Healthcare Provision	
Summary of Comments Received (respondent ref in brackets)	**Council's Response**
Thresholds	
▪ Clarification needed on surgeries described as being "under pressure" – e.g. criteria, average list sizes in other practices, justification for using the average list size as an appropriate threshold (23)	▪ As GP's do not have an obligation to accept patients – it would be futile to assume a GP:patient ratio that was too high. The average GP list size in the UK is less than 2,000. Given the rural nature of West Berkshire and the associated additional service delivery costs, it is considered reasonable to base the threshold for "under pressure" facilities on the average list size in the district i.e. 1,950.
▪ Practices should be pushed to achieve a similar GP:patient ratio to the average of the top 3 performing practices – a contribution should only be required when this figure is exceeded rather than accepting an average of the entire surgery list (3)	▪ See comments above.
▪ Planning obligations must not be used to resolve existing service deficiencies (14)	▪ There is no intention to use planning obligations to resolve existing service deficiencies. Where a surgery is already under pressure, any additional development in the catchment area would exacerbate the problem. Contributions would only be required to meet the costs attributed to the additional development.
▪ Contributions should be "sought" to meet requirements where they meet tests in 1/97 (14)	▪ Contributions will only be required where they meet the tests outlined in Circular 1/97.

Healthcare Provision	
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▪ No account is taken of spare capacity for improvements within GP surgeries – physical construction assumed to be only solution (12) (1)	▪ It is accepted that physical construction is not the only solution to increase capacity. The formula included is based on floorspace as that is considered to be the simplest way to attribute the cost of additional development.
<u>Calculation of Contributions</u>	
▪ No point in devising complex formulae when the correct approach is as to consider each site on its merits as stated in para 4.5 (23)	▪ The formula has been included to provide some indication of the level of contributions that may be required. However each site will be considered on its merits.
▪ No justification has been given for occupancy rate of 2.54 persons – paper should include a breakdown of this figure (12) (1)	▪ The average occupancy rate used in the formula was taken from the 2000 based population projections for West Berkshire, produced by the Greater London Authority.
▪ Occupancy assumptions about each development should be determined on an application by application basis taking into account housing mix (12) (1)	▪ Average household size is considered a good proxy, however, occupancy assumptions can be altered to take account of housing mix where appropriate.
▪ Average occupancy rate used in formula is too high – should use figure from 2001 census and then kept under review especially if development is phased over a number of years (19)	▪ Now that information from the 2001 census is available, the formula can be adjusted to take this into account. In the same way that household size must be kept under review, the capital cost of provision must keep pace with inflation.
▪ Cost per dwelling should be discounted in respect of small sites (12) (1)	▪ In accordance with the revised core guidance paper contributions will be considered from developments of 1 dwellings or more but it would not be appropriate to discount contributions for smaller schemes.

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▪ Health care provision should be included in the basic tariff (3)	▪ It is not proposed to proceed with the basic level of contribution and a formula is proposed for assessing health care contributions. See revisions to Core Guidance Paper.
<u>Funding</u>	
▪ Healthcare provision is normally secured through the system of taxation. The expectation that developers will contribute amounts to double counting. (24)	▪ Circular 1/97 allows for contributions towards community facilities (para B10). The revenue costs of providing healthcare will be met through taxation. It is unreasonable to expect the cost of new facilities made necessary by additional development to be borne by the public purse.
▪ Primary Care Trusts should have an investment programme based on the future needs on the District, including strategy to accommodate the anticipated level of growth as set out in the local plan. (24)	▪ See above
<u>Other</u>	
▪ Agreed / Support (2) (32) ▪ Evidence needed to indicate whether the PCTs have been involved/ consulted in the process (23)	▪ Support is noted. ▪ The Primary Care Trusts were consulted on the guidance.