

**PINS REFERENCES: APP/V2255/V/24/3355313 AND
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LPA REFERENCES: 21/503906/EIOU AND 21/503914/EIOU

**Representation to the Planning Inspector from The Action Group (Rule 6
Party) on the s.106 Agreement – Highsted Park North**

Dear Inspector,

I write on behalf of the Teynham & Highsted Community Action Group in relation to the proposed Section 106 Agreement for the Highsted Park North development.

1.1 Acute Healthcare – Objection to the Proposed Contribution

The draft Section 106 Agreement provides two possible levels of acute healthcare contribution to Medway Maritime Hospital:

- “Health Care Contribution – Acute A”: the sum of £4,335,534 as a contribution towards the delivery of acute hospital inpatient ward accommodation at the Medway Maritime Hospital.
- “Health Care Contribution – Acute B”: the sum of £1,500,000 as a contribution towards the delivery of acute hospital inpatient ward accommodation at the Medway Maritime Hospital.

The Agreement further provides that the level of affordable housing is directly tied to which acute healthcare contribution is selected via the “Affordable Housing Base Provision”, namely:

- 6.08% of the total number of dwellings where the Health Care Contribution – Acute A is deemed payable;
- 10% of the total number of dwellings where the Health Care Contribution – Acute B is deemed payable.

It is clear from this drafting that a substantial reduction in the acute healthcare contribution—from £4.335m down to £1.5m—is linked to a marginal increase in affordable housing (from 6.08% to 10%).

We object to this approach for the following reasons:

(a) The reduced sum of £1.5m is not sufficient to mitigate acute care impacts

Based on the evidence already before the Inquiry (including the NHS’s own submissions), the scale of impact generated by a development of this size cannot be mitigated by a payment of only £1.5m. The NHS has previously confirmed a requirement for £4.335m, and that figure remains the only contribution proportionate to the acute service demand arising from the development.

(b) The structure of the Agreement invites acceptance of a materially inadequate healthcare contribution

By explicitly linking the acute healthcare payment to affordable housing provision, the drafting risks encouraging a choice of “Acute B” not on planning merit, but on viability grounds. This would leave the local NHS with insufficient mitigation and therefore fails the tests in Regulation 122 of the Community Infrastructure Levy Regulations (necessity, direct relationship, and scale/kind).

(c) The public interest is served by maintaining the full Acute A sum (£4.335m)

The pressures on Medway Maritime Hospital are well established before the Inquiry. Reducing the contribution to £1.5m would shift costs onto the NHS and local taxpayers, contrary to the intention of planning obligations.

For these reasons, we respectfully request that the Inspector ensure that only the “Health Care Contribution – Acute A” (£4,335,534) is considered acceptable for Medway Maritime Hospital.

1.2 Affordable Housing – Objection to Proposed Provision (6.08%–10%)

The Section 106 Agreement sets the following “Affordable Housing Base Provision”:

- 6.08% if Acute A is chosen;
- 10% if Acute B is chosen;
- 11.28% if no acute contribution is payable.

We object to these proposed levels for the following reasons:

(a) The Swale Local Plan requires 40% affordable housing in rural areas

The Local Plan policy requirement is both clear and long-standing. A provision of only 6–10% would represent a severe departure from adopted policy, especially in a rural area where affordable housing pressures are particularly acute.

(b) The Agreement explicitly allows viability to dilute affordable housing further

The Agreement states that affordable housing levels are subject to the level of financial contributions deemed payable and may be replaced by such percentage as otherwise agreed or

determined pursuant to a Viability Review. This introduces ongoing uncertainty and risks further reductions below even the already inadequate 6.08–10% range.

(c) Linking affordable housing delivery to reduced healthcare contributions is inappropriate

It is not good planning practice for one essential mitigation (acute hospital capacity) to be traded off against another fundamental requirement (affordable housing). Each obligation must be justified on its own merits, with reference to adopted policy and robust evidence.

1.3 Undefined Tenure Mix

A clear balance of tenure mix needs to be defined. For example 60% social or affordable rent and 40% shared ownership

1.4 No Local Priority Designated

Local nomination rights need to be secured, so that the affordable homes go first to people living within a set distance (eg. 5km) of the centre of each development

1.5 Mixed Layout and Quality Required

Affordable homes should be spread throughout the sites and built to the same standard as the market homes.

1.6 Acute Healthcare – Trigger Points

We are concerned at the phasing of the payments.

(a) There is no plan for temporary or short-term healthcare capacity while the development grows. We would like to see a hospital capacity plan from the NHS showing how acute services will keep up with early occupation.

(b) We note that 30% of the Acute Health Care Contribution is payable prior to the occupation of 50% of Dwellings. However, pressure on hospital capacity will start to increase at an earlier stage. We would like to see a first payment tranche brought forward to the occupation of the 100th home, to enable the NHS to expand capacity earlier.

1.7 Recommendations for Improvement: Acute Healthcare Contribution v Affordable Housing Provision

We respectfully request that:

(a) The Inspector requires the full “Health Care Contribution – Acute A” (£4,335,534) to be secured, and reject any reduction to £1.5m, which would be inadequate to mitigate the development’s impacts on acute services at Medway Maritime Hospital.

(b) The affordable housing provision should be no lower than 10%

Both obligations are necessary, proportionate and justified. Neither should be reduced through the viability-driven mechanism within the draft Agreement.

2.1 Sittingbourne Northern Relief Road (SNRR) – Summary of Objection

We raise objections to the SNRR obligations contained within Schedule 14 of the draft s.106 agreement. As currently drafted, the provisions do not secure the timely, coordinated or guaranteed delivery of the road and expose the community and local network to significant risk of congestion, delay and incomplete infrastructure.

2.2 Lack of a Fixed, Enforceable Completion Deadline

Schedule 14 focuses on procedural steps rather than a binding requirement for the SNRR to be fully completed and open to traffic by a specific occupation threshold. This enables prolonged delay during the build-out period, leaving mitigation incomplete and traffic impacts unaddressed.

2.3 Risk of Partial or Non-Functioning Road Delivery

The agreement permits phased delivery and certification of partial 'Practical Completion'. This creates the risk that a non-connecting or incomplete 'stump road' could be deemed compliant despite failing to function as a relief road.

2.4 Risk of 'Value-Engineered' or Downgraded Road

The requirement for a Highways Agreement does not prevent later substitution of a lower-specification or alternative alignment. A strategic route of this scale should not be vulnerable to after-the-event redesign.

2.5 Absence of Coordination Between North and South Delivery Timelines

The SNRR only functions properly if both the northern and southern relief roads are delivered. The agreement contains no mechanism requiring coordinated delivery or linking occupation to the completion of both halves of the road. If the southern relief road is delayed, the northern road could operate for years leaving no through connection to the M2 – creating extra traffic flow on the already congested A2.

2.6 No Consequences for Late or Non-Delivery

There is no penalty, default mechanism or compensatory mitigation if delivery is delayed. For a strategic highway, reliance on procedural compliance alone is inadequate and exposes the community to prolonged impacts.

2.7 Unsecured Land Interests and Vesting Arrangements

Schedule 14 does not require all land interests to be secured prior to commencement. The absence of such a requirement risks future blockages, ransom strips or legal disputes, all of which could delay delivery.

2.8 Road Not Required to Be Open to All Traffic

The drafting does not expressly require the SNRR to be open to all classes of traffic upon completion, nor does it include fixed requirements for safety audits or operational readiness. This omission risks the road being technically constructed but not fully open.

2.9 No Interim Traffic Mitigation Plan for the A2

If the SNRR is delayed, the draft agreement contains no requirement for temporary mitigation to protect the A2 and local roads from increased traffic generated by the development.

2.10 Transfer of Ownership Without Financial Security

Clauses 19 and 20 allow ownership to change without requiring replacement bonds, guarantees or evidence of financial capacity. This is a significant weakness for an infrastructure requirement of this scale.

2.11 Trigger Ambiguity Under Schedule 2

The SNRR's commencement and occupation triggers interact with general trigger provisions in Schedule 2, creating scope for delay, ambiguous enforcement and late notification.

2.12 No Linkage Between SNRR and Other Highway Upgrades

None of the junction improvements or associated works in Schedule 15 are aligned with SNRR delivery, creating the risk that connecting infrastructure is incomplete when the road is constructed.

2.13 Ecological Impact Not Reflected in Delivery Obligations

The recital acknowledges the SNRR crosses the Countryside Gap at Stones Farm and requires additional SPA mitigation, yet Schedule 14 contains no corresponding ecological sequencing or construction-phase protections.

2.14 Recommendation for Improvement

We respectfully request that the Inspector consider requiring a strengthened highways delivery structure. This should include: (a) a requirement that the entirety of the Relief Roads - across both the North and South development areas - is fully constructed, connected and open to traffic before any dwellings are occupied; (b) a formal mechanism linking the delivery timetables of the North and South sections to prevent long-term incomplete routes; (c) performance bonds or escrow arrangements to ensure delivery even if the land changes ownership; (d) clear, enforceable trigger points aligned with completion of supporting junction works; and (e) explicit ecological sequencing requirements to ensure that SPA mitigation obligations are fulfilled in full. These measures would provide certainty, improve enforceability and ensure that the SNRR functions as intended, avoiding prolonged traffic pressure on the A2 and surrounding communities.

3.1 Summary of Objection – GP and Primary Healthcare

We object to the GP and primary healthcare provisions contained in Schedule 8 of the draft Section 106 Agreement. As drafted, the obligations do not guarantee timely or adequate delivery of primary care services for early or later residents. They place minimal enforceable requirements on the NHS Integrated Care Board (ICB), expose the community to prolonged periods without local provision and allow significant slippage in timing, scale and quality of delivery.

3.2 Early Residents Without Any GP Provision

The first GP site transfer and Primary/Community Health Contribution do not occur until 200 dwellings are occupied. This leaves the first 199 households without new GP capacity, placing additional pressure on already overstretched local practices.

3.3 Health Care Delivery Proposal at 100 Occupations Is Non-Binding

Schedule 8 §4.4 requires only the submission of a Health Care Delivery Proposal by 100 occupations. This requirement is procedural only and does not require delivery, approval or implementation. It permits prolonged delay without any breach of the Agreement.

3.4 No Requirement for the GP Facility to Open by Any Specified Stage

The Agreement requires land transfer, payment of contributions and approval of a design brief but does not require the GP surgery to be constructed, fitted out or opened by any occupation threshold. This omission is a fundamental risk to service provision.

3.5 NHS ICB Not a Party to the Agreement

The NHS Kent & Medway ICB is not a signatory to the Agreement. It therefore has no enforceable obligation to construct, fit out, fund or operate the GP facilities. All obligations fall on the developer until land transfer, after which the NHS may decline to proceed without any breach of the s.106 obligations.

3.6 No Timeframe for NHS Delivery

Schedule 8 contains no requirement for the NHS ICB to secure funding, procure contractors or open the facility within a specified timeframe. The absence of a delivery deadline undermines the purpose of the contribution.

3.7 Developer Discharged Even If No Surgery Is Ever Built

Once the land is transferred, the contribution is paid and a design brief is approved, the developer is considered to have discharged all obligations. This remains true even if no building is ever constructed, leaving residents without local healthcare provision.

3.8 Fifteen Year Refund Clause Creates Delivery Risk

If the NHS does not spend the Primary/Community Health Contribution within 15 years, the unspent funds must be returned to the developer. This creates a financial incentive for delay or non-delivery.

3.9 Contribution May Not Match Construction Inflation

The contribution of £1,666,872 risks being eroded by construction and medical inflation. Without robust indexation, the funding may be insufficient to build a viable modern primary care facility.

3.10 Healthcare Capacity Not Linked to Population Growth

The Agreement does not set minimum floorspace, consulting room numbers or staffing levels. Given the combined North and South density of 8,400 homes, the likely patient demand could exceed 20,000 people, far beyond what the specified land parcels can accommodate.

3.11 Expansion Site Triggered by Combined North and South Dwellings

The second health site (0.58 ha) is triggered by North + South dwelling totals. However, the North s.106 cannot compel the South development to proceed or meet milestones. This interdependency creates uncertainty over when necessary expansion can occur.

3.12 Absence of Temporary or Mobile GP Services

The Agreement contains no obligation to provide modular buildings, mobile GP units or any form of interim provision during the long period before permanent facilities are operational.

3.13 No Requirement for Early On-Site Health Services

There is no requirement for temporary health visitor, nurse practitioner or community health services to be available on-site during early phases.

3.14 No Local Oversight or Community Governance

There is no role for Parish Councils, ward councillors or local community representatives in reviewing the Health Care Delivery Strategy or approving the design and phasing of the new facility.

3.15 No Independent Verification or Audit

The Agreement provides no requirement for independent healthcare planners, estates experts or auditors to review whether proposed facilities meet the projected clinical need or NHS Primary Care Network standards.

3.16 Approval Mechanism Is Vague

Terms such as the 'Health Care Delivery Strategy' and 'Design Brief' lack defined minimum requirements. There is no mandated content for phasing, commissioning timetable, workforce planning or construction sequencing.

3.17 Misalignment With Other Community Infrastructure

The timing of GP provision is not aligned with delivery of schools, community centres or public transport. This creates fragmented provision and undermines early-phase community cohesion.

3.18 No Safeguard if NHS Declines the Initial 0.25ha Site

If the NHS ICB finds the 0.25ha site too small, unsuitable or unviable, the Agreement provides no fallback mechanism. The developer would still be considered compliant, leaving residents without provision.

3.19 Expansion Site Not Required to Be Serviced

The 0.58ha expansion site does not have to be serviced or connected to utilities. Unserviced land cannot be used for clinical development and risks being functionally worthless due to high connection costs.

3.20 Recommendations for Improvement

We respectfully request that the Inspector consider requiring earlier transfer of land and funding (prior to 100 occupations), binding commitments from the NHS ICB to construct and operate the facility within defined timescales, and a requirement for temporary on-site services during early occupation. Local oversight mechanisms and independent verification should also be introduced to ensure that the capacity delivered meets the actual needs of the new population.

4.1 Summary of Objection – Community Facilities

We object to the community facilities provisions within the draft Section 106 Agreement. The obligations lack clarity, enforceability and early-phase delivery commitments. There are significant risks that key facilities will be delayed, poorly governed or inadequately maintained - leaving early and long-term residents without the infrastructure required for a functioning community.

4.2 Legal Complexity and Opacity

The Agreement defines contribution triggers and delivery mechanisms in complex, highly legalistic language. This obscures the timing and sequencing of community facilities delivery, making the obligations difficult to interpret and monitor.

4.3 Late Delivery for Early Residents

Open spaces, children's play areas, community buildings and other critical amenities may not be delivered until late phases. Early residents could wait years for basic amenities that are essential for family life and community well-being.

4.4 Risks From Phased Handover

Phased transfer of land and facilities increases the risk of inconsistent maintenance standards, fragmented open space networks and areas left unfinished or inaccessible for prolonged periods.

4.5 Stewardship Organisation Not Required to Be Independent

The stewardship body responsible for managing community facilities may be developer-controlled or operated by a commercial partner. This reduces independence, limits accountability to residents and risks decisions being driven primarily by cost constraints rather than community need.

4.6 No Democratic Oversight Mechanism

There is no formal role for Parish Councils, ward councillors or community groups in the planning, delivery or management of community facilities. Community assets intended to serve local households for decades lack essential democratic oversight.

4.7 No Requirement to Publish Budgets or Maintenance Plans

The stewardship organisation is not required to publish annual accounts, maintenance budgets or asset management plans. Residents may face rising service charges with no transparency over how funds are used.

4.8 No Long-Term Maintenance Reserve

The Agreement does not require a sinking fund or reserve to cover long-term maintenance of play areas, paths, open spaces or community buildings. Without this, early underfunding may lead to deterioration or significant future cost-shifting to residents.

4.9 No Safeguards on Transfer of Stewardship Functions

The Agreement contains no controls over changes in ownership or responsibility for stewardship functions. The developer could transfer obligations to an entity lacking competence, financial stability or commitment to the community.

4.10 Patchwork Ownership and Inconsistent Standards

Phased ownership and handover arrangements risk inconsistent standards across the site, fragmented management and uncertainty regarding responsibility for different parcels of land.

4.11 Facilities Potentially Inaccessible Due to Surrounding Construction

Facilities may technically be delivered early in a legal sense but remain unsafe or effectively unusable if surrounded by construction zones, lacking completed footpaths, lighting or safe access routes.

4.12 Community Buildings Not Guaranteed in Early Phases

The Agreement does not guarantee the early delivery of community halls, meeting rooms or multi-use spaces. Without these, early residents will lack essential places for social interaction, local events and support services.

4.13 No Minimum Standards for Community Facilities

There is no definition of minimum building size, internal layout, accessibility, sustainability or fit-out standards. This risks community buildings being delivered to a basic standard that is inadequate for long-term use.

4.14 No Fallback Mechanism if Stewardship Body Fails

The Agreement provides no automatic step-in rights for Swale Borough Council or Parish Councils if the stewardship organisation becomes insolvent, withdraws or fails to maintain facilities. This could leave essential assets without effective management.

4.15 No Bonding or Financial Security for Delivery

There is no requirement for performance bonds, escrow funds or other financial guarantees to secure the delivery or long-term maintenance of community facilities. This places all risk on residents and the Council.

4.16 Recommendations for Improvement

We respectfully request that the Inspector consider amendments to secure earlier delivery of key facilities, formal community oversight mechanisms, financial transparency requirements, long-term maintenance reserves and fallback arrangements allowing the Council or Parish Councils to take over management if the stewardship body fails.

Yours sincerely

Cllr Julien Speed

Teynham & Highsted Community Action Group

24 November 2025