EXTRAORDINARY PLANNING COMMITTEE: 28TH July 2020
SUPPLEMENTARY INFORMATION

The "Supplementary Information" report supplements the main Planning Agenda. It is produced on the day of the Committee and is circulated at the Committee meeting. It is used as a means of reporting matters that have arisen after the Agenda has been completed/circulated, which the Committee should be aware of before considering any application reported for determination.

Correspondence received is available for inspection.

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19/00250/OUT	Outline application for development (including demolition) of up to 2,750 dwellings; business, general industrial and storage and distribution uses; two primary schools; neighbourhood centre; public open space; greenspace; drainage features; acoustic barrier; and other associated infrastructure (some matters reserved); and Full application for the development of a spine road and associated junctions with the A426 north of Lutterworth, Gilmorton Road, Chapel Lane, and the A4304 east of M1 Junction 20; comprising carriageway, footway, cycleway and associated infrastructure to include earthworks, bridge structures, services, drainage, landscaping, lighting and signage

Additional Consultee Representations

University Hospital of Leicester (UHL)
See Appendix A

East Leicestershire and Rutland CCG
See Appendix B

Lutterworth Town Council
See Appendix C

Additional Neighbour Representations

6 Additional representations has been received against the application raising similar issues to those already reported, with the below additional issues:

- Were any of the objections taken into consideration at all?
- Can you assure the people of Lutterworth that they'll be an adequate amount of services to cover Lutterworth itself and Lutterworth East i.e. emergency vehicles in particular the ambulance service?
- We already have 4 major housing estates which have built in Lutterworth over the last 3/4 years where is the evidence that this volume of housing is required in this area.

Officer Comment on additional UHL representations

Members will have noted in the body of the committee report beginning at para 6.27 the issue of Section 106 contributions for UHL is set out, at paragraph 6.42 a series of points of clarification of UHL's population modelling have been set out. Reflecting the content of this report the council raised seven matters with UHL the response to these is set out in full in appendix 7 of UHL representations in appendix A of this report.

Responses to the UHL comments are set out below, for ease of reference the questions are paraphrased and set out in the same order as in UHL's response.

Q1 Does the requested contribution serve a planning purpose and is it necessary?

The response from UHL makes reference to the impact of the development resulting from the increased population. It then seeks to equate the requested funding with that sought in relation to as education and libraries. Whilst County Councils have a statutory responsibility to provide education this is not wholly funded nationally. The NHS is centrally funded with contracts being negotiated locally for by the CCG the provision of services. The funding which the CCG receives is calculated using a formula which takes into account population growth, using Office of national Statistics projected populations. UHL is a contracted provider of services and is bound by contract to provide those services it has contracted to provide.

The evidence submitted states that UHL's funding is calculated on the basis of previous years activity, consequently with new population there is a deficit as unfunded treatments are carried out. What is not explained is why, when contracts are negotiated locally, there cannot be an element for population growth, this is taken into account in both central funding to the CCG and in the forward planning in the Leicestershire Joint Strategic Needs Assessment. Furthermore there is a time lag between the commencement of development and its occupation providing a further opportunity to take into account the implications of the potential increase in demand.

Reference is made to the Equalities Act 2010. This raises the question would the funding gap have an adverse impact on people with disabilities. It is suggested that there would be longer waiting times for patients and that due to the high level of bed occupancy the Trust cannot deliver optimal treatment. However, these potential impacts would apply to the whole of the population not one group in particular and there is no evidence that they would have a greater effect on persons with protected characteristics. Further, the issue the Council must decide is whether the request meets the tests set out in Regulation 122 of the Community Infrastructure Levy Regulations 2010, in particular is it "necessary to make the development acceptable in planning terms". For the reasons set out in the body of the report it is considered that the request does not meet the test and as such it is not a material consideration in the determination of the planning application and that is unaffected by the Equalities Act.

Q2 Does the development give rise to the additional burden on the service.

As has been previously stated the direct impact i.e. increased pressure on the service is one which arises from the increase in population. However, the cause of the pressure is the funding arrangement and its apparent failings, which are as a result of the payments being based on the previous year's activity and not reflecting any increase in funding for population growth which forms part of national funding calculations. The submissions made by UHL refer to the number of bed spaces available and that the hospital is operating at capacity. There is no satisfactory evidence linking the requested contribution to the provision of additional spaces in order to relieve the capacity issue and the contribution would therefore in any event fail the second and third of the Regulation tests.

Q3 The parallels between this application and the recent decision by the Secretary of State on the planning appeal in Teignbridge.

UHL's response seeks to distinguish this application from the Teignbridge case in that the application before the Council requires an Environmental Impact Assessment (EIA) to be submitted. A requirement of the EIA is that it identifies the direct and indirect impacts of the development in a number of areas including population and human health. The EIA carries this out this exercise and in the original submission and the supplementary information submitted 18 May 2020 recognises the need to mitigate that impact. Any mitigation would be through payments as part of a Section 106 Agreement. However, officers are not satisfied that it has been satisfactorily demonstrated that the contribution is necessary to make the development acceptable in that the existing funding mechanisms should address the issue.

UHL have suggested that in effect another government body is being asked to pay a contribution that should be paid by the developer.

This does not recognise that the NHS is fully funded centrally. UHL's request amounts to an additional burden being placed upon a local developer to meet the health needs of persons for whom the NHS is already making funding provision for. The issue raised by UHL is the time lag before it is in receipt of any re-directed funding. The issue is not the total sum of funding it is the manner in which it is distributed. It is not reasonable to expect developers to pay for services for which the NHS is already in receipt of funding.

Q5 UHL assert they were not consulted during the local plan process.

UHL were not directly consulted during the local plan process, however, as noted in the report there was extensive consultation with CCGs and NHS England. These are the bodies responsible for funding the services.

Q6 The availability of alternative places for treatment.

In Appendix 3 of their submission, appendix A of this report UHL have provided evidence of the hospitals and service providers that are used by patients who choose to use services other than those provided by UHL. The submitted calculations for use of UHL's services reflect this.

Q8 Levels of bed occupancy.

Ideally UHL would like to operate at a bed occupancy rate of 85%, however, it is currently operating at 100%. It is UHL's assertion that the development will exacerbate the existing situation and the contribution will mitigate this impact. The test as set out in the Community Infrastructure Levy Regulation 2010 requires inter alia that the obligation be "directly related to the development". Whilst UHL refer to the level of bed occupancy their request does fails to demonstrate how there would be any direct link between the contribution from the development and an increase in physical capacity. It is unclear how the requested contribution addresses the issue of the bed occupancy rate.

Q*9 Ensuring the funding is used for patient care for those arising from the development.*

UHL have indicated that they would be willing to enter into such an undertaking.

Additions to Officer Report in relation to UHL Population Modelling

Paragraph 4.42 of the main body of the report in respect of the UHL request for a section 106 contribution refers to a number of questions that have been raised with UHL about the methodology used in the UHL modelling. The modelling work was undertaken by UHL in an attempt to demonstrate that their requested contribution satisfied the Regulation 122 tests and, most particularly the tests in sub-paragraphs (b) and (c) of Regulation 122(2) i.e. that the contribution sought is ;
b) directly related to the development; and
c) fairly and reasonable related in scale and kind to the development.

The Council's analysis raised a number of issues with the modelling. Paragraph 4.46 of the main report refers to the issue of net migration. It is any net gain in population within UHL's catchment which affects demand for services.

In UHL's modelling the development population of 7,520 appears to have been derived by a process which in effect assumes that all people will in effect be moving to what is now a greenfield site, and that the types of households and the age structure profile of those moving to the development will be similar to the profile of those moving to the area in the 2010-11 period (as shown in 2011 Census data). That profile is focused more towards people aged 25-49.

However, no consideration has been given to Borough or the catchment's wider demographic dynamics. UHL's modelling takes no account of the changes which are occurring within the existing population within the catchment area. This is relevant as firstly part of the need for new homes in the District arises as the population is ageing and this is leading to falling average household size: some new homes are thus needed to accommodate the existing population. Over time, as the population ages, the population in existing dwellings will fall.

This is of particular relevance in this case as with this development delivery is phased over time. The Local Plan Housing Trajectory envisaged first completions in 2023/4 with delivery of 1260 dwellings on the site over the plan period to 2031, with the build out continuing thereafter until c. 2037/8.

The ONS 2018-based Household Projections for Harborough, show average household size falling from 2.38 to 2.35. This would imply that even with no population growth (i.e. the population remaining at 92,500), there would need to be 2,246 homes to accommodate the existing population (equating to 6% household growth).

It is the net increase in population within the catchment area which affects the demand for healthcare services. As no consideration is given to these age structure dynamics (which are of particular relevance given the phased build-out of the scheme over a number of years), UHL's modelling is likely to overstate the population growth which is expected to arise.

UHL's use of a household size figure of c. 2.7 might be appropriate to estimate the size of the population within the development itself (or at least a phase in the early years). However, it is not appropriate to use it for considering the net growth in population in the Trusts catchment area – which is the correct indicator in considering additional healthcare needs.

The focus of the modelling should have been on the net change in population within the catchment area which results in demand for additional services; rather than the net change in population on the development site (as UHL contend for).

One of the other matters raised was movement within the Trust's catchment area and from beyond. The research identified that the assumption that 38.5% of the population growth arises from movements into the catchment is not unreasonable.

There is nothing in the foregoing which changes the Council's position as set out in the main body of the report and in response to UHL's rely to matters raised with them and set out in these papers.

Officer Comment on updated S106 funding requests

CCG Request for funding

Members will have noted at paragraph 4.2.35 and 6.76 of the main report that reference is made to updating the position in respect of the CCG's request for a section 106 contribution towards medical facilities in Lutterworth. The documents submitted are attached at **Appendix B** of this Supplementary Information List.

The submission from the CCG explains that NHS England does not fund infrastructure projects such as new or extended practices.

An increase in population is identified by the CCG which takes account of the new population to the proposed development through migration into the area, relocation of some existing population and the occupation of properties vacated by existing residents relocating to the proposed development. The number of new residents translates into a number of additional appointments, to fulfil these appointments additional floorspace is required within the surgery. The two practices which cover the proposed development operate from the Lutterworth Health Centre. Clinical space within the health centre would need to be extended to meet the needs of the increased population. The CCG have examined the potential for providing a s surgery as part of the proposed development. This option has been rejected for operational and practical reasons which are set out in the submission. In order to calculate the size and therefore cost of the extension the CCG have applied nationally adopted standards.

The submitted calculation is considered to support the request for funding. However, the request is for the contribution to be paid before the first occupation of any dwellings. Whilst the CCG have established that the current practices are operating at capacity a phased approach to payments would be recommended and negotiated appropriately.

Policing contribution

It will be noted from **Para 6.77** of the main report that Leicestershire Police have requested a contribution towards additional equipment and premises.

On the basis of the evidence currently submitted the only element of the contribution that is considered to meet the tests set out in the Community Infrastructure Levy Regulations is that for additional premises. The justification for the scale of the contribution has yet to be satisfactorily proven. It is recommended that a robust method of calculating the level of contribution be agreed and pursed as per the recommendation to the committee.

Section 106 Contributions

Below is an update on the latest position on the requested contributions:

Body	Request	Required for	Council's position at present
CCG	£1,906,420	Extension to premises	In principle acceptable subject to more detailed discussion
Police	£350,000	New premises	In principle acceptable subject to more detailed discussion
UHL	£914,452	Staffing	Not supported

Amendments to Officer Recommendation

The Officer recommendation on Page 1 should be amended to include the wording in *italics and underlined* and remove the wording which has been ~~*struck through*~~

Planning Permission is **APPROVED**, for the reasons set out in the report, subject to:-

(i) The proposed conditions set out in **Appendix A (with delegation to the Development Planning Manager to agree the final wording of these)**; and

(ii) The Applicant's entering into a legal agreement under Section 106 of the Town and Country Planning Act 1990 (and S38/S278 of the Highways Act 1980) to provide for the obligations set out in **Appendix B** and justified in **Section 6c** of this report *and the Planning Committee Supplementary report, and in the case of the Leicestershire Police request for a contribution which is Regulation 122 of the Community Infrastructure Levy Regulations compliant except;*

(a) if the contribution is found to be compliant but the applicant refuses to accept it the application is referred back to this committee; or

(b) it is found not to be reg.122 compliant the agreement be entered into without such a contribution

(with delegation to the Development Planning Manager to agree the final wording and trigger points of the obligations)~~; and~~

Amended Conditions / Informatives

The following conditions should be amended to include the wording in *italics and underlined*, and remove the wording which has been ~~*struck through*~~

Construction site access

38. No part of the development north of the A4304 hereby permitted shall commence until details of a construction site access to the northern development site from the A4304 have been submitted to and approved in writing by the District Planning Authority. The approved construction site access shall be implemented in full prior to the commencement of any ~~development~~ *works* on the northern part of the site.

    REASON: To ensure that vehicles entering and leaving the site may pass each other clear of the highway, in a slow and controlled manner, in the interests of general highway safety and in accordance with the National Planning Policy Framework (2019) and to accord with Policy L1 of the Harborough Local Plan.

Construction site access

39. No part of the development south of the A4304 hereby permitted shall commence until details of a construction site access to the southern development site from the A4304 have been submitted to and approved in writing by the District Planning Authority. The approved construction site access shall be implemented in full prior to the commencement of any ~~development~~ *works* on the southern part of the site.

    REASON: To ensure that vehicles entering and leaving the site may pass each other clear of the highway, in a slow and controlled manner, in the interests of general highway safety and in accordance with the National Planning Policy Framework (2019) and to accord with Policy L1 of the Harborough Local Plan.

~~**Gilmorton Road Bridge**~~

~~45. No later than 9 months following the 650th dwelling or a vehicular connection from the spine road onto Gilmorton Road as shown on drawing no's~~

- ~~LESR-ACMXX-XX-DR-HW-00012 rev P08 and~~
- ~~LESR-ACM-XX-XX-DR-HW-00013 revP08~~

~~shall be available for use by vehicular traffic, access to Gilmorton Road bridge shall be restricted to use by emergency service vehicles, buses, cyclists, pedestrians and equestrians.~~

~~REASON: To mitigate the impact of the development, in the general interests of highway safety and in accordance with the National Planning Policy Framework (2019) and to accord with Policy L1 of the Harborough Local Plan.~~

Additional Conditions

The Following additional conditions are recommended:

Specialist Housing

A minimum of 10% of the proposed dwellings shall be specialist accommodation Class C3 as defined in the Town and Country Planning (Use Classes) Order 1987, as amended.

REASON To ensure that there is a range of accommodation on site to meet the needs of the whole community in accordance with the provisions of Policy H4 of the Harborough District Local Plan.

APPENDICES

Appendix A – University Hospital of Leicester (UHL)

University Hospitals of Leicester NHS
NHS Trust

Caring at its best

EVIDENCE FOR S106 DEVELOPER CONTRIBUTIONS FOR SERVICES

In relation to planning application for: Hybrid planning application comprising: Outline application for development (including demolition) of up to 2,750 dwellings; business, general industrial and storage and distribution uses; two primary schools; neighbourhood centre; public open space; greenspace; drainage features; acoustic barrier; and other associated infrastructure (some matters reserved); and full application for the development of a spine road and associated junctions with the A426 north of Lutterworth, Gilmorton Road, Chapel Lane (including the partial closure and realignment of Chapel Lane to motor vehicles and horse riders), and the A4304 east of M1 Junction 20; comprising carriageway, footway, cycleway and associated infrastructure to include earthworks, bridge structures, services, drainage, landscaping, lighting and signage.

LPA reference: 19/00250/OUT

Glossary of terms:

- *Accident and emergency care: Accident and Emergency Departments may be i) major units, providing a 24 hour service seven days a week to which the great majority of emergency ambulance cases are taken, or ii) smaller units commonly called minor injury units, in which services are often only available for limited hours and which may not deal with emergency ambulance cases.*

- *Acute care: This is a branch of hospital healthcare where a patient receives 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: a payment made by the commissioner to a provider to deliver a specific and defined range of services, regardless of the volume of services delivered. The value is independent of the actual number of patients treated or activity completed. Block contracts generally operate on a annual basis.*

- *Clinical Commissioning Group (CCG): CCGs are clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area.*

- *Dr Foster: Dr Foster provides healthcare information and intelligence particularly about the performance of NHS trusts. Dr Foster uses data-driven methodologies to support organisations to improve quality and efficiency.*

- *Emergency care: Care that is unplanned and/or urgent.*

- *NHS Improvement (NHSI): NHSI was a health services organisation that was responsible for supporting NHS trusts to provide consistently safe, high quality care within a local health system that is financially sustainable. On 1st April 2019, NHSI and NHS England came together as one organisation to better support the NHS to deliver improved care for patients.*

- *Office of National Statistics: Known as ONS*

- ***Operational Pressures Escalation Levels (OPEL):*** *OPEL is a standard framework for Trusts to report levels of pressures nationally using a consistent approach.*

- ***Planned care:*** *Medical care that is provided by a specialist or facility upon referral and that requires more specialised knowledge, skill, or equipment that can be provided by the referrer.*

- ***Premium Costs:*** *Premium costs incurred by an NHS trust include the supply of agency staff, Locum Medical Staff and payments to deliver services to meet operational pressures which exceed the costs incurred when delivering with substantive staff. It also covers sub-contracting the provision of certain services to third parties to meet demand.*

- ***Premium Costs:*** *The costs incurred for the supply of agency staff.*

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

- ***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).*

Introduction to University Hospitals of Leicester NHS Trust

1 The University Hospitals of Leicester NHS Trust, ("the Trust") has an obligation to provide healthcare services to one million residents of Leicester, Leicestershire and Rutland. Although run independently, the Trust has been set up in law under the National Health Services Act 2006 which consolidate the previous Health Services Acts. 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 April 2000 with the merger of the Leicester General Hospital, Glenfield Hospital and Leicester Royal Infirmary. 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 Leicester, Leicestershire and Rutland. The Trust is spread over the General, Glenfield and Royal Infirmary hospital. The Trust also has its very own Children's Hospital and work closely with partners at the University of Leicester and De Montfort University providing world-class teaching to nurture and develop the next generation of doctors, nurses and other healthcare professionals, many of whom go on to spend their working lives with us.

3 The Trust provides a wide range of planned and emergency services to patients (see Appendix 1). It is the major provider of secondary care services to the population of, and specialist tertiary services including cancer, renal transplant and other specialist services to patients across Leicester, Leicestershire and Rutland, and is the sole, capable provider of major trauma services. The services at the University Hospitals of Leicester will be used by the new occupants of this development.

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 presently available to the Trust) 87% of LLR residents chose the Trust for their first outpatient appointment and the Trust delivered over 92% of Leicester, Leicestershire and Rutland residents' total admissions, including admissions for specialised services (see Appendix 2) The calculations in this evidence base are based upon this percentage share.

Funding Arrangements for the NHS Trust

5 The three Leicester, Leicestershire and Rutland Clinical Commissioning Groups (CCGs) commission the Trust to provide acute healthcare services to the populations of Leicester, Leicestershire and Rutland under the terms of the NHS Standard Contract. 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. These commissioners commission planned and emergency (activity arising from major trauma and A&E), acute hospital medical and surgical care and specialist and tertiary healthcare from the Trust and agree service level agreements, including activity volumes and values on an annual basis. The commissioners have no responsibility for providing healthcare services. They commission (specify, procure and pay for) services, which provides associated income for the Trust. 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 17/18 and with which the Trust is compliant states "The Trust must accept any Referral of a Service User however it is made unless permitted to reject the Referral under this Service Condition"1. 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 UHL major trauma service will be taken to the Trust major trauma centre facilities.

Payment system

6 The Department of Health dictates the costs they think NHS health services should be priced at. The tariff is broken down with 65% for staffing costs, 21% other operational costs, 7% for drugs, 2% for the clinical negligence scheme and 5% for capital maintenance costs. The National Tariff is set by the Department of Health, NHS England and NHS Improvement. The process for deriving the tariff involves taking the national average cost base for the delivery of hospital care and factoring in a number of adjustments to take account of cost inflation, efficiency and the Clinical Negligence Scheme for Trusts (CNST). Between 2011-12 and 2015-16, the National Tariff was reduced, on average, by 1.5% per year, due to the fact that the uplift for cost inflation was less than the efficiency factor. The net change tariff prices over the previous 12 years can be seen in Appendix 4.

7 Payments for all non specialised elective and non-elective admissions (including A&E attendances and ambulatory / same day emergency care) are covered by a block contract based on locally agreed planned activity which in turn is based on last year's activity levels and a nationally set tariff. The Trust does not receive additional funding for any additional activity in relation to the care that is contracted under the block contract.

8 None of the additional expenditure spent outside the current year's funding is ever recovered in the following year's funding. The new funding is only based on the previous year's activity. **The commissioning is not related to Local Planning Authorities' housing needs,**

[1] NHS Standard Contract- Service Condition SC7

projections or land supply. There is no possibility to change the NHS funding model, or spending priorities of the Government.

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

9 The Trust can receive additional PSF funding which supplements the income.

10 If the Trust meets its agreed Control Total then it will receive its PSF.

11 PSF is received quarterly and dependent upon delivery of the Control Total. If the Trust does not achieve its Control Total then the Trust will lose access to PSF from the point of coming off target.

12 The development will put an extra pressure on the Trust's ability to achieve the agreed surplus because each additional patient not part of the agreed contract will consume the available funding.

13 The Commissioning for Quality and Innovation (the "CQUIN") payment framework makes a proportion of NHS healthcare provider income conditional on achieving certain improvement goals. In 2017/18 the Trust was conditional upon achieving improvement goals. The conditional income for 2016/17 was £15.9m and in 2017/18 was £16.8m.2 An impact which interferes with the achievement of the CQUIN's improvement goals will jeopardise the additional income received through the CQUIN. This residential development will have a detrimental impact on the Trust's ability to provide those goals. We can provide 18/19 and 19/20 figures once available.

Planning for the Future

14 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.

15 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.

16 The funding from the CCG is 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.

[2] University Hospitals Leicester NHS Trust, Annual Reports and Accounts 2017/2018

Current Position

Emergency admissions and the direct impact on emergency health care services

17 Across England, the number of acute beds is one-third less than it was 25 years ago[3], but in contrast to this the number of emergency admissions has seen a 37% increase in the last 10 years[4]. The number of emergency admissions is currently at an all-time high. UHL growth is shown in Figure 1.

Emergency Admissions	Year
104,384	2014/15
108,191	2015/16
108,077	2016/17
118,598	2017/18

18 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 faces sanctions for external factors which it is unable to control.

19 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[5]. 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%,

[3] Older people and emergency bed use, Exploring variation. London: King's Fund 2012
[4] Hospital Episode Statistics.www.hesonline.nhs.uk/Ease/servlet/ContentServer?siteID=1937
[5] British Medical Journal- Dynamics of bed use in accommodating emergency admissions: stochastic simulation model

patients are at more risk of delays to their treatment, sub-optimal care and being put at significant risk.

20 Appendix 5 details the Trust's utilisation of acute bed capacity, which exceeded the optimal 85% occupancy rate for the majority of the year. (UHL 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 and services are forced to operate at over-capacity. Any new residential development will add a further strain on the current acute healthcare system.

The direct impact on the provision of emergency and planned health care caused by the proposed development

21 The population increase associated with this proposed development will significantly impact on the service delivery and performance 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

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

22 The NHS, is experiencing staff shortages. UHL 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. They are an essential part of UHL 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.

23 For the additional **4,164** acute interventions, 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 CCG 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.

24 The Trust 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 contribution due to Premium Cost requirement, thus enabling the Trust to reinvest this to provide the necessary capacity for the Trust to maintain service delivery 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.

Impact Assessment Formula

25 The Trust has identified the following:-.

A development of **2,750 dwellings** equates to a total population of **7,520** of which **2,896** are new residents. Using existing 2020 demographic data as detailed in the calculations in Appendix 3 will generate **4,164** acute interventions for the total population of the new development over the period of 12 months. This comprises additional interventions by point of delivery for:

- **443** A&E based on **5.9%** of the total population requiring an attendance
- **291** Emergency admissions based on **3.9%** of the population requiring an admission
- **54** Elective admissions based on **0.7%** of the population requiring an admission
- **307** Day-case admissions based on **4.1%** of the population requiring an admission
- **2,431** Outpatient admissions based on **32.3%** of the population requiring an admission
- **532** Diagnostic Imaging based on **7.1%** of the population requiring diagnostic imaging

The final calculation includes a deduction of the existing population activity pressure generated by this development.

Premium Costs:

26 For all the anticipated hospital based interventions, the Trust will have no method of recovering the additional Premium Costs needed to ensure the level of service required for the new population.

Formula:
Development contribution (new population only) = [Total development population x average activity (based on an average activity rate in the development area for each activity type) x average tariff (based on audited reference costs)] – [Existing population x average activity (based on an average activity rate in the development area for each activity type) x average tariff (based on audited reference costs)]

Premium costs (new population only) = [Total development population x average activity rate per head of new population x average tariff x proportion of Trust costs of 60% x total NHSI Agency premium Cap (55%)] – [Existing population x average activity rate per head of new population x average tariff x proportion of Trust costs of 60% x total NHSI Agency premium Cap (55%)]

27 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 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 **2,750 dwellings** is **£914,452.00.** This contribution will be used directly to provide additional health care services to meet patient demand as detailed in Appendix 3.

28 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 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.

Failure to receive contribution will put significant additional pressure on the current service capacity leading to patient risk and dissatisfaction with the Trust services resulting in both detrimental clinical outcomes and patient safety.

As to the payment of the contribution, this may be phased and agreed with the developer and the Council

Summary

29 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 sought is to enable the Trust to provide services needed

by the occupants of the new development. The contribution requested cannot be sourced from elsewhere.

30 The development directly affects the ability to provide the health service required to those who live in the development and the community at large. This will mean that patients will receive substandard care, resulting in poorer health outcomes and pro-longed health problems. Such an outcome is not sustainable. 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:"* NPPF paragraph 8. There will be a dramatic reduction in safety and quality as the Trust will be forced to operate over available capacity as the Trust is unable to refuse care to emergency patients. There will also be increased waiting times for planned operations and patients will be at risk of multiple cancellations. This will be an unacceptable scenario for both the existing and new population. The contribution is necessary to maintain sustainable development. Further the contribution is carefully calculated based on specific evidence and fairly and reasonably related in scale and kind to the development. It would also be in the accordance with Council's Adopted Local Plan.

Harborough District Council

Harborough Adopted Local Plan – 2011-2031, Adopted April 2019

Funding infrastructure

11.1.4 Providing some forms of infrastructure is largely dependent on a commercial relationship between developers and infrastructure providers. The public utility providers are private companies that charge for their services, so their upfront provision costs are off-set not only by what developers pay in terms of initial charges but also by future revenues arising from billing new customers. However, the use of other types of infrastructure, such as new public road, schools and health facilities, may not be directly charged to uses. Although some government derived funding sources pay for such provision, there is also a reliance on developer contributions in one form or another, especially where the extra capacity required directly arises from development generated demand.

Harborough Core Strategy – 2006 -2028

2.35 The People:

P1 Ensuring delivery of new housing to accommodate population growth does not impact adversely on existing settlement and landscape character;

P7 Addressing the problem of rural accessibility in relation to key local services, including healthcare, and affordable housing;

Policy CS12: Delivering Development and Supporting Infrastructure

Policy CS12: Delivering Development and Supporting Infrastructure a) The overall levels and distribution of development referred to in strategic policies in this document will require the provision of infrastructure as set out in the Local Infrastructure Schedule contained in Appendix 2.

Chapter 8 of the NPPF elaborates paragraph 8 in paragraph 92, which directs that:

> *To provide the social, recreational and cultural facilities and services the community needs, planning policies and decisions should:*
>
> *a) … ;*
>
> *b) … ;*
>
> *c) guard against the unnecessary loss of valued facilities and services, particularly where this would reduce the community's ability to meet its day-to-day needs;*
>
> *d) ensure that established shops, facilities and services are able to develop and modernise, and are retained for the benefit of the community; and*
>
> *e) … .*

In the circumstances, without the requested contributions to support the services infrastructure the planning permission should not be granted.

Conclusion

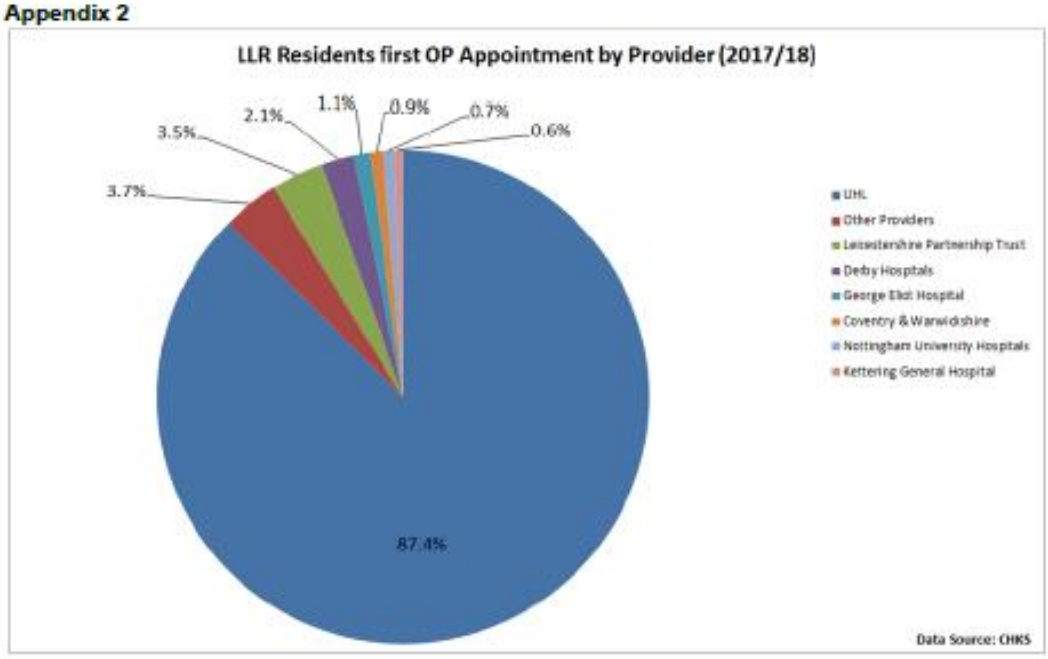
31 In the circumstances, it is evident from the above that the Trust's request for a contribution is not only necessary to make the development acceptable in planning terms it is directly related to the development; and fairly and reasonably related in scale and kind to the development. The contribution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

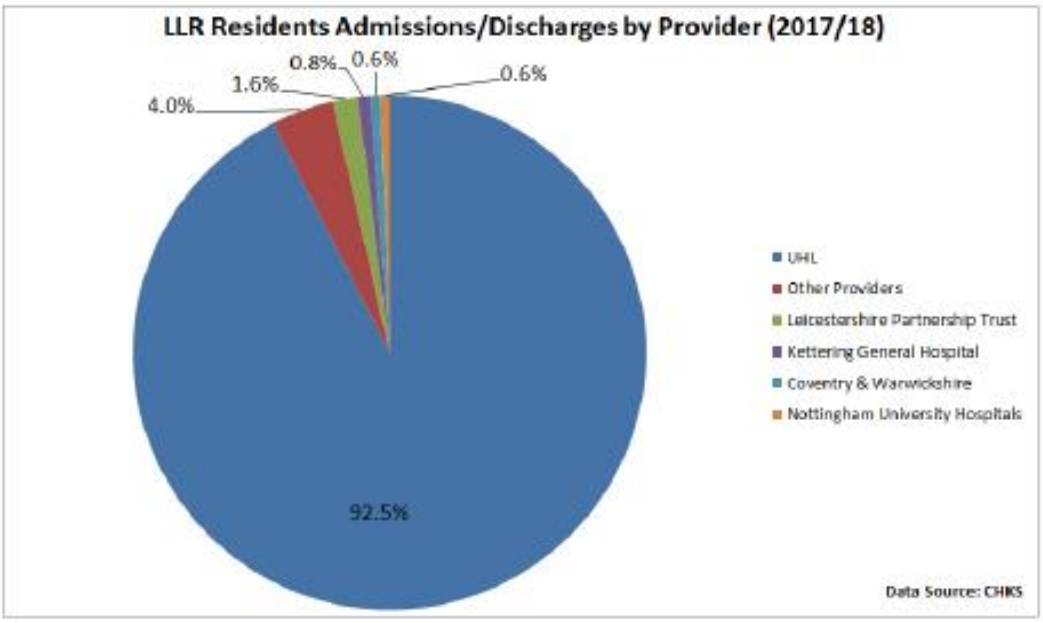
23 July 2020

Appendix 1

Clinical based Services	Maternity
Abdominal Aortic Aneurysm (AAA) Screening	Maxillofacial
Allergy	Musculo-Skeletal (Orthopaedics)
Anaesthetics	Neonatal Service
Blood Clot Prevention	Nephrology and Dialysis
Blood Transfusion	Neurology
Bone Bank	Neuro-psychology
Breast Care	Occupational therapy
Cancer Services and Clinical Haematology	Operating Theatre Services
Children's Services	Ophthalmology
Cardiology and Cardiac services	Pain management
Clinical Genetics	Pathology
Colorectal Surgery	Pharmacy
Continence Service	Phlebotomy
Critical Care	Physiotherapy
Cystic Fibrosis	Plastic surgery
Dementia	Podiatry
Dental Services	Pulmonary rehabilitation
Dermatology	Respiratory disorders, Lung disorders, and
Diabetes	Thoracic medicine
Diet and Nutrition	Renal
Digestive diseases	Rheumatology
Disablement Services	Sexual health clinics
Ear, Nose and Throat (ENT)	Sickle Cell and Thalassaemia Service
East Mercia Urology	Sleep disorders
Emergency Department	Speech and language Therapy Service
Endocrinology	Sport and exercise medicine
Extra Corporeal Membrane Oxygenation (ECMO)	Stroke services
Fracture Clinic	Theatre Arrivals Areas
Gastroenterology	Urology
General Medicine	Vascular services
General Surgery	Vascular Studies Unit
Gynaecology	
Haematology	
Hearing services	
Heart Services	
Hepato-Pancreato-Biliary unit	
Hypertension	
Imaging Services	
Infection Prevention	
Infectious Diseases	
Information about breast cancer	
Kidney Services	
Leicester Fertility Centre	
Lupus	

Appendix 2


LLR Residents first OP Appointment by Provider (2017/18)
87.4%
3.7%
3.5%
2.1%
1.1%
0.9%
0.7%
0.6%
UHL
Other Providers
Leicestershire Partnership Trust
Derby Hospitals
George Eliot Hospital
Coventry & Warwickshire
Nottingham University Hospitals
Kettering General Hospital
Data Source: CHKS


LLR Residents Admissions/Discharges by Provider (2017/18)
92.5%
4.0%
1.6%
0.8%
0.6%
0.6%
UHL
Other Providers
Leicestershire Partnership Trust
Kettering General Hospital
Coventry & Warwickshire
Nottingham University Hospitals
Data Source: CHKS

University Hospitals of Leicester NHS
NHS Trust

Caring at its best

Appendix 3

University Hospitals of Leicester NHS Trust

Evidence for S106 Developer Contributions for Services

Description		
Hybrid planning application comprising: Outline application for development (including demolition) of up to 2,750 dwellings; business, general industrial and storage and distribution uses; two primary schools; neighbourhood centre; public open space; greenspace; drainage features; acoustic barrier; and other associated infrastructure (some matters reserved); and full application for the development of a spine road and associated junctions with the A426 north of Lutterworth, Gilmorton Road, Chapel Lane (including the partial closure and realignment of Chapel Lane to motor vehicles and horse riders), and the A4304 east of M1 Junction 20; comprising carriageway, footway, cycleway and associated infrastructure to include earthworks, bridge structures, services, drainage, landscaping, lighting and signage.		
LPA Reference		19/0250/OUT
Additional Emergency Admissions		734
Acute Interventions:		
- A&E		443
- Emergency Admissions		291
- Elective Admissions		54
- Day Case Admissions		307
- Outpatient Appointments		2,431
- Critical Care Services		106
- Diagnostic Testing		532
Financials		
Delivery Cost for Planned Dwellings	£	1,803,184
Premium costs of Delivery	£	572,016
Adjustment due to existing population	-£	1,460,748
Dwellings & Occupation Assumptions		
Dwellings		2,750
Assumed Population multiplier		see Appendix 6

Total Developer Contribution (new population only)	**£**	**914,452**

Version 5 Amendments

20/21 national (consultation) tariff cost uplift added at +2.5%
New population influx of 38%
Impact of 20/21 block contract agreement applied, increasing scope of claim to all activity types

University Hospitals of Leicester NHS

NHS Trust

Caring at its best

University Hospitals of Leicester NHS Trust

Application Reference:	19/0250/OUT
Local Authority / Area	Harborough
Population Estimate:	183,400 (based on ONS Mid 2018)

Development Dwellings	2,750
Population Multiplier	see Appendix 6
Development Population	7,520
New Population Influx Rate	38.5%

New population only (see Appendix 6): 2,896

Pay Costs	613,905
All other costs	373,063
Total Costs*	986,968

Staffing cost %	62%
Premium Staff Cost %	51%

Activity Type	Activity	Activity Rate per Annum per head of Population	Delivery Cost per Activity £	12 months Activity for proposed Population	Delivery Cost for Planned Dwellings £	Premium costs of Delivery £	Adjustment due to existing population £	Cost Pressure (Claim) £
A&E Attendances	10,810	5.9%	211	443	£ 93,723	£ 29,731	-£ 75,924	£ 47,530
Non Elective Admissions	7,090	3.9%	2,178	291	£ 633,228	£ 200,876	-£ 512,974	£ 321,130
Elective Admissions	1,313	0.7%	4,722	54	£ 254,210	£ 80,642	-£ 205,934	£ 128,918
Day Case (Elective)	7,488	4.1%	704	307	£ 216,225	£ 68,592	-£ 175,162	£ 109,654
Outpatient Appointments	59,285	32.3%	127	2,431	£ 308,636	£ 97,907	-£ 250,024	£ 156,519
Critical Care Services	2,581	1.4%	1,081	106	£ 114,386	£ 36,286	-£ 92,663	£ 58,009
Diagnostic Imaging	12,975	7.1%	134	532	£ 71,160	£ 22,574	-£ 57,646	£ 36,088
ESRF	3,541	1.9%	166	145	£ 24,065	£ 7,634	-£ 19,495	£ 12,204
Radiotherapy	3,156	1.7%	199	129	£ 25,707	£ 8,155	-£ 20,825	£ 13,037
Unbundled Inpatient HRGs	8,220	4.5%	183	337	£ 61,846	£ 19,619	-£ 50,101	£ 31,364
Total					£ 1,803,184	£ 572,016	-£ 1,460,748	£ 914,452

Total Development Contribution (new population only)	£ 914,452
Contribution per Dwelling	£ 333

Explanatory note: Data used to calculate contribution

Clinical activity recording

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 data is anonymised, validated and submitted monthly to a national data warehouse so that it is available nationally and publicly. Note this activity count does not represent discrete patients, but the amount of activity undertaken.

Calculating the Trust's claim

The data table above calculates the impact of the development on the Trust's resources and mitigates this by creating a financial claim to meet additional costs.

Assumptions and explanations

The Trust's calculation establishes the additional impact the new development will impose on the Trust's resources. To start the calculation, the total population of the development is calculated by multiplying the number of dwellings by the average number of people expected to live in each house.

However, the total impact of the development is abated to 38.5% of total cost pressure. This abatement recognises that, according to the Trust's specialist planning advice, 38.5% of people moving into the development are new to the county (or, by leaving a void elsewhere, cause others to move into the county) and therefore are not included in the funding allocation with which the county's clinical commissioning groups buy the Trust's services. In this way, the calculation avoids double counting the impact from existing county residents' demands already anticipated in the Trust's annual plans.

The calculation's steps

Column 1 shows the different types of activity undertaken by the Trust. Column 4 provides the Trust's total activity in a 12 month period. and column 2 is a percentage rate of provision for the development population.

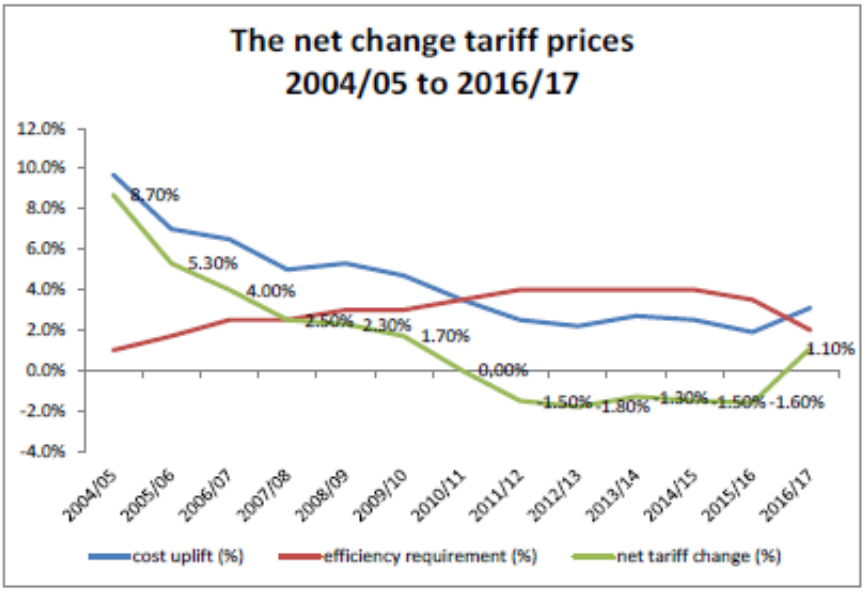
Each activity undertaken by the Trust has a nationally determined cost associated with it. These costs are an average cost of activity across the NHS and are known as 'NHS reference costs'. They are published annually. The Trust uses this average figure for each activity type to calculate the financial impact of caring for new people housed in the development. The reference costs can be found in Column 3, entitled "Delivery cost per activity".

However, over and above the reference cost of delivery, the Trust will face additional cost pressure from employing premium rate staff to meet the additional demand. The cost of this is shown in column 7, "Premium cost of delivery". This has been calculated by dividing Staff Pay - Premium by the sum of Staff Pay - Substantive and Staff Pay - Premium and multiplying by 100.

The Trust recognises that the rate of influx of new population into the Harborough area is 38.5%. Therefore, an adjustment for the impact of exisiting population has been included in column 8, by multiplying the total cost pressure of the whole population of the new development by 61.5%. This is then subtracted from the cost pressure of the whole cost of delivery to give a final requested amount, being the total cost pressure of the new population only.

Appendix 4

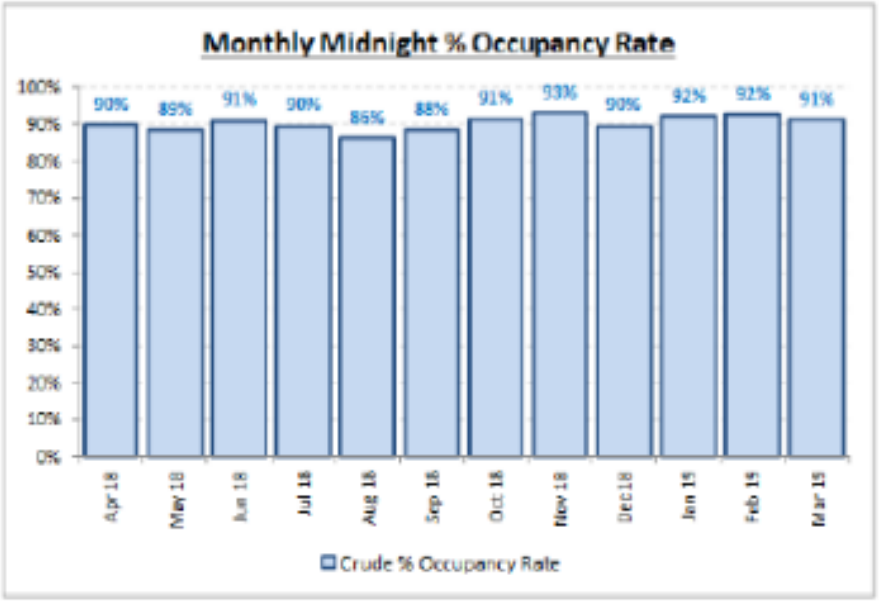
The net change tariff prices



Appendix 5

Bed occupancy rate

Month	Beds Occupied	Beds Available	Crude % Occupancy Rate
Apr 18	43,011	47,760	90%
May 18	43,165	48,701	89%
Jun 18	42,199	46,350	91%
Jul 18	43,089	48,019	90%
Aug 18	42,357	49,042	86%
Sep 18	42,013	47,490	88%
Oct 18	44,757	48,918	91%
Nov 18	43,567	46,890	93%
Dec 18	43,631	48,639	90%
Jan 19	46,669	50,654	92%
Feb 19	41,984	45,416	92%
Mar 19	45,955	50,282	91%
Grand Total	507,797	578,161	88%



Appendix 5

Questions from Andrew Senior and Response from Leenamari Aantaa-Collier

1. **Can you supply the methodology used to calculate the new population compared to the existing relocating population?**

- Developed a household profile (by age and sex) for the area based on ONS. The area used was 'East Midlands' because the population we seek to calculate is moving into the Trust's operational area; i.e. from outside of Leicestershire and Rutland.
- Calculated the number of households at the proposed development in each group
- Using ONS household formation rates, estimated the population at the development
- Using Migration data from the 2011 Census, identified the proportion of each age group who will have moved from within the area (Leicestershire and Rutland) and the proportion of those who have moved from outside of the area.
- This generates the total number of expected residents at the proposed development and splits them by those from within the Trust's operational area and those from outside the Trust's operational area.
- The exercise was carried out both the market housing and affordable housing separately. Migration trends for population in affordable housing are different to those in market housing.

2. **In respect of the above can you also supply the calculation?**

Due to a request from Harborough District Council to further examine the calculation, the calculation below has now been superseded by the new population modelling supplied by DLP in Appendix 6.

Calculation:

Dwellings: 1,925
Market Population (total) 4,408
Market Population (same area) 2,366 (54%)
Market Population (inflow) 2,042 (46%)
Affordable Population (total) 1,889
Affordable Population (same area) 1,533 (81%)
Affordable Population (inflow) 356 (19%)

Combined total 6,297
Combined same area 3,899 (62%)
Combined inflow 2,393 (38%)

3. **Can you supply the total sum requested and the methodology / calculation for arriving at it?**

Development contribution = New development population (only the population new to the Trust's catchment area) x average emergency activity

(based on an average activity rate in the development area) x average tariff (based on audited reference costs)

Premium costs = New development population x average activity rate per head of new population x average tariff x proportion of Trust costs of 60% x total NHSI Agency premium Cap (55%).

The Trust's calculation establishes the mitigation of the impact that the new development will impose on the Trust's services. To start the calculation, the total population of the development is calculated by multiplying the number of dwellings by the average number of people expected to live in each house. The Trust uses an average number of people per household published by the local council to make this calculation, unless provided with a different average by the development's builder.

As explained above the final population figure is then adjusted to only take into account the new population in the Trust's catchment area and the likely occupants from the development areas who are likely to use the Trust's services.

4. **In respect of the point above your email of 20 April refers to a new block contract which no longer pays for treatments over and above that contracted for. How long is the contract for and does the non-payment for excess treatments reflect new practice generally or is the outcome of this particular negotiation? The previous calculations included a percentage for treatment above the block contract. Will any revised calculation be reflecting this?**

The contract negotiations between UHL and the CCGs are now based on a block contract. Whilst the current contract is for one year only the block contract is now here to stay. As per the previous calculations the requested sum is based on the careful calculation based on reference costs (actual audited costs for the service), the difference only being that instead of receiving funding for a percentage of additional in year activity, the Trust receives no additional funding over and above agreed figure based on previous year's activity and an element of 'growth'.

The allocated 'growth' is broadly intended to uplift income to accommodate the increasing costs of delivering healthcare to the existing population. This includes the cost of inflation, increased costs of an ageing population, growth in demand for certain medical technologies etc. Only a very small element of growth in population is allocated to CCG based on the number of people registered in the GP practices.

Finally as explained above the revised calculation deducts the existing population.

5. **Your email of 20 April refers to activity rates I assume that these form part of the methodology for calculating the sums of money requested.**

The Trust holds its own statistics for each activity that takes place in the Trust. This activity is related to each patient and the patient's address. Each activity has a standard cost. The updated consultation response in Appendix 3 shows the total activity which is then related to a specific development area.

This calculation methodology takes into consideration only those likely patients attending the Trust service from this development as some patients will use other the hospitals not related to the Trust as explained above.

6. **Are all A&E patients taken to Leicester or are other nearby hospitals, Coventry, used? Do patient for other treatments also use other nearby hospitals? Is there an allowance for this in the calculation or is it reflected in the activity rates used to calculate demand?**

   Please see the above answer

7. **My understanding is that the monies will be used to provide additional staff. What mechanisms are in place or could be put in place to ensure that this is where the funding is directed?**

   The monies are used to service the additional population from this development. Each patient creates an activity. The activity will have a tariff. The total costs of the activity includes amongst other things pathology tests, drugs, imaging, endoscopy, critical care, blood and operating theatres.

   As to the premium costs this is to cover the additional costs paid towards having to hire staff at a premium rate to cater for the increased population. The Trust is only seeking for what is over and above the normal rate as shown in the consultation response and above

   The Trust is happy to provide an undertaking that the contribution is used as requested and the breaking it down as explained above i.e. towards the extra activity created by the new population of the development.

8. **There is reference to the phasing of payments a methodology for this will need to be agreed. The payments could be by the build rates identified in the local plan or by a methodology based on actual completion rates on site. I would caveat this by saying as the monies are to mitigate an anticipated shortfall any methodology may result in over or under payments in a particular year and may need to include a smoothing mechanism.**

   Agreed, although the contribution needs to be in place on the commencement of the development it could be phased e.g. on the commencement of every 150th dwelling. The review of the amount/activity rates can be done on the yearly or every second year basis.

9. **Is there the need for a review mechanism? The original submission was predicated on a single payment. As the current discussions are about phased payments on a development likely to take twenty years to complete I assume there will be a number of contract periods and any scheme would reflect this.**

   Please see above

10. **The final sentence of paragraph 17 of your email refers to the COVID-19 situation. I am assuming that information on patient treatment has been skewed by the current situation and it is unclear when realistic figures will be available. If my understanding is correct and to help move matters forward a realistic average may be a starting point for discussion.**

    The data used for the revised calculations is from our historic reference costs and will not be impacted by Covid-19. The data for future submissions may however be impacted by Covid-19 and we would propose agreeing a prior year as a baseline for future calculations; that is until the long-term impact on the Trust is fully known.

11. **The original report refers to a "shortfall in funding" which is not the issue but the impact on services, however, there is later reference to employing agency staff, because in effect funding is a year behind, and the requirement to cover this "gap" in funding. Is the point that it is this year on year gap that needs to be dealt with?**

    The issue is fairly straight forward. The new population will create an impact on the Trust's services. This impact is similar that it creates on education, highways, libraries and on the additional staff costs for the Council's own monitoring officer. The impact is potentially long term as it affects the Trust's ability to provide services at the safe level required as explained. The issue is how to mitigate the impact? The Developer should be not paying something that has already been paid for. The Trust has provided careful calculation methodology as required by CIL Regulation. The Trust does not get paid for the additional new population creating the impact on the services as explained. The calculation methodology explains the lack of funding created by the new population. If the developer contributes towards the financial gap in the funding then the impact is mitigated. The Trust could mitigate the impact in various ways but the Trust considers that this is modest but very effective way of dealing with the direct impact as the mitigation model will take the immediate impact away as explained below.

    As the funding is based on the previous year's activity, and not what could be in the future created by the potential development (this includes known exciting permissions) then by contributing towards the gap in the funding it allows the Trust to function at the level which is required (this includes the extra staffing). As explained the Trust is only seeking the element over and above of standard staffing costs that is created by having to hire locums. (Please see the Spring Lane Appeal decision)

    It would be wholly unreasonable that the developer would not contribute towards the impact. It is not for the taxpayer to fund the impact that the development will create (please see the case of *Tesco* previously referred to).

12. The second point in the submission refers to bed occupancy levels and the impact that this has on the performance of A & E, the ability to move patients onto a ward if they cannot be discharged. It appears that the Royal Infirmary is operating at 100% occupancy, not the ideal of 85%. What I don't understand is why the provision of agency staff will help ease this situation if patients cannot be moved onto wards is this not a capacity issue?

Not every patient needs to be admitted to a ward. If the Trust has the additional staffing as required, it will reduce the time needed for a correct diagnosis and for those patients that do not need additional inpatient allow a quicker discharge. For those patients who do need a bed it can ensure they are placed into the correct ward at the earliest opportunity; which is proven on average to improve patient outcomes and reduce the overall length of stay. Without the additional staffing patients are more likely to be admitted unnecessarily to a ward whilst waiting for the correct diagnosis; creating a negative impact on the services. In short the additional staffing will mitigate the direct impact of the development by: reducing the time for a correct diagnosis, reducing waiting times, improving length of stay, improving patient outcomes and bed occupancy levels.

Appendix 6 – Responses from DLP Consultants to Andrew Senior

Part response to Andrew Senior's email 3.7.2020/ UHL synopsis from University Hospitals of Leicester NHS Trust – Question Headers refers to the Paragraph Numbering therein
UHL Synopsis Paragraph 6

The original assumptions about population presumed that the population of the new development would be an entirely new population. UHL did not make an allowance for relocations, the effect of household formation or the accommodation of existing population. In my email of 30 April clarification of the revised methodology was requested on following points amongst others;

(1) Can you supply the methodology used to calculate the new population compared to the existing relocating population?

Response:
This question is repeated at Paragraph 6.42 of the Council's updated Report to Committee.

For the avoidance of doubt, the summary calculation submitted on behalf of UHL noted that a more detailed analysis of the headship rates and population profile of migrants into the Trust's operational area would likely show fewer older people and more family sized households, which would typically mean a higher population and therefore higher household size.

This response to the district Council's questions and outputs for the detailed analysis and calculation should be read in that context. Furthermore, since submission of UHL's email dated 20 April 2020 the most recent 2018-based subnational household projections have been published (as of 29 June 2020).

All analysis has been updated using these projections as a baseline. This increases the starting point (in terms of average household size for the East Midlands, for the 'year 2020') from 2.29 (as reported in UHL's 20 April email and utilised in the calculation at Appendix 3 of that submission) to 2.34 persons per household. This, however, only provides the starting point for the modelling undertaken on behalf of UHL.

It should also be noted that the outputs summarised below comprise components of a single result that outlines the proportion of the total estimated population at the new East of Lutterworth development that will be new to the respective service catchments for Acute Healthcare and Primary Care (regarding the request for planning contributions submitted on behalf of the CCG). This follows completion of a Memorandum of Understanding between the respective bodies in July 2020, providing a commitment to jointly develop and fund methodologies for calculating the health impacts from new developments. This includes, but not limited to, the assessment of population and activity impacts.

The individual steps and components that link the modelling on behalf of UHL and the CCG are summarised below:

Modelling Steps:

- **Step 1**: Use the total number of proposed dwellings as the basis for the model
- **Step 2**: Model the tenure of the proposed development based on the proposed affordable housing contribution and breakdown of affordable housing tenures
- **Step 3**: Generate a figure for total population based on official subnational population and household projections (2018-based; 2020) (based on total number of dwellings)
- **Step 4(a&b)**: Estimate the split of future residents (by persons by age and sex) using Census migration flows data (**a**) and household tenure (**b**) that are likely to move to the new development from within and beyond the respective catchments for UHL and the CCG. For UHL the catchment is defined by the Leicester and Leicestershire Local Enterprise Partnership together with flows to/from Rutland. For the CCG, the 'best fit'

catchment for Primary Care is based on two Middle Super Output Area boundaries for Lutterworth.

- **Step 5(a-c)**: Apply any relevant adjustments to estimate sources of population from inside or outside the respective service catchments. This step addresses any plan-led assumptions for migration and changes in projected migration flows since the 2011 Census (**a**) and adjusts for the proportion of full-time student households(**b**) together with an adjustment to ensure that the relative proportion of children aged 0-15 is held constant as a component of the total person flows (**c**).
- **Steps 6 and 7**: The provides the output terms of the population at the proposed development. These steps produce of a single result wherein persons already assumed to be resident in the existing Primary Care catchment are a component of the proportion of the population not new to the UHL Trust's operational area.
- **Step 8**: Deals with the 'backfilling' of dwellings vacated within the catchment for Primary Care only and the resulting allowance for the proportion occupied by in-migrants.

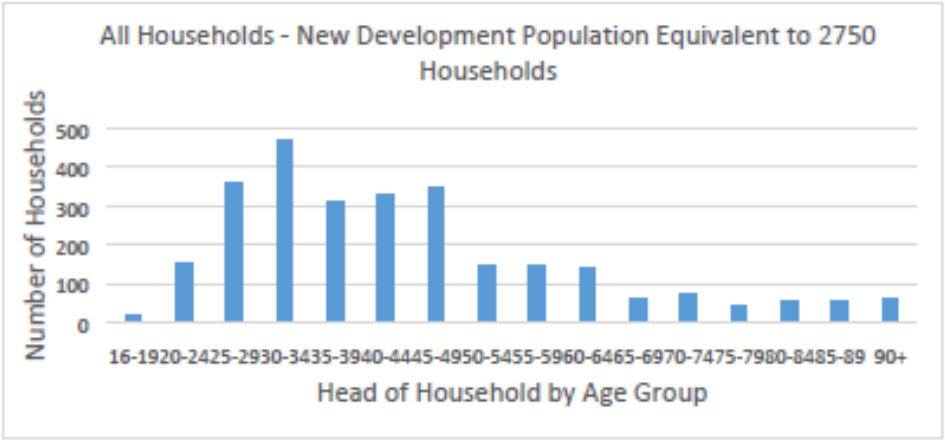
(2) In respect of the above can you also supply the calculation?

Response:
Steps 6 and 7 are outputs from the model. The calculation undertaken on behalf of UHL and the CCG provides a reasonable and proportionate assessment of the impact of the development for the purposes of calculating planning contributions. This is consistent with the approach to the preparation of evidence that the NPPF requires to support plans and policies. The approach provides a carefully considered and detailed methodology for calculating the proportion of the proposed development's uplift in population that will create an additional demand on the Trust's health care services, i.e. those persons currently living outside of the Trust's operational area.

The analysis estimates that the new development will generate a total of **7,520 residents**, modelled in-line with Census data. The is based on modelling the split of future residents (by persons by age and sex), which establishes a profile with demographic characteristics that differ from the existing population within the catchment(s). The age-sex profile takes account of differences in migration flows by household tenure and increased migration flows since 2011.

Figure 1 below illustrates the profile of household formation based on the age-sex profile set out in accordance with official subnational household projections for the East Midlands:

Figure 1. Household Formation Based on Anticipated Population by Age and Sex (7,520 Residents)



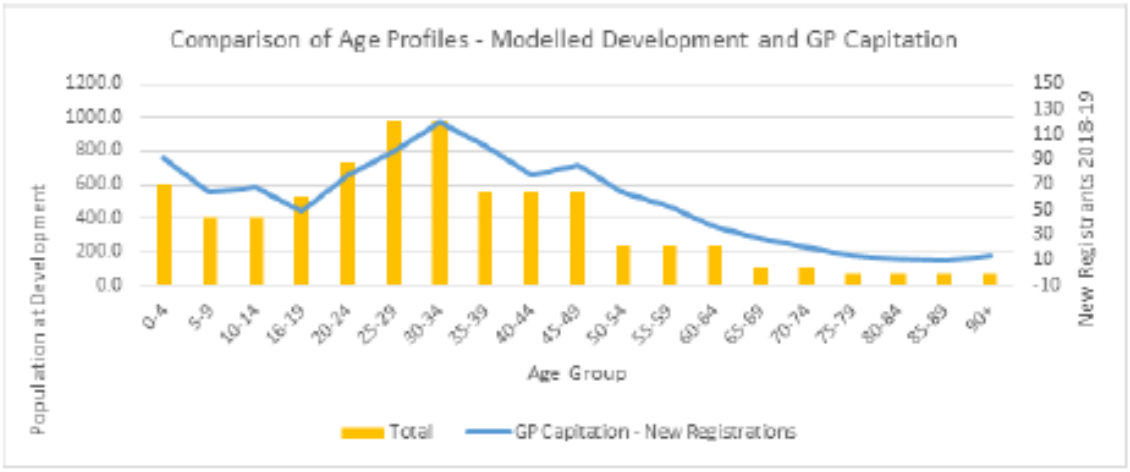
This approach provides a realistic basis upon which to identify the age-sex characteristics of population moving into the new development, who, by definition, must relocate from elsewhere to occupy the new dwellings.

Estimates of population by sex and age are necessary to maintain consistency with Step 3 of the approach and establish the total population of the development through continued application of household headship rates. These are based on the proportion of people in a particular demographic group who were the household reference person (HRP) (i.e. head of a household). It can therefore be ensured that the total population of the development reflects use of the 2018-based household headship rates and ensure that the number of households formed reflects the total number of dwellings to be provided.

The approach to modelling establishes that the age-sex and household profile of the new development will not necessarily correspond to the official subnational population and household projections. It is therefore the case that the average household size of new development may be larger than for the average households size in Leicestershire and Rutland or the 'best fit' catchments for Primary Care.

Household Representative Rates are not adjusted as part of the modelling assumptions The increased household population associated with age-sex profile for the new population is considered to represent a realistic profile for the development based on available data for the UHL Trust's operational area. While adjustments have been considered would assume a lower average household size (and thus a lower total population when Step 3 of the model is repeated) this would be on the basis of a departure from the official subnational household projections. Based on the inputs reviewed as part of the modelling assumptions there is considered to be insufficient justification to do this, nor any robust evidence for how formation rates for particular age groups should be altered in the case of one specific development.

Furthermore, capitation data for the Practice Registers has been reviewed based on the age profile of new registrants for the facilities that would serve the new development. These data are independent from the modelling inputs across Steps 1-5 but show a broadly similar age-profile to inform assumptions for household formation.



This calculation in-turn establishes the proportion of future residents moving into the development from outside both the 'best fit' catchment for Primary Care and outside of the wider operational area of the UHL Trust.

For the characteristics of the East of Lutterworth application proposals established under Step 1 and Step 2 this means that **38.5%** of the total population are new to the UHL Trust's operational area. Of the 61% of residents drawn from within the UHL Trust's operational area, 33% of the population at the

new development are considered to originate within the 'best-fit' catchment for Primary Care. This reflects the relative importance of migration across shorter distances and local patterns of household formation. This means that **67.4% of** the direct impact of the new population at the East of Lutterworth development is new to the 'best fit' catchment for Primary Care.

The Trust's calculation for the impact of the new development on Acute Healthcare should therefore take account of **2896 additional residents** not otherwise captured by its contract with commissioners over the next 12 month contract period.

The Clinical Commissioning Group's calculation for the impact of the new development on Primary Care should also take account of **5068 additional residents** not expected to be previously resident within the catchments identified to serve demand for these services.

The respective outputs are tabulated as follows, in relation to the population within the new development:

Table 1. Population at New Development Comprising Existing Residents within the Catchment for Primary Care Services

	Dwellings Modelled	Total Popn.	Previously Resident in Primary Care Catchment	Average HH Size
Application Proposals	2750	7520	2451	2.73
% at Development			**33%**	

Table 2. Population at New Development Comprising Existing Residents originating within the UHL Trust's Operational Area

	Dwellings Modelled	Total Popn.	Previously Resident in UHL Trust Area	Average HH Size
Application Proposals	2750	7520	4623	2.73
% at Development			**61.5%**	

UHL Synopsis Paragraph 8
It appears that a figure of 30% has been used with reference to the amount of affordable housing. In the case of this development the amount should be 40%. This has the effect, given the methodology employed, of exaggerating the amount of the contribution sought.
Response:

This comment was raised in Harborough District Council's initial list of questions but the same concern with the approach to modelling has not been reiterated in the Council's updated Report to Committee. Nonetheless, the Council's claim that the proportion of affordable housing within the total development has been modelled at 30% is incorrect. This total development modelled by tenure is summarised below:

Table 3. Proposed Development by Total Units and Affordable Housing Tenure

	Market Units	Affordable Units
Total Units	2750	
Market Units	1650	
Affordable Units (40% of total)		1100
Affordable Tenure Breakdown		
Social Rent (75% of total affordable)		825
Intermediate (25% of total affordable)		275
Total Units	1650	1100

In terms of the modelling assumptions by tenure Step 4(b) of the approach takes account of the fact that Census data groups intermediate affordable housing products (such as shared ownership) as part of owner occupied tenures.

This approach treats all intermediate tenures (**275 units**) as part of the modelled population, reflecting the treatment of Census data. This means that the proportion of the future population will be split using Census migration data for movement by persons (i.e. the split of 'inflow' and persons already resident in Leicester and Leicestershire).

Market units (comprising **1650 units** of the scheme total) are unaffected by this element of the approach. This means that the total impact of the development (in terms of modelling future population that may be new to the UHL Trust's operational area) should be based on a total **1925 units** (1650 + 275 = 1925).

Based on information from the Census for the proportion of social rented households that moved from outside Leicestershire one year before Census Day (i.e. 933 / 4953 = 18.8%) it is considered that 19% of the proposed affordable housing provision as 'social rented' tenure (**156 units**) should be modelled as part of the potential future impact of development. The population of this proportion of affordable housing would entirely comprise **inflow** into the Trust's operational area.

In reviewing this element of the modelling one should be cognisant that the provision of affordable housing has changed since the date of the 2011 Census. Specifically, 'affordable rent', which is more closely related to open market rents, is likely to blur the distinction between modelling of movement of populations associated with open market and affordable tenure, the adoption of any local allocation criteria.

The population of **669** 'social rented' units is nonetheless omitted from the modelling on the assumption that all future residents of those households will be already resident in the Trust's operational area.

UHL Synopsis Paragraph 10

The issue in relation to their methodology is that it appears to take no account of migration other than in migration into the Trust's operational area. Whilst there will be those who move in to the new development from outside the area, there will be those within the area who move out of the area i.e. out-migration and, therefore, the effect of the development itself will not necessarily be a net additional effect. Without knowing what the "net" position is and how the number of "new" people from the development relates to that net number, there is no means of knowing whether it is reasonable to treat them all as an additional burden.

Response:

This question is effectively repeated at Paragraph 6.46 of the Council's updated Report to Committee.

It is fundamentally incorrect to seek to incorporate assumptions for net population change within the wider area as a component of modelling the population at the new development and thus impacts which are directly related to it, as prescribed in the relevant tests for planning obligations.

The question as phrased effectively seeks to conflate an assessment of the net impact[6] of the population at the development itself with a broader assessment of housing need in the respective catchments. The modelling undertaken for the UHL Trust and CCG provides the output that is required in terms of the net impact of the population at the development itself, based on the proportion arising from outside of the respective service catchments.

It is inherent within the logic of this approach that, as new dwellings, the entire population must originate from a location outside of the immediate development, at the point units are first occupied. Moreover, it is entirely impossible that the new development will directly contribute to out-migration prior to the units in question actually existing physically or being first occupied.

Likewise, it is logically flawed to suggest any relationship between the new development (which offers opportunities for a proportion of the new population to arise within the existing catchment) to have any relationship with levels of out-migration from the existing population.

There are any number of characteristics (including but not limited to natural population change, the strength of the housing market and demand for jobs or services) that could otherwise influence net population change. It is neither relevant nor possible to capture these specifically in the context of estimating the population at the new development. Put simply, it is entirely possible that even if 100% of the population of the new development originated within the existing catchment the area would see a gain in population. This would be determined by other dynamics in the housing market, including who occupies those dwellings vacated by existing residents (the modelling of 'backfilling' for the CCG only partly aims to reflect this).

Likewise, no development could take place and yet the characteristics of those out-migrating from the catchment might be fundamentally different to the profile of those moving in; hence significant population gain could occur in any event.

It should also be noted that this question from the district Council in-fact serves to prove the logic of assessing the specific impact of net population gain from new development, rather than undermining it. Both Leicestershire (County) and Harborough (district) together with the 'best fit' catchment for Primary Care show net population gain through the 2011 to 2018 series of Mid-Year Population Estimates. Nothing in national data specifically links these rates of increase to trends in housebuilding, and the relationship is unlikely to be explicit.

[6] It is relevant to note that to our knowledge Harborough District Council has not sought detailed calculations from all infrastructure providers making requests for planning contributions that would illustrate the net gain of population gain at the new development for the purposes of assessing impact and demand in each case.

The modelling undertaken on behalf of UHL and the CCG, when accounting for the respective proportion of residents originating within the service catchments, generates the following net population gain per dwelling. This adjusts for the already resident population:

Table 4. Average Net Gain of Population Per Dwelling, By Catchment

	Dwellings Modelled	Total Popn.	Previously Resident in Catchment	New Population	Average Gain Per Dwelling (Persons)
Primary Care Catchment	2750	7520	2451	5069	1.84
UHL Trust Operational Area	2750	7520	4623	2897	1.05

Measured on this basis, the net gain in population is significantly less than the overall average household size at the new development.

This can be compared with respective findings for Harborough and Leicestershire (County). Table 5 correlates the annual net population change recorded by mid-year estimates with Communities and Local Government data for net additional dwellings (Live Table 122). Both geographies show a net gain in population.

Moreover, the net gain per dwelling is in-fact on average greater than the outputs from modelling for the CCG and UHL that takes account of the origin of new population within the development:

Table 5. Average Net Gain of Population Per Dwelling - Leicestershire and Harborough

	Leicestershire			Harborough		
Year	Net Popn Change	Live Table 122 Net Additional Dwellings	Population Gain Per Dwelling	Net Popn Change	Live Table 122 Net Additional Dwellings	Population Gain Per Dwelling
2011/12	5,000	2046	2.443793	700	240	2.916667
2012/13	4,700	1741	2.699598	1,000	295	3.389831
2013/14	5,800	2263	2.56297	500	346	1.445087
2014/15	6,700	3272	2.047677	1,200	496	2.419355
2015/16	7,100	3893	1.823786	1,200	636	1.886792
2016/17	9,700	3856	2.51556	1,200	468	2.564103
2017/18	8,100	3877	2.089244	1,000	580	1.724138
2018/19	7,900	3736	2.114561	1,300	729	1.783265

The overall trends may be partly related to characteristics of migration inflow and outflow including details of age and sex. To some extent it is likely these are captured by the same inputs used to modelling the new development. Some of the difference, such as growth in student numbers, will be less well-related to new development or natural population change and Step 5 of the approach to modelling seeks to take account of this.

This does not make the assessment of net population change elsewhere (i.e. outside of the new

development) relevant to assessing the direct impact of net population gain as modelled. The fact that the development itself will have a direct impact, in terms of population gain, is nonetheless clearly established and is modelled on an appropriate basis.

UHL Synopsis Paragraph 11

The council has commissioned its own review of the methodology used to calculate the net population growth arising from the development. This review has identified a number of areas within the methodology where clarification is required these are.

The response to these questions also addresses those repeated at Paragraph 6.24 (sub-paragraphs 1-9) in the Council's updated Report to Committee.

(1) Which does the Trust consider to be the correct calculation of the development population – 6,600 (as per the Appendix 3 calculation) or 6,297 (as per Appendix 5 of UHL's submission of 19 June)?

Response:

The relevance of this question is superseded by the clarification provided due to the outputs of the detailed calculation that UHL previously indicated would need to be prepared on its behalf (see summary of approach and outputs above). Neither figure reflects a comprehensive assessment of the population at the new development. For the avoidance of doubt, the difference was accounted for previous assumptions regarding average household size:

- 6,297 based on 2750 dwellings at 2.29 persons per household (source: 2016-based subnational household projections for the East Midland (year 2020) that have since been superseded
- 6,600 based on 2750 dwellings at 2.40 persons per household (source: unstated though the 2011 Census records an average household size of 2.42 in Harborough district)

(2) The specific data sources used in calculating the expected population are not stated – i.e. what dataset and for what year has been used to develop the household profile? How has the number of households at the proposed development in each household group been estimated? What data source has been used to calculate household formation rates (and for which years is the data used?).

Response:

A summary of inputs for the respective steps of the model is provided elsewhere. Household formation rates have not been adjusted from this given in the 2018-based subnational household projections for the 'current year' 2020

(3) Has an allowance been made for a level of vacant homes within the development?

Response:

No Allowance has been made for vacant dwellings. This would be a perverse assumption on the basis that relevant triggers in any planning obligation would be based on the sale and occupation of dwellings. It is not reasonable to assume that when these triggers are reached dwellings will have been bought/acquired/let only to be left vacant.

While natural 'churn' of stock will lead to short void periods these will be continual over the lifetime of the development, just as is the case with existing dwelling stock. The occupation of any vacant dwelling at any point in time could in-fact create an additional demand for services, depending on the origin of the household population taking up the unit.

(4) Has an allowance been made for the phased build-out of the scheme over a 15 year period within the calculation of the additional population arising, and the impact that this has on headship rates/ household size (not just within the development but within the wider population)?

Response:
The modelling is an estimate of the population arising at the new development and should in practice be interpreted as a figure that could be applied pro-rata to the number of completions in a given year. A comparison of the age-sex migration profile drawn from the 2011 Census and the most recent capitation data from Practice Registers shows a high degree of consistency over time.

This question is not considered to go to the principle of whether the evidence to support the request for planning contributions satisfies the three tests. The approach has been carefully considered to illustrate net impact that a fairly and reasonably related in scale and kind in terms of the population at the new development. Insofar as whether there is merit in considering a periodic update of assumptions regarding the population at the development this is something that could be addressed as part of any mechanism for review negotiated within the obligation itself.

It is not the objective of the modelling to project forward the population at the development beyond occupation, albeit the age-sex profile would in practice be likely to generate a higher rate of births and lower death rate than observed amongst the existing population in the overall dwelling stock. Future service planning can be undertaken by UHL/CCG respectively once the new population is recorded amongst official population estimates and through monitoring of birth and death rates affecting the catchment for Primary Care.

Similarly, headship rates have been held constant at the 'current year' 2020. If trends in headship rates from future years was incorporated into later phases of development this would reflect the ongoing impact of constraints to household formation reflected in national datasets and thus an increase in the assumed average household size. The estimate provided by the modelling avoids such assumptions.

(5) Should the concealed household adjustment calculation in Appendix 3 have been 62% consistent with the DLP calculation of the population growth from within the catchment area, as shown in Appendix 55 of UHL's submission of 19 June?

Response:
This is primarily a matter for UHL's explanation of the funding calculation. However, this question is unclear as the adjustment referred to is an output of the steps for modelling outlined previously but should not be referred to as a figure for 'concealed households'. As outlined by the results from the detailed calculation the assumptions for population arising at the new development should take account that 61.5% originates within the UHL Trust's operational area.

(6) What geography has been used in calculating the proportion of moves within/ outside of the area?

Response:

For the purposes of modelling of behalf of the UHL Trust all data are obtained for the area of the Leicester and Leicestershire Local Enterprise Partnership (LEP) together with Rutland, which correspond to the University Hospitals Leicester (UHL) Trust's operational area. The data employed are:

- **Migration by sex by age – Persons.** This is the starting point to identify the following proportion of usual residents in the area not registered at the same address one year before Census day:
  - The proportion of usual residents that lived at a different address within the UHL Trust area one year ago; and
  - The proportion of usual residents that lived at a different address outside the UHL Trust area

Due to the incorporation of Rutland within the UHL Trust's geography it is not robust to state that the first sub-bullet above is satisfied by counting only person movements for a change of address within the LEP geography (or equally movements that originate and remain within Rutland). Flows between the two areas are also relevant to identifying instances of migration that would have no net impact on the population in the Trust's operational area. Origin-destination data for specific flows between the two areas allow the respective cross-boundary movements to be separately identified and incorporated into the proportion of the total captured by the first sub-bullet. This is illustrated in Table 6 below:

Table 6. Changes of Address within the UHL Trust Operational Area

	Address one year before 2011 Census		Total Person Movements within Catchment
Component of UHL Trust Geography	**Leicester and Leicestershire**	**Rutland**	
Leicester and Leicestershire	77,029	375	77,404
Rutland	427	1,747	2,174
Total	77,456	2,122	79,578

For the purposes of modelling the net additional impact of the population within the catchments for Primary Care services equivalent data are available for a best-fit catchment comprising two Middle Super Output Areas (Harborough 006 and Harborough 0107). It should be noted that these flows represent a proportion of those also contained in the UHL Trust's operational area. Again, an allowance has been made for flows between the two MSOAs as a proportion of the Harborough total. The flows data for the best-fit Primary Care catchment are shown below:

Table 7. Changes of Address within the 'Best Fit' Primary Care Catchment

Age	Lived at same address one year ago	Adjusted Person Movements within 'best fit' Area	Adjustment to 'Best Fit' Movements	Inflow: Total	Adjusted Inflow from Harborough District	Adjustment to flows from elsewhere in Harborough District
All categories: Age	17,155	591	*92*	1,023	214	*-92*
Age 0 to 4	827	62	*10*	89	22	*-10*
Age 5 to 15	2,349	87	*11*	95	26	*-11*
Age 16 to 19	800	16	*2*	33	6	*-2*
Age 20 to 24	652	76	*10*	124	23	*-10*
Age 25 to 34	1,125	95	*17*	224	41	*-17*
Age 35 to 49	3,960	149	*23*	247	53	*-23*
Age 50 to 64	4,032	57	*11*	129	25	*-11*
Age 65 to 64	1,927	23	*5*	51	11	*-5*
Age 75 and over	1,483	27	*4*	32	8	*-4*

[7] E02005372 and E02005376

(7) Which specific Census data table has been used to calculate the proportion of people moving within and into the area? Has the calculation equally taken into account moves out of Leicester and Rutland?

Response:
The data employed for migration by age and sex from the 2011 Census comprise **UKMIG001** - *Migration by sex by age* together with **MM01CUK_ALL** - *Origin and destination of migrants by age (broad grouped) by sex* when accounting for flows between Leicester/Leicestershire and Rutland

(8) Which Census dataset has been used to assess migration trends separately by tenure? It would be helpful to understand the specific table reference or how the difference between tenures has been modelled.

Response:
2011 Census dataset **UKMIG011** - *Household migration by tenure* which has been applied together with the overall assumptions for the age-sex profile of migration (by source) referred to above.

Appendix 7 – Responses to Andrew Senior, sent on 16.07.2020

Part response to Andrew Senior's email 3.7.2020/ UHL synopsis

Question 1

The initial question is whether the UHL requested contribution serves a planning purpose and is necessary. UHL have identified a gap in its funding due to the way in which the block grant forward funding operates which does not appear to take into account population growth attributable to new housing developments and a subsequent increase in demand until the year following the impact. It seems that this is a systemic problem given that the identification of growth underlies the Health and Well Being Strategy and there is information available on planned and actual growth readily available. While it is said that the planning purpose of the requested contribution is to ensure adequate health care and treatment, the issue is not whether a person will be treated or not, but the effect on the quality of the service in terms of delay. However, given that NHS treatment is intended to be provided from national taxation, what is being said in substance is that the planning system/developers should subside UHL for the effects of the NHS's funding mechanisms. That is not obviously a planning purpose.

Answer

As explained in our evidence submitted, our email of 20 May and our further email on 9th June, the "funding gap" is not the impact. The impact is created by the new population on the services in the similar way that it creates an impact on education, libraries and as confirmed in the Developer's EI assessment. I refer you once more to the case of *Tesco Stores Ltd* case[8] where Lord Hoffmann a examined the evolution of planning obligations in the context of, inter alia, mitigating the impacts of development proposals upon community facilities and services that are usually funded by the public purse as already explained many times over.

This issue was also dealt in the *Spring Lane, Radford Semele, Leamington Spa* appeal[9] Inspector Hand considered the request from SWFT for a contribution from the developer for the unfunded revenue requirements to ensure delivery of its healthcare services. Although he considered the National Tariff funding model may be illogical "*unfortunately it is how the system appears to operate*".[10] The Inspector considered that the contribution sought met the requirements of the CIL regulations and expressly

[8] *Tesco Stores Ltd v SSE* [1995] 1 WLR 759, at 780.
[9] APP/T3725/A/14/2221858 (DL dated 10 March 2015).
[10] DL para 36.

rejected as irrelevant the contention that because residents may pay taxes that would address the needs of the NHS[11].

As explained in the evidence and repeated in the previous correspondence, without the contribution the impact is a long term one and will affect the population of this development as the service level is affected. To say that the level of service and delay is not a serious impact and that only the lack of service is, is completely unreasonable and has no regard to patients' quality of life and related socio – economic impact that delay and lower service levels create. It is also contrary to the Equality Act.

Could you please re-read the previous evidence provided, our consultation response and numerous previous responses which outline these points clearly.

We do need to point out that if this argument, if carried forward, would mean that there would be no contribution towards education, Council's own monitoring s106 services or library services.

Question 2

A key issue is whether UHL can show that the development necessarily gives rise to the additional burden on its services and that this arises from the development, as opposed to a failure in the funding mechanism, whether caused by its structure or a lack of reasonable coordination between CCG and Trust in agreeing block contracts for care and treatment based on up to date information as to new or anticipated housing development? Consideration also needs to be given to whether the housing development that is permitted is likely to be built out and occupied within 12 months and, if not, whether there is sufficient time for the NHS bodies to take it into account in their funding arrangements to align any additional burden from the development with their funding.

Answer

The impact is not the failure in the funding mechanism as explained many times over and in the previous paragraphs. The Trust has provided a very clear evidence on the impact as it holds statistics on the use of Trust services from a different postcodes. Please see question 8 below provided by the Council where the impact is recognised in addition to the EI assessment, previous appeals including Teignbridge.

[11] DL, paras 36-37

The impact affects real patients with real healthcare issues across the Harborough Community. The number of acute beds is one-third less than it was 25 years ago whilst the number of emergency admissions have increased significantly over the last 10 years. The Trust has confirmed that it is operating at full capacity.

The mitigation is carefully calculated so that the developer does not pay more than is needed to mitigate the impact. **There is no possibility to change the NHS funding model**, or spending priorities by the healthcare service providers; this is in the same way that the Council cannot change its funding from the Government. The funding gap will always exist and will not be paid back retrospectively. This same argument could be used in the case of contribution towards education, Council's own monitoring s 106 services or library services for which the Council has not provided a careful calculation methodology regardless of requests to provide the information.

Question 3

In a recent planning appeal in Teignbridge determined by the Secretary of State the issues raised by UHL's request were addressed in some detail and the requested contribution was found to fail the regulation 122 tests. The key considerations leading to this conclusion were the fact that the proposed development was on a site allocated in an adopted development plan and the proposals of that plan had been the subject of consideration with the relevant health care providers over the course of the preparation of the plan.

Answer

The Teignbridge appeal is different to this proposed application.

This proposed application is **an EIA development for which the 2017 Town and Country Planning (Environmental Impact Assessment) Regulations 2017 will apply**. In the case of the EIA development, the developer is required to provide specific information for inclusion in Environmental Statements. Pursuant to regulation 4(2)(a) of the 2017 EIA regulations the EIA must identify, describe and assess in an appropriate manner, in light of each individual case, **the direct and indirect** significant effects of the proposed development on, inter alia, **population and human health**.

Furthermore, pursuant to regulation 18(f) of the 2017 EIA regulations the developer is required to ensure the ES is prepared by **competent experts.**

The Teignbridge appeal related to an application that the 2017 EIA Regulations did not apply.
The EI Statement clearly identifies the impact on Trust services and the Trust has confirmed this by way of submitting clear evidence on the impact, together with an appropriate and effective mitigation measure.

In any event, as to asking another Government body to pay the developer contribution based on the fact that the NHS should be aware of the known developments is wholly unlawful. Consultation with NHS England or associated service providers in the Local Plan process is simply immaterial because LP process does not, and cannot, influence the funding model or spending priorities of another Government body. This argument could be used on any contribution like Council's own monitoring s106 Agreements contribution.

It is not the position of the taxpayer to subsidise the private development company by asking the tax payer to pay the contribution.

Please see also the below answer

Question 5

With reference to growth in particular to large-scale strategic schemes, within the District, these sites have been allocated through the local plan process. The consultation with health bodies in the preparation of the Harborough Local Plan is set out below

2013 Scoping consultations

Leicestershire and Rutland PCT

2015 Options consultation

NHS UK,

West Leicestershire CCG

NHS Property

Leicester City CCG

2017 Pre-submission Draft consultation

East Leicestershire and Rutland CCG

West Leicestershire CCG

Leicester City CCG

No responses were received to these consultations.

Answer

Please see answer to the previous question. Please also note that CCGs, NHS UK, NHS Property do not provide the health services. The Trust provides the direct acute and planned health care services to the community of Harborough and has not been quite clearly consulted with. None of the mentioned consultees above are directly impacted by this development in relation to the provision of acute services. In any event this is an EIA Development.

Question 6

There is an assumption that all patients will be treated at UHL when there are other available hospitals close to the development.

Are all A&E patients taken to Leicester or are other nearby hospitals, Coventry for example?

Do patients for other treatments also use other nearby hospitals?

Is there an allowance for this in the calculation or is it reflected in the activity rates used to calculate demand?

The response also asserts that the methodology also takes into consideration only those attending the Trust's service as some patients will use other hospitals. It is unclear from the way that the calculation is presented how that has been done. It may be that this is the function of the average activity rate which does this, but this has not been adequately explained. It is unclear how the average activity rates been derived?

Answers

Please see the Trust's responses to the above repeated questions in responses in January, April and in June emails to Andrew Senior.

The Trust holds its own statistics for each activity that takes place in the Trust. This activity is related to each patient and the patient's address. Each activity has a standard cost. The updated consultation response in Appendix 3 shows the total activity which is then related to a specific development area.

This calculation methodology takes into consideration only those likely patients attending the Trust service from this development as some patients will use other the hospitals not related to the Trust as explained in previous responses.

Question 8

Issues with bed occupancy levels and the impact that this has on the performance of A & E, the ability to move patients onto a ward if they cannot be discharged. It appears that the Royal Infirmary is operating at 100% occupancy, not the ideal of 85%. This issue of bed blocking appears to be an existing issue. Nothing has been submitted to show what relief in bed spaces can be achieved by the means of the contribution sought or a relationship between this and the development. UHL argue that more staff will enable them to manage bed spaces more efficiently, however, there is no satisfactory evidence that the contribution sought will deliver a benefit, which is fairly and reasonably related to the permitted development.

Answer

The new development will exacerbate the current situation. The contribution will mitigate this impact and this way will benefit the service as explained in the evidence. To say that it does not benefit the service is wholly irrational, as the contribution will go towards the activity created by the development as explained. Please explain how the Council considers this does not mitigate the activity rates created by this proposed development. More importantly, the legal test is not *"a benefit which is fairly and reasonably related to the permitted development"*. Please see previous appeal decisions, s 106 TCPA 1990 as amended, CIL 122 test and the related case law sent to you. Furthermore, this proposed development is not yet permitted development.

Question 9

In terms of mechanics, there is now reference in the UHL correspondence to an undertaking to ensure that any monies are spent on patient care for those arising from the development so as to satisfy the requirements that any contribution should be directly related to and fairly and reasonably relate in scale and kind to, the development. My understanding is that the monies will be used to provide additional staff. What mechanisms are in place or could be put in place to ensure that this is where the funding is directed? Is there a draft clause to be incorporated into any section 106 agreement? Would it allow for the re-payment of any part of the contribution which is not spent on activity relating to the

development? In this context, there is a suggestion that there would be a yearly or biennial review of the sums to be paid. The developer will want and can reasonably expect some certainty at the outset of the development as to the extent of the contributions, even if that is provided only as a maximum annual figure.

Answer

The Trust has quite clearly informed the Council in the previous correspondence that it is happy to give an undertaking to allocate the contribution towards the new activity created by the proposed development and to negotiate an appropriate clause to the s 106 agreement.

Remaining Questions:

The answers as to the remaining questions relate to the calculation of exact calculation of the new population figure. This work is done in conjunction with CCG, as the health service providers wish to make consistent approach to the matter.

16.07.2020

Appendix B – East Leicestershire and Rutland CCG

East Leicestershire and Rutland Clinical Commissioning Group

CCG Headquarters
Leicestershire County Council
Room G30, Pen Lloyd Building
County Hall, Glenfield
Leicester LE3 8TB
Web: eastleicestershireandrutlandccg.nhs.uk

From the office of: Tim Sacks
Telephone: 0116 295 6225
Email: tim.sacks@EastLeicestershireandRutlandccg.nhs.uk

22nd July 2020

Development Site Details

19/00250/OUT - Land East Of Lutterworth, Gilmorton Road, Lutterworth, Leicestershire

ELR CCG Role & Responsibility	According to the World Health Organisation (WHO) constitution of July 1946 "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" The role of the CCG as commissioner of health services is to deliver services that meet this. It is important to recognise that 90% of all contacts with a health professional in the UK start and finish with General Practice. It is therefore imperative that there are the appropriate facilities to allow General Practice services to be available to serve local residents effectively and have sufficient capacity to meet the increased patient demand that comes with new housing developments. The developer contribution through Section 106 supports the physical capacity of a GP practice allowing for the essential recruitment of additional clinicians to treat the increased patient population The CCG will only seek developer contributions from new development proposals where infrastructure schemes have been identified and where the contribution sought complies with the Community Infrastructure Levy (CIL) Regulation **122** tests; (1) This regulation applies where a relevant determination is made which results in planning permission being granted for development. (2) A planning obligation may only constitute a reason for granting planning permission for the development if the obligation is— (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. (3) In this regulation— "planning obligation" means a planning obligation under section 106 of TCPA 1990 and includes a proposed planning obligation CCGs are not allocated additional funding either in the form of capital or revenue from NHS England for infrastructure projects such as new or extended General Practice premises to cater for the impact from new residential developments. Without mitigation by way of S106 contribution from developers, the CCGs has no way of funding the additional costs of buildings that would be required to enable any demand from new and increased populations to be met.
Local Development Plan Policy	This request for S106 developer contributions to fund the extension of the existing General Practice premises at Gilmorton Road is aligned to a number of planning documents referenced below; 1. <u>Harborough Local Plan 2011-2031 (Adopted April 2019)</u>, ➢ Section 15- L1 East of Lutterworth Strategic Development Area I - a neighbourhood centre as a social and retail hub for the new community to be provided before the completion of 700 dwellings **to include some or all of the following**: i. a supermarket or shops to meet local convenience needs; ii. a public house/café; iii. a doctors' surgery;

Environmental Impact Assessment	iv. a community hall; v. and other community facilities or **upgrade of existing facilities**; ➢ 15.2.4 The SDA will create a sustainable urban extension to Lutterworth, essentially mirroring the existing town to the west of the M1, with new development to the east of the M1…. **However, its residents will need to access facilities within the existing part of Lutterworth for** secondary schools, leisure **and health facilities**. 2. East of Lutterworth Strategic Development Area- ENVIRONMENTAL STATEMENT VOLUME 1: ➢ 5.5.18: The NHS East Leicestershire and Lutterworth Clinical Commissioning Group (CCG) state that the both existing GP Practices in Lutterworth have limited capacity. **Therefore, additional demand will be placed on these services which cannot be accommodated without mitigation**. ➢ 5.5.34: The population increase as a consequence of the Proposed Development is likely to impact on the provision of medical facilities and services. The Community Hub identified on the Parameters Plan includes the potential for medical facilities on site (D1 use class), which could include a GP and/or dental surgery. **In addition, financial contributions will be made where appropriate to mitigate this.** ➢ 5.5.39: In the longer term, the social, health and community needs of the community will have been met by the Proposed Development through appropriate provision. ➢ 5.5.43 **Financial contributions will be made where necessary towards improvements to health facilities**. The cumulative effect with other developments that have planning permission will be taken into consideration in determining this contribution.

Necessary to make the development acceptable in planning terms & Impact of new development on GP practices

Currently, the two GP practices, which would cater for this proposed development, will not have the capacity to serve the new population from this development.

The development is proposing 2750 dwellings, which, based on the average household size of 2.42 (based on Office for National Statistics average household size 2017) per dwelling, could result in an increased patient population of 6655 patients.

This method of calculation does not consider a significant number of factors that impact on large new developments. The CCG commissioned a detailed study to provide a clearer picture in response to questions raised by Harborough District Council regarding the net impact of the proposals in terms of population gain.

The outputs of the analysis summarised below outlines the proportion of the total estimated population at the new East of Lutterworth development that will be new to the catchment for the purposes of Primary Care services.

The analysis estimates that the new development will generate a total of **7,520 residents**, modelled in-line with Census data. This is based on modelling the split of future residents (by persons by age and sex), which establishes a profile with demographic characteristics that differ from the existing population within the catchment. The age-sex profile takes account of differences in migration flows by household tenure and increased migration flows since 2011. This indicates in accordance with the official subnational household projections the population would form into **2750 households** at an average household size of **2.73** persons per household.

Average Household Size for 2750 Dwellings Based on Age-Sex Profile of New Population and 2016-based Household Projections

	Dwellings Modelled	Total Popn.	Previously Resident in Primary Care Catchment	Average HH Size
Application Proposals	2750	7520	2451	2.73
% at Development			33%	

From this figure of 7520, 33% of the population are considered to originate ***within*** the 'best-fit' catchment for Primary Care. This reflects the relative importance of migration across shorter distances and local patterns of household formation. This means that **67.4%** of the direct impact of the new population at the East of Lutterworth development is new to the 'best fit' catchment for Primary Care.

The Clinical Commissioning Group's calculation for the impact of the new development on Primary Care therefore takes into account **5068 additional residents** not expected to be previously resident within the catchments identified to serve demand for these services.

In addition a separate element of modelling deals with the population of existing dwellings within the catchment for Primary Care based on assumptions for the direct impact on patterns of migration and household formation arising as a result of the new East of Lutterworth development. The

result for the impact of population gain resulting from 'backfill' (447 persons) represents 31.6% of the total population of 1415 residents within the new development (in market and shared ownership housing) assumed to relocate from within the existing Practice catchments. This is as a result of assuming that the population within the new development originating from the existing catchments will comprise a mixture of **existing households** and **newly forming households** and that due to improved affordability a greater proportion of the existing dwellings that are vacated (**287 dwellings**) will be taken up by other existing residents within the Primary Care catchments.

This impact of 447 persons originating from outside of the Primary Care catchment to occupy existing dwellings is additional to the demographic impact of the population *within* the new development.
The total impact of net population gain within the Primary Care catchment should therefore be expressed as **5068 persons plus 447 persons resident in existing dwellings = 5,515 total**.

The following calculation shows the impact of the new population in terms of number of additional consultations expected to provide appropriate primary care to the additional patient in this development.

This figure is derived from The Department of Health (NHS England) document- Facilities for Primary and Community Care Services 2013, which uses the space calculation in Health Building Note HBN11-01 (Chapter 4 pages 15-18) to establish the core GMS (General Medical Services) space required for a practice patient population.

Consulting room

Proposed population	**5515**
Access rate (appointments)	5260 per 1000 patients per year
Anticipated annual appointments	**5515** x 5260/1000 = 29009
Assume 100% patient use of room	**29009**
Assume surgery open 50 weeks per year	**29009**/50=580 per week
Appointment duration	15 mins
Patient appointment time per week	580 x15/60= 145 hours of clinic per week

Treatment room

Proposed population	**5515**
Access rate (appointments)	5260 per 1000 patients per year
Anticipated annual appointments	**5515** x 5260 = **29009**
Assume 20% patient use of room	**29009** x 20% = **5801**
Assume surgery open 50 weeks per year	**5801** / 50= **116** per week
Appointment duration	20 mins
Patient appointment time per week	**116** x 20/60= **39** hours of clinic per week

GP practice(s) most likely to be affected by growth and	**Lutterworth Health Centre**: This contains; • **The Wycliffe Medical Practice**

therefore directly related to the housing development	• **The Masharani Practice**. Both practices are located in Lutterworth and have practice boundaries that cover the area of the proposed development (Appendix 1 & 2). There are **NO** other practice boundaries that cover the proposed new development (Appendix 3) According to the GMS Contract clause, 13.2.1 a patient must live within the practice boundary to be entitled to register with the practice. Patients can request to register with other practices, but Patient Registration Policy clause 2.1 outlines that it is reasonable grounds for refusal if the patient lives outside the practice boundary. Therefore, the two GP practices identified above would be the only practices that have CIL compliant infrastructure schemes identified to increase capacity and enable them to register new patients stemming from the proposed new development. The CCG therefore considers that these GP practices will be the most affected by the additional demand created. Due to the increase in patient demand from the proposed new development, there is a need to substantially increase clinical space. If clinical space is not increased the GP practices could be forced to close their patient registration lists and accept no further patient registrations. If this were to happen because of the proposed new development, it would have a significant adverse impact on the wellbeing of number of patients who use the health service from these practices. This in turn will have a detrimental socio economic impact on the community at large

<table>
<tr>
<td>Practice Proposal/ Plans to address capacity issues as a result of the proposed development, necessary to make the development acceptable in planning terms</td>
<td>Obtaining a healthcare contribution from the proposed new development will mitigate the impact and will provide vital funding towards new clinical space at the two practices mentioned above. This will help to increase patient access for the additional patients as well as ensuring that the practices do not close their patient registration lists.

The Health Centre has the opportunity to reconfigure and extend their current facilities to increase clinical space. East Leicestershire and Rutland CCG have examined the options available on the current site to reconfigure and expand Lutterworth Health Centre in partnership with both GP practices and the building's owner. At its May 2019 meeting the Governing Body of the CCG supported the expansion of Lutterworth Health Centre identifying the option to reconfigure the existing building to maximise space available and an additional extension to provide the increased capacity required.

Options were also assessed to provide these services from a branch surgery site on the Lutterwoth East development, but this was discounted for a number of reasons;

1. It is not viable to set up a contract for a new provider on the East Lutterworth site as the new population will not be sufficient to sustain a fully operating general practice
2. Neither of the practices are willing to take on a branch surgery due to the logistical and staffing issues associated with split sites
3. Economies of scale and therefore the ability to provide a greater number of appointments to patients with services based on one site, which would not be possible with split sites
4. Number of patients and the phasing of the development would mean that the surgery would initially only be open for limited hours and would never have the population base to open a full service, thus disadvantaging patients who would need to attend both sites for services

Without the increase in clinical space at these two practices, the opportunity for patients from the new proposed development to book an appointment and / or be seen by a clinician would be extremely limited and could have signficant consequences for the health of local residents and patients.</td>
</tr>
<tr>
<td>Fairly and reasonably related in scale and kind to the development.</td>
<td>The proposed extension has been costed using indicative size requirements for each of the practices. When considering the capacity required, the HBN11-01: Facilities for Primary and Community Care Services sets a standard size of 16 m² for a consulting/examination room. Other support service spaces are also indicated e.g. utility rooms. pp

There is also a national calculation used to assess the additional m^2 necessary for health care premises, this factors in a range of criteria recognising economies of scale in larger practices.

<table>
<tr><th>Number of patients</th><th>Size GIA</th><th>m^2 needed per patient</th></tr>
<tr><td>3500</td><td>587</td><td>0.16</td></tr>
<tr><td>5000</td><td>638</td><td>0.12</td></tr>
<tr><td>8500</td><td>1000</td><td>0.11</td></tr>
<tr><td>10000</td><td>1130</td><td>0.11</td></tr>
<tr><td>13700</td><td>1200</td><td>0.0875</td></tr>
<tr><td>16000</td><td>1428</td><td>0.0892</td></tr>
<tr><td>23000</td><td>2000</td><td>0.0869</td></tr>
</table>
</td>
</tr>
</table>

<table>
<tr>
<td></td>
<td>
It is important to note that the cost per m^2 was previously quoted at £1902 $m^{2.}$ This accounted only for the actual cost of the building and was based on figures calcuated in 2011 and did not include the entire costs of the development. Since this application was submitted a full detailed costing has been undertaken based on 2020 costs. This can be seen in Appendix 4.

The updated costs per m^2 (building only) :
2011- £1902 exl VAT
2020- £3107 exl VAT

Additional costs including on costs, fees etc will take the total to £3980 m^2 exl VAT
The calculation for the cost of the development is set out below:

This is the cost of providing additional accommodation for 5515 patients

<table>
<tr>
<td>Additional patients to be accommodated
5515</td>
<td>x</td>
<td>Standard area m²/person Based on total list size of approx. 22,615 (current list size of 17,100 plus 5515) = 0.0869</td>
<td>x</td>
<td>Cost of extension including fees £/ m² £3980</td>
<td>=</td>
<td>Total cost

5515 x 0.0869 x £3980 = £1,906,420</td>
</tr>
</table>
</td>
</tr>
<tr>
<td>Financial Contribution requested</td>
<td>
<u>The contribution of £1,906,420 is sought to increase practice capacity at the Lutterworth Health Centre, Gilmorton Road, Lutterworth, LE17 4EB; and to increase practice capacity at the Wycliffe Medical Practice and The Masharani Practice to accommodate the additional patient demand as a result of the new development at Land East Of Lutterworth, Gilmorton Road, Lutterworth, Leicestershire.</u>

The CCG and the practices would wish for any contributions to be paid prior to the first occupancy of any dwellings on the site.
</td>
</tr>
</table>

Lutterworth Town Council

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EAST OF LUTTERWORTH SDA
PLANNING APPLICATION 19/00250/OUT
REPRESENTATION TO PLANNING COMMITTEE
JULY 2020

Executive Summary

a. The compliance of this application to the Local Plan is in serious question.

b. Many of the issues can be resolved by the adoption of spine road Option 1 rather than the presented Option 4. This would give greater acceptability and improved noise and air quality without impacting the new development.

c. Experts have been ignored. We cannot have planning approval for such a large development where expert advice is disregarded. The result is a sub optimal, not the required "exemplar" development.

d. Air Quality has been disregarded. The opportunity exists for a holistic approach that resolves a 20-year-old AQMA, benefits thousands of current and future residents, and does not place the burden on the new development.

e. The Planning Committee Report states that the chosen spine road option DOES NOT perform best in terms of air quality and noise – the best performing option is Option 1, yet this is being disregarded.

f. The report states that residents will be exposed to unacceptable noise levels around 70 decibels, resulting in windows having to be kept closed. One primary school will have background noise of 64 decibels.

g. The full application for the spine road is incomplete in terms of detail, management plans and control processes. There is not one commitment regarding construction traffic management, public traffic management, hours of work, work processes, or anything that could (and might need to) be enforced.

h. The committee must stop this application based on the spine road routing alone. Re-submission of the application using spine road Option 1 would remove all major objections and would enable compliance with Law and Local Plan. Members must require a detailed spine road Construction Traffic Management Plan to be submitted prior to any further

application, and that Lutterworth Town Council are party to that agreement. An agreed, formal process for raising issues with the applicant's developer once any construction has commenced must be put in place.

i. Leicestershire County Council, along with Harborough District Council, have this opportunity to substantially increase the wider benefit by re-routing the spine road and relieving Lutterworth town centre of heavy traffic WITHOUT impacting the new development. In doing so, they would remove the Lutterworth AQMA, reduce noise levels, improve the public realm within the centre of Lutterworth (a Local Plan requirement), improve the pedestrian crossing experience over High Street, and enable the progression of the Lutterworth Town Centre masterplan. Lutterworth is part of Leicestershire – all we are asking is that the District Council and County Council do what is best for their residents in the wider context. The opportunity to do so exists now – if it is ignored, the opportunity is lost forever.

Introduction

Lutterworth Town Council recognises that the East of Lutterworth Strategic Development Area is provided for within the Harborough District Local Plan 2011 – 2031, and the Town Council also recognises the requirement for new housing.

However, the 361 pages of the planning report relating to application 19/00250/OUT clearly state that it considers **TWO** planning applications. The "outline" permission is for the housing development, internal road network and associated buildings, all of which would be subject to further scrutiny as part of a reserved matters process, while page 1 of the document states the existence of a **"full" application for the Spine Road.** The "full" application has not been made clear at any previous stage of the application process and means that any decision that approves the overall application accepts that the Spine Road will be built exactly as depicted – there is no "Reserved Matters" process that can give further scrutiny to the detail.

Therefore, this representation will apply focus to the spine road in addition to commenting on the wider application. This will be done by considering the following:

- Compliance with the Harborough District Local Plan 2011-2031
- Compliance with expert advice presented as part of the application process
- Lutterworth Town Air Quality Management Area
- Construction Traffic Management Plan

SPINE ROAD

1. Compliance with the Harborough District Local Plan 2011 – 2031

Policy L1

Policy L1 of the Local Plan is the main policy that governs the development of the Strategic Development Area and contains specific requirements regarding the creation of the Spine Road. However, other policies, specifically Policy HC2 – Built Heritage, and Policy GD5 – Landscape Character also influence the requirements.

The requirements of Policy L1 are detailed in the Explanations, commencing on page 193 of the Local Plan.

- 15.2.2 requires that the development *"…should be in accordance with a masterplan that is produced with the full engagement of the existing community of Lutterworth and which has the support of the population through a consultation process as part of either a Supplementary Planning Document, a Neighbourhood Plan or a planning application."*

- The reality is that none of this has been satisfied. The applicant has "engaged" with the community by holding two "exhibitions" detailing their intentions. While the community expressed their views, many of which were negative, no changes have been made to the proposed masterplan as a result of those views. It is completely inaccurate to suggest that the community is engaged with this development whatsoever. In the Planning Committee Report, paragraph 3.49 states that of 950 visitors to the exhibition (out of 10,750 residents), 252 comment forms were received. At no stage does it demonstrate that any of the comments were addressed, or that local views were taken in to account. This does not in any way demonstrate support, indeed the lack of such demonstration indicates that they have no support to demonstrate. Far from being "consultation", this process has effectively amounted to "dictation".
- The applicant has produced a planning application and believes they have engaged in consultation. The Local Plan requires that this consultation process has the support of the population, yet the HDC planning portal demonstrates that there are 162 objections to the scheme and absolutely none in support. The applicant has not in any way demonstrated support, and by no measure can it be claimed that the Local Plan requirement has been satisfied.
- Lutterworth Town Council DID hold specific public engagement on this issue on 22nd March 2019. The results were that 82.5% of those who responded were against the proposals, a significant number of which stating the lack of a by-pass for Lutterworth and significant traffic impact amongst their reasons.

- 15.2.6 requires the provision of a spine road, which is predicted to remove some of the through traffic from Lutterworth town centre.
  - However, paragraph 6.7.1 states that *"…the development may result in increased traffic flows with an impact on the AQMA"*
  - Further, paragraph 6.7.10 tells us that there is only one point in Lutterworth (off the Gilmorton Road) where there are any predicted reductions in pollution. Remember – the Gilmorton Road is going to be closed to through traffic, so this is hardly an ecological coup. However, we are told that pollution will INCREASE along the A4304 to the south of Misterton, and off Gilmorton Road to the north of the proposed spine road.
  - Paragraph 6.7.17 states that the development will make no difference to the Lutterworth AQMA (despite a Local Plan requirement to do so), and yet the report is worded such that it is made to sound like a good thing!
  - This proposal will not, on its own admission, satisfy the Local Plan. It cannot be passed in its current form.

- 15.2.9 is more specific on the subject. While 15.2.6 predicts that some traffic will be removed as a result of the spine road, this clause states that the objectives are to *"deliver a spine road to alleviate pressure upon Lutterworth High Street and the Air Quality Management Area".*
  - Paragraph 6.3.40 of the Planning Committee Report states a position that is clearly in breach of this requirement of the Local Plan. It states that *"…the primary purpose of the spine road is to provide a development access and it is not intended to be a by-pass for Lutterworth Town Centre…".* This is a clear breach of the Local Plan – the use of the word "by-pass" is irrelevant – it is clear from this that the applicant does not intend that the spine road should give any relief to Lutterworth High Street or the AQMA. The application should be refused on this point alone.
  - As evidence to this fact, there is no reference to any signage that will direct traffic away from Lutterworth, and certainly no reference to any form of traffic prohibition that will require heavy vehicles to avoid Lutterworth.
  - Effectively, the choice of route will be left to drivers – the applicant will do nothing in this regard to achieve the Local Plan objectives. No lorry driver will take a new, longer,

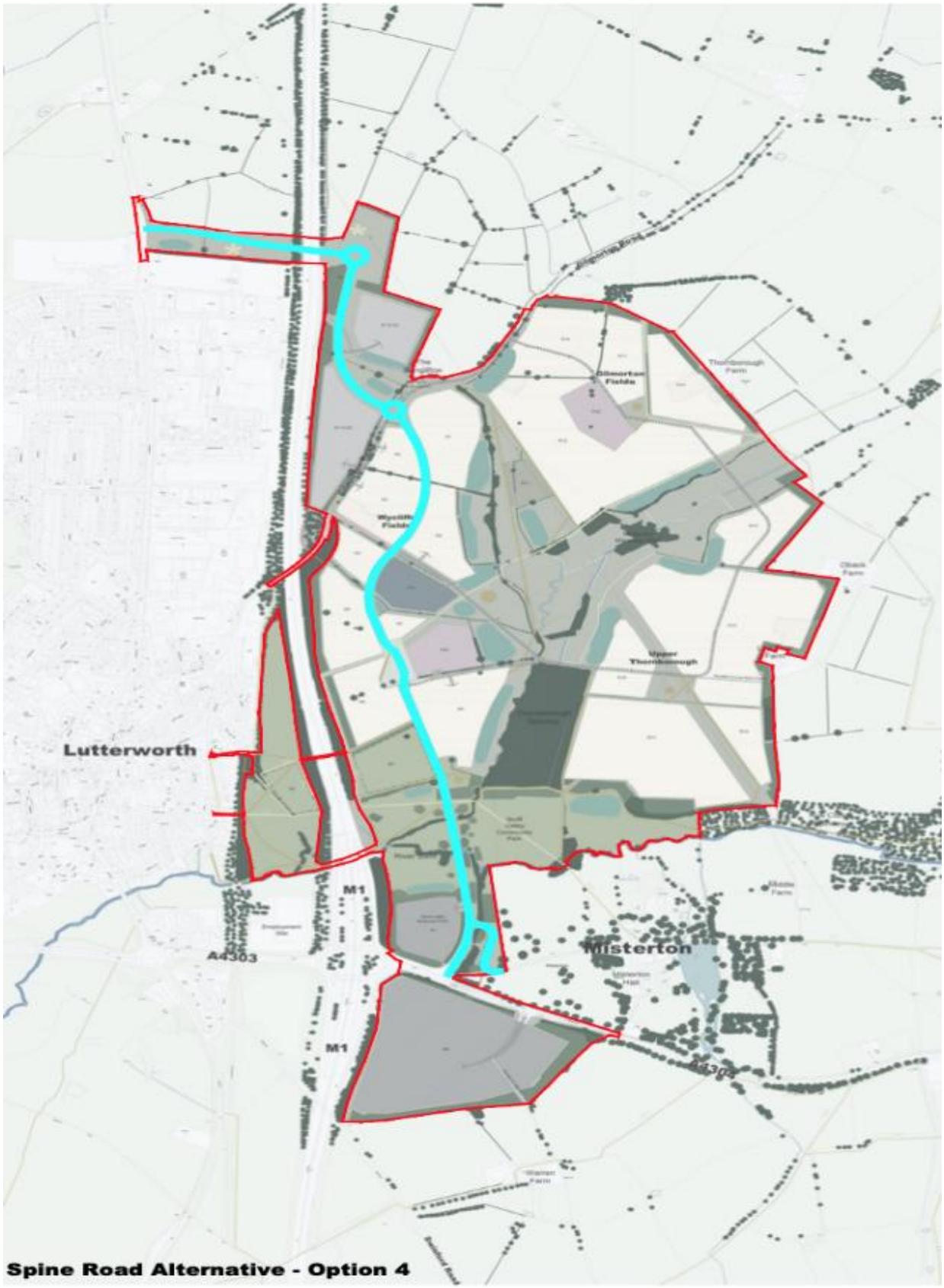
more diversionary route when they can take the same direct route that they have always taken.

- Paragraph 7 of this clause requires the applicant to deliver *"...an exemplar scheme which demonstrates the highest standards of urban design"*.
  - However, paragraph 4.4.13 of the Planning Committee Report tells us that *"…residents occupying premises close to the M1 may be afforded a poor standard of living accommodation."*
  - Paragraph 4.4.8 tells us that in residential zone R6 (between the proposed spine road and the motorway), even with a 4m high noise reduction barrier, background noise levels are expected to be in the region of 70 decibels. We later learn that it will take a noise barrier over 6m high to reduce these.
  - Paragraph 4.4.14 requires that a condition is placed on the application that ensures that background noise levels in the gardens of dwellings does not exceed 50 decibels and does not exceed 35 decibels within internal rooms with the windows open. Such a condition is not necessary if the design of the development has prevented the problem in the first place.
  - Paragraph 4.4.3 tells us that it is the expectation of the HDC Contaminated Land and Air Quality Officer that in residential zones R6 and R8 (between spine road and M1, to the south of Gilmorton Road) a new AQMA will be created as a result of the development and spine road design.
  - Finally, in paragraph 6.94 we are told that spine road option 1 performed best in terms of Air Quality and Noise, yet despite the issues raised in the preceding points, the applicant has selected a sub optimal spine road option.
  - **This can hardly satisfy the Local Plan requirement for *"…an exemplar scheme which demonstrates the highest standards of urban design".***

- 15.2.21 readily admits that the development will increase peak time traffic in Lutterworth by between 10% and 17% until the spine road is built
  - The forecast in the Local Plan is that this would be circa 2030, however it is already behind that schedule
  - Lutterworth is therefore destined for an increase in town centre traffic for the next 10 years, in the hope that the spine road will offer some relief.
  - As we have seen, there is nothing in the Planning Committee Report that demonstrates that there are planned measures in place to actually make this reduction happen. This is a full application that is being considered, and yet there is no reference to any form of mitigation that will be put in place to offset the impacts of the development that will last for the next 10 years.

- 15.2.24 states that *"Following completion of the spine road, traffic management measures and public realm improvements will be developed to remove or minimise the passage of HGVs through the centre of Lutterworth…"*
  - This is not just a paragraph in the explanations. **This is also a specific policy commitment, in Policy L1, Section 6.**
  - Again, there is nothing in the Planning Committee Report that demonstrates how this will take place, nor is there any commitment as to the measures that will be implemented.
  - Further, any form of local knowledge of Lutterworth will reveal the flaw in the plan.
    - In order to relieve Lutterworth High Street, there has to be somewhere else for the traffic to go. There are currently no other local options to take traffic around Lutterworth.
    - The only possible option would be the spine road, however the proposed design and location of the spine road causes a problem.

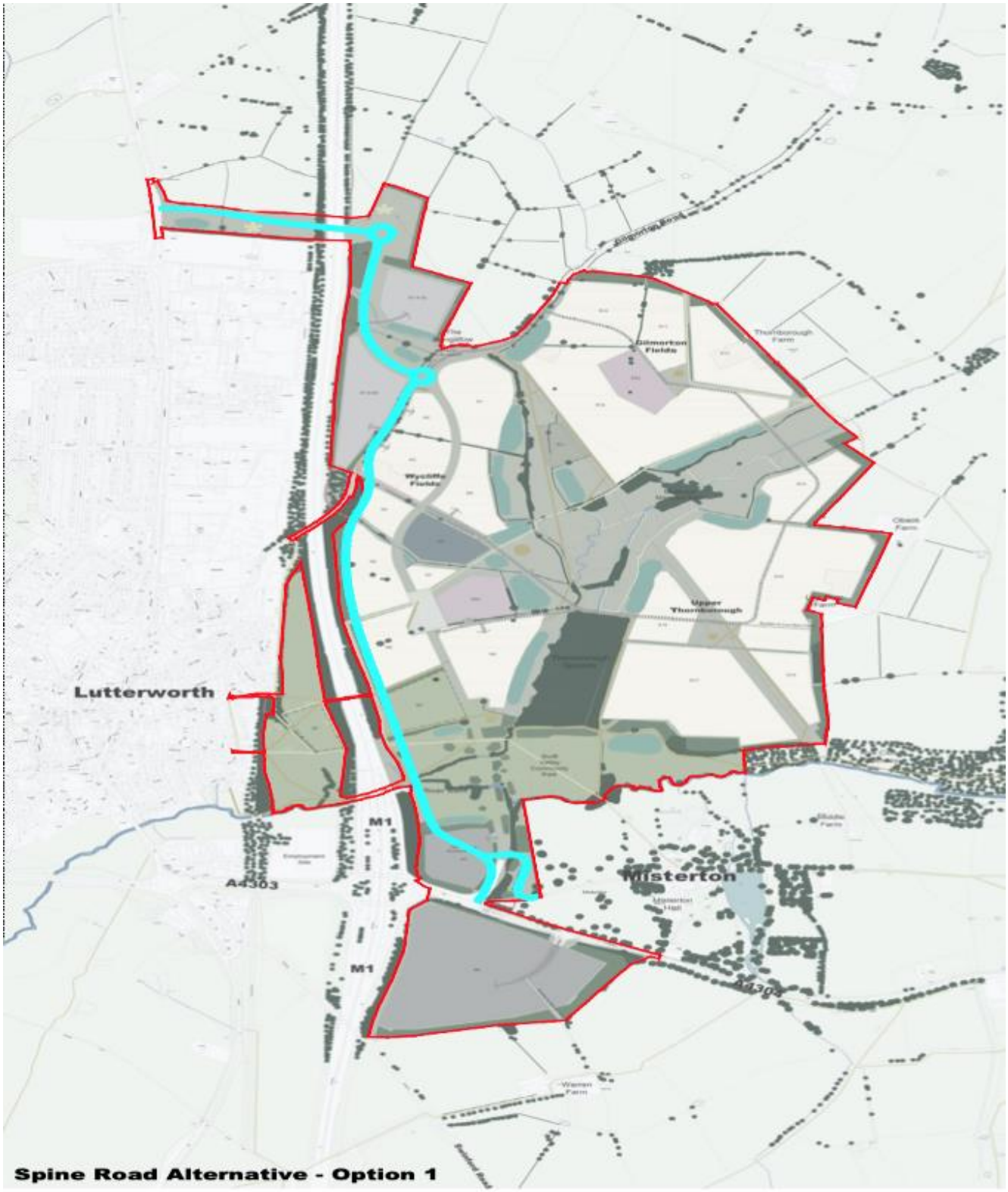
- As it stands, the spine road option that is proposed is known as Option 4, and it is designed to take traffic on a meandering route through the new development.
- Running from the south, it will take traffic past a new business area, through the centre of the proposed Swift Valley Community Park, past the sports pitches, through the centre of the proposed Wycliffe Fields housing development, past the classroom buildings of the southern-most school, past the community hub, and continues through the Wycliffe Fields development to the junction with the Gilmorton Road.
- Therefore, any traffic that IS diverted from Lutterworth centre will take this route, impacting residents, school children and those engaged in leisure pursuits within the new development.
- So, in 10 years-time when the decision is taken to enact Policy L1 Section 6, the ONLY alternative will be to use a spine road that is badly placed for the purpose and that will simply move the problem from Lutterworth to Lutterworth East. Option 4 is shown below.



- However, there is an alternative. Spine Road Option 1 does not have any of the problems generated by Option 4, as it is designed to run largely parallel to the M1.
    - Therefore, rather than running THROUGH housing developments, community hub areas, community parks, past schools etc, it is designed to avoid these and run at the side of the development.
    - The ONLY sacrifice is that rather than running past the new business area in the south, it would run through it. It would hardly impact the business

operators and would significantly benefit the residents and users of the Lutterworth East development.

- The plan of Option 1 is shown below.



- This version of the spine road WOULD be appropriate to take diverted traffic from Lutterworth and WOULD NOT carry the problem from one area to another.
- Paragraph 6.94 of the Planning Committee Report states that spine road Option 1 performed best in terms of air quality and noise.

- The applicant, however, refuses to listen. As we will see in the next section, it is not only Lutterworth Town Council who are not being listened to.

Policy HC1 – Built Heritage

The setting of the Grade 1 listed St Leonards Church, Misterton is discussed at length within the Planning Committee Report, especially with regard to the impact of the proposed spine road upon it's setting. Policy HC1, Section 1, states that "…*development affecting heritage assets will be permitted where it protects, conserves or enhances the significance, character, appearance and setting of the asset, including where possible better revealing the significance of the asset and enabling its interpretation"*. Under no circumstances does spine road Option 4 comply with this requirement, indeed it is one of the main thrusts of Historic England's objection that the Option chosen harms the setting of the church.

Further, Section 2 of Policy HC1 states that where the development would lead to less than substantial harm to the asset or its setting, this harm will be weighed against the public benefits of the proposal. The simple fact is that while Option 4 causes harm to the setting of St Leonards Church, a viable alternative is available which in the opinion of Historic England does not cause such harm but does give equal public benefit in providing a spine road for the development.

Explanation 8.1.1 states that *"…the character, quality and diversity of the District's extensive historic environment will be taken fully in to account with a view to its conservation and enhancement in the context of the sustainable development of the District".* Allowing a sub-optimal spine road option which has greater impact on the setting of an asset cannot possibly comply with this Local Plan policy commitment.

Explanation 8.1.5 states that where a proposal will cause harm to an asset the Council will require evidence that there are considerable public benefits to justify the harm or that there are no other mechanisms for supporting the retention of the asset. In this case, there is an alternative mechanism, and that is that spine road Option 1 is adopted in place of Option 4, and this change is supported by Historic England.

Explanation 8.1.6 states that where planning permission is granted, appropriate conditions may be applied and planning obligations may be secured to ensure that assets are appropriately conserved. There is therefore an opportunity here for the planning committee to approve planning permission with the condition that the spine road follows the route laid out in Option 1, thus preserving the St Leonards asset to the satisfaction of Historic England.

Policy GD5 – Landscape Character

Policy GD5 requires that developments respect and where possible enhance local landscapes, settings of settlements and settlement distinctiveness. Further, they should avoid the loss of, or substantial harm to, features of landscape importance, and they should safeguard important public views, skylines and landmarks.

The scale of the Lutterworth East development is such that it will obliterate the landscape setting in which it sits. Views from Misterton over to Gilmorton, and vice versa, will be lost for ever, and while the line of site between St Leonards Church and St Marys Church in Lutterworth may well be retained, the accompanying view will take in to account new warehousing to the south and a new business park to the west. None of this could be considered to respect or enhance the local setting.

Policy H4 – Specialist Housing

Harborough District Council are clear on the provision of Specialist Housing. They state that on all developments of over 100 dwellings, they would require at least 10% of dwellings to

be in the specialist Housing category. Further, that it must be conveniently located to local retail and community services.

In the 361 pages of the Planning Committee Report, we can find not one reference to the provision of Specialist Housing within the development.

Summary

Serious questions have to be asked regarding the compliance of certain parts of this development to Policies L1, HC1, GD5 and H4.

- The failure to comply with the highlighted requirements of Policy L1 will have a detrimental impact on Lutterworth. This can be resolved by a change of spine road option.
- The sub optimal choice of spine road option leads to an impact on Policy HC1 and is in direct contravention with advice received within the report from Historic England. Again, changing spine road option will resolve this.
- The destruction of the character of the landscape, along with existing views, hardly complies with Policy GD5.
- Policy H4 remains entirely unsatisfied, indeed seemingly entirely ignored.

2. <u>Compliance with expert advice presented as part of the application process</u>

Expert advice has been received from a number of areas:

- Historic England
- The Landscape Partnership (report commissioned by Harborough District Council)
- Wood Consultants (report commissioned by Lutterworth Town Council)
- Leicestershire County Council Planning Ecologist
- Harborough District Council Environment Health Officer (Noise)

Historic England

In paragraphs 4.1.8 to 4.1.51 of the Planning Committee Report, Historic England clearly describe the spine road routing (known as "Option 4") as an *"alien feature"* that detracts from the setting of St Leonards church. Further, that the routing is *"very harmful"* and that they are *"keen for an option running parallel to the M1"*. They state that *"Option 1 creates a greater visual separation between the road and the church"*, and that ***"the application contains no justification why this option has not been pursued and why the <u>more harmful Option 4</u> has been put forward".***

There is a statutory requirement to have special regard to the desirability of preserving the setting of a listed building (Section 66, paragraph 1 of the 1990 Act), which the selected spine road option does not comply with. Historic England state that ***"…we consider the proposed development would not meet the criteria of, and would be contrary to, Policy L1 'Lutterworth East SDA'. This states within criteria u, that "the proposed new access road should be routed to have regard to any undesignated archaeology and minimise its impact on all heritage assets, particularly the inter-visibility between the Church of St Leonard and the Church of St Mary. We, therefore, recommend that the new spine road is re- located to run parallel and close to the M1 as we have previously stated throughout our advice".***

Please note:

- ***Effect on listed buildings and conservation areas are valid reasons for refusal of a planning application***
- ***Adverse impact on archaeology is a valid reason for refusal of a planning application***
- ***Failure to adhere to statutory instruments is a valid reason for rejecting a planning application***

Spine Road Option 1 **would** satisfy this objection. Historic England further state that, **"…***the current plan for the Spine Road is in breach of NPPF paragraphs 192, 193, 194 and 196"***.** These require that great weight should be given to the assets' conservation. This is irrespective of whether any potential harm amounts to substantial harm, total loss or less than substantial harm to its significance. Further, any harm to, or loss of, the significance of a designated heritage asset (from its alteration or destruction, or from development within its setting), should require clear and convincing justification. Where a development proposal will lead to less than substantial harm to the significance of a designated heritage asset, this harm should be weighed against the public benefits of the proposal including, where appropriate, securing its optimum viable use.

There is no adequate justification to impact on the setting of St Leonards church, especially as there is an alternative routing for the spine road that Historic England would accept. Further, the public would not receive any greater benefit from the routing of the spine road as per the plan. Indeed, it can be argued that the alternative, Option 1, gives residents of the new development greater benefit.

Please note

- ***Failure to adhere to statutory instruments is a valid reason for rejecting a planning application***

In a response to these concerns, the applicant has said that to adopt spine road Option 1 would potentially impact on a greater amount of non-designated archaeological resources, and therefore Option 4 has been chosen, despite the fact that Option 1 performs best in terms of air quality and noise. It must be made clear that Historic England have picked up on this response and have clearly stated that these areas are of **less** importance, and that the focus must be on the protection of the environment around St Leonards church, effectively dismissing the reasoning used by the applicant.

Historic England are experts. At every stage of their evidence they continually refer to the need to re-locate the spine road adjacent to the M1, following spine road Option 1 routing. They clearly state that this is the best option as far as the protection of heritage assets is concerned. They are completely aligned with all other expert opinion regarding spine road routing. Yet their expertise is being ignored in this application.

Harborough District Council

HDC commissioned a report which looked at the routing of the Spine Road, carried out by **the Landscape Partnership**. This report rejects the applicant's chosen option and favoured Option 1, stating that it

1. was more closely aligned with the M1
2. would have benefits of reducing severance of the new community by combining the two main north south transport corridors together in one zone (a requirement of the Planning Inspector)
3. would reduce the need for multiple access points along the route and aid the flow of traffic from the A4304 and the A426
4. would enable improved air quality and lower road speeds within the main residential development (a requirement of the Local Plan)
5. would ensure that the closest housing was set further from the M1 (recognising the concerns of the HDC Environment Team Leader in terms of noise impact on residents)
6. would satisfy the requirements of Historic England, to reduce the effects on the setting of Misterton church.
7. could form a more efficient relief road for Lutterworth, a requirement of Local Plan Policy L1, Explanation 15.2.9

This report will not have been cheap but is yet again a clear statement from experts that is being ignored.

Lutterworth Town Council
LTC commissioned a report (the Wood Report) to review the findings of the Landscape Partnership. While agreeing with those findings, it pointed out that claims by the applicant of a traffic reduction in Lutterworth "once the spine road was complete" completely ignore the fact that the development itself **is not complete** at this stage, and therefore the full traffic flow volumes are not being seen. There is therefore serious doubt regarding the claims of future traffic reduction, and the benefit that this will bring to Lutterworth, as the plans do not include any direction or incentivisation for traffic to use the spine road in place of Lutterworth High Street.

Leicestershire County Council Planning Ecologist
In Planning Committee Report paragraph 4.3.7 it is stated that they are unhappy with the Spine Road design, impacting great crested newts in the north, and otter, crayfish and water vole in the south, and states that the findings of the invertebrate study have not been fed in to the spine road design.

Please note

- ***Failure to comply with nature conservation is a valid reason for rejecting a planning application***

Harborough District Council Environmental Health Officer (Noise)
In Planning Committee Report paragraphs 4.4.11 to 4.4.13, it is stated that *"…it remains our opinion that little consideration has gone into the reconfiguration of the site, taking into account the high levels of noise emanating from the M1 motorway. We believe that by replacing previous plots along the M1 corridor identified as commercial / industrial with residential, the development does not comply with "good acoustic design", as quoted in ProPG."* Further, that *"…we still hold concerns and reservations that the development could result in residents occupying premises close to the M1 may be afforded a poor standard of living accommodation, reliant on windows being closed throughout the day and evening as well as being unable to use external gardens without being subject to potential disturbance."*

Paragraph 6.5.30 clearly states that the background noise levels in the school that is located next to the proposed spine road will reach 64 decibels and will preclude the use of open windows.

Paragraph 6.40 of the Planning Committee Report states very clearly that out of the four available options, spine road Option 1 performs best in terms of noise and air quality. We must remember that the primary purpose of the Lutterworth East development is to provide 2,750 houses in which people will live. To then select a spine road option that is sub optimal in terms of noise and air quality, in a place where some 8,000 residents will call home, and where school children will not be able to have classroom windows opened can only be considered to be negligent at best. This is a FULL planning application for the spine road, yet experts and common sense are directing that the wrong routing option has been chosen. Please listen to the experts and refuse this application.

Urban Design Group
The Urban Design Group, a London based charity that promotes high standards of performance in urban planning and design are particularly critical.

In paragraphs 4.6.1 to 4.65, they tell us that the chosen spine road option will create a divided community, and that the proposal does not meet the requirements of the NPPF. Further, that

the 40mph speed limits at the northern and southern reaches of the spine road will be a considerable hazard to children. They point out that a bypass road was available as an option and would have resolved many of the issues. They have intimated that the Road Safety Audit applied to the spine road is not appropriate for the type of road that is being built but is applicable to trunk road and motorway improvement schemes. Further, it makes no mention of the presence of a school on the route or the potential for children to cross at non designated crossing points, and the crossings that are provided have been assessed against the wrong set of criteria. There appears to be concern within their representation that appropriate standards have not been achieved.

Summary

Six sets of experts have offered consistent opinion and advice indicating that the selected spine road option is the wrong one, and either directly stating that Option 1 is the best option or highlighting issues that Option 1 would solve. Despite this, the applicant continues to ignore this and refuses to amend the plan accordingly. This is a Full application for the spine road – expert advice MUST be listened to, respected, and adhered to, especially where that advice is all pointing in the same direction. It is only the applicant that insists on routing the spine road along the lines of Option 4 – everyone else, without exception, insists that Option 1 is the best routing for all reasons.

3. <u>Lutterworth Town Air Quality Management Area</u>

In 2001 it was established that the annual mean air quality objective for nitrogen dioxide in Lutterworth town centre was not being achieved and it was declared an Air Quality Management Area. The objective was to reduce nitrogen oxide levels to 40 µgm-3 NO2 when expressed as an annual mean, to be achieved by 31st December 2005. After a Detailed Assessment it was concluded that as there was no other significant source of nitrogen dioxide in the area, road traffic was the major cause.

In 2013 it was determined that the previous action plan included many community-based interventions which resulted in a negligible impact on air quality, and significant improvement to relied primarily on a major road building scheme which was determined as not feasible.

The assessment also included a study which found that:

- Annual average daily traffic was approximately 15,000 vehicle movements
- HGVs make up approximately 6% of the annual average daily traffic and contribute 40 to 45% of nitrogen dioxide
- Cars make up approximately 85% of annual average daily traffic and contribute 45 to 50% of nitrogen dioxide
- There is a correlation between the total number of hourly vehicle movements and hourly average nitrogen dioxide concentration

In 2013, an Air Quality Management Area Action Plan was put in place. In Table 5 on page 27 it identifies options to improve Air Quality in Lutterworth. The third option was stated as:

- Construction of a new eastern route in Lutterworth, as considered in the Lutterworth traffic study

The positive impacts were

- Would remove HGV traffic from the town centre – this would remove 6% of the traffic but 45% of the nitrogen dioxide.
- Air quality within Lutterworth town centre would improve significantly

- That it was the best of the options in terms of supporting the economic growth of Lutterworth (improved access to junction 20)

The negative impacts were

- Has a high scheme cost
- Would be difficult to implement due to modifications required to the motorway junction

In 2020, seven years later, we are in a position whereby £83m is being proposed to be spent on a spine road for the new development, a spine road which the Local Plan states must alleviate pressure upon Lutterworth High Street and the Air Quality Management Area, a spine road that could be routed to avoid impacting the new residential development, and a spine road that could easily be built as the "eastern route in Lutterworth" from the 2013 Air Quality Management Area Acton Plan. The provision of this money removes the negative impact of "high scheme cost", and as the motorway junction works are also taking place as part of the Lutterworth East development this negative impact is also removed.

In Planning Committee Report paragraph 4.4.1, Harborough District Council's Contaminated Land and Air Quality Officer stated:

"*In order to provide an air quality benefit to Lutterworth, the A426 should be declassified between the junction with the A4303 (Whittle roundabout and the point where the spine road joins the A426. The spine road should then be classified as the A426, a weight restriction should then be placed on a portion of the current A426 (Rugby Road, High Street and Market Street) between the junction with the A4303 (Whittle roundabout) and the junction with George Street. This would remove traffic from the currently congested centre of Lutterworth and provide an eastern relief road. This would result in the AQMA being undeclared.*"

Local Plan Policy CC1 (Climate Change) requires major developments to demonstrate how carbon emissions can be minimised, and also commits HDC to reduce the carbon footprint. Given that Lutterworth features a hill over which all traffic must pass, the diversion of traffic to a new road with greater flow and less incline will inevitably reduce the carbon footprint of the area.

Ian Bartlett, HDC Environment Team Leader states in his submission to the planning application that he continues to be concerned about the development, and says that *"…we would object to the application on the grounds that policy IN2 of the Local plan has not been met, and that the development fails to comply with paragraph 170e of the NPPF 2019 i.e.*

> *"Development should, wherever possible, help to improve local environmental conditions such as air and water quality…"*

Please note

- ***Failure to adhere to statutory instruments is a valid reason for rejecting a planning application***

Paragraph 6.94 of the Planning Committee Report clearly states that spine road Option 1 performs best in terms of air quality and noise. Combined with the above comments from experts in the field, it is unfathomable that a County Council is choosing a spine road option that does not give the greatest health benefits to the local residents, especially when the reasons for making this choice (protection of heritage assets) are completely contested by the relevant experts, in this case Historic England.

Summary
So, we have the "best of options" as identified in the 2013 AQMA Action Plan; we have the funding for an eastern road in Lutterworth; we have the funding for the motorway junction works; we have a very clear statement from the HDC Contaminated Land and Air Quality Officer; we have the ability to deliver HDC Policy L1 Section 6; we have the ability to deliver on Policy CC1; we have the ability to solve the AQMA once and for all; we have the ability to avoid breaches of the Local Plan and the NPPF; and we have the **refusal** of Leicestershire County Council to listen.

4. <u>Construction Traffic Management Plan</u>
Paragraph 6.3.73 of the Planning Committee Report refers to the Construction Traffic Management Plan. This reference is in relation to the outline application, which in essence is not a problem at this stage

With a **full** planning application, we would expect all elements associated with it to be included, yet this is not the case. The plan does not include a definitive Construction Traffic Management Plan for the creation of the Spine Road (a 10-year project), indeed the application excludes the Spine Road from the requirements of many of the clauses and proposed planning conditions which serve to protect the locality during the construction period. Passing this application as it stands will mean that planning officers will have no control over what the developer does while constructing the spine road, and the impact on the locality will go unchallenged.

Paragraph 6.7.9 tells us that in the initial year of spine road construction (2021), Lutterworth will experience an additional 151 heavy goods vehicle movements per day as a result of the development. Yet there is no plan to manage this traffic, to direct it, to route it or control it.

Lutterworth Town Council made representations to the planning process, and these are listed in paragraphs 4.5.27 to 4.5.34 of the Planning Committee Report. These representations dealt in detail with requirements of a Construction Traffic Management Plan along with a wider Traffic Management Plan. None of these comments, as far as can be determined, have been addressed.

Summary
This is a Full planning application for the spine road. There is no Construction Traffic Management Plan, there is no Traffic Management Plan, there are no indicated planning conditions that determine how the work will be carried out, how it will be monitored, or a process for dealing with breaches or complaints. To grant full planning permission for the spine road in these circumstances would be reckless, especially as, again, all expert evidence indicates that the wrong option has been chosen.

OUTLINE APPLICATION
There are numerous points that can be raised regarding the outline application.

LTC are very concerned about yet more warehousing being inflicted upon Lutterworth, especially as the Local Plan itself states that there is no commercial justification for the additional warehouses, and that they are included in order to generate revenue to pay for the motorway junction improvements. Those improvements are not necessary for the provision of the Lutterworth East SDA unless the development significantly increases the traffic in the area, a fact that nobody will openly admit to. However, the requirement for these

improvements to be made has been placed on the development by Leicestershire County Council themselves, the very people that are developing the warehouses.

Concern is also evident regarding the provision of medical services. The Local Plan indicated a new doctor's surgery within the SDA itself, however it now appears that the circa 8,000 new residents will have to rely on expanded services in Lutterworth, and Lutterworth will have to cope with the additional traffic and demand.

Finally, Lutterworth Town Council is to say the least disappointed in the Section 106 agreement that has been negotiated by Harborough District Council. Nearly £17m has been directed towards the redevelopment of the Whittle junction – a junction that had a recent capacity increase at a cost of £1m, and that isn't going to reach capacity until after 2036 according to the Planning Committee Document. Further, there is provision of over £900,000 for a local rugby club and over £500,000 for local cricket clubs. However, the Lutterworth Town Centre masterplan which is intended to re-vitalise the town and help allow it to accommodate the increase in residents receives less that £179,000. To be clear, the expected cost of the Town Centre Masterplan is around £4m – there are seven elements within the masterplan, and the £179k would cover about 50% of the cheapest single element.

Conclusion

a. There are serious questions about the compliance of this application to the Local Plan. In many cases these issues can be resolved by the adoption of spine road Option 1 rather than the presented Option 4. If this happened, the development would be more acceptable to the locality, would bring greater benefit to the locality in terms of air quality, noise reduction and improvements in Lutterworth town centre, and would do so without impacting the new development.
b. The opinions of experts have largely been ignored, especially in relation to the impacts of the proposed spine road routing. We cannot have a situation whereby such a large development is carried through without taking heed and following the advice of experts. The result will be a sub optimal development that leaves the locality with significant, unresolvable problems in the future.
c. Air Quality is a significant issue in the area. There is an opportunity for a holistic approach to be taken that resolves an AQMA that has been in existence for 20 years, benefits thousands of current and future residents, and does not place the burden on the new development. Instead, the applicant is heading towards the creation of a **second** AQMA.
d. The chosen spine road option is not the best option for air quality and noise – this is accepted by the officers and clearly stated in the report. There is an opportunity to improve the lives of thousands of people by choosing the right spine road option, yet LCC are refusing to benefit residents.
e. The full application for the spine road is at best woefully incomplete in terms of detail, management plans and control processes. Other than a cursory map indicating its proposed routing, there is little that a planning committee could point to that could be called a detailed plan. An application to build a house would require more detail regarding construction and conditions than has been provided for the spine road. The proposal is for a scheme lasting over 10 years, and yet there is not one commitment regarding construction traffic management, public traffic management, hours of work, work processes, or anything that could (and might need to) be enforced.

We ask that the committee do the right thing for the locality and stop this application based on the spine road routing alone. Re-submission using Option 1 would remove all major objections and would enable compliance with Law and Local Plan.

Further, we ask that Members require a detailed Construction Traffic Management Plan to be submitted prior to any further application for construction of the spine road, and that Lutterworth Town Council are party to that agreement process. Finally, that there is an agreed process for raising issues with the applicant once any construction has commenced, in order that local resident issues that may materialise can be represented in a formal manner.

Leicestershire County Council, along with Harborough District Council, have an opportunity to use the money that will be spent on the development to substantially increase the benefit that it delivers by re-routing the spine road and relieving Lutterworth town centre of heavy traffic WITHOUT moving that traffic in to the centre of the new development. In doing so, they would be able to produce their desired development; they would be able to remove an AQMA in Lutterworth; they will reduce noise levels; they will improve the public realm within the centre of Lutterworth (a Local Plan requirement); they will improve the pedestrian crossing experience over High Street; and they will enable the progression of the Lutterworth Town Centre masterplan. Lutterworth is part of Leicestershire – all we are asking is that the District Council and County Council do what is best for their residents in the wider context.

The opportunity to do the right thing for all residents exists now – if it is ignored, the opportunity is lost forever.

Planning Committee Speakers List – 28th July 2020

Speakers please note that the Council's constitution requires evening meetings to end after three hours, unless the Committee votes to continue the meeting. If a meeting does adjourn, remaining business will be considered at a time and date fixed by the Chairman or at the next ordinary meeting of the Committee and the existing speakers list will be carried forward.

Application	Parish	Speaker	Type
19/00250/OUT	Lutterworth / Misterton	Andrew Furlong	O
		Sarah Premar	O
		David Gair	O
		Richard Nunn	T/PC
		Alberto Costa MP	S
		Gary Stephens	AG
		Clive Posford	A
		Councillor Mrs Page	STC
		Councillor King	STC
		Councillor Beadle	WM
		Cllr Sarfas	WM

Key to Speaker Type: O = Objector, S = Supporter, PC = Parish Council, A = Applicant/to speak on behalf of applicant, AG = Agent, STC = subject to confirmation (requiring the consent of the Chairman and a majority of the Committee), WM = Ward Member

PLANNING COMMITTEE MEMBERSHIP 2019/20

Councillors Mrs Ackerley, Dr Bremner, Mrs Burrell, Champion (Chairman), Frenchman, Galton, James, Liquorish and Modha (Vice-Chairman).

Please note – any Councillor unable to attend a meeting can be substituted with prior notice being given. Any substitutions will be announced at the start of each meeting.