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Case No: CO/2298/2022

IN THE HIGH COURT OF JUSTICE
KING'S BENCH DIVISION
PLANNING COURT

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 13/02/2023

Before :

THE HON. MR JUSTICE HOLGATE

Between :

**R (on the application of the University Hospitals of
Leicester NHS Trust)**

Claimant

- and -

Harborough District Council

Defendant

**(1) Leicestershire County Council
(2) Hadraj Limited**

**Interested
Parties**

**Paul Cairnes KC and Dr Ashley Bowes (instructed by The Wilkes Partnership Solicitors)
for the Claimant**

**Dan Kolinsky KC and David Lock KC (instructed by Harborough District Council) for the
Defendant**

**Zack Simons and Isabella Buono (instructed by Leicestershire County Council) for the
First Interested Party**

Hearing dates: 7 and 8 December 2022

JUDGMENT APPROVED

This judgment was handed down remotely at 10.00am on 13 February 2023 by circulation to the parties or their representatives by e-mail and by release to the National Archives.

The Hon. Mr Justice Holgate:

Introduction

1. The claimant, the University Hospitals of Leicester NHS Trust (“the Trust”), challenges the grant of planning permission by the defendant, Harborough District Council (“HDC”), by a decision notice dated 17 May 2022 to the first interested party, Leicestershire County Council (“LCC”), in relation to land east of Lutterworth, Gilmorton Road, Lutterworth, Leicestershire (“the site”). LCC is the principal landowner of the site. The second interested party, Hadraj Limited, owns part of the site but did not take part in these proceedings.
2. The decision notice grants *inter alia*:-
 - (i) outline planning permission for up to 2,750 dwellings, business, general industrial, storage and distribution uses, two primary schools, a neighbourhood centre, public open space, green space and associated infrastructure; and
 - (ii) detailed planning permission for a spine road and associated junctions with the A426 and the A4304 east of junction 20 of the M1.
3. The site comprises 225 ha of predominantly agricultural land and lies predominantly to the east of the M1. The town of Lutterworth lies to the west of the motorway. A proportion of the residential development, 40%, would be provided as affordable housing. There would be 10 ha of B1/B2 general employment land, 13 ha for B8 storage and distribution uses and 111 ha for green infrastructure. Condition 3 of the permission restricted the development to the principles and parameters shown in a number of specified documents. Condition 5 required a phasing programme to be approved and then the development to be carried out in accordance with that programme.
4. HDC adopted the Harborough Local Plan 2011-2031 on 30 April 2019. The spatial strategy in Policy SS1 requires 12,800 dwellings to be provided during the plan period. Much of that figure comprises development already completed, or committed by the grant of planning permissions. The site is allocated as a strategic development area (“SDA”). It is the largest allocation in the Local Plan and represents about a third of the housing allocated in the district (see Policy H1). The site is to provide 1,260 new homes during the plan period to 2031.
5. HDC’s housing trajectory assumed in 2019 that housing completions on the site would begin in 2023/4 and continue through to 2030/31. It was also assumed that about 1,490 homes would be completed between 2031 and 2036, after the end of the local plan period. So it was projected that 25 dwellings would be completed in 2023/4, rising to about 200 dwellings a year during the period 2027/8 to 2030/31. It is estimated that the 23 ha of employment land will generate about 2,500 new jobs.
6. Policy L1 of the Local Plan allocated the Lutterworth SDA as a “new neighbourhood”, a sustainable urban extension to Lutterworth with facilities for living, working and recreation. Thus, in addition to the employment land, Policy L1 requires the provision of community facilities, including two 2-form entry primary schools in parallel with the progress of the housing development, appropriate contributions to secondary

education if necessary and a neighbourhood centre. That centre is to include shops to meet local needs, a public house or café, a doctor's surgery and a community hall. In other words, the educational and medical facilities to be provided on site are those which would be expected for a sustainable community on this scale.

7. The Trust does not object to the development as a matter of principle. The central issue in this case is whether HDC erred in law by not requiring the payment of a contribution under s.106 of the Town and Country Planning Act 1990 ("TCPA 1990") of about £914,000 towards the delivery of health care by the Trust to mitigate what are said to be the harmful effects of additional demands upon its services from that proportion of the people moving to the site who would be new to the Trust's area (referred to as "new residents"). The Trust estimates that the 2,750 houses on the site would accommodate 7,520 people, of whom 38.5%, or 2,896 people, would be new residents in the Trust's area.
8. Under the legislation governing the National Health Service ("NHS"), the Trust is responsible for providing acute services to NHS commissioning bodies, who at the relevant time were the Clinical Commissioning Groups ("CCGs"). According to the Trust's representations to HDC, the relevant CCGs were the Leicester CCG, the Leicestershire CCG and the Rutland CCG. Mr. Cairnes KC, who together with Dr. Bowes appeared on behalf of the claimant, told the court that the geographical area covered by these three CCGs is co-extensive with that of the Trust. There are about 1 million residents in that area (para. 2 of claimant's skeleton).
9. From the 2020/21 financial year the CCGs pay for services provided by the Trust under a block contract. Those payments represent the Trust's main source of income to pay for its acute care services. Under a block contract a trust receives a lump sum in respect of all the services contracted for, in contrast to a "pay by results" arrangement, under which a trust receives a rate for each patient actually treated for the condition treated. As Haddon-Cave LJ explained in *R (Shepherd) v NHS Calderdale Clinical Commissioning Group and Monitor* [2019] PTSR 790 at [44], a block contract provides for payment by way of a fixed sum regardless of the number and type of activities undertaken by the provider of services.
10. Each of the Trust's block contracts lasts for one year and are re-negotiated at the end of that year. The funding paid by a CCG "is based upon locally agreed planned activity which is informed by the previous year's activity". If the activity during the year of a block contract is greater than that which was assumed in arriving at the lump sum figures, the Trust is not entitled to any additional payment, whether during that year or retrospectively in the next year (see claimant's skeleton para. 40). Equally if the level of activity during a year turns out to be less than had been assumed for the purposes of the contract, the Trust is not required to repay any money to the CCGs. One advantage of block contracts is that they facilitate financial planning by a trust (see para. 36 of the claimant's skeleton).
11. The Trust's concern relates solely to the first financial year (or more precisely that part of the financial year) in which a "new resident" begins to occupy a dwelling and is treated by the Trust. It says that any treatment it provides for such residents is not accounted for in the funding agreed under the block contract for that year. Net increases in population from new development are not inputs to the funding mechanisms used within the NHS or the negotiations for block contracts.

12. The Trust is operating at what it describes as “full capacity”. But even so, it is not able to turn away new residents living on the site, whether for that reason or because the block contract has not allowed for that additional activity. Instead, those patients will be treated, but there will be a consequential increase in the time taken to provide treatment for patients in general. In addition, there will be delays in being able to allocate patients on arrival to the appropriate type of bed, because the relevant occupancy benchmark is already exceeded. The Trust’s case is that these adverse impacts on the timing of treatment appropriate for achieving good health outcomes and on the health of the community are land use planning considerations relevant to the determination of the planning application for the Lutterworth SDA.
13. The object of the s.106 contribution sought by the Trust is to provide funding for additional staff, drugs, materials and equipment which will mitigate those impacts.
14. Although the Trust has often objected to the use of the term “funding gap”, the Trust itself has used that language in its representations to HDC in order to explain its case on how the development will cause those impacts (see e.g. pp.37 and 39 of Appendix 7 to the Trust’s representations dated 23 July 2020 - answers to questions 1 and 3). As Mr. Cairnes KC rightly accepted, if the Trust could not point to a funding gap for the provision of health services attributable to the occupation of housing on the site, there would be no relevant impacts from the SDA scheme to justify a s.106 contribution. Equally, and as a matter of common sense, the size of that gap would be relevant to determining the amount of any s.106 contribution which may be justified. As a result of this concession many of the Trust’s complaints in this case fall away. Nevertheless, I will address the arguments
15. It is important to note that the Trust’s case relates solely to an alleged funding gap during the first financial year in which a new resident occupies a dwelling on the site. This is because the Trust accepts that when the block contract comes to be re-negotiated for the next financial year, the baseline population used in arriving at a revised lump sum figure takes into account new residents who have arrived at some point in the previous financial year. The Trust also accepts that there is no justification for requiring the developer/landowner of the site to make a contribution to its funding to cover any impact upon its health services arising from those same people after the financial year in which they start to live on the site. It is accepted that that is a cost for which NHS funding should be, and is, provided.
16. The Trust’s requested contribution of about £914,000 has been expressed as a one-off lump sum payable “up front”. However, it recognises that a development on this scale will take many years to build. Accordingly, it would accept that any s.106 contribution should also be phased.
17. To put the Trust’s concern into a practical context, we are talking about additional pressure on acute services from development on the site reaching 210 or so new homes in any one year. Using the Trust’s figures, that would equate to about 575 additional persons on the site, of whom the Trust says 38.5% would be new to its area, or 221 persons. That figure of 221 may be compared to the 1 million persons already living within its catchment (about 0.02%). Mr. Lock KC and Mr. Kolinsky KC, who appeared for HDC, pointed out that the single payment lump sought, £914,000, represents about 0.07% of the most recent figure for the Trust’s turnover, £1.28 billion.

18. HDC says that the Trust failed to satisfy the authority that population growth is not, or could not be, taken into account in the negotiations between the Trust and the CCGs each year. It considered that *inter alia* insufficient information had been provided by the Trust to demonstrate the funding gap which was said to give rise to the harmful consequences relied upon by the Trust, so as to justify the s.106 contribution sought. This was despite the considerable efforts made by HDC to understand the Trust's position, which included obtaining advice from two leading counsel, including one with expertise in the NHS and its funding arrangements.

19. The remainder of this judgment is set out under the following headings:

Heading	Paragraph
A summary of the grounds for judicial review	20-21
Legal principles	22-30
Ground 3 and the speech of Lord Hoffman in the Tesco case	31-42
The statutory framework for funding NHS services	43-74
Chronology	75-120
Ground 1	121-130
Ground 3	131-152
Ground 2	153-165
Ground 4	166-179
Delay	180
Conclusion	181

A summary of the grounds for judicial review.

20. In summary, the claimant raised the following grounds of challenge in its skeleton:

Ground 1: The defendant misconstrued provisions about “health” in national and local policy and therefore ignored, or failed to understand, the impacts upon the claimant’s capacity to provide healthcare services to the community it serves, leading it to disregard the health impacts of the development.

Ground 2: The defendant misunderstood the claimant’s funding system, leading it to disregard the financial impacts of the development.

Ground 3: The defendant proceeded on the fallacious basis that the claimant’s funding system meant that a mitigating contribution did not meet the requirements of the Community Infrastructure Levy Regulations 2010 (“the CIL Regulations 2010”).

Ground 4: The defendant refused to consider any of the claimant’s evidence and representations after 28 July 2020, thereby failing to take into account material considerations and/or failed or refused to take that evidence back before members of the Planning Committee and/or failed to disseminate that environmental information to the public prior to the final determination.

However, during his oral submissions Mr Cairnes KC said that the claimant no longer pursues that last part of ground 4 concerned with “environmental information”.

21. I will address those grounds in the following order: ground 1, then ground 3, ground 2 and ground 4, because the questions of legal principle raised under ground 3 affect ground 2.

Legal Principles

Material planning considerations

22. Section 70(2) of the TCPA 1990 provides *inter alia* that in determining an application for planning permission a local planning authority “shall have regard to the provisions of the development plan, so far as material to the application ... and to any other material considerations”. The effect of s.38(6) of the Planning and Compulsory Purchase Act 2004 is that the authority must determine the application in accordance with the development plan unless material considerations indicate otherwise.
23. A matter is a material, or relevant, consideration if (i) it serves a planning purpose, that is one which relates to the character or use of land and (ii) it fairly and reasonably relates to the development (*R (Wright) v Resilient Energy Severndale Limited* [2019] 1 WLR 6562 at [36]-[44]).
24. There are three categories of consideration: -
- (i) Those expressly or impliedly identified by the legislation as mandatory considerations to which the decision-maker *must* have regard (e.g. relevant provisions of the development plan);
 - (ii) Those considerations which the legislation identifies as irrelevant;
 - (iii) Those considerations which are relevant and which the decision maker *may* take into account in the exercise of his judgment.

25. A failure to take into account a relevant consideration in category (iii) is not unlawful unless the court considers that it was so obviously material “that it was irrational not to take it into account”. A decision-maker is not obliged to work through every relevant consideration in category (iii) in order to decide whether or not to take it into account. If a consideration in category (iii) is taken into account, the weight to be given to it is a matter for the decision-maker, who might decide, for example, to give it no weight. Such a decision on weight can only be challenged if irrational (*R (Friends of the Earth Limited) v Secretary of State for Transport* [2021] PTSR 190 at [116] to [121]).

Planning obligations

26. Section 106(1) of the TCPA 1990 provides: -

“Any person interested in land in the area of a local planning authority may, by agreement or otherwise, enter into an obligation (referred to in this section as a “planning obligation”), enforceable to the extent mentioned in subsection (3)–

- (a) restricting the development or use of the land in any specified way;
- (b) requiring specified operations or activities to be carried out in, on, under or over the land;
- (c) requiring the land to be used in any specific way; or
- (d) requiring a sum or sums to be paid to the authority on a specified date or dates or periodically.”

Although, s.106(1)(d) refers to the payment of money to a local planning authority, no point is taken about the fact that the payment in this case was sought by another body, the Trust.

27. *Aberdeen City and Shire Strategic Development Planning Authority v Elswick Development Company Limited* [2017] PTSR 1413 sets out principles for determining the legality of a s.106 obligation and its materiality when deciding a planning application ([33] to [35], [41] to [44] and [47] to [52]). However, regulation 122 of the CIL Regulations 2010 did not form part of the legal framework in Scotland considered by the Supreme Court.

28. In addition, regulation 122 of the CIL Regulations 2010 provides: -

- “(1) This regulation applies where a relevant determination is made which results in planning permission being granted for development.
- (2) Subject to paragraph (2A), 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.

(2A) ...

(3) In this regulation—

“planning obligation” means a planning obligation under section 106 of TCPA 1990 and includes a proposed planning obligation; and

“relevant determination” means a determination made on or after 6th April 2010—

(a) under section 70, 73, 76A or 77 of TCPA 1990 of an application for planning permission; or

(b) under section 79 of TCPA 1990 of an appeal

29. It is common ground that for the obligation sought by the Trust to have been material to the determination of the planning application for the SDA, HDC had to be satisfied that each of the three tests in reg.122(2) was met. Regulation 122 made the application of those tests, including the necessity test in sub para. (a), a legal requirement, rather than a policy requirement as had previously been the case (*R (Working Title Films Limited) v Westminster City Council* [2017] JPL 173 at [20]; *Good Energy Generation Limited v Secretary of State for Communities and Local Government* [2018] JPL 1248 at [71]-[72] and [75]). The application of each of those tests is a matter of evaluative judgment for the local planning authority, subject only to judicial review applying the *Wednesbury* standard (see e.g. *Smyth v Secretary of State for Communities and Local Government* [2015] PTSR 1417 at [118]; *Working Title Films* at [25]). Although the application of the three tests in reg.122(2) is a matter of judgment for the decision-maker, the interpretation of the language used in para.(2) is a matter of law for the court. The Trust alleges under ground 3 that HDC misinterpreted reg.122(2)(a). I will deal with that point below.

Judicial review of the decisions of local planning authorities

30. The principles are well-established and do not need to be rehearsed here. An officer’s report should be read and considered in accordance with the principles summarised in *Mansell v Tonbridge and Malling Borough Council* [2019] PTSR 1452 at [41] to [42]; *R (Hayes) v Wychavon District Council* [2019] PTSR 1163 at [26] to [27]; and *R (Plant) v Lambeth Borough Council* [2017] PTSR 453 at [66] to [72]. A report should be read with reasonable benevolence and flexibility. It does not have to summarise each and every representation made to the authority. A key consideration is whether the officer’s advice was significantly misleading (*R v Selby District Council ex parte Oxtan Farms* [2017] PTSR 1103, 1111).

Ground 3 and the speech of Lord Hoffmann in the *Tesco* case

31. It is helpful at this point to put into context the basis upon which the Trust has sought to advance its legal arguments under ground 3. The Trust has contended that it was

irrelevant for HDC to take into account its funding arrangements, because they do not relate to the development or the use of land or to the development of the site. Accordingly, whether the claimant could itself “mitigate” harm resulting from the development was legally irrelevant. If the availability of alternative funding arrangements were to be material, a body with tax raising or borrowing powers would be unable to obtain a contribution from a developer under s.106 of the TCPA 1990.

32. Plainly, that line of argument might have wide ramifications for the development control system, such that it might have been appropriate to invite the Secretary of State to assist the court. However, given the way in which the claimant’s submissions proceeded, it was unnecessary to seek that assistance. Indeed, those sweeping contentions initially made by the Trust are inconsistent with the concession recorded in [14] above.
33. No authority was cited in the claimant’s skeleton or in the Statement of Facts and Grounds to support the broad argument initially advanced under ground 3. Nevertheless, it appeared from the correspondence between the Trust and HDC during 2020 and 2021 that the claimant has been relying upon a passage from the speech of Lord Hoffmann in *Tesco Stores Limited v Secretary of State for the Environment* [1995] 1 WLR 759 at 776G to 777A. It emphasised that passage repeatedly in its representations to HDC. When he opened the case I understood Mr. Cairnes KC to adopt that passage as part of his argument, although he very fairly said that he was not aware of it being applied in any subsequent authority. He also said that the claimant was not relying upon any other authority to support ground 3 specifically. That same passage from the speech of Lord Hoffmann was also relied upon in opinions provided by counsel in 2008, 2015 and 2016 to other NHS Trusts. It has formed part of the underpinning for much of the argument which has been taking place in planning appeals on contributions of the kind sought by the claimant in the present case. Although the Trust’s position is now as set out in [14] above, the potential ramifications of the arguments which have previously been raised make it necessary to address Lord Hoffmann’s dictum.
34. In *Tesco* at pp.774H to 775H Lord Hoffmann discussed the now revoked DoE Circular 16/91 which set out the Secretary of State’s then policy on the use of planning obligations. This included a policy requirement to consider whether a planning obligation is necessary to make a development proposal acceptable.
35. He then went on to discuss planning policy on “external costs” at pp.775H to 776F. That section included a reference to *R v South Northamptonshire District Council ex parte Crest Homes Plc* [1994] 3 PLR 47, where the Court of Appeal had held that there was nothing unlawful about a development plan policy requiring developers of sites which would double the size of a small town to contribute to the costs of road infrastructure, schools and a community centre made necessary as a result. There was nothing controversial about requiring a developer to pay for, or towards, infrastructure made necessary by his development.
36. The passage upon which the claimant has often relied follows at pp. 776G – 777A under the heading “legislation in support of the new policy”:-

“The government policy of encouraging such agreements has been buttressed by amendments to the planning and highways legislation

to confer upon local planning authorities and highway authorities very wide powers to enter into agreements with developers. The new section 106 of the Town and Country Planning Act 1990 says in express terms that agreements under that section may require a developer to pay sums of money. The new section 278 of the Highways Act 1980, substituted by section 23 of the new Roads and Street Works Act 1991, confers a broad power upon a highway authority to enter into agreements by which some other person will pay for the construction or improvement of roads or streets. Parliament has therefore encouraged local planning authorities to enter into agreements by which developers will pay for *infrastructure and other facilities* which would otherwise have to be provided at the public expense. These policies reflect a shift in Government attitudes to the respective responsibilities of the public and private sectors. While rejecting the politics of using planning control to extract benefits for the community at large, the Government has accepted the view that market forces are distorted if commercial developments *are not required to bear their own external costs.*” (emphasis added)

37. The Trust has treated that passage as supporting the proposition not only that a development *may* be required to meet its own external costs in relation to publicly funded facilities, but also that the public funding available to provide such facilities is legally irrelevant to the determination of a planning application. I do not accept that either *Tesco* or the passage cited at pp776G-777A can be treated as having laid down any such principle for a number of reasons:

- (i) Lord Hoffmann did not address that issue;
- (ii) The *Tesco* case was not concerned with that issue. The Secretary of State dismissed *Tesco*’s appeal against refusal of planning permission for a superstore, deciding that its offer to fully fund a link road, which bore little relationship to the proposal, should not be treated as a reason to allow the appeal. The narrow questions before the House of Lords were (1) whether the Secretary of State had wrongly treated the offer as legally irrelevant and (2) if not, whether his judgment on a matter of weight was open to challenge. Both questions were answered in the negative and so the Secretary of State’s decision should not have been quashed by the High Court;
- (iii) The leading speech was given by Lord Keith of Kinkel with whom three other Law Lords agreed. None of those four agreed with the speech of Lord Hoffmann;
- (iv) Lord Hoffmann himself agreed with Lord Keith at p.771D and expressly did so again in relation to the narrow issues in the appeal at pp.783E to 784C. The intervening passages, particularly that cited from pp.776G to 777A, were not, with respect, necessary to decide the issues in the appeal. In particular, the appeal was not concerned with whether the Secretary of State had failed to *require* a s.106 obligation to be made, or had approached that issue unlawfully. It does not appear that the link road was an “external cost” of *Tesco*’s development;

- (v) The passage at pp. 776G to 777A did not lay down principles of law. Rather it discussed how the introduction of certain legislation had enabled effect to be given to the then Government's policy approach to external costs. That passage is also reflected in what Lord Hoffmann said at p. 779F-G.
 - (vi) Lord Hoffmann went on to state that the law does not require a necessity test to be satisfied for a planning obligation to be taken into account in favour of a decision to grant planning permission (pp.779H-780E). Subsequently, the legislature has decided to impose that very test (reg. 122(2)(a) of the CIL Regulations 2010).
38. Counsel were able to find only one decision which had referred to the passage cited from Lord Hoffmann in *Tesco*, namely *Swindon Borough Council v Secretary of State for Housing, Communities and Local Government* [2021] PTSR 432 (see [42]-[51]). The discussion there was mainly concerned with the wider scope of what may lawfully be *achieved* by a planning obligation as compared to a planning condition. Lewison LJ acknowledged at [51] that the permissible extent of a planning obligation may have been altered by reg.122 of the CIL Regulations 2010. That regulation has imported the criteria in *Newbury District Council v Secretary of State for the Environment* [1981] AC 578 for the legality of a planning condition when deciding whether a planning obligation may be taken into account in the determination of a planning application. All parties agreed that those criteria fell to be applied by HDC in this case.
39. Mr. Cairnes KC made it clear in his reply that the claimant no longer relies upon the passage cited from Lord Hoffmann. In my judgment he was right to do so. It is also necessary to bear in mind that the Trust raises no legal objection to the fact that the development of the site will not contribute to the ongoing costs of treating "new" residents on the site beyond their first year of occupation. Those costs will be borne by the public purse. On analysis, therefore, this challenge is concerned essentially with the way in which HDC handled the material that was presented to it by the Trust and the application of the tests in reg.122 of the CIL Regulations, particularly the necessity test.
40. Following the hearing in this case, the Supreme Court handed down its judgment dismissing the appeal from the Court of Appeal, *DB Symmetry Limited v Swindon Borough Council* [2023] 1 WLR 198. The parties agreed that any submissions they wished to make should be dealt with in writing. Submissions were made by the claimant and by the defendant.
41. At [55]-[65] Lord Hodge DPSC discussed the wider ambit of the power to enter to enter into a s.106 obligation as compared with the power to impose a condition in a planning permission. At [57] he stated that it is well-established that a local planning authority may achieve, by obtaining the *agreement* of landowner to a planning obligation, a purpose which it could not achieve by imposing a planning condition. At [59] *et seq* he then identified two constraints on the use of planning obligations in the determination of an application for planning permission. First, a planning obligation which has nothing to do with a proposed development is irrelevant to that decision ([60] – [61]). Second, Parliament has imposed limitations on the use of planning obligations in the determination of planning applications through reg.122 of the CIL Regulations ([62]). However, in the *DB Symmetry* case the parties agreed that the

dedication of an access road as a public highway would have satisfied the tests in reg.122. The court did not address that regulation any further.

42. I agree with Mr Kolinsky KC that the present case is concerned with the application of reg.122 and that *DB Symmetry* does not assist in the resolution of the issues which have to be determined here. I did not understand the written submissions of the claimant to take a different view on those points or attempt to resurrect its earlier reliance upon Lord Hoffmann in *Tesco* at pp.776G to 777A. For completeness I note that the Supreme Court did not endorse that passage.

The statutory framework for funding NHS Services

43. This judgment refers to the statutory framework as it was at the date of the planning permission challenged in the proceedings, 17 May 2022. The parties agreed that reforms to the NHS which came into effect after that date do not affect the legal issues raised by this case or the effect of the court's decision on those issues.
44. By s.1 of the National Health Service Act 2006 the Secretary of State is under a duty to promote a comprehensive health service in England designed (*inter alia*) to secure improvement in physical and mental health and in the prevention, diagnosis and treatment of physical and mental illness (s.1(1)) and to exercise his functions under the Act so as to secure that services are provided in accordance with the Act (s. 1(2)). Parliament allocates money to the Secretary of State for the NHS, over 90% of which is passed by him to the NHS Commissioning Board (otherwise known as NHS England).
45. NHS England is established under s.1H of the 2006 Act. It is subject to the duty in s.1(1) concurrently with the Secretary of State (s.1H(2)). It has the function of arranging for the provision of services for the health service in England and must exercise its functions in relation to "clinical commissioning groups" so as to secure that services are provided in accordance with the Act (s.1H(3)).
46. A CCG is a clinically led statutory body with the function of arranging for the provision of health services for the purposes of the health service in England (s. 1I). A CCG has a duty to arrange for the provision of a range of secondary care services including hospital accommodation, medical, nursing and ambulance services, and services for the diagnosis and treatment of illness and the care of persons suffering from illness, to such extent as it considers necessary to meet the reasonable requirements of "the persons for whom it has responsibility" (s.3(1)). They are persons provided with primary medical services by a member of the CCG (i.e. GPs) and other persons usually residing in the area of the CCG (s.3(1A)). Thus, the responsibility of the CCG is not limited to those who are registered with a GP. In addition, regulations under s.3(1B) may extend that responsibility.
47. By s.3A of the 2006 Act a CCG also has a power to arrange "for the provision of such services and facilities as it considers appropriate for the health service" that relate to improving *inter alia* the health of the persons for whom it has responsibility or for treating illness in those persons.

48. By s.3(1F) a CCG, in exercising its functions under ss.3 and 3A, must act consistently with the discharge by the Secretary of State and NHS England of their duty under s.1(1) of the Act.
49. Section 13D of the 2006 Act imposes a duty on NHS England to exercise its functions effectively, efficiently and economically. Section 14Q imposes a like duty upon each CCG.
50. NHS England is obliged to determine and then pay the amount to be allotted in a financial year to each CCG towards meeting the expenditure of that group “which is attributable to the performance by it of its functions in that year” (s.223G(1) of the 2006 Act). NHS England may make a new allotment increasing or decreasing an allotment previously made (s.223G(4)). By s.223H a CCG must ensure that its expenditure on the performance of its functions does not exceed the amount allotted to it under s.223G and any other sums received by it in that year under the Act, or otherwise in order to defray such expenditure.
51. By s.14Z11 a CCG must prepare and publish a “commissioning plan” before the start of its financial year setting out how it proposes to exercise its functions during that period, including the discharge of its duty under s.223H. Under s.14Z12 a CCG may revise its plan.
52. Section 25 of the 2006 Act empowers the Secretary of State to establish by order NHS trusts, such as the claimant, to provide goods and services for the purposes of the health service. A trust must exercise its functions effectively, efficiently and economically (s.26). The Trust is one of the providers from whom the CCGs obtain services in order to discharge their functions.
53. Section 27 and sched.5 of the 2006 Act set out financial provisions governing NHS trusts. By para.2(1) each trust “must ensure that its revenue is not less than sufficient, taking one financial year with another, to meet outgoings properly chargeable to revenue account.” An NHS trust has power to borrow subject to borrowing limits (paras.3 to 5 of sched.5). Instead of making a loan the Secretary of State may pay an amount to a trust as “public dividend capital” (para.6 of sched.5). The Secretary of State may also make supplementary payments to a trust (para. 7 of sched. 5). It is common ground that the Trust has been in deficit since 2014 and has received substantial loans from the Secretary of State to cover those deficits, which have since been converted into public dividend capital (i.e. written off as loans and treated as capital invested in the Trust).
54. Section 9 of the 2006 Act provides for “NHS contracts” under which a commissioning body (e.g. a CCG) arranges for the provision to it by a provider (e.g. a NHS trust) of goods or services reasonably required for the purpose of its functions (s.9(1)). Such contracts do not give rise to contractual rights or liabilities (s.9(5)), but a dispute may be referred to the Secretary of State for determination (s.9(6)).
55. Under reg.17 of the National Health Service Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 (SI 2012 No. 2996) (“the 2012 Regulations”) NHS England is required to draft terms and conditions appropriate to be used in commissioning contracts and may do so in the form of model contracts. NHS England has drafted a Standard Contract which CCGs are required to use. The contract

provides that, subject to any express provision of the contract to the contrary, the commissioner of services must pay to the provider for all services it delivers sums in accordance with the National Tariff (“NT”) (see below), to the extent applicable.

56. “Monitor” was established by the Health and Social Care (Community Health and Standards) Act 2003. Under the Health and Social Care Act 2012 (“the 2012 Act”) Monitor acts as the independent regulator of NHS health care services in England. Its main duty is to protect and promote the interests of people who use health care services by promoting provision which is economic, efficient and effective (s.61(1)). “In carrying out its main duty, Monitor must have regard to the likely future demand for health care services” (s.61(2)). Monitor must also exercise its functions with a view to preventing anti-competitive behaviour in the provision of health care services which is against the interests of people who use those services (s.61(3)).
57. Chapter 4 of Part 3 of the 2012 Act deals with the NHS Payment Scheme. Under s.116 Monitor is obliged to publish the NT. By s.116(1) Monitor must set out in the NT which health care services are to be treated as “specified services”, methods used for determining the national prices of those services and national prices for such services. By s.116(2) the NT may provide rules under which a commissioner and a provider may agree to vary the specification or the national price of a “specified service”. Section 116(4) and (5) also enable Monitor to lay down rules determining the price payable for a service which is not a “specified service” under s.116(1).
58. Where a health service is “specified in the NT” (see s.116(1)) a commissioner must pay the national price in the NT for that service (s.115(1)). Sections 115(1) and 124 of the 2012 Act enable a commissioner and a provider to agree a “local modification” of a national tariff subject to approval by Monitor. But such a modification may only be approved if it would be uneconomic without the modification for the provider to provide the service in accordance with the NT. If a health service is “not specified in the NT”, the price payable for the service is determined in accordance with rules in the NT for that purpose (s.115(2)).
59. The Health and Care Act 2022 was passed on 28 April 2022. Many of its provisions came into force on 1 July 2022, after the date when the planning permission challenged by the Trust was granted. CCGs are abolished and replaced by Integrated Care Boards (“ICBs”). However, the Trust’s representations to HDC and the authority’s decisions were based upon the legislation unamended by the 2022 Act. Some of the technical documents on funding presented to the court relate to ICBs, but it is common ground that, for the purposes of this case, there is no material difference between those documents and the preceding editions, or between the commissioning functions of CCGs and ICBs, or their relationships with NHS trusts.
60. In December 2021 NHS England published a “Technical Guide to Allocation Formulae and Convergence”. This deals with the allocation of funding by NHS England to ICBs under s.223G of the 2006 Act and covers the 3-year period 2022/3 to 2024/5. The preceding document which dealt with the allocation of funding to CCGs, and concerned the 5-year period 2019/20 to 2023/4, was published in May 2019. The starting point for determining the population base was GP registrations as at October 2021. GP registrations in October 2021 were projected forward for each year from 2022/3 through to 2024/5, using the ONS 2018-based Sub-National Population Projections published at the level of Local Authority Districts. Weights were applied

to these figures to reflect a range of differences across the country, including ages of the population, variations in health and deprivation, and higher costs of delivery of services in some parts of the country. It is common ground that this method (i) did not take into account persons residing in an area but not registered with GPs and (ii) relied upon the ONS projections for population figures for subsequent years rather than updated GP registrations. The earlier document published in May 2019 used GP registrations average over the 12 months to October 2018 and population projections in the ONS 2016-based projections.

61. The parties referred to the Bulletin published by the ONS on its 2018-based projections for England. The East Midlands is projected to be the fastest-growing region in England with a projected increase in population of 7% between 2018 and 2028. For North West Leicestershire the increase is 15.9%. The document explains that the factors contributing to changes in population, whether positive or negative, are firstly, “natural change”, the difference between births and deaths and secondly, net migration (page 9). That second factor includes movements between different local authority areas. Population projections may be used to inform planning and the making of policy at a local level. That *may* include planning development to accommodate such movements of population. But the projections are not informed by local development plans, local development aims, or local policies on growth (pp. 9 and 11).
62. The upshot is that although the ONS projections are not influenced by specific development plan policies, or the grant of planning permissions in accordance with such policies, a local planning authority may adopt policies to accommodate projected population growth to the extent they consider appropriate. Accordingly, it would be wrong to infer that there is no connection between an ONS projection of population growth in an area, used in the funding of CCGs, and new development in an area to accommodate that growth. On the contrary, the two are related. They are not divorced.
63. The other aspect of funding concerns the Trust itself. During its consideration of LCC’s application for planning permission HDC sought to understand from the Trust how the funding gap relating to the first year of occupation by new residents is said to arise and whether that would (or could) be addressed in future by the Trust switching from a block contract arrangement to “Payment by Results” (“PbR”), or by population growth being taken into account in the annual negotiations with the CCGs for a fresh block contract for the next financial year.
64. In its responses the Trust explained how the choice between PbR and block contracts is affected by many considerations apart from the short-term cost of funding first-year treatment for new residents in new development. Accordingly, it would be inappropriate for the Trust to switch to PbR simply to address that issue.
65. The argument at the hearing therefore focused on the alternative possibility that annual renegotiations for future block contracts do address population growth and hence the alleged funding gap. Because these negotiations involve the CCGs, HDC had also sought to understand from the Trust how population growth is taken into account in their funding arrangements.

66. In *Shepherd* Haddon-Cave LJ stated that the NT provides for national prices to be the subject of “local variations” pursuant to s.116(2)(b) (see [55] and [72]). According to para. 26 of the original note on NHS funding agreed between the parties for this hearing, it is common ground that a block contract is a type of “local variation” authorised by s.116(2). At [44] of *Shepherd* Haddon-Cave LJ said that block contracts are “expressly permitted” by the NT and available under existing NHS England model commissioning contracts. The parties in this case agreed with that statement and so it might have been thought that they would also be able to agree where block contracts are dealt with in the NT. Unfortunately, that turned out not to be the case.
67. HDC submitted that it is either a requirement, or at the very least permissible, for a block contract to take into account growth in population during the course of the relevant financial year. Chapter 3 of the NT for 2021/2 sets out “aligned payment and incentive rules” for services without national prices for 2021/2 (para. 40). Mr Lock KC relied on Rule 2 in Chapter 3 of that NT to support the proposition that this is a requirement rather than a mere ability. Rule 2 states that the provider and the commissioner must agree “the *expected* level of elective activity for the payment period” (emphasis added). Mr. Lock KC also pointed to Rule 1(c) which states that “rule 2 and the aligned payment and incentive specified in that rule applies to all secondary care services where ... (i) the commissioner and provider have an expected annual contract value of £10 million or more”. Plainly, that threshold is easily surpassed by the Trust’s block contract.
68. Mr. Cairnes KC submitted that rule 2 of the NT does not apply because the Trust does not have “an aligned payment and incentive version of a block contract” and therefore does not fall within Chapter 3 of the NT. He submitted that the block contract is instead subject to the rules in section 4.2 by virtue of para. 44 of the NT. Those rules do not contain any *requirement* of the kind set out in rule 2d of Chapter 3. He said that the Trust had operated a “blended” arrangement with the CCGs, blended in the sense that the contract was part PbR and part block contract, but the Trust had moved from that blended arrangement to an arrangement which was *entirely* a block contract. He said that Chapter 3 of the NT only applies to blended contracts.
69. I note two things. First, para. 42 of the NT says that “the aligned payment and incentive approach is *based* on the blended payment model introduced in the 2019/20 tariff” and that a “blended payment approach remains the direction of travel for the NHS payment systems” (emphasis added). Somewhat confusingly, the equivalent paragraph in the NT for 2022/3 (para. 43) states that “the aligned payment and incentive *is a type of blended payment* based on the model introduced in the 2019/20 tariff” (emphasis added). Second, Rule 4 in Chapter 3 also appears to define the interface between contracts falling within Chapter 3 and contracts falling within Chapter 4 by reference to a contract value of £10 million (see also para. 45 of Chapter 4). These points would tend to support Mr. Lock’s submission.
70. However, neither the Trust nor HDC were able to point to any text which would enable the court to resolve this dispute on the interpretation and application of the NT one way or the other. The NT rules are sadly lacking in clarity. The court is left in this position. “Block contract” is not defined or explained in the NT shown to the court. The term is not even used. Likewise the NT does not define “aligned payment and incentives” or a “blended” arrangement, nor does it relate these expressions to “block contracts”.

71. The second witness statement from Lorraine Hooper, the Chief Financial Officer of the Trust did nothing to assist on this issue. Indeed, at para. 4 she stated that the Trust's contractual terms changed from *PbR to block contract*, without mentioning any blended arrangement. That conflicts with the statement made by Mr Cairnes KC (see [68] above) and so only adds to the confused position presented to the court.

72. I also note para. 7 of the same statement in which Ms. Hooper says: -

“I can confirm that the Government Guidance and contracting rules do not take into consideration how many potential houses are going to be built in accordance with the local plan or existing planning permissions. Moreover, the claimant Trust is required to take the relevant Government Guidance of funding models into account and is not required to adapt its funding model to suit the development plans or policies of the local planning authority. Indeed, were it to do so it would be rightly criticised for not following the correct and appropriate guidance in respect thereof.”

That passage misses the point. HDC does not contend that the guidance or rules do, or should, take into account development plan policies. Instead, the focus is on the extent to which population growth (which may include growth accommodated in new development) is, or can be, taken into account according to those documents. In any event, broad assertion is no substitute for accurate citation or analysis of the rules themselves. The same applies to para. 10 of the witness statement.

73. Fortunately, it is unnecessary for me to resolve the issue on how the NT is to be interpreted and applied. HDC's case does not depend upon being able to show that Rule 2d in Chapter 3 of the NT applied to the Trust's arrangements. Its alternative position was that the NT Rules (and the Model Contract) do not preclude the CCGs and the Trust from negotiating a block contract which has regard to population growth, or to additional activity resulting from first year occupancy of new development, when negotiating a block contract for the next financial year. Mr. Cairnes KC accepted that that is correct.

74. In a note produced on the second day of the hearing the Trust added:-

“there is no evidence the CCG would fund a contract on a level of need which is not within the NT.”

That bland formulation cannot be treated as detracting from what Mr Cairnes KC had clearly accepted (see [73] above), if that is what was intended. First, it does not contradict the clear acceptance that the NT does not preclude regard being had to *anticipated* levels of activity. Second, what is meant by “not within the NT” is not explained, nor is any source cited. Third, the Technical Guidance for the allotment of funds by NHS England to CCGs allows for some population growth within a financial year. The Trust has not advanced any reason or explanation as to why money allocated for that purpose should not be taken into account *for that purpose* when a block contract comes to be negotiated by a CCG and a NHS trust.

Chronology

Overview

75. In January 2015 HDC issued a “call for sites” consultation as part of its preparation of a new local plan. In February 2015 LCC responded by submitting a proposal for “Lutterworth East” to accommodate up to 2,500 dwellings and other uses. They produced a concept masterplan and a phasing plan.
76. In September 2015 HDC issued a local plan options consultation document to which LCC responded by proposing a Strategic Development Area (“SDA”) at Lutterworth East. The consultation included NHS UK, NHS Property, West Leicestershire CCG and Leicester City CCG.
77. Between September and November 2017 HDC consulted on its draft Local Plan proposed to be submitted to the Secretary of State for independent examination under the Planning and Compulsory Purchase Act 2004. This included Lutterworth East as a SDA for 2,750 dwellings and 23 ha of employment use. The draft projected first completions of dwellings in 2022/3. The consultation included East Leicestershire and Rutland CCG, West Leicestershire CCG and Leicester City CCG. They did not respond. The Trust says that it was not consulted.
78. In March 2018 HDC submitted its draft Local Plan to the Secretary of State for examination with its proposal for the SDA on the same site.
79. The examination hearings were held in October 2018, with one day allocated to the proposal for East Lutterworth. In advance of the hearings LCC submitted hearing statements describing the processes agreed with HDC for making a planning application, the development and its programme. It was estimated that 1,710 dwellings would be built within the plan period and the site would be fully built out by 2037/8. LCC held a “stakeholder day” comprising a workshop with local representatives, statutory consultees and stakeholders. East Leicestershire and Rutland CCG attended.
80. On 8 March 2019 LCC made a planning application which resulted in the permission the subject of the claim. The Trust and the East Leicestershire and Rutland CCG were consulted in February, August and November 2019.
81. On 8 April 2019 the Inspector submitted to HDC his report on the examination of the Local Plan. On 30 April 2019 HDC adopted the Local Plan including its allocation of the SDA.
82. On 3 May 2019 the Trust submitted to HDC its first consultation response on the planning application. It requested a s.106 contribution of £1,399,318. There then followed lengthy correspondence between the Trust and HDC on the justification for the authority to require the developer to pay this contribution.
83. On 9 April 2020 HDC’s Planning Committee deferred consideration of the planning application, in part to consult on late representations from the Trust on its request for a s.106 contribution.

84. Between 19 June and 23 July 2020 the Trust provided responses to points raised by HDC. The Trust's final updated consultation response and Appendices were sent on 23 July 2020.
85. On 23 July 2020 HDC published the officers' report to the meeting of the Planning Committee on 28 July 2020. This was the main report before the Committee. But because the Trust's final consultation response was only sent to HDC on that same day, the report could not reflect any differences from earlier consultation responses by the Trust. Accordingly, the officers prepared a "Supplementary Information" report for the Planning Committee which appended the Trust's final response of 23 July 2020 and provided the officers' additional views.
86. At the meeting on 28 July 2020 the Committee resolved to approve the application subject to *inter alia* LCC entering into a s.106 agreement to provide for certain obligations, including financial contributions, but not the contribution sought by the Trust.
87. On 6 October 2020 the Trust's solicitors sent two letters to HDC, one of which was a letter before action. The Trust complained about the approach taken in the officers' report to reg.122 of the CIL Regulations 2010 and alleged inaccuracies in the way in which the Trust's position had been represented to members of the Committee. Mr. Cairnes KC relied upon that material, together with subsequent correspondence in support of ground 4. HDC responded on 16 November 2020.
88. A further officers' report was presented to the planning committee on 20 July 2021 to update members on progress made in agreeing s.106 obligations which had been authorised at the meeting in July 2020. The report also explained why various appeal decisions by Planning Inspectors which the Trust had submitted from time to time did not alter the advice previously given that the Trust's request for a financial contribution should not be accepted.
89. On 10 August 2021 HDC wrote to the Trust asking for further explanation of the NHS funding model. The letter said that, on the basis of the information provided by the Trust, a s.106 contribution was not justified. The Trust responded on 24 September 2021.
90. On 9 December 2021 HDC sent a lengthy letter explaining why it would not require LCC to make the financial contribution under s.106 requested by the Trust. This has been referred to by HDC and LCC as a "decision letter" in order to support a submission that the time for bringing a judicial review under CPR 54 in relation to the s.106 issue should be treated as running from 9 December 2021, rather than from 17 May 2022 when HDC issued its decision notice granting planning permission. I will deal with the allegation of delay towards the end of this judgment.
91. On 14 December 2021 the Trust submitted to HDC another planning appeal decision ("the IKEA decision") upon which the Trust relies in its submissions under ground 4.
92. I will set out a summary of certain passages in the Trust's consultation responses and the officers' reports in July 2020. However, I have considered all the material identified by counsel as relevant and read the material referred to as a whole. I will

deal with relevant aspects of the correspondence between the Trust and HDC following the resolution passed on 28 July 2020 under ground 4.

The Trust's consultation response dated 23 July 2020

93. The main response document began by describing the Trust and the usage of its hospitals (paras.1 to 4). The Trust was established in 2000 and runs the Leicester General Hospital, the Glenfield Hospital and the Leicester Royal Infirmary. "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 CCGs commission from the Trust planned and emergency, acute medical and surgical care and some specialist and tertiary care. "The Trust is required to provide the commissioned health services to all people that present or who are referred to the Trust." This obligation extends to all services, from emergency treatment at A&E to routine and non-urgent referrals.

94. Paragraphs 6 to 13 summarised the "payment system". It briefly referred to "tariffs" (para. 6). In para. 7 the Trust stated that its relevant services were 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." It was said that the Trust does not receive any additional funding for any additional activity in relation to the care that is contracted for under the block contract. Paragraph 8 stated:-

"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, projections or land supply. There is no possibility to change the NHS funding model, or spending priorities of the Government*" (original emphasis)

95. In paras. 15 and 16 the Trust said this about "planning for the future":-

"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.*" (emphasis added)

96. Paragraph 18 explained that the Trust's hospitals are at full capacity. It was subsequently clarified that this did not mean that additional patients could not be treated, but rather that the consequence of additional activity would be an increase in waiting times and a decline in quality of service. Paragraph 19 explained that a

maximum bed occupancy rate of 85% is used to maintain standards of care. Higher occupancy rates can adversely affect the quality of service provided and the ability of the Trust to place a patient in the right type of bed. Information was provided on the extent to which the 85% factor has been and is being exceeded.

97. Paragraphs 21 to 24 of the response described the alleged impact on staffing and services from new residents during their first year in occupation of dwellings in the scheme. There then followed an explanation of the Trust's "Impact Assessment Formula" ["IAF"] to arrive at the requested contribution, then said to be £914,452. This assumed that the 2,750 dwellings would accommodate 7,520 people, of whom 38.5% or 2,896 people would be new to the Trust's area. It was estimated in Appendix 3 that these new persons would give rise to an additional 4,164 acute interventions split between specified types of treatment. The response also explained one component of the sum sought, "premium costs", as the consequential need to employ agency staff at higher costs.

98. Paragraphs 27, 28 and 29 of the Trust's response stated:-

"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.”

99. Appendix 6 to the Trust’s response contained a technical report by its planning consultants, DLP, answering a number of questions from HDC about the methodology, assumptions and data sources used in the IAF. During the hearing the Trust accepted that this Appendix did not address the issue of the extent to which funding is not, or could not, be available to the Trust for any treatment provided for “new” residents at East Lutterworth during their first year of occupation. The Trust accepted that the IAF assumes that there is a funding gap and then estimates the sum of money referable to the costs of “first year” interventions for new residents at the SDA.

100. Appendix 5 to the Trust’s consultation response contained answers from the Trust’s Solicitor to questions from HDC.

101. Question 4 asked: -

“In respect of the point above your email of 20 April refers to a new block contract which no longer pays for treatment 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 include a percentage for treatment above the block contract. Will any revised calculation be reflecting this?”

to which the Trust responded:-

“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.*” (emphasis added)

102. Question 11 asked:-

“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?”

to which the Trust responded: -

“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 not be 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 [sic] 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 the standard staffing costs that is created by having to hire locums. (Please see the Spring Lane Appeal decision)

It would not 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.”

103. Given the points accepted by the Trust during the hearing (see [99] above), this response was incorrect in suggesting that the IAF “explains the lack of funding created by the new population.”

104. In appendix 7 to the Trust's response of 23 July 2020, the Trust provided answers to questions raised by HDC on 16 July 2020. In response to question 1, the Trust said:-

“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 where Lord Hoffmann examined the evolution of planning obligations in the context of, inter alia, mitigating the impacts development proposals upon community facilities and services that are usually funded by the public purse as already explained many times over.*” (emphasis added)

105. In question 2 HDC asked whether the Trust could show that the development would necessarily give rise to an additional burden on its services and that this would arise from the development, “as opposed to a failure in the funding mechanism, whether caused by its structure or the lack of reasonable co-ordination between CCG and the Trust in agreeing block contracts for care and treatment based on up-to-date information as to new or anticipated housing development.” The Trust responded:-

“The impact is not the failure in the funding mechanism as explained many times over and in the previous paragraph.”

The Trust added that “the funding gap will always exist and cannot be paid back retrospectively”.

106. In response to question 9 in Appendix 7, the Trust said that it would be willing to give an undertaking to allocate the monies paid under the s.106 contribution requested “towards the new activity created by the proposed development” and to negotiate an appropriate clause for inclusion in the s.106 agreement.

The officers' report for the meeting on 28 July 2020

107. The officers' report stated that the Trust had submitted further representations to HDC on an earlier report by officers to the meeting of the Planning Committee on 9 April 2020, when it had been necessary to defer consideration of the planning application.

108. Paragraphs 4.2.36 to 4.2.46 of the report published on 23 July 2020 contained a summary of the Trust's representations. Paragraphs 4.2.48 to 4.2.55 then summarised a further response by the Trust, this time dealing with a report by officers to a meeting of the Planning Committee on 21 April 2020. I note that the Trust has not criticised the accuracy or adequacy of those summaries. In addition there was attached to the officers' report for the meeting on 23 July 2020 one of the several iterations of the Trust's consultation response on the planning application. This one was dated 3 July 2020. It covers essentially the same key points as the Trust relied upon in its representations dated 23 July 2020. The Trust's contentions as summarised in the officers' report are similar to those repeated in its claim. It is self-evident that these points were taken into account by the members of the Committee.

109. At para. 6.27 of their report officers recorded that in April 2020 HDC had already considered that the Trust's request for a s.106 contribution should not be supported. The Trust's subsequent representations had sought to address the advice previously given to members and they were summarised in the officers' report for the meeting on 28 July 2020.

110. Mr. Kolinsky KC submitted that a key aspect of the officers' report concerned the first of the three tests in reg. 122 of the CIL Regulations 2010, namely, was the financial contribution necessary to make the proposed development acceptable in planning terms. He said that HDC was not satisfied that the reasons advanced by the Trust in support of the contribution satisfied that first test. For example, it had not been shown that there would be a funding gap as asserted by the Trust. Accordingly, Mr. Kolinsky KC submitted that HDC had been entitled to reach the conclusion that the requested contribution failed at the first hurdle, even before coming to the second and third tests in reg.122(2)(b) and (c) of the CIL Regulations 2010.

111. The officers' report began to deal with the first test in reg. 122(2) at para. 6.31:-

“6.31. Under the CIL regulations the first test is to establish that the funding is necessary in that it serves a planning purpose and it is needed to enable the development to go ahead. The planning purpose would be to ensure the provision of adequate health care and treatment. In this case the matter seems to be about delay in patients receiving treatment. Given that the overall funding of the NHS is through national taxation, the difficulty in treating patients would appear to be a contractual issue which itself appears to be a national one.

6.32 .A request must be directly related to the development; this raises a number of issues. The first is does the funding serve a substantial planning purpose or does the impact arise because of other matters. To this end it is necessary to examine the funding mechanism. *As has been set out previously UHL is funded through a block grant negotiated annually based on the previous year's activity. What is unclear is why the negotiation of the block grant cannot take into account an element for growth in population or household numbers. There are a number of sources of information about planned growth and consultation with local authorities could identify any unplanned growth. The second matter is the speed of occupation of any new dwellings. From the grant of planning permission to the occupation of any dwellings there is a time lag and during this period it is clear how many dwellings would be occupied and potentially how many new residents there would be. This would appear to give an opportunity to negotiate a contract which reflects this known growth. It is not clear from the evidence submitted by UHL why the CCG block contract cannot be adjusted to take into account the anticipated growth of an area.*

6.33 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 subsidise UHL for the effects of the operation of NHS's funding mechanisms.

6.34 In terms of direct relationship, a key consideration is whether UHL can show that the development necessarily gives rise to the additional burden on the developer and that it 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 the CCG and the 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 whether there is sufficient time for the NHS bodies to take it into account in their funding arrangements.” (emphasis added)

As Mr Kolinsky KC submitted, the lack of information from the Trust to demonstrate a funding gap was the key issue identified by officers in para.6.32 of their report. Their suggestion in para.6.33 that there could be a “systemic problem” depended on whether further information from the Trust could demonstrate the existence and extent of such a gap.

112. At para. 6.39 *et seq.* the officers’ response identified concerns with the handling of population figures in the Trust’s representations. Paragraph 6.43 recorded the Trust’s statement that the funding of CCGs only allowed “for a small element of population growth”. The report made it clear that the Trust had not explained the extent to which growth had been allowed for in the funding of the bodies who would be commissioning services from the Trust.

113. If the first two tests in reg.122(2) are passed, the third test is whether the contribution is fairly and reasonably related in scale and kind to the development. Paragraph 6.50 of the officers’ report considered whether the deployment of the requested contribution would satisfy the third test:-

“6.50 A further issue with revenue funding of this kind is evidencing that the monies are deployed in a way which directly and fairly reasonably relates in scale and kind to the permitted development. Where infrastructure is involved, it can be scaled to meet the requirements of a given new population by reference to a robust methodology. Where revenue funding is involved, in this case staff, it is more difficult to attribute their time to patients arising from the development or to ensure that the monies are directed at services which will meet the actual healthcare needs of the new population as opposed to being subsumed in

general budgets. This is key to the directly related and fairly and reasonably related in scale and kind tests of regulation 122. In its submission of 20 April UHL undertook to demonstrate how funding would be accounted for. UHL have set out the following. The monies are used to service the additional population from this development. Each patient creates an activity which has a tariff. The total costs of the activity includes among other things pathology tests, drugs, imaging, endoscopy, critical care, blood and operating theatres. 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. 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.”

114. Given that any contribution would be for the purpose of providing additional staff and service capacity, para. 6.51 advised that it was unclear that there were any mechanisms in the NHS to ensure that the funding was deployed correctly so as to satisfy the third test.
115. Paragraphs 6.55 to 6.73 of the report brought together the officers’ conclusions on the Trust’s request for the contribution. On the first test in reg. 122(2), officers advised that because of the time lag between the grant of any permission and the first occupation of any dwellings there was an opportunity for the CCGs and the Trust to address their funding arrangements so that there would not be a reduction in the standard of care. NHS funding and health service planning at a local level appeared to take account of population growth and it had not been shown to HDC why NHS funding would not respond appropriately to it. If there was a funding gap as alleged by the Trust, for example, because of a time lag between the “new residents” occupying dwellings and NHS funds becoming available, that was a problem in the system of funding (paras. 6.57 to 6.59). It is necessary to note that that last statement assumed that there would be such a gap. One of the problems throughout the protracted consideration of the Trust’s request for a financial contribution under s.106 was that the Trust failed to show that the annual negotiations of a new block contract do not, and could not, address the issue of population growth satisfactorily, albeit that the commissioning bodies were receiving some funding for such growth.
116. In relation to the second test in reg.122(2), whether the contribution sought was “directly related to the development”, a number of issues were identified. These included concerns about the robustness of the methodology to demonstrate the level of population growth attributable to the development, in particular the data sources and geographical areas used (para. 6.64).
117. In relation to the third test, officers took the view that the cost of using agency staff was a function of recruitment and capacity issues within the NHS, rather than being directly attributable to the development (paras. 6.68 to 6.69). The report also referred back to the issue summarised in [114] above.

The supplementary information reported to the Committee meeting on 28 July 2020

118. In relation to funding issues, the officers advised the committee *inter alia*:-

“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 year’s 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.*” (emphasis added)

and subsequently:-

“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.”

That last paragraph must be read in the light of the preceding passages.

119. The supplementary information provided to members also addressed the population modelling carried out for the Trust. This was relevant to the second and third tests in reg.122(2).
120. Mr. Cairnes KC rightly pointed out that HDC’s officers accepted the Trust’s assumption that 38.5% of the occupiers of the dwellings on the SDA would be people moving into the Trust’s catchment area. But as Mr. Kolinsky KC pointed out, HDC raised a number of technical issues and concerns about the derivation of the population projections to which that figure of 38.5% was applied (see p. 4 of the report). In other words, officers remained unsatisfied about the prior stage of the Trust’s analysis concerned with the population estimates themselves.

Ground 1

121. The first aspect of ground 1 is whether HDC misinterpreted the policy in the 2019 edition of the National Planning Policy Framework (“NPPF”) on the significance of “health” in determining planning applications.

122. Paragraph 8 of the NPPF sets out the three overarching objectives of the planning system for achieving sustainable development, the second of which is:-

“a social objective – to support strong, vibrant and healthy communities, by ensuring that a sufficient number and range of homes can be provided to meet the needs of present and future generations; and 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;”

123. Chapter 8 of the NPPF is concerned with “promoting healthy and safe communities”. Paragraph 91 states:-

“91. Planning policies and decisions should aim to achieve healthy, inclusive and safe places which:

(a) ...

(b) ...

(c) enable and support healthy lifestyles, especially where this would address identified local health and well-being needs – for example through the provision of safe and accessible green infrastructure, sports facilities, local shops, access to healthier food, allotments and layout changes that encourage walking and cycling.”

Paragraph 92 states:-

“92. To provide the social, recreational and cultural facilities and services the community needs, planning policies and decisions should:

(a) ...

(b) take into account and support the delivery of local strategies to improve health, social and cultural well-being for all sections of the community;

.....”

124. The Trust criticises paras. 6.28 and 6.30 of the officers’ report as having misinterpreted those policies and related policies. The whole section, from paras. 6.28 to 6.30, reads as follows:-

“6.28 Before turning to the detail of matters relating to the request it is worth setting out the national policy context. The NPPF at paragraphs 91 and 92 refers to promoting healthy and safe communities. These take a broad approach to health, healthy lifestyles and local infrastructure to facilitate this. It does not refer to health in terms of treating illness.

6.29 The PPG makes a number of references to health. As with the NPPF it refers to facilitating healthier lifestyles, the PPG also refers to the provision of facilities for health care. The guidance then sets out the bodies that need to be engaged in improving health, wellbeing and the provision of health infrastructure. It makes specific reference to the Director of Public Health, the Health and Wellbeing Boards, NHS England and locally the CCG. The last two bodies are referred to particularly as these can provide information on their current and future strategies to refurbish, expand, reduce or build new facilities to meet the health needs of the existing population as well as those arising as result of new and future development.

6.30 The emphasis here is on planning new facilities and opportunities for healthier lifestyle and living not the treatment of illness. It may be helpful to set out some matters of principle before turning to the detail.”

125. The Trust criticises the statement in para. 6.28 that although the NPPF takes a broad approach to health, healthy lifestyles and local infrastructure, “it does not refer to health in terms of treating illness”. A similar point was made in para. 6.30. The Trust submits that healthcare services, including the treatment of ill health, are firmly within the ambit of the national policies referred to above. The Trust criticises the approach taken in the officers’ report because it resulted in HDC *excluding* the health impacts of the development in relation to the services provided by the Trust. That is the second aspect of ground 1. In other words HDC failed to take that “obviously material consideration” into account.
126. The claimant’s reading of the officers’ report is untenable. No criticism is made by the Trust of para. 6.29. Paragraph 6.30 simply makes the point that the emphasis of the matters summarised in para. 6.29 is the provision of facilities rather than the treatment of illness. It did not purport to exclude health treatment as a material consideration. Read fairly and as a whole, the same is also true of para. 6.28 of the officers’ report.
127. It is also necessary to keep in mind the context, namely that HDC was solely being asked to consider a request by the Trust for a contribution to the provision of services rather than infrastructure. Elsewhere in their report the officers said that it is more difficult to relate the use of a financial contribution for the provision of services to the effects of a development, as compared with a need for infrastructure. That was a judgment on a matter of fact and degree. That is consistent with Mr. Kolinsky’s acceptance that there is no hard-edged distinction between the two. The officers’ report did not proceed on the basis that contributions to the provision of services should not be considered.
128. The second aspect of ground 1 shows why this complaint is hopeless. If HDC had adopted the interpretation alleged by the Trust and regarded *treatment* of ill health as excluded, then it would not have gone on to consider at such length the Trust’s case on the merits. HDC took a great deal of trouble to seek further information and explanations from the Trust and, in due course, to obtain specialist legal advice.

129. The officers' reports amply demonstrate that HDC was fully aware of, and took into account, the health impacts which the Trust said would flow from the development. The references in the officers' reports to a funding gap relied upon by the Trust does not detract from that fact. The need for treatment for new residents *after* their first year of occupation was not raised by the Trust as a planning consideration. Mr. Cairnes KC accepted that the Trust's reliance upon treatment impacts in relation to the *first* year of occupation depended upon the Trust's contention that there would be a funding gap in relation to the costs of that treatment. He accepted that the Trust's argument for requiring a s.106 financial contribution from the developer fell away if there was no funding gap.
130. The Trust's contention that HDC misinterpreted policy and excluded, or failed to have regard to, impacts upon treatment services is impossible. Ground 1 must be rejected.

Ground 3

The short answer

131. The claimant submits that HDC took into account an irrelevant consideration, namely the Trust's funding arrangements. The Trust says that that was not a material planning factor because it does not relate to the development or use of land, nor does it relate to the development for which planning permission was granted. Whether the Trust could itself "mitigate the harm it would suffer because of the development" was irrelevant. Instead, the decision HDC had to make "was about [LCC] and whether it could or should be obliged to mitigate the negative effects of the proposed development to make it acceptable". This then led to the following sweeping assertion:-

"Fundamentally, it is not the defendant's place to investigate how the claimant is funded, much less dictate how it should be funded, when deciding a planning application."

132. The Trust did not cite any authority to support its position. As I have noted above, Mr. Cairnes KC abandoned any former reliance by the Trust upon the speech of Lord Hoffmann in *Tesco*.
133. The Trust's objection to HDC's approach related in part to the latter's interest in the possibility of *alternative* funding arrangements, in particular a switch from block contracts to PbR. But irrespective of HDC's questions about PbR, the defendant's wanted to know whether the arrangements relating to block contracts (the approach actually applied by the Trust) do or could allow for population growth over the year in question to be taken into account and, if not, why that is so. On any fair reading of the officers' reports and the correspondence, that second matter was a freestanding concern which was in no way dependent upon, or affected by, the questions raised by HDC in relation to the possibility of the Trust switching to PbR. The claimant failed to satisfy HDC on that second issue in any event. Accordingly, any complaint about the PbR issue could not possibly provide a basis for the court to intervene.
134. As we have seen, each of the CCGs in this case had a duty to arrange for the provision of secondary care services in relation to "the persons for whom it has

responsibility”, which include those registered with a GP and those usually residing in their areas (see [46] above). So when persons new to the area begin to reside in homes on the site, they become persons for whom the CCG is responsible to provide secondary services under s.3(1) of the 2006 Act.

135. As Mr. Cairnes KC rightly accepted, additional demand arising from new residents would only have a harmful impact on the provision of commissioned services, through increased waiting times or other decline in standards of service, if there is a gap in the Trust’s funding to pay for additional staff and treatment. That is why the Trust sought a financial contribution rather than, for example, an obligation on the developer to provide infrastructure or some other physical form of mitigation. If there were to be no funding gap resulting in that harm there would be no relevant impacts to justify a s.106 contribution (see [14] above). It is the very nature of the harm claimed by the Trust which makes the alleged funding gap an integral part of its case. The Trust’s argument that the funding arrangements of the NHS or of the Trust are irrelevant is unsustainable.
136. That conclusion is reinforced by considering how the costs of treating “new residents” on the development site are addressed in the financial year after they have moved in and subsequently. There is no funding issue because it is common ground that such persons are taken into account in the funding for CCGs and in the relevant block contract payments to the Trust. Rightly, the Trust does not seek any s.106 contribution for such costs. In such circumstances a local planning authority could not properly require the owner or developer of the site to pay for those additional costs. A s.106 obligation to that effect would not be necessary to make the development acceptable (reg.122(2)(a) of the CIL Regulations 2010) and could not properly be taken into account in the decision on whether or not to grant planning permission. If, however, planning permission were to be granted on that basis, it would be liable to be quashed. In effect, the developer would be paying for a community benefit, increasing the funding of the NHS, which had no proper planning purpose or relationship to the development (see *Tesco* and *Wright*).
137. The analysis cannot be any different in relation to the costs of treating new residents to the area during their first year in occupation of homes on the development site. HDC was entitled to consider whether there was a funding gap for the Trust in relation to those costs. HDC was entitled to ask the Trust to provide information to see whether it was satisfied about the existence of such a gap and, if so, its size.
138. The members were advised by officers, and they are to be taken as having agreed, that the Trust failed to provide sufficient information to show that there was any funding gap. The request for a financial contribution did not satisfy the necessity test in reg.122(2)(a) of the CIL Regulations 2010 (see e.g. [111] above). Those were matters of judgment for HDC and the claimant has not shown any public law error in that respect. Indeed, it was a perfectly rational and unsurprising judgment for the authority to have made. That is sufficient to dispose of ground 3. However, the arguments in this case have raised wider issues and it would be helpful for me to address them. If it had been necessary for me to do so I would have relied upon my conclusions below (excluding [147]-[151]) as further reasons upon which to reject ground 3.

Wider issues

139. The Trust made the broad assertion that HDC's approach "would preclude any public body with tax-raising (or borrowing) powers from being funded by a developer in a planning obligation". This is misconceived. The Trust does not have the power to raise taxes and HDC's approach did not assume that the Trust should borrow additional monies or that some other public authority should raise additional taxes. Instead, HDC was concerned to understand whether the costs identified by the Trust could be met having regard to the funding available to CCGs. That simply flowed from the very nature of the planning obligation which the Trust sought, namely a financial contribution to fill a funding gap. But where, for example, a development would itself cause direct harm to a public facility, so that the three tests in reg.122(2) of the CIL Regulations 2010 are satisfied, the local planning authority would be entitled to require the developer to mitigate that harm under a s.106 obligation, irrespective of whether the authority responsible for that facility is able to raise taxes or has borrowing powers.
140. In any event, the justification advanced by the Trust for a s.106 contribution needs to be seen in the context of the statutory framework for the provision of secondary health care services. The contribution would relate to people who are new to the Trust's area. But those people are entitled to such services wherever they may live in the country. They would be so entitled if the development were to be refused planning permission and so they did not move to the Trust's area. The relevant CCG for the area in which they live would remain under a statutory duty to arrange for the provision of the same treatment as would otherwise be provided by the Trust. The obligation to provide, and financial responsibility for, those services lies with the NHS. The context is far removed from the analogy of a typical s.106 obligation given by Mr Cairnes KC, namely where a developer is required to mitigate a reduction in the performance of a local highway network that would be caused by a new development. There, the highway authority is not under a statutory duty to fund improvements to the network, let alone to provide for highway facilities made necessary by a specific development.
141. The question therefore arises how could an applicant for planning permission for a new development be required lawfully by a system of land use planning control to contribute to the funding of treatment within the NHS? It is well established that planning permission cannot be bought and sold, for example, by making a payment for community purposes unrelated to the development authorised. Furthermore, planning legislation does not confer any general power to raise revenue for public purposes (see e.g. *Attorney General v Wilts United Dairies Limited* (1921) 37 TLR 884; (1922) 38 TLR 781; *McCarthy & Stone (Developments) Limited v Richmond London Borough Council* [1992] 2 AC 48).
142. Ordinarily a resident of the development at East Lutterworth who had moved to the Trust's area would previously have been the responsibility of a CCG elsewhere in the country. So it has not been suggested that the development would increase the burden on the NHS in England as a whole. The attempt by the Trust to obtain a financial contribution under s.106 therefore depends upon their demonstrating a *localised* harm. The only harm they seek to rely upon concerns the provision by the Trust of services commissioned by the CCGs. On the Trust's own case, that has to depend upon them showing a funding gap in relation to treatments for residents new to the area during their first year. The Trust accepts that there is no justification for any payment relating to other "first year" residents who are simply moving home within the Trust's area, or

to any resident after their first year at East Lutterworth. The extent to which funding is available to the Trust for the services it provides to the CCGs is the only possible justification for drawing these distinctions. Whether a funding gap genuinely exists was critical to the Trust's request for a financial contribution under s.106.

143. Accordingly, HDC was fully entitled to ask questions and to seek information in order to see whether there is a real funding gap for treatment by the Trust of "new" residents in their first year of occupation. Indeed, if the local planning authority had agreed to require the developer to pay the contribution sought by the Trust before granting planning permission without being adequately satisfied that there was a relevant funding gap, it would have been open to criticism. In the event of the issue having to be determined in a planning appeal, HDC would have been at risk of being ordered to pay costs for unreasonable conduct.
144. The Trust's doctrinaire approach to the funding issue, as revealed by ground 3, is troubling. It involves a wholly unwarranted interference with the proper discharge by a planning authority of its statutory functions. It has been no more than a smokescreen behind which the Trust has sought to deflect the perfectly proper questions posed by HDC.
145. The Trust also submits that HDC misdirected itself as to the correct interpretation of reg.122(2)(a) of the CIL Regulations 2010 by treating it as meaning that "it could only require a planning obligation to mitigate harm to a public service if the provider of that public service could not itself mitigate the harm." Mr. Cairnes KC was not able to point to any paragraph in the officers' report to that effect or to any line of reasoning which impliedly imposed that limitation upon the scope of reg.122(2)(a). The Trust's complaint simply overlooks the fact that its own case was based upon an assertion that there was a funding gap that could not be overcome. The fact that HDC sought to examine whether that was so simply involved them in considering the merits of the Trust's request for a s.106 contribution. It did not involve any erroneous interpretation of reg.122(2)(a).
146. When the officers' reports and the correspondence between the parties are read fairly and as a whole, it is absurd for the Trust to claim that HDC attempted to dictate how it should be funded. This suggestion appears to rely upon the final paragraph of the letter from HDC's Chief Executive dated 9 December 2021. By that stage HDC had taken advice from leading counsel specialising in NHS law to assist its understanding of NHS funding and the Trust had failed over a long period to explain why the annual review of block contract payments could not satisfactorily address the funding issue raised by the Trust.

What if a funding gap could be demonstrated for a particular NHS trust?

147. But what if in a future case a NHS trust could demonstrate that it would suffer a funding gap in relation to its treatment of new residents of a development during the first year of occupation? On one level it would be a matter for the judgment of the local planning authority as to whether the three tests in reg.122(2) of the CIL Regulations 2010 are satisfied and whether it would be appropriate to require a financial contribution to be made, after taking into account other requirements and any impact on the viability of the scheme. But all that assumes that there is no legal (or other) objection to a contribution of the kind sought in the present case. The

argument in this case does not enable the court to decide that issue as a legal question. This judgment should not be read as deciding that there would be no legal objection.

148. Where a housing development is carried out, some of the new residents may be entitled to social welfare benefits, which, like the need for secondary healthcare, arises irrespective of where that person lives. Of course, no one would suggest that the developer should make a contribution to funding those benefits.
149. The funding of treatment in NHS hospitals would appear to be different in two respects. First, in an area of net in-migration any increase in the need for treatment and staff will be experienced in the relevant local area, not nationally. Second, because the patients would receive treatment even if they had not moved home, a local funding gap would only arise if funding for the relevant NHS trust did not adequately reflect a projected increase in population and/or the national funding system did not adequately provide for a timely redistribution of resources. Population projections will involve some areas of out-migration as well as areas of net in-migration. It is therefore significant that CCG funding across the country takes into account ONS population projections. Accordingly, in the distribution of national funds there may be increases or decreases in funding for individual CCGs by reference to size of population.
150. It seems to me that two points follow. First, even if it could be shown in a particular area that there is a funding gap to deal with “new” residents, HDC was entitled to raise the possibility that this is a systemic problem in the way national funding is distributed. Although the Trust criticised HDC for taking it upon themselves to raise this point, it strikes me as being a perceptive contribution to a proper understanding of the issue. If there really is a systemic problem, this may raise the question in other cases whether it is appropriate to require individual development sites across the country to make s.106 contributions to address that problem. However, for the purposes of dealing with the present challenge, HDC’s decision rested on the Trust’s failure to show that there was a funding gap in this case, not any systemic issue.
151. Second, whether there is a lack of funding for a Trust to cope with the effects of a substantial new development is likely to depend not on those effects in isolation, but on wider issues raised by the population projections used as one of the inputs to determine funding for CCGs. The interesting arguments from counsel in this case suggest that these issues merit further consideration as a matter of policy outside the courts and even outside the planning appeal system.
152. Ground 3 must be rejected.

Ground 2

153. The Trust submits that HDC failed to take into account a relevant consideration, namely the “short and long term” impacts of the proposed development and the “gap in the claimant Trust’s funding because its funding model does not take into account local housing needs, projections, allocations, planning permissions or housing supply”. As para. 70 of the Trust’s skeleton puts it, ground 2 “addresses the impacts upon the finances of the claimant.” Paragraph 70(c) and (d) states “the impact upon the claimant’s finances relates to the character or use of land because it arises directly from the development...” “The claimant cannot avoid the impacts.” Paragraph 70(e)

states that HDC was “obliged to consider the financial impacts on the claimant. This was because they were so obviously material that not to take them into account was irrational.”

154. Those paragraphs only serve to show how muddled the Trust’s case has been. Ground 3 complains that the Trust’s funding arrangements were not a relevant planning consideration at all, whereas ground 2 complains that HDC failed to take them into account.

155. Under ground 2 the Trust submits:-

- a. Because HDC erroneously insisted that it was for the Trust to mitigate the financial impacts arising from the East Lutterworth scheme, the authority disregarded those impacts when considering the planning application;
- b. Alternatively, HDC erroneously adopted the position that the Trust *could* avoid those impacts by adjusting its funding scheme (see the officer’s report to the meeting on 28 July 2020 at para. 6.32);
- c. The Trust was unable to switch to PbR, nor claim extra money as marginal payments through the block contract scheme. The additional pressures arising from the “new” population on the East Lutterworth site could place part of the Trust’s “conditional funding” at risk.

156. There is no merit in any of the submissions advanced under ground 2. Points (i) and (ii) assume that there would be a financial impact on the Trust because of a funding gap to cover the costs of treating new residents during their first year of occupation. What the Trust repeatedly failed to explain in its representations to HDC was why the annual negotiations for a block contract for the next financial year do not, or could not, take into account population growth during that year, given that CCG funding has an element for future population growth. HDC’s position was made clearly enough in, for example, paras. 6.32 to 6.34 of the officers’ report to the meeting on 28 July 2020 and in the Supplementary Information given to the Committee (see [111] above).

157. Read fairly the advice given by officers to members was not based upon changes to the scheme for block contracts in the NHS being necessary. Even if a population increase attributable to a specific development or policy cannot be taken into account in the discussions between CCGs and the Trust each year, the fundamental question still remained to what extent is *population growth* in the area taken into account in the negotiations, or could be taken into account, given the agreed position that funding for that purpose is provided to the CCGs for the relevant year.

158. The nearest the Trust got to addressing that question was in Appendix 5 to its response document dated 23 July 2020 when it said that the Trust would receive funding based on the “previous year’s activity”. “an element of ‘growth’ ”. The Trust then went on to assert that “only a very small element of growth in population is allocated to CCG”. That assertion does not sit very well with the ONS material which both sides showed to the court. But leaving that point to one side, the Trust failed to deal with an obviously important point. They did not explain how much population growth was allowed for in the funding provided to the CCGs and then to the Trust, and how that compared, for example, to up to 220 “new” persons that might be

expected to start living at East Lutterworth in any year, or to any other annual population estimate from HDC based on its housing trajectory. That would be directly and obviously relevant to whether there was a funding shortfall at all, and if so how much.

159. The problem is that the Trust continued to assert that there was a funding gap without demonstrating that there was. Clearly this was a highly technical issue on which the Trust was well placed to provide proper assistance to the local planning authority, and it ought to have done this.

160. Read properly, the stance taken in the officers' reports on the block contract arrangements did not involve telling the Trust to mitigate any financial impact arising from the development or that the NHS funding scheme should be adjusted. Instead, it was concerned with understanding how population growth is, and can be, factored into the funding of the CCGs and the block payments they make to the Trust.

161. Lastly, I turn to the Trust's complaints under point (iii). The PbR issue fell away (see [64]-[65] and [133] above) and need not be addressed further.

162. In its representations dated 23 July 2020 the Trust stated that it expected to receive conditional funding of about £16m to £17m from the Provider Sustainability Fund if it achieved certain "improvement goals". Plainly, the assertion that the development would affect the ability of the Trust to achieve those goals depended on whether there was a funding gap. The point made by the Trust did not go to that fundamental issue and gave rise to no error of law on the part of HDC.

163. Paragraph 3(ii) of Ms Hooper's second witness statement gives an explanation of the limited circumstances in which "marginal payments" may be made for additional activity. I assume that that statement is correct. Even so the court was not shown any passage in HDC's consideration of the funding issue which relies upon marginal payments or is inconsistent with that evidence. This point did not go to the fundamental matter relied upon by HDC.

164. For completeness I would mention that Ms. Hooper goes on to assert, without referring to any source or supporting material, that the funding provided by a block contract is "entirely based on historical funding levels". As we have seen, that is inconsistent with what the Trust told HDC in its representations and with how both the Trust and HDC explained to the court the block contract regime.

165. For the above reasons, ground 2 must be rejected.

Ground 4

166. The Trust submits that applying the principles in *R (Kides v South Cambridgeshire District Council* (2003) 1 P & CR 19 at [122]-[126], HDC's officers were under a duty to refer the planning application back to the Committee so that it could consider the representations submitted by the Trust to HDC between the date of the resolution to grant permission on 28 July 2020 and the issuing of the decision notice on 17 May 2022.

167. It is important to note [122] of the judgment of Jonathan Parker LJ in which he stated:-

“In my judgment, an authority’s duty to “have regard to” material considerations is not to be elevated into a formal requirement that in every case where a new material consideration arises after the passing of a resolution (in principle) to grant planning permission but before the issue of the decision notice there has to be a specific referral of the application back to committee. In my judgment the duty is discharged if, as at the date at which the decision notice is issued, the authority has considered all material considerations affecting the application, and has done so with the application in mind – albeit that the application was not specifically placed before it for reconsideration.”

It is clear from [123] that the Court of Appeal had in mind a material consideration which arises for the *first time* after the Committee’s resolution to grant permission.

168. Likewise [125] and [126] refer to an officer becoming aware of a new material consideration or to a “new factor” which has arisen:-

“125. On the other hand, where the delegated officer who is about to sign the decision notice becomes aware (or ought reasonably to have become aware) of a new material consideration, s.70(2) requires that the authority have regard to that consideration before finally determining the application. In such a situation, therefore, the authority of the delegated officer must be such as to require him to refer the matter back to committee for reconsideration in the light of the new consideration. If he fails to do so, the authority will be in breach of its statutory duty.

126. In practical terms, therefore, where since the passing of the resolution some new factor has arisen of which the delegated officer is aware, and which might rationally be regarded as a “material consideration” for the purposes of s.70(2), it must be a counsel of prudence for the delegated officer to err on the side of caution and refer the application back to the authority for specific reconsideration in the light of that new factor. In such circumstances the delegated officer can only safely proceed to issue the decision notice if he is satisfied (a) that the authority is aware of the new factor, (b) that it has considered it with the application in mind, and (c) that on a reconsideration the authority *would* reach (not *might* reach) the same decision.”

169. It is important to note that the principles in [122]-[126] were laid down solely in the context of the decision-maker’s statutory obligation to take into account “any other material consideration” (s.70(2) of the TCPA 1990). That obligation has been reconsidered more recently by the Supreme Court and the Court of Appeal in, for example, *R (Samuel Smith Old Brewery (Tadcaster)) v North Yorkshire County Council* [2020] PTSR 221; *Oxton Farm v Harrogate Borough Council* [2020] EWCA Civ 805 at [8]; and *R (Friends of the Earth Limited) v Secretary of State for Transport* [2021] PTSR 190 at [116] to [121]. The parties in this case did not address how *Kides*

now sits with this subsequent high authority and whether it needs to be understood in a different light. But this is not a matter which I need to consider in order to determine ground 4.

170. In any event, in *R (Dry) v West Oxfordshire District Council* [2011] 1 P & CR 16 Carnwath LJ (as he then was) said that the statement in *Kides* should be treated as “guidance” on what is admissible, “erring on the side of caution”. It must be applied with common sense and with regard to the facts of the particular case. *Dry* also illustrates that ultimately it is for the court to decide whether a post-committee factor is “material”.
171. Mr. Cairnes KC did not suggest that the post-resolution correspondence in this case identified a new material consideration which had arisen for the first time after the officers’ report to the committee meeting on 28 July 2020. Nor does the Trust say that their correspondence identified some material change of circumstances.
172. In my judgment the Trust’s request for a s.106 contribution had been considered at great length by HDC’s officers prior to, and in the body of, their report to the meeting on 28 July 2020. Furthermore, ground 4 should be approached on the basis that the court has rejected the legal criticism of the officers’ report, including the “Supplementary Information” document. Essentially, the post-resolution correspondence involved more submissions on the same topics, often repeating what had already been said to HDC several times. The court needs to be careful not to apply the guidance in *Kides* in such a way as would undermine the proper process for the determination of planning applications, or else there would be a risk that a Planning Committee’s job would never be done.
173. I accept the submission of Mr. Kolinsky KC that there is a short answer to ground 4. A major deficiency in the Trust’s request for a financial contribution, which officers had already identified to the committee, was its failure to show that there was a funding gap and to explain why that was so. The subsequent correspondence from the Trust did not remedy that deficiency. There was no legal obligation for officers to report to the committee material from the Trust which did not address that concern. It could not alter the position reached at the meeting on 28 July 2020 materially. Nevertheless, I will briefly refer to the points which the Trust has relied upon.
174. Mr. Cairnes KC laid emphasis upon an appeal decision by an Inspector dated 6 December 2021 at Ikea Way, Exeter where a s.106 obligation to deal with the so-called “12-month time lag” was required. The decision cannot be taken as establishing any principles. The Inspector accepted that a funding gap appeared to exist on the evidence before him in that case (DL 27 and DL 29). The Inspector even appears to have implied that whether there was a deficit in the NHS Trust’s budget was not material (DL 27), which plainly was wrong for the reasons I have given. Certainly, it is not the way the Trust has argued its case here. Ultimately, such a decision letter was of no real use to a decision-maker dealing with the financial issues in the present case without being told by the Trust what relevant materials the Planning Inspector had been given, in particular dealing with the legal, policy and contractual aspects of funding. If, for example, those materials did not remedy the deficiency in the information on funding arrangements supplied by the Trust to HDC the decision letter would not matter.

175. Furthermore, the officers' report to committee had already referred to a range of Inspector's decisions in the summary of the Trust's representations and had advised why they did not assist. That was a matter of planning judgment which has not been challenged. Similarly, there is nothing in the several references in post-resolution correspondence to other planning appeal decisions.
176. The letter from the Trust's Solicitors complained about a number of alleged errors in the officers' report to committee. None of those points is capable of supporting a *Kides* challenge. I have already rejected several of the criticisms. Several are not even new points. For example, the absence of *retrospective* funding to cover "first year" treatment had been addressed in the officers' report (see e.g. para. 4.2.49). More pertinently, the points made by the Trust assume that a funding gap, or deficit, exists in the first place. The very fact that the Trust repeated this same point in purporting to address HDC's concern that the gap had not been adequately explained and demonstrated, only serves to show that the Trust was still refusing or failing to deal with that issue. The Trust's assertion in relation to para. 6.58 of the officers' report that ONS projections only take into account natural growth is simply wrong. The projections take into account net in-migration which is relevant to the need for new development. What the Trust continually failed to do was to explain how much population growth (and of what kind) was (or could be) allowed for in the funding of the CCGs and in arriving at a new block contract each year, applying NHS rules.
177. HDC made clear in, for example, its letters dated 16 November 2020 and 10 August 2021 that the Trust had not addressed the population growth issue in the context of annual renegotiations of the block contract, taking into account the methodology of ONS projections. The reply from the Trust dated 24 September 2021 failed to deal with that central point. For example, it referred again to the passage in *Tesco* at [1995] 1 WLR 776G to 777A and said that "the tenet" of HDC's most recent letter "misses the point completely; the way the Trust is funded is irrelevant". Fortified by that misconception of the law, the letter mainly comprised a recycling of points made several times before. Reference was made once again to the use of "historical population" figures based on GP registrations, demographic weighting factors, and the use of ONS data. But no further explanation was offered on the treatment of population growth.
178. By now HDC would have been entitled to regard this protracted, unhelpful process as exasperating. The letter from HDC's Chief Executive of 9 December 2021 was reasonable and is unsurprising. HDC's officers were entitled to point to the net in-migration population forecasts produced by ONS and to conclude that the Trust had not made out its case that there would be a funding gap under the arrangements for a block contract. Given the failure, or unwillingness, of the Trust to engage with that issue over such a long period of time, it is not surprising that the Chief Executive expressed confidence that there was no problem.
179. There was nothing of any substance in the post-resolution material which officers were legally obliged to report back to the committee before planning permission could be granted in accordance with the members' resolution. Accordingly, ground 4 must be rejected.

Delay

180. If any ground of challenge had been made out, HDC and LCC invited the court to reject the claim on the grounds of delay, by treating the letter from HDC dated 9 December 2021 as the effective decision, rather than the issuing of the decision notice on 17 May 2022. Counsel recognised that this would involve creating an exception to the principle laid down by the House of Lords in *R (Burkett) v Hammersmith and Fulham London Borough Council* [2002] 1 WLR 1593. The justification for, and extent of, any such exception would be closely related and would require full argument. In the absence of such argument it would be inappropriate for this court to consider the point. In any event, because I have rejected each of the grounds of challenge, there is no need to do so.

Conclusion

181. For the reasons given above, the claim is dismissed.