3M	RBCH/PHT	2020/21
Other	Miscellaneous	£2.2M	RBCH/PHT	2020-23
<b>East Dorset Acute Hospitals Sub Total</b>		<b>£375.7M</b>		
Christchurch Hospital Community Hub	HIP2 Bid (1% seed funded)	£10M	RBCH/PHT	2022-24
Royal Bournemouth Hospital Community Hub (incl. wards & infrastructure)	HIP2 Bid (1% seed funded)	£87M	RBCH/PHT	tbc
Poole Hospital Community Hub (incl. wards & theatres)	HIP2 Bid (1% seed funded)	£53.4M	RBCH/PHT	2028
<b>HIP2 SUB TOTAL</b>		<b>£150.5M</b>		
<b>Total</b>		<b>£526.2M</b>		

## Appendix 3 – Acute Care Capital Plan Submission 29 May 2020 – West Dorset area

Infrastructure Project	Type	Cost (£)	Delivery Agency	Timescale Delivery
Emergency Department / Hospital expansion	Works	£62m		
Multi storey Car Park	Works	£12m		
Residential / Health / Community	Works	£7m		
Hospital Support Services		£4m		
<b>Total</b>		<b>£85M</b>		

## Appendix 4 Community and Mental Health Capital Plan Submission 29 May 2020 – East and West Dorset areas

Infrastructure Project	Type	Cost (£M)	Delivery Agency	Timescale Delivery
Eating Disorders Unit at St Ann's	Works	£7.6M	DHUFT	2020-22
Alderney OPMH	Works	£12.2M	DHUFT	2020-23
8 Bed CAMHS PICU-Alumhurst Rd site-acute ward	Works	£15.0M	DHUFT	2020-23
Alumhurst Road - 2 storey extension - Pebble	Works	£1.0M	DHUFT	2020-21
Blandford Hub-WAVE 4	Works	£4.2M	DHUFT	2020-22
Business Support Vehicle Replacement Programme	Vehicles	£0.7M	Vehicles	2020-26
Estate Refurbishment	Works	£3.0M	DHUFT	2020-26
Estates Backlog	Works	£15.0M	DHUFT	2020-26
IT Infrastructure	IT	£28.2M	IT	2020-26
Equipment incl. Medical Equipment	Equipment	£3.6M	Equipment	2020-26
Electronic Prescribing and Medicines AdministrationSystem (EPMA)	IT	£1.2M	IT	2020-22
Other	Miscellaneous	£5.6M	Miscellaneous	2020-26
<b>Dorset Healthcare Sub Total</b>		<b>£97.3M</b>		
St Ann's Hospital, to expand MH facilities in Dorset.	HIP2 Bid (1% seed funded)	£35.0M	DHUFT	tbc
Forston site redevelopment. To improve MH facilities in West Dorset	HIP2 Bid (1% seed funded)	£25.0M	DHUFT	tbc
Sherborne Community Hub	HIP2 Bid (1% seed funded)	£18.2M	DHUFT	tbc
Boscombe development	HIP2 Bid (1% seed funded)	£11.0M	DHUFT	tbc
Wimborne Hub	HIP2 Bid (1% seed funded)	£5.0M	DHUFT	tbc
Shaftesbury Hub	HIP2 Bid (1% seed funded)	£20.0M	DHUFT	tbc
Weymouth Hub	HIP2 Bid (1% seed funded)	£30.0M	DHUFT	tbc
<b>HIP2 Sub Total</b>		<b>£144.2M</b>		
<b>Total</b>		<b>£241.5M</b>		

## Appendix 5 – Primary Care calculator

A calculator is currently being used by the CCG to generate a cost per development towards primary care facilities (capital costs). It calculates the cost per home in any development. This assumes a certain amount of floorspace in a doctor's surgery.

The floorspace assumptions are:

Number of patients	2,000	4,000	6,000	8,000	10,000	12,000	14,000	16,000	18,000	20,000
Type of premises										
A – single storey premises	A	A	B	B	B	B	B	B	B	B
B – two storey premises with one staircase and one lift										
Gross internal area (GIA) allowance	199	333	500	667	833	916	1,000	1,083	1,167	1,250

Then using the following steps:

- Each new dwelling will accommodate 2.4 people (with no adjustment made for number of dwelling bedrooms)
- Each whole time equivalent general practitioner supports a population of 1800 people and requires 1 clinical room in which to meet the needs of this population. The NHS funds the GP
- 1 clinical room needs to adhere to the HBN guidance referenced above at a minimum of 16 square metres.
- The average cost per square metre to building a GP clinical room is £3,500 plus vat in Dorset. This is without any land being purchased and assuming extensions to GP surgeries can be provided with the current overall existing site.

An example:

- Proposed housing development of 750 new homes
- 750 new homes x 2.4 people per home = 1800 additional people
- 1800 people will require 1 additional GP
- 1 additional GP (funded by NHS) will need a clinical room to see these people in
- 1 additional room needs to be 16sqm @ £3,500 per sqm
- Developer contribution needs to be = **£56,000 (minimum)**

NB: additional space may be required due to the need to increase the area in the waiting room/reception/admin space etc. due to the current configuration of the existing building.

## Appendix 6 – Acute care calculator

A calculator is also currently being used by the Hospital Trusts to generate a cost per development towards acute care interventions (revenue costs). It calculates the cost per home in any development. The development contribution covers the cost of hospital visits by occupiers within the first year of occupancy of a new home. As the Hospital Trusts costs are covered in arrears the contribution is justified on the basis that the developer must cover the costs for the first 12 month period of occupancy. These costs are not capital (i.e. buildings and equipment), but staff costs for each intervention. The Hospital Trusts have no method of recovering these additional 12 months costs so they are a gap that needs funding to ensure the level of service required.

This approach is calculated on a site by site basis. Using an occupancy rate of 1.65 people per dwelling and 2018 demographic data it forecasts the number of times each new person is likely to need hospital treatment in a 12 month period. The costs of each hospital visit (intervention) are based on Reference Cost information submitted to NHS England and subject to external audit scrutiny:

- A&E based on the equivalent percentage of the population requiring an attendance
- Emergency admissions based on the equivalent percentage of the population requiring an admission
- Elective admissions based on the equivalent percentage of the population requiring an admission
- Day-case admissions based on the equivalent percentage of the population requiring an admission
- Outpatient attendances based on the equivalent percentage of the population requiring an attendance
- Diagnostic Imaging based on the equivalent percentage of the population requiring diagnostic imaging

The formula for calculating the contribution is:

Development Population x % Development Activity Rate per head of Population x Cost per Activity = Developer Contribution Premium Costs

The following is a worked example of the acute care calculator for a planning application for 695 dwellings:

Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust											
Application Reference:	APP/19/00237/P	Land North of Bearwood, Magna Road and Knighton Lane, Poole						Expenditure Profile £k			
Local Authority / Area	Poole BC							2017/18*	2018/19**		
Activity Type	EL & DC	OP & Diag	Non EI	A&E			Clinical Pay	135,063	83,832		
Trust Population Catchment Estimate	420,846	359,112	348,310	363,705			All other costs	157,922	92,425		
Population Estimate of Planned Scheme	1							Total Costs*	292,985	176,258	
Deprivation Weighting % (Public Health England)	0.00%	0.00%	0.00%	0.00%			Staffing cost %	46.10%	47.56%		
Development Dwellings	695	695	695	695			Premium Staff Cost %	5.87%	6.30%		
Population Multiplier	1.65	1.7	1.7	1.7			* Total Operating Costs Note 5.1 2017/18 Accounts				
Development Population	1,147	1,147	1,147	1,147			** YTD M7 2018/19				
Activity Type	Trust Level Activity 2017/18 Reference Costs	Delivery Cost Quantum 2017/18 Reference Costs £	Delivery Cost per Activity 2017/18 Reference Costs £	Scheme Specific Deprivation Weighting £	% of Resident Population profile attending at POD	Acute Interventions (Activity)	Delivery Cost for Planned Population £	Deliver Cost for Specific Scheme Deprivation Weighted	Premium costs of Delivery £	Cost Pressure (Claim) £	
A&E Attendances	95,223	14,779,590	155.21	0.00	26.18%	309	41	46,600	1,397	47,997	
Non Elective Admissions	30,797	61,767,725	2005.64	0.00	8.84%	104	177	203,359	6,097	209,457	
Non Elective (Short Stay)	28,964	11,977,762	413.54	0.00	8.32%	98	34	39,435	1,182	40,617	
Elective Admissions	7,887	34,344,833	4354.61	0.00	1.87%	22	82	93,585	2,806	96,391	
Day Case (Elective)	53,292	34,855,789	654.05	0.00	12.66%	150	83	94,977	2,848	97,825	
Outpatient Appointments	360,628	43,323,573	120.13	0.00	100.42%	1,186	121	138,345	4,148	142,493	
Outpatient Appointments (Procedure)	55,218	10,146,444	183.75	0.00	15.38%	182	28	32,401	971	33,372	
Diagnostic Imaging	55,153	6,821,639	123.69	0.00	15.36%	181	19	21,783	653	22,437	
<b>Total</b>	<b>687,162</b>	<b>218,017,355</b>				<b>2,233</b>			<b>20,103</b>	<b>690,589</b>	
									<b>Contribution per Dwelling £</b>		<b>994</b>

Source: Shakespeare Martineu

