

Statement of Common Ground

Between Portsmouth City Council (Local Planning Authority) and NHS Hampshire and Isle of Wight Integrated Care Board

Primary Healthcare Infrastructure

FINAL October 2026

Plan	Portsmouth Local Plan
Parties	Portsmouth City Council and NHS Hampshire and Isle of Wight Integrated Care Board
Subject	Primary healthcare infrastructure, developer contributions and delivery mechanisms
Status	Final for Local Plan Examination Hearings
Date	October 2026

Note: This revised draft Statement of Common Ground (SoCG) has been prepared by PCC and amended by the ICB following further discussions on 1 October 2026. This version removes explanatory text and discussion (previously at Sections 2 and 3) and instead sets out the topics of agreement and disagreement.

1. Introduction

1.1 This Statement of Common Ground (SoCG) is prepared between Portsmouth City Council (PCC) as the Local Planning Authority for the City of Portsmouth and NHS Hampshire and Isle of Wight Integrated Care Board (ICB).

1.2 The ICB is the statutory NHS body responsible for commissioning and planning NHS services for its population, including primary medical services and associated infrastructure planning. In the planning system, the ICB provides evidence on primary care estate capacity, assesses the infrastructure impact of planned growth and advises the Local Planning Authority on proportionate mitigation required to maintain access to primary healthcare.

1.3 The purpose of this document is to identify areas of agreement and disagreement between the two parties in relation to primary healthcare infrastructure and to assist the Inspectors in assessing the soundness and legal compliance of the Portsmouth Local Plan.

There are two appendices to this SoCG. Appendix A sets out a modification proposed by the ICB but not agreed with PCC. Appendix B tabulates GP capacity across Portsmouth.

1.4 This SoCG has been prepared in accordance with paragraph 27 of the 2024 National Planning Policy Framework (NPPF) and the Planning Practice Guidance on Maintaining Effective Cooperation. It has also had regard to guidance prepared by the Planning Advisory Service on Statements of Common Ground.

1.5 The SoCG has been prepared in parallel with the examination of the Portsmouth Local Plan. The Plan, upon adoption, will supersede the existing Portsmouth Plan (2012). The new Local Plan will cover the period to 2040 and sets out the vision, objectives and policies to guide future development in the City over the plan period.

1.6 This SoCG does not predetermine the outcome of individual planning applications. It records the parties' current positions on the Local Plan evidence base, primary healthcare infrastructure need, and the delivery mechanisms required to ensure that planned growth is supported by adequate healthcare infrastructure over the plan period.

2. Background and Evidence

2.1 The ICB has engaged in plan-making in Portsmouth since 2023. The ICB submitted a Regulation 19 representation in September 2024 on the Pre-Submission Portsmouth Local Plan (2024) and a Regulation 19 representation on the Pre-Submission Local Plan Addendum (2025). The ICB also provided comments on the versions of the Infrastructure Delivery Plan published in 2024 and 2025.

2.2 The Infrastructure Delivery Plan identifies a significant existing deficit in primary healthcare provision, including a shortfall of approximately 3,779 sqm of clinical floorspace and over 60,000 patients above capacity across the system.

2.3 Planned population growth associated with the Local Plan is expected to generate additional demand requiring approximately 1,862 sqm of additional clinical floorspace. The IDP identifies an indicative capital cost for this additional primary care floorspace between £7m and £17.2m.

2.4 The ICB's position is that existing primary care capacity constraints are relevant to whether planned growth can be accommodated without mitigation. The ICB is not seeking developer contributions to remedy unrelated historic deficits. Any contribution sought from a development would be limited to the additional infrastructure required to mitigate the impact of the development-generated population.

2.5 The ICB's healthcare contribution methodology assesses the additional population generated by residential development, the current patient list size and capacity of affected GP practices, the additional

floorspace required to accommodate the development-generated population, and the capital cost of reconfiguration, extension or new build solutions where capacity cannot otherwise be provided. The identified infrastructure requirement may therefore be addressed through a range of estate solutions, including reconfiguration or extension of existing premises, new or additional premises, or land or floorspace provision, depending on local estate feasibility and the development-generated requirement.

2.6 The parties agree that primary healthcare infrastructure is essential infrastructure necessary to support sustainable development and healthy communities. The parties also agree that continued cooperation will be required between PCC and the ICB to update the IDP, monitor delivery and consider appropriate funding and delivery routes.

2.7 The outstanding issue between the parties is not whether every residential development should make a healthcare contribution, but whether the Local Plan provides a sufficiently clear and deliverable route, through CIL, section 106 and/or other forms of provision, to secure proportionate growth-related primary healthcare infrastructure where this is required to mitigate the impacts of development.

3. Topics of Agreement and Disagreement

Topic	Position	Summary
Existing primary care capacity deficit	Agreed, with clarification	There is a significant existing deficit. Existing deficit is relevant to whether growth can be absorbed, but developer contributions should not be used to remedy unrelated historic deficits.
Growth impact	Agreed	Planned growth will generate additional demand for primary healthcare services and will exacerbate existing pressures without mitigation.
Need for additional infrastructure	Agreed	Additional primary healthcare infrastructure is required to support planned growth, including approximately 1,800+ sqm of additional clinical floorspace identified in the IDP.
NHS capital funding	Agreed	NHS capital funding alone should not be assumed to meet all growth-related primary healthcare infrastructure needs.

Topic	Position	Summary
Role of developer contributions	Agreed	Developer contributions have a role in mitigating development-generated primary healthcare infrastructure impacts. Any contribution would be limited to the additional infrastructure requirement attributable to development and would take account of mitigation already secured or demonstrably committed through another funding source.
CIL role	Agreed in principle	CIL may contribute to strategic or cumulative healthcare infrastructure projects, subject to transparent governance, prioritisation and allocation.
CIL sufficient alone	Partially not agreed	The ICB does not agree that CIL alone provides sufficient delivery certainty. Whilst recognising the role of CIL in funding infrastructure, the ICB considers that greater transparency is required regarding how healthcare projects are identified, prioritised, funded and reported through the Infrastructure Funding Statement process in order to demonstrate deliverability. PCC agrees that CIL may not provide sufficient funding for infrastructure. Where additional infrastructure is required to mitigate development-generated demand, CIL and/or section 106 may form part of the funding and delivery arrangements. The appropriate delivery mechanism will reflect the nature, scale and timing of the infrastructure requirement. Any section 106 obligation must satisfy the Regulation 122 tests.

Topic	Position	Summary
Need for section 106	Partially not agreed	The ICB considers that section 106 may be required where application-specific evidence demonstrates that healthcare mitigation is necessary, directly related, and fairly and reasonably related in scale and kind. PCC agrees that section 106 may be appropriate on a case-by-case basis where application-specific evidence demonstrates that mitigation is required and the proposed obligation satisfies the Regulation 122 tests.
Local Plan modification	Not agreed	The ICB proposes a modification to the Local Plan policy or supporting text, as set out in Appendix A of this SoCG, to clarify the mechanisms through which evidenced growth-related primary healthcare infrastructure may be secured. PCC do not agree a modification. PCC consider that Policy PLP50: Infrastructure Delivery provides an appropriate mechanism for ensuring that infrastructure is provided in a timely manner and where appropriately evidenced. The proposed modification is bespoke to healthcare and similar wording has not been provided for other types of infrastructure.
Avoiding double counting	Agreed	Healthcare contributions should not be double counted and should reflect mitigation already secured or demonstrably committed through CIL, section 106, direct provision or other funding.
Delivery certainty	Not agreed	The parties have not yet agreed a mechanism to secure, transfer, ring-fence, index, monitor and deliver healthcare infrastructure in step with growth.

Topic	Position	Summary
Plan effectiveness	Not agreed	The ICB considers that plan effectiveness remains unresolved until there is sufficient clarity regarding how identified growth-related primary healthcare infrastructure will be prioritised, funded and delivered in step with development. PCC consider that Policy PLP50: Infrastructure Delivery provides an appropriate mechanism for ensuring that infrastructure is provided in a timely manner and where appropriately evidenced.

4. Further Joint Working

4.1 The parties will continue to engage constructively during the examination of the Portsmouth Local Plan and, where possible, will seek to narrow the outstanding matters identified in this SoCG.

4.2 The ICB will continue to provide updated evidence on primary care capacity, potential mitigation projects and the healthcare contribution methodology. PCC will continue to engage with the ICB on the IDP, CIL governance, Infrastructure Funding Statement reporting and any relevant Local Plan hearing matters.

4.3 If a mutually acceptable version of this SoCG is not agreed, the parties agree that the areas of agreement and disagreement recorded in this document may assist the Inspectors in understanding the remaining issues to be considered through the examination process.

5. Signatories

For Portsmouth City Council	For NHS Hampshire and Isle of Wight Integrated Care Board
Name: Lucy Howard	Name: Katie Bradley
Position: Head of Planning Policy	Position: Senior Strategic Estates Manager
Date: 7 October 2026	Date: 08/10/2026

Appendix A - Potential Local Plan Clarification Wording

This appendix is included to assist further discussion between the parties. It is not intended to predetermine the wording of any Main Modification but records the ICB's preferred clarification to the Local Plan or supporting text.

Residential development can generate additional demand for primary healthcare services. Where the relevant NHS body demonstrates that existing primary care premises capacity cannot accommodate the population generated by a development, the Council will work with NHS Hampshire and Isle of Wight ICB to secure proportionate mitigation. This may include on-site provision, land or floorspace, Community Infrastructure Levy funding, or section 106 planning obligations where the statutory and national policy tests are met. Contributions will be calculated using transparent evidence on population yield, GP capacity, floorspace standards and appropriate capital cost benchmarks, and will not be used to remedy historic deficits unrelated to the development.

Appendix B – GP Capacity Across Portsmouth

This appendix is included to provide the background to current Primary Care Capacity

PCN	GP Practice	Patient List Size	Current Patient Capacity	Under / Over Capacity
Brunel	East Shore Partnership: Baffins Surgery	9,695	10,075	-380
Brunel	East Shore Partnership: Milton Park Surgery	3,977	4,132	-156
Brunel	The Lighthouse Group Practice: Devonshire Avenue Practice	2,966	3,088	-122
Brunel	The Lighthouse Group Practice: Southsea Medical Centre	9,352	9,735	-384
Brunel	The Unicity Surgery	17,863	11,825	6,038
Island City	Derby Road Group Practice	13,634	5,625	8,009
Island City	Derby Road Group Practice: Copnor Road Surgery	2,998	1,237	1,761
Island City	Island City Practice: John Pounds Surgery	4,637	3,590	1,047
Island City	Island City Practice: Lake Road Health Centre	15,867	12,323	3,544
Island City	Island City Practice: Sunnyside Medical Centre	16,381	12,778	3,603
Portsdown	Portsdown Group Practice: Allaway Avenue Surgery	2,345	1,737	609
Portsdown	Portsdown Group Practice: Cosham Park House Surgery	18,043	13,555	4,488
Portsdown	Portsdown Group Practice: Heyward Road Surgery	4,115	3,047	1,068
Portsdown	Portsdown Group Practice: Somers Town Hub	10,178	7,537	2,642
Portsdown	Portsdown Group Practice	17,203	12,844	4,359
Portsmouth North	Kirklands Surgery	9,854	4,790	5,064
Portsmouth North	The Drayton Surgery	14,037	10,403	3,634
Portsmouth North	The Drayton Surgery: Highclere Surgery	10,260	7,604	2,656
Portsmouth South Coast	Craneswater Group Practice	6,195	6,394	-199
Portsmouth South Coast	Craneswater Group Practice: Salisbury Road Surgery	4,839	4,994	-155
Portsmouth South Coast	Trafalgar Medical Group Practice: Eastney Health Centre	19,312	11,053	8,259
Portsmouth South Coast	Trafalgar Medical Group Practice: Osborne Road	8,681	4,968	3,713
Patient Totals		222,433	163,333	59,100

