**Application reference: 21/01830/FUL | Land West Of Hither Green Lane Redditch Worcestershire B98 9AZ**

**Worcestershire Acute Hospitals NHS Trust’s Consultation Response and Regulation 122 CIL compliance statement in respect of the above planning application:**

This document provides a summary of the impacts of new housing developments on Worcestershire Acute Hospital NHS Trust’s (WAHT) services, as well as a calculation of the contribution sought to mitigate the impact of the development on WAHT. It provides a sense of the operating scope and environment of Worcestershire Acute Hospitals NHS Trust (WAHT). It explains:

* The impact and consequences of increasing demand upon the Trust.
* The context of the Trust and the services it provides.
* How funding flows within the NHS to show how WAHT is paid for the care it provides to the people of Worcestershire.
* The relationships WAHT has within the health and social care system in Worcestershire.

A glossary of terms can be found in Appendix 1.

**About Worcestershire Acute NHS Trust**

1. The Trust was created pursuant to the National Health Services Act 2006 (as amended) which consolidates previous Health Services Acts. The Trust has a primary obligation 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.
2. The Trust is a Secondary Care Acute services provider and delivers a range of planned and emergency hospital services to residents of Worcestershire. The Trust is subject to NHS standards, performance ratings and systems of inspection
3. WAHT was formed in 2004 by the amalgamation of three separate hospital trusts based in Redditch, Kidderminster and Worcester. Thus today, WAHT provides services for the whole population of Worcestershire from:

* The [Alexandra Hospital](https://www.worcsacute.nhs.uk/our-hospitals/alexandra-hospital-redditch/) in Redditch,
* [Kidderminster Hospital and Treatment Centre](https://www.worcsacute.nhs.uk/our-hospitals/kidderminster-hospital-and-treatment-centre) and
* [Worcestershire Royal Hospital](https://www.worcsacute.nhs.uk/our-hospitals/worcestershire-royal-hospital/) in Worcester.

1. Until 2004, each hospital provided a broad range of services for their local populations. Subsequently, the Trust has re-designed most of its services to operate on a county-wide basis (where practicable) in order to provide efficient, high quality care achieved through economies of scale. This has maximised the clinical expertise of its workforce and uses the facilities of its physical assets, such as emergency departments, wards, operating theatres, laboratories and diagnostic equipment, to best effect. Each site provides a different combination of planned and emergency services to patients from across the county, including the new occupants of this development. Despite these changes, WAHT is at the furthest end of a continuum of NHS trusts that face demand that outstrips their capacity to provide care. The services the Trust provides are listed in Appendix 2.
2. To illustrate the scale of WAHT’s activities, in 2018/19 the Trust provided care to more than 231,448 different Worcestershire patients – that is 40% of the Worcestershire population received care at one of our hospitals. The Trust saw 634 patients per day, which amounts to:

* 156,160 A&E attendances (12,220 more than the previous year)
* 152,712 Inpatients (including day cases)
* 641,486 Outpatients (including diagnostics & outpatient procedures)
* 5,261 births

1. WAHT employs nearly 6,000 people and around 800 people volunteer to help to deliver care. The Trust has an annual turnover of over £400 million. The Trust ended the 2018/19 financial year with a significant deficit above the level originally planned. The adverse position was driven largely by the provision of additional capacity to address increasing demand and workforce pressures.
2. Every NHS Trust is authorised to operate by a licence issued by the Independent Regulator. Each NHS Trust’s licence sets out the conditions under which it must operate including:

* The health services that the Trust is authorised and required to provide to the NHS.
* The standards to which they must operate and against which the Care Quality Commission (CQC) will inspect and assess.

1. In common with other NHS providers, WAHT (at each site) is regulated by and inspected against national quality standards by the CQC. In addition, NHS England/Improvement monitors each NHS Trust to ensure they do not breach the terms of their authorisation as an NHS Trust. If an NHS Trust significantly breaches the terms of its authorisation, or finds itself in difficulty, NHS England/Improvement has a range of intervention powers, including powers to:

* Issue warning notices.
* Require the Board of Governors or Board of Directors to take certain actions.
* Suspend or remove the Board of Governors or members of the Board of Directors.

In the most serious cases, where NHS Improvement intervention cannot resolve the breach, an NHS Trust can be dissolved.

1. WAHT has received a number of warning notices and has had conditions placed on its license by the CQC over the last few years. These have mainly been related to the capacity to provide urgent care, particularly to delays in ambulance handovers, fifteen-minute triage breaches and harm reviews.
2. The Trust has put in place a number of initiatives over the last three years to improve performance including;

* Initiation of a Patient Flow Programme (now superseded by the *Home First* programme) which improves the rate and efficiency with which patients flow through hospital in-patient services and back into the community in response to increasing demand. The programme has entire work-streams dedicated to improving patient safety and experience in the A&E Department and improving admission and discharge of patients through the hospital.
* An emphasis on appropriate care for those living with frailty who need acute hospital services. Frailty expertise is being introduced to Trust-wide pathways, beginning in both Emergency Departments.
* A *Same Day Emergency Care* model established at Worcestershire Royal Hospital is to be introduced at the Alexandra hospital during 2020/21. It is designed to treat patients on the day of attendance and should reduce hospital admissions by up to 20%. An expanded Medical Ambulatory Emergency Care facility opened in November 2017, followed by a Surgical Decisions Unit in 2019. Both provide alternatives to admission for emergency and urgent patients. In late 2018 a GP out of hours service was co-located with Ambulatory Emergency Care to ensure that patients receive timely assessments where their condition is more suited to primary care.
* Additional bed capacity has been required beyond normal surge capacity at the Worcestershire Royal and Alexandra hospitals throughout 2019/20 to cope with additional demand. This has required capital development to enable reconfiguration of wards and creation of 123 beds across both sites.
* Theatre and outpatient productivity programmes continue to be implemented to enable the most efficient use of outpatient clinics and theatres so that additional demand can be accommodated.

**THE SHORT AND LONG TERM IMPACT ON NHS SERVICES**

**Impact of increasing demand 1 – operational issues**

1. Each part of the health system has seen year on year growth in activity which manifests in an increase in demand for healthcare services, particularly for emergency care. Examples of the impact of these pressures include delays in offloading patients from ambulances at WAHT’s EDs; shortage of beds for those requiring admission to hospital; extended stays in hospital for patients who are otherwise fit for discharge where additional care is needed when they leave hospital. These pressures put attainment of the Trust’s NHS constitutional standards at risk (e.g. the Emergency Department “4 hour wait” and referral to treatment times).
2. It is important to note that an NHS hospital trust never closes its doors and has a legal obligation to assess and, where necessary, treat all patients who present at ED as well as those patients referred by GPs for non-emergency care. This means that increasing demand must always be accommodated[[1]](#footnote-1). There is no option for the Trust to refuse to admit or treat a patient on the grounds of a lack of capacity to provide the service/s. In some cases, patients are able to exercise choice over where they access NHS services, but in the case of an emergency, they are taken to their nearest appropriate A&E Department by the ambulance service. The Trust’s sites are the nearest in regards to this proposed development. Whilst changes to the way the Trust’s services operate have enabled improvements in productivity and efficiency (see paragraph 10), ongoing growth in demand requires investment in additional capacity in order to maintain safe hospital services.
3. This development individually and cumulatively will increase the impact on the services WAHT provides.

**Impact of increasing demand 2 – workforce issues**

1. Provision of safe hospital-based services relies on sufficient capacity within a suitably sized and skilled clinical workforce and within appropriate physical assets. WAHT has invested in two stepped costs in the last 5 years to increase the size of its physical assets to respond to increasing demand. In 2016, the Emergency Department (ED) at Worcestershire Royal Hospital was enlarged using space adjacent to the original smaller department. However, further increases in demand mean that the sizes of the Emergency and Urgent Care departments at both Worcester Royal and the Alexandra Hospital are already insufficient. In 2019, WAHT opened an additional 44 acute beds at the Alexandra Hospital in Redditch and has commenced a programme of refurbished ward accommodation at Worcestershire Royal Hospital, increasing its bed capacity on this site by 79. This was necessary to accommodate patients who need to be admitted following presentation to ED.
2. The Trust provides the majority of healthcare services through employed staff but has sub-contracted agency and/or locum staff for services because of operational pressures that result from the impact of increased demand. These are employed at a premium cost. The supply of our clinical professional workforce is nationally determined and there is limited opportunity for the Trust to influence local supply, other than through recruitment and retention. Nationally, many health professions are suffering chronic shortages. Unable to attract permanent staff, WAHT (like other acute trusts) has addressed these workforce shortages by growth in its use of locum and agency staff. In turn, their scarcity has driven up prices to a premium within a national labour market where prices are buoyed by annual increases in NHS service demand. In 2018/19, WAHT paid £46m in temporary staffing costs 16.4% of which was spent at premium rates.

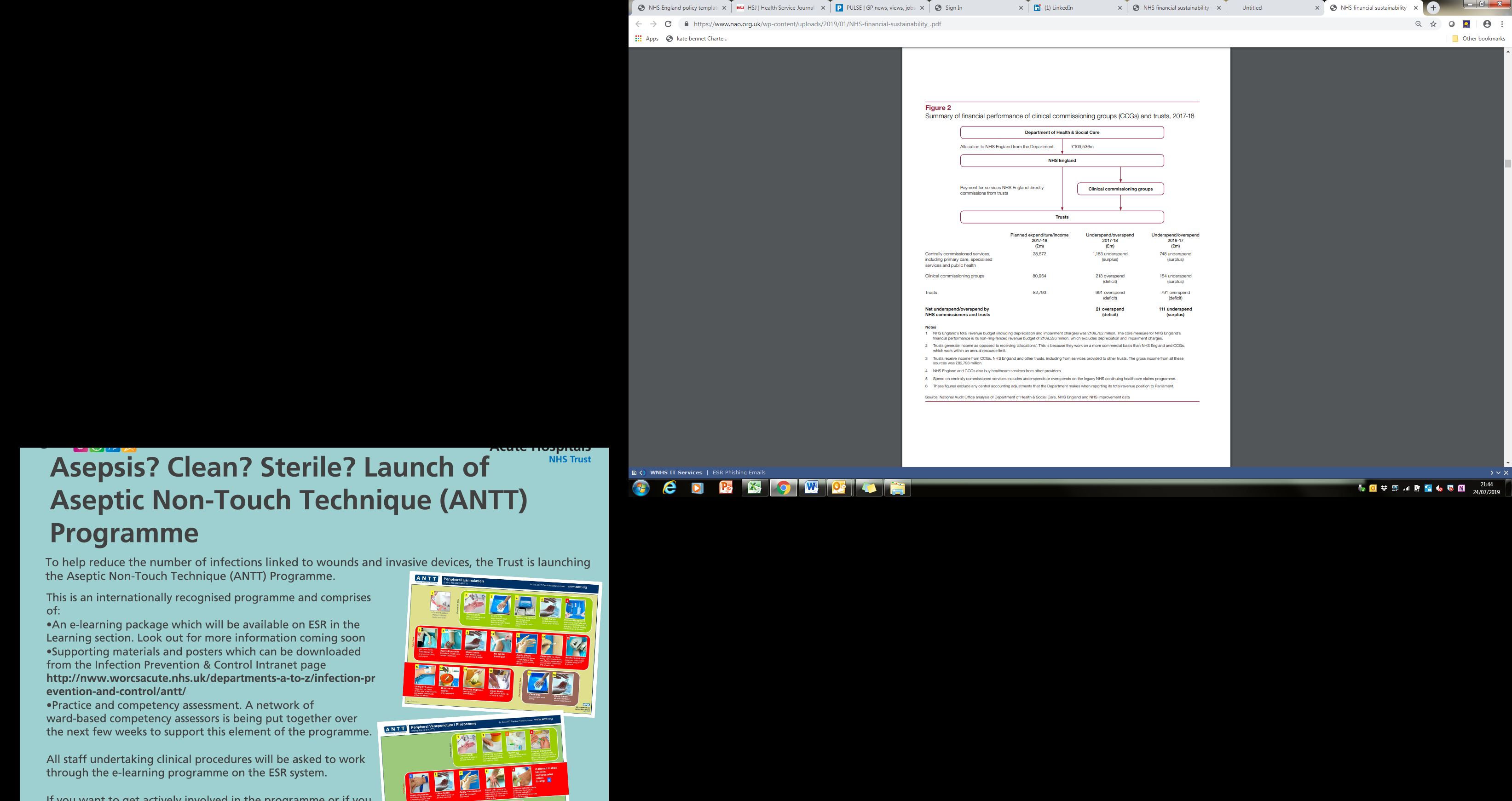
**Impact of increasing demand 3 – quality & safety issues**

1. Despite recent capacity increases, the Trust’s hospitals are operating at full capacity and there are limited opportunities to improve this further. NHS provider trusts are contractually required to comply with NHS Standard Contract quality requirements. However, at WAHT, there is insufficient operational capacity to accommodate population growth created by the development without reduction in the quality of the service (as outlined by the standards set out in the NHS Standard Contract). Ultimately, the Trust will be sanctioned financially for external factors which it is unable to control.
2. In order to maintain adequate standards of care, a key factor to deliver on-time care without delay is the availability of beds to ensure timely patient flow through the hospital. 85% bed occupancy represents the benchmark for patient safety, and it is inadvisable for bed occupancy to regularly exceed that figure[[2]](#footnote-2). NHS Improvement states that bed occupancy above 92% leads to accelerated deterioration in A&E performance. An 85% bed occupancy rate results in better care for patients and better outcomes because it enables patients to be placed in the right bed, under the right team and to get the right clinical care for the duration of their hospital stay. Where the right capacity is not available in the right ward for the treatment of a particular condition, the patient will be admitted and treated in an alternative ward or department and transferred as a more appropriate bed space becomes available. Multiple bed/ward moves increases the length of stay for the patient and is known to have a detrimental impact on the quality of care and recovery time. Consequently, when hospitals run at occupancy rates higher than 85%, patients are more at risk of delays to their treatment, of receiving sub-optimal care and have a poor experience during their hospital stay.
3. Appendix 3 shows that the Trust’s utilisation of acute bed capacity exceeded the optimal 85% occupancy rate for the last three years and increased to an average occupancy rate of 97.34% in 2018/19. This demonstrates that current occupancy levels are unsatisfactorily high, and the problem will be compounded by an increase in the population that does not coincide, with an increase in the number of appropriately-staffed bed spaces available at the hospital. This is an inevitable result where clinical facilities are forced to operate at over-capacity and is why there is now a very real need to expand the Trust facilities. Any new residential development will add a further strain on the current acute healthcare system.
4. Without mitigating the impact, this development will have individual and cumulative detrimental impact on the safety and quality of services.

**MITIGATING THE SHORT AND LONG TERM IMPACT ON NHS SERVICES**

**Funding of NHS activities**

1. Within universal coverage healthcare systems such as the NHS, services are provided free of charge. In England, publicly-provided healthcare is ultimately funded from taxation. This section describes how funding allocations, made by central government to the Department of Health and Social Care, are distributed to the NHS and onwards to NHS acute hospital service providers, such as WAHT.
2. In a given year, the level of NHS funding is set by central government through the Comprehensive Spending Review process. The process estimates how much funding the NHS will receive from central sources.  The NHS receives about 80% of the health budget, which is allocated in England to NHS England/Improvement (NHSE/I), the governing body of the NHS in England. In turn, NHSE/I allocates funds to Clinical Commissioning Groups (CCGs).
3. CCGs are clinically-led, statutory NHS bodies which are responsible for identifying the health needs of their local population. They plan and commission health care services from providers such as WAHT to meet those needs. CCGs exist to maintain and improve the health of their registered population and are, therefore, concerned with preventing as well as treating ill-health. With effect from 1st April 2020, Herefordshire and Worcestershire have a joint CCG which commissions planned and emergency acute healthcare services for the population of both counties.
4. CCGs commission most services from NHS provider organisations using their funding allocation under the terms of the NHS Standard Contract. Almost half their allocation is used to purchase acute hospital care. WAHT is the predominant acute provider for Worcestershire. The CCG also commissions acute hospital services from other trusts for Worcestershire where WAHT does not provide a particular service or does not have the capacity to meet demand. The remainder of the allocation is spent on other types of health provision (e.g. mental health and community services) and CCG running costs.
5. The following diagram, from a recent National Audit Office report[[3]](#footnote-3), shows these funding flows together with recent national financial performance.



**CCG Funding Allocations**

1. CCGs are allocated NHS funding to carry out their role using a nationally determined formula. The formula is based on independent academic research overseen by an independent external group, the Advisory Committee on Resource Allocation. Allocations are based on a weighted capitation rate. The starting point for determining a target CCG allocation is the latest estimate of the number of patients registered with a GP practice located within the CCG area (the *registered GP population)*. However, a CCG’s allocation is then ‘weighted’ according to a number of factors such as age, health inequalities, deprivation levels. A per capita rate of NHS funding is calculated for each CCG area and multiplied by the number of people registered with GP practices[[4]](#footnote-4).
2. Allowance for growth in the number of people registered with GP practices is applied to projected CCG allocations by NHS England. This population growth is based on mid-year estimates from Office for National Statistics’ age-sex specific population projections. CCG projected funding allocations comprise indicative amounts that are often adjusted, year on year, to account for in-year factors, policy changes or NHS-wide based financial out-turns, most particularly national deficits. Despite recent multi-year financial settlements for the NHS, multi-year financial allocations are subject to annual confirmation or amendment within the framework set by each year’s Comprehensive Spending Review.

**How are NHS providers paid?**

1. WAHT is part of the healthcare system in Worcestershire. Its partners include i) the Worcestershire Health & Care Trust, which provides community services such as district nursing; ii) Worcestershire County Council which provides Adult Social Care, including a range of domiciliary and care home services, as well as Public Health which commissions WAHT to provide screening services; iii) General Practice which provides in and out of hours primary care; iv) West Midlands Ambulance Service which serves all WAHT’s hospitals with both an emergency service and a patient transport service.
2. NHS providers do not have directly allocated funds. Rather, each has annual contracts negotiated with CCGs. These contracts serve as a mechanism by which CCGs commission service providers to care for those members of the population who need healthcare. Contracts include service specifications, based on clinically evidenced and recognised guidelines, which are used to monitor the quality of service delivery.
3. The annual contracts between CCGs and providers are activity based. The Trust’s contract income comprises two payment types i) payments for episodes of activity, known as tariff payments and ii) block payments, most usually for emergency and urgent care activity.
4. The National Tariff Payment System is published annually by NHSE/I. It is a system whereby CCGs pay NHS healthcare providers a standard national price (tariff) for each patient seen or treated and is based on the average cost of delivering that care across all NHS organisations***.*** The Department of Health sets the tariff annually. Tariff currently comprises 65% for staffing costs, 21% other operational costs, 7% for drugs, 2% for clinical negligence scheme premia and 5% for capital maintenance costs. The tariff is derived from the national average cost base for the delivery of hospital care and is adjusted to account for inflation, efficiency improvement and other cost base pressures. (e.g. changes to the Clinical Negligence Scheme for Trusts (CNST) premium and introduction of new medical technologies).
5. Block payment arrangements fund the Trust for a quantum of activity and include “floors” and “ceilings” to prescribe (and proscribe) activity levels. If these are under or over-achieved, penalties are applied, usually in the form of marginal payments for additional activity. In accordance with NHS policy, WAHT’s provision of non-elective admissions, A&E attendances and Same-Day Emergency Care is governed by a block contract, negotiated and agreed annually, based on the previous year’s activity levels. Overachieved activity is paid for at marginal rate, currently 20% of full cost. This does not cover the cost of providing the activity.
6. Tariff and block activity payments combine to represent out-turn activity levels for a provider for the previous year. These are the basis of the annual contract refresh. Rates of growth encountered during the current year are never entirely funded in the following year by CCGs. Additional expenditure which results from increasing demand in year, over and above contracted values, is never paid for retrospectively and so becomes an unfunded in year pressure. Thus, payment for growth always lags behind activity increases.
7. The Trust’s income does not take into consideration local housing need, housing projections or existing planning permissions. The income is always based on existing activity as explained above.

**Direct Impact of the Development and Mitigation Formula**

1. The existing service infrastructure for emergency and planned health care in WAHT is unable to meet the additional demand generated by the proposed development. The new population associated with the proposed development (individually and cumulatively) will impact significantly on service delivery and performance of the Trust until the annual contract refresh includes the activity volumes associated with the population increase. Therefore, the development and its associated demand for acute and planned health care will have an adverse effect on the Trust’s ability to provide “on time” care without delay. This will result in the Trust receiving financial penalties for not achieving performance standards (e.g. referral to treatment times).
2. The only way that the Trust can achieve the “on time” service delivery without delay and comply with NHS quality requirements is that the developer mitigates the impact and contributes towards the cost of the Trust providing the necessary capacity to maintain service delivery during the first year of occupation of each dwelling. Without securing such contributions, the Trust will have no funding to meet healthcare demand arising from each dwelling during the first year of occupation and the healthcare provided by the Trust would be significantly delayed and compromised, putting local people at risk.
3. The calculation used to calculate the mitigation required to offset the impact of additional demand created by the development can be found in Appendix 4.

**Explanation of formula to calculate s106 developer contribution**

1. All activity undertaken by the Trust is traceable to a patient through the patient’s address, NHS number and registered GP, which are recorded each time a patient is treated. This activity count does not represent discreet patients, but the amount of activity (episodes of care) undertaken.
2. The Trust has calculated the financial impact of the development on its resources and the mitigation required to meet additional costs. The calculation table (Appendix 4) is colour-coded to support the reader’s understanding of the calculation.
3. The Trust’s is careful to establish only the demand for Trust services that arises from people who will move into the development from outside Worcestershire, since these people are not included in the Worcestershire CCG’s funding envelope. This “new population” is calculated using the characteristics of the development, to establish a predicted number of people per household. The proportion of the development population who will be new to Worcestershire is established by analysis of census data and subregional population predictions. The method has been specifically developed for these calculations by a specialist planning consultancy. The Trust updates its population prediction data periodically.
4. Principally, demand for the Trust’s services arises from referrals from GPs and from attendances at Emergency Departments. To establish the predicted impact of the development on the Trust’s services, the Trust identifies activity for a number of points of service delivery within the LSOA in which the development will be built. This is predicated on the likelihood that population new to Worcestershire will use the GP and hospital services local to the LSOA. These usage rates are then multiplied by the new population to arrive at the new population’s impact.
5. For a detailed explanation of the calculation, please refer to Appendix 4.
6. As a consequence of the above and due to the payment mechanisms the Trust is subject to, it is necessary that the developer contributes towards the cost of enabling the Trust to provide services during the first year of occupation of each dwelling. The contribution requested is based on this calculation 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 securing such contributions, the Trust would be unable to support the proposals and would object to the application because of its direct and adverse impact on the delivery of healthcare in the county. Without the contribution being paid, the development would not be acceptable in planning terms because there would be inadequate health services available to support it and there would be detrimental impact to others in Worcestershire.
7. Therefore, the contribution requested for this proposed development of 216 dwellings is £153,253.44. This contribution will be used directly to provide additional services to meet patient demand as indicated in Appendix 4.

**Summary**

1. As its evidence demonstrates, the Trust is currently operating at full capacity in the provision of acute and planned healthcare. The contribution is being sought not to support a public body but rather to enable that body (i.e. the Trust) to provide services needed by the occupants of the new homes. The development directly affects the Trust’s ability to provide the health services to those who live in the development and the community at large. Without contributions to maintain the delivery of health care services at the required quality standard, and to secure adequate health care for the locality, the proposed development will strain services, putting people at significant risk of receiving substandard care, leading to poorer health outcomes and prolonged health problems. Such an outcome is not sustainable and will have detrimental socio-economic impact on the community.
2. The Trust acknowledges that housing developments are constructed and occupied in phases and therefore is willing to negotiate staged payments of the total sum claimed. The money will be spent to meet the marginal costs of direct delivery of healthcare for the additional population. This will include the cost of medical, nursing and other health professional staff, which may be incurred at a premium rate. The money will also meet increases in other direct costs associated with healthcare delivery, for example, diagnostic examinations, consumables, equipment.

The table below is indicative of the range of costs that will be mitigated by s.106 claims.

|  |  |  |
| --- | --- | --- |
| ***Cost descriptor*** | | |
| Emergency Department | Drugs | Outpatients |
| Blood | Endoscopy | Pathology |
| Consultants | High cost drugs | Pharmacy |
| Critical Care | Junior doctors | Prostheses/implants/devices |
| Clinical Negligence Scheme for Trusts | Nursing | Imaging |
| Other diagnostics | Specialist nursing | Operating theatres |
| Dental | Therapies | Ward and other settings |

**Policy**

1. One of the three overarching objectives to be pursued in order to achieve sustainable development is to include *b)* ***a social objective –*** *to support strong, vibrant and healthy communities … 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:”* NPPF paragraph 8. There will be a dramatic reduction in safety and quality as the Trust will be forced to operate over available capacity as the Trust is unable to refuse care to emergency patients. There will also be increased waiting times for planned operations and patients will be at risk of multiple cancellations. This will be an unacceptable scenario for both the existing and new population. The contribution is necessary to maintain sustainable development. Further the contribution is carefully calculated based on specific evidence and fairly and reasonably related in scale and kind to the development. It would also be in the accordance with Council's Adopted Development Plan as follows:

***Borough of Redditch Local Plan No.4 (Adopted 30 January 2017)***

*Health 1.53 The ‘Health Profile for Redditch 2012’ (NHS) suggests that the health of people living in the Borough is mixed compared with the England average. Levels of alcohol-specific hospital stays among those under 18, smoking in pregnancy and estimated levels of healthy eating and obesity are worse than the England average. The rates of statutory homelessness, long term unemployment and drug misuse are lower than average.*

*1.56 The proportion of children in Reception year who are classified as obese is similar to the England average. Levels of physical activity in schools are better than the England average. It is estimated that levels of healthy eating and obesity in adults are worse than the England average. Rates of road injury and deaths are lower than the England average.*

Chapter 8 of the NPPF elaborates paragraph 8 in paragraph 92, which directs that:

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

*a) … ;*

*b) … ;*

*c) guard against the unnecessary loss of valued facilities and services, particularly where this would reduce the community’s ability to meet its day-to-day needs;*

*d) ensure that established shops, facilities and services are able to develop and modernise, and are retained for the benefit of the community; and*

*e) … .*

In the circumstances, without the requested contributions to support the services infrastructure the planning permission should not be granted.

**04 March 2022**

**Appendix 1: Glossary of terms**

**Definitions**

* ***Accident and emergency care:***[*Accident and Emergency Departments*](https://www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/a/accident_and_emergency_department_de.asp?shownav=1)*may be i) major units, providing a 24 hour service seven days a week to which the great majority of emergency ambulance cases are taken, or ii) smaller units commonly called minor injury units, in which services are often only available for limited hours and which may not deal with emergency ambulance cases.*
* ***Acute care:*** *This is a branch of hospital healthcare where a patient receives short-term treatment for a severe injury or episode of illness, an urgent medical condition, or during recovery from surgery. In medical terms, care for acute health conditions is the opposite from chronic care or longer-term care.*
* ***Block Contract:*** *a payment made by the commissioner to a provider to deliver a specific and defined range of services, regardless of the volume of services delivered. The value is independent of the actual number of patients treated or activity completed. Block contracts generally operate on a annual basis.*
* ***Clinical Commissioning Group (CCG):*** *CCGs are clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area.*
* ***Community care:*** *long-term care for people who are elderly or disabled which is provided within the community rather than in hospitals, especially as implemented in the UK under the National Health Service and Community Care Act of 1990*
* ***Dr Foster****: Dr Foster provides healthcare information and intelligence particularly about the performance of NHS trusts. Dr Foster uses data-driven methodologies to support organisations to improve quality and efficiency.*
* ***Emergency care:*** *Care that is unplanned and/or urgent.*
* ***NHS Improvement (NHSI):*** *NHSI was a health services organisation that was responsible for supporting NHS trusts to provide consistently safe, high quality care within a local health system that is financially sustainable. On 1st April 2019, NHSI and NHS England came together as one organisation to better support the NHS to deliver improved care for patients.*
* ***Office of National Statistics****: Known as ONS*
* ***Operational Pressures Escalation Levels*** *(OPEL)****:*** *OPEL is a standard framework for Trusts to report levels of pressures nationally using a consistent approach.*
* ***Planned care:*** *Medical care that is provided by a specialist or facility upon referral and that requires more specialised knowledge, skill, or equipment that can be provided by the referrer.*
* ***Premium Costs:*** *Premium costs incurred by an NHS trust include the supply of agency staff, Locum Medical Staff and payments to deliver services to meet operational pressures which exceed the costs incurred when delivering with substantive staff.* *It also covers sub-contracting the provision of certain services to third parties to meet demand.*

**Appendix 2: List of services provided by Worcestershire Acute NHS Hospitals Trust**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Alexandra Hospital** | **Kidderminster Treatment Centre** | **Worcestershire Royal Hospital** |
| Emergency Department, including trauma |  |  |  |
| Emergency department |  |  |  |
| Minor injuries service |  |  |  |
| Urgent medical admissions |  |  |  |
| Stroke service |  |  |  |
| Cardiac angiography |  |  |  |
| Diabetes service |  |  |  |
| Outpatient Renal dialysis |  |  |  |
| Oncology - chemotherapy |  |  |  |
| Oncology – radiotherapy |  |  |  |
| Elective surgery – high risk/complex |  |  |  |
| Elective surgery |  |  |  |
| Intensive care |  |  |  |
| Daycase surgery |  |  |  |
| Radiology diagnostics |  |  |  |
| Endoscopy |  |  |  |
| Outpatient appointments (all specialties) |  |  |  |
| Maternity services – ante-natal |  |  |  |
| Maternity services – delivery suite |  |  |  |
| Neonatal ITU |  |  |  |
| Paediatric emergency service and in-patients |  |  |  |
| Paediatric clinics |  |  |  |
| Public health screening services, breast, AAA, bowel |  |  |  |

**Appendix 3: Bed Occupancy**

The table below details the Trust’s actual average occupancy of the general bed base for the three years shown. This should be compared with an optimal occupancy rate of 85%,

|  |  |  |  |
| --- | --- | --- | --- |
| **Actual bed occupancy of general bed base by day** | **2016/17** | **2017/18** | **2018/19** |
| Core bed occupancy (excluding surge capacity) | 93.57% | 97.27% | 97.34% |
| Bed occupancy including surge capacity | 93.90% | 95.75% | 96.08% |

This high occupancy rate creates significant impact on available bed capacity in the hospital on a day-to-day basis, creating delays in getting patients transferred from the Emergency Department once it is determined they require admission.

**Appendix 4 Calculation of contribution requested for this proposed development**



**Explanatory note: Data used to calculate contribution**

**Clinical activity recording**

All activity undertaken by the Trust is traceable to a patient through the patient’s address, NHS number and registered GP which are recorded each time a patient is treated. This data is anonymised, validated and submitted monthly to a national data warehouse so that it is available nationally and publicly. Note this activity count does not represent discrete patients, but the amount of activity undertaken.

**Calculating the Trust’s claim**

The data table above calculates the impact of the development on the Trust’s resources and mitigates this by creating a financial claim to meet additional costs. The table is colour-coded to support the reader’s understanding of the calculation.

**Assumptions and explanations**

The Trust’s calculation establishes the additional impact the new development will impose on the Trust’s resources. To start the calculation, the total population of the development is calculated by multiplying the number of dwellings by the average number of people expected to live in each house. The Trust uses an average number of people per household published by the local council to make this calculation, unless provided with a different average by the development’s builder.

However, the total impact of the development is abated to 44% of total cost pressure. This abatement recognises that, according to the Trust’s specialist planning advice, 55.8% of people moving into the development are new to the county (or, by leaving a void elsewhere, cause others to move into the county) and therefore are not included in the funding allocation with which the county’s clinical commissioning groups buy the Trust’s services. In this way, the calculation avoids double counting the impact from existing county residents’ demands already anticipated in the Trust’s annual plans.

**The calculation’s steps**

Column 1 (light yellow) shows the different types of activity undertaken by the Trust. Column 2 (purple) provides the Trust’s total activity in a 12 month period and column 3 is a percentage rate of provision for the county's population.

The first blue column (column 4) shows the amount of activity undertaken by the Trust that originated from the LSOA/ward in which the new development is being constructed. Column 5 shows the percentage rate of provision for that LSOA. All of this data is derived from the Trust’s records of patients seen over the 12 month period used for the calculation.

Each activity undertaken by the Trust has a nationally determined cost associated with it. These costs are an average cost of activity across the NHS and are known as ‘NHS reference costs’. They are published annually. The Trust uses this average figure for each activity type to calculate the financial impact of caring for new people housed in the development. The reference costs can be found in the first orange column (column 6), entitled “Delivery cost per activity”.

The additional activity anticipated as a result of the new population (column 7) is derived from a multiplication of the development’s new population by the historical percentage rate of provision for that LSOA (column 5).

The additional impact that will result from the new population (column 8) is a product of multiplying the delivery cost (column 6) by the additional activity (column 7).

However, over and above the reference cost of delivery, due to long-standing, national, workforce shortages, the Trust will face additional cost pressure from employing premium rate staff to meet the additional demand. The cost of this is shown in column 9, “Premium staffing”. This has been calculated by dividing Staff Pay - Premium by the sum of Staff Pay - Substantive and Staff Pay - Premium and multiplying by 100. Thus, to demonstrate total impact, columns 8 and 9 have been added together to show the cost pressure created by the new population for each type of activity (column 10).

1. NHS Standard Contract- Service Condition SC7 [↑](#footnote-ref-1)
2. BMA 2017 Beds in the NHS [↑](#footnote-ref-2)
3. <https://www.nao.org.uk/wp-content/uploads/2019/01/NHS-financial-sustainability_.pdf> [↑](#footnote-ref-3)
4. <https://www.england.nhs.uk/wp-content/uploads/2019/01/note-on-ccg-allocations-2019-20-2023-24.pdf> [↑](#footnote-ref-4)