APPEAL BY BRANDON ESTATES LIMITED

LAND AT COVENTRY STADIUM, RUGBY ROAD, COVENTRY, CV8 3GP

PINS REF: APP/E3715/W/23/3322013 - LPA REF: R18/0186

LEGAL SUBMISSIONS ON BEHALF OF:

UNIVERSITY HOSPITALS & WARWICKSHIRE NHS TRUST

INTRODUCTION

1. The Trust provides acute and specialist hospital care. The Integrated Care Board ("ICB") purchases (or "commissions") those services from the Trust.

THE ISSUE IN A NUTSHELL

2. This development will give rise to new local residents. Those new residents will, regrettably but inevitably, present at the Trust for treatment.

3. The Trust's consultation response explains that 85% bed capacity is the figure beyond which patients are at risk of delays to their treatment and sub-optimal care.[1]

4. The same consultation response explains that the Trust's utilisation of bed capacity already exceeds 85% most of the year, and exceeds 100% when required to bed patients in non-inpatient areas (for example overnight surgery patients).[2]

5. In practical terms, that means it would take longer for people to be seen at A&E. That can have a radical impact on the outcomes of those people. It could mean the difference between a stroke patient recovering, being wheelchair bound or dying.

6. Clearly, therefore, left unmitigated, those impacts would not result in a development which ***"deliver[ed], or contribute[d] to, new and improved health services and facilities***

[1] *Appendix 1 – NHS Trust, University Hospitals Coventry and Warwickshire (UHCW) submission to the appeal* para.10.
[2] Ibid at para.11.

…" contrary to policy H1 Local Plan nor *"enable and support healthy lifestyles …"* nor *"… address health and well-being needs"* contrary to paragraph 92 NPPF. As such, there would be a powerful factor weighing against the grant of planning permission if this impact were not adequately addressed.

7. The essential question posed in this appeal is whether that impact is able to be mitigated by the Trust itself. The short answer to that question is: no. CD 18.7 demonstrates the shortfall in funding which would arise if the development were to be permitted and occupied. That shortfall is £222,924 which amounts to £133,754 when the affordable housing and Elective Recovery Fund elements are removed.

8. The Council says the Trust could make up the difference itself by re-negotiating the block element of its contract with ICBs.

9. The two statements from Mr Gilks explain why that assertion is wrong. The choice before the Inspector is therefore either: (a) allow the significant planning harm contrary to local and national policy or (b) grant permission subject to the obligation sought.

10. The contribution is: (a) necessary, (b) directly related to the proposed development and (c) fairly related in scale and kind to the development.

THE FACTS

11. In its initial consultation response, the Trust requested £160,091.83 to meet the additional year 1 costs caused by the occupation of the scheme. That was calculated on the basis of 137 dwellings. However, the Trust notes the scheme has been amended to 124 dwellings and accordingly the Trust amends its request to **£133,754**.

12. In its CIL Compliance Statement filed on 5 September 2023, the Local Planning Authority submitted, **for the first time**, that the Trust's request is not CIL compliant. At no point prior to 5 September had the LPA questioned the Trust's request, nor had it one so on other applications.

13. Through these submissions, the Trust responds to the LPA's belated reasons why it contents any contribution towards the Trust would not comply with the CIL Regulations. These submissions should be read alongside the two witness statements filed by Daniel Gilks, the Associate Director of Finance for the University Hospitals of Coventry and Warwickshire NHS Trust.

SUBMISSIONS

14. The LPA's reasons are set out at paras.2.18-2.20 of its CIL Compliance Statement. They are supplemented by a witness statement on behalf of Ella Casey. We tackle each in turn.

15. The CIL Compliance Statement reasons are not well founded for the following reasons:

16. First, it is said that a contribution to a service provider funded by national taxation is unlawful as a matter of principle. That proposition is advanced without authority and is plainly wrong. The LPA (and Warwickshire County Council) seek funding towards a range of public bodies already funded via (local) taxation, see for example:

    a. Highways.
    b. Education.
    c. Public Rights of Way.

17. Second, it appears to be said the contribution would not serve a planning purpose or have a substantial connection to the development and must not be marginal or trivial. If that is what is said, it does not bear out on the evidence:

    a. The Rugby Local Plan identifies, as part of its spatial vision *"to ensure access to … health services"* and Policy H1 provides that new proposals will be supported which *"deliver, or contribute to, new and improved health services and facilities …"*. To which end under the reasoned justification to Policy D4 (para.11.18) the adequacy of *"secondary health care provision"* (such as that provided by the Trust) is specifically identified as being sought via planning obligations. It is therefore not open to the LPA to now say the contribution sought by the Trust

would not serve a *planning* purpose when it, itself, has identified such matters as serving a planning purpose via its statutory development plan.

b. In its initial consultation response (and in the first witness statement of Daniel Gilks), the Trust has demonstrated the impact of additional presentations caused by the development on the provision of its services. The LPA does not engage with that evidence.

c. The impact on Trust cannot sensibly be described as marginal or trivial.

18. Third, the LPA says the contribution is not "necessary" because NHS care is intended to be provided via general taxation. This approach is both contrary to principle and internally inconsistent:

a. Holgate J rejected the notion that a provider of state services, funded by taxation, is precluded *per se* from being funded through a planning obligation, see: ***R(University Hospitals of Leicester NHS Trust) v Harborough DC*** [2023] EWHC 263 (Admin) at [139]:

"… where, for example, a development would itself cause direct harm to a public facility, so that the three tests in reg.122(2) of the CIL Regulations 2010 are satisfied, the local planning authority would be entitled to require the developer to mitigate that harm under a s.106 obligation, irrespective of whether the authority responsible for that facility is able to raise taxes or has borrowing powers."

b. Accordingly, the question is a factual one, namely whether there is a gap in funding which would give rise to land-use consequences as a direct consequence of the implementation of the planning permission.

c. In any event, the LPA does not dispute the need for additional funding to provide extra education capacity.[3] The education authority is also funded by general taxation and, like the Trust, is under a statutory duty to meet the

[3] 8 additional early years places, 42 additional primary school places, 30 additional secondary school places and 6 additional post 16 spaces, in addition to 2 additional pupils with special educational needs.

education needs of its area, see s.13 Education Act 1996. The approach of the LPA is therefore internally inconsistent and therefore irrational. If it were adopted, it would lead the Inspector into legal error and expose the decision to challenge.

19. Without the funding contribution, the scheme would fail to sustain the existing health facilities contrary to Policy H1 and the spatial vision of the development plan. As explained in the unchallenged evidence of the Trust, the scheme would give rise to a reduction in service provision for local people if the additional staff capacity cannot be funded. Accordingly, the contribution it is necessary to make the development acceptable in planning terms and is therefore "necessary" within the meaning of Regulation 122 CIL Regulations 2010.

20. Fourth, the LPA say that it has not been demonstrated that the burden on services arises directly from the development. The original consultation response annexed the LSOA data for the ward in which the development is proposed and demonstrated the additional cost of providing services to patients likely to draw upon its services. In much the same fashion as the education authority calculates the additional need for capacity created by the development.

21. Fifth, the LPA challenges whether it is likely the need will arise from new residents or existing ones and therefore whether the development is fairly related to the development in scale and kind. In response, the Trust submits it has only accounted for likely new residents as follows:

    a. Affordable housing occupiers have been excluded on the basis that they will likely be filled by people already registered for a GP locally and therefore will have been accounted for in the Trust's funding settlement.

    b. Planned care already covered by the Elective Recovery Fund is also excluded.

c. It is common ground between the Appellant and the Council that there is a 5.6 years' supply of market housing.[4] Accordingly, it is highly likely the market element of the scheme will be filled by residents from the wider area, rather than those presently registered for a GP locally.

d. Indeed, as the Local Plan explains, the adopted housing requirement not only meets the OAN for Rugby it also incorporates an element of unmet need for Coventry.[5] Accordingly, the 5.6 years' land supply against that requirement indicates the new market occupiers are likely to be drawn from beyond the Coventry and Rugby areas.

e. Finally, is notable that the County Council also use GP records to calculate the need for additional school places.[6] That methodology is accepted by the LPA, even though it makes no adjustment for existing residents or those which are home schooled or using the private sector.

22. Accordingly, the Trust has demonstrated that the contribution is fairly and reasonably related in scale and kind to the development proposed, given that local market housing needs are already being met.

23. Finally, the LPA say that because the funding settlement to ICBs includes an element of population growth, population increases (such as represented by the appeal scheme) should already have been accounted for when the funding settlement for the Trust was agreed. The answer to that is as follows:

    a. As Mr Gilks explains in his statement, the ONS population projections are only one part of considerations which inform the level of funding each ICB receives from central government, other factors such as levels of deprivation and heath inequalities are also factored-in (para.6.3).

[4] SoCG, para.4.1.
[5] Para.4.7.
[6] *Education Services Developers' Guide to Contribution for Education and Early Years' Provision* (August 2019), p.7.

b. The relevant population for ICBs is the GP registration list, not the ONS projections (para.6.6). That is obvious because it is the GP registered population is known, whereas ONS projections may never come to fruition For example, a local planning authority may plan to meet more or (more commonly) less than the ONS figures would suggest is required. Alternatively, housing may not come forward in accordance with the trajectory envisaged by the development plan or grants of planning permissions.

c. The funding formula used by the ICB to commission acute and specialist hospital services from the Trust is based on the previous year's GP registration (para.7.1). It follows from the manner in which the ICB is funded that, even if the Trust requested an uplift on the funding settlement calculated in accordance with the GP registration to account for projections uplifts in population, the ICB would not have the funds to oblige the request (para.7.2).

d. On the basis that the market element of the scheme (not otherwise funded by the ERF) is not registered at a local GP surgery for the first year of the occupation, then the additional impact on capacity has not been accounted for in the funding settlement. As the unchallenged evidence is that the Trust is operating at full capacity, it follows that the £133,754 is the difference between the funding it receives from the ICB and the cost (on the basis of 124 dwellings).

24. As to the witness statement of Ms Casey:

25. First, it is said that the Trust should use the lead-in time for the development to secure an uplift in funding.[7] As Mr Gilks explains, that will address the impact on local health provision. That is because:

    i. The block element of the API contract is calculated by reference to a range of factors, including levels of deprivation and trends for certain conditions. The ONS projections are indeed an input to the funding formula but they do not dictate the overall figure.

[7] Casey PoE, para.5.4-5.8.

ii. In any event, the ONS projections do not translate into actual levels of growth. They are a *projection* of the level of growth, which councils through their plan-making and individual applications may or may not meet. The actual level of growth may be higher or lower than the ONS projections.

iii. The API contract is a matter of national health policy. It cannot be negotiated away by the Trust seeking to reflect planned levels of growth (through individual grants of planning permission) in its funding settlement.

iv. Even if the ICB were receptive to the Trust's request for additional block-funding to account for such anticipated growth, the ICB does not itself have the avaiable funding to accede to that request.

26. Second, Ms Casey appears to suggest that *"how things work in practice"* is irrelevant.[8] That is plainly wrong. The relevant question is whether "*a development would itself cause direct harm to a public facility"* (*per* Holgate J in ***Leciestershire*** at [139]). If that is demonstrated, it is legally irrelevant whether "*the authority responsible for that facility is able to raise taxes or has borrowing powers"* or, indeed, whether, theoretically some alternative funding formulae would avoid the problem. The question is simply a factual one: has harm been demonstrated such as to make a planning obligation necessary? Mr Gilks has clearly demonstrated, through his two statements, that the operation of the applicable funding formula would leave a material shortfall if this development were to go ahead which, if not funded, would in turn adversely impact on the treatment of patients in A&E locally.

27. As Inspector Hand observed in the Spring Lane, Lemington decision[9] at DL,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 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*

[8] Casey PoE, para.6.3.
[9] APP/T3725/A/14/2221858 (10 March 2015).

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."

28. Third, Ms Casey attempts to explain the starkly different approach to education funding by asserting that is for capital purposes.[10] That is (a) factually wrong and (b) irrelevant:

    a. The secondary, post-16 and SEND elements of the education funding are purely for revenue purposes.[11] The only element of the £1,200,051 figure is the £686,121 for a temporary primary classroom; but

    b. In any event, there is no principled reason to take a different view to capital and revenue and funding, both must be justified on the same basis, i.e. the LPA would need to show the *"development would itself cause direct harm to a public facility, so that the three tests in reg.122(2) of the CIL Regulations 2010 are satisfied…".*

29. The difference in treatment is even more bizarre, considering the education authority is funded on the basis of capacity only after developers have been required to contribute, as the PPG explains:

    "What funding is avaiable for education?

    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.

[10] Casey PoE, para.5.10.
[11] CD 17.2 (WCC CIL Compliance Statement).

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."[12]

30. Unlike the education authority, the Trust is not funded on forecast shortfalls (instead on the basis of last year's GP registrations) nor is there any central funding avaiable for new A&E capacity if there is an uplift in presenting patients. Also, unlike the education authority, the Trust is able to demonstrate that without the funding there would be *"direct harm to a public facility"* because, unlikely the education authority, it cannot fall back on central government funding to make-up the difference if a developer obligation is not secured.

CONCLUSION

31. In summary, the contribution is:

    a. Necessary, because without it there would be a detrimental effect on acute and specialist hospital provision locally, contrary to the development plan.

    b. Directly related to the development, because that impact on that public service would be caused by the increased demand placed by the increase in local population occupying the development.

    c. Reasonably related in scale and kind, because the Trust is operating at full capacity and its funding only accounts for last year's GP list of patients. The non-EFR funded occupiers of the market housing are highly unlikely to be registered for GP services locally and therefore will not have been accounted for in the GP list.

    d. That is all the more likely given the development is: (a) not allocated in the development plan and (b) would represent growth over and above the market housing requirement locally.

32. The LPA do not dispute the methodology deployed by the Trust to calculate the gap. The sole objection is that the Trust should avoid the gap arising by using the lead-in

[12] PPG "Planning Obligations" para.007.

time to secure an uplift in funding from the ICBs which commission its services. As Mr Gilks that will not be possible for the block element of the contract (which is all that is sought via this contribution) because (a) planed growth represented by grants of planning permission is not a factor in the formula and (b) even if the Trust did manage to persuade the ICBs that factor should be taken into account, the ICB could not increase the funding because it, itself, is not funded in that way and so does not have the funds avaiable to accede to such a request.

33. The simple truth is that the development *would* give rise to a significant planning impact. Whether the NHS *should* adopt some alternative funding formula which accounts for new planning applications and which therefore mitigated that impact is a matter of national health policy which is a legally irrelevant consideration for this Inspector, as the Spring Lane Inspector rightly accepted. The possibility to devise some alternative funding arrangement (which accounts for individual planning determinations) does not change the material planning consideration which arises here: without the funding, there *will* be an adverse impact on the provision of local healthcare and that is be directly related to the change in the character of the use of the land represented by the appeal scheme.

34. Accordingly, the contribution should be found to be CIL compliant and approved.

ASHLEY BOWES

LANDMARK CHAMBERS
180 FLEET STREET
LONDON, EC4A 2HG

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