APPEAL BY WADDETON PARK LTD

PINS REFERENCE: APP/Y1138/W/22/3313401

LAND AT HARTNOLLS BUSINESS CENTRE

CIL REGULATION 122

(LACK OF) COMPLIANCE

STATEMENT - NHS

OUTLINE PLANNING APPEAL FOR THE EXTENSION TO THE EXISTING BUSINESS PARK FOR UP TO 3.9HA OF EMPLOYMENT LAND AND UP TO 150 RESIDENTIAL DWELLINGS WITH ASSOCIATED OPEN SPACE AND INFRASTRUCTURE (WITH MEANS OF ACCESS TO BE DETERMINED ONLY).

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1.0 NHS

1.1 Two funding requests have been made by NHS bodies:

The first is from the Royal Devon University Healthcare NHS Foundation Trust and dated 20/05/2022. The request is that:

> *"The contribution in the amount £165,819.00 sought will go towards the gap in funding created by each potential patient from this development."*

1.2 In short this is plainly a revenue contribution that is sought that falls outside the scope of S106 (since it is not infrastructure). I provide a more fulsome explanation of non-compliance with CIL regulation 122 at Section A below.

1.3 The second is from NHS Devon Clinical Commissioning Group (CCG) and is dated 02/09/2021. I deal with this at Section B below.

Section A – Royal Devon University Healthcare NHS Foundation Trust

1.4 The attached 'evidence' document recognises (at paragraph 4) that *'This population grows, particularly in the summer months'* (which recognises that the services that the trust provides are provided at source irrespective of where presenting patients are resident or which GP surgery list they are on.

1.5 At paragraph 18 and 19 the trust demonstrates a lack of understanding of how the NHS funding process allocates resources.

1.6 Both of these requests are misconceived since funding has already been made to the healthcare providers (via the CCG) to accommodate population growth. Both requests fail to appreciate that the appeal proposals are, in part, a response to plan failure due to housing undersupply in response to predicted population growth that the DP provides for. As I demonstrate

below funding to healthcare providers has been made assuming population growth (from the same source – ONS population forecasts).

1.7 The effect of both these requests is to seek to 'double count' that predicted population growth. Both requests demonstrate a failure to understand that planning applications (such as the appeal proposals) are simply the 'supply side delivery' that seeks to meet that predicted population growth that is enshrined in DP as housing allocations. To attempt to utilise proposed planning application numbers as a justification for funding requests is plainly 'double counting' i.e. to add the planning application unit numbers to the dwellings numbers already enshrined in DP.

1.8 These requests follow a pattern of similar requests that have been considered and dismissed by the SoS and in the High Court. I will not, in this brief statement, set out the full and detailed rationale for why these requests are unjustified/unlawful but I summarise the key points below.

1.9 The first point is that NHS funding is a complex process where needs are assessed and funding provided to Clinical Commissioning Groups (CCG's). Funding requests should not be made by 'contractors' (or service providers) those contractors should raise funding matters with the CCG. If providers consider the funding levels inadequate then that matter needs to be addressed with their client (the CCG) who make the funding allocations across a range of providers/contractors (i.e. the CCG has statutory duties but providers [such as NHS Trusts] do not). NHS Trusts have contractual duties that are agreed (via contract with the CCG). An NHS Trust can only fail to be funded if they have made a commercial decision to move away from the NHS Standard contract set up by the 2012 Act. It cannot arise from following the NHS funding process (which has population projection 'baked in').

1.10 The second point is that the NHS funding process 'bakes in' population growth as part of its' allocation formula. As the relevant technical guidance (see CD67) clarifies:

> *"For the 2019/20 to 2023/24 allocations <u>they are projected forward using the ONS projections for resident populations in CCGs</u> by quinary age-sex group."* (paragraph 3.1.2, page 15, Technical Guide to Allocation Formulae and Pace of Change For 2019/20 to 2023/24 revenue allocations, my underlining).

1.11 Thus, it is quite clear that population projections (from ONS) are used at the start of <u>both</u> the DP making and NHS resource allocation process to take account of likely population increases over time (i.e. ONS growth assumptions feed into both projection processes).

1.12 In this case we know that the forecast number of new households expected to be resident in Mid Devon are not yet resident in the area (since housing delivery is behind trajectory). The appeal proposals will, if allowed, address that under-provision in part, but there will still be an undersupply of new homes against forecast (and therefore lower population growth in Mid Devon than forecast).

1.13 The NHS resource allocation process provides for forecast population increase and, as explained above, the full effect of that forecast increase will not take place in the predicted timeframe (due to under-delivery against DP housing targets). Therefore it can be concluded that the CCG has been funded based on an expectation of population growth that has not occurred in full. As such there is no validity to a claim to fund healthcare providers in this area at this time. The situation may be different if growth had out-stripped forecasts – but that's evidently not the case in this appeal.

1.14 Therefore I conclude that the healthcare funding requests made are plainly misconceived.

1.15 The point raised was recently considered by Justice Holgate who recognised (at paragraph 62, page 16 of his recent decision CO/2298/2022, see CD21):

> *"Accordingly, it would be wrong to infer that there is no connection between an ONS projection of population growth in an area, used in the funding of CCGs, and new development in an area to*

accommodate that growth. On the contrary, the two are related. They are not divorced."

1.16 Justice Holgate goes on to explain this confusion more fully, at paragraphs 71, 72,and 74 (of his decision) and goes on to conclude at paragraphs 136, 142 and, probably most importantly, at paragraph 144, that:

"The Trust's doctrine approach to the funding issue, as revealed by ground 3 is troubling. It involves a wholly unwarranted interference with the proper discharge by a planning authority of its statutory functions. It has been no more than a smokescreen behind which the Trust has sought to deflect the proper questions posed by HDC."

1.17 I conclude that this particular funding request is similar to that considered by Justice Holgate. Justice Holgate's decision makes it abundantly clear that such requests for funding are misconceived.

1.18 Further, in this particular case, due to the Council being behind trajectory in the delivery of new homes to accommodate the predicted population growth for which the CCG has been funded it is highly likely that it has received funds but that the forecast in-migration element of that growth has not materialised (due to the lag in the timely delivery of new homes). How received funds based on a forecast population increase in an area that has not materialised as quickly as forecast (due to the slow pace of increasing the stock of accommodation) has been spent is another question.

Section B - NHS Devon Clinical Commissioning Group (CCG)

1.19 The request is based on the premise that:

"this new development will increase the local population by a further 350 persons" (page 3 of CCG letter dated 02/09/2021).

1.20 Firstly this figure is incorrect (since it fails to appreciate that the new affordable homes will, in part, accommodate existing concealed households in the locality that are already GP registered in the locality).

1.21 Secondly the methodology cannot sit 'over' the NHS funding methodology. The request fails to appreciate the point made in Section A i.e. that the CCG funding is, plainly, 'population growthed'.

1.22 Thirdly, as and when infrastructure improvements are needed those improvements can be funded by the NHS, including the expansion of GP surgeries, up to a 100% funding level.

1.23 The *National Health Service (General Medical Services Premises Costs) Directions 2013 (*CD68) set out the framework for premises development and improvement. Part 2 of those regulations deals with premises development and improvement. Regulation 8 (a) sets out that the types of premises that may be the subject of improvement grants are:

> *"improvements to practice premises in the form of building an extension to the premises, bringing into use rooms not previously used to support delivery of primary medical services or the enlargement of existing rooms."*

1.24 GP premises extensions fall within this definition.

1.25 Essentially, whilst GP Practices are normally independent entities with their own insurances and liabilities, the CCG have a duty of care to patients, staff and other premises users. Therefore, to ensure that all premises which provide NHS services are safe and fit-for-purpose, and that any related building works comply with relevant guidelines and regulations it is important that necessary due diligence is carried out via the expression of interest/grant funding process.

1.26 An increase in the medical services footprint of a surgery can have financial implications for the CCG via increased rent reimbursement. Such implications therefore need to be quantified and approved in terms of need, affordability and value for money, and be considered against the wider premises and estates strategy of a CCG.

1.27 The approval process ensures that schemes align with the CCG's strategies, particularly in the context of the forecasted population growth in the area in addition to any movement of any secondary care services into primary care settings. A summary of GP funding and contracts (prepared by The Kings Fund, is included as CD69)

1.28 Thus, it is clear that:

- NHS funding is available to fund privately owned GP surgery improvement works.
- Up to 100% NHS funding for improvements are available.
- The exact level of funding surgeries will receive depends on a multitude of factors that are considered during the funding process.

1.29 So, where does this leave us in this particular case?

1.30 We know that 'population growthed' funding for the health service is based on ONS population projections.

1.31 We know that ONS population projections are converted into the number of new homes required to accommodate that predicted growth via the planning system (normally housing numbers in development plans).

1.32 In this particular case we know that the Council are behind trajectory with the delivery of new homes, but that there has been no such delay in the funding of the CCG.

1.33 We know that some of the premises identified by the claimant are privately owned, whilst some are not (see CD70) and that 100% improvement grants are available for the improvements sought by the claimant. Therefore it is clear that it is <u>not necessary</u> for the S106 request to be met if the proposed improvements are to be delivered.

1.34 We know that Justice Holgate rebuked the Trust for using a doctrine approach to the funding issue as a smokescreen (at paragraph 144 of his recent decision) and that a similar approach underpins the request made in this case.

1.35 Here, the funding request is based on an abstract formula that relates to that 'doctrine approach' (i.e. it double counts) but otherwise has no clear basis. The formula does not:

- set out how the capacity assessment for each premises has been assessed, nor where that capacity figure has been derived from (it is not publicly available)
- nor does it consider options for increasing capacity,
- nor does it set out how/why the floorspace level increase requested relates to the (already funded) population increase that the formula uses

1.36 The Devon Health Contributions document referred to (on page 3) is of no help – it was not subjected to consultation and pre-dates Justice Holgate's consideration of the matter (and can therefore be accorded no weight in the determination of this appeal), and it is not specific to the particulars of this appeal.

1.37 Fundamentally, it is clear that the basis of the request for funding is based on the double counting that Justice Holgate criticised the NHS for basing their claim in that case upon.

1.38 In relation to what and when the funding request is sought for there is significant opaqueness. The request covers 4 surgeries but it is plain that no great consideration has been given to how any funding would be spent (see ownership details at CD70). It is unclear how seeking funding for two practices that form part of the College Surgery Partnership (a practice that includes 5 separate physical surgery sites – see CD71), relates to payments made to that practice.

1.39 There is no evidence of any immediate plans to carry out improvements to any of the premises cited (and one clearly has excess space – see marketing details at CD72).

1.40 Particularly for premises that are privately owned practices it's extremely odd that the request is made by the CCG, rather than the GP practices themselves (who are best placed to judge on how to cope with the implications of increasing patient list sizes). It is unclear what the CCG will actually do with the monies, bearing in mind that unless the GP surgery owners want to extend their premises (and there is no evidence before the inquiry of that), there is no way to carry out capacity improvements (i.e. the funding process is GP surgery initiated with the approval of the CCG, not normally the other way around).

1.41 Justice Holgate was clear that:

> *"The attempt by the Trust to obtain a financial contribution under s.106 therefore depends upon their demonstrating a localised harm."*

1.42 There is no assessment of any of the premises so the funding request is not supported by any evidence that the improvements sought are actually necessary (and the available evidence points in a contrary direction). It may be that the only way to improve capacity is to physically increase the size of the premises – but this inquiry has no way of determining that.

1.43 Therefore, there is simply not the evidence before the inquiry to demonstrate any such harm, and there is no evidence that underpins that such a contribution is necessary (particularly since there are existing NHS funding mechanisms to accommodate 100% of the proposed works).

1.44 We therefore conclude that the funding request fails to demonstrate the necessity required to comply with the provisions of CIL regulation 122.