REBUTTAL PROOF OF EVIDENCE OF BEN JAMES HUNTER

Appeal reference: APP/X2410/W/23/3316574

Appeal under Section 78 of the *Town and Country Planning Act 1990* in respect of:

'Outline application for up to 150 dwellings, together with new open space, landscaping and drainage infrastructure, with all matters reserved accept for access (as amended to include proposed junction improvement works at Barkby Road cross roads, received 20/05/2022)'

Site address: Barkby Road Queniborough Leicestershire

Appeal by: David Wilson Homes

JUNE 2023

1. I am Sarah Shuttlewood, Head of Contracts with the Leicester, Leicestershire and Rutland (LLR) Integrated Care Board (ICB). I have 40 years' experience working in the NHS, initially as a clinician (nurse and midwife) and for the last 15 years in a commissioning and contracting capacity.

2. This rebuttal proof of evidence ('rebuttal') has been prepared in direct response to a number of points in the evidence of James Hunter.

3. I note that Mr Hunter has no experience in the NHS as an organisation, delivery of health care services, management and/or the funding of it.

4. In response to Mr Hunter's proof of evidence sections 3.1-3.3, 4.25, 4.26, 4.27 and 4.28 I will make the following comments and corrections of facts.

Integrated Care Board (ICB)

5. The ICB plans and commissions health care services from providers and has delegated responsibility for commissioning primary health care services. ICBs exist to maintain and

improve the health of their registered population and are, therefore, concerned with preventing as well as treating ill-health.

Integrated Care Partnership (ICP)

6. Local Authorities together with ICBs, have an obligation to prepare joint strategic needs assessments. These strategies then inform joint health and wellbeing strategies to meet the assessed needs.[1] Both the needs assessments and wellbeing strategies must then be taken into account when an ICB and the responsible Local Authority exercise any of their functions. [2]

Commissioning Health Care Services/Facilities Through NHS Funding

7. In a given year, central government through the Comprehensive Spending Review process sets the level of NHS funding. The process estimates how much funding the NHS will receive from central sources. The NHS receives about 80% of the health budget, which is allocated in England to NHS England (NHSE), the governing body of the NHS in England. In turn, NHSE allocates funds to Integrated Care Boards (ICBs). ICBs are statutory NHS bodies.

8. NHS-funded primary care services are delivered by independent contractors, usually GP partnerships, through GMS (General Medical Services), APMS (Alternative Provider of Medical Services) or PMS (Personal Medical Services) Contracts. GMS and PMS contracts are in perpetuity whereas APMS are a fixed term, generally 5-10 years.

9. General Practices are funded using a weighted capitation formula based on existing registered patients. This is updated quarterly in arrears. In addition, practices get income from achieving quality indicators as part of the Quality Outcomes Framework (QOF) and participating in nationally commissioned Enhanced Services (DES) and ICB commissioned Locally Commissioned Services (LCS).

10. The projected ICB allocations by NHS England makes an allowance for growth in number of people registered with GP practices. This population growth is based on midyear estimates from the ONS age-sex specific population projections. In addition, consideration is given to other matters like deprivation and case-mix of the patient population. Local housing projections, local housing land supply or existing planning permissions are not taken into consideration. The population projections only consider natural trends based upon births, deaths and natural migration and make a number of assumptions about future levels of fertility; mortality and migration based previously observed levels. The funding for ICB is reactive and the funding received from Central Government is limited. In the case of patient movement the funding does not follow the patient in any given year.

Infrastructure Facilities Funding

11. NHS England does not routinely allocate any additional funding to the ICB in the form of capital or revenue towards infrastructure projects to cater for the impact from new residential developments.

12. The most recent NHS England capital fund for investment in primary care infrastructure was the Estates and Technology Transformation Fund (ETTF). This was a national programme

[1] S 116A of the 2007 Act and the Health and Social Care Act 2012
[2] S 116B of the Health and Care Act 2022

for investment in general practice facilities and technology across England (between 2015/16 and 2019/20). The programme saw various schemes across Leicester, Leicestershire and Rutland ICB, however the scheme ceased and there has been no subsequent capital funding for primary care.

13. Within the GP contracts between the ICB and GP practices, practices are required to provide premises which are suitable for the delivery of primary care services and meet the reasonable needs of patients in their catchment area.

14. The Regulations governing GP contracts require ICBs to reimburse the practices for their premises through rents payable for lease property or pay a "notional rent" (a market rent assessed by the District Valuer on the assumption of a "notional" 15-year lease) in respect of a GP-owned building[3]. For new builds or extensions, the ICB needs to agree the additional rent from a limited revenue budget. If the ICB has no ability to reimburse then the project to increase the capacity by way of alteration extension, or building a new facility will be at risk.

Capacity of Practices

15. The ICB has analysed the space needs of the practices concerned and concluded that jointly there are 7 clinical rooms short. This is currently making timetabling of rooms very complex.

16. The table at Appendix 1 shows the number of clinical rooms of each practice and the staffing demands for those rooms by showing the number of GP's, nurses and other direct patient care staff (FTE) at each surgery. (Appendix 2) The trainee staff are assumed to require clinical space for 50% of the time, as they will be studying/observing for the remainder.

17. Additional healthcare staff (including Pharmacists, Paramedics, Care Coordinators, Nursing Associates) are employed by the Primary Care Network (PCN) also spend time at the practices. These are known as the **ARRS staff** (Additional Roles Reimbursement Scheme) and enables PCNs to create bespoke multidisciplinary teams, based on local population need. The PCN employs 11 ARRS staff (Appendix 3). The two practices provide 35% of the PCN combined patient list, indicating that the 11 staff should be spending 35% of their time working out of the two practices.

18. Finally there are **trust staff** attached to the practice for various hours/times, and these roles include Midwifes, Mental Health facilitators and practitioners, Turning Point (who run monthly sessions), and a Learning Disability Psychologist.

19. In conclusion, Appendix 1 shows that when the needs of this staff cohort is translated into clinical rooms, there is a shortfall of 7.

Premises Development in Primary Care

20. At the moment an ICB does not hold capital and does not own buildings, the procurement of new premises is either by:

    - a Third Party development (where a third party developer funds the capital to build a new building, owns it and charges a commercial rent via a normally 25-year

[3] https://www.kingsfund.org.uk/publications/gp-funding-and-contracts-explained

lease that represents the developer's return on capital, with the ICB reimbursing that rent); or
- a GP owner-occupied scheme (where the GPs own and develop but receive a notional rent, as described above, to fund the cost of the build).

21. Either way, such developments are most likely to occur for occupiers who hold an existing GMS or PMS contract, as APMS contract holders will not have a sufficient contract term to either enter a 25-year lease or invest in a new GP premises development.

The Decision-making Process and Planning Policy Context

22. Particularly as to paragraph 4.18, Mr Hunter states that "there is a general view that contributions to the NHS are not appropriate".

23. As I understand, the starting point for the determination of planning applications is the development plan, so far as material to the application, and to any other material consideration.

24. Whether or not a particular factor is capable of being a material consideration is a matter of law albeit that its factual context and weight are matters for the decision-maker. The health of communities has been a key element of Government policy for many years and is reflected in adopted development plan.

Development Plan Policy:

Charnwood Local Plan 2011-2018 core Strategy Adopted 2015

Strategic objectives

SO3: to promote health and wellbeing, for example by ensuring that residents have access to health care, local parks, greenspaces and natural environment, the countryside and facilities for sport and recreation, creative and community activities.

National Planning Policy Framework (NPPF)

25. Paragraph 2 of the NPPF states:

The NPPF must be considered in preparing the development plan and is a material consideration in planning decisions. Planning policies and decisions must also reflect relevant international obligations and statutory requirements.

26. The ICB is delivering primary care services at the point of demand through General Practice, under the statutory requirement. Paragraph 2 of the NPPF contains an imperative upon the decision makers to reflect statutory obligations.

27. In addition, the health of communities has been a key element of Government policy for many years and is as stated above reflected in adopted development plans. Please see NPPF Section 2 paragraph 8, Section 8 paragraphs 91 and 93.

28. I understand that the developer contributions are only sought from new development applications proposals where the contribution requested complies with the Community Infrastructure Levy (CIL) Regulation 122 tests:

    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.

29. As to the following comment of Mr Hunter in relation to the paragraphs mentioned in Paragraph 4 above, I have the following additional comments;

30. The argument that that the NHS is funded from taxation, and it is therefore not necessary to request the contribution, is an argument that could be used against other contributions like, highways, education as they too are funded from taxation. As demonstrated, there is no funding from the taxation to expand the needed infrastructure to mitigate the detrimental impact created by this proposed development. There is no double funding.

31. The infrastructure funding does not follow the patient to a different practice. This requested infrastructure is not for the first year of occupation but for the duration of the dwellings. It is also noted that one patient may attend the primary care more often with more complicated health issues than another. To say that this development will always be occupied only by young families who have less health needs is irrational. People will get older and health needs are different from birth to old age but can be equally less or more demanding.

The Remaining Section 4 of Mr Hunter's Evidence

32. In response to the remaining paragraphs in section 4 of Mr Hunter's proof I have the following comments:

33. It is true that a patient has a choice to choose their own GP practice. However, most patients usually choose the closest GP practice to their home as if attending a practice outside the catchment area, that particular practice does not need to provide all those services which would be available to the patient in their own catchment area. Registering with a practice further away from home can affect decisions about referrals for hospital tests and treatment, or access to community health service.

34. The advertisement referred to in these paragraphs are just standard NHS guidance as to how to register, not an indication as to available patient capacity in the stated surgeries.

35. Patient lists are regularly updated, contrary to paragraph 4.10. The two practices have provided the following information:

    Jubilee Medical Practice:

    > To undertake a list cleansing exercise, the procedure is to look at the entire list of patients who have medication on repeat but who have not had it issued in the last year. Then it is cross referenced with patients who have not had an appointment in the last one year or more and then manually look at those patients who fit in both categories to see if it is clear and obvious that they are not living in the area. This

would give us a good snapshot of possible patients no longer in this locality. Regarding deceased patients, they are automatically de-registered by an independent organisation.

The County Practice:

The practice had a list cleansing exercise in March 2023. All patients who had not had their blood pressure checked in the last 5 years and those who had not had a smear in the last 5 years. It resulted in removing about 30 patients who clearly didn't live in the catchment area anymore.
Deceased patients are discussed at our practice meeting every Monday. They are automatically removed as soon as the paperwork has been done. This can take a couple of weeks if the coroner is involved.

36. The decision by the ICB to close lists is not taken lightly and it is a much more complex process than Mr Hunter suggests. It is based on a combination, including the following factors - high patient registration, premises development work (being required), performance issues, workforce capacity and/or recruitment problems.

37. As to the table 2 of Queniborough Ward, there is no reference where this table is coming from and what year. Whilst it might be the case that some new householders will not register with the two nearest practices (both approximately 1.6 miles away (measured by road network) from the development site), the spread of practices means the next nearest practice (Highgate Medical Centre) which is approximately 4.5 miles away (measured by road network), making it less practical and involving more travel for residents.

38. In addition, whilst there may be initial phone consultations, the latest national policy is that the majority of appointments are face-to-face.

39. I can confirm that there is no capacity for the current practices to increase hours. Extended hours are already implemented.

40. Mr Hunter is referring to various appeal decisions. It is not possible to comment on these appeals as they are case sensitive.

Conclusion

41. The contribution requested is necessary. Without the contribution to increase the clinical capacity, the proposed development will put too much strain on the said health infrastructure, putting people at risk. Waiting times would increase and access to adequate health service would decline, resulting in poorer health outcomes and prolonged health problems not only for the occupants of this development but for the existing local community. Such an outcome is not sustainable as it will have a detrimental socio-economic impact.

42. In addition, having no or limited access to primary care will have a knock-on effect on secondary healthcare, in particular on A&E services, as those people who cannot access their primary care facility usually will present themselves at the A&E department adding additional pressure on the already stretched secondary care service.

43. The development directly affects the ability to provide the health service required to those who live in the development and the community at large. Without securing such

contributions, the ICB would be unable to support the proposals and would object to the application because of the direct and adverse impact that the development will have on the delivery of primary health care.

Sarah Shuttlewood

Head of Contracts, LLR ICB

Date: 2nd June 2023

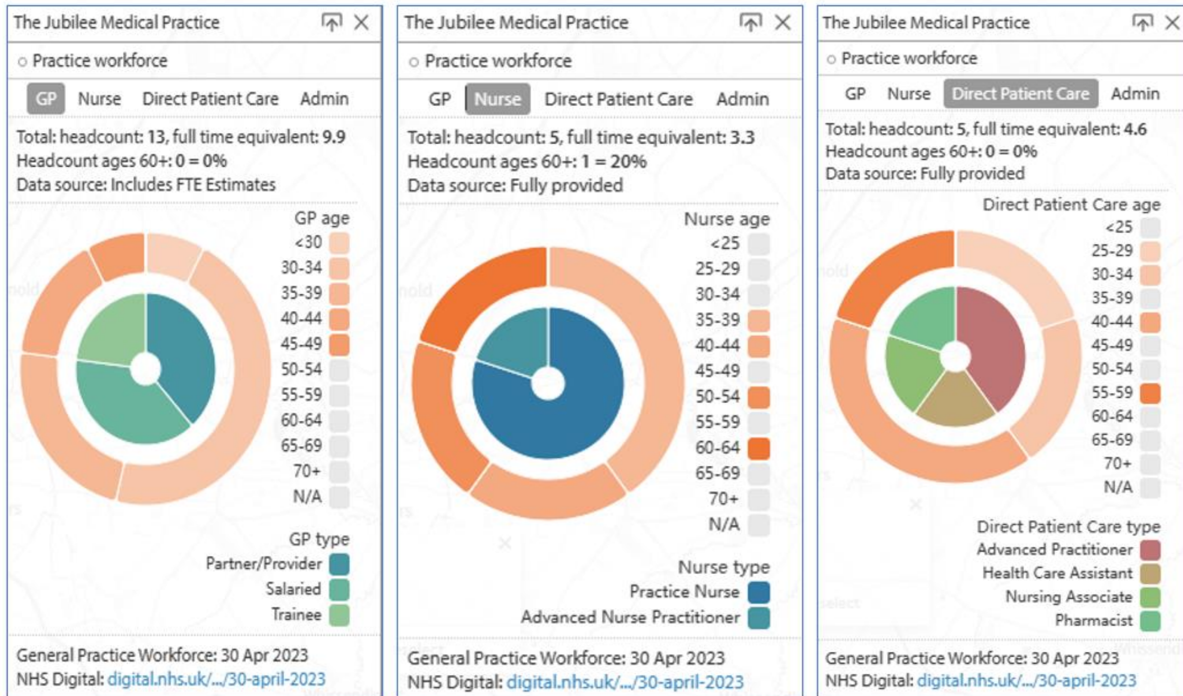
Appendix 1 Assessment of clinical rooms at The Jubilee and The County Practices

GP Practice	Practice Code	Registered Patients (Apr. 23)	Current Capacity	Capacity Needed					Potentially Available Clinical Room Capacity + or (-)
			Clinical Rooms per Premises	GP's, Nurses and direct patient care staff (FTE)	GP Trainees	PCN ARRS Staff (Apr. 2023)	Attached Staff (FTE)	Notes	
The County Practice	C82042	12,787	15	13	6		1	GP Trainees require own clinical room 50% of time	-2
The Jubilee Practice	C82078	12,164	16	15	3		0.5	GP Trainees require own clinical room 50% of time	-1
PCN ARRS Workforce						35% of 11		Syston proportion of ARRs staff in post based on % of PCN registered population. Plans to increase ARRS numbers hampered by physical capacity issues	-4
Totals		**24,951**	**31**	**28**	**9**	**4**	**2**		**-7**

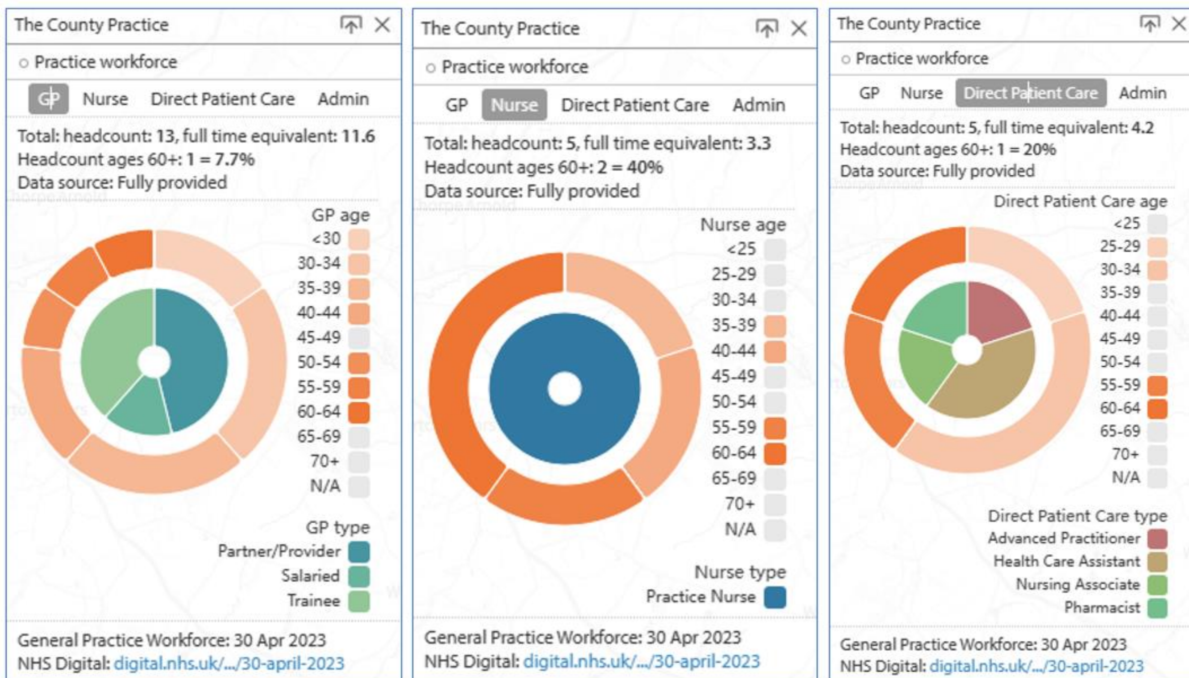
References
https://digital.nhs.uk/data-and-information/publications/statistical/general-and-personal-medical-services
https://digital.nhs.uk/data-and-information/publications/statistical/primary-care-network-workforce/30-april-2023
https://shapeatlas.net/

Appendix 2 – General Practice Workforce at the two practices at Apr 2023

The Jubilee Medical Practice



The County Practice



Appendix 3 - ARRS staff (Additional Roles Reimbursement Scheme) employed by the PCN (Primary Care Network at Apr 2023)

PCN_NAME	MELTON, SYSTON AND VALE PCN							
Data_source	CENSUS YEAR	CENSUS MONTH	PCN CODE	STAFF GROUP	STAFF_ROLE	DETAILED_STAFF_ROLE	FTE	Clinical Rooms
NWRS Staff	2023	4	U25294	Other Admin/Non-clinical staff	Managers	Manager	1	
NWRS Staff	2023	4	U25294	Other Direct Patient Care staff	Paramedics	Paramedic	1	1
NWRS Staff	2023	4	U25294	Other Direct Patient Care staff	Nursing Associates	Nursing Associate	0.88	1
NWRS Staff	2023	4	U25294	Other Direct Patient Care staff	Pharmacists	Pharmacist	1	2
NWRS Staff	2023	4	U25294	Other Admin/Non-clinical staff	Other Admin/Non-clinical	Other	1	
NWRS Staff	2023	4	U25294	Other Direct Patient Care staff	Care Coordinators	Care Coordinator	0.533333333	0.5
NWRS Staff	2023	4	U25294	Other Direct Patient Care staff	Pharmacy Technicians	Pharmacy Technician	0.693333333	1
NWRS Staff	2023	4	U25294	Other Direct Patient Care staff	Care Coordinators	Care Coordinator	0.8	1
NWRS Staff	2023	4	U25294	Other Direct Patient Care staff	Paramedics	Paramedic	0.986666667	1
NWRS Staff	2023	4	U25294	Other Direct Patient Care staff	Physician Associates	Physician Associate	1	1
NWRS Staff	2023	4	U25294	Other Direct Patient Care staff	Pharmacists	Pharmacist	0.986666667	1
NWRS Staff	2023	4	U25294	Other Direct Patient Care staff	Care Coordinators	Care Coordinator	1	1
NWRS Staff	2023	4	U25294	Other Direct Patient Care staff	Care Coordinators	Care Coordinator	0.533333333	0.5
NWRS Staff	2023	4	U25294	Other Direct Patient Care staff	Pharmacists	Pharmacist	0.853333333	1
NWRS Staff	2023	4	U25294	Other Direct Patient Care staff	Care Coordinators	Care Coordinator	0.933333333	1
NWRS Staff	2023	4	U25294	Directors	Medical Clinical Director (GP)	Clinical Director – Medical	0.106666667	
NWRS Staff	2023	4	U25294	Other Direct Patient Care staff	Pharmacists	Pharmacist	1	1
NWRS Staff	2023	4	U25294	Other Direct Patient Care staff	Care Coordinators	Care Coordinator	0.8	1
NWRS Staff	2023	4	U25294	Other Direct Patient Care staff	Nursing Associates	Nursing Associate	0.96	1
NWRS Staff	2023	4	U25294	Other Direct Patient Care staff	Pharmacists	Pharmacist	1	1
NWRS Staff	2023	4	U25294	Other Direct Patient Care staff	Social Prescribing Link Workers	Social Prescribing Link Worker	1	1

NWRS Staff	2023	4	U25294	Other Direct Patient Care staff	Pharmacy Technicians	Pharmacy Technician	1	1
NWRS Staff	2023	4	U25294	Other Direct Patient Care staff	Care Coordinators	Care Coordinator	1	1
NWRS Staff	2023	4	U25294	Other Direct Patient Care staff	Physician Associates	Physician Associate	1	1
NWRS Staff	2023	4	U25294	Other Direct Patient Care staff	Pharmacy Technicians	Pharmacy Technician	0.64	0.5
NWRS Staff	2023	4	U25294	Other Direct Patient Care staff	Trainee Nursing Associates	Trainee Nursing Associate	0.986666667	1
NWRS Staff	2023	4	U25294	Other Direct Patient Care staff	Social Prescribing Link Workers	Social Prescribing Link Worker	1	1
NWRS Staff	2023	4	U25294	Other Direct Patient Care staff	Care Coordinators	Care Coordinator	1	1
NWRS Staff	2023	4	U25294	Directors	Medical Clinical Director (GP)	Clinical Director – Medical	0.106666667	
NWRS Staff	2023	4	U25294	Other Direct Patient Care staff	Pharmacists	Pharmacist	0.986666667	1
NWRS Staff	2023	4	U25294	Other Direct Patient Care staff	Pharmacists	Pharmacist	1	1
NWRS Staff	2023	4	U25294	Other Direct Patient Care staff	Pharmacy Technicians	Pharmacy Technician	0.6	0.5
NWRS contracted services	2023	4	U25294	Other Direct Patient Care staff	Paramedics	Paramedic	1	1
NWRS contracted services	2023	4	U25294	Other Direct Patient Care staff	Pharmacists	Pharmacist	0.8	1
NWRS contracted services	2023	4	U25294	Other Direct Patient Care staff	Pharmacists	Pharmacist	1	1
NWRS contracted services	2023	4	U25294	Other Direct Patient Care staff	Other Direct Patient Care	Other	1	1
								31
							PCN Pop	72237
							2 Prac Pop	24951
							% of Total Pop	35%
							ARRS Staff @35%	11

Source: NHS Digital