Royal United Hospitals Bath
NHS Foundation Trust

This is a consultation response to the planning application ref: PL/2023/10205 Outline planning application for residential development of up to 66 dwellings and associated public open space with all matters reserved except for access.

Land North of Southwick Road and South of The Rank, North Bradley, Wiltshire

Introduction

Planning applications must be determined in accordance with the development plan unless material considerations indicate otherwise. The creation and maintenance of healthy communities is an essential component of sustainability as articulated in the Government's National Planning Policy Framework, which is a significant material consideration. Development plans have to be in conformity with the NPPF and less weight should be given to policies that are not consistent with the NPPF. Consequently, local planning policies along with development management decisions also have to be formulated with a view to securing sustainable healthy communities. Access to health services is a fundamental part of sustainable healthy community.

As the attached document demonstrates, Royal United Hospitals Bath NHS Foundation Trust (the Trust) is currently operating at full capacity in the provision of acute and planned healthcare.

It is further demonstrated that this development will create potentially long term impact on the Trust ability provide services as required.

The Trust's funding is based on previous year's activity it has delivered subject to satisfying the quality requirements set down in the NHS Standard Contract. Quality requirements are linked to the on-time delivery of care and intervention and are evidenced by best clinical practice to ensure optimal outcomes for patients.

The contract is agreed annually based on previous year's activity plus any pre-agreed additional activity for clinical services. The Trust is unable to take into consideration the Council's housing land supply, potential new developments and housing trajectories when the contracts are negotiated. Further, the following year's contract does not pay previous year's deficit retrospectively. This development creates an impact on the Trust's ability provide a services required due to the funding gap it creates. The contribution sought is to mitigate this direct impact.

CIL Regulation 122 and 123

The Trust considers that the request made is in accordance with Regulation 122:

"(2) A planning obligation may only constitute a reason for granting planning permission for the development if the obligation is—

(a) necessary to make the development acceptable in planning terms;
(b) directly related to the development; and 4
(c) fairly and reasonably related in scale and kind to the development."

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S 106

S 106 of the Town and Country Planning Act 1990 (as amended) allows the Local Planning Authority to request a developer to contribute towards the impact it creates on the services. The contribution in the amount **£45,926.00** sought will go towards the gap in the funding created by each potential patient from this development. The detailed explanation and calculation are provided within the attached document.

Without the requested contribution, the access to adequate health services is rendered more vulnerable thereby undermining the sustainability credentials of the proposed development due to conflict with NPPF and Local Development Plan policies as explained in the attached document.

Royal United Hospitals Bath NHS Foundation Trust

18/12/2023

Royal United Hospitals Bath NHS Foundation Trust

Consultation Response and Regulation 122 CIL compliance statement

Application Reference: PL/2023/10205

Application Description: Outline planning application for residential development of up to 66 dwellings and associated public open space with all matters reserved except for access

Land North of Southwick Road and South of The Rank, North Bradley, Wiltshire

INTRODUCTION

1. This document provides a summary of the impacts of new housing developments on Royal United Hospitals Bath NHS Foundation Trust's (the RUH) capacity to provide health services, as well as a calculation of the contribution sought to mitigate the impact of the development on the Trust. It provides a sense of the operating scope and environment of the RUH. 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 the Trust is paid for the care it provides to the people in its catchment area
   - How the impact on the capacity to provide health services can be mitigated by way of developer contribution.
   - The relationships RUH has within the health and social care system in Somerset, Wiltshire and the Mendips.

   A glossary of terms can be found in Appendix 1.

About the Royal United Hospitals NHS Foundation Trust

2. The Royal United Hospitals NHS Foundation Trust (RUH) is a medium sized district general hospital, which serves a population of approximately five hundred thousand local residents across Bath and North East Somerset (BaNES), West Wiltshire and the Mendips. The Trust is the only provider locally of acute services and delivers a range of specialised services to patients from across the UK.

3. The Trust is currently operating at its maximum capacity, and as the local population grows, is experiencing ever-greater demands on services to meet the needs of the local people. Over the next years, demand is forecast to continue to rise. This challenge is further exacerbated by the

new residential housing increasing the population base for the Trust area for which the Trust does not receive any funding during the first year of the occupation of the development.

4. The Trust is also a vital part of the local economy. The organisation is one of the largest local employers, with over 5500 staff in a huge range of positions, including entry-level roles. In addition, the Trust also provides training and education opportunities, in partnership with local universities and higher education providers.

5. This proposed development will individually and cumulatively have a short and long-term impact on the Trust services and facilities. Without the mitigation of the impact by way of the developer contribution, the impact will have a detrimental socio economic impact making the development unsustainable.

EVIDENCE

Background

6. Royal United Hospitals Bath NHS Foundation Trust ("the Trust") has a licence to provide healthcare services to a catchment population of around 500,000 people in Bath and the surrounding area. Although run independently, NHS Foundation Trusts remain fully part of the NHS. They have been set up in law under the Health and Social Care (Community Health and Standards) Act 2003 as legally independent organisations called Public Benefit Corporations, with the 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. NHS Foundation Trusts were established as an important part of the government's programme to create a "patient-led" NHS. Their stated purpose is to devolve decision-making from a centralised NHS to local communities in an effort to be more responsive to their needs and wishes. However, they cannot work in isolation, they are bound in law to work closely with partner organisations in their local area.

7. The Trust is a public sector NHS body and is directly accountable to Parliament for the effective use of public funds. The Trust is set up in law, as stated previously, funded from the social security contributions and other State funding, providing services free of charge to affiliated persons of universal coverage. The Trust is a secondary care provider delivering a range of planned and emergency hospital services.

8. The Trust is commissioned to provide healthcare services to the population of Bath and North East Somerset, Wiltshire, Somerset and South Gloucestershire:

9. The Trust delivers a range of services to support its community including:

- Accident and Emergency (A+E)
- Acute Services (A)
- Cancer Services (CR)
- Community Services (CS)
- Diagnostic, Screening and/or Pathology Services (D)
- End of Life Care Services (ELC)
- Patient Transport Services (PTS)
- Radiotherapy Services (R)
- Urgent Care/Walk-in Centre Services/Minor Injuries Unit (U)

In addition, the Trust is separately commissioned to provide specialised care in a number of areas including:

- Cardiology Primary Percutaneous Coronary Intervention (PPCI) (Adults)
- Pulmonary Hypertension: Shared Care (Adults)
- Specialised Rheumatology Services (Adults)
- Breast Radiotherapy Injury Rehabilitation Service (Adult)
- External Beam Radiotherapy Services Delivered as Part of a Radiotherapy Network (Adults)
- Haematopoietic Stem Cell Transplantation (Adult)
- Specialised Human Immunodeficiency Virus Services (Adults)
- Cancer Chemotherapy (Adults)
- Cancer Chemotherapy (Children, Teenagers and Young Adults)
- Cancer Head and Neck (Adults)
- Cancer: Teenage and Young Adults
- Specialised Services for Pain Management (Adults)
- Paediatric Surgery: Chronic Pain
- Paediatric Medicine: Rheumatology
- Paediatric Medicine: Gastroenterology, Hepatology and Nutrition
- Paediatric Oncology
- Neonatal Critical Care
- Complex Gynaecology - Specialist Gynaecological Cancers
- Public Health national screening programmes

10. The Trust, in partnership with local universities and colleges, also plays a major role in education and research.

11. In common with other areas, the local population of the Trust is evolving:

- There is a growing population of people with more complex needs, in all age groups but in particular growth in an aging population and patients with long-term conditions.
- There are rising public expectations of public services.
- Within the Trust's boundaries there is a large student population that is temporary and always changing.
- Improvements in local transport and infrastructure have resulted in an increased demand for housing from those working out of area.

12. Together the over 5500 dedicated employees of the Trust delivers high quality services from the main major acute hospital site in Combe Park in Bath and a number of community birthing centres and other outpatient clinics within community hospitals across the region.

13. The acute facilities at the main hospital site will be used by the new occupants of this development.

14. The Trust was established as an NHS Foundation Trust in November 2014. NHS Foundation Trusts are part of the NHS and subject to NHS standards, performance ratings and systems of inspection. They have a duty to provide NHS services to NHS patients according to NHS quality standards and principles. They have stronger local ownership and greater involvement of their local communities through their links with their members; local people, patients, carers and staff are all able to become members of their local NHS Foundation Trust. As of 2020 the Trust has 11,000 public members from the local catchment area who are able to take part in the decision making and can take part in Trust elections.

15. Every NHS Foundation Trust is authorised to operate by a licence issued by the Independent Regulator, NHS Improvement. The terms of each NHS Foundation Trust's licence sets out the conditions under which they 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 will inspect;
- A list of assets such as buildings, land or equipment that are designated as 'protected' because they are needed to provide required NHS services;
- The amount of money an NHS Foundation Trust is permitted to borrow.

16. Like all other NHS bodies, the Trust is inspected against national standards by the Care Quality Commission (CQC). The Independent Regulator, NHS Improvement, monitors the Trust to ensure they do not breach the terms of their authorisation. If the Trust significantly breaches

the terms of its authorisation, or finds itself in difficulty, NHS Improvement has a range of intervention powers, including but not limiting to:

- Issuing warning notices;
- Requiring the Board of Governors or Board of Directors to take certain actions;
- Suspending or removing the Board of Governors or members of the Board of Directors.

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

THE SHORT AND LONG TERM IMPACT ON THE TRUST'S SERVICES

Impact of Increasing Demand – Operational Services arising from the proposed development

18. Across England, the number of acute beds is one-third less than it was 25 years ago[1], but in contrast to this the number of emergency admissions has seen a 37% increase in the last 10 years[2]. The number of emergency admissions is currently at an all-time high.

19. The Trusts' hospital is operating at nearly full capacity and there are limited opportunities for it to improve the use of its bed base. Whilst the Trust is currently managing to provide the services in a manner that complies with the Quality Requirements of the NHS, there are not sufficient resources within the existing services to accommodate population growth created by the development (individually and cumulatively) without the quality of the service as monitored under the standards set out in the Quality Requirements dropping, and ultimately the Trust facing sanctions for external factors which it is unable to control.

20. In order to maintain adequate standards of care as set out in the NHS Standard Contract quality requirements, it is well evidenced in the Dr Foster Hospital Guide that a key factor to deliver on-time care without delay is the availability of beds to ensure timely patient flow through the hospital. The key level of bed provision should support a maximum bed occupancy of 85%. The 85% occupancy rate is evidenced to result in better care for patients and better outcomes[3]. This 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 (see Appendix 2). Where the right capacity is not available in the right wards for treatment of his/her particular ailment, the patient will be admitted and treated in the best possible alternative location and transferred as space becomes available, but each ward move increases the length of stay for the patient and is known to have a detrimental impact on the quality of care. It also increases the recovery time which in turn

[1] Older people and emergency bed use, Exploring variation. London: King's Fund 2012
[2] Hospital Episode Statistics.www.hesonline.nhs.uk/Ease/servlet/ContentServer?siteID=1937
[3] British Medical Journal- Dynamics of bed use in accommodating emergency admissions: stochastic simulation model

will have detrimental socio economic impact. Consequently, when hospitals run at occupancy rates higher than 85%, patients are at more risk of delays to their treatment, and sub-optimal care and being put at significant risk.

21. Appendix 2 details that the Trust's utilisation of acute bed capacity exceeded the optimal 85% occupancy rate throughout 2019/20. This demonstrates that current occupancy levels are highly unsatisfactory, and the problem will be compounded by an increase in the population, which does not coincide with an increase in the number of bed spaces available at the Hospital. This is the inevitable result where clinical facilities are forced to operate at over-capacity, and is why there is now a very real need to manage demand. Any new residential development will add a further strain on the current acute healthcare system.

22. Appendix 3 shows reference costs and activity for the financial year 2019/20 (2020/21 reference costs will be available in March 2022). During 2019-20:

- 95, 274 residents attended the Trust's A&E Department (the equivalent of 10 out of 50 residents).
- 119, 280 residents were admitted to hospital (the equivalent of 13 admissions for every 50 residents).
- The equivalent of every resident attended an outpatient appointment and/or procedure (501, 955 attendances)

23. In total, for the financial year 2019/20, 17,588 theatre procedures took place in the RUH (NULL, Day Cases, Emergency and Inpatient procedures), 10,708 scopes were undertaken (Inpatient and Outpatient) and there were 40,116 cardiac interventions (Outpatient, Outpatient Procedures, Follow-Up Outpatient Procedures, Non-Elective Inpatients, Day Cases and Elective Inpatients. Additionally, 308,653 radiological examinations or scans took place (Outpatients, GP Patients, A&E Patients, Inpatients and Day Cases).

Impact of Increasing Demand – Capacity

24. Provision of safe hospital-based services relies on sufficient capacity within a suitably sized and skilled clinical workforce and within appropriate physical assets. 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. Locums 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. The Trust has addressed these workforce shortages by having

to use locum and agency staff. In turn, their shortage has driven up prices to a premium within a national labour market where prices are maintained by annual increases in NHS service demand.

Impact of increasing demand – Quality & Safety Issues

25. The Trust understands that the existing population, future population growth and an increased ageing population will require additional healthcare infrastructure to enable it to continue to meet the increasing demands and complexity of the hospital healthcare needs of the local population.

26. It is not possible for the Trust to predict when planning applications are made and delivered and, therefore, it cannot plan for additional development occupants as a result. The Trust has considered strategies to address population growth across its area and looked at the overall impact of the known increased population to develop a service delivery strategy to serve the future healthcare needs of the growing population. This strategy takes into account the trend for the increased delivery of healthcare out of hospital and into the community. However, the commissioning operates based on previous year's performance and does not take into account potential increase in population created by a prospective developments, housing projections or housing land supply.

27. Despite recent capacity increases, the Trust's hospitals are operating at full capacity and there are limited opportunities to improve this further. NHS provider the Trusts are contractually required to comply with NHS Standard Contract quality requirements. However, at the Trust, 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.

28. 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[4]. 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.

[4]BMA 2017 Beds in the NHS

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.

29. Appendix 2 shows that the Trust's utilisation of acute bed capacity exceeded the optimal 85% occupancy rate for the last four years. 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 increase it. Any new residential development will add a further strain on the current acute healthcare system. Without mitigating the impact, this development will have individual and cumulative detrimental impact on the safety and quality of services.

The Direct Impact on the Provision of Planned and Acute Healthcare Caused by the Proposed Development

30. The existing service delivery infrastructure for acute and planned health care is unable to meet the additional demand generated as a result of the proposed development for **66 dwellings** (individually and cumulatively). The population increase associated with this proposed development will significantly impact on the service delivery and performance of the Trust until contracted activity volumes include the population increase.

31. The increased in demand would result in the Trust's failure to deliver consistently the access standards and time frames for some services in line resulting in increased waiting times for care and treatment and deteriorating outcomes for patients. This is most notably in the Emergency Department Performance, particularly bed capacity and the flow of patients through the hospital from admission to discharge. The pressures caused by the increased demand on specifically relates to the Trust's ability to manage within its bed base and maintain timely flow of patients out of the Emergency Department, Medical Assessment Unit and Surgical Assessment Unit to the main inpatient wards[5]. It is essential that the Trust is able to offer a high quality and safe service to patients presenting as an emergency.

[5] Annual Report 2019-2019

32. The only way that the Trust can maintain the "on time" service delivery without delay and comply with NHS quality requirements is if the developer will mitigate by way of developer contribution towards the cost of providing the necessary capacity for the Trust to maintain service delivery during the first year of occupation of each dwelling. Without securing such contributions, the Trust will have no or limited funding to meet healthcare demand arising from each household during the first year of occupation. The health care provided by the Trust would be significantly delayed and compromised, putting the local people at risk. This impact created by this development will have a long term effect on the ability to provide the required services.

MITIGATING THE IMPACT- ASSESSMENT FORMULA

General

33. In any given year, the level of NHS funding is set by central Government through Comprehensive Spending Review process. The process estimates how much funding the NHS will receive from central sources. The monies are then allocated to NHS England/ Improvement, which in turn allocate the funds to Integrated Care Boards (ICB)ICB.

34. The Bath and North East Somerset, Swindon and Wiltshire Integrated Care Partnership (ICB) and NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board (BNSSG ICB)) and NHS England commission the Trust to provide acute healthcare services to the local population.

35. The ICBs then commission most services from NHS provider through NHS standard contract and using nationally determined formula. The ICBs commission planned and emergency acute healthcare from the Trust and agree a contract, including activity volumes and values on an annual basis. The ICBs have no responsibility for providing direct healthcare services to the public.

36. The commissioning does not take into consideration the local housing need, housing projections or existing planning permissions. The Trust cannot change or influence this fact in the same way that the Local Authority cannot influence the funding mechanism received from the Government.

37. The Trust is required to provide appropriate health services to all people that present or who are referred to the Trust. 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. This obligation extends to all services from emergency treatment at A&E to routine/non-urgent referrals. Whilst patients are able in some cases to exercise choice over where they access NHS services, in the case of an emergency

they are taken to their nearest appropriate A&E Department by the ambulance service or where directed by out of hours' service.

38. The most effective way of dealing with the impact is to make sure that acute health services can be carried out without interruption as explained in this consultation response. Without mitigation, the additional demand created by the development will have a deleterious effect on the provision of health services. Mitigation for this increased demand will enable the Trust to maintain required service levels without deterioration in the quality of care provided and patient experience, maintaining clinical space to the maximum by contributing to staffing that keeps patients flowing through the Trust's services. This, in turn, will also produce better outcomes for patients.

Payment System

39. Predominately, the Trust uses the National Tariff system for billing commissioners for services. This tariff is derived from the mandated national cost collection, which all NHS trusts and foundation trusts submit.

40. However, some areas of activity are held at a fixed cost regardless of the volume of activity seen by the Trust

41. Funding for non-elective activity, including A&E attendances is accounted for within the block financial envelopes allocated to the Trust. This is adjusted each year, but not in-year, to reflect changes in activity levels and case mix should there be material changes to relevant services.

42. The planning assumptions undertaken by both the Trust and the commissioners uses the previous years' activity as a basis and reflects changes in demographics using a national growth metric known as IHAMS. These are not amended in-year to reflect any changes in demographics. This means that only those residents currently residing in the area will be taken into consideration. Those prospective residents who will arrive because of a new planning permission are not part of the commissioning process.

43. For 2019/20 the Trust has also agreed a block contract value for outpatient activity. An outpatient block contract will be mandated nationally for all hospitals for 2020/21 in accordance with Government Guidance.

44. A blended block approach has also been proposed nationally for all maternity pathways.

45. The Trust has to achieve 52-week wait standards for elective care. This means that each patient referred to the Trust for elective care should not wait over 52 weeks to commence treatment. If a patient waits for longer than 52 weeks the Trust will be subject to financial sanctions, which is commensurate to the number of breaches.

46. Any new development has the potential to affect the Trust's ability to achieve its performance targets.

Other Possible Funding of Income

47. As a Foundation Trust, there is no routine eligibility for capital allocations from either the Department of Health or local commissioners to provide new capacity to meet additional healthcare demands. The main source of funding for re-investment in maintaining local services is the annual surplus generated by the Trust. The RUH have delivered a surplus in previous years but was not projecting to in 19/20 in this situation there would be no available capital allocation.

48. As a Foundation Trust, there is eligibility to request a loan from the Department of Health's Independent Trust Financing Facility to fund capital development proposals.

49. Loan applications would be subject to existing borrowing limits with existing loan providers and would have to be paid back with interest.

50. Charitable Donations are managed in line with the provisions of the Charities Act. The Charity Trustee oversees the use of any donated funds and in doing so fulfils its responsibility to ensure that all expenditure demonstrates 'Additionality', i.e. that charitable funds are not used to pay for items of equipment or facilities which are needed to deliver day-to-day services.

51. In its modest but effective mitigation, the Trust has carefully considered its funding from the ICB and is requesting only the amount that it cannot obtain through its contracts with ICB or recover retrospectively. The CCG and the Trust are unable to change the existing funding mechanism regardless whether it is a known allocated site or not or subject to planning permission.

52. The calculation will take into consideration, once agreed with the Council, the existing population in the Trust's catchment area, so only the new population which is not already in the Trust's catchment area is taken into consideration in the methodology making the contribution fairly and reasonably related in scale and kind of the development.

53. Further, the Trust holds statistics on all patients and activity generated from specific LSOA area and GP practices and is therefore able to estimate the potential level of activity arising from the proposed development making the methodology directly related to this development.

54. This proposed development comprises of **66 dwellings** and based on the 2011 Census average household size per dwelling, the Trust has calculated that this development will accommodate a new population of **106 residents**.

55. As detailed in the calculations in Appendix 4, 106 **residents** are currently generating an average of **56 acute interventions** each per year.

Formula

(Development New Population x % Development Activity Rate per head of Population x Cost per Activity X 80%) + (Development New Population x % Development Activity Rate per head of new Population x 20% (Cost per Activity - Tariff) = Developer Contribution

New population = total population – percentage of existing population in the Trust's catchment area.

56. The costs consequences of the number of interventions and the costs of them arising from this proposed development are set out in detail in Appendix 4.

57. Due to the payment mechanisms and that the proposed development will create a gap in the funding, it is necessary that the developer contributes towards the cost of providing capacity for the Trust to maintain service delivery during the first year of occupation of each dwelling. The Trust will only receive a proportion of commissioner funding to meet each dwelling's healthcare demand in the first year of occupation due to the preceding year's outturn activity volume based contract and there is no mechanism for the Trust to recover these costs in subsequent years (see Appendix 4). Without securing such contributions, the Trust would be unable to support the proposals and would object to the application because of the direct and adverse impact of it on the delivery of health care in the Trust's area.

58. Therefore, the contribution requested for this proposed development of **66 dwellings** is **£45,926.00**. This contribution will be used directly to provide additional services to meet patient demand as indicated in Appendix 4

59. The Trust is happy to negotiate appropriate timing for the payment of the contribution. It is essential however, that the contribution is in place prior to the occupants residing in the development.

60. The Trust is happy to work with the Council and provide any further information it requires. It is happy to negotiate a suitable abatement in relation to the provision of affordable housing on site.

Policy support

61. The Council does not have a specific policy that directly relates to health infrastructure services and facilities. However, Section 70(2) of the TCPA 1990 provides that in determining an application for planning permission, the LPA; "shall have regard to the provisions of the development plan, so far as material to the application, and to any other material consideration".

62. Paragraph 2 of the NPPF states:

The National Planning Policy Framework must be taken into account in preparing the development plan, and is a material consideration in planning decisions. Planning policies and decisions **must** also reflect relevant international obligations and statutory requirements (emphasis added).

The health of communities has been a key element of Government policy for many years. 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:"(paragraph 8 of NPPF).

Further, the Trust is delivering NHS health care services at the point of demand under the statutory requirement. Paragraph 2 contains an imperative upon the decision makers to reflect statutory obligations.

In addition, the health of communities has been a key element of Government policy for many years and is as stated above reflected in adopted development plan. Please see NPPF Section 2 paragraph 8, Section 8 paragraphs 92 -93 and 96 addition

Notwithstanding above the Local Plan Policy ensures that the developer adequately mitigates the impact it creates.

63. BaNES Local Plan (adopted 2014)

Policy CP13

Infrastructure provision

New developments must be supported by the timely delivery of the required infrastructure to provide balanced and more self-contained communities.

The Council will work in partnership with adjoining authorities, local communities and relevant agencies and providers to ensure that social, physical and green infrastructure is retained and improved for communities.

Developer contributions will be based on the Planning Obligations SPD and its successors.

Infrastructure proposals should not cause harm to the integrity of European wildlife sites which cannot be mitigated.

Summary

64. As our evidence demonstrates, the Trust is currently operating at full capacity in the provision of acute and planned healthcare. The contribution is being sought to provide health infrastructure services and facilities needed by the occupants of the new homes. The development directly affects the ability to provide the health service required to those who live in the development and the community at large.

65. Without contributions to maintain the capacity by delivery of health care services at the required quality standard and to secure adequate health care for the locality the proposed development will put too much strain on the said health infrastructure, putting people at significant risk. This development imposes an additional demand on existing over-burdened healthcare services, and failure to make the requested level of healthcare provision will detrimentally affect safety and care quality for both new and existing local population. This will mean that patients will receive substandard care, resulting in poorer health outcomes and pro-longed health problems. Such an outcome is not sustainable as it will have a detrimental socio economic impact.

66. 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 increasing the capacity by direct delivery of healthcare for the additional population. As the calculation is directly linked to the patient address, it is also easily verified. 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 and maintenance. The lack of mitigation creates greater impact on the capacity to provide health services than the impact to be mitigated by way of contribution.

67. In the circumstances, without the requested contributions to support the increasing the capacity the planning permission should not be granted.

18/12/2023

Appendix 1: Glossary of Terms

- **Accident and emergency care:** Accident and Emergency Departments may be either major units, providing a 24-hour service seven days a week to which the great majority of emergency ambulance cases are taken, or small units commonly called casualty departments, 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 active but 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:** An arrangement in which the health services provider (as used in the UK, providers refer to corporate entities such as hospitals and trusts, and not to individuals) is paid an annual fee in installments by the Healthcare Commissioner in return for providing a defined range of services, regardless of the volume of services delivered.

- **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 Intelligence 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 which is unplanned and/or urgent.

    - Integrated Care Boards (ICB): a statutory organisation bringing the NHS together locally to improve population health and establish shared strategic priorities within the NHS. They are responsible for the commissioning of health care services for their local area.

    - Integrated Care Partnership: a combination of ICB, Local Authority, NHS Trusts and other Partners who have a duty to prepare plan how the assessed needs in relation to the local authority's area are met.

- **NHS Improvement (NHSI):** NHSI are a health services regulator, they are responsible for overseeing NHS foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care.

- **Office of National Statistics**: Known as ONS

- **Operational Pressures Escalation Levels (OPEL):** OPEL is a standard metric for Trusts to report levels of pressures nationally using a consistent framework.

- **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: Extract from Fit for the Future, The Dr Foster Hospital Guide 2012 & RUH Bath Acute Occupancy



HOSPITALS UNDER PRESSURE

KEY FINDINGS

FULL TO BURSTING

The peak occupancy rate for NHS beds is 92%. For 48 weeks a year most trusts are more than 90% occupied.

SUPPORT IN THE COMMUNITY

A lack of integration with social care and community services is contributing to the pressure on NHS hospitals.

A WORSENING PROBLEM

Rising numbers of emergency admissions of frail elderly patients have required an additional 10,000 bed days over the past five years. That is equivalent to two new hospitals.

DECREASED AVAILABILITY

The number of acute and general beds in the NHS has decreased by a third in the past 25 years.[1]

8

TECHNICAL BRIEFING

The number of hospital beds has decreased by a third in the past 25 years[1], as hospital stays have become shorter. However, admissions are rising, especially for groups such as the frail elderly (see page 11). This is one of the main causes for the growing pressure on hospital beds.

The NHS publishes figures for NHS trusts giving the average percentage of hospital beds that are occupied. These figures disguise the highs and lows in occupancy that occur week by week and season by season. According to these figures, the NHS has an average occupancy rate of just over 85%[2].

When occupancy rates rise above 85% it can start to affect the quality of care provided to patients and the orderly running of the hospital.[3]

Our analysis calculates the number of patients in hospital each day and compares it to the number of beds the hospital says it has available.

Our figures reveal the extent to which occupancy varies from the low points at weekends and during bank holidays to the high points, when occupancy rates at some hospitals can reach 100%. This analysis shows that the average mid-week occupancy in the NHS is 88%, and that for most of the year most NHS hospitals are experiencing occupancy rates above 90%.

Total Acute Occupancy %	01 - Apr	02 - May	03 - Jun	04 - Jul	05 - Aug	06 - Sep	07 - Oct	08 - Nov	09 - Dec	10 - Jan	11 - Feb	12 - Mar
2018/2019	96.2%	92.3%	92.7%	94.1%	94.1%	94.6%	95.1%	96.1%	90.5%	93.9%	95.7%	94.0%
2019/2020	95.1%	92.5%	92.2%	93.3%	92.8%	95.3%	95.5%	96.6%	94.5%	96.3%	95.8%	82.7%
2020/2021	49.1%	55.5%	78.7%	83.4%	87.2%	88.2%	89.8%	86.2%	86.2%	85.6%	86.6%	84.1%
2021/2022	88.3%	86.1%	87.8%	89.2%	90.0%	90.9%	92.1%	92.6%	89.6%	89.6%	89.2%	91.7%

**The above table includes escalation and IT. It excludes closed and empty beds, maternity and NICU*

Appendix 3: Reference Costs

Activity Type	Trust Level Activity		This LSOA		Activity Costs		Proposed Development			
	Activity 2019/20	% Activity Rate per Annum	Activity	Activity Rate per Annum	Total Delivery Cost Trust-wide	Delivery Cost per Activity 2019.20 Reference Costs	12 months Activity for proposed Population	Delivery Cost for Planned Dwellings	Premium costs of Delivery	Cost presuure
A&E Attendances	95,274	19.1%	167	12.4%	£ 19,395,746	£ 203.58	13	£ 2,671.4	£ 106.0	£ 2,777.4
Non Elective Admissions	28,915	5.8%	138	10.2%	£ 97,921,441	£ 3,386.53	11	£ 36,722.1	£ 1,462.0	£ 38,184.1
Non Elective (Short Stay)	55,406	11.1%	-		£ 30,240,389	£ 545.80		£ -	£ -	£ -
Outpatient Appointments	414,005	82.8%	167	12.4%	£ 54,928,604	£ 132.68	13	£ 1,741.0	£ 69.0	£ 1,810.0
Outpatient Appointments (Procedure)	87,950	17.6%	167	12.4%	£ 16,863,755	£ 191.74	13	£ 2,516.1	£ 100.0	£ 2,616.1
Diagnostic Imaging	36,338	7.3%	70	5.2%	£ 3,417,697	£ 94.05	6	£ 517.3	£ 21.0	£ 538.3
Total	717,888		709		£222,767,632		56	44,168	1,758	45,926

Impact per Dwelling	£ 998.39
Total Mitigation Request	£ 45,926

Royal United Hospitals Bath
NHS Foundation Trust

Appendix 4: Calculation of contribution requested for this proposed development

[Royal United Hospital Foundation Trust]

Royal United Hospitals Bath
NHS Foundation Trust

Application Reference:	PL/2023/10205
Local Authority / Area	Wiltshire
Population Estimate (LSOAs):	1,349
LSOA (Name and Code):	Wiltshire 037A - E01032053
Population Estimate (Trust wide):	500,000
Development Dwellings	66
Development Dwellings EXC Affordable Housing	46
Population Multiplier	2.30
Development Population	106
Deduction of existing population	TBC
Final population	TBC

	Expenditure Profile £	
	2018.19	2019.2
Staff Pay - Substansive	£ 199,830,070	£ 219,701,000
Premium Staff - Agency / Bank Staff	£ 12,177,177	£ 16,283,000
Total Costs	**£ 338,155,070**	**£ 380,876,360**

Substansive staffing costs % of total	59%	58%
Premium Staff Cost as % of total staff costs	6%	7%

Activity Type	Trust Level Activity		This LSOA		Activity Costs		Proposed Development			
	Activity 2019/20	% Activity Rate per Annum	Activity	Activity Rate per Annum	Total Delivery Cost Trust-wide	Delivery Cost per Activity 2019.20 Reference Costs	12 months Activity for proposed Population	Delivery Cost for Planned Dwellings	Premium costs of Delivery	Cost presuure
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Non Elective Admissions	28,915	5.8%	138	10.2%	£ 97,921,441	£ 3,386.53	11	£ 36,722.1	£ 1,462.0	£ 38,184.1
Non Elective (Short Stay)	55,406	11.1%	-		£ 30,240,389	£ 545.80		£ -	£ -	£ -
Outpatient Appointments	414,005	82.8%	167	12.4%	£ 54,928,604	£ 132.68	13	£ 1,741.0	£ 69.0	£ 1,810.0
Outpatient Appointments (Procedure)	87,950	17.6%	167	12.4%	£ 16,863,755	£ 191.74	13	£ 2,516.1	£ 100.0	£ 2,616.1
Diagnostic Imaging	36,338	7.3%	70	5.2%	£ 3,417,697	£ 94.05	6	£ 517.3	£ 21.0	£ 538.3
Total	**717,888**		**709**		**£222,767,632**		**56**	**44,168**	**1,758**	**45,926**

Impact per Dwelling	£ 998.39
Total Mitigation Request	£ 45,926

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 55.8% 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).