Unresolved Healthcare Evidence and Accountability

Supplementary representation on planning application UTT/26/1635/OP

Application	UTT/26/1635/OP - Land north and south of The Broadway, Great Dunmow
Representation by	Carl Rolph, Save Church End
Address	Castaway, Beaumont Hill, Dunmow, Essex CM6 2AW
Date and evidence	17 September 2026 - NHS Essex ICB FOI response 2627232

Purpose and requested action

Please place this representation on the public planning file and read it alongside my earlier objections. It reports new scheme-specific information disclosed by NHS Essex Integrated Care Board on 17 September 2026. The central issue is not the performance of individual GP practices. It is that the responsible NHS commissioner has not produced the cumulative, acute-hospital, ambulance, community-capacity and delivery evidence needed to show how the healthcare consequences of this development will be met.

The absence of an assessment is not evidence that capacity exists. The Council should not treat healthcare impacts as resolved until it has obtained and published a coordinated, scheme-specific NHS response, supported by the relevant hospital trusts, community provider and ambulance service, and established what operational capacity will be delivered, by whom, when and with what enforceable safeguard.

The principal finding: essential questions remain unanswered

NHS Essex ICB states publicly that its statutory role includes planning and funding hospital care, community services and primary care. Its FOI response nevertheless confirms that it has not undertaken a specific cumulative healthcare-demand analysis for Great Dunmow and holds no scheme-specific forecast of the acute-hospital, ambulance or community capacity required for this proposal.

The ICB also says that it holds secondary-care activity datasets capable of analysis at LSOA, ward or postcode-sector level. No Great Dunmow analysis of those datasets was disclosed. The result is an accountability gap: no identified body has yet shown which services will absorb the extra demand, what additional operational capacity is required, who will provide and fund it, when it will be available, or what happens if it is not delivered.

The missing cumulative assessment is especially serious because it does not account for the full development baseline. That baseline must include the committed Easton Park/Highwood Quarry development of up to 1,200 homes, as well as the other large estates already built, partly occupied or permitted across Great Dunmow and the relevant healthcare catchment. Assessing the 850-home proposal in isolation would materially understate the population and service demand that the NHS must plan for.

This healthcare disclosure also illustrates a wider cumulative-infrastructure problem. Great Dunmow has absorbed substantial development over approximately two decades, while further permissions and major proposals continue to advance. The application record does not yet contain one coordinated

assessment demonstrating how the combined growth will be supported across healthcare, roads and public transport, schools, clean water, wastewater and drainage, and energy infrastructure, including electricity and gas where relevant. Separate topic reports do not answer the cross-service question of what capacity exists, what additional infrastructure is required, who will deliver it, when it will operate and what prevents occupation before it is ready.

Existing Great Dunmow primary-care deficit

NHS Essex ICB has confirmed the following current floorspace position:

Practice	Existing deficit	ICB evidence
Angel Lane Surgery	510 m2	Existing floorspace-capacity deficit
John Tasker House Surgery	373 m2	Existing floorspace-capacity deficit
Combined position	883 m2	Calculated total of the two disclosed deficits

The ICB also records approximately 149,000 consultations per year across the two practices and warns that this figure is probably under-recorded. This is not evidence of spare capacity; it is evidence of already heavily used services operating with a substantial premises deficit.

Additional demand from the proposed development

The ICB's figures distinguish the adopted Local Plan allocation from the larger application:

Scenario	Dwellings	Additional patients	Additional GP space
Local Plan allocation	715	1,787	122.5 m2
Current application	850	2,125	145.7 m2
Increase above allocation	135	338	23.2 m2

Using the ICB's stated rate of £6,204 per square metre, 145.7 m2 produces an indicative capital figure of approximately £903,900. That arithmetic is derived from the disclosed formula; the ICB has not stated that figure as a formal contribution request and has not specified the payment or occupation trigger.

Assessments and delivery arrangements not produced

The response confirms that the ICB has not produced or identified:

- a cumulative healthcare-demand assessment covering Easton Park/Highwood Quarry (up to 1,200 homes) and all other housing already built, partly occupied, approved or proposed across Great Dunmow and the relevant healthcare catchment;
- a scheme-specific assessment of acute-hospital use by Great Dunmow residents;
- forecasts for emergency demand, staffed beds, occupancy, waiting times, elective care, diagnostics, workforce or estate constraints at the relevant hospitals;
- a forecast of additional hospital or ambulance activity arising from this development or cumulative Great Dunmow growth;
- an assessment of the additional acute, ambulance and community capacity required, its cost, funding, delivery body or operational date; or
- a coordinated consultation with the relevant acute NHS trusts or ambulance service.

The proposed healthcare response is not defined or secured

The ICB says that the additional space is intended for general practice, but the operator, commissioning route, fit-out funding, revenue funding and staffing plan remain to be determined. It would initially seek to work with existing practices to expand their premises and normally seek a financial contribution rather than land or premises. It does not commission on the basis of a specified number of additional doctors, nurses or appointments.

Most importantly, the ICB expressly confirms that there is no binding safeguard in place if the facility, staffing or commissioning is not delivered. A building, serviced shell, financial contribution or allocation of land is not the same as an operating service. The application does not yet show that mitigation would translate into premises, clinicians, appointments, community services, hospital capacity or ambulance capacity when the residents create the demand.

Developer contributions collected but not transferred or spent

The ICB table contains nine monetary entries relating to Great Dunmow or the surrounding area. Those entries total £419,589.83 as collected by Uttlesford District Council. The same table records £0 transferred to the ICB and £0 spent to date.

Three application references appear more than once, but the response does not explain whether these are separate instalments or duplicated entries. It also does not identify where the money is currently held, its intended project, interest, indexation, spending deadline, repayment provisions or why it has not delivered additional capacity in Great Dunmow.

ICB table total	Transferred to ICB	Spent to date
£419,589.83	£0	£0

Planning implications

- The central planning problem is an unresolved evidence and accountability gap. The Council has not been given an evidence-based account of which services will absorb the demand, what extra capacity is necessary or how and when it will be delivered.
- A long build-out period does not supply the missing evidence or mitigation. It only spreads occupation over time. After approximately two decades of substantial local growth, future delivery

time should not be treated as a substitute for identified projects, funding, accountable delivery bodies and enforceable triggers.

- The healthcare gap forms part of a wider unresolved cumulative-infrastructure question across roads and public transport, education, clean water, wastewater and drainage, and energy. The Council should assess the combined effect of completed, occupied, committed and proposed schemes rather than treating each application and service in isolation.
- The absence of cumulative, acute-hospital and ambulance analysis is an evidence gap, not evidence that no impact will occur.
- The ICB's acknowledged secondary-care datasets should be analysed at the best available Great Dunmow geography. If a provider holds operational evidence, the ICB and Council should obtain and coordinate it rather than leave the question unanswered.
- The acknowledged existing premises deficit is supporting evidence of the baseline. A further 2,125 patients cannot reasonably be assessed as though Great Dunmow begins from a position of adequate provision.
- An undefined future financial contribution does not demonstrate delivery of premises, clinicians, appointments, hospital capacity or ambulance capacity.
- The additional 135 dwellings are not neutral: the ICB's own figures add 338 patients and 23.2 m2 of GP-space need above the Local Plan allocation.
- The history of collected but untransferred and unspent healthcare contributions raises a direct deliverability concern. Further contributions should not be treated as effective mitigation without an identified project, accountable recipient, timetable and enforceable trigger.

Action required before determination

1. Require NHS Essex ICB, as system planner and commissioner, to coordinate and submit a formal scheme-specific consultation response.
2. Require that response to identify the accountable organisation for every element and to incorporate formal evidence from the relevant acute trusts, community provider and East of England Ambulance Service.
3. Require a cumulative healthcare assessment covering Easton Park/Highwood Quarry (up to 1,200 homes) and every other completed, partly occupied, committed and proposed estate in Great Dunmow's relevant healthcare catchment, using the ICB's acknowledged activity datasets and stating their geographical and methodological limitations.
4. Require the healthcare assessment to be reconciled with the Council's cumulative assessment of transport, education, water, wastewater, drainage and energy infrastructure so that dependencies and competing delivery assumptions are visible.
5. Identify the operational healthcare project, operator, premises, capital and fit-out funding, revenue funding, workforce plan and delivery date.
6. Publish the formal healthcare contribution calculation and secure payment and occupation triggers through the Section 106 agreement.
7. Audit the £419,589.83 identified by the ICB and establish where it is held, its intended use and why none has been transferred or spent.
8. Do not treat healthcare impacts or mitigation as resolved unless the necessary operational capacity and enforceable delivery safeguards have been demonstrated before the development creates the demand.

Evidence source

Sources: NHS Essex ICB, FOI Request 2627232, Formal Scheme-specific Healthcare Consultation Response, received 17 September 2026, four pages; and NHS Essex ICB, Our purpose and statutory duties. The FOI response should be published with this representation.

NHS
Essex
Integrated Care Board

Information Governance Team
EICB.FOI@nhs.net

FOI Request: Formal Scheme-specific Healthcare Consultation Response
Our Reference Number: 2627232

Date: 9th17th September 2026

Further to your requests made to **Essex Integrated Care Board** for information relating to the above and pursuant to the Freedom of Information Act 2000, please see the organisation's response below:

I am writing to request NHS Essex ICB's formal scheme-specific response to planning application UTT/26/1635/OP for up to 850 dwellings at The Broadway, Great Dunmow. The evidence already supplied in response to FOI request 2627171 records substantial existing primary-care pressure and a material floorspace deficit. The current planning application proposes space for a healthcare facility, but space alone does not guarantee additional doctors, nurses, appointments or an operational service.

The NHS assessment must also address acute hospital care. The population generated by 850 dwellings will create additional emergency, inpatient, outpatient, elective, maternity, paediatric and diagnostic demand, as well as ambulance demand. Please establish the acute-hospital catchments used by Great Dunmow residents, including the respective roles of Broomfield Hospital and Princess Alexandra Hospital, using actual patient-flow evidence rather than an assumption about administrative boundaries. Please provide a formal consultation response addressing:

1. the present registered-list, clinical-workforce, appointment and floorspace position for the Great Dunmow practices;
Under section 21 of the Freedom of Information Act 2000, a public authority does not have to provide information in response to a request when that information is reasonably accessible to the applicant by other means.
Registered lists are published at Patients registered at a GP practice - NHS England Digital

Clinical workforce information is published at Workforce - NHS England Digital

An indicative 149k consultations (per annum) are recorded for John Tasker House and Angel Lane Surgery. This is likely to be under-recorded so is indicative only.

Angel Lane Surgery is currently operating with a 510m^2 deficit in floorspace capacity. John Tasker House Surgery is currently operating with a 373m^2 deficit in floorspace capacity.

2. cumulative demand from housing already built, approved and proposed in and around Great Dunmow;
There is no specific demand analysis undertaken by the ICB on this specific issue.

3. the additional patient demand expected from 850 dwellings, rather than the Local Plan allocation of 715;
Additional patient demand that would be expected from 715 dwellings is 1,787; additional GP floorspace required would be 122.5m^2. Additional patient demand that would be expected from 850 dwellings is 2,125; additional GP floorspace required would be 145.7m^2. The difference in

additional patient demand is an increase of 338. The difference in additional GP floorspace required is an increase of 23.2m^2.

4. the acute hospitals presently used by Great Dunmow residents and the proportion of relevant activity directed to Broomfield Hospital, Princess Alexandra Hospital and any other provider;
The ICB has not undertaken a scheme-specific analysis of acute hospital utilisation by Great Dunmow residents, nor produced an assessment of the proportion of activity attributable to individual acute providers in relation to this development proposal.
The ICB holds secondary care activity datasets containing geography fields such as LSOA, ward and postcode sector-derived geography rather than full patient postcodes. Therefore, the ICB does not hold any recorded information in relation to this specific request.

5. the current and forecast position at those hospitals for emergency demand, staffed beds and occupancy, waiting times, elective and diagnostic demand, workforce vacancies and estate constraints;
No specific forecasting is held by the ICB in relation to the development of homes in the Dunmow area.

6. the additional hospital and ambulance activity expected from 850 dwellings and from cumulative completed, approved and proposed Great Dunmow growth;
No specific forecasting is held by the ICB in relation to the development of homes in the Dunmow area.

7. the specific additional acute, ambulance and community capacity required, its cost, funding source, responsible delivery body and operational delivery date;
No specific forecasting is held by the ICB in relation to the development of homes in the Dunmow area.

8. whether the relevant acute NHS trusts and ambulance service have been formally consulted on this application, and copies of their scheme-specific responses;
This process has not been managed by the ICB. Those organisations would need to be contacted separately.

9. the services intended for the proposed facility and whether this represents new capacity or relocation of an existing service;
The additional space identified in answer 3 is for primary medical services (general practice).

10. the intended operator, commissioning route, capital and fit-out funding, revenue funding and staffing plan;
To be determined. The ICB would initially seek to work with existing local practices to expand their premises.

11. the number of additional doctors, nurses and appointments that would be delivered;
The ICB does not commission primary care services on the basis of specific staffing numbers or appointments.

Commented [G91]: @JOSHI, Janette (NHS ESSEX ICB - 06Q) Hi Janette - do you know if this information would be held anywhere within the ICB?

Commented [IG2R1]: @MACPEPPLE, Ekelechi (NHS ESSEX ICB - 99F) - can we determine this from the national datasets held?

12. the Section 106 contribution, land or premises specification and occupation trigger required by the ICB;

The ICB would normally request a financial contribution to mitigate the impact of a development of 850 dwellings, rather than land or premises. The payment trigger would be negotiated through the planning process. The ICB calculates the Capital cost of additional health services arising from the development proposal as follows:

- *Additional population growth* is calculated using the Uttlesford District Council average household size of 2.5 taken from the 2011 Census: Rooms, bedrooms and central heating, local authorities in England and Wales (rounded to the nearest whole number).
- *Additional floorspace required to meet growth (m²)* is based on 120m² per 1750 patients (this is considered the current optimal list size for a single GP within the Essex ICB). Space requirement aligned to DH guidance within "Health Building Note 11-01: facilities for Primary and Community Care Services".

- *Capital required to create additional floor space (£)* is based on £6,204/m2 derived from BCIS cost multiplier (£4,575/m2) for health centres using rates for gross internal floor area for the building costs including prelims updated to Q4 2025 and rebased for Essex, plus fees (13%) and VAT (20%) rounded to nearest £100.

13. what binding safeguard is required if the facility, staffing or commissioning is not delivered; and

There is not a binding safeguard in place.

14. healthcare contributions received from completed Great Dunmow developments, including the amount received, the body that received it, where it was spent and what additional capacity was delivered in Great Dunmow.

Application	Town	Development	Monies collected by Uttlesford District Council	Monies transferred to ICB	Monies spent to date
UTT/13/2107/OP	Dunmow	Land West of Woodside Way, Woodside Way, Great Dunmow	£308,346.18	£0	£0
UTT/14/0127/FUL	Gt. Dunmow	Land south of Ongar Rd, Great Dunmow	£17,358.06	£0	£0
UTT/16/1435/FUL	Gt. Dunmow	Land North of Ongar Rd, Great Dunmow	£20,626.61	£0	£0
UTT/19/1437/FUL	Gt. Dunmow	77 High St, Great Dunmow CM6 1AE	£9,155.17	£0	£0
UTT/16/1435/FUL	Gt. Dunmow	Land north of Ongar Rd, Great Dunmow	£20,626.61	£0	£0
UTT/14/0127/FUL	Gt. Dunmow	Land south of Ongar Rd, Great Dunmow	£17,358.03	£0	£0
UTT/14/0005/OP	Gt. Dunmow	Land off Tanton Rd, Flitch Green, Dunmow	£16,964.00	£0	£0
UTT/23/0638/FUL	Dunmow	Stane House, 77 High St, Dunmow	£305.17	£0	£0

UTT/19/1437/FUL	Gt. Dunmow	77 High St, Great Dunmow CM6 1AE	£8,850.00	£0	£0

If you are dissatisfied with the response you have received, you have the right to request a review of our decision or make a complaint about how your request has been handled. Your request should be made within 40 working days of receipt of this letter, and we will reply within 20 working days of receipt. Any such request received after 40 working days will only be considered at the discretion of the organisation.

If our decision is unchanged following a review and you remain dissatisfied with this, you then have the right to make a formal complaint to the Information Commissioner who can be contacted at:
Information Commissioners Office, Wycliffe House, Water Lane, Wilmslow, Cheshire SK9 5AF.

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Should you require any further information, please do not hesitate to contact the FOI team via the methods above.

Yours sincerely,

Jimmy Allimadi
FOI Officer