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Dear Mr Kemp

Buckinghamshire Healthcare NHS Trust - Statement of Position

Further to our detailed submission, we wanted to make sure the following points are considered and covered in the examination:

General matters

b. Is the draft charging schedule supported by appropriate available evidence on infrastructure planning and economic viability and is there sufficient and suitable evidence of an aggregate funding gap to demonstrate the need for a CIL charge?

Residential developments place significant pressure on all forms of existing healthcare provision and the need for improved and expanded facilities. This means that planning obligations requiring developments deliver new healthcare facilities are often necessary, or CIL funding is leveraged for the same purpose. Development plan documents and CIL charging schedules must recognise this and set appropriate expectations for either the delivery of new facilities or the need to secure CIL funding. This will ensure that health is appropriately recognised, while helping to facilitate conversations between local planning authorities and the NHS when securing necessary funds to support planned growth.

Buckinghamshire Healthcare NHS Trust (BHT) provide secondary Acute and Community health care services for both inpatients and outpatients across the County of Buckinghamshire. Within the acute sectors, significant pressures on services arising from new housing developments are being seen. These developments have introduced both an increase in patient numbers, but also a varied demographic of younger families which place a different level of need on services, such as paediatrics and injuries associated with play, which places pressure on A&E services.

The draft charging schedule currently lacks any acknowledgement of the need to expand or improve acute healthcare infrastructure to support anticipated growth, and the Infrastructure Delivery Plan (IDP) simply states that funding opportunities for acute provision are also available at a higher regional / national level. No requirements for acute facilities have therefore been included within the IDP.

It must be recognised that while BHT receive central government funding, this is not keeping pace with the demand being placed on services and is insufficient for the capital works planned by the Trust, in conjunction with the wider Buckinghamshire Clinical Commissioning Group (BCCG) strategy to transform service delivery. Other sources of funding include the LEP and charitable donations, however they too are inadequate to meet rising costs associated with population growth.

The CCG commissions planned and emergency healthcare from the Trust via the NHS National Standard Contract, including activity volumes and values on an annual basis. Contract volumes are negotiated, based on historical contract performance. Each year's CCG allocation reflects last year's allocation as stated, with an uplift which is centrally determined for growth:

- a) Growth reflects the increasing costs of delivering health care, including inflation, growth in demand for certain medical technologies;
- b) Local population growth feeds nationally into CCGs' target allocations. This is derived from ONS data. However this process takes 3 years to affect growth allocations to the CCG;
- c) Until this population growth is added to CCG allocations, it does not form part of the contracts between commissioners and the Trust;
- d) The Trust does not receive funding retrospectively

The range of care provided by BHT and the way that it operates with the CCG was highlighted in previous representations, to ensure that CIL or S106 contributions are not sought solely for the purposes of primary care by the CCG, but that the secondary and community care provided by BHT is also fully understood and acknowledged by the Councils.

Despite this, the authorities have chosen to progress a CIL charging schedule which currently excludes the opportunity to fund new BHT capital projects, while also applying a CIL charge to any new floorspace delivered by the Trust. Currently, no evidence has been put forward as to how this approach is reasonable or deliverable and there remain significant concerns around the additional financial pressure this will place on the Trust to deliver health services for the community. Without consideration of services provided by BHT, the funding gap will fail to demonstrate the overall health need.

Residential Levy Rates

Is the threshold of 400 dwellings/10 ha for a zero rate appropriate? Should the areas to which this applies be clarified and, if so, how? Are school sites within such areas exempted?

It is understood that the viability assessment accommodates that large sites (400 homes or more, 10 hectares or more or 4,000 square metres or more) should be exempt from CIL and should continue to rely on S106 planning obligations; this is due to the scale of site-specific development mitigation and infrastructure requirements on large sites, such as new schools and roads.

As the local authorities have taken the unusual approach of applying a blanket CIL charge to a range of uses (including community facilities and hospitals), it is unclear whether this exemption would apply across all CIL chargeable development. Logically, it would make sense that the exemption should apply, given the local authorities own admission that large sites require infrastructure provision such as health centres, hospitals and schools, which will be funded in part by planning obligations or CIL.

Notwithstanding the above, it remains unclear why this is even a matter for discussion, based on the lack of evidence provided to justify a CIL charge on state funded infrastructure needed to support planned growth.

It is therefore recommended that a zero rate CIL charge should apply to all forms of NHS healthcare and state funded education development across the district areas, regardless of the development size. Furthermore, if a facility is being delivered in kind by a developer, a zero CIL rate for new healthcare development will improve the viability of the scheme overall allowing for greater levels of affordable housing to be delivered and/or other public benefits.

Other uses

a. Are the rates for other uses such as non-residential institutions (D1), assembly and leisure uses (D2) appropriate and justified by the viability evidence?

The June 2019 Viability Assessment recommendation is for the Council to consider certainly not more than (as a maximum) a similar to proposed nominal (£35/sq. m) or a nil a (£0/sq. m). The Councils have chosen to adopt a £35/sq. m charge and this will apply to all D1 community uses.

This is of significant concern as unusually for an acute provider, BHT also provide comprehensive community services to the county of Buckinghamshire, including the Chiltern and South Bucks Districts. The primary community care commissioned by Buckinghamshire CCG is included in the infrastructure delivery plan (IDP) and may result in contributions from CIL and yet the community care services provided by the Buckinghamshire Healthcare Trust is not covered in the IDP.

As a main provider of community services, BHT would have hoped to be involved in the preparation of the IDP alongside the CCG. The community services that BHT provide through adult and paediatric community healthcare teams include both community hospital inpatient and outpatient services at Amersham Community Hospital (Waterside Unit for inpatients) and Chalfont & Gerrards Cross Community Hospital.

The range of community service we be required to provide include but are not limited to:

- Continence
- Diabetic specialist nursing
- Education
- Dietetics
- Falls service
- Integrated home care services
- Musculoskeletal assessment and treatment
- Musculoskeletal assessment and treatment
- Pain management
- Palliative and end of life care and services
- Podiatry
- Mental health support
- Public health nursing
- Specialist nursing
- Wheelchair service

The NHS estate has a key role in delivering efficiency and supporting the transformation of services, it's also one of the costliest NHS overheads. For the period 1st April 2018 to 31st March 2019, NHS organisations reported **the total costs of running the NHS estate were £9.5 billion**. A charge of £35 per sqm on new community floorspace provided by the NHS will simply add to this burden and the Trusts ability to operate effectively as a community care provider, occupying D1 buildings. A CIL charge will ultimately work against and

undermine the Council's ability to deliver the housing needed and overarching policies within the plan, as the necessary infrastructure becomes stalled and unviable.

Whilst we understand that CIL is typically used to increase the capacity of existing infrastructure, other infrastructure costs include the provision of IT to support teams or specialist equipment and consumables. Investment here is critical and directly related to ensuring facilities are able to cope with expanding and changing patient needs.

b. Should a rate of £35/sq m be applied to all other development types, including schools and hospitals?

The district authorities have chosen to apply a rate of £35 per square metre to uses which will include D1 health facilities and C2 uses, in which hospitals fall. Hospital developments have not been considered as part of the viability assessment. It is therefore unclear why the Councils have taken this approach based on the viability evidence put forward. However, the conclusion seems to be that all development places stress on infrastructure, although no detail on what type of infrastructure hospitals place stress on have been provided or how £35 per square metre is a nominal and affordable charge.

A 'nominal' charge of £35 per square metre is not considered nominal and would ultimately exacerbate existing deficiencies. In fact, based on the capital project pipeline, significant additional net floorspace is anticipated over the next few years as detailed below:

We plan to expand Amersham hospital to meet these future needs of the population to provide a centre of excellence for outpatients with access to modern diagnostics and flexible, multi-purpose modern facilities. In the future we will provide fully integrated services (physical health, mental health and voluntary services).

Based on the above projects in Amersham, additional monies would be needed to pay proposed CIL charges. Such an approach will simply delay or halt new hospital development entirely, and the viability and deliverability of the Plan put at risk.

Conclusion

The healthcare infrastructure that currently exists to serve the local authorities areas requires extensive investment to both maintain current service levels and to cope with increased development coming through in the future. The funding streams we have are not sufficient to meet all the investment and works required.

Yours sincerely



Tim Seymour
Head of Planning & Business Development
On behalf of the Buckinghamshire Healthcare NHS Trust