NORTH LONDON PARTNERS in health and care

SECURING DEVELOPER CONTRIBUTIONS FOR HEALTHCARE:

March 2022

Contents

EXECUTIVE SUMMARY

This guide aims to establish a collaborative and consistent approach to developer contributions for healthcare in the five north London boroughs of Barnet, Camden, Enfield, Haringey and Islington. It establishes principles, outlines good practice and recommends standardised processes. It will need to be kept up to date to reflect changes to national planning policy and legislation.

Section 106 (s106) obligations and the Community Infrastructure Levy (CIL) are developer contributions secured when planning permission is granted. S106 and CIL are two different processes, but they work in parallel. S106 contributions seek to address the site-specific impacts of major developments, whilst CIL is intended to address the cumulative impact of development in an area.

Housing and population growth continues to place significant pressure on existing healthcare services and infrastructure. Developer contributions, both financial and 'in kind', provide additional infrastructure capacity to respond to growth and enable service change.

Developer contributions are an important source of capital funding for the NHS to provide new and improved healthcare premises and other infrastructure. However, the use of contributions must be justified and support the delivery of NHS service and estate plans. The guide recommends standard criteria to prioritise the use of developer contributions to maximise benefit.

There is the need for continuous engagement between boroughs and NHS organisations from plan making to project delivery. The need for developer contributions is based on infrastructure planning which should be seen as a shared exercise.

The guide recommends a standard approach to assessing the healthcare impact of development proposals and calculating s106 requirements where necessary. The HUDU Planning Contributions Model (HUDU model) provides a standardised and transparent approach to calculate potential developer contributions, to size a new 'in-kind' facility and assess the cumulative impact of development in an area.

The guide has been prepared in collaboration with the five London boroughs who support the principles and agree to implement the guidance locally. The guide was approved by the NHS North Central London Estates Board in March 2022.

The implementation of this guide in each borough will need to reflect local circumstances, policies and processes. The guide includes an appendix which sets out the different local policies and processes to secure and allocate developer contributions. This will be kept under review.

INTRODUCTION

Section 106 (s106) obligations and the Community Infrastructure Levy (CIL) are developer contributions secured when planning permission is granted. S106 and CIL are two different processes, but they work in parallel. Generally, s106 contributions seek to address the site-specific impacts of major developments, whilst CIL, where introduced by a local authority, is intended to address the cumulative impact of most development in an area. S106 obligations are secured in a legal agreement between a developer (landowner) and a local planning authority. The legal agreement defines the purpose of the obligation and any spending restrictions. CIL is a non-negotiable charge on most development and a charging authority (a London borough) has discretion as to how it allocates CIL receipts to help fund infrastructure to support the development of its area.

S106 contributions can be 'in kind' (a new healthcare facility) or financial contributions paid when development commences or is occupied. All north London boroughs have secured s106 health contributions as part of development proposals, but the amount secured and received varies significantly.

Each borough has adopted a CIL charging schedule. The scale of CIL receipts depends on the charging rates set by each borough and the overall amount of chargeable development in an area.

The Community Infrastructure Levy (Amendment) (England) (No. 2) Regulations 2019 made changes to how CIL is charged, collected and reported and clarified the relationship between CIL and s106 contributions. The Government have updated the national Planning Practice Guidance on Community Infrastructure Levy and Planning Obligations to reflect the amended regulations.

National guidance distinguishes between the purpose of s106 obligations to mitigate site-specific impacts and CIL which can be used to address the cumulative impact on infrastructure in an area. In practice, the use of s106 obligations to mitigate site-specific impacts will tend to apply to larger, strategic developments which generate a critical mass of demand for new or improved infrastructure, where there is insufficient existing capacity to accommodate the additional demand. Government guidance recognises that CIL is the most appropriate mechanism for capturing developer contributions from smaller developments.

However, planning authorities can now use CIL and pooled section 106 obligations to contribute towards the same piece of infrastructure, subject to three planning tests (Regulation 122) to ensure that s106 contributions are necessary, reasonable and directly related to the development. Authorities can choose to pool funding from different routes to fund the same infrastructure provided that authorities set out in infrastructure funding statements which infrastructure they expect to fund through CIL.

National guidance supports the use of standardised or formulaic approaches to assess infrastructure needs and s106 and CIL requirements. For healthcare, this should include the use of the HUDU Planning Contributions Model supported by other evidence.

CIL Regulation 123 Lists have been replaced by an infrastructure funding statement (under Regulation 121A) which identifies the infrastructure required to support development in an area and how it will be funded, using CIL, or s106 obligations, or a combination of both. The first statements were produced in December 2020. The statements also include details of how much money has been raised through CIL and s106 obligations and how it has been spent. There remains a significant amount of unspent s106 health contributions and a priority is to allocate and spend these funds.

In August 2020, the Government consulted on a White Paper 'Planning for the Future', which included a proposal to replace the CIL and s106 planning obligations with a new consolidated Infrastructure Levy, which would be charged as a fixed proportion of development value above a set threshold. The Government has yet to respond to the consultation. A Planning Bill was introduced in the Queen's Speech on May 2021.

LOCALISING THE GUIDANCE

Whilst a consistent approach is recommended, implementation of this guidance in each borough will need to reflect the following factors:

- The status of the Council's Local Plan and existing policies and guidance on developer contributions;
- the scale of opportunity in terms of the quantum and type of housing development;
- existing processes to allocate developer contributions, in particular with regard to CIL.

Housing and population growth in the north London boroughs

Borough	Population growth 2020-2030[1]	Ten-year housing target[2]	% of housing supply from large sites[3]
Barnet	25,800	23,640	82%
Camden	10,800	10,380	68%
Enfield	5,800	12,460	72%
Haringey	12,500	15,920	84%
Islington	8,600	7,750	38%

[1] GLA 2020-based housing led (Identified Capacity variant) projections.

[2] The London Plan March 2021, Table 4.1 - 10 year targets for net housing completions (2019/20 - 2028/29).

[3] large sites over 0.25 hectares in size as identified in the 2017 SHLAA.

The scale of housing and population growth varies considerably across the five boroughs. Housing growth is focused in Opportunity Areas as designated in the London Plan. The largest areas of growth are in

- Barnet - Colindale/Burnt Oak and Brent Cross/Cricklewood Opportunity Areas
- Haringey - Wood Green Opportunity Area and north Tottenham in the Lee Valley Opportunity Area.
- Enfield - Meridian Water in the Lee Valley Opportunity Area and New Southgate Opportunity Area.
- Camden - Kings Cross and Euston Opportunity Areas

Opportunities to secure s106 contributions will arise as a result of the site-specific impact of development proposals on large sites. In Barnet, Enfield, Haringey and Camden a significant proportion of housing supply is from large sites. In Islington a larger proportion of growth is from smaller sites which will still have a cumulative impact on infrastructure.

NHS ORGANISATIONS AND STRATEGIES

The NHS comprises of a number of organisations that commission and provide healthcare services and provide and manage infrastructure to enable the delivery of services. Services are commissioned by clinical commissioning groups (CCGs) and NHS England on a local, regional and national basis. Commissioners are now working more closely together, aligning their objectives with NHS providers and taking a more strategic, place-based approach. In 2016, NHS organisations, local councils and others came together to form sustainability and transformation partnerships. These partnerships are evolving to form even closer, more formalised partnerships, as integrated care systems. The NHS Long Term Plan confirmed that all parts of England would be served by an integrated care system from April 2022. This includes North Central London.

Each of the five boroughs in North Central London are working towards developing a local partnership to tackle local challenges. Borough-based Integrated Care Partnerships will bring together a range of organisations – both commissioners and providers of health and social care – to work differently and even more collaboratively to improve the health and wellbeing of the local population and reduce the health inequalities that exist within each borough.

North Central London Integrated Care Partnerships

In April 2020, Barnet, Camden, Enfield, Haringey and Islington Clinical Commissioning Groups (CCGs) merged together to form a single CCG across north central London. The merge allows for a more efficient partnership for the commissioning and integrating services at a local and strategic level. The CCG covers the five boroughs of Barnet, Camden, Enfield, Haringey and Islington – the same footprint as the emerging integrated care system.

The NHS estate is owned or leased by providers, including GP practices and NHS Trusts and by two NHS property companies - Community Health Partnerships and NHS Property Services who own and manage a number of larger health buildings. Strategies for the NHS estate therefore bring these property interests together to identify opportunities and priorities for investment and disinvestment to support service delivery and change.

The 2018 North Central London Estates Plan sets out six estates priorities to enable the delivery of health and care services to:

- develop a place based approach to support service delivery and optimise use of assets, drawing on the principles of One Public Estate
- respond to care requirements and changes in demand by putting in place a quality estate, further enabling us to tackle health inequalities and wider determinants of health
- increase the operational efficiency of the estate – improving utilisation; tackling backlog maintenance; and optimising running costs;

- enhance delivery capability – supporting wider changes in health care delivery, alongside workforce and digital enablers, including supporting opportunities to create Homes for NHS staff;
- enable the delivery of a portfolio of estates transformation projects that support the implementation of vision for care and further development of social and affordable housing.

The estate strategy identifies a total required capital investment of £614m. An investment pipeline has been developed to prioritise projects based on a set of criteria and to identify all potential funding sources. The priority projects include acute, mental health and primary care schemes involving new buildings and the redevelopment and optimisation of existing sites. The strategy also includes a disposal plan recognising that the disposal of surplus sites can generate receipts for capital investment and deliver new homes.

The NCL Estates Strategy was updated by June 2021 and the investment pipeline has been reviewed and re-prioritised.

North Central London CCG has carried out a locality planning exercise which has gathered, analysed estates data to develop locality infrastructure plans. The work assessed the impact of COVID-19 on future estate and workforce requirements. Future estate opportunities have been identified, including those arising from housing growth and regeneration and the use of developer contributions. The next phase will focus on the delivery of local care plans including a capital pipeline. The development of Primary Care Networks will shape these plans.

Local care plans aim to integrate community health and wellbeing bringing together primary care, community physical and mental health services, local authority and voluntary and community sector services, and developing a coordinated approach to manage and improve population health and reduce health inequalities. To support the plans, principles for integrated community health and wellbeing hubs have been developed which will apply to new and existing larger health buildings.

Local authorities have a responsibility for local public health and integrating health and social care through the creation of statutory health and wellbeing boards. The planning of new health services and facilities is determined by local commissioning priorities which are informed by borough Joint Health and Wellbeing Strategies and Joint Strategic Needs Assessments.

NHS FUNDING

In January 2019, NHS England published Clinical Commissioning Group (CCG) allocations covering a five year period 2019/20 to 2023/24. These CCG allocations cover the costs of commissioning core services including general and acute hospital care, maternity, mental healthcare and prescribing. ‘Place-based’ CCG allocations also include General Practice

(GP) and specialised services. Allocations for other primary care (e.g. dental services and services directly commissioned by NHS England) are operated differently.

Population figures for CCG allocations are based on GP registered list sizes. Increases for future years are based on the Office of National Statistics (ONS) projections for resident populations. In London, ONS projections often do not fully capture rapid population growth generated by large housing developments.

The availability of new NHS capital funding for estate development is constrained and funding is subject to bidding and business case processes set within an overall national and system-level capital budget. The business case approval process (see appendix) can take at least two years and often longer. While NHS providers remain legally responsible for maintaining their estates and for setting and delivering their organisational-level capital investment plans, every ICS/STP will be responsible for ensuring overall capital spending across its system remains within these budgets.

The sources of estates funding include:

- Funding for strategic projects (STP capital funded schemes) and new hospitals – the New Hospitals Programme (NHP) as part of the delivery of the Health Infrastructure Plan (HIP).
- A specific fund for primary care estate and technology called the Estates and Technology Transformation Fund which is funding a number of projects in NCL
- Landlord capital
- Savings and re-investment through optimisation of the estate
- Improvement Grants for GP premises
- One Public Estate initiatives. One Public Estate partnerships across NCL are taking a strategic approach to asset management and delivering projects.
- Local Authority Capital Programme
- Disposal receipts
- Developer contributions

Developer contributions are an important source of capital funding for the NHS, to provide new and improved infrastructure in response to housing and population growth and to enable service change. For many NHS estate projects there is a funding gap towards which developer contributions could be allocated.

There are revenue consequences of capital investment in new or improved premises, including rent and service charges which need to be addressed when securing and allocating developer contributions.

A COLLABORATIVE APPROACH TO SECURING DEVELOPER CONTRIBUTIONS

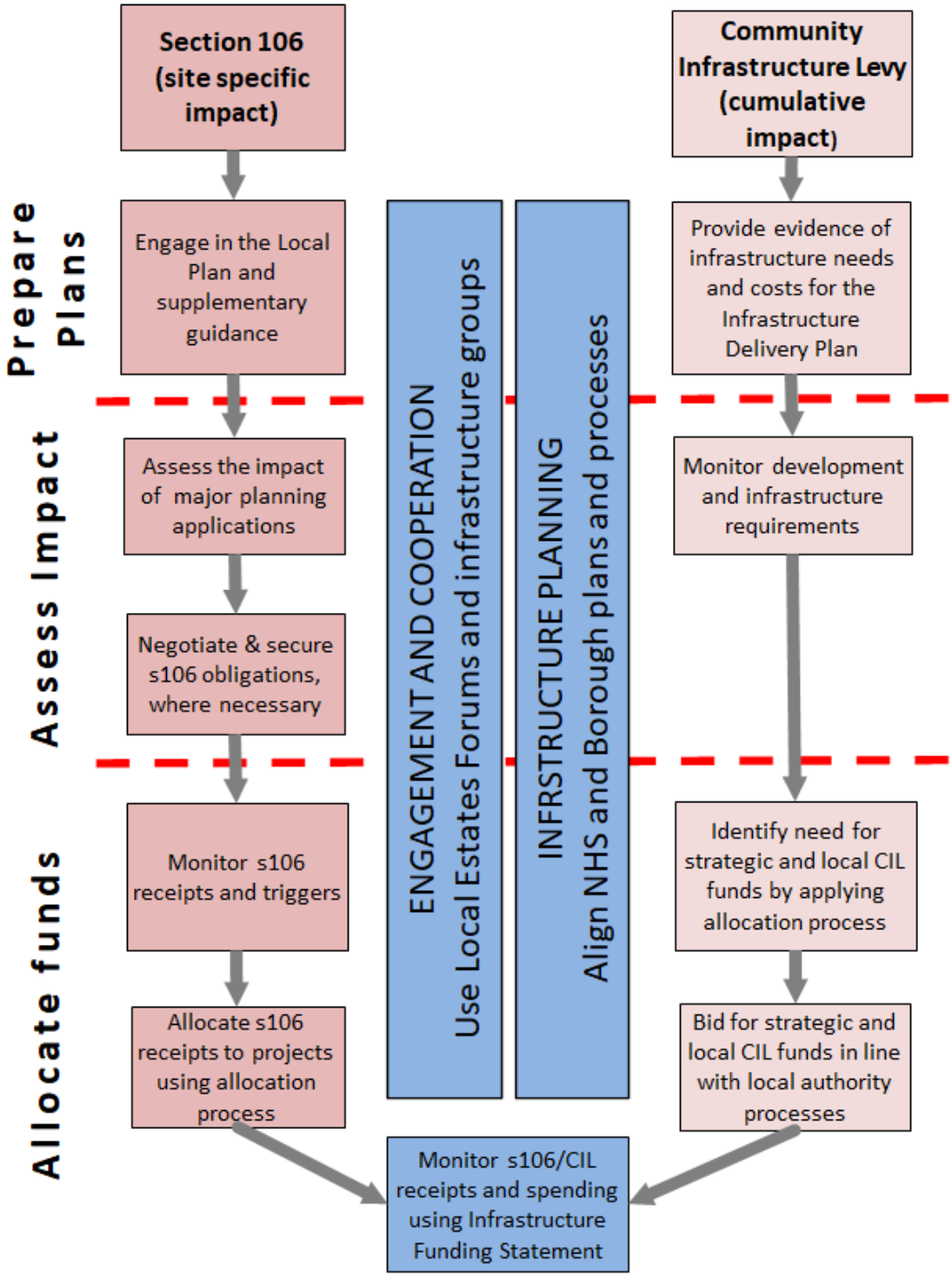
This guide aims to establish a collaborative and consistent approach to developer contributions for healthcare.

The following diagram (Diagram 1) illustrates a step-by-step approach, based on continuous engagement and collaboration between boroughs and NHS organisations from plan making to project delivery including infrastructure planning as a joint exercise between boroughs and NHS organisations.

Infrastructure planning underpins both the s106 and CIL processes. CCGs and boroughs are working together to identify future healthcare infrastructure requirements as part of evidence for Local Plans and to help allocate CIL and s106 receipts. The Council's infrastructure delivery plan and infrastructure funding statement should align with NHS estates strategies and the pipeline of capital projects and be kept under review. Much of the evidence needed has been provided by the NHS locality planning work and further work on local care plans and capital pipelines of schemes. Evidence of longer-term infrastructure requirements covering a plan period up to 15 years could be provided by the HUDU Planning Contributions Model.

Local Estate Forums and other partnership groups allow evidence and plans to be shared and can facilitate discussions regarding development proposals, infrastructure requirements and projects which will help prioritise investment.

Diagram 1: An approach to securing and allocating developer contributions



Preparing plans

CCGs are statutory consultees on Local Plans and there is a legal duty for boroughs to cooperate with CCGs and NHS England on the preparation of Local Plans. Therefore, it is important that CCGs and other NHS organisations collectively engage in the Local Plan process to help shape planning policies, to promote health as a priority for s106 contributions, to allocate sites for new health facilities where needed and to identify NHS sites which could be redeveloped to provide modern health facilities and/or new housing. A collaborative response bringing together input from NHS Trusts and NHS Property Services and local public health teams is encouraged.

Where new or improved health facilities are needed, sites should be identified and allocated a health use. The CCG should attempt to identify site requirements over the full Local Plan period. However, it may only be possible to identify broad locations or different site options for longer term requirements.

The provision of a new health facility should support the delivery of NHS clinical strategies and models of care and should address the cumulative impact of development and population growth in an area and the capacity of existing services and premises. A strategic approach addressing the healthcare requirements over a wider area, for example a locality or a regeneration area, should help avoid the piecemeal provision of healthcare floorspace within development proposals.

Local Plans should include policies which support the use of developer contributions for healthcare and s106 planning obligations should be sought from large developments where necessary where there is a site-specific impact. Policies should advocate the use of the HUDU Planning Contributions Model.

Local Plan policies and supporting guidance will set out the types and sizes of development from which s106 planning obligations will be sought. A commonly used threshold is 10 or more residential units as defined as major development. Large development proposals are more likely to have a site-specific impact than smaller schemes which will generate a cumulative impact and therefore could be addressed by CIL. The appropriate threshold will be determined by the scale and nature of development in a borough. For example, Enfield seeks s106 health contributions on schemes over 50 residential units. Other types of development, such as student accommodation and care homes will also have an impact on healthcare infrastructure and s106 planning obligations should be sought where justified.

Boroughs should consult CCGs on their CIL draft charging schedule and work with CCGs to provide evidence of infrastructure needs and costs and a funding gap. The infrastructure delivery plan and infrastructure funding statement should identify projects towards which CIL and s106 funds could be allocated.

Assessing the impact of development

CCGs should be notified of major planning applications. The CCG should provide a named contact or contacts, or a generic email address to the borough to facilitate this.

The borough should seek the CCG's views on large development proposals when engaged in pre-application discussions with a developer. CCGs should work with boroughs to ensure that new health facilities on sites identified in the Local Plan are secured, or to seek s106 financial contributions where necessary to address a site-specific impact.

Where a large development proposal is subject to Environmental Impact Assessment (EIA), CCGs should be consulted at the scoping stage to ensure that the impacts on health infrastructure are properly assessed. CCGs and developers should agree the approach to be used, including data sources and assumptions. The assessment may give rise to further discussions with the CCG regarding existing and planned healthcare capacity and potential mitigation in the form of developer contributions. The Environmental Statement will also assess the cumulative impact of developments within the wider area.

A borough may also require a health impact assessment to be submitted with a large planning application. In addition to addressing wider health and wellbeing issues, it will typically assess the impact on healthcare services and infrastructure. CCGs should liaise with borough public health teams regarding this assessment.

CCGs and boroughs should work together to monitor housing and population growth and identify when and where growth might trigger the need for new or improved health infrastructure or might affect the timing and capacity of an existing project. Boroughs should consult CCGs when reviewing the infrastructure delivery plan and the annual infrastructure funding statement to ensure that they capture projects which could require developer contributions.

Securing s106 financial contributions

Boroughs can seek to secure s106 contributions for a wide range of purposes, including transport and highways, affordable housing, local employment and training, green and social infrastructure, including health.

A s106 contribution must be necessary, directly related to the development and reasonable. These requirements are known as the Regulation 122 tests.

CCGs and boroughs should work together to ensure that a s106 health contribution is justified and based on evidence, demonstrating that:

1. the contribution is necessary, showing that there is insufficient healthcare capacity in the area to accommodate additional demand generated the development;

2. the contribution is directly related to the development proposal by identifying how it will be used to address the impact, for example, to increase capacity at a nearby health centre;
3. the contribution is reasonable, based on a clear calculation of the costs involved in providing the additional capacity needed.

The HUDU Planning Contributions Model should be used to help calculate a financial contribution or size an 'in kind' health facility. Paragraph 11.1.37 of the London Plan (March 2021) supports the use of the model. Additional evidence will be needed to assess the capacity of existing infrastructure and to identify how the s106 contribution would be spent. The Strategic Health Asset Planning and Evaluation (SHAPE) tool is a useful map-based application that links published data and helps identify existing healthcare services and assets in an area and can help assess existing capacity.

S106 contributions are negotiated taking into account the financial viability of the development proposal and borough priorities, particularly the need for affordable housing. Whilst national guidance states that funds can be used from both CIL and s106 planning obligations to pay for the same piece of infrastructure, it may not be possible, or preferable in some cases, particularly where there are financial viability issues to secure a s106 health contribution in addition to a general CIL payment.

CIL payments can be more certain that s106 contributions and are paid on commencement of development rather than completion. However, CIL funding cannot be used to make the development acceptable in planning terms. Nevertheless, the CCG and borough should work together to establish the need for additional healthcare capacity related to a specific development and to identify the requirement for a CIL allocation in the borough infrastructure delivery plan.

In-kind health facilities

The requirement for a new health facility should be identified in the Local Plan. S106 in-kind contributions can be used to support the provision of new health facilities, particularly in Opportunity Areas where there is little or no existing infrastructure. There may be different site options and the CCG and borough should work together to identify the preferred site option having regard to the location, scale of development and phasing of each site.

A new health facility secured as an in-kind obligation as part of a development proposal must be necessary to make the development acceptable in planning terms. However, the size of the facility may also need to address the wider cumulative impact of development in the area. In this case, the use of s106 contributions and/or CIL receipts from neighbouring developments could help deliver the facility.

New health facilities also offer the opportunity to transform services, in line with NHS commissioning priorities and new models of care. The requirement for on-site health

provision should be assessed on a case-by-case basis, having regard to the current provision and capacity of services and premises, the cumulative demand for services in the wider area, and service and estate strategies. The piecemeal provision of smaller facilities, such as small GP surgeries should be avoided.

New s106 in kind health facilities should be deliverable and affordable, having regard to the availability of NHS capital funding and the revenue cost implications of rent and service charges.

A facility provided by a developer as shell and core space at an open market rent should therefore not be considered as a s106 obligation. Market rents and service charges, particularly in high cost areas are not affordable to NHS organisations. Where possible, rental levels for a s106 shell and core health facility should be reduced below market rents, having regard to development viability and other s106 priorities. Advice from the District Valuer should be sought and the rental level should be specified in the s106 legal agreement. The agreement could also seek a review of lease arrangements and rental and service charge costs. Different funding options for delivering new facilities could be considered, including the use of developer contributions or other funding sources to fit out premises and reduce or negate rental costs, for example providing a facility on a virtual freehold basis.

CCGs and boroughs should work together to identify and address the financial risks of delivering large new facilities, particularly in regeneration areas where demand for services can be hard to predict. CCGs and boroughs should explore different solutions to reduce the risks and make best use of new facilities, which may include flexible design and management of space, temporary uses and different delivery models.

The CCG has developed an estate development toolkit which seeks to align the planning process with the NHS business case process. Appendix 3 sets out an indicative timeline for NHS capital approval process. It is important each stage of the business case process from PID / feasibility study to full business case supports the requirement for a new in-kind health facility and the use of developer contributions to deliver projects.

S106 Legal Agreement

A legal agreement will define the purpose of a planning obligations and how it will be discharged. To ensure that a financial contribution is spent appropriately, the legal agreement may define how the contribution will be spent, or a geographic restriction, and may also place a time-limit on spending the contribution.

The s106 legal agreement should set out the appropriate trigger points for the payment of the financial contribution, or the provision of an in-kind facility. This could be upon commencement of a specified number of residential units, or as per a certain phase of the development.

Where an in-kind facility is proposed, the legal agreement should include definitions of shell and core and fit out, lease arrangements and rental levels and a trigger for delivery, for example when a facility is part of a development phase or required before a specified number of homes are built or occupied.

It is recognised that NHS service and estate strategies and priorities will change over time along with development timescales and the demand for services. Where appropriate, the agreement should include a clause to trigger a financial contribution in lieu of the facility if it is no longer required, to be spent on alternative healthcare provision. In cases where a large outline permission is phased, the legal agreement may refer to the need for a healthcare delivery plan, which would be required to be submitted and agreed at a later detailed application stage. This approach has been used in north London.

The design and specification of new health facilities should comply with the requirements set out in the Department of Health and Social Care Health Building Notes and Health Technical Memoranda. The CCG should provide standard specifications for shell and core and fitted out health premises. The business case should inform the design and specification of the facility dictated by service requirements. The facility should be designed and configured to allow for flexibility of use to enable the NHS to collocate services, accommodate multidisciplinary team working, and where possible to allow the occupied space to expand or reduce as future demand and service requirements change. These requirements could be agreed at the appropriate design stage or phase of a development. The CCG should be consulted on a draft legal agreement and advice should be sought from the District Valuer, NHS Property Services and estate advisors, and a clinical planner or architect may need to be engaged.

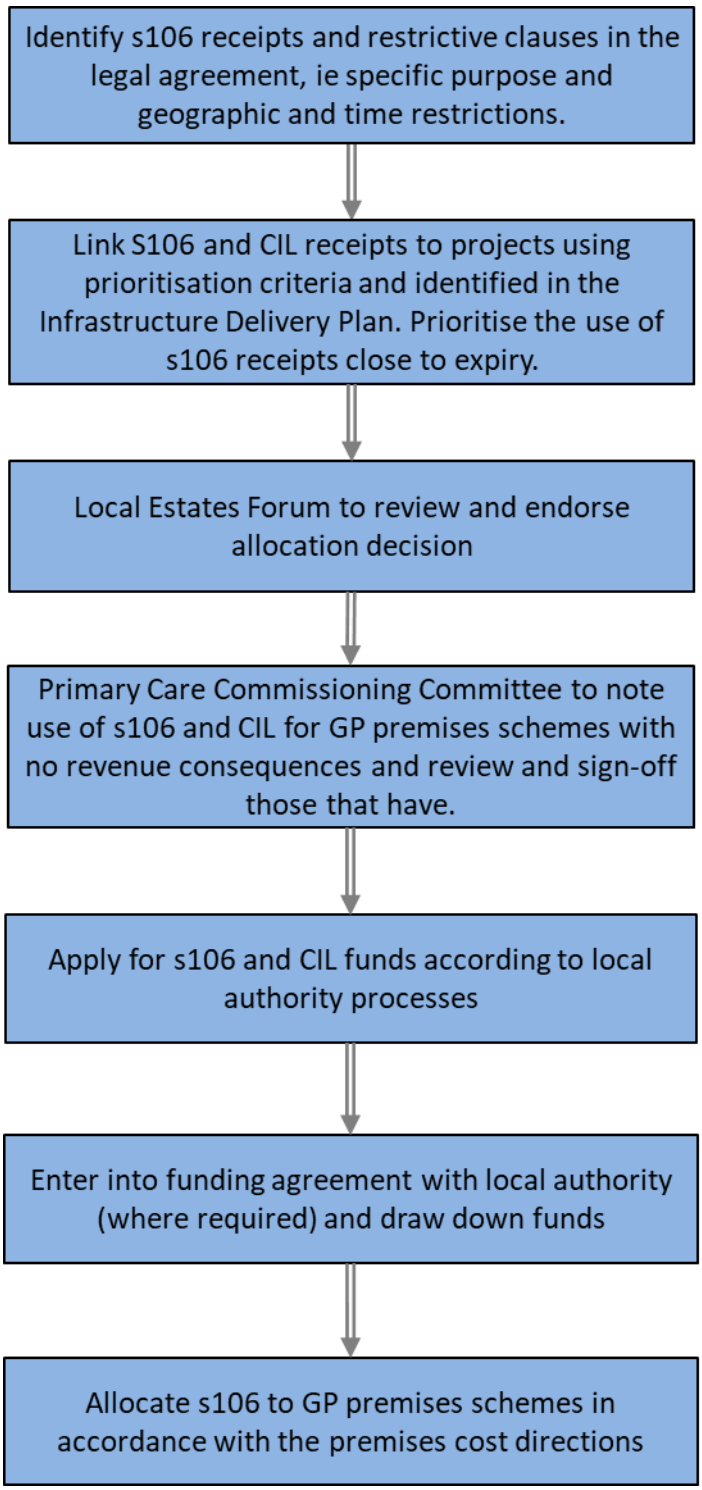
Allocating developer contributions to projects

Developer contributions are an important source of capital funding for the NHS which can help to provide new and improved healthcare premises and other infrastructure. However, the use of contributions must be justified and support the delivery of NHS estate plans and commissioning priorities and enable the transformation of services.

Allocating section 106 contributions

The s106 legal agreement may define how the contribution will be spent, or a geographic restriction. CCGs and boroughs should work together to monitor s106 contributions and allocate receipts to identified healthcare projects. These projects should reflect the NCL estates strategy and estate priorities and should be identified in the borough's infrastructure delivery plan and infrastructure funding statement. S106 contributions can be paid on commencement of development, on occupation, or in the case of large, phased developments, in stages. Earmarked s106 contributions not yet received but expected could be set aside for a specific project. S106 receipts that are time limited and close to expiry should be prioritised.

Diagram 2: Overall process to allocate and spend s106 contributions



The diagram above sets out a suggested process to allocate and draw down s106 funds. The first step is to identify banked and future s106 funds and to link to potential healthcare projects taking into account any spending restrictions. There may be an opportunity to pool s106 contributions and to link CIL receipts where there is a funding gap.

The second step is to prioritise projects where funding is needed to ensure successful delivery, to provide additional capacity and to support the transformation of services. The following criteria should be used.

Diagram 3: Criteria for prioritising projects

The allocation of s106 to identified projects could be discussed at the Local Estate Forum and at Council officer infrastructure groups before an NHS decision is made. Internal estates oversight groups monitor and review progress on projects and spending.

The NHS Primary Care Commissioning Committee has a role to approve the use of s106/CIL for GP premises schemes which have revenue implications.

To release s106 funds the CCG should submit a report to the borough identifying how the s106 funds would be used to deliver a project or programme, including details of engagement and project sponsorship where needed, project timescales and justification in terms of alignment with the Local Plan and infrastructure delivery plan and spending priorities set out in the infrastructure funding statement.

S106 funds are transferred as a grant, in some cases with conditions to ensure that the monies are used appropriately. A funding agreement may be required. The Infrastructure Funding Statement monitors the allocation and use of s106 contributions.

Allocating CIL receipts

Local authorities must spend the CIL receipts on infrastructure needed to support the development of their area, and they will decide what infrastructure is needed. The annual infrastructure funding statement should report on the infrastructure projects or types of infrastructure that the authority intends to fund wholly or partly by 'strategic' CIL.

Although the allocation of CIL is discretionary, boroughs are strongly encouraged to indicate how existing and future strategic CIL receipts will be broadly allocated by infrastructure type, such as healthcare, to help CCGs and other NHS organisations to plan for infrastructure with some certainty. It is recognised that CIL receipts will not pay for all infrastructure needs. It is suggested that the same criteria are used to prioritise projects where CIL funding is needed to ensure successful delivery and fill a funding gap and to meet shared strategic health and care objectives.

Boroughs will set up their own arrangements for allocating their CIL using their capital programme to agree expenditure. Projects submitted for CIL funding will be assessed against available CIL receipts, infrastructure priorities identified in the infrastructure delivery plan and evidence of deliverability. To release CIL funding, a funding agreement may be required supported by a project plan or business case to set out in detail how the funding will be used and the timing of payments to ensure that a project is delivered.

Local authorities must allocate at least 15% of CIL receipts towards local projects that are agreed with the local community in areas where development is taking place (known as neighbourhood CIL). In areas which have a Neighbourhood Plan, 25% of CIL receipts can be used for neighbourhood projects. CCGs should respond to consultations on the allocation of neighbourhood CIL, for example where improvements to a local GP surgery or a health centre may be identified as local priority.

Appendix 1 Local Policies and Processes

Borough	Allocating Strategic and Local CIL	Securing and Allocating S106
Barnet	Barnet (strategic) CIL is allocated by the Council's Capital Strategic Board and reported as part of the annual capital programme. An officer CIL / S106 Group advises on infrastructure requirements and projects. The Council allocates the Neighbourhood Portion of CIL through three Area Committees. Each area committee has an allocation of £400,000 per year and sets local priorities. Applications for projects should be supported by ward members. Approval of Barnet CIL funding is subject to the submission of a detailed request form to the Council's Capital Strategic Board. Projects are identified in accordance with the Infrastructure Delivery Plan.	The Council's Planning Obligations SPD (April 2013) identifies that new health facilities as part of a large development may be secured as a s106 planning obligation (for example in Colindale and Brent Cross), but financial contributions should come from CIL. The allocation of s106 receipts should be accordance with the terms of each s106 legal agreement. The CCG attends a CIL/S106 Officer Group which discusses the allocation of s106 receipts and future bids which are submitted to Council's Capital Strategic Board. Projects are identified in accordance with the Infrastructure Delivery Plan. S106 funds have been drawn down as a grant paid by the Council to the CCG. The release of funds have been subject to a funding agreement which acknowledges the role of the CCG to distribute funds towards the specified project and to monitor and report on the expenditure. The full grant must be spent on the project and within the specified end date.
Camden	70% of the Camden's CIL is spent on borough-wide strategic infrastructure to support growth. A Strategic CIL Funding List indicates projects which are expected to the funded by strategic CIL. The list (Dec 2020) includes three health projects. It will be updated at regular intervals to reflect changing priorities and the availability of funding.	Camden Planning Guidance on Developer Contributions (March 2019) states that planning obligations will be used for local infrastructure requirements directly related to a development site. Since CIL has been introduced, s106 contributions have not be secured for projects on a strategic funding list (formerly CIL Regulation 123 list).

Borough	Allocating Strategic and Local CIL	Securing and Allocating S106
	25% of the Camden CIL will be allocated locally by ward councillors. The spending process is guided by Local CIL priority lists for each ward. These lists have been developed by ward members in consultation with their local communities usually every three years. A proposal to spend Local CIL must be submitted on the standard form and submitted or sponsored by ward councillors. Local CIL has been allocated towards improvements at a GP practice.	S106 contributions were secured before the introduction of CIL. S106 funds are generally allocated on a ward basis. Ward members are consulted on suggested projects and recommendations are reported to the Cabinet Member. Sign-off as grant funding is delegated to the Executive Director. S106 health contributions have been spent on two healthcare projects.
Enfield	In Enfield 80% of CIL receipts are allocated towards strategic projects. To date most receipts have been allocated towards infrastructure in Meridian Water. CIL is allocated to strategic projects by a Strategic Infrastructure Delivery Board in conjunction with Corporate Finance and reported as part of the annual capital programme. This is supported by an officer-led Infrastructure Delivery Steering Group who identifies projects in line with the priorities in the Infrastructure Delivery Plan and Council Plan. 15% of CIL receipts are ringfenced for spending on local projects known as Enfield Neighbourhood Fund. The Council is currently seeking small scale projects of between £10-60k. 50% of the current £1.4m fund will be allocated towards 'external' projects.	The Council's Section 106 SPD (Nov 2016) supports s106 health contributions and use of the HUDU Model. The CCG are notified of large planning applications and s106 contributions have recently been secured. The allocation of s106 receipts should be in accordance with terms of each s106 legal agreement. Project bids are submitted via an application form to Infrastructure Delivery Steering Group who assess and recommend projects in line with the priorities in the Infrastructure Delivery Plan and Council Plan. The Strategic Infrastructure Board scrutinises and approves s106 in line with the Council's scheme of delegation. The CCG has recently bid for s106 funds to help deliver a new health facility. S106 funds will be drawn down as a grant paid by the Council to the CCG.

Borough	Allocating Strategic and Local CIL	Securing and Allocating S106
	Applications for neighbourhood CIL will be assessed on priorities set out in the Council's Plan and recommendations in an Enfield Poverty and Inequality Commission report. Bids will be assessed by Executive Management Team and awarded by the Leader of the Council.	
Haringey	Between 70-80% of CIL receipts are spent on strategic CIL (SCIL) projects. The SCIL Infrastructure List includes social and community facilities. The Council's Infrastructure Funding Statement (2019-20) sets out spending criteria for SCIL. Normally, SCIL projects must be spent on projects included on the annual Capital Programme. However, projects outside of the Capital Programme can be considered for SCIL by the Assistant Director for Planning and referred to the Capital Board. Haringey allocates 15% of CIL receipts towards Neighbourhood CIL projects (NCIL). This increases to 25% where there is an adopted Neighbourhood Plan. Local projects are identified in consultation with local neighbourhoods. Haringey is currently split into 9 NCIL areas. The Infrastructure Funding Statement (2019-20) includes a methodology for allocating NCIL to the neighbourhood areas. The Council will be running a Round 2 consultation to help decide what to spend NCIL on in the future.	The Council's Planning Obligations SPD (March 2018) states that CIL is the principal source of funding for new and expanded social and community infrastructure, including health. New on-site provision as part of a development may be required and is secured by a planning condition. The allocation of s106 receipts should be in accordance with terms of each s106 legal agreement. To date, no s106 planning obligations for health have not been secured. S106 and CIL monies should be spent on projects which deliver the Borough Plan priorities for Housing, People, Place and the Economy. The priorities are informed by the Local Plan Infrastructure Delivery Plan which includes health infrastructure needs.

Borough	Allocating Strategic and Local CIL	Securing and Allocating S106
Islington	CIL receipts in Islington are split into three categories: Strategic CIL (50%): Used for strategically important infrastructure projects on the Council's Capital Programme. Strategic / Local CIL (35%): enables ward councillors to allocate 35% of CIL to projects which are considered to be strategically and locally significant. Local CIL (15%): For spend on ward based local projects. Each ward in the borough has a Community Plan containing a ward councillor approved list of local infrastructure projects. Any person can make a proposal for a Community Plan project to their relevant ward councillors. To allocate CIL, the Council has adopted a Borough Investment Plan. Strategic and Strategic / Local CIL can only be spent on projects included in the plan. The plan is informed by the Local Plan Infrastructure Delivery Plan which identifies needs and future requirements. The Council's Investment Panel is comprised of officers and members and is accountable for recommending approval of all CIL/s106 investment decisions and spend oversight.	The Planning Obligations SPD (Dec 2016) identifies that health infrastructure is normally addressed through CIL but there could be some provision on site secured as s106, particularly on large sites as the need arises. There were s106 contributions secured and received before the introduction of CIL. Planning obligations are categorised as either discretionary or non-discretionary. Non-discretionary funds are secured for specific purposes and the allocation should be in accordance with terms of each s106 legal agreement. Discretionary funds are collected funds to be spent in the vicinity of the development site to mitigate the impacts in locality. These funds are allocated at a ward level to projects in each Community Plan. In all cases, allocation is subject to ward councillor approval following consideration by the Council's Investment Panel. S106 health funds have been allocated by ward councillors to a GP practice, but further funds need to be allocated.

Appendix 2 Case Studies

Barnet

This case study demonstrates the benefits of good engagement and agreed processes to allocate and spend s106 contributions.

- £2.5m received in approximately 150 individual agreements
- Funds pooled to deliver new health facility in Colindale.
- £1.2m was allocated in 2019/2020, including £900,000 for Barnet Hospital Urgent Treatment Centre project
- CCG attends CIL/s106 Council Officer Group
- Working with Council to identify remaining available funds, with priority given to spending time-limited funds before they expire.
- Established process to transfer funds and funding agreement in place based on a template provided by Capsticks.

Enfield

This case study demonstrates the benefits of good engagement and agreed policy and processes to support to secure s106 contributions.

- Planning policy supports s106 health contributions.
- CCG notified of new applications and involved in discussions of large regeneration/development schemes.
- £6.9m of new s106 funds have been sought and secured, using the HUDU model
- Mechanism introduced with cash contributions secured in lieu of a new facility if not provided or required in future.
- Regular meetings established between the CCG and planners.
- CCG has applied for release of s106 funds to help deliver a new facility.

Appendix 3 Indicative timeline for NHS capital approval process

The following table provides an indicative timeline for the NHS approval process for capital expenditure. Whilst this provides an overview and some useful assumptions, it is not a definitive description of the timeline as all projects are different, and whilst some projects may proceed through the process more quickly, others can take significantly longer. This will be dependent on the complexity and value of the project, and its funding source, as some sources may have additional approval requirements.

However, a period of two years would be a reasonable minimum period to expect a new project to progress to the point at which a firm commitment can be provided to proceed, with this being based on a simple SOC – OBC – FBC process with limited complications and straightforward approvals. It should be noted that many projects have taken far longer than this to secure approvals.

Approvals stage	**Period to proceed to approval**	**Comments**
Project Initiation Document (PID) / Strategic Outline Case (SOC)	3 months	The PID gathers information needed for the project board to decide whether to go ahead with the project or not. It provides information about the direction and scope of the project and acts as a baseline document against which to assess progress of the project and, ultimately, whether it has been successful or not. The PID is similar in nature to a SOC, and the result of its approval will be the authority to progress to the later stages of the business case process.
Options appraisal	3 months	The post-PID options appraisal will take the options raised in the PID or SOC and consider which of these is the most appropriate. This is not normally a compulsory part of the process but is considered good practice especially for larger projects. It may be that the options appraisal is drafted concurrently with the OBC.
Outline Business Case (OBC)	6 months	The main purpose of the OBC is to revisit the case for change and the preferred way forward identified in the SOC, establish the option which optimises value for money, outline the deal and assess affordability, and demonstrate that the proposed scheme is deliverable. The OBC requires a very detailed level of information on the project, and its approval provides the authority to proceed to procure the preferred solution.

Approvals stage	Period to proceed to approval	Comments
Full Business Case (FBC)	3 months	The FBC provides the evidence that the most economically advantageous offer is being procured and is affordable. In addition, the FBC explains the fundamentals of the negotiated deal and demonstrates that the required outputs can be successfully achieved. The approval of the FBC provides the approval for the signature of contracts relating to the project.

Appendix 4 Summary of the HUDU Planning Contributions Model

The HUDU Planning Contributions Model (HUDU Model) has been developed to assist NHS organisations and local authorities address the impact of new residential development and population growth on healthcare services and infrastructure and help secure developer contributions. The model provides a standardised and transparent approach to calculate potential developer contributions, to size a new 'in-kind' facility and assess the cumulative impact of development in an area.

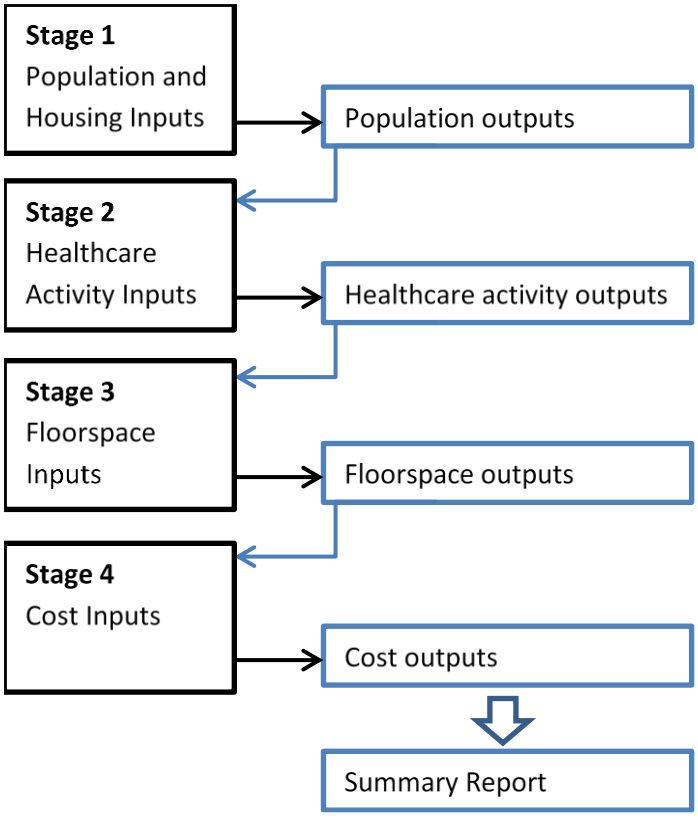
There are three analysis options. The Single Development option enables the user to assess the healthcare, floorspace and cost impacts of a single residential development. It generates a s106 capital cost requirement. In addition to residential development, the model can be used to assess the impacts of other types of development, such as student accommodation or care homes.

Using the Housing Trajectory and Population Projection analysis options, the model can be used as a forward planning tool to estimate future healthcare requirements and costs to support the preparation and review of Local Plans and infrastructure plans. The information can only be used as part of the evidence base for a borough CIL and kept under review to 'trigger' the need for investment in health infrastructure where CIL funds are needed to help fill a funding gap.

The HUDU model which was first created in 2005 and then updated and placed on a website in 2009. A third version of the model was introduced in 2016 and added new functionality and analysis options. The model is updated annually with the latest available data.

The model relies on a number of assumptions about population, healthcare activity, floorspace and costs, which are built into the model as a series of defaults. Where possible, default data is provided at a London borough / CCG level.

The HUDU model uses a step-by-step approach whereby the user progresses through the screens and calculations in sequence, with outputs generated at the end of each stage:



The model is demand-based and does not address existing or planned health service or estate capacity. Users should refer to other sources of data to assess estate or workforce using published sources wherever possible, for example from NHS Digital. The Strategic Health Asset Planning and Evaluation (SHAPE) tool is a useful mapped based application that links national data and helps identify existing services and assets in an area.

The HUDU Model is made available free of charge to all NHS Organisations and Local Authorities in London.

Please contact HUDU to obtain access http://www.healthyurbandevelopment.nhs.uk/contact-us/

Resources

Department of Health and Social Care NHS property and estates: Naylor review (2017) https://www.gov.uk/government/publications/nhs-property-and-estates-naylor-review and Government response (2018) https://www.gov.uk/government/publications/naylor-review-government-response

Department of Health and Social Care health building notes and health technical memoranda https://www.gov.uk/government/collections/health-building-notes-core-elements

District Valuer Services (DVS) Services for the Health Sector https://www.gov.uk/government/publications/services-for-the-health-sector

NHS England allocations of financial resources to Clinical Commissioning Groups (CCGs) https://www.england.nhs.uk/allocations/

NHS England NHS Long Term Plan (2019) and Long Term Plan Implementation Framework https://www.longtermplan.nhs.uk/

North London Partners in Health and Care (August 2019), NHS Long Term Plan in NCL https://www.northlondonpartners.org.uk/ourplan/

NHS England Capital regime, investment and property business case approval guidance for NHS providers https://www.england.nhs.uk/financial-accounting-and-reporting/capital-regime-investment-and-property-business-case-approval-guidance-for-nhs-providers/

NHS England Business case approval process – Capital Investment, Property, Equipment and Digital Technology https://www.england.nhs.uk/bus-case/

NHS Improvement Obtaining funds through section 106 (s106) and community infrastructure levy (CIL) https://improvement.nhs.uk/resources/obtaining-funds-through-section-106-s106-and-community-infrastructure-levy-cil/

London Estates Board and London Estates Delivery Unit and resources https://www.healthylondon.org/our-work/london-estates-transformation/

Mayor of London The London Plan 2021, including Chapter 11 Funding the London Plan https://www.london.gov.uk/what-we-do/planning/london-plan/new-london-plan/london-plan-2021

NHS Digital Data and information https://digital.nhs.uk/data-and-information

NHS London Healthy Urban Development Unit (HUDU) HUDU Planning Contributions Model https://www.healthyurbandevelopment.nhs.uk/our-services/delivering-healthy-

urban-development/hudu-model/ and Health Impact Assessment tools https://www.healthyurbandevelopment.nhs.uk/our-services/delivering-healthy-urban-development/health-impact-assessment/

Public Health England, Strategic Health Asset Planning and Evaluation (SHAPE) https://shapeatlas.net/