NHS Devon

Mid Devon District Council
Planning and Building Control
Phoenix House
Phoenix Lane
Tiverton
Devon
EX16 6PP

NHS Devon LPA Engagement
Commercial Development Team
1st Floor Estates and Facilities
Torbay Hospital
Lowes Bridge
TQ2 7AA

Date: 7th September 2023

With Reference To:

PINS Ref: APP/Y1138/W/22/3313401 Land at Hartnolls Business Centre

Applicant Name: Waddeton Park Ltd

Description: 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).

Address: Land at NGR 298976 112882 (Hartnoll Farm) Tiverton Devon

Dear Robert,

This is a response to the inquiry by Waddeton Park Limited with pins reference: APP/Y1138/W/22/3313401 for Land at Hartnolls Business Centre specifically David Seaton's document titled CIL Regulation 122 (Lack of) Compliance Statement – NHS.

I note that Mr Seaton refers to the NHS Devon Integrated Care Board (ICB) as a Clinical Commissioning Group (CCG). ICBs changed from CCGs on the 1st of July 2022. It is also noted that Mr Seaton is not an expert or experienced in NHS funding.

This response is specific to Section B which relates to the NHS Devon ICB's contribution request for primary care infrastructure. Section A relates to a separate request that was submitted by Royal Devon University Healthcare NHS Foundation Trust.

Decision Making Process and Planning Policy Context

The starting point for the determination of planning applications is in the development plan. Section 70(2) of the Town and Country Planning Act 1990 ("TCPA 1990") establishes that a local planning authority (LPA) 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'. Section 38(6) Planning Compulsory Purchase Act 2004 states that applications for planning permission should be determined in accordance with the Development Plan unless any material considerations state otherwise. Determining whether something constitutes a material consideration is a matter of law. However, the health of communities has

been a key element of Government policy for many years and is reflected in adopted development plan.

Paragraph 2 of the NPPF 2021 states: “The National Planning Policy Framework must be considered in preparing the development plan and is a material consideration in planning decisions. Planning policies and decisions must also reflect relevant international obligations and statutory requirements.”.

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:” (Please see NPPF Section 2 paragraph 8, Section 8 paragraphs 92 -93 and 96).

Paragraph 34 sets out that the plan should set out the contributions expected from the development including infrastructure needs and specifies that this may be health. As per 36, tests of soundness will be applied to non-strategic policies in a proportionate way, considering the extent to which they are consistent with relevant strategic policies.

It is noted that this Council resolved to withdraw from the Mid Devon Community Infrastructure Levy (CIL) draft Charging Schedule on 6th January 2021.

Furthermore, the site to which this funding relates is a windfall site and is not an allocated site. The site will largely compromise new employment land with 150 dwellings and there is no affordable housing. In paragraph 3.111 of the Local Plan adopted by Mid Devon for 2013 to 2033 it states that the ‘need for additional health care provision could be accommodated within the community facilities’ highlighting that there is need for additional healthcare in an area less than 7 miles away from the site.

We would like to highlight that the question of whether NHS Primary Care contribution requests and methodology are deemed to be CIL compliant was considered at the recent Common Moor Drove appeal (APP/Q3305/W/22/3311900) brought by PCL Planning whereby the inspector concluded:

> *79. Via correspondence of 2 March 2023 Malcolm Dicken also set out that had ONS projections been factored into capital expenditure, some £4,075,750 would have been allocated to the Somerset ICB for premises upgrades between 2020 and 2023. The actual level of funding provided was £883,000 over that period. It is logically challenging to reconcile that ICB funding acknowledges population growth in respect of revenue, but not in respect of capital. Nonetheless sufficient floorspace must be available to enable appointments for patients, thereby ensuring effectiveness of service delivery.*
>
> *82. …..Accordingly the obligations contained with the UU and S106 are necessary to make the development proposed acceptable and in accordance with the provisions of NPPF paragraph 57 and CIL Regulation 122…..*

The NPPF clearly states that health infrastructure contributions are expected to be sought from developers to mitigate the impacts that will be created from new developments:

NPPF 5th September 2023:

34. Plans should set out the contributions expected from development. This should include setting out the levels and types of affordable housing provision required, along with other infrastructure (such as that needed for education, health, transport, flood and water management, green and digital infrastructure).

In the most recent implemented Infrastructure Delivery Plan for Mid Devon which was published in 2009 it recognised and acknowledged the need for developer contributions to support primary care infrastructure and stated:

5.3 There is a case for contributions from development to the provision of new GP surgeries, the need for which arises from development. The Primary Care Trust suggest that an appropriate GP list is about 1500 – 1700 patients. A 6000 list GP surgery (with 4 GPs) would require a building of about 600 square metres at a build cost of about £3.5 million. The Primary Care Trust has a limited budget for improvements to existing surgeries.

A draft IDP was produced by Mid Devon District Council in 2016, although it was never implemented, it did identify that there was a requirement for additional primary care infrastructure at a cost of approximately £3.2m that would be part funded via CIL.

As stated above, on the 6th of January 2021 Mid Devon District Council withdrew its Community Infrastructure Levy and in the cabinet report to the Council in December 2020 it stated that S106 planning obligations would be sought:

Financial Implications: Withdrawal of the Mid Devon Community Infrastructure Levy (CIL) draft charging schedule will mean it will no longer be examined by an Independent Inspector, and capable of being adopted by the Council as a means to secure monies towards the provision of infrastructure in the district. The Council will continue to be able to seek developer contributions, as currently is the case, through S106 planning obligations.

In respect of the CIL Regulation 122 (Lack of) Compliance Statement – NHS (August 2023) we would like to address the following statements made by PCL Planning in Section B:

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).

The application made for this development clearly states in the planning committee agenda (18th of January 2023) that there was no provision for affordable housing:

The proposed 150 houses would be market houses only without provision of affordable housing or custom build. This is because it is contended by the submission that the market housing is required to enable the provision of the new access road, with its additional capacity for the EUE, and to provide subsidy for the upgrade to the AD CHP at Red Linhay.

The office also stated that this was one of the reasons for refusal:

No s106 legal agreement to secure affordable housing.

However, in respect of affordable housing NHS England have stated that affordable housing is typically linked to 'local' occupation, however this is broadly on the basis of Local Authority area, which is far broader than the catchment of a GP surgery. Additionally, affordable housing is typically occupied to greater intensity than market housing.

The next point raised in the statement states:

> *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'.*

Section A and Section B of the appellant's statement cover different requests, Section A covers a revenue request to acute care, while Section B covers a capital request to primary care. The Section A points have been raised in the Leicester and Worcestershire cases (though the judge stopped short of ruling that such a contribution could never come forward, but highlighted further evidence is needed to demonstrate the claim, i.e., quantifying any gap, directly linking it to the development etc.) – the Section A request is not being fought in this appeal.

To state that the capital request falls under the same thinking as the revenue request demonstrates an overreliance on the Leicester case. Revenue funding is covered by the NHS 'Technical guide to allocation formulae and convergence for 2023/24 and 2024/25 allocations' (March 2023), this document is quoted in Section A though not referenced (para. 1.10 and the quote referring to ONS projections). While the word 'revenue' is not built into the naming of the document, the footer on each page calls the March 2023 guidance 'Technical guide to allocation formulae and convergence: for 2023/224 and 2024/25 revenue allocations' – the inclusion of the word 'revenue' adding additional clarity for this discussion. The appellant's reference back to Section A for the capital request does not assist their claim that the NHS is funded for such a capital request as it does not consider capital guidance or funding allocations.

The correct guidance for capital is 'Capital guidance 2022 to 2023' (April 2022) subject to 'Capital guidance update 2023/24' (January 2023). These documents state that 'from 2022/23 onwards this [system level allocation] also includes £0.1bn of capital for investment in primary care BAU [business as usual] and GP IT'. £0.1bn per annum split between 42 ICBs equates to £2.38m per ICB for all primary care capital costs. Alongside this level of funding, the 'Delivery plan for recovering access to primary care' (May 2023) highlights that 'government will update planning obligations guidance to ensure that primary care infrastructure is addressed by local planning authorities as they do for other infrastructure demands' (part D under 'Building capacity' titled 'Higher priority for primary care in housing developments'). While this is an NHS document, it has Government support and was announced by the SoS for Health on 9 May 2023. Reading across the guidance available, it is evident that Government's approach is not to fully fund primary care capital, but for new developments to mitigate the harm that they create in line with the requirements of the CIL Regulations.

Further, the April 2022 capital guidance highlights that the NHS can use other funding streams for capital under the heading 'Other sources of finance', stating 'capital receipts from external charitable sources and grants will provide additional spending power on top of the issued ICS capital envelope'. There have been arguments in the past that s.106 would merely reduce government

funding, this statement demonstrates that s.106 can be spent in addition to government funding and not as an alternative.

> *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.*

There is no reference provided for the 100% funding figure by the appellant at para. 1.22, but it is believed that it refers either to Estates and Technology Fund - ETTF or the negotiated, but not yet implemented, update to the premises cost directions which allowed for 100% improvement grants subject to a rent abatement period. As there is a rent abatement period in the negotiated changes, this is clearly a capital cost to the ICB, providing further clarity that Section B is referring to incorrect guidance when cross-referencing Section A.

It is agreed that extensions such as those to support housing fall under the premises costs direction as referred to in para 1.23 and 1.24, though that doesn't demonstrate the availability of funding that would mitigate the harm of the development, merely provides an avenue for using funding from the development to mitigate harm.

> *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)*

In the recent 2021 Comprehensive Spending Review (CSR) there has been no capital allocation for primary care infrastructure leaving the only access to funding being via the Minor Improvement

Grant (MIG) which in 2023/24 was £225,000 for the whole NHS Devon ICB area, equating to approximately £1,216 per surgery.

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.

The appellants conclusion that

1. *'NHS funding is available to fund privately owned GP surgery improvement works'* is correct with the exception that MIG funding is severely limited as shown above to be only £1,216 per surgery for the current financial year.
2. *'Up to 100% NHS funding for improvements are available'*. Apart from the MIG there is no capital funding available from the CSR. The table shown in **Appendix A** demonstrates that the primary care MIG funding over the last three years totalled only £625,000. However, if you were to assume the ONS projected population increase for Devon over the same period then a sum of £6,375,502 would have been required, a shortfall of £5,750,502.
3. *'The exact level of funding surgeries will receive depends on a multitude of factors that are considered during the funding process.'*. Apart from the MIG there is no capital funding available to the ICB from the CSR therefore it must prioritise the limited funding available from the MIG which will need to consider multiple factors such as accessibility adaptation, re-configuration, compliance adherence etc. There is no headroom from the limited grant to consider population growth from new developments and the ICB will seek external sources of funding other than central government tax revenue which includes developer contributions through Section 106 (paragraph 34 NPPF).

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 not necessary for the S106 request to be met if the proposed improvements are to be delivered.

The point that is missed in arguments around allocations linked to weighted population is that this only defines how to split the total, it does not mean that all needs are covered. Government funding is set via the spending review process, this does not provide all the capital that all arms of Government require but splits the tax revenue and an element of Government borrowing between departments. NHS funding flows from this system. It is expected that the NHS will seek additional funding outside of Government funding allocations. If the NHS were expected to be fully funded through tax revenues, there would be no need for Chapter four of the NHS Act 2006 (as amended); s.222 confers the power to raise money on NHS bodies. Additionally, as discussed, the primary care recovery plan specifically highlights that contributions from housing are needed – this wouldn't be necessary if there was capital funding for expansions linked to housing in place.

> *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.*

The recent decision made by Justice Holgate was both case specific and not related to primary care infrastructure, so it is difficult to understand how this relates to the current appeal. The case was brought by an NHS Foundation Trust and related to revenue funding for services and not capital infrastructure requirements.

> *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.*

In the above the appellant refers to the NHS Devon ICB methodology formula and that there would be double counting if developer contributions were also approved. As stated previously in our responses to how primary care infrastructure is funded, the ICB has made it clear that central government funding is not proportionate to the impacts created by housing developments which is further evidenced by the statement in the NHS England 'Delivery Plan for recovering access to primary care' published in May 2023.

The NHS Devon ICB formula and methodology used for calculating the impact on Primary Care is completely different to that referenced in Section A which is used for Acute Trust (Secondary Care) additional activity and revenue funding.

The Devon County Council (DCC) developer contribution guide is referenced as part of the NHS Devon ICB contribution request, and it clearly states how the current primary care estate that will be assessed by the proposed development. It is very important to note that when we establish there is sufficient capacity then no developer contributions are requested. The contribution guide was established as part of a joint approach which included NHS England, DCC and the Devon Local Planning Authorities to ensure that it was CIL compliant.

When assessing the impact from developments and the need for additional infrastructure all possibilities are explored and dependent on the size of the development the potential options could include, freehold land, a built surgery gifted to the NHS, surgery extensions and/or re-configurations. The contributions are sometimes pooled with other s.106 contributions for the same surgery along with any other additional NHS funding that may be available at the time.

Jon Murphy, Primary Care Estates Directorate, NHS England has confirmed that:

> Primary Care matters are delegated from NHS England down to the local commissioner – the Integrated Care Board (and before this the local Clinical Commissioning Group) and that under such powers and in conjunction with the local planning authority have set and established a set of principles and methodology for the calculation of the impact that new housing developments would have on the provision of primary care.

The methodology that has been used to calculate both the impact and mitigation is the NHS Devon ICB's delegated process.

> *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.*

The Justice Holgate judgement was case specific and directly related to the NHS Acute contribution requests for the additional activity costs and is separate from primary care infrastructure impacts and mitigations. This was discussed and considered as part of the Common Moor Drove appeal whereby the inspector was directly concerned with understanding the Leicester/Harborough judgement and requested that the NHS explained why primary care was different and concluded that the approach taken was CIL compliant and necessary.

> *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).*

Since the initial submission made at that time by NHS Devon Clinical Commissioning Group in September 2021 there have been key improvements to how we assess the surgeries that will be affected and how the contributions will be used.

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The NHS has introduced a system known as SHAPE (Strategic Health Asset Planning & Evaluation) which provides a map of where the GP surgery inner catchment areas are, these define which patients are able to register. Using this tool, we are now able to reduce the surgeries that will be affected by this development to the following surgeries (see **Appendix B**):

1. Clare House (Amicus)
2. Castle Place Practice
3. Sampford Peverell Surgery

With reference to CD72 Willand Surgery (College Surgery Partnership) no longer forms part of the NHS contribution request as its catchment boundary does not cover the Hartnoll Farm Business Park.

Furthermore, as part of a national process, NHS Devon Integrated Care Board (ICB) formerly the CCG has undertaken a strategic review of primary care estates infrastructure and future requirements. As part of this process NHS Devon ICB now has a scheme of projects that are under consideration for future expansion and for the above surgeries these include:

Clare House: Conversion of attic space to allow administration space downstairs to be converted to clinical use or/and reconfiguration of two large clinical rooms to create four smaller clinic rooms.

Castle Place: Creation of a branch surgery to provide additional capacity utilising pooled s.106 contributions and other funding sources.

Appendix C shows the full impact form this development on the surgeries above and also has updated the cost per dwelling based on current construction costs from £559 to £608 per dwelling.

> *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).*

As the appellant has stated GP premises are privately owned practices however providing additional capacity has a direct capital impact on the ICB, therefore all contributions are requested by NHS Devon ICB and future payment to the practice are abated.

> *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).

There is a direct corelation between the number of registered patients for a practice, the available infrastructure capacity and waiting times for an appointment. As widely publicised, there are significant demands and pressures on primary care which have been exacerbated by both previous and new populations increases as a direct result of new housing.

Conclusion

We can confirm that there is no extra capital funding available to cater for the additional impact that this development will create. The request is not dissimilar to any education contribution except where the department of education reduces its capital funding earmarked towards a specific school infrastructure where the developer should be contributing towards, the ICB has no capital funding to reduce from.[1]

Without developer contributions to mitigate the impacts of this development, direct harm will be created to both existing and new residents within the GP catchment area. Furthermore, having no or limited access to the primary healthcare service will, in turn, affect the acute services. This is because patients who have no ability to access the primary care will present themselves at the A&E department. Thus, in turn, creating a further additional detrimental impact from this development on the local Foundation Trust services. Access to health services is paramount to a sustainable development. Without the mitigation towards health infrastructure requested, the development will have a detrimental socioeconomic impact and will not meet the health needs of the present without compromising the ability of future generations to meet their own needs. This is contrary to paragraph 2 of the NPPF.

As such concerns are now being raised at both the Local Plan making process and as a direct response to planning applications by local residents and Parish/Town councils that their GP surgeries are struggling to cope with existing demands.

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[1] "Government provides funding to local authorities for the provision of new school places, based on forecast shortfalls in school capacity. There is also a central programme for the delivery of new free schools.

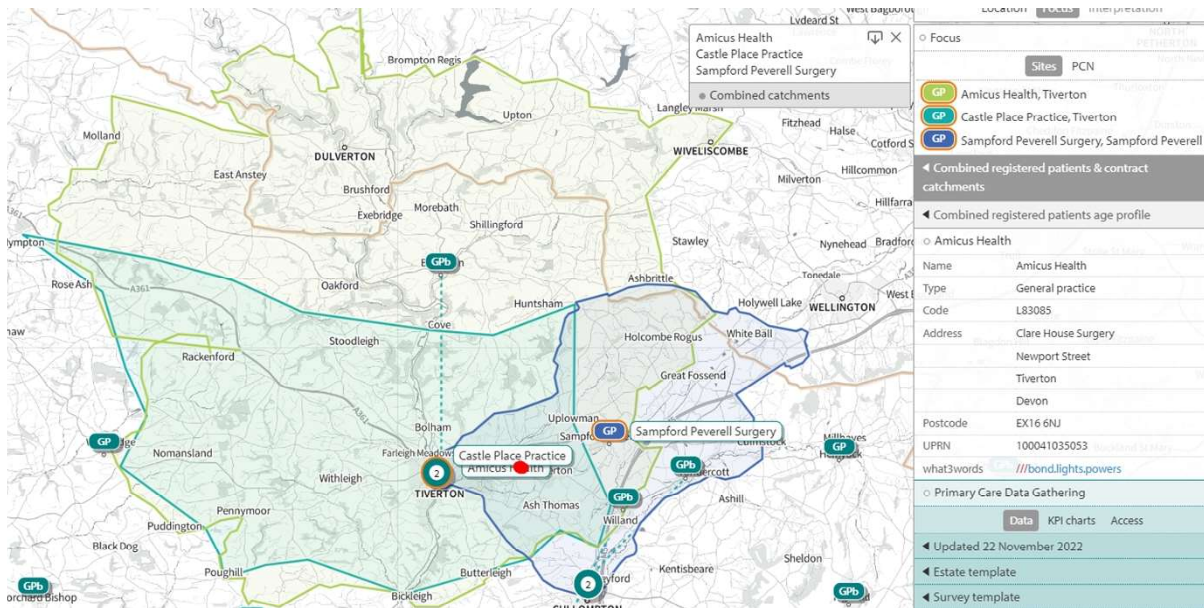
Funding is reduced however to take account of developer contributions, to avoid double funding of new school places. Government funding and delivery programmes do not replace the requirement for developer contributions in principle.

Paragraph: 007 Reference ID: 23b-007-20190315"

Appendix A – Population Forecast vs Primary Care Capital Funding

Year	Population Increase (ONS)	Addtl GP Infrastructure Rqd (m2)	Primary Care Capital Required	Minor Improvement Grant (MIG)	Deficit
2021	7,594	607	£ 2,172,956	£ 200,000	£ 1,972,956
2022	7,393	591	£ 2,115,438	£ 200,000	£ 1,915,438
2023	7,294	583	£ 2,087,108	£ 225,000	£ 1,862,108
Total	**22,280**	**1,782**	**£ 6,375,502**	**£ 625,000**	**£ 5,750,502**

Appendix B – GP Inner Catchment Areas



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Appendix C – Hartnoll Farm Impact Calculation

Application Number	21/01576/MOUT Hartnoll Farm Response
Local Authority	Mid Devon District Council
ICB	Devon

	Combined	Amicus House - Clare House Surgery	Castle Place Practice	Sampford Peverell Surgery	
Distance to Site (miles)					
[Application Number] No of Dwellings	150	150	150	150	
[Application Number] No of Dwellings	0				
Combined Dwellings	150	150	150	150	0
Occupancy Rate	2.33	2.33	2.33	2.33	2.33
Combined Population Increase	350	350	350	350	0
Consented & Commenced Dwellings	0				
Consented & Commenced Population	0				
Pre Development Impact					
Current No of Patients	30004	14043	13633	2328	
Patient Capacity	27701	13846	12622	2118	#VALUE!
Under/Over Capacity	2303	197	1011	210	#VALUE!
% Under/Over Capacity	108%	101%	108%	110%	#VALUE!
Consented & Commenced					
Current No of Patients	30004	14043	13633	2328	#VALUE!
Patient Capacity	27701	13846	12622	2118	#VALUE!
Under/Over Capacity	2303	197	1011	210	#VALUE!
% Under/Over Capacity	108%	101%	108%	110%	#VALUE!
Post Development Impact					
Expected List size	30354	14393	13983	2678	#VALUE!
Under/Over Capacity	2653	547	1361	560	#VALUE!
% Under/Over Capacity	110%	104%	111%	126%	#VALUE!
Space Requirement	0.073	0.070	0.070	0.080	#N/A
a) Actual GIA m2	2022.16	969.22	883.53	169.41	
b) Current Patient List m2	2190.29	983.01	954.31	186.24	#VALUE!
c) New Patient List m2	2047.67	993.69	908.00	197.37	#VALUE!
d) Over/Under Capacity m2	25.51	24.46	24.47	27.96	#VALUE!
New Space Required (m2)	25.51	24.46	24.47	27.96	#VALUE!
Premises Cost	£ 3,577	£ 3,577	£ 3,577	£ 3,577	£ 3,577
Cost of new space	£ 91,262	£ 87,511	£ 87,511	£ 100,013	#VALUE!
Cost per dwelling	£ 608	£ 583	£ 583	£ 667	#VALUE!