

P26-0444

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Dear Lucy

Response to the request for financial contributions towards secondary healthcare infrastructure in respect of Land south of Coate Road, Devizes (PL/2026/01963)

I have been asked to consider and respond to the request of Royal United Hospitals Bath NHS Foundation Trust (the Trust) for financial contributions towards secondary healthcare infrastructure in support of the planning application at Land south of Coate Road.

A funding gap

In accordance with s.223C of the Health and Care Act 2022, NHS England must ensure sufficient funding is received to exercise their functions provided by Hospital Trusts. As such, funding is available to address the impacts on healthcare provision arising from developments such as that proposed without any developer contributions.

The request of the Trust nevertheless seeks funding, which is already secured through another route, and so is not necessary to make the development acceptable in planning terms. Such contributions would be unlawful in the absence of a demonstrable funding gap, as set out in paragraphs 135 and 136 of the High Court Judgment of *R (on the application of the University Hospitals of Leicester NHS Trust & Harborough District Council [2023] EWHC 263 (Admin)*.

Indeed, since the time of this Judgment, such requests from Trusts have been rejected including by the s78 Inspector in paragraph 131 of the appeal decision at Land at Warwickshire Police Headquarters, Leek Wootton (ref: 3319752).

The starting point therefore is that as set out in case law and by s78 appeal decisions, no contribution can be lawfully secured towards secondary healthcare in the absence of a demonstrable funding gap. However, in the event that such a contribution was deemed to be lawful, I proceed to consider the extent of that contribution below.

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Errors within the request of the Trust

The contribution sought is calculated and explained in Appendix 4. However, this has been miscalculated. For example, in respect of A&E attendances, Appendix 4 identifies that:

- There were 42 attendances arising from a population of 1,362 people in a year, which represents an activity rate of 3.1%.
- This would mean that there would be 8.7 attendances per annum ($=281 \times 3.1\%$) arising from the net increase of 281 people assumed by the Trust.
- However, the table in Appendix 4 incorrectly identifies that there would be 17 attendances per annum, and the contribution has been calculated on this basis.

Indeed, all of the contributions sought have similarly been miscalculated. Once corrected, the methodology of the Trust would give rise to a need for **£41,994.01** rather than **£92,783** as set out in the following table.

Activity Type	Trust Level Activity		This LSOA		Activity Costs		Proposed Development			
	Activity (A)	Activity rate (B=A/500,000)	Activity (C)	Activity rate (D=C/1,163)	Total delivery cost Trust-wide (E)	Delivery cost per activity (F=E/A)	12 months activity for proposed population (G=Cx281)	Delivery cost for planned dwellings (H=FxG)	Premium costs of delivery (I=Hx0.2)	Cost pressure (J=I+H)
A&E Attendances	48,128	9.6%	42	3.1%	£14,780,084	£307.10	8.7	£2,668.18	£533.64	£3,201.82
Non Elective Admissions	27,732	5.5%	43	3.2%	£78,937,480	£2,846.44	8.9	£25,319.63	£5,063.93	£30,383.55
Outpatients Appointments (follow up only)	75,380	15.1%	81	5.9%	£35,339,760	£468.82	16.8	£7,855.60	£1,571.12	£9,426.72
Diagnostic Imaging (inpatient only)	23,788	4.8%	51	3.7%	£7,390,662	£310.69	10.6	£3,277.80	£655.56	£3,933.36
Total	175,028		154		£136,447,986		44.9	£34,995.01	£6,999	£41,994.01

The population resident in the development

Appendix 4 of the request of the Trust identifies that each dwelling is assumed to accommodate 2.3 persons which was based on the average household size of the 2011 Census according to paragraph 54. On this basis, a development of 175 dwellings would accommodate 403 people.

However, the more recent results of the 2021 Census are now available, and these demonstrate that in accordance with national trends, the average number of people per dwelling has reduced. Indeed, these identify that there were 498,138 household residents in 226,105 dwellings across Wiltshire, with an average of 2.2 residents in each dwelling. Therefore, on the basis of the most

recent evidence, a development of 175 dwellings would accommodate 386 rather than 403 residents.

The newly arising population

Appendix 4 of the request identifies that only 55.8% of residents will be new to the area based on the specialist planning advice of the Trust. Accordingly, 225 of the 403 residents (55.8%) assumed by the Trust based on out-dated information or 215 of the 386 residents (or 55.8%) that arises from the latest evidence will be new to the area and place an additional demand on secondary healthcare.

However, rather than assuming that 55.8% of the residents will be new to the area, the Trust instead assume that none of the residents within affordable homes will be new to the area which is appropriate given that the affordable homes will be allocated to people within the area, but then unrealistically assume that all of the residents within market housing will be new to the Trust's area. This is misconceived as inevitably a proportion of the homes will be occupied by households including first time buyers and households arising from household breakdowns within the local area. The consequence of this is that the contribution sought by the Trust is not fairly and reasonably related in scale even if such a contribution was necessary.

Once the resident population is calculated based on the most recent information contained in the 2021 Census and the proportion of residents that are new to the local population is calculated in accordance with the specialist planning advice of the Trust rather than the unrealistic assumptions of the Trust, as set out in the following table, a contribution of **£32,065.29** would be justified if there was a demonstrable funding gap, rather than the £92,783 sought by the Trust. Otherwise, as set out in the *Harborough Judgement*, no contribution could be justified.

Activity Type	Trust Level Activity		This LSOA		Activity Costs		Proposed Development			
	Activity (A)	Activity rate (B=A/500,000)	Activity (C)	Activity rate (D=C/1,163)	Total delivery cost Trust-wide (E)	Delivery cost per activity (F=E/A)	12 months activity for proposed population (G=Cx215)	Delivery cost for planned dwellings (H=FxG)	Premium costs of delivery (I=Hx0.2)	Cost pressure (J=I+H)
A&E Attendances	48,128	9.6%	42	3.1%	£14,780,084	£307.10	6.6	£2,037.34	£407.47	£2,444.81
Non Elective Admissions	27,732	5.5%	43	3.2%	£78,937,480	£2,846.44	6.8	£19,333.26	£3,866.65	£23,199.92
Outpatients Appointments (follow up only)	75,380	15.1%	81	5.9%	£35,339,760	£468.82	12.8	£5,998.29	£1,199.66	£7,197.94
Diagnostic Imaging (inpatient only)	23,788	4.8%	51	3.7%	£7,390,662	£310.69	8.1	£2,502.82	£500.56	£3,003.39
Total	175,028		154		£136,447,986		34.3	£26,721.08	£5,344.22	£32,065.29

Summary

In light of the preceding analysis, I would welcome:

- Confirmation that the Trust agree with the *Harborough Judgment* and the findings of the *s78 appeal decision at Leek Wootton* that no contributions can lawfully be secured towards secondary healthcare in the absence of a demonstrable funding gap, or if not an explanation as to why this is the case.
- On the assumption that the Trust agree with the relevant case law, any evidence that the Trust is able to provide to demonstrate that there is a funding gap which cannot be addressed by other funding streams notwithstanding the statutory duty for the NHS to provide such funding.
- Confirmation that in the event that there is a demonstrable funding gap, the request of the Trust has been miscalculated and should be corrected to £41,994.01, or if not an explanation as to why this is the case.
- Confirmation from the Trust that it should be assumed that there are 2.2 people per dwelling in accordance with the findings of the most recent Census and that 55.8% of residents will be new to the population, such that in the event that there is a demonstrable funding gap the contribution should be £32,065.29, or if not an explanation as to why this is the case.

As set out above, on the basis of the available information, **no contribution** towards secondary healthcare infrastructure can lawfully be secured. However, in the event that there was a demonstrable funding gap notwithstanding the fact that NHS England provides funding for secondary healthcare, the proposed development would give rise to 215 net additional patients. Using the calculations of the Trust, this would justify a contribution of **£32,065.29**.

I trust that the Trust is able to readily respond to each of the preceding points, such that both parties will be able to reach agreement on the need for and extent of contributions necessary to make the development acceptable in planning terms.

Yours sincerely

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