CIL Compliance Statement – September 2023

APPEAL BY BRANDON ESTATES
AT COVENTRY STADIUM, RUGBY ROAD, COVENTRY, CV8 3GJ

RBC REFERENCE: R18/0186

THE PLANNING INSPECTORATE REFERENCE: APP/K3715/W/23/3322013

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1.0 Introduction

1.1 This statement relates to the Public Inquiry following an appeal by Brandon Estates against the refusal of demolition of existing buildings and outline planning application (with matters of access, layout, scale, and appearance included) for residential development (Use Class C3) including means of access into the site from the Rugby Road, provision of open space and associated infrastructure and provision of sports pitch, erection of pavilion and formation of associated car park.

1.2 This statement outlines how each of the obligations requested by the Local Planning Authority would comply with the tests set down in Section 122 and 123 of the Community Infrastructure (CIL) Regulations 2010 (as amended) (the Regulations). The obligations requested were also contained within the Council's Committee Report (CD06). Where they are not specified within the Officer's report they were reported to Planning Committee and are included within either this report or WCC's CIL compliance statement.

1.3 Rugby Borough Council do not have an adopted CIL Charging Schedule.

1.4 Warwickshire County Council's CIL Compliance Statement outlines the requirements for the obligations they have requested and their CIL compliance. As such the following obligations are not covered within this statement:

- Education
- Highway works and sustainable transport; and
- Public rights of way

1.5. The obligations requested from Rugby Borough Council are outlined below and will be discussed in Section 2 of this statement:

- Play and Open Space
- Health Care Facilities
- Affordable Housing
- Sports Provision (3G Sports Pitch)

2.0 Planning Obligations and CIL Compliance

2.1. Paragraphs 54, 56 and 57 of the Framework, policies D3 and D4 of the Local Plan and the Planning Obligations SPD set out the need to consider whether financial contributions and planning obligations could be sought to mitigate against the impacts of a development and make otherwise unacceptable development acceptable.

2.2. Regulation 122 of the Community Infrastructure Levy (CIL) Regulations 2010 (as amended) makes it clear that these obligations should only be sought where they are: (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. If a requested planning obligation does not comply with all of these tests, then it is not possible for the Inspector to take this into account when determining the appeal.

Play and Open Space

2.3. Policy HS4(A) of the Local Plan states that residential development of 10 dwellings and above shall provide or contribution towards the attainment of the Council's open space standards as set out within the policy. It also states that contributions through CIL/S106 will be sought from developments where the proposal would further increase an existing deficit in provision or where the proposal will result in the provision standards not being met within the ward or parish it is located within (contained within appendix 4 of the local plan). Policy HS4(B) states that new open space should be accessible and of high quality, meeting a set of criteria.

2.4. Appendix 4 sets out the surplus and deficits for each parish/ward and concludes the following for Brandon and Bretford (reference 15):

Parish	Population	Provision	Children's Play (0.2ha per 1,000 pop.)	Natural and semi natural (2.5ha per 1,000 pop)	Amenity Greenspace (0.5ha per 1,000 pop)	Allotments (0.8ha per 1,000 pop)	Parks and Gardens (1ha per 1,000 pop)
Brandon and Bretford	630	Current Provision	0.04	0.00	1.55	0.00	0.00
		Surplus/ Deficit	-0.09	-1.58	1.24	0.91	-0.63

2.5. Although landscape is a reserved matter, as it is the only reserved matter it is known that there will be 5.495ha of green space within the application site. The above table shows that there is a deficit of Children's Play, Natural and Semi-Natural and Parks and Gardens. It was deemed that Parks and Gardens could not be provided on site due to the nature of this typology. In addition, an off site contribution was not deemed CIL

compliant due to no designated open spaces for this typology being within the accessibility requirements of the site (800 metres). The same assessment was made for Allotments.

2.6. Although there is a surplus of amenity greenspace within the parish it was assessed that this provision needed to be provided on site due to the requirement for dwellings to be within 100 metres of a Local Area of Play. Due to this the one site open space is split as follows:

- Children's Play – 0.595ha
- Natural and Semi-Natural – 1.8ha
- Amenity Greenspace – 3.10ha

2.7. The Planning Obligations SPD states that where on site open space is not provided an off-site contribution is required towards Play and Open Space, subject to negotiation with the Council. However, the application provides on-site open space and green infrastructure to cater for the recreational needs of the existing and new community on site.

2.8. It should be noted that the appellant has proposed a level of open space above that of the Local Plan requirement which is shown on the Open Space Plan submitted as part of the draft Section 106. Therefore, the financial contribution requested as part of the committee report has increased. A contribution of £152,320.32 is sought for the maintenance of the on-site open space in accordance with the SPD and calculated as follows:

Type – Open Space	**On site provision**	**Cost of Maintenance**	**Maintenance time period**	**Cost of maintenance provision**
Provision for Children and Young People	0.595ha	2.91	10	£17,320.32
Amenity Greenspace	3.10ha	0.54	5	£83,700.00
Natural and Semi-Natural	1.8ha	0.57	5	£51,300.00

Note: the maintenance is calculated as provision (sqm) x cost of maintenance x time period.

2.9. The section 106 secures these contributions and sets out that if the Borough Council or its nominee does not accept the transfer of this public open space then details of a

Management Company should be submitted along with it and a maintenance schedule to maintain the public open space in perpetuity.

2.10. The planning obligation is necessary to make the development acceptable in planning terms; is directly related to the development; and is fairly and reasonably related in scale and kind to the development. The formula used to calculate the cost for maintenance are provided by up to date costings for these types of open space. The contribution meets the tests laid out in paragraph 57 of the National Planning Policy Framework and guidance on Planning Obligations in the Planning Practise Guidance. The contribution sought also fulfils the tests in Regulation 122 of the Community Infrastructure Levy Regulations 2010 (as amended by the 2011 and 2019 Regulations).

Affordable Housing

2.11. Policy H2 of the Local Plan (2019) states that affordable homes should be provided on all sites of at least 0.36 hectares or capable of accommodating 11 dwellings or more. This policy further states that on previously developed land 20% affordable housing would be required. The scheme is compliant with this policy and will deliver 25 affordable dwellings.

2.12. The s106 will secure the delivery of this provision which is necessary to meet identified affordable housing needs and to be policy compliant and so complies with Regulation 122 of the Community Infrastructure Levy Regulations 2010 (as amended) as it is directly related to the appeal scheme and fairly and reasonably related in scale and kind to the appeal development.

Health Care Facilities

2.13. Paragraph 91 of the NPPF states that planning decisions should aim to achieve healthy, inclusive and safe places and enable and support healthy lifestyles, especially where this would address identified local health and wellbeing needs.

NHS Trust - University Hospitals Coventry and Warwickshire (UHCW)

2.14. UHCW submitted an updated request through the consultation on this appeal. It is appended at Appendix 1 of this statement as it is not included as a Core Document.

2.15. UHCW have requested a contribution to address NHS revenue shortfalls for acute and emergency treatment. This is by way of a monetary contribution of £160,091.83 towards

the funding gap in respect of A&E and acute care at University Hospitals Coventry and Warwickshire.

2.16. The request states that 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. It also states that the funding is negotiated on a yearly basis and this will eventually catch up with the population growth. It is rare that a development is permitted and delivered in the same year and therefore it seems difficult to accept that predications on population growth in line with Council's five-year housing land supply positions could not be made.

2.17. It is stated that the Trust's hospitals are now at full capacity and there are limited opportunities for it to further improve hospital capacity utilisation. The population increase associated with this proposal is stated to directly impact the Trust by adding 820 acute interventions. Due to this the Trust would be required to source agency staff to meet this additional demand until it is in receipt of ICB funding to enable recruitment of substantive posts to manage this additional demand.

2.18. This contribution has been considered and it is not considered that the payments to make up funding which is intended to be provided through national taxation can lawfully be made subject to a valid Section 106 obligation, and such payments must serve a planning purpose and have a substantial connection to the development and not be merely marginal or tivial. Notwithstanding the above, the legal requirements of reg. 122(2) of the CIL Regulations 2010 (as amended) are also not satisfied due to the quality of information submitted by UHCW to date. The contribution is not necessary, when funding for this type of NHS care is intended to be provided through national taxation. UHCW is unable to demonstrate that the burden on services arises directly from the development proposed, opposed to a failure in the funding mechanisms for care and treatment. The request made is to meet a funding gap over the forthcoming 12 month period and is requested on commencement of development, consideration should be given as to whether it is likely that this development is likely to be built out and occupied by residents from outside of the existing trust area within 12 months, and therefore be the source of burden on services as calculated. UHCW has not demonstrated through evidence that the burden on services arises fairly from the assessment of genuine new residents likely to occupy the dwellings. Therefore, it has not been demonstrated that the request fairly and reasonable relates in scale and kind to the development proposed.

2.19. Further, the Council understands from the cases of R(Worcestershire Acute Hospitals NHS Trust) v Malvern Hills DC and others [2023] EWHC 1995 (Admin) that Acute NHS Trust funding from CCGs (or their successors ICBs) includes an element for population growth. The Trust's request does not appear to acknowledge this nor explain how much of the funding it receives from CCGs / ICBs is attributable to population growth.

2.20. The Council is not satisfied that the Trust has shown that there will be any residual funding gap, nor, if there is such a funding gap, what the size of that gap is. Therefore it would be unlawful to require the payment of the contribution sought by the Trust.

2.21. It should also be noted that the request made is for 137 dwellings which was the number of dwellings originally proposed on the site. However, this was amended to 124 dwellings in 2021. Therefore, it is not directly related to the development. Notwithstanding this, if the request was amended to relate to 124 dwellings the above assessment still stands.

2.22. This request is therefore not considered to meet the test of the CIL Regulations and the Council invite the inspector to remove this from the submitted draft Section 106 agreement.

NHS Coventry and Warwiskshire CCG (the CCG)

2.23. The CCG has requested a contribution of £82,170 towards addressing the deficiencies in services within a specific area of the site. The proposed development would create an increased population of 298 patients which would equate to an additional floorspace GIA of 28 square metres. The total cost of this additional capacity would equate to £82,170. The detailed calculation for this contribution is set out in CD9.18. the contribution would be used for improvements to off-site primary medical care and healthcare facilities at one of the 6 practices specified within CD9.18.

2.24. The provision of a health care contribution for the CCG is required for compliance with policies D3 and D4 of the Local Plan (2019). The requirement of funding for Health Care provision at an identified local GP surgery or healthcare facility addresses the impacts of the development on existing and future needs of this vital infrastructure provision, helping to meet the overarching social objectives contained within the NPPF in achieving sustainable development, thus making the obligation necessary. The identified increase in patients would have a direct impact on the local health care facilities identified, as set

out in CD9.18, arising from the additional demand on services directly related to the population generated from the development.

2.25. The extent of the CCG contribution is directly related in scale and kind to the development, the obligation is calculated using population projections applied to all developments of this typology. The obligation sets out current capacity of local services and how this proposal leads to direct impact, the developer is not obligated to provide contributions to address need in excess of that generated directly from the development, therefore, the contribution fairly relates in scale and kind to the development proposal.

Sports Provision (3G Sports Pitch)

2.26. The obligations related to the 3G sports pitch secure a construction scheme, a community use agreement and a management and maintenance scheme.

2.27. A maintenance contribution is not secured as a figure but as a scheme due to not knowing the specification of the pitch and therefore not being able to calculate a related contribution. The management and maintenance scheme is required in order to ensure adequate maintenance for a prolonged period of time for the pitch so it remains in a useable condition for its lifetime.

2.28. A community use agreement is considered to be necessary for the 3G pitch provision to ensure that the proposed benefits of the pitch are realised.

2.29. It is considered that these obligations are necessary for the above reasons, they relate directly to the development as the 3G pitch is within the proposal and they are fair and reasonably related in scale and kind to the development.

2.30. The provision of these obligations are required for compliance with policies D3 and D4 of the Local Plan (2019).

Appendix 1 - NHS Trust, University Hospitals Coventry and Warwickshire (UHCW) submission to the appeal

University Hospitals Coventry and Warwickshire NHS Trust

Planning application for COVENTRY STADIUM, RUGBY ROAD, COVENTRY, CV8 3GJ

LPA reference: R18/0186

Glossary

- ***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.*
- ***Emergency care:*** *Care which is unplanned and urgent.*
- ***Integrated Care Boards (ICB****): a statutory organisation bringing the NHS together locally to improve population health and establish shared strategic priorities within the NHS. They are responsible for the commissioning of health care services for their local area.*
- ***Integrated Care Partnership****: a combination of ICB, Local Authority, NHS Trusts and other Partners who have a duty to prepare plan how the assessed needs in relation to the local authority's area are met.*
- ***NHSI:*** *NHS Improvement are a health services regulator, they are responsible for overseeing NHS foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care.*
- ***ONS:*** *Office of National Statistics*

- ***PFI:*** *Private Finance Initiative (PFI arrangement) is a procurement method which uses private sector capacity and public resources in order to deliver public sector infrastructure and/or services according to a specification defined by the public sector.*

- ***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:*** *The costs incurred for the supply of agency staff above the costs of a substantive member of staff.*

- ***Provider Sustainability Fund (PSF):*** *a fund that supplements the health provider's income*

- ***Step change:*** *The sudden and significant level of change required when a tipping point in additional activity is reached. (In this case, the point at which additional resources and/or clinic capacity is required).*

- ***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.*

- ***Tertiary care:*** *Highly specialised medical care usually over an extended period of time that involves advanced and complex procedures and treatments performed by medical specialists in state-of-the-art facilities. (For example; cancer treatment).*

University Hospitals Coventry and Warwickshire NHS Trust's Consultation Response and Regulation 122 CIL compliance statement in respect of the above planning application:

This document provides a summary of the impacts of new housing developments on University Hospitals Coventry and Warwickshire NHS Trust's (the Trust) capacity to provide services, as well as a calculation of the contribution sought to mitigate the impact of the development on the Trust. It provides a sense of the operating scope and environment of the Trust. It explains:

• The impact and consequences of increasing demand upon the Trust's capacity.

• The context of the Trust and the services it provides.

• How funding flows within the NHS to show how the Trust is paid for providing the health service to the proposed development and the community.

• How the mitigation calculation is directly related to the development and how the developer is able to mitigate the impact created.

Introduction to University Hospitals Coventry and Warwickshire NHS Trust

1 University Hospitals Coventry and Warwickshire NHS Trust, has an obligation to provide healthcare services and manages two hospitals in Coventry and Rugby, being the Hospital of St. Cross, Rugby, and University Hospital, Coventry. Although run independently, the Trust has been set up in law under the National Health Services Act 2006. The primary obligation is 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. The Trust was established as an NHS Trust in 1993. NHS 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, principles and the NHS Constitution. Like all other NHS bodies, NHS Trusts are inspected against national standards by the Care Quality Commission, NHS Improvement and other regulators/accrediting bodies.

2 The Trust is a public sector NHS body and is directly accountable to the Secretary of State 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 Coventry and Warwickshire and works as a University Teaching Hospital alongside Warwick Medical School. Acute healthcare services incorporate activities delivered in a hospital setting.

3 The Trust provides a wide range of planned and emergency services to patients across its two hospital sites in Coventry and Rugby (see Appendix 1) It is the major provider of secondary care services to the population of Coventry City and Rugby Borough, and specialist tertiary services including cancer, renal transplant and other specialist services to patients across Coventry, Warwickshire (including Rugby Borough) and further afield, and is the sole, capable provider of major trauma services in Coventry and Warwickshire and beyond.

Who is using the University Hospital?

4 Since 2008, patients have been able to choose which provider they use for their healthcare for particular services. The current NHS Choice framework, published in April 2016 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 (for example emergency care), and for hospital healthcare it only applies to first outpatient appointments, specialist tests, maternity services and changing hospitals if waiting time targets are not met. In 2017/18 (the most recent data available to UHCW Trust) **84%** of Coventry and Rugby residents chose

UHCW for their first outpatient appointment and UHCW delivered over **91%** of Coventry and Rugby's residents' total admissions, including admissions for specialised services (see Appendix 2).

Planning for the Future

5 The Trust understands that the existing population, future population growth and an increased ageing population will require additional healthcare infrastructure to enable it to continue to meet the increasing demands and complexity of the hospital healthcare needs of the local population.

6 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.

7 The funding from the ICB is currently negotiated on a yearly basis and this will eventually catch up with population growth, but cannot take into account the increased service requirement created by the increase in population due to development, including that from this development, in the first year of occupation.

Current Position

Emergency admissions and the direct impact on emergency health care services

8 Across England, the number of acute beds is one-third less than it was 25 years ago[1], but in contrast to this the number of emergency admissions has seen a 37% increase in the last 10 years[2]. The number of emergency admissions is currently at an all-time high. UHCW growth is shown in Figure 1.

Emergency Admissions	Year
52,706	2014/15
57,642	2015/16
58,434	2016/17
61,372	2017/18

Figure 1

[1] Older people and emergency bed use, Exploring variation. London: King's Fund 012
[2] Hospital Episode Statistics.www.hesonline.nhs.uk/Ease/servlet/ContentServer?siteID=1937

9 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 and its regulators, there are no sufficient resources or space within the existing facilities to accommodate population growth 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.

10 The Trust's current ability to cope with the number of A&E attendances and it's responsiveness to emergency admissions has been specifically commented on by the Care Quality Commission as "Requiring Improvement" in its most recent inspection report (April 2018). Stating 'Patients waiting for admission to a ward spent longer in the Emergency Department than in most other hospitals in England.' 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 maximum bed occupancy of 85%. The 85% occupancy rate is evidenced to result in better care for patients and better outcomes[3]. 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 treatment of his/her particular ailment, the patient will be admitted and treated in the best possible alternative location and transferred as space becomes available, but each ward move 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.

11 Appendix 5 details the Trust's utilisation of acute bed capacity, which exceeded the optimal 85% occupancy rate for the majority of the year. (UHCW exceeds 100% when required to bed patients in non-inpatient areas, for example, bedding emergency patients overnight in the day surgery unit).This demonstrates that current occupancy levels are highly unsatisfactory, and the problem will be compounded by an increase in need created by the development 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. Any new residential development will add a further strain on the current acute healthcare system.

12 The population increase associated with this proposed development will significantly impact on the service delivery, performance and the capacity of the Trust until contracted activity volumes include the population increase. As a consequence of the development and its associated demand for emergency healthcare there will be an adverse effect on the Trust's ability to provide on-time care delivery without delay, this will also result in financial penalties due to the Payment by Results regime.

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

The direct impact on the delivery of suitably and safely staffed hospital services, caused by the proposed development

13 The NHS, in common with public health services in many other countries is experiencing staff shortages. UHCW has a duty to provide high-quality care for all and ensure that it is appropriately and safely staffed in order to manage both the unpredictable demand for major trauma and emergency care, and diagnostic and elective care. Rising unplanned demand for care in a hospital setting, often paid for at a Premium Cost, has detrimentally impacted on the financial position of the Trust. To ensure the continuing provision of the highest standard of patient care, the need will arise for the Trust to employ both medical and non-medical agency staff where prospective cover arrangements are not in place. Agency staff play a vital role in the NHS, giving hospitals the flexibility to cope with fluctuating staff numbers and helping Trusts to avoid potentially dangerous under-staffing. Agency staff can be cost effective, because they are only hired when needed and don't carry the same longer-term costs, as directly employed staff – such as pensions, sick pay and holiday pay. They are an essential part of UHCW staffing resources presently and with current vacancy rates any expansion in service will require agency staffing at premium cost. As an NHS Trust we are required to manage the value of agency costs within a threshold set by our NHSI. The Trust needs to ensure that the level of services is delivered as required, by the NHS Standard Contract for Services regardless of the increased demand due to the development. To engage agency staff is the only option to keep up with the required standard and to create the needed capacity.

14 For the additional **820** acute interventions from this proposed development, the Trust will be required to source additional, suitably qualified agency based staff to work alongside the permanent workforce in order to meet this additional demand, until it is in receipt of ICB funding to enable recruitment of substantive posts to manage the additional demand. The normal funding arrangement is only related to the existing staff levels. It does not include the additional staffing demand required to address the required additional service levels.

15 UHCW has a duty to provide high-quality care for all and ensure that it is appropriately and safely staffed in order to manage both the unpredictable demand for both emergency as well as required elective care. There is no way to reclaim this additional premium cost for un-anticipated activity. The only way that the Trust can maintain the "on time" service delivery without delay and comply with NHS quality, constitutional and regulatory requirements is through developer contributing (requiring the developer to meet the funding gap directly created by the development population) due to the nature of the marginal rate operation of the emergency tariff , the cap on elective and Premium Cost requirement, thus enabling the Trust to reinvest this to provide the necessary capacity for the Trust to maintain service delivery and capacity during the first year of occupation of each unit. Without securing such contributions, the Trust will have no funding to meet healthcare demand arising from the development during the first year of occupation and the health care provided by the Trust would be significantly delayed and compromised, putting the residents and other local

people at potential risk. Without the contribution the impact will have a significant financial and practical knock on effect as each patient not effectively either discharged or place in the correct ward in time will increase the costs, prolongs the patient's recovery and creates lack of capacity to provide health services.

Funding Arrangements for the NHS Trust

16 Coventry and Warwickshire Integrated Care Board (ICB) commissions the Trust to provide acute healthcare services to the populations of Coventry and Warwickshire. NHS England (Specialised Commissioning) commissions the Trust to provide certain specialist and tertiary services to the people of Coventry and Warwickshire and beyond. This commissioning activity involves identifying the health needs of the respective populations and commissioning the appropriate high quality services necessary to meet these needs within the funding allocated. The ICB commissions planned and emergency (activity arising from major trauma and A&E), acute hospital medical and surgical care and specialist and tertiary healthcare from UHCW and agree service level agreements, including activity volumes and values on an annual basis. The ICB has no responsibility for providing healthcare services. They commission (specify, procure and pay for) services, which provides associated income for the Trust. The Trust directly provides the majority of healthcare services through employed staff but has sub-contracted some non-clinical services through its PFI arrangements.

17 The Trust is required to provide the commissioned health services to all people that present or who are referred to the Trust. The NHS Standard Contract for Services, condition SC7 for 2022 with which the Trust is compliant states "Nothing in this SC7 allows the Provider to refuse to provide or to stop providing a Service if that would be contrary to the Law." 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 Accident and Emergency (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. In respect of major trauma, all patients who receive their trauma within the boundaries of the UHCW major trauma service (including the whole of Coventry & Warwickshire) will be taken to the University Hospital major trauma centre facilities.

How are NHS providers paid?

18 NHS providers do not have directly allocated funds. Rather, each has annual contracts negotiated with ICBs. These contracts serve as a mechanism by which ICBs commission service providers to care for those members of the population who need healthcare. Contracts include service specifications, based on clinically evidenced and recognised guidelines, which are used to monitor the quality of service delivery.

The annual contracts between ICBs and providers are activity based. The Trust's contract income has comprised of two payment types i) payments for episodes of activity, known as tariff payments and ii) block payments, most usually for emergency and urgent care activity.

19 i) The National Tariff Payment System, published annually by NHSE/I, is a system where ICBs pay NHS healthcare providers a standard national price (tariff) for each patient seen or treated and is based on the average cost of delivering that care across all NHS organisations. The Department of Health sets the tariff annually. Tariff is currently composed of 65% for staffing costs, 21% other operational costs, 7% for drugs, 2% for the clinical negligence scheme and 5% for capital maintenance costs. The tariff is derived from the national average cost base for the delivery of hospital care and is adjusted to account for inflation, efficiency improvement and other cost base pressures. (e.g. changes to the Clinical Negligence Scheme for Trusts (CNST) premium and introduction of new medical technologies).

20 ii) Block payment arrangements fund the Trust for a quantum of activity and include "floors" and "ceilings" to prescribe (and proscribe) activity levels. If these are under or over-achieved, penalties are applied, usually in the form of marginal payments for additional activity. In accordance with NHS policy, the Trust's provision of non-elective admissions, A&E attendances and Same Day Emergency Care has been governed by a block contract, negotiated and agreed annually, based on the previous year's activity levels. Thus, overachieved activity is paid for at marginal rate, currently 20% of full cost. This does not cover the cost of providing the activity.

21 Funding arrangements for NHS acute trusts changed as a result of the COVID pandemic. All activity in 2021/22 was paid for under block payment arrangements and additional funds were received to support the direct costs of responding the COVID pandemic . However, as the Trust emerges from the COVID pandemic, the way in which Acute Trusts are funded has changed from block payment back to a national tariff payment system (NTPS) which aims to transition out of the COVID block funding arrangements by using a blended payment model known as Aligned Payment Incentive (API).

22 The API applies to all NHS acute provider contracts and consists of a fixed element of funding which will fund an agreed level of activity based on the volume and type of activity delivered in the previous year, with applicable to contracts with a value of greater than £30m, this is an additional element paid at 75% of tariff if the provider can demonstrate that it has gone further to reduce the backlog of elective activity which has arisen as a result of COVID.

23 Out-turn activity levels for a provider for the previous year are the basis of the annual contract refresh. Rates of growth encountered during the current year are never entirely funded in the following year by ICBs. Additional expenditure which results from increasing demand in year, over and above contracted values, is

never paid for retrospectively and so becomes an unfunded in year pressure. Thus, payment for growth always lags behind activity increases.

24 The Trust's funding formulae or income does not take into consideration the local housing need, housing projections or existing planning permissions. The income is always based on the previous year's activity as explained above.

25 Further, additional funding- Provider Sustainability Fund (PSF): a fund that supplements the health provider's income, focused on supporting sustainability of NHS providers.

26 In 2019/20, the Trust is due to receive additional PSF funding which supplements the income, subject to the Trust planning and in the contract negotiations, it is assumed that the Trust will plan to achieve the Trust's waste reduction target of 5%.

27 If the Trust meets its agreed 5% then it will receive its PSF.

28 If the Trust does not achieve its 5% then the Trust it will lose PSF.

29 In addition the Trust has given a target to eliminate 78 week waits for elective care. This means that each patient referred to the Trust for elective care should not wait over 78 weeks for their treatment. If this happens then the Trust will be subject to financial sanctions. The potential amount lost is proportionate to the number of breaches.

Please see Week waiting times figures below

Weeks Waiting	Mar-19	Mar-20	Apr-21	Oct 21	Nov 21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
total	**28,306**	**30,246**	**51,143**	**54,582**	**55,072**	**54,829**	**56,011**	**57,108**	**58,161**	**60,050**	**61,145**	**62,827**
104+	0	0	2	100	105	117	106	66	0	0	0	0
78+	0	0	554	1,183	882	735	540	408	424	438	318	167
52+	0	2	4,354	4,253	3,870	3,818	3,470	3,366	3,493	3,663	3,859	4,219
18+	4,216	8,052	23,432	23,160	23,001	23,866	24,282	25,251	25,819	27,438	26,839	28,189
0-18	24,090	22,194	27,711	31,422	32,071	30,963	31,729	31,857	32,342	32,612	34,306	34,638

30 The development will put an extra pressure on the Trust's ability to achieve the agreed financial target because each additional patient not part of the agreed contract will consume the available funding ability to reach the required week wait. This in turn will affect the Trust's capital programme.

31 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.

32 There is no ability to reclaim the 100% of tariff above the baseline for additional activity.

33 The Trust is expected to generate surpluses for re-investment to develop local services, or alternatively must seek to secure external financing in the form of loans (although due to the current financial constraints in the NHS, access to such funds is extremely limited). This development will directly impact on the service capacity requirements of the Trust to meet additional demand, against which the Trust will have no means of fully recouping the funds required for reinvestment

Explanation of formula for mitigating s106 developer contribution

34 All activity undertaken by the Trust is traceable to a patient through the patient's address, NHS number and registered GP which are recorded each time a patient is treated. This activity count does not represent discreet patients, but the amount of activity (number of episodes of care) undertaken.

35 Principally, demand for the Trust's services arises from referrals from GPs and from attendances at Emergency Departments. To establish the predicted impact of the development on the Trust's services, the Trust identifies activity for a number of points of service delivery within the LSOA in which the development will be built. This is predicated on the likelihood that population new to Coventry and Rugby area will use the GP and hospital services local to the LSOA. These usage rates are then multiplied by the new population to arrive at the new population's impact.

Formula:

Emergency and Elective admissions *(including Elective & Daycase admissions, outpatients, Diagnostics)* **:**

36 For the **820** admissions, representing 42% of the residents, the Trust will have no method of recovering the 100% of tariff needed to invest in the stepped change needed for services.

Formula:

Admissions - Development Population x Average Admission Activity Rate per Head of Population x Average Admission Tariff x 100% Cost per Admission Activity – existing population = Developer Contribution

Premium Costs:

37 For all the **820** anticipated hospital based interventions, the Trust will have no method of recovering the additional Premium Costs needed to ensure the level of service required.

Formula:

Development Population x Average Admission Activity Rate per Head of Population x Average Tariff x proportion of Trust staff cost of total cost (60%) x NHSI Agency Premium Cap (55%) = Developer Contribution.

The final figure is abated by 35% to represent the population that the Trust assumes to be in the catchment area.

38 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 and Elective 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 137 dwellings is **£160,091.83** (to include deduction of affordable housing) .This contribution will be used directly to provide additional health care service capacity to meet patient demand as detailed in Appendix 3.

39 The contribution requested (see Appendix 3) 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 capacity to provide healthcare services available to support it, also it would adversely impact on the delivery of healthcare not only for the development but for others in the Trust's area.

40 Having considered the cost projections, and phasing of capacity delivery we require for this development it is necessary that the Trust receive 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

41 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 known population growth, it cannot plan for unanticipated additional growth in the short to medium term. The contribution is being sought to provide services needed by the occupants of the new development, and the funding for which, as outlined above, 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.

42 Without contributions to maintain the delivery of health care services at the required quality, constitutional and regulatory standards and to secure adequate health care for the locality, the proposed development will put too much strain on the said services, putting people at significant risk. Such an outcome is not sustainable.

Legal and Policy

43 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".

44 Paragraph 2 of the NPPF states:

The National Planning Policy Framework must be taken into account 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 (emphasis added).

The health of communities has been a key element of Government policy for many years. 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).

Further, the Trust is delivering NHS health care services at the point of demand under the statutory requirement. Paragraph 2 contains an imperative upon the decision makers to reflect statutory obligations. In addition, the Council must, in exercising **any** its functions, have regard to the health needs and, health and wellbeing strategy[4] prepared as part of the Integrated Care Partnership.

Local Plan 2019

Policy HS1

45 Healthy, Safe and Inclusive Communities. The potential for creating healthy, safe and inclusive communities will be taken into account when considering all development proposals. Support will be given to proposals which:

- Deliver, or contribute to, new and improved health services and facilities in locations where they can be accessed by sustainable transport modes.

Conclusion CIL 122 test

46 In the circumstances, it is evident from the above that the Trust's request for a contribution is not only necessary to make the development acceptable in planning terms it is directly related to the development; and fairly and reasonably related in scale and kind to the development. The contribution will ensure that health services are maintained for current and future generations and that way make the development sustainable.

[4] The Local Government and Public Involvement in Health Act 2007 and as amended by the health and Social Care Act 2022 S 116B.

Appendix 1

Services provided at University Hospital

General Acute Services:
Acute Medicine
Accident and Emergency
Age Related Medicine and Rehabilitation
Anaesthetics
Assisted Conception
Audiology
Breast Surgery
Cardiology Critical Care
Colorectal Surgery
Dermatology
Diabetes and Endocrinology
Ear, Nose and Throat
Gastroenterology
General Medicine
General Surgery
Gynaecology
Haematology
Hepatobiliary and Pancreatic Surgery
Upper Gastrointestinal Surgery
Maxillo Facial Surgery
Neurology and Neurophysiology
Obstetrics
Ophthalmology
Optometry
Orthodontics
Orthopaedics Trauma
Orthoptics
Paediatrics
Pain Management
Plastic Surgery
Renal Medicine
Reproductive Medicine
Respiratory Medicine
Rheumatology
Urology
Vascular Surgery
Specialised Services:
Bone Marrow Transplantation
Cardiothoracic Surgery
Clinical Physics
Haemophilia
Invasive Cardiology
Neonatal Intensive Care and Special Care
Neuro Imaging
Neurosurgery
Oncology and Radiotherapy
Plastic Surgery
Renal Dialysis and Transplantation
Diagnostic and Clinical Support Services:
Biochemistry
Dietetics
Echo Cardiography
Endoscopy
Haematology
Histopathology
Medical Physics/Nuclear Medicine
Microbiology
Occupational Therapy
Pharmacy
Physiotherapy
Respiratory Function Testing
Ultrasound
Vascular Investigation

Services provided at Hospital of St Cross

Acute Medicine:

Acute Medicine

Acute Surgery

Ambulatory Care

Breast Screening

Colorectal Cancer Screening Centre

Day Surgery, Overnight Stay / 23 hour Surgery

Endoscopy

Laboratory Services

Macular Unit

Magnetic Resonance Imaging (MRI) Scanning

Outpatients Services

Satellite Renal Dialysis Unit

Scanning, Bone Density

Urgent Care Centre

X-ray including Ultrasound

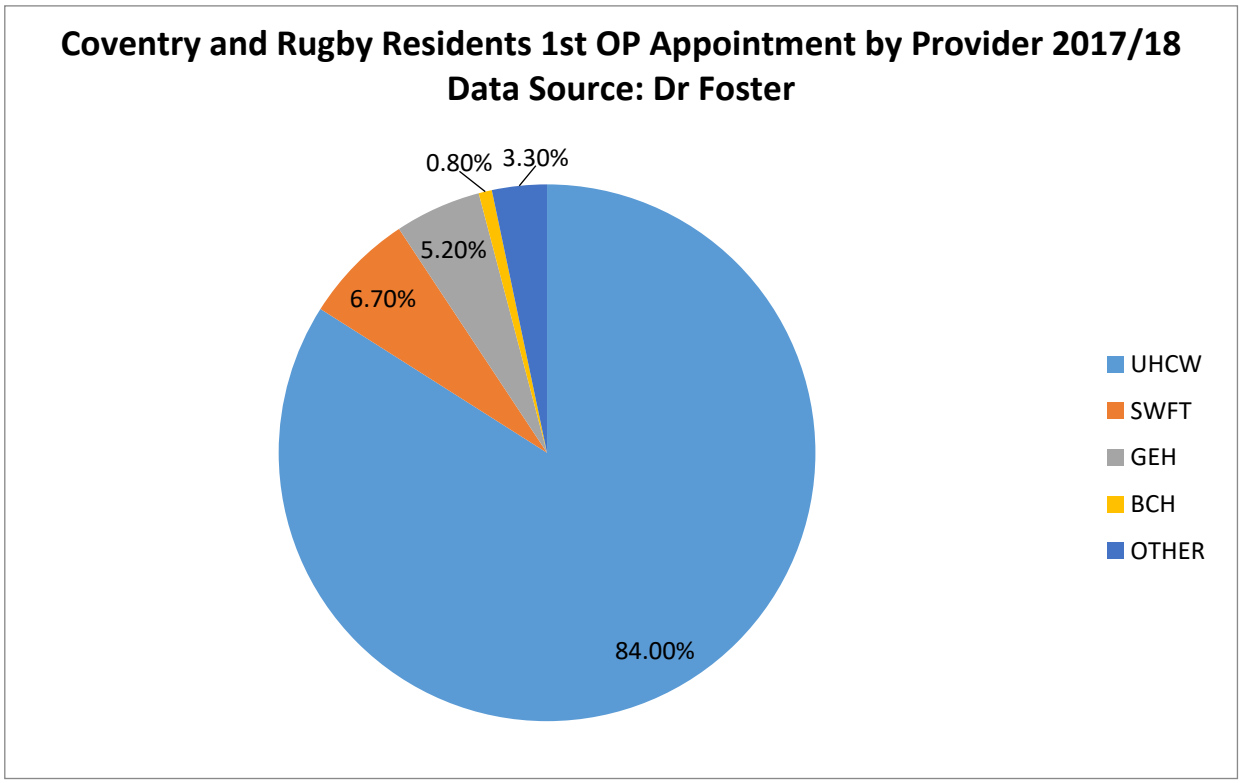
Inpatient Medical Services

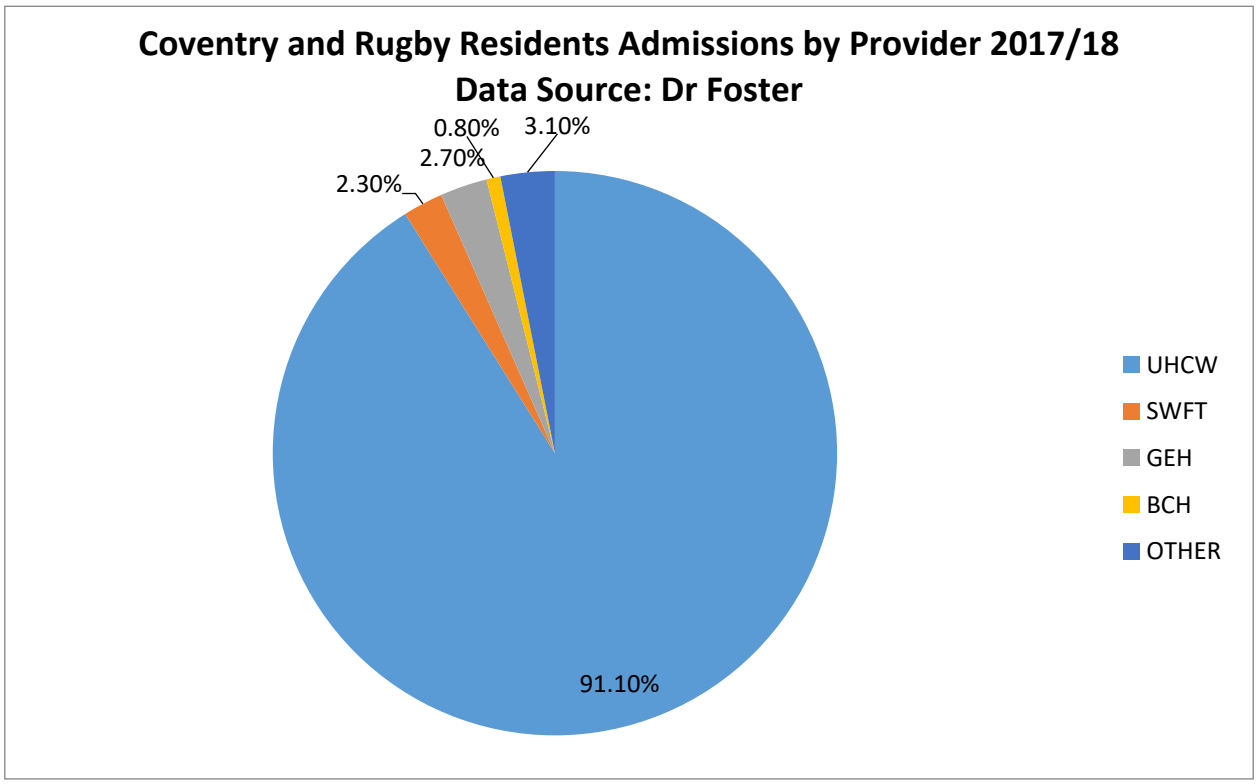
Inpatient Elective Surgery

Inpatient Rehabilitation Service

Intermediate Care

Appendix 2


Coventry and Rugby Residents 1st OP Appointment by Provider 2017/18
Data Source: Dr Foster
0.80%
3.30%
5.20%
6.70%
84.00%
UHCW
SWFT
GEH
BCH
OTHER


Coventry and Rugby Residents Admissions by Provider 2017/18
Data Source: Dr Foster
0.80%
3.10%
2.70%
2.30%
91.10%
UHCW
SWFT
GEH
BCH
OTHER

Appendix 3

Application Ref: Rugby R18/0186 - Rugby Road

Rugby Please Select
ONS Mid 2017 Population Estimate: 106350

Development Dwellings: 137 **Development Population:** 322

Pay	60%
All Other Cost	
Total Cost	
Marginal Rate on Emergency Admissions	20%
Capped Contract	0%
Agency Cap Uplift	55%

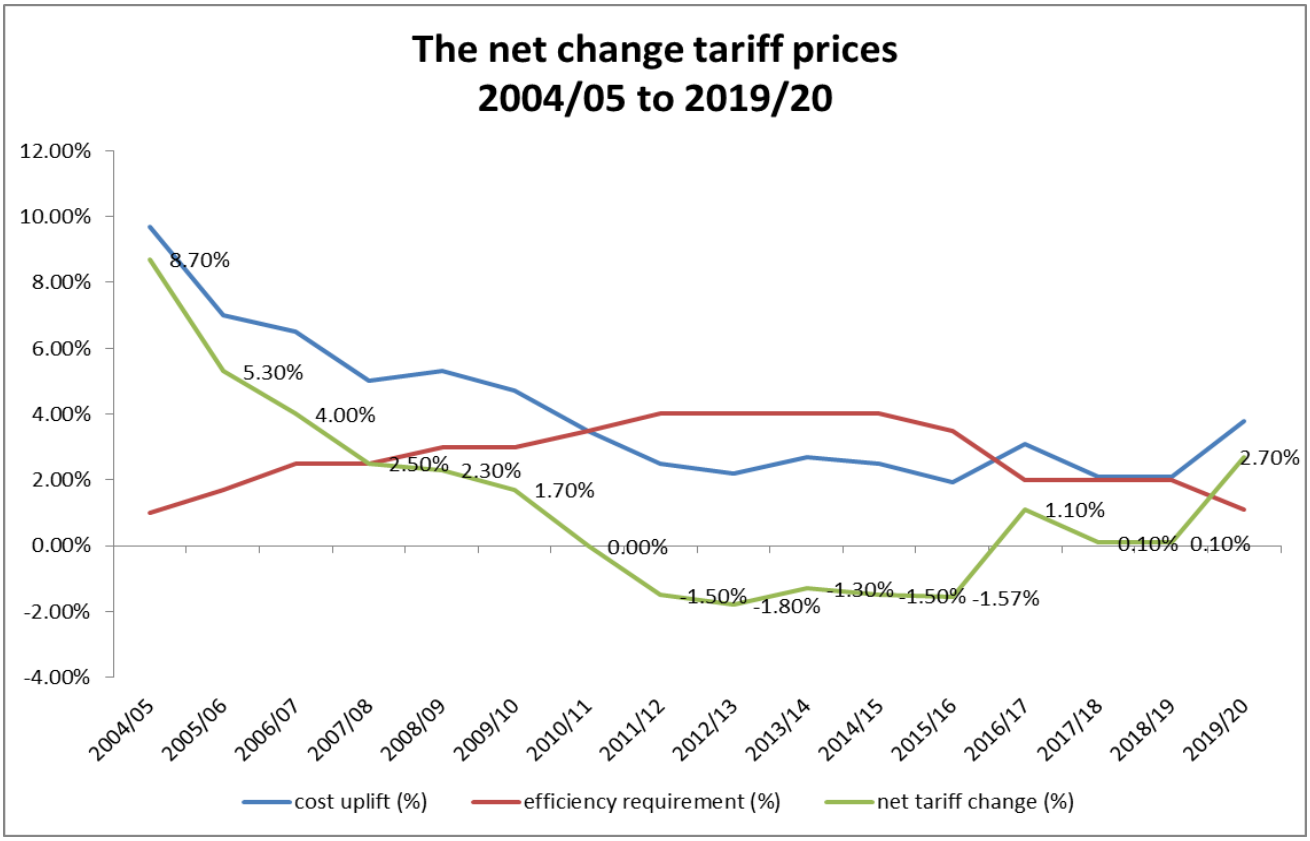
Activity Type	Activity 2018/19	% Activity rate per annum per head of population	Activity rate per annum per head of population	Avg Tariff	12 mths Activity for 137 Dwellings	Delivery Cost for 137 Dwellings	Marginal Rate for New Activity	Marginal Impact	Premium Cost of Delivery	Cost Pressure (Claim)
A&E Attendances	41,939	39%	4:11	£ 114.69	127	£ 14,561	20%	£ 11,649	£ 4,805.07	£ 16,453.73
Non Elective Admissions	13,326	13%	1:11	£ 1,887.33	40	£ 76,137	20%	£ 60,910	£ 25,125	£ 86,035.18
Elective Admisisons	2,189	2%	0:1	£ 3,592.62	7	£ 23,807	0%	£ 23,807	£ 7,856	£ 31,663.56
DC Admissions	14,394	14%	1:11	£ 635.25	44	£ 27,681	0%	£ 27,681	£ 9,135	£ 36,815.15
Outpatient appointments	163,360	154%	16:11	£ 98.96	495	£ 48,939	0%	£ 48,939	£ 16,150	£ 65,088.92
Diagnostic Imaging	35,610	33%	4:11	£ 71.41	108	£ 7,698	0%	£ 7,698	£ 2,540	£ 10,238.59
Total						**£ 198,823**	**£ 0**	**£ 180,683**	**£ 65,612**	**£ 246,295**

Cost Per Dwelling	£ 1,797.77
35% affordable housing adjustment	-£ 86,203.29
Revised Cost	£ 160,091.83

Note that the total number of dwellings is assumed to contain 35% affordable housing, so the S106 calculation is reduced to reflect and the likely effect on net migration

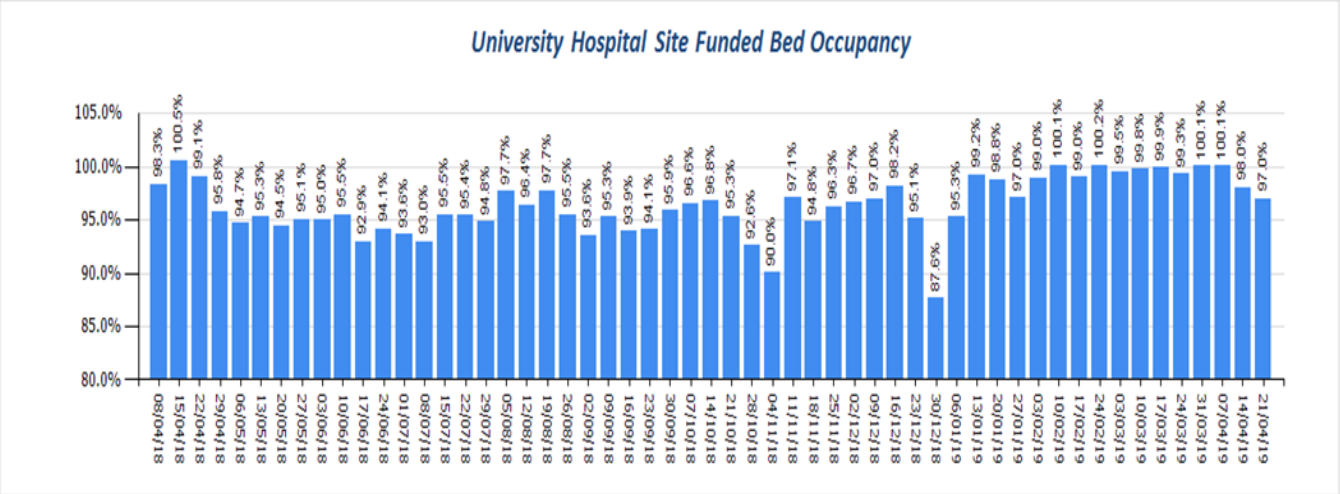
Appendix 4

The net change tariff prices



Appendix 5

Bed occupancy rate


University Hospital Site Funded Bed Occupancy
105.0%
100.0%
95.0%
90.0%
85.0%
80.0%
98.3%
100.5%
99.1%
95.8%
94.7%
95.3%
94.5%
95.1%
95.0%
95.5%
92.9%
94.1%
93.6%
93.0%
95.5%
95.4%
94.8%
97.7%
96.4%
97.7%
95.5%
93.6%
95.3%
93.9%
94.1%
95.9%
96.6%
96.8%
95.3%
92.6%
90.0%
97.1%
94.8%
96.3%
96.7%
97.0%
98.2%
95.1%
87.6%
95.3%
99.2%
98.8%
97.0%
99.0%
100.1%
99.0%
100.2%
99.5%
99.8%
99.9%
99.3%
100.1%
100.1%
98.0%
97.0%
08/04/18
15/04/18
22/04/18
29/04/18
06/05/18
13/05/18
20/05/18
27/05/18
03/06/18
10/06/18
17/06/18
24/06/18
01/07/18
08/07/18
15/07/18
22/07/18
29/07/18
05/08/18
12/08/18
19/08/18
26/08/18
02/09/18
09/09/18
16/09/18
23/09/18
30/09/18
07/10/18
14/10/18
21/10/18
28/10/18
04/11/18
11/11/18
18/11/18
25/11/18
02/12/18
09/12/18
16/12/18
23/12/18
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24/03/19
31/03/19
07/04/19
14/04/19
21/04/19