Torbay and South Devon
NHS Foundation Trust

P/2017/1133 - Land To The South Of White Rock Adjacent To Brixham Road Aka Inglewood Paignton

Torbay and South Devon NHS Foundation Trust's Consultation Response and Regulation 122 CIL compliance statement in respect of the above planning application :

Definitions

- ***Accident and emergency care:*** *An A&E department (also known as emergency department or casualty) deals with genuine life-threatening emergencies requiring urgent assessment and/or intervention.*

- ***Acute care:*** *This is a branch of hospital healthcare where a patient receives active but short-term treatment for a severe injury or episode of illness, an urgent medical condition, or during recovery from surgery. In medical terms, care for acute health conditions is the opposite from chronic care, or longer term care.*

- ***Block Contract:*** *An NHS term of art for an arrangement in which the health services provider (as used in the UK, providers refer to corporate entities such as hospitals and trusts, and not to individuals) is paid an annual fee in installments by the Healthcare Commissioner in return for providing a defined range of services.*

- ***Clinical Commissioning Group:*** *CCGs are clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area.*

- ***Commissioning for Quality and Innovation payment frame (CQUIN)*** *is a framework that supports improvements in the quality of services and the creation of new, improved patterns of care. The system was introduced to make a proportion of healthcare providers' income conditional on demonstrating improvements in quality and innovation in specified areas of patient care.*

- ***Dr Foster****: Dr Foster allows the Trust to understand the patient flow throughout the regions around the hospital and has developed methodologies to support organisations to improve quality and efficiency through the use of data.*
- ***Emergency care:*** *Care which is unplanned and urgent.*
- ***NHSI:*** *NHS Improvement*
- ***ONS:*** *Office of National Statistics.*
- ***OPEL:*** *Operational Pressures Escalation Levels are way for Trusts to report levels of pressure consistently nationally.*
- ***Planned care:*** *Medical care that is provided by a specialist or facility upon referral by a primary care physician and that requires more specialised knowledge, skill, or equipment than the primary care physician can provide.*
- ***Premium Costs:*** *Premium costs incurred can include the supply of agency staff, Locum Medical Staff and payments to deliver services to meet operational pressures, which exceed the costs incurred when delivering with substantive staff. The Trust also sub-contracts the provision of certain services to third parties to meet demand.*
- ***Secondary care:*** *Medical care that is provided by a specialist or facility upon referral by a primary care physician and that requires more specialised knowledge, skill, or equipment than the primary care physician can provide*
- ***Sustainability and Transformation Fund (STF): a fund that supplements the health provider's income***

Introduction

As our evidence will demonstrate, Torbay and South Devon NHS Foundation Trust (the Trust) is currently operating at full capacity in the provision of acute and planned healthcare. It is further demonstrated that although the Trust has plans to cater for the known population growth, it cannot plan for unanticipated additional growth in the short to medium term. The Trust is paid for the activity it has delivered subject to satisfying the quality requirements set down in the NHS Standard Contract. Quality

requirements are linked to the on-time delivery of care and intervention and are evidenced by best clinical practice to ensure optimal outcomes for patients. The contract is agreed annually based on previous year's activity plus any pre-agreed additional activity for clinical service development and predicted population growth (this does not include ad-hoc housing developments and it does not take into consideration LPA's housing need or housing projections). The following year's contract does not pay previous year's increased activity. The contribution is being sought not to support a government body but rather to enable that body to provide services needed by the occupants of the new development, and the funding for which, as outlined below, cannot be sourced from elsewhere. 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 the contribution, the development is not sustainable and should be refused.

The Trust considers that the request made is in accordance with Regulation 122:

"(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."

Regulation 123 does not apply to this s 106 Contribution. The request is not to fund infrastructure as defined by S 216 of the Planning Act 2008.

Evidence

1. Torbay and South Devon NHS Foundation Trust has an obligation to provide healthcare services. Although run independently, NHS Foundation Trusts remain fully part of the NHS. They have been set up in law under the Health and Social Care (Community Health and Standards) Act 2003 as legally independent organisations called Public Benefit Corporations, with the primary obligation to provide NHS

services to NHS patients and users according to NHS principles and standards - free care, based on need and not ability to pay. NHS Foundation Trusts were established as an important part of the government's programme to create a "patient-led" NHS. Their stated purpose is to devolve decision-making from a centralised NHS to local communities in an effort to be more responsive to their needs and wishes. However, they cannot work in isolation; they are bound in law to work closely with partner organisations in their local area.

2. The Trust is a public sector NHS body and is directly accountable to Parliament for the effective use of public funds. The Trust is funded from the social security contributions and other State funding, providing services free of charge to affiliated persons of universal coverage. The Trust is commissioned to provide acute healthcare services to the population of (but not limited to) the Clinical Commissioning Group (CCG):

    - South Devon and Torbay CCG

3. The Trust is a secondary care and community services provider delivering a range of planned, emergency hospital and community care with social care services to residents of the aforementioned areas. It provides urgent and emergency care services for residents for whom it is the nearest Accident and Emergency (A&E) provider and often for residents from further afield when their closest A&E is under particular pressure.

4. The Trust is an integrated organisation providing acute health care services from Torbay Hospital, community health services and adult social care.

5. The Trust was established as an NHS Foundation Trust in October 2015. NHS Foundation Trusts are part of the NHS and subject to NHS standards, performance ratings and systems of inspection. They have a duty to provide NHS services to NHS patients according to NHS quality standards and principles. They have stronger local ownership and greater involvement of their local communities through their links with their members. Local people, patients, carers, and staff are all able to become members of their local NHS Foundation Trust.

6. Every NHS Foundation Trust is authorised to operate by a licence issued by the Independent Regulator. The terms of each NHS Foundation Trust's licence sets out the conditions under which they must operate including:

   - The health services that the Trust is authorised and required to provide to the NHS;
   - The standards to which they must operate and against which the Care Quality Commission (CQC) will inspect;
   - A list of assets such as buildings, land or equipment that are designated as 'protected' because they are needed to provide required NHS services;
   - The amount of money an NHS Foundation Trust is allowed to borrow.

7. Like all other NHS bodies, NHS Foundation Trusts are inspected against national standards by the Care Quality Commission (CQC). The Independent Regulator, NHS Improvement, monitors each NHS Foundation Trust to ensure they do not breach the terms of their authorisation. If an NHS Foundation Trust significantly breaches the terms of its authorisation, or finds itself in difficulty, NHS Improvement has a range of intervention powers, including powers to:

   - Issue warning notices;
   - Require the Board of Governors or Board of Directors to take certain actions;
   - Suspend or remove the Board of Governors or members of the Board of Directors.
   - In the most serious cases, where NHS Improvement intervention cannot resolve the breach, an NHS Foundation Trust can be dissolved.

Funding Arrangements for the NHS Foundation Trust

8. South Devon and Torbay CCG commission Torbay and South Devon NHS Foundation Trust to provide acute and community healthcare services to the population of those areas under the terms of the NHS Standard Contract. This

involves identifying the health needs of the population and commissioning the appropriate high quality services necessary to meet these needs within the funding allocated. The CCG commission planned and emergency acute healthcare from the Trust and agree a service level agreement, including activity volumes and values on an annual basis under Block Contract. The Trust directly provides the majority of healthcare services through employed staff but has some staff sub-contracted and/or locum staff for services when under operational pressure.

9. The Trust is required to provide the commissioned health services to all people that present or who are referred to the Trust. "*The Trust must accept any Referral of a Service User however it is made unless permitted to reject the Referral under this Service Condition*"[1]. There is no option for the Trust to refuse to admit or treat a patient on the grounds of a lack of capacity to provide the service/s. This obligation extends to all services from emergency treatment at A&E to routine/non-urgent referrals. Whilst patients are able in some cases to exercise choice over where they access NHS services, in the case of an emergency, they are taken to their nearest appropriate A&E Department by the ambulance service. The Torbay and South Devon is one of the nearest A&E departments to this proposed development. Since 2008, patients have been able to choose which provider they use for their healthcare for particular services. The 2014/15 Choice Framework explains when patients have a legal right to choice about treatment and care in the NHS. The legal right to choice does not apply to all healthcare services, and for acute healthcare it only applies to first outpatient appointments, specialist tests, maternity services and changing hospitals if waiting time targets are not met.

Performance Trajectory

10. The Trust is asked to submit monthly performance trajectories in relation to certain standards in order to receive money from the Sustainability and Transformation Fund. One of the standards which the trajectories impose upon all Trusts is the 4-hour A & E waiting time. Failure to deliver services in accordance with the performance trajectory agreed, results in withdrawal of STF.

[1] NHS Standard Contract- Service Condition SC7

11. Operational Pressures Escalation Levels are way for the Trust to report levels of pressure consistently. Under OPEL, there are 4 escalation levels, where Level 1 shows the Trust is maintaining patient flow and able to meet anticipated demand. In contrast, escalation to Level 4 shows the Trust is unable to deliver comprehensive care and there is a greater risk on patient care and safety being compromised.

    Please see the two diagrams at **Appendix 4** which demonstrate the Trusts performance in relation to the national standards described above. It can be clearly seen that the Trust is frequently experiencing major pressures and its inability to cope with the increasing patient demand. New development within the regions will inevitably add to the already over-burdened NHS and will put the Trust at a serious risk of losing the ST funding. In 2017/18 the Trust was unable to meet its trajectory and lost over £1million. This is something that the Trust is not able to recover. Further and most importantly, this will affect the Trust's ability to provide the service required. This development will have a direct impact on the Trust's performance.

Improvement Goals

12. The Commissioning for Quality and Innovation (the "CQUIN") payment framework makes a proportion of NHS healthcare provider income conditional on achieving certain improvement goals. In 2016/2017 the Trust was conditional upon achieving improvement goals. The conditional income for 2015/2016 was £4,125,000 in 2016/17 was £4,634,000 and in 2017/2018 it was £4,686,000.[2] An impact which interferes with the achievement of the CQUIN's improvement goals will jeopardise the additional income received through the CQUIN. This residential development will have a detrimental impact on the Trust's ability to provide those goals.

Planning for the Future

13. It is evident that the existing, ageing population and future population growth will require additional healthcare infrastructure to enable it to continue to meet the acute and community healthcare needs of the local population.

[2] Torbay and South Devon NHS Foundation Trust, Annual Reports and Accounts 2016/2017 page 133

14. It is **not** possible for the Trust to predict when planning applications are made and delivered and, therefore, cannot plan for additional development occupants as a result. The Trust has considered strategies to address population growth across its area and looked at the overall impact of the known increased population to develop a service delivery strategy to serve the future healthcare needs of the growing population. This strategy takes into account the trend for the increased delivery of healthcare out of hospital and into the community. However, the commissioning operates based on previous year's performance and does not take into account potential increase in population created by a prospective development. It does not take into account housing land supply, housing need or housing projections.

Current Position

15. Across England, the number of acute beds is one-third less than it was 25 years ago[3], but in contrast to this the number of emergency admissions has seen a 22% increase in the last 10 years[4]. The number of emergency admissions is currently at an all-time high.

16. The Trust's hospitals are now at full capacity and there are limited opportunities for it to further improve hospital capacity utilisation. Whilst the Trust is currently managing to provide the services in a manner that complies with the Quality Requirements of the NHS, there are not sufficient resources or space within the existing services to accommodate sudden population growth created by the development, without the quality of the service as monitored under the standards set out in the Quality Requirements dropping, and ultimately the Trust facing sanctions for external factors which it is unable to control.

17. In order to maintain adequate standards of care as set out in the NHS Standard Contract quality requirements, it is well evidenced in the Dr Foster Hospital Guide that a key factor to deliver on-time care without delay is the availability of beds to ensure timely patient flow through the hospital. The key level of bed provision should support a maximum bed occupancy of 85%. The 85% occupancy rate is evidenced to

[3] Older people and emergency bed use, Exploring variation. London: King's Fund 2012
[4] Hospital Episode Statistics.www.hesonline.nhs.uk/Ease/servlet/ContentServer?siteID=1937

result in better care for patients and better outcomes[5]. This enables patients to be placed in the right bed, under the right team and to get the right clinical care for the duration of their hospital stay. Where the right capacity is not available in the right wards for the treatment of a particular ailment, the patient will be admitted and treated in the best possible alternative location and transferred as space becomes available. Multiple bed/ward moves increases the length of stay for the patient and is known to have a detrimental impact on the quality of care. Consequently, when hospitals run at occupancy rates higher than 85%, patients are at more risk of delays to their treatment, sub-optimal care and being put at significant risk.

22 **Appendix 2** details that the Trust's utilisation of acute bed capacity exceeded the optimal 85% occupancy rate for the majority of 2017/18. This demonstrates that current occupancy levels are highly unsatisfactory, and the problem will be compounded by an increase in the population, which does not coincide, with an increase in the number of bed spaces available at the Hospital. This is the inevitable result where clinical facilities are forced to operate at over-capacity and is why there is now a very real need to expand the Trust facilities. Any new residential development will add a further strain on the current acute healthcare system.

23 During 2016/17, residents from South Devon and Torbay CCG attended the Trust's A&E Department 65,664 times and this number increased to 66,791 in 2017/2018. The first 8 months of 2018/2019 has seen 45,428 residents attended that when annualised will see a further annual increase to 68,142 A&E visits.

18. Residents from the area are currently generating significant interventions per head of population per year. This is detailed in full in Appendix 3.

19. The population increase associated with this proposed development will significantly impact on the service delivery and performance of the Trust until contracted activity volumes include the population increase. As a consequence of the development and its associated demand for acute and planned health care, there will be an adverse effect on the Trust's ability to provide "on time" care delivery without delay due to inadequate funding to meet demand because of the preceding year's outturn activity

[5] British Medical Journal- Dynamics of bed use in accommodating emergency admissions: stochastic simulation model

volume based contract which will result in financial penalties due to the Payment by Results regime.

20. The only way that the Trust can maintain the "on time" service delivery without delay and comply with NHS quality requirements is that the developer contributes towards the cost of providing the necessary capacity for the Trust to maintain service delivery during the first year of occupation of each dwelling. Without securing such contributions, the Trust will have no funding to meet healthcare demand arising from each dwelling during the first year of occupation and the health care provided by the Trust would be significantly delayed and compromised, putting the local people at risk. The lack of funding will have a long term impact on the Trust's ability to provide services.

Impact Assessment Formula

21. The Trust has identified the following:-

22. A development of **400 dwellings** equates **960** new residents (based on the current assumption of 2.4 persons per dwelling, using existing 2018[6] demographic data). This residential development will therefore generate **2,616 acute interventions** over the period of 12 months. This comprises additional interventions by point of delivery for:

- **376** A&E based on % of the population requiring an attendance
- **97** Non elective admissions based on % of the population requiring an admission
- **33** Elective admissions based on % of the population requiring an admission
- **105** Day-case admissions based on % of the population requiring an admission
- **1,298** Outpatient admissions based on % of the population requiring an admission
- **708** Diagnostic Imaging based on % of the population requiring diagnostic imaging

[6] ONS 2018Population Estimates)

Formula:

Increase in Service Demand:

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

23. As a consequence of the above and due to the payment mechanisms and constitutional and regulatory requirements the Trust is subject to, it is necessary that the developer contributes towards the cost of providing capacity for the Trust to maintain service delivery during the first year of occupation of each unit of the accommodation on/in the development. The Trust will not receive the full funding required to meet the healthcare demand due to the baseline rules on emergency funding and there is no mechanism for the Trust to recover these costs retrospectively in subsequent years as explained. Without securing such contributions, the Trust would be unable to support the proposals and would object to the application because of the direct and adverse impact of it on the delivery of health care in the Trust's area. Therefore the contribution required for this proposed development of **400 dwellings** is **£353,857.00.** This contribution will be used directly to provide additional health care services to meet patient demand.

24. The contribution requested is based on these formulae/calculations, and by that means ensures that the request for the relevant landowner or developer to contribute towards the cost of health care provision is directly related to the development proposals and is fairly and reasonably related in scale and kind. Without the contribution being paid the development would not be acceptable in planning terms because the consequence would be inadequate healthcare services available to support it, also it would adversely cause short and long term impact on the delivery of healthcare not only for the development but for others in the Trust's area.

25. Having considered the cost projections, and phasing of capacity delivery we require for this development it is necessary that the Trust receives 100% of the above figure prior to implementation of the planning permission for the development. This will help us to ensure that the required level of service provision is delivered in a timely manner. Failure to access this additional funding will put significant additional

pressure on the current service capacity leading to patient risk and dissatisfaction with NHS services resulting in both detrimental clinical outcomes and patient safety.

Summary

26. As our evidence demonstrates, the Trust is currently operating at full capacity in the provision of acute and planned healthcare. It is further demonstrated that although the Trust has plans to cater for the ageing population and growth, it will not be able to plan for the growth in a piecemeal manner. The contribution is being sought not to support a government body but rather to enable that body to provide services needed by the occupants of the new homes. 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 contributions to maintain the delivery of health care services at the required quality standard and to secure adequate health care for the locality the proposed development will put too much strain on the said service infrastructure, putting people at significant risk. This development imposes an additional demand on existing over-burdened healthcare services, and failure to make the requested level of healthcare provision will detrimentally affect safety and care quality for both new and existing local population. This will mean that patients will receive substandard care, resulting in poorer health outcomes and pro-longed health problems. Such an outcome is not sustainable.

27. One of the three overarching objectives to be pursued in order to achieve sustainable development is to include *b)* ***a social objective*** *– to support strong, vibrant and healthy communities … 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:"* NPPF paragraph 8. There will be a dramatic reduction in safety and quality as the Trust will be forced to operate over available capacity as the Trust is unable to refuse care to emergency patients. There will also be increased waiting times for planned operations and patients will be at risk of multiple cancellations. This will be an unacceptable scenario for both the existing and new population. The contribution is necessary to maintain sustainable development. Further the contribution is carefully calculated based on

specific evidence and fairly and reasonably related in scale and kind to the development. It would also be in the accordance with Council's Adopted Local Plan.

Adopted local plan review policies

Policy SC1 Healthy Bay

All development should contribute to improving the health and well-being of the community, reducing health inequalities and helping to deliver healthy lifestyles and sustainable neighbourhoods proportionate to the scale of the proposal.

To achieve these requirements, applicants should demonstrate that they have had regard to the following:

1. *Consideration of the opportunities available to address the cause of ill-health in the local area;*

2. *Promotion of healthy, safe and active living for all age groups, including healthy living, options for older people; and*

3. *Improvement of access to medical treatment services, including the provision of healthcare clusters where appropriate,*

Major residential developments of 30 or more dwellings or other development creating over 1,000 square metres of floorspace will be required to undertake a screening for Health Impact Assessment (HIA), and a full HIA if necessary, proportionate to the development proposed, to demonstrate how they maximise positive impacts on health and healthy living within the development and in adjoining areas. This will also apply to smaller-scale developments where there are reasons to indicate that a proposal may give rise to a significant impact on health.

Chapter 8 of the NPPF elaborates paragraph 8 in paragraph 92, which directs that:

To provide the social, recreational and cultural facilities and services the community needs, planning policies and decisions should:

a) … ;

b) … ;

c) guard against the unnecessary loss of valued facilities and services, particularly where this would reduce the community's ability to meet its day-to-day needs;

d) ensure that established shops, facilities and services are able to develop and modernise, and are retained for the benefit of the community; and

e) … .

Further, the Planning Practice Guidance ('PPG') provides that:

Local planning authorities should ensure that health and wellbeing, and health infrastructure are considered in local and neighbourhood plans and in planning decision making. Public health organisations, health service organisations, commissioners and providers, and local communities should use this guidance to help them work effectively with local planning authorities in order to promote healthy communities and support appropriate health infrastructure.

Paragraph: 001 Reference ID: 53-001-20140306

The PPG goes on to suggest that information about the impact of a development on the demand for healthcare services[1]:

… should assist local planning authorities consider whether the identified impact(s) should be addressed through a Section 106 obligation or a planning condition.

…Paragraph: 004 Reference ID: 53-004-20140306

[1] It is acknowledged that this arises in the context of a discussion of consultation with Clinical Commissioning Groups and NHS England, but plainly it would also apply with equal force to information provided by the Trust.

28. In the circumstances, without the requested contributions to support the services infrastructure the planning permission should not be granted.

Date: 7 December 2018

Appendix 1
Extract from Fit For the Future, The Dr Foster Hospital Guide 2012

HOSPITALS UNDER PRESSURE

KEY FINDINGS

FULL TO BURSTING
The peak occupancy rate for NHS beds is 92%. For 48 weeks a year most trusts are more than 90% occupied.

SUPPORT IN THE COMMUNITY
A lack of integration with social care and community services is contributing to the pressure on NHS hospitals.

A WORSENING PROBLEM
Rising numbers of emergency admissions of frail elderly patients have required an additional 10,000 bed days over the past five years. That is equivalent to two new hospitals.

DECREASED AVAILABILITY
The number of acute and general beds in the NHS has decreased by a third in the past 25 years.[1]

8

TECHNICAL BRIEFING

The number of hospital beds has decreased by a third in the past 25 years[1], as hospital stays have become shorter. However, admissions are rising, especially for groups such as the frail elderly (see page 11). This is one of the main causes for the growing pressure on hospital beds.

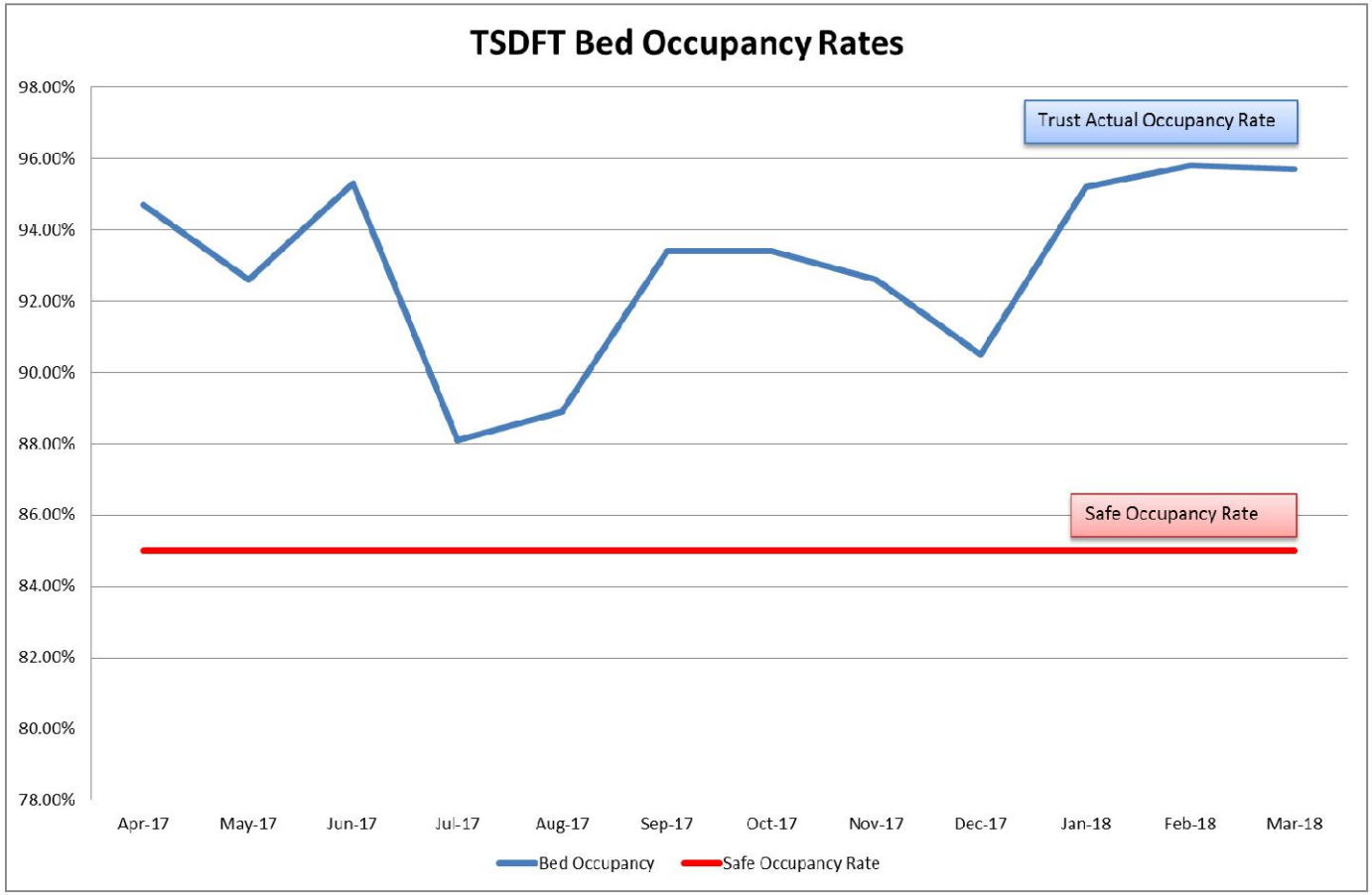
The NHS publishes figures for NHS trusts giving the average percentage of hospital beds that are occupied. These figures disguise the highs and lows in occupancy that occur week by week and season by season. According to these figures, the NHS has an average occupancy rate of just over 85%[2].

When occupancy rates rise above 85% it can start to affect the quality of care provided to patients and the orderly running of the hospital.[3]

Our analysis calculates the number of patients in hospital each day and compares it to the number of beds the hospital says it has available.

Our figures reveal the extent to which occupancy varies from the low points at weekends and during bank holidays to the high points, when occupancy rates at some hospitals can reach 100%. This analysis shows that the average mid-week occupancy in the NHS is 88%, and that for most of the year most NHS hospitals are experiencing occupancy rates above 90%.

Appendix 2 - The chart below details Trust's actual bed occupancy during April to July 2018 as published in the reported open data figures available from the Daily Sitrep Occupancy reporting performance data TSDFT. The Daily Sitrep Occupancy takes a figure as at 8am each day, therefore capturing all of the overnight admissions.



NHS
Torbay and South Devon
NHS Foundation Trust

Appendix 3
Breakdown of Costs for requested contribution

Torbay & South Devon NHS Foundation Trust

Application Reference:	P/2017/1133	Land To The South Of White Rock Adjacent To Brixham Road Aka Inglewood Paignton
Local Authority / Area	Torbay	
Population Estimate (LSOAs):	291,933	(based on ONS Mid 2016)
Population Estimate (HGS):	291,933	(based on ONS Mid 2016)

Development Dwellings	400
Population Multiplier	2.4
Development Population	960
	100%

	Expenditure Profile £k	
	2016/17*	2017/18**
Clinical Pay	226,009	223,189
All other costs	191,139	187,533
Total Costs*	417,148	410,722

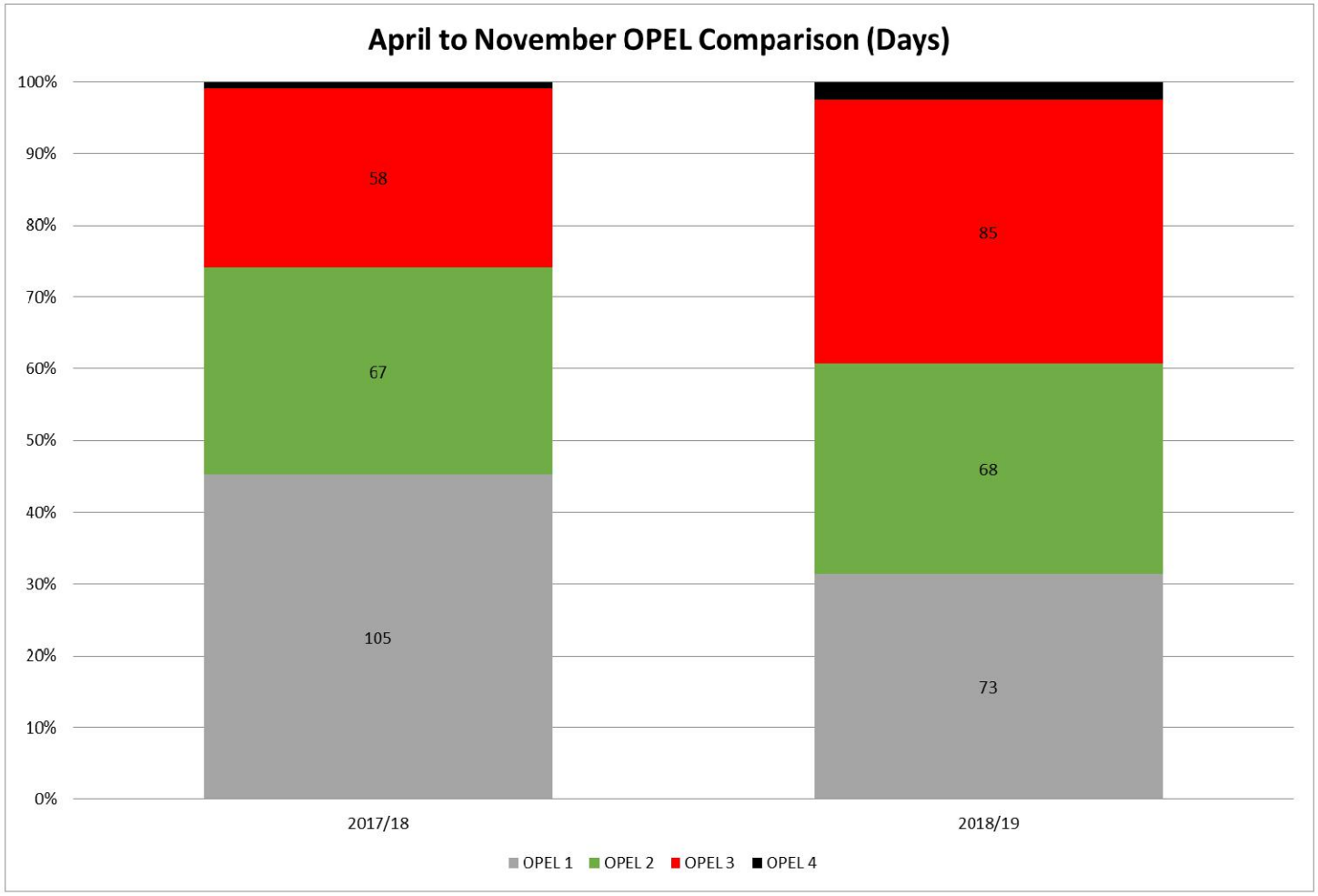
Staffing cost %	54%	54%
Premium Staff Cost %	51%	51%

* Total Operating Costs Note 5.1 2016/17 Accounts
** 2017/2018 TSDFT Accounts

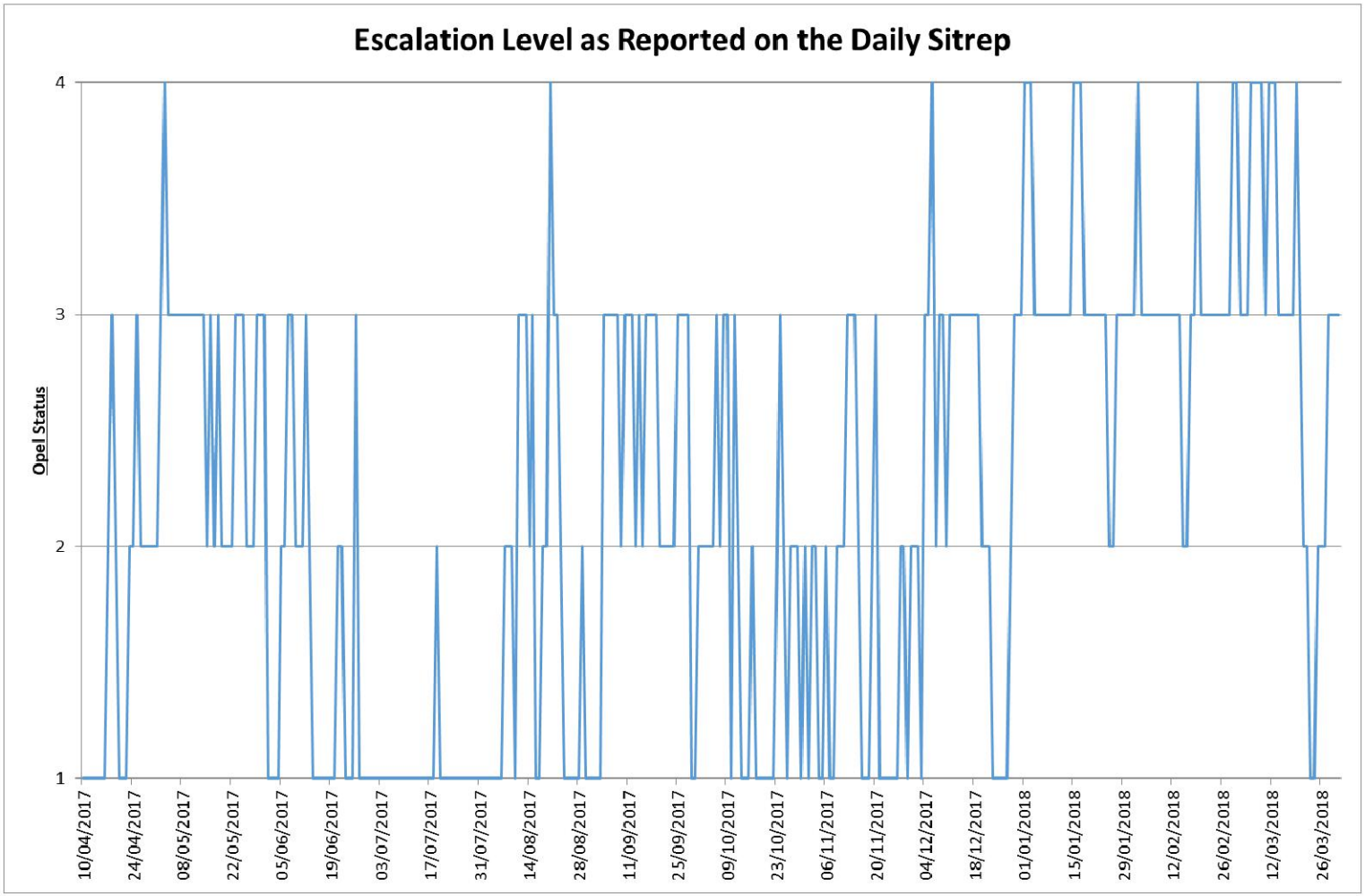
Activity Type	Trust Level Activity 2016/17 Reference Costs	% Activity Rate per Annum - Trust wide	Activity Rate per Annum per head of Population	Activity - this LSOA	Activity Rate per Annum per head of Population - this LSOA	Delivery Cost per Activity 2016-17 Reference Costs £	12 months Activity for proposed Population	Delivery Cost for Planned Dwellings £	Marginal Rate (MRET) on Efficiencies £	Premium costs of Delivery £	Cost Pressure (Claim) £
A&E Attendances	114,197	39.1%	11:29	114,197	39.1%	143	376	53,701		14,838	14,838
Non Elective Admissions	29,594	10.1%	2:29	29,594	10.1%	1,975	97	192,202	192,202	53,109	245,311
Non Elective (Short Stay)			0:0								
Elective Admissions	10,039	3.4%	1:29	10,039	3.4%	3,289	33	108,578		30,002	30,002
Day Case (Elective)	31,808	10.9%	3:29	31,808	10.9%	609	105	63,700		17,601	17,601
Outpatient Appointments	394,847	135.3%	39:29	394,847	135.3%	86	1,298	111,665		30,855	30,855
Outpatient Appointments (Procedure)			0:0								
Diagnostic Imaging	215,162	73.7%	21:29	215,162	73.7%	78	708	55,188		15,249	15,249
Total							2,616		192,202	161,654	353,857

Contribution per Dwelling £	885

Appendix 4 – These charts demonstrates that the Trust has had to escalate to the nationally agreed level 3 and 4 more frequently compared to previous years, this indicates that demand is exceeding the capacity.



Appendix 4 continued…



SHAKESPEAREMARTINEAU

Section 106 Appeal decisions

No	Appeal Decision	Reference
1.	Appeal decision of Land North of Campden Road, Shipston-on-Stour, Warwickshire	APP/J3720/A/14/2221748
2.	Appeal decision of Land at Spring Lane, Radford Semele, Leamington Spa, CV31 1XD	APP/T3725/A/14/2221858
3.	Appeal decision of Arden Heath Farm, Loxley Road, Stratford-upon-Avon, CV37 7DU	APP/J3720/W/15/3004380
4.	Appeal Decision of Land South of Stockton Road, Long Itchington, Warwickshire	APP/J3720/W15/3009042
5.	Appeal decision in relation to South of Gallows Hill/West of Europa Way, Heathcote, Warwick.	APP/T3725/A/14/2229398
6.	Appeal of Land at ASPS Bound by Europa Way (A452) to the East and Banbury Road (A425) to the West.	APP/T3725A/14/2221613

In the matter of articles 101 and 102 of the Treaty of the Functioning of the European Union

And in the matter of The Town & Country Planning Act 1990

And in the matter of:

The South Warwickshire Foundation Trust

OPINION

Paul Cairnes
No5 Chambers

The Wilkes Partnership
41 Church Street
Birmingham
B3 2RT

Ref: Leenamari Aantaa-Collier

1. Opinion.

In this matter I am instructed on behalf of the South Warwickshire NHS Foundation Trust ('the SWFT'). For the reasons that are set out in detail herein my opinion may be summarised as follows:

(a) Any increase in population will have an additional impact upon the ability of the SWFT to meet its NHS obligations during any given year until that increased activity is factored into the ceiling activity volume for the following year.

(b) The social impacts of new development within the SWFT area will amount to a material consideration in planning terms for the purposes of decision-makers. In particular, the potential impact of development proposals upon the health of communities would ordinarily be afforded significant weight by decision makers.

(c) The financial formula proposed by the SWFT is a robust calculation of the resultant shortfall in funding generated by new residential development. It also meets the statutory tests in the Community Infrastructure Levy Regulations 2010 and the policy tests in the National Planning Policy Framework.

(d) The activities provided by the SWFT (i.e. providing NHS care to NHS patients according to NHS quality standards and principles – free care based on need, not ability to pay) would not fall within the definition of an 'undertaking' for the purposes of EC competition law.

(e) The provision by SWFT of free care based on need, not ability to pay, would also place contributions it receives as falling within the article 107(2)(a) TFEU exception, which excludes certain categories of State aid as being compatible with the internal market.

2. Background.

2.1 The South Warwickshire NHS Foundation Trust ('the SWFT') is the major provider of acute and community health services to the population of South Warwickshire. It was established in March 2010 pursuant to the provisions of the Health and Social Care (Community Health and Standards) Act 2003 ('the 2003 Act').

2.2 An NHS foundation trust is a 'public benefit corporation' authorised to provide goods and services for the purposes of the health service in England[1]. NHS Foundation Trusts are part of the NHS and subject to NHS Standards, performance ratings and systems of inspection.

2.3 The 2003 Act provides for an independent regulatory body[2] (known as 'Monitor') to ensure that a Foundation Trust exercises its functions in a manner that is consistent with the performance by the Secretary of State of the duties under sections 1, 3 and 51 of the National Health Service Act 1977[3]. All NHS Foundation Trusts are authorised to operate under a licence issued by Monitor[4]. The licence sets out the conditions of operation[5], including (in the case of the SWFT):

- The health services that the trust is authorised and required to provide to the NHS.
- The standards to which it must operate and against which the Care Quality Commission will inspect.
- A list of assets such as buildings, land or equipment that are designated as protected because they needed to provide required NHS services.
- The amount of money and NHS foundation trust is allowed to borrow.

Whilst the role of Monitor is to ensure that they do not breach the terms of their authorisation, in common with all NHS bodies NHS Foundation Trusts are inspected against national standards by the Care Quality Commission[6].

2.4 As indicated in the NHS publication "*A Short Guide to NHS Foundation Trusts*", they "have a primary purpose of providing NHS care to NHS patients according to NHS quality standards and principles – free care based on need, not ability to pay"[7].

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[1] 2003 Act, s.1(1).
[2] See 2003 Act, ss.2-3 and Schedule 2.
[3] The duty as to health service and services generally and as to university clinical teaching and research.
[4] 2003 Act, s.6.
[5] 2003 Act, ss.6 & 14.
[6] Established pursuant to the Health & Social Care Act 2008.
[7] See para 1.2.

2.5 The funding arrangements for the SWFT are principally made pursuant to an Activity Based Payment System. This may be summarised as follows[8]:

- The South Warwickshire Clinical Commissioning Group ('CCG') commissions the SWFT to provide acute and community health care services to the population of South Warwickshire under the terms of the NHS standard contract.
- This involves identifying the health needs of the population and commissioning the appropriate high quality services necessary to meet these needs within the budget allocated.
- The CCG commissions planned and emergency acute healthcare from SWFT and agrees a service level agreement, including activity volumes and values on an annual basis.
- The SWFT is required to provide the commissioned health services to all people that present or who are referred to the Trust. The conditions attached to its licence require the Trust to accept any referral however it is made unless expressly permitted to reject the referral. In essence, there is no option for the Trust to refuse to admit or treat a patient on the grounds that it lacks the capacity to provide the services required.
- In 2003 the Department of Health introduced the National Tariff Payment by Results System ('PbR'). The Trust is paid a set rate for each PbR-eligible activity it delivers, subject to quality and access time standards being met.
- This is not the only source of income for the SWFT. It has an annual turnover of c£220m, of which £116m relates to the National Tariff system (£55m of this is through the National Tariff PbR and £61m paid as a block contract).
- The National Tariff is derived by the Department of Health looking at the costs that they think appropriate for NHS health services. It is broken down as follows:
    - 65% for staffing costs
    - 21% for other operational costs

[8] Taken from the evidence of Mel Duffy (encl.7 to my instructions) as modified by her instructions during our conference on 28 November 2014.

- 7% for drugs
- 2% for clinical negligence contingency
- 5% for capital maintenance costs

- The 5% capital allowance within the Tariff is not sufficient to provide for new infrastructure. Furthermore, the capital costs of healthcare are not limited to buildings but also include costly equipment and technology.
- The remainder of the Trust funding is provided through Community Services contracts and other NHS services contracts (which do not contain any element for capital costs). The tariff reduces by 1.5% per year equating to a requirement for the Trust to find efficiency savings of around 4.5% each year.

2.6 Although the Trust is paid for the activities it delivers, this is dependent upon the quality requirements set out in the NHS Standard Contract. These requirements are linked to the on-time delivery of care. A topical illustration of this is contained within the 2014/2015 contract, which indicates that unless 95% of attendees at A+E (measured on a monthly basis) are admitted, transferred or discharged within 4 hours of their arrival then the SWFT will be fined. The fines are significant, amounting to £200 per attendee above the 95% but capped at 8% of the attendees that month. Similarly, the 18 week Referral to Treatment target requires the Trust to treat 90% of admitted patients within 18 weeks of their original referral to treatment. For every patient that breaches the 18 week target a fine of £400 would be levied over the 90% threshold.

2.7 The methodology by which payments pursuant to the National Tariff are made is particularly significant in planning terms. Whilst the evidence prepared by Mel Duffy originally stated that the "[T]*he Trust is paid retrospectively for the activity it delivers...*"[9] her fuller description in conference demonstrated this to be incorrect. The correct position is as follows:

[9] See para 15 on p.6.

- Whilst the SWFT receives the National Tariff for each PbR eligible activity delivered, this is calculated according to the activities delivered over the preceding year.
- This defines the annual ceiling activity volume for the purposes of the SWFT contract for the following year i.e. the CCG agree the National Tariff PbR annually but subject to a ceiling activity volume that is premised upon the outturn activity volume[10] of the preceding year.
- The SWFT is not paid for any additional activity beyond that ceiling.
- All other activities are subject to block contracts and make no provision for in-year growth.

2.8 As indicated above, the funding arrangements make no provision for new capital assets such as building and technology to address increased demands. As a Foundation Trust the SWFT is eligible to request a loan from the Department of Health Independent Trust Financing facility to fund capital development proposals. Such loans are subject to borrowing limits, restrictions on the security for the loans and the approval by Monitor of the repayment proposals. Furthermore, because the loans are for capital projects they are not appropriate for covering the costs incurred in meeting unexpected eligible activities over and above the annual ceiling activity volume. The SWFT has sought to factor demographic changes and capital costs into its annual accounts. This recognised the need for a capital budget to address, inter alia, equipment and technology refurbishment costs. As indicated in the statement of Mel Duffy[11] the SWFT has planned to address population and demographic projections through the provision of new capital infrastructure, in particular 3 development projects comprising 2 new ward blocks at Warwick Hospital and a new Stratford Hospital. No developer contributions are being sought for these projects.

2.9 The practical consequences of the above may be summarised as follows:

- Unplanned population increases within the SWFT area during any given year have a significant impact on the service delivery and performance of

[10] i.e. the National Tariff PbR eligible activities actually delivered.
[11] See paras 20 and 21 on p.7.

the Trust. This is because they generate additional activities beyond the ceiling activity volume until the following year when contracted activity volumes are raised to accommodate the population increase.

- Furthermore, the SWFT has to treat all attendees irrespective of whether the population increases generate additional activities beyond the ceiling activity volume.
- Such additional activities beyond the ceiling activity volume will be unfunded. Although they will be used to assist in the determination for the activity ceiling volumes for the following year there is no funding provision for those additional activities during the first year in which they are generated. Moreover, there is no retrospective element in the national Tariff PbR system (or loan schemes) to reimburse the SWFT for those additional activities.
- The impact of additional activities has the potential to result in the SWFT failing to meet its quality requirements as set out in the NHS Standard Contract. This would have an additional adverse impact through the imposition of fines.

2.10 As a result of the above the SWFT has produced an Impact Assessment Formula to calculate the potential impact on both planned and acute healthcare provision as a result of developments within its area[12]. This formula appears to be generally robust. It is premised upon the most recent Census figures (2011) that are used to calculate the projected population increases due to a proposed development. That figure is then used to calculate the likely level of eligible activities (termed 'interventions') generated by the development for which the SWFT is responsible. The cost of those additional activities is then based upon existing rates as per the National Tariff PbR. Because of the annual nature of calculating the funding arrangements for the SWFT (as explained above) such contributions are sought only for a period of one year.

2.12 I did have some concern that the formula does not make any allowance for people moving within the district and consequently already catered for in the

[12] See Mel Duffy statement, paras 29-32 and Appendices 4 & 5.

existing activity ceiling volume. However, it is reasonable to assume that if they move within the area then their previous accommodation will be taken up due to general shortage of housing in the country. Similarly, because the activity ceiling volume is worked out on an annual basis this seems the best manner in which to recognise that developments will be delivered at different times during the year.

3. Legal Framework

Planning Obligations.

3.1 Section 70(2) of the TCPA 1990 provides that in determining an application for planning permission, the LPA 'shall have regard to the provisions of the development plan, so far as material to the application, and to any other material consideration'[13].

3.2 The wide scope of what can constitute a material consideration is illustrated in in the case of *In R (on the application of Copeland) v Tower Hamlets LBC*[14] where the High Court held that promoting social objectives such as healthy eating fell within its ambit (in the context of a grant of planning permission for a fastfood takeaway).

3.3 Relevant Government policy is a material consideration[15]. The most important manifestation of Government policy is the National Planning Policy Framework ('NPPF'). This provides, inter alia, for the assessment of planning obligations [16]. The NPPF requires decision-makers to consider whether otherwise unacceptable development could be made acceptable through the use of conditions or planning obligations. Planning obligations should only be used where it is not possible to address unacceptable impacts through a planning condition[17].

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[13] The presumption in favour of the adopted development plan policies is provided for in s.38(6) PCPA 2004.
[14] [2011] JPL 40 (Cranston J).
[15] See *Carpets of Worth Ltd v Wyre Forest DC* (1991) 62 P&CR 334 (CA); and *Tesco Stores Ltd v SOSE* [1995] 1 WLR 759.
[16] See s.106 TCPA 1990.
[17] NPPF, para 203.

3.4 The NPPF also indicates that planning obligations should only be sought where they meet all of the following tests[18]:

- necessary to make the development acceptable in planning terms;
- directly related to the development; and
- fairly and reasonably related in scale and kind to the development.

3.5 The Planning Practice Guidance ('PPG') provides some explanation and elaboration upon the above policies. It explains that obligations mitigate the impact of unacceptable development to make it acceptable in planning terms; and that the tests are set out as statutory tests in the Community Infrastructure Levy Regulations 2010 and as policy tests in the National Planning Policy Framework[19]. Elaboration includes the connection with other contributions; negotiations; restrictions (such as small schemes, self-builds and rural exception sites) etc.

3.6 As confirmed in the PPG[20], planning obligations can only be required to address the otherwise unacceptable impacts of a proposed development. Whether or not a particular proposal adequately addresses the adverse impacts and/or those impacts are outweighed by other benefits will necessarily remain a matter of planning judgment for the decision-maker. However, because it represents a key element of Government policy, it is to be expected that the potential impact of development proposals upon the health of communities would ordinarily be afforded significant weight by decision makers[21].

EC Competition Law & State Aid.

3.7 Article 101 of the Treaty of the Functioning of the European Union[22] ('TFEU') prohibits "as incompatible with the internal market" various agreements or decisions of undertakings "which have as their object or effect the prevention, restriction or distortion of competition within the internal market" including those which "apply dissimilar conditions to equivalent

[18] NPPF, para 204. The need for flexibility to reflect market conditions and the potential impact upon viability also needs to be taken in account (para 205).
[19] Paragraph: 001 Reference ID: 23b-001-20140306.
[20] Paragraph: 008 Reference ID: 23b-008-20140306.
[21] NPPF, see para 7 (the social role to sustainable development) and part 8 generally.
[22] Formerly article 81 of the European Economic Community Treaty ('the EEC Treaty').

transactions with other trading parties, thereby placing them at a competitive disadvantage."

3.8 Article 102 of the TFEU[23] prohibits the abuse of a dominant position within the internal market (or a substantial part of it) as incompatible with the internal market in so far as it may affect trade between Member States.

3.9 Articles 103 to 106 of the TFEU are concerned with the implementation of regulations by the Commission to address the prohibitions; that such prohibitions are to be considered firstly by the national law of member States applying the above principles; and the obligation upon the Commission to ensure compliance.

3.10 In support of the principle of a common market within the EU, article 107(1) of the Treaty of the Functioning of the European Union ('TFEU') provides as follows:

> "[A]ny aid granted by a Member State or through State resources in any form whatsoever which distorts or threatens to distort competition by favouring certain undertakings…shall, in so far as it affects trade between Member States, be incompatible with the internal market."

3.11 However, article 107(2) excludes certain categories of State aid as being compatible with the internal market, including:

> "(a) aid having a social character, granted to individual consumers, provided that such aid is granted without discrimination related to the origin of the products concerned."

3.12 If any EU Member State wishes to grant State aid to a particular undertaking it must notify the Commission of its intention to do so[24].

4. Discussion.

4.1 The National Tariff PbR funding arrangements for the SWFT are premised upon the number of eligible activities conducted in the previous year[25]. This

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[23] Formerly article 82 of the EEC Treaty.
[24] Article 108(3) TFEU (formerly article 93 of the EEC Treaty).
[25] Referred to by Mel Duffy as 'outurns'.

number also determines the ceiling activity volume against which the performance of the SWFT is measured for meeting the quality requirements as set out in the NHS Standard Contract.

4.2 Any increase in population will therefore have an additional impact upon the ability of the SWFT to meet its obligations during any given year until the increased activity is factored into the ceiling activity volume for the following year. Unless provided through an alternative source this will amount to permanent shortfall in funding for the SWFT.

4.3 New residential developments within the area covered by the SWFT will prima facie increase the population for which it is responsible to provide acute and community health services. The social impacts of such development will therefore amount to a material consideration in planning terms for the purposes of decision-makers.

4.4 The potential adverse impact upon the continued ability of the SWFT to provide acute and community health services as a result of proposed development will necessarily engage a judgment as to whether a proposal is acceptable in planning terms. As indicated above, the impact of development proposals upon the health of communities would ordinarily be afforded significant weight in the exercise of that planning judgment. If that judgment considers the adverse impacts upon the delivery of healthcare to the community to be unacceptable in planning terms (due to unfunded demands as explained in section 2 above) then there would have to be appropriate mitigation to make it acceptable.

4.5 The financial formula proposed by the SWFT is a robust calculation of the resultant shortfall in funding generated by new residential development. The use of the formula means that the calculated sums are directly related to the development proposed. Moreover, the use of existing National Tariff PbR costs and Census data to assess the financial impact of the activities generated by a proposed development means that the sums are fairly and reasonably

related in scale and kind to the development[26].

4.6 The antitrust provisions of the TFEU operate in connection with 'undertakings'. Whilst SWFT necessarily engages in economic activity it is necessary to look at the service that it ultimately provides i.e. its primary purpose is providing NHS care to NHS patients according to NHS quality standards and principles – free care based on need, not ability to pay. As explained in the FENIN litigation before the ECJ this suggests that it would not fall within the definition of an 'undertaking' for the purposes of EC competition law.

4.6 In the FENIN case an association of medical goods suppliers complained to the European Commission that certain management bodies representing 80% of the Spanish health service (SNS) were systematically delaying payment to their members. The nature of the complaint was that these management bodies comprised undertakings and the delays in payment constituted an abuse of a dominant position within the meaning of articles 81 and 82 EC respectively. The Court of First Instance held[27] that the management bodies running the SNS could not be regarded as undertakings performing an economic activity for the purposes of community competition law. The concept of an undertaking in community competition law covered any entity engaged in an economic activity, irrespective of its legal status and the way in which it was financed. In that connection, it was the activity of offering goods and services in a given market, rather than the business of purchasing as such, that was a characteristic feature of an economic activity. Thus, when determining the nature of that subsequent activity, it would be wrong to dissociate the activity of purchasing goods from the subsequent use to which they were put. The nature of the purchasing activity therefore had to be determined according to whether or not the subsequent use of the purchased goods amounted to an economic activity. Consequently an organisation which purchased goods

[26] It is not unlike the methodology commonly used for the calculation of education provision arising out of new development.

[27] *Federacion Nacional de Empresas de Instrumentacion Cientifica, Medica, Tecnica y Dental (FENIN) v Commission of the European Communities* 2003/GC 04.03.2003 T-319/99; [2003] ECR II-357.

(even in greater quantities), not for the purpose of offering goods and services as part of an economic activity, but in order to use them in the context of a different activity, such as one of a purely social nature, did not act as an undertaking simply because it was the purchaser in a given market. Whilst such an entity might wield very considerable economic power, it nevertheless remained the case that, if the activity for which that entity purchased the goods or equipment was not an economic activity, it was not acting as an undertaking for the purposes of community competition law and was therefore not subject to the prohibitions laid down in the treaty.

4.7 The association then appealed the decision to the ECJ[28]. The appeal was dismissed. The ECJ held that in Community competition law, the definition of an 'undertaking' covered any entity engaged in an economic activity, regardless of its legal status and the way in which it was financed. It was the activity that consisted of offering goods and services on a given market that was a characteristic feature of an economic activity. There was no need to dissociate the activity of purchasing goods from the subsequent use to which they were put in order to determine the nature of that purchasing activity. The nature of the purchasing activity had to be determined according to whether or not the subsequent use of the purchased goods amounted to an economic activity.

4.8 Applying the above principles to the funding arrangements for the SWFT it is clear that the ultimate use of its funding (from whatever source) is to provide NHS healthcare to the community that is free at the point of delivery. Irrespective of the above, it is also clear that the provision by SWFT of free care based on need, not ability to pay, would also place contributions it receives as falling within the article 107(2)(a) TFEU exception, which excludes certain categories of State aid as being compatible with the internal market.

20 January 2015

Paul Cairnes
No5 Chambers

[28] [2006] ECR 1-6295; 5 CMLR 559; [2006] All ER (D) 140 (Jul).

In the matter of The Town & Country Planning Act 1990

And in the matter of the Community Infrastructure Levy Regulations 2010

And in the matter of:

The South Warwickshire Foundation Trust

OPINION

Paul Cairnes
No5 Chambers

The Wilkes Partnership
41 Church Street
Birmingham
B3 2RT

Ref: Leenamari Aantaa-Collier

1. Opinion.

In this matter I am instructed on behalf of the South Warwickshire NHS Foundation Trust ('the SWFT'). For the reasons that are set out in detail herein my opinion may be summarised as follows:

(a) The external costs associated with a proposed development are a material consideration in the decision-making process.

(b) The external costs associated with new development and calculated pursuant to the SWFT Impact Assessment formula are focussed only upon the additional expenditure in providing the required NHS services pursuant to the obligations in their licence.

(c) Those services (and consequential additional costs) do not fall within the definition of 'infrastructure' for the purposes of the CIL regime. Consequently, these additional external costs can lawfully be the subject of planning obligation following April 2015 (so long at the sums sought meet the statutory tests in regulation 122).

(d) Where the sums sought by SWFT pursuant to its Impact Assessment formula meet the tests in regulation 122 it necessarily follows that such sums sought cannot amount to a generalized tariff (or tax) on development. They represent the lawful application of the provisions in s.106 TCPA 1990.

(e) The SWFT Impact Assessment formula has been recently considered and endorsed in an appeal in Leamington Spa (PINS Ref: APP/T3725/A/14/2221858). Although not binding, this decision is manifestly a material consideration in future decisions where the SWFT is seeking sums pursuant the formula in order to mitigate the impact of development proposals.

2. Background.

2.1 The South Warwickshire NHS Foundation Trust ('the SWFT') is the major provider of acute and community health services to the population of South Warwickshire. It was established in March 2010 pursuant to the provisions of the Health and Social Care (Community Health and Standards) Act 2003 ('the 2003 Act').

2.2 An NHS foundation trust is a 'public benefit corporation' authorised to provide goods and services for the purposes of the health service in England[1]. NHS Foundation Trusts are part of the NHS and subject to NHS Standards, performance ratings and systems of inspection.

2.3 The 2003 Act provides for an independent regulatory body[2] (known as 'Monitor') to ensure that a Foundation Trust exercises its functions in a manner that is consistent with the performance by the Secretary of State of the duties under sections 1, 3 and 51 of the National Health Service Act 1977[3]. All NHS Foundation Trusts are authorised to operate under a licence issued by Monitor[4]. The licence sets out the conditions of operation[5], including (in the case of the SWFT):

- The health services that the trust is authorised and required to provide to the NHS.
- The standards to which it must operate and against which the Care Quality Commission will inspect.
- A list of assets such as buildings, land or equipment that are designated as protected because they are needed to provide required NHS services.
- The amount of money and NHS foundation trust is allowed to borrow.

Whilst the role of Monitor is to ensure that they do not breach the terms of their authorisation, in common with all NHS bodies NHS Foundation Trusts are inspected against national standards by the Care Quality Commission[6].

2.4 As indicated in the NHS publication "*A Short Guide to NHS Foundation Trusts*", they "have a primary purpose of providing NHS care to NHS patients according to NHS quality standards and principles – free care based on need, not ability to pay"[7].

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[1] 2003 Act, s.1(1).
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[4] 2003 Act, s.6.
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[6] Established pursuant to the Health & Social Care Act 2008.
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2.5 The funding arrangements for the SWFT are principally made pursuant to an Activity Based Payment System. This may be summarised as follows[8]:

- The South Warwickshire Clinical Commissioning Group ('CCG') commissions the SWFT to provide acute and community health care services to the population of South Warwickshire under the terms of the NHS standard contract.
- This involves identifying the health needs of the population and commissioning the appropriate high quality services necessary to meet these needs within the budget allocated.
- The CCG commissions planned and emergency acute healthcare from SWFT and agrees a service level agreement, including activity volumes and values on an annual basis.
- The SWFT is required to provide the commissioned health services to all people that present or who are referred to the Trust. The conditions attached to its licence require the Trust to accept any referral however it is made unless expressly permitted to reject the referral. In essence, there is no option for the Trust to refuse to admit or treat a patient on the grounds that it lacks the capacity to provide the services required.
- In 2003 the Department of Health introduced the National Tariff Payment by Results System ('PbR'). The Trust is paid a set rate for each PbR-eligible activity it delivers, subject to quality and access time standards being met.
- This is not the only source of income for the SWFT. It has an annual turnover of c£220m, of which £116m relates to the National Tariff system (£55m of this is through the National Tariff PbR and £61m paid as a block contract).
- The National Tariff is derived by the Department of Health looking at the costs that they think appropriate for NHS health services. It is broken down as follows:
    - 65% for staffing costs
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- 7% for drugs
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- The 5% capital allowance within the Tariff is not sufficient to provide for new infrastructure. Furthermore, the capital costs of healthcare are not limited to buildings but also include costly equipment and technology.
- The remainder of the Trust funding is provided through Community Services contracts and other NHS services contracts (which do not contain any element for capital costs). The tariff reduces by 1.5% per year equating to a requirement for the Trust to find efficiency savings of around 4.5% each year.

2.6 Although the Trust is paid for the activities it delivers, this is dependent upon the quality requirements set out in the NHS Standard Contract. These requirements are linked to the on-time delivery of care. A topical illustration of this is contained within the 2014/2015 contract, which indicates that unless 95% of attendees at A+E (measured on a monthly basis) are admitted, transferred or discharged within 4 hours of their arrival then the SWFT will be fined. The fines are significant, amounting to £200 per attendee above the 95% but capped at 8% of the attendees that month. Similarly, the 18 week Referral to Treatment target requires the Trust to treat 90% of admitted patients within 18 weeks of their original referral to treatment. For every patient that breaches the 18 week target a fine of £400 would be levied over the 90% threshold.

2.7 The methodology by which payments pursuant to the National Tariff are made is particularly significant in planning terms:

- Whilst the SWFT receives the National Tariff for each PbR eligible activity delivered, this is calculated according to the activities delivered over the preceding year.
- This defines the annual ceiling activity volume for the purposes of the SWFT contract for the following year i.e. the CCG agree the National

Tariff PbR annually but subject to a ceiling activity volume that is premised upon the outturn activity volume[9] of the preceding year.

- The SWFT is not paid for any additional activity beyond that ceiling.
- All other activities are subject to block contracts and make no provision for in-year growth.

2.8 The funding arrangements make no provision for new capital assets such as building and technology to address increased demands. As a Foundation Trust the SWFT is eligible to request a loan from the Department of Health Independent Trust Financing facility to fund capital development proposals. Such loans are subject to borrowing limits, restrictions on the security for the loans and the approval by Monitor of the repayment proposals. Furthermore, because the loans are for capital projects they are not appropriate for covering the costs incurred in meeting unexpected eligible activities over and above the annual ceiling activity volume. The SWFT has sought to factor demographic changes and capital costs into its annual accounts. This recognises the need for a capital budget to address, inter alia, equipment and technology refurbishment costs. The SWFT has planned to address population and demographic projections through the provision of new capital infrastructure, in particular 3 development projects comprising 2 new ward blocks at Warwick Hospital and a new Stratford Hospital. No developer contributions are being sought for these projects.

2.9 The practical consequences of the above may be summarised as follows:

- Unplanned population increases within the SWFT area during any given year have a significant impact on the service delivery and performance of the Trust. This is because they generate additional activities beyond the ceiling activity volume until the following year when contracted activity volumes are raised to accommodate the population increase.
- Furthermore, the SWFT has to treat all attendees irrespective of whether the population increases generate additional activities beyond the ceiling activity volume.

[9] i.e. the National Tariff PbR eligible activities actually delivered.

- Such additional activities beyond the ceiling activity volume will be unfunded. Although they will be used to assist in the determination for the activity ceiling volumes for the following year there is no funding provision for those additional activities during the first year in which they are generated. Moreover, there is no retrospective element in the national Tariff PbR system (or loan schemes) to reimburse the SWFT for those additional activities that they are obliged to undertake.
- The impact of these additional activities has the potential to result in the SWFT failing to meet its quality requirements as set out in the NHS Standard Contract. This would have an additional adverse impact through the imposition of fines.

2.10 As a result of the above the SWFT has produced an Impact Assessment Formula to calculate the potential impact on both planned and acute healthcare provision as a result of developments within its area[10]. This formula appears to be generally robust. It is premised upon the most recent Census figures (2011) that are used to calculate the projected population increases due to a proposed development[11]. That figure is then used to calculate the likely level of eligible activities (termed 'interventions') generated by the development for which the SWFT is responsible. The cost of those additional activities is then based upon existing rates as per the National Tariff PbR. Because of the annual nature of calculating the funding arrangements for the SWFT (as explained above) such contributions are sought only for a period of one year.

2.12 The formula does not make any allowance for those people moving within the district and consequently already catered for in the existing activity ceiling volume. However, it is reasonable to assume that if they move within the area then their previous accommodation will be taken up due to general shortage of housing in the country. Similarly, because the activity ceiling volume is worked out on an annual basis this seems the best manner in which to

[10] See Mel Duffy statement, paras 29-32 and Appendices 4 & 5.
[11] This may need to be reviewed following the publication of the latest CLG household projections on 27.02.15.

recognise that developments will be delivered at different times during the year.

3. Legal Framework

Planning Obligations.

3.1 Section 70(2) of the TCPA 1990 provides that in determining an application for planning permission, the LPA 'shall have regard to the provisions of the development plan, so far as material to the application, and to any other material consideration'[12].

3.2 The wide scope of what can constitute a material consideration is illustrated in in the case of *In R (on the application of Copeland) v Tower Hamlets LBC*[13] where the High Court held that promoting social objectives such as healthy eating fell within its ambit (in the context of a grant of planning permission for a fastfood takeaway).

3.3 Relevant Government policy is a material consideration[14]. The most important manifestation of Government policy is the National Planning Policy Framework ('NPPF'). This provides, inter alia, for the assessment of planning obligations[15]. The NPPF requires decision-makers to consider whether otherwise unacceptable development could be made acceptable through the use of conditions or planning obligations. Planning obligations should only be used where it is not possible to address unacceptable impacts through a planning condition[16].

3.4 The NPPF also indicates that planning obligations should only be sought where they meet all of the following tests[17]:

- necessary to make the development acceptable in planning terms;

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[12] The presumption in favour of the adopted development plan policies is provided for in s.38(6) PCPA 2004.
[13] [2011] JPL 40 (Cranston J).
[14] See *Carpets of Worth Ltd v Wyre Forest DC* (1991) 62 P&CR 334 (CA); and *Tesco Stores Ltd v SOSE* [1995] 1 WLR 759.
[15] See s.106 TCPA 1990.
[16] NPPF, para 203.
[17] NPPF, para 204. The need for flexibility to reflect market conditions and the potential impact upon viability also needs to be taken in account (para 205).

- directly related to the development; and
- fairly and reasonably related in scale and kind to the development.

Since April 2010 the tests of acceptability for planning obligations have been placed on a statutory footing in the CIL regulations[18].

3.5 The Planning Practice Guidance ('PPG') provides some explanation and elaboration upon the above policies. It explains that obligations mitigate the impact of unacceptable development to make it acceptable in planning terms; and that the tests are set out as statutory tests in the Community Infrastructure Levy Regulations 2010[19] and as policy tests in the National Planning Policy Framework[20]. Elaboration includes the connection with other contributions; negotiations; restrictions (such as small schemes, self-builds and rural exception sites) etc.

3.6 As confirmed in the PPG[21], planning obligations can only be required to address the otherwise unacceptable impacts of a proposed development. Whether or not a particular proposal adequately addresses the adverse impacts and/or those impacts are outweighed by other benefits will necessarily remain a matter of planning judgment for the decision-maker. However, because it represents a key element of Government policy, it is to be expected that the potential impact of development proposals upon the health of communities would ordinarily be afforded significant weight by decision makers[22].

The Community Infrastructure Levy Regime

3.7 Part II of the Planning Act 2008 authorises the Secretary of State to make regulations for the establishment of a Community Infrastructure Levy ('CIL'). The declared purpose of the CIL regime is to capture more planning gain to finance additional investment; to make the planning charge-setting process simpler and more certain; to provide a fairer means of securing contributions

[18] Regulation 122.
[19] Regulation 122.
[20] Paragraph: 001 Reference ID: 23b-001-20140306.
[21] Paragraph: 008 Reference ID: 23b-008-20140306.
[22] NPPF, see para 7 (the social role to sustainable development) and part 8 generally.

from developers for infrastructure; and to encourage regions and LPAs to plan positively for housing and economic growth.

3.8 Whilst the basic structure of the CIL regime is set out in the 2008 Act the detailed provisions are now contained within the Community Infrastructure Levy Regulations 2010[23]. Section 211(1) of the 2008 Act requires a charging authority which proposes to charge CIL to issue a document known as a charging schedule. This schedule should set out for the LPA's area the rates, all other criteria, by reference to which the amount payable is to be calculated. Section 211(2) requires the charging authority, in setting the CIL rates, to have regard[24] to:

(a) the actual and expected costs of infrastructure;

(b) matters specified by CIL regulations relating to the economic viability of development[25]; and

(c) the actual and expected sources of funding for infrastructure.

3.9 The 2008 Act also requires charging authorities to prepare lists of projects which they propose will be funded by CIL, and to circumscribe the circumstances where CIL can be spent on projects which are not listed.

3.10 Section 216(1) provides that the regulations must apply CIL, or cause it to be applied "*to funding infrastructure supporting development by funding the provision, improvement, replacement, operation or maintenance of infrastructure.*" Section 216(2) prescribes those matters to which the CIL regulations will apply. It provides a definition of the infrastructure that can be funded through CIL, including *roads and other transport facilities*[26], *flood defences*[27], *schools and other educational facilities*[28], *medical facilities*[29], *sporting and recreational facilities*[30] and *open spaces*[31]. Pursuant to these

[23] As amended by the Community Infrastructure Levy (Amendment) Regulations 2011.
[24] In the manner and to the extent specified by the regulations.
[25] Such as the economic effects of planning permission or the imposition of CIL.
[26] s.216(2)(a).
[27] s.216(2)(b).
[28] s.216(2)(c).
[29] s.216(2)(d).
[30] s.216(2)(e).
[31] s.216(2)(f).

statutory provisions the regulations accordingly provide that 'infrastructure' is to be given the meaning provided in s.216(2) of the 2008 Act[32]. It is to be noted that the 'facility' is usually understood in the context of something physical[33]

3.11 On the adoption of CIL or following the national transition period that expires on 6 April 2015[34] the CIL regulations restrict the local use of planning obligations for pooled contributions towards items that can be funded by CIL. Pooled contributions may still be sought from up to five separate planning obligations for an item of infrastructure that is not intended to be funded locally through CIL. Where infrastructure is not capable of being funded through CIL[35] then LPAs are not limited in terms of the planning obligations that may be pooled (subject to them meeting the tests identified above).

3.12 The CIL legislative framework is intended to provide infrastructure to support the development of an area rather than to make individual planning applications acceptable in planning terms. It does not replace the system of planning obligations. There will still be site specific mitigation measures required to make a planning application acceptable.

4. Discussion.

4.1 In *Tesco Stores Ltd v Secretary of State for the Environment*[36] the House of Lords considered the extent to which a planning obligation was a lawful consideration in the decision-making process. In effect a very low threshold was set for lawfulness, as indicated by Lord Kieth of Kinkel[37]:

> "An offered planning obligation which has nothing to do with the proposed development, apart from the fact that it is offered by the developer, will plainly not be a material consideration and could only be regarded as an attempt to buy planning permission. If it has some connection with the proposed development which is not de minimis, then regard must be had to it. But the extent, if any, to which it should

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[32] Regulation 59(1).
[33] "*a building, service, or piece of equipment provided for a particular purpose...*' (Compact OED) – see also the meaning usually given to 'infrastructure' (para 4.6 below).
[34] CIL (Amendment) Regulations 2014.
[35] Such as Affordable Housing.
[36] [1995] 2 AER 636.
[37] At p.770.

affect the decision is a matter entirely within the discretion of the decision maker and in exercising that discretion he is entitled to have regard to his established policy."

4.2 Furthermore, the issue of whether planning obligations should meet the costs of consequential external impacts was addressed by Lord Hoffman[38]:

> "Parliament has therefore encouraged local planning authorities to enter into agreements by which developers will pay for infrastructure and other facilities which would otherwise have to be provided at the public expense. These policies reflect a shift in Government attitudes to the respective responsibilities of the public and private sectors. While rejecting the politics of using planning control to extract benefits for the community at large, the Government has accepted the view that market forces are distorted if commercial developments are not required to bear their own external costs."

4.3 The approach in *Tesco Stores* has not been changed following the introduction of regulation 122 as confirmed by Bean J in *R (oao Welcome Break Group Limited) v Stroud District Council*[39]:

> "48. There is nothing novel in regulation 122 except the fact that it is contained in a statutory instrument. Its wording derives from Departmental Circular 05/05, which in turn was the successor to previous circulars such as 16/91. Circular 16/91 required that the obligation to be imposed as a condition should be 'necessary to the grant of permission' or that it 'should be relevant to planning and should resolve the planning objections to the development proposal concerned.'...
>
> 50...[The ratio of the *Tesco* case remains good law] An offered planning obligation which has nothing to do with the proposed development apart from the fact that it is offered by the developer is plainly not a material consideration and can only be regarded as an attempt to buy planning permission. However, if it has some connection with the proposed development which is more than de minimis then regard must be had to it. The extent, if any, to which it affects the decision is a matter entirely within the discretion of the decision-maker."

4.4 As explained by Lord Hoffman in *Tesco Stores* the external costs associated with a proposed development are manifestly a material consideration[40] in the decision-making process and can properly be subject to a planning obligation.

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[38] At p.776.
[39] [2012] EWHC 140, at paragraphs 48 *et seq.*

4.5 If those external costs do not fall within the ambit of CIL then they can still properly be made the subject of a planning obligation after April 2015. This is because the CIL regime applies to infrastructure. Although the definition in s.216 of the Planning Act 2008 is flexible, it must be construed in the context of the usual meaning given to the 'infrastructure' i.e. "the basic physical and organizational structures (e.g. buildings, roads, or power supplies) needed for a society or enterprise to function[41].

4.6 As explained in section 2 above, the SWFT is required to provide the commissioned health services to all people that present or who are referred to the Trust. It is paid a set rate for each PbR-eligible activity it delivers but is limited to a ceiling activity volume that is premised upon the previous year. It necessarily follows that residents from new developments will burden the SWFT with additional and unfunded costs for a limited period. These external costs associated with new development and calculated pursuant to the SWFT Impact Assessment formula are focussed only upon the additional expenditure in providing the required NHS services pursuant to the obligations in their licence. Those services (and consequential additional costs) do not fall within the definition of 'infrastructure' for the purposes of the CIL regime. Consequently, these additional external costs can lawfully be the subject of planning obligation following April 2015 (so long at the sums sought meet the statutory tests in regulation 122).

4.7 It has been suggested that the Impact Assessment formula by which SWFT have calculated these external costs effectively amounts to a generalised tariff or tax on development. I do not consider such as analysis to be correct for the following reasons:

- Section 106 TCPA 1990 expressly permits the payment of a money sum pursuant to a planning obligation. The payment of such sums will have to be within the ambit of lawfulness as indicated in *Tesco Stores*

[40] And therefore must be taken into account in the decision-making process (see TCPA 1990, s.70(2) and PCPA 2004 s.38(6)). If a material consideration is **not** taken into account then any planning permission would be subject to judicial review on *Wednesbury* principles.
[41] OED.

(above) and the statutory tests in regulation 122.

- The Impact Assessment formula clearly demonstrates the financial implications placed upon the SWFT by new development proposals and how these will adversely impact upon the health of the community (a core planning principle in the NPPF[42]). The formula demonstrates what is necessary to make the development acceptable in planning terms by addressing those adverse impacts;
- The formula is based upon robust and up-to-date data producing a clear and transparent correlation between the size of a proposed development and its likely impact on the SWFT. Consequently, the formula ensures that the sums sought are directly related to the development, fairly and reasonably related in scale and kind to the development.
- The Impact Assessment formula therefore meets the statutory tests in regulation 122.
- In such circumstances it necessarily follows that the sums sought cannot amount to a generalized tariff (or tax) on development but the lawful application of the provisions in s.106 TCPA 1990.

4.8 This approach has recently been endorsed in an appeal decision concerning development at Spring Lane, Radford Semele, Leamington Spa[43]. The Inspector determined the contested issue of the SWFT Impact Assessment formula as follows:

> 35. The appellant opposed the hospital contribution on three grounds, firstly that the hospital service was funded by the NHS, itself funded by the taxpayer which would include the new residents of the estate, leading to doublecounting. Secondly, the SW Trust has planned for an 11% growth and is not seeking any s106 contribution for the capital element of this, but funding it itself, why should they not do the same for running costs? Thirdly the costs generated by occupiers of the new houses will not fall in the next year, as the houses are not likely to be built and occupied for at least 18 months after the date of the decision. Two appeal decisions were provided where Inspectors had agreed that NHS contributions were not required in areas covered by the same NHS trust as this appeal.
>
> 36. I do not pretend to be an expert in NHS funding, but it was explained at the Inquiry that the running costs of the service were funded on the basis of

[42] NPPF, paragraph 17.
[43] PINS Ref: APP/T3725/A/14/2221858.

current costs. So next year's budget will be based on this year's population figures. Even if a trust is well aware of population growth that will effect next year that cannot be built into the budget. That may be illogical, as the appellant argued, but unfortunately it is how the system appears to operate. The year after, the budget will catch up, so there is always a shortfall of one year in the funding arrangements. It seems from the evidence before me that the local trust is already fully stretched financially. Therefore, insofar as any shortfall is attributable to the housing development subject to this appeal, and there is no dispute about the calculation of the actual sums involved, it would seem to me to be directly related to the development and so compliant with the CIL tests.

37. The fact that the occupiers of the houses may pay taxes is irrelevant, as they will pay taxes that would contribute, in some small way, to most of the elements of the s106 obligation, and indeed of all s106 obligations. The obligation is also worded so that the payments are triggered by 50% and 90% occupation of the houses, so there is no question of the developer paying up front for a cost that will not fall to the SW Trust for several years.

38. I do not know how the case was presented at the Inquiries where my colleagues decided against the SW Trust, but from the contents of the decision letters it seems that neither had the matter explained in the same clear way that was presented to me.

4.9 Although this decision is not binding it is manifestly a material consideration in future decisions where the SWFT is seeking sums pursuant the formula in order to mitigate the impact of development proposals.

11 March 2015

Paul Cairnes
No5 Chambers

TOWER HAMLETS PRIMARY HEALTH CARE TRUST

and

NHS LONDON HEALTHY URBAN DEVELOPMENT UNIT

Re provision of payments for health services in Section 106 agreements

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OPINION

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TOWER HAMLETS PRIMARY HEALTH CARE TRUST

and

NHS LONDON HEALTHY URBAN DEVELOPMENT UNIT

Re provision of payments for health services in Section 106 agreements

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OPINION

Introduction

1. We have been asked to advise the Tower Hamlets Primary Care Trust ("the THPCT") and the NHS London Healthy Urban Development Unit ("the NHS HUDU") that is connected therewith. We have been asked to consider the legal position of obtaining, through the use of Section 106 planning obligations, funding from developers for health services.

2. Those instructing us have helpfully set out the background circumstances that have led to the need to seek our advice and have also provided us a copy of their written advice to the THPCT contained in a letter dated 19th October 2007. Save where necessary to assist our analysis, we shall not rehearse in detail the legislative and policy background to the making of such agreements since this is obviously familiar to those for whom this opinion is intended.

3. The concern has arisen on the part of the THPCT following representations made to it by developers' representatives that funding cannot be secured through S.106 agreements where reliance is placed upon a model provided by the NHS HUDU, where policy justification is missing or incomplete and where the funding sought relates to revenue payments.

Legal and policy background

4. The relevant parts of the provisions of S.106 of the *Town and Country Planning Act 1990 (as amended)* are as follows:

> [106 Planning obligations]
> [(1) Any person interested in land in the area of a local planning authority may, by agreement or otherwise, enter into an obligation (referred to in this section and sections 106A and 106B as "a planning obligation"), enforceable to the extent mentioned in subsection (3)-
> ...
> (d) requiring a sum or sums to be paid to the authority on a specified date or dates or periodically.
> (2) A planning obligation may-
> ...
> (e) if it requires a sum or sums to be paid, require the payment of a specified amount or an amount determined in accordance with the instrument by which the obligation is entered into and, if it requires the payment of periodical sums, require them to be paid indefinitely or for a specified period.
> ...] [our emphasis]

5. It can be readily seen, as those instructing us have already advised, that the provisions are widely drafted. The courts have made plain that the planning system is a self-contained code and they will not artificially alter its extent and meaning. One must therefore look with care at the words of the relevant statutory provision.

6. In the case of planning obligations, the ambit of the provisions is plainly and sufficiently wide to lawfully permit payment by developers on a variety of basis that include periodic and future payments based upon a formulaic approach. The limitation in practice that has arisen derives from tests laid down in policy guidance on the use of planning obligations.

7. The relevant advice on the use of planning agreements is contained in ODPM Circular 05/2005 (Planning Obligations). The relevant part of the guidance is contained in Annex B at paragraph B5:

> **The Secretary of State's policy requires, amongst other factors, that planning obligations are only sought where they meet all of the following tests. The rest of the guidance in this Circular should be read in the context of these tests, which must be met by all local planning authorities in seeking planning obligations.**
> **A planning obligation must be:**
> **(i) relevant to planning;**
> **(ii) necessary to make the proposed development acceptable in planning terms;**
> **(iii) directly related to the proposed development;**
> **(iv) fairly and reasonably related in scale and kind to the proposed development; and**
> **(v) reasonable in all other respects.**

8. The House of Lords considered the ambit of planning obligations in the well-known case of *Tesco Stores Ltd v. Secretary of State for the Environment* [1995] 1 W.L.R. 759. The challenge arose out of rival schemes being considered for the grant of planning permission and whether the offer to fund a link road by a competitor of Tesco could be taken into account in determining the merits of the rival proposals. The Secretary of State took the reverse position to his inspector and granted the rival scheme of Tesco's competitor, taking into account the link road funding to be provided by way of planning obligation. Tesco challenged that decision and the House of Lords considered the extent to which the agreement in question was a lawful material consideration in the decision-making process. As the learned authors of the Planning Encyclopedia note, the effect of the decision in that case sets a very low threshold for lawfulness (see Vol. 2 para. P106.24). As Lord Keith of Kinkel stated in his speech in the Tesco case (at p. 770):

> **An offered planning obligation which has nothing to do with the proposed development, apart from the fact that it is offered by the developer, will plainly not be a material consideration and could be regarded only as an attempt to buy planning permission. If it has <u>some connection with the proposed development which is not de minimis</u>, then regard must be had to**

> it. But the extent, if any, to which it should affect the decision is a matter entirely within the discretion of the decision maker and in exercising that discretion he is entitled to have regard to his established policy. [our emphasis]

9. In addition, Lord Hoffman added his own analysis to that of the speech of Lord Keith of Kinkel and said (at p.776):

> Parliament has therefore encouraged local planning authorities to enter into agreements by which developers will pay for infrastructure and other facilities which would otherwise have to be provided at the public expense. These policies reflect a shift in Government attitudes to the respective responsibilities of the public and private sectors. While rejecting the politics of using planning control to extract benefits for the community at large, the Government has accepted the view that market forces are distorted if commercial developments are not required to bear their own external costs. [our emphasis]

Recent decision letters

10. We have been supplied with several recent planning decisions: one given on appeal determined by an inspector and two where the Secretary of State (for Communities and Local Government) herself has recovered jurisdiction. Each of these appeals included the consideration of funding for healthcare. We shall comment briefly on each in turn.

11. The appeal relating to East and West Arbour Streets shows that the policy upon which reliance was made to support funding for healthcare was inadequate. It is significant to note that the inspector expressly endorsed the provision of healthcare as a planning matter (at para. 15).

12. The appeal relating to Leighton Buzzard South likewise expressly concedes that new development can have an impact on healthcare and that this can form the proper basis for a development contribution (at para. 6.49 of the inspector's report). Again, the authority's argument in relation to healthcare foundered on the inadequacy of the policy relied on (at para. 6.53).

13. The facts of the appeal relating to Honeypot Lane included an agreed contribution towards health services (at para. 27(xi) of the inspector's report). The Secretary of State agreed with the inspector's conclusions on the acceptability of a contribution to healthcare (at para. 15 of the Secretary of State's decision letter).

Analysis

14. In our view, the essential point to consider therefore becomes whether the funding being sought relates to an external cost (per Lord Hoffman in the Tesco case) of a proposed development or whether, in contradistinction, the funding is simply sought to be extracted from a developer to benefit the community generally (as disapproved of in the Tesco case). Any addition to the funding of infrastructure and services that are used by the general public as well as, for example, occupants/users of a proposed development, will inevitably benefit the wider community. The difference between what is lawful and what is not will depend upon whether or not the need for the facilities or services sought to be funded by planning agreement derives in a tangible way (even if de minimus – see Lord Keith of Kinkel in the Tesco case) from the impact of the proposed development.

15. In our view the correct approach therefore to considering any financial request from THPCT to a developer for a contribution to the funding of healthcare in its area is to identify whether the need for funding derives from an impact assessed to arise from the development proposed. This proposition might be easily stated but in practice might not be so easy to determine in a case where the funding sought relates to future on-costs of healthcare as opposed to current infrastructure. Nonetheless, we think it should be a relatively straightforward exercise for someone with suitable expertise and experience to calculate the likely

generation of users of healthcare services from a proposed development. This is entirely consistent with the advice in Chapter 7 of *Planning Obligations: Practice Guidance* (July 2006) issued by the DCLG.

16. It will be important that account is be taken of the extent to which those likely users are existing inhabitants of an area and the extent to which they are new users attracted to an area by reason of the new development. This point was specifically mentioned by the inspector in the Arbours Streets appeal (at para. 14 of the decision letter).

17. The funding of healthcare is an on-going matter for a relevant authority such as the THPCT. It must be tempting to seek payments wherever possible to bolster the finitely limited funds of the healthcare system whenever an opportunity arises. Those payments however must be legitimately sought. We do not see anything unlawful in developers being required to add to the funding for healthcare where it is the impact of their developments that gives rise to, or is part of what gives rise to, the need for future services and/or infrastructure. These are clearly external costs and as such are material planning considerations.

18. What is apparent from reading the decision letters and we think must be right as a matter of proper and practical analysis, is that the assessment of the impact of a proposed scheme of development must be seen much more as a science, in the same way that traffic impact analyses and shopping impact assessments are nowadays examined in planning applications and appeals.

Conclusions

19. Accordingly, for the reasons and analysis that we have set out above, we would answer the questions posed in our instructions as follows:

1. Q: *Is seeking the provision of, or payments towards, the cost of physical facilities for the delivery of health services legitimate under section 106 of the Act?*

   A: Yes provided the need for the physical facilities can be directly attributed to the likely impact of occupants/users of the planned development over and above the needs and natural growth of the existing inhabitants of the area.

2. Q: *Is seeking the provision of time limited revenue funding to offset all or some proportion of the cost of health services, that is running costs or labour and supplies, legitimate?*

   A: Yes provided the running costs, labour and supplies can be directly related to the impact of occupants/users of the planned development over and above the needs and natural growth of the existing inhabitants of the area.

3. Q: *Is there is any real or necessary distinction to be made between (i)revenue that is contributions to the running cost of services, (ii) maintenance payments that are for physical facilities and (iii) capital that is the cost of acquiring by lease or the purchase of additional accommodation?*

   A: No provided the funding sought can be justified as relating to the impact of the proposed development in accordance with the answers in 1 and 2 above.

4. Q: *Is it is lawful for a Local Authority to make a distinction between the rules applying to one form of community facility in respect of section 106 and another (in particular by treating revenue support as legitimate for*

public transport or employment training support but excluding it on principle for health services)?

A: Yes if the rules represent a policy position that is sound in terms of its derivation. The essential thing is to identify how an assessed impact of a development proposed will be accommodated within the existing and future infrastructure and services of a local planning authority. Once that impact is identified, any policy should identify how a developer is to contribute to the external cost(s) of a proposed development. The meaning and effect of such policy should be clear and transparent. If there is to be a distinction between contributions for different services, it should be justified by reference to the way those services are and will be provided.

5. Q: *Does the absence of specific reference to the use of the NHS London Healthy Urban Development Unit ("HUDU") model in a policy or SPD, prevent the application of the HUDU model in order to calculate the appropriate scale of a health contribution, otherwise defined as acceptable?*

   A: No provided a sound assessment can be demonstrated for the need for funding arising from a proposed development. If reliance upon the model is made, its robustness should be demonstrated. No doubt account will be taken of any criticisms of its shortcomings identified in planning appeal decisions.

6. Q: *In the absence of an adopted Borough section 106 policy or an adopted SPD, are section 106 contributions for health ruled out?*

   A: No since the principle of funding healthcare provision is, and has been accepted as, a material planning consideration. However, the emphasis of the modern plan-led system and the transparency of policy requirements for any developer mean that guidance

should be produced as soon as possible and as detailed as possible. In the absence of a policy or where policy is insufficiently comprehensive, pre-application discussions with developers should identify as early as possible the need for healthcare funding, the method by which the costs of that need will be determined and the basis for any payment(s) sought.

20. We have tried to advise as comprehensively but succinctly as possible. If we can advise further or amplify anything raised herein, please do not hesitate to contact us. We would be happy to help consider any draft development plan guidance and/or help with any assistance sought from appropriate third party experts.

21. In conclusion, we think that the following points should be borne in mind when seeking to justify funding for healthcare services through the mechanism of planning obligations:

    a. National policy is crystal clear in permitting the THPCT to ask for contributions for health funding;

    b. Those contributions can be more forcefully and readily made in a sound policy context;

    c. Points (a) and (b) are not enough to guarantee delivery of funding alone. Rather:

        i. The need for funding must be evidence-based in its justification, probably supported by appropriate expert evidence; and

        ii. That justification must expressly derive from national planning and development plan policies.

22. We think the essential point to grapple with in any specific application is to identify the incremental change that is likely to occur as a result of a proposed

development and distinguish from that impact what is likely to happen due to the natural changes and increases in population in the relevant area outwith the proposed development. The former should properly be part of the developer's costs (and therefore funding sought using S.106 obligations) whereas the latter will be part of the ongoing infrastructure requirements of the health authority. The mechanism for delivering any funding such as capital or periodic payments and the formula for their calculation will then have to take into account how the impact of the development for which healthcare funding is necessary will occur over time. It may be that the funding for the impact will have to be considered in both capital and revenue terms.

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