TOWN AND COUNTRY PLANNING ACT 1990
(as amended)

Appeal by David Wilson Homes East Midlands and
Anthony Raymond Shuttlewood

Land off Cossington Road, Sileby,

Leicestershire, LE12 7SL

HEALTH MATTERS

Section 106 Planning Obligation Requirements

Leicester City Clinical Commissioning Group ("CCG")

REBUTTAL TO LEICESTER CITY CCG REQUESTS FOR SECTION 106 HEALTH CONTRIBUTIONS LETTER DATED 14TH APRIL 2022

Ben James Hunter

BA DipMS

PINS Reference: APP/X2410/W/21/3287864

LPA Ref: P/21/0491/2

Date: 25th April 2022

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1 Introduction

1.1 This document is produced in response to the letter sent to the Inspector of the Cossington Lane, Sileby Appeal, dated 14th April 2022, by Leicester City Clinical Commissioning Group ("CCG") in response to the Appellant's Education and Healthcare Proof dated 28th February 2022.

1.2 This letter responds to individual points made in the original Proof submitted by the Appellants. This Rebuttal will respond to these points, which are transcribed verbatim below for your convenience.

1.3 Before commencing, it should be noted that on page 2 of the CCG's document that the tests of CIL regulation 122 are detailed. The first test is that a planning obligation needs to be necessary to make the development acceptable in planning terms. This test is repeated at the end of page 5. This test is critical, because a CCG contribution is *never* necessary to make a development acceptable in planning terms, as the NHS Constitution means that it cannot be necessary. Principle 1 of the NHS Constitution states that the NHS provides a comprehensive service available to all. If that is the case, Planning Obligations are not necessary to make a development acceptable in planning terms. If a development is funding places, whilst the NHS is also funding the exact same places, then that is double funding.

1.4 It should also be noted that the CCG evidence ignores the remaining two tests of CIL Reg 122, as will be demonstrated throughout this Rebuttal. The first test is discussed on page 5 of the document, and no other tests are referenced.

1.5 Turning now to the CCG's document dated 14th April 2022, specifically the fourth paragraph of page 6 onwards:

2 CCG Evidence

2.1 Paragraph 2 of page 6 of the document states the following:

The current medical centres providing primary care are up to their capacity contrary to the statements made and have no ability to absorb the level of population increase as a direct result of this development.

2.2 As of 24th April 2022, Highgate Medical Centre, which the CCG confirm is one of two facilities that serves Sileby, is accepting new Patients. Their website states:

The doctors welcome new patients who live within our practice area. Our practice area includes Sileby, Barrow upon Soar, Seagrave, Rothley, Ratcliffe on the Wreake and Cossington.

2.3 As of 24th April 2022, Banks Surgery, which the CCG confirm is the second of two facilities that serves Sileby, is also accepting new Patients. Their website states:

The doctors welcome new patients who live within our practice area. To check whether you reside within our boundary, please click here and enter your postcode.

2.4 If these Surgeries were truly up to their capacity, they would be closed to new Patients. They are not, so this cannot be the case.

2.5 The letter states in the final paragraph of Page 6 the following:

It is true that the patient has a choice to choose their own GP practice. However, most patients usually join the closest GP practice to their home as if attending a practice outside the catchment area, that particular practice does not need to provide all those services which would be available to the patient in their own catchment area due to the funding arrangement with the CCG. Registering with a practice further away from home can affect decisions about referrals for hospital tests and treatment, or access to community health services.

2.6 The NHS Constitution sets out quite clearly, in an unequivocal manner, the grounds for not accepting a Patient application. These are: The Patient lives outside of the Practice area; the Patient has a history of violence; and the Practice List is closed. As discussed in paragraphs 2.2 onwards, neither of these facilities has a closed Practice List. There is a process to go through in order to close the Practice List, which includes an approval process. If either facility was to close, NHS England will help the prospective Patient find an alternative facility.

2.7 There is no caveat for Primary Healthcare equivalent to that which applies to mainstream Education i.e. a duty on the statutory body to secure sufficient provision

without any limitation on where it is secured from, unlike the statutory duty on Education Authorities. On the contrary, the NHS Constitution is clear and obligatory, thus CIL Regulation 122 cannot be met.

2.8 The first paragraph on page 7 states:

To operate effectively, the provision of primary health care with in the community is divided into catchment areas. It would be wholly ineffective way of providing care if all patients would be pepper potted around various practices without a catchment area. This development will have an adverse impact on the ability to provide primary care as both close practices are already at full capacity.

2.9 As discussed previously, neither Practice has a closed Practice List, and both are accepting new Patients. This is demonstrably untrue.

2.10 Paragraph 1 of Page 7 continues:

It is wholly unfair approach to take that those people who are coming from this development would need to seek an alternative GP practice outside the designated catchment area.

2.11 There is no evidence that this will be necessary as both Surgeries are accepting new Patients.

2.12 Paragraph 1 of Page 7 continues:

This would also make it impossible to plan an effective primary care within the CCG's commission area. The purpose of Primary Care is that it is provided locally. It is therefore absolutely necessary that that the developer will mitigate the impact by creating patient space allowing more GPs operating within the catchment area.

2.13 Again, this is simply not true. A planning obligation for NHS provision can never be absolutely necessary to make a development acceptable in planning terms, as the NHS Constitution states that every Patient/person will be accommodated.

2.14 The second paragraph of Page 7 states:

It is already recognised by Mr Hunter in paragraph 5.6 of his report that the average house hold is currently 2.49 and only decreasing during the 25 year period to 2.37. It is likely that this development will be built faster rate than 25 year period. In those circumstances the 2.42 per household is a reasonable estimate.

2.15 The main issue with using 2.42 is that it assumes 100% of the people moving on to the development site will require new GP provision, when, as discussed in the Proof, many will already be registered with GP Practices. To be CIL Regulation 122 compliant (fair and reasonably related in scale and kind to the development) the CCG should be looking at Net impact, not housing occupancy (Gross impact).

2.16 The third paragraph of Page 7 states:

The advertisement referred to in these paragraphs are just standard NHS guidance as to how to register, not an indication as to available patient capacity in the stated surgeries.

2.17 This is not the case. A GP Practice is either Open or Closed. It is the only indication allowed under the NHS Constitution. Both Surgeries have Open Patient Lists, and are therefore not at capacity.

2.18 The third paragraph continues:

Where a development brings increased demand on a practice the CCG would apply, like in this case, for this to be mitigated by the developer. This is entirely in line with planning policy and should not result in a practice having to close its list and the patients of the new development not being able to register with a local practice.

2.19 This is not true. This exact issue was dealt with at an Appeal in Staffordshire[1] in 2008. The Secretary of State's letter confirming the Inspector's Report says:

[1] APP/C3430/A/06/2027165 Cat and Kittens Lane, Featherstone, Staffordshire, WV10 7RP

Health care

44. The Secretary of State notes that the appellants' commitment to the proposed GP's practice/health centre is solely to offer the Primary Care Trust a free site for such a facility if they want to establish one. She agrees with the Inspector that the issue of funding any additional GP(s) is very much a matter for the PCT and not something that can reasonably be expected to be funded by the appellants. She therefore agrees with the Inspector that this issue does not amount to harm to weigh against the appeal proposals (IR13.92).

2.20 This exact issue was also discussed at an Appeal in Nottinghamshire[2] in 2021, where the Inspector stated:

Health Contribution

55. A figure of £316,403.64 is sought from the Nottingham and Nottinghamshire Clinical Commissioning Group (CCG) on the basis that the nearest surgeries to the appeal site are at capacity. The justification for the contribution rests on CCG's consultation response[20] supplemented by an email[21]. These explain that '*at capacity*' means the practices have no more space available to them either within their building or the ability to convert space internally.

56. As the Council's planning witness accepted, this does not mean; 1) that the surgeries are unable to accommodate new patients, or 2) that existing or projected appointment wait times would be unacceptably long. There is no dispute that the nearest surgeries are accepting new patients and no evidence of excessive waiting times or any other operational issues was put to the Inquiry.

57. The contribution has been calculated via a standard formula which assumes each unit on the site would be equivalent to the average house size in the Borough. That approach ignores the site-specific housing mix set out above. Based on an average 2.3 people per dwelling, it is then calculated that the appeal scheme would generate an increased patient population of 810. However, in light of the Appellant's evidence on the likely origin of future residents[22], that assumption is fundamentally flawed.

58. There is nothing in the responses to demonstrate that the CCG has looked at the specific impact of the proposed development on GP practices in the area. Instead it has relied on a standard, per dwelling, approach which fails to accord with the approach to contributions advocated for in the SPD.

59. Finally, the supplementary email draws attention to the CCG's intention to relocate one of the four surgeries to a new building with sufficient space to accommodate one of the other practices. However, there is nothing to suggest that the delivery of this programme, which appears at an advanced stage, is dependent on s106 funding from this development or any others.

[2] APP/B3030/W/20/3260970 Land at Flowserve Pump Division, Hawton Lane, Balderton, Nottinghamshire, NG24 3BU

60. For the reasons set out above, the health contribution does not meet the statutory CIL tests, it is also difficult to identify what harm would arise from the failure to provide it.

2.21 The first paragraph of Page 8 states:

The comparison with schools is misconceived. It is well known fact that pupils also have a choice of schools.

2.22 This is not a fact by any means, and is actually untrue. Schools have to provide a physical place for each and every pupil that needs one. This is the statutory duty of the Education Authority, and is stipulated in the Education Act. The Education Authority has to secure a physical location for a school from someone, whether that be a developer, purchasing land from a land owner, Compulsory Purchase Order, etc. Pupils themselves **do not have a choice of school**. When applying for a school place, the pupil has the opportunity **to express a preference**. The Education Authority, as the admissions body, assigns the pupil a place based on their preference, and applying the admissions criteria. If there is space at the school that is Preference No. 1, the pupil is allocated that place. If the admissions criteria need to be applied, that pupil may be allocated a space at an alternative school if they do not rank high enough within the admissions criteria and the school is oversubscribed. As long as an alternative school can be offered, then the Education Authority has fulfilled their statutory duty.

2.23 The second paragraph of page 8 states the following:

It is not for the planning system to dictate the GP opening hours as suggested without having no actual understanding and/ or evidence the practicalities and management of a particular GP practice and the impact that any increase on workings hours would have on the primary care health providers.

2.24 This is a misrepresentation of the paragraphs. The Proof was not suggesting that the Planning system dictates opening hours. On the contrary, it was making a wider point about how “capacity” is measured. It is agreed that it is not for the Planning system to dictate opening hours. Measuring “capacity” is straight-forward when it comes to schools (more teaching space equates to a greater physical capacity under

the statutory measurement tool). However, it is more difficult when it comes to NHS facilities, as longer opening hours means more capacity; more doctors and nurses potentially means more capacity as more Patients can be seen in a day.

2.25 The Banks Surgery advertises on its website that it is open 8.30am to 6pm, 5 days a week. That is 47.5 hours in total. However, NHS GP contractual Core Hours are 8am to 6.30pm, Monday to Friday. That is 10.5 hours and 52.5 hours a week in total. Operating at core hours would increase utilisation and capacity for patients by around 10%.

2.26 According to its website, Highgate Medical Centre is open 45 hours a week. The same argument applies.

2.27 The third paragraph of Page 8 states the following:

We can confirm the following.

1) The surgery cannot accommodate new patients.

2.28 This is not true. As discussed throughout this Rebuttal and the original Proof, the Patients lists are open.

2) New patients would mean that the waiting times accessing the GP would become unreasonably long. This in turn will create a further impact on the local acute hospital as the patients who are not able to attend their own GP usually seek help from the A &E of the local acute hospital. The impact that the new population will create on the provision of primary health care service is not only on the new population but it would affect the existing population. This is clearly against the Development Plan Policy and the NPPF.

2.29 This statement contradicts the previous statement.

2.30 Furthermore, it is unclear what constitutes “unreasonably long”, and no evidence has been provided to suggest that this is the case.

3) *The capital funding from NHS does not follow each patient as explained above and therefore the increase in capacity for the new population from this proposed development is absolutely necessary in the amount requested to mitigate the impact of the new population affecting the delivery of primary care of the new population from this proposed development and the existing community.*

2.31 The evidence of the Appellant has never claimed that Capital funding will "follow each Patient". What we have stated is that approved physical expansions of GP Practices are either funded by the NHS directly, or, if Privately funded, reimbursed by the NHS. This is guaranteed. Therefore, developer funding to expand provision that will then be reimbursed by the NHS is double funding and therefore not CIL Regulation 122 compliant.

2.32 The first paragraph of Page 9 states:

Statistically 18–64-year-olds account for over half of clinical staff contacts. The other half is taken by younger children, babies and elderly population.

2.33 Younger households use GP Surgeries with less regularity than older households. On that basis, young households subsidise older Patients.

2.34 Paragraph 2 of Page 9 states:

This is incorrect, please see above explanation. There is no direct funding as suggested and therefore there is no double funding. In any event, the case of Tesco Stores Ltd and Secretary of State for Environment [1995] 2AER 636, the Court took the view that Government has accepted that the market forces are distorted if commercial developments are not required to bear their own costs and developer should contribute towards costs which normally be responsible of the public sector.

2.35 This is not what paragraph 12.19 of the Proof is saying. Approved expansion works by a GP Practice, however they are financed, are reimbursed by a particular funding stream based on rental value. This is known as Notional Rent Reimbursement[3]:

[3] https://www.bma.org.uk/advice-and-support/gp-practices/gp-premises/rent-reimbursement-for-gp-practices

7 REIMBURSEMENT

The enlargement of General Practice premises can be funded by capital grant from the NHS Commissioning Board or by an increase in the Reimbursement indicated by the increase in floor area/rateable value of the premises. If the former, then rent abatement applies. This is all set out in the National Health Service (General Medical Services – Premises Costs) Directions 2013 that came into force 1st April 2013.

GP practice funding is separate from patient funding. It is governed by The National Health Service (General Medical Services – Premises Costs) Directions 2013. GP practices (contractors) are eligible for rental reimbursements. The type of reimbursement applicable depends upon who owns the building. For instance:

- *Where the GP owns the building, this is known as 'notional rent'*
- *Where the GP is paying off a mortgage, this is known as 'borrowing cost reimbursements' (historically known as 'cost rent')*
- *Where the GPs are tenants in a building owned by an NHS landlord or a private owner, they receive leasehold cost reimbursements.*

***Notional Rent**: The amount of notional rent to be paid to the practice is based on the current market value (CMR), determined by a surveyor. CMR is assessed on notional lease terms, which assume a 15 year lease internal repairing obligations with the landlord responsible for external and structural repairs and insurance.*

***Leasehold Rent Reimbursement**: The level of leasehold rent that may be granted is determined by the CMR value of the premises, or the actual lease rent, whichever is the lower. The CMR value of the premises is as assessed by independent valuation conducted by the district valuer, who must determine what might be reasonably expected to be paid for the premises.*

***Borrowing Cost Reimbursements**: GPs who own their premises and have incurred costs, such as mortgage or loan for repairs, may be eligible to have their borrowing costs reimbursed.*

2.36 The process of Notional Rent Reimbursement is regulated, and includes legal and professional fees and expenses. The regulations deal with rateable value, borrowing costs, Stamp Duty Land tax and rely on the involvement of the District Valuer. Thus, there is no necessity for a funding route that does not require repayment (for

example, a loan or mortgage) and consequently the necessity restriction in CIL Regulation 122 is not met.

2.37 The third paragraph of page 9 states:

The argument that that the NHS is funded from taxation is an argument that could be used against other contributions like, highways, education, monitoring s 106 officer, management of open space to name a few. Please also see the answer to paragraphs 12.15-12.17 above.

2.38 This is, again, demonstrably untrue. School places are funded, via Basic Need funding from the Department of Eductaion, on the basis of the number of places over capacity a Planning Area is forecast to be, **minus funding secured via Section 106 or CIL** to avoid double-funding. There is no NHS Constitution equivalent for Highways, Education, etc. The NHS Constitution guarantees that everyone that requires NHS Services is seen.

2.39 Paragraph 4 of page 9 states:

The contribution is to be used either for reconfiguration and refurbishment and/or extension of the two said GP premises to create the additional space required as per the consultation response.

2.40 As discussed throughout this Rebuttal, this amounts to double-funding.

2.41 The Conclusion of the document states:

As explained, the contribution is absolutely necessary to mitigate the impact that this proposed development will create on primary care in the local community. It is clearly demonstrated that the contribution is directly linked to this development and that it is fairly and reasonably related in scale and kind to the proposed development. Without the requested contribution, the access to adequate health services is rendered more vulnerable thereby undermining the sustainability credentials of the proposed development due to conflict with NPPF and Local Development Plan.

2.42 This is wrong for all of the reasons previously stated throughout this Rebuttal.

3 Conclusion

3.1 The fundamental and incontrovertible evidence discussed above in this Rebuttal is that the NHS Practices that will serve this development are open to new Patients, and the NHS Constitution guarantees that all Patients will be seen by a GP Practice should they need one. On that basis, there is no justification for planning obligations.

3.2 I trust that the information contained in this Rebuttal is sufficient to demonstrate this. However, if further discussions are necessary prior to the conclusion of the Appeal, I would be happy to discuss them in more detail.

Signed:

Ben Hunter
Associate Director – Education and Social Infrastructure
EFM (on behalf of David Wilson Homes)

25th April 2022