From: Desiree Dzormeku [mailto:Desiree.Dzormeku@shma.co.uk]
Sent: 30 January 2019 16:36
To: Gibbons, Kelly <Kelly.Gibbons@herefordshire.gov.uk>
Cc: Rajwinder Rayat <Rajwinder.Rayat@shma.co.uk>; Towle, Lauren <Lauren.Towle@wvt.nhs.uk>; Dawson, Alan <Alan.Dawson@wvt.nhs.uk>
Subject: Consultation responses on behalf of Wye Valley NHS Trust.

Dear Sir,

Please find attached our submission in respect of the application below and on behalf of our client, Wye Valley NHS Trust.

- P184662/O Holmer House Farm, Case officer - Kelly Gibbons

Yours faithfully,

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FRAUD PREVENTION

Please do not reply to or act upon any email you might receive purporting to advise you that our bank account details have changed. Please always speak to the lawyer acting for you to check any changes to payment arrangements. We will also require independent verification of changes to any bank account to which we are asked to send money.

Wye Valley NHS Trust

EVIDENCE FOR S106 DEVELOPER CONTRIBUTIONS FOR SERVICES

Holmer House Farm

LPA reference: P184662/O

Definitions

- ***Accident and emergency care:*** *An A&E department (also known as emergency department or casualty) deals with genuine life-threatening emergencies requiring urgent assessment and/or intervention.*

- ***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.*

- ***Clinical Commissioning Group:*** *CCGs are clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area.*

- ***Emergency care:*** *Care which is unplanned and urgent.*

- ***NHSI:*** *NHS Improvement*

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

- ***PbR:*** *Payment by Results is a system of paying NHS healthcare providers a standard national price or tariff for each patient seen or treated, taking into account the complexity of the patient's healthcare needs.*

- ***PFI:*** *Private Finance Initiative (PFI arrangement) is a procurement method which uses private sector capacity and public resources in order to deliver public sector infrastructure and/or services according to a specification defined by the public sector.*

- ***Premium Costs:*** *The costs incurred for the supply of agency staff.*

- ***Step change:*** *The sudden and significant level of change required when a tipping point in additional activity is reached. (In this case, the point at which additional resources and/or clinic capacity is required).*

- ***Secondary care:*** *Medical care that is provided by a specialist or facility upon referral by a primary care physician and that requires more specialised knowledge, skill, or equipment than the primary care physician can provide.*

As our evidence will demonstrate, the Trust is currently operating at full capacity in the provision of acute and planned healthcare. It is further demonstrated that although the Trust has plans to cater for the known population growth, it cannot plan for unanticipated additional growth in the short to medium term. The contribution is being sought not to support a government body but rather to enable that body to provide services needed by the occupants of the new development, and the funding for which, as outlined below, cannot be sourced from elsewhere. The development directly affects the ability to provide the health service required to those who live in the development and the community at large.

Introduction to Wye Valley NHS Trust

1 Wye Valley NHS Trust, ("the Trust") has an obligation to provide healthcare services. The Trust has been set up in law under the National Health Services Act 2006. The primary obligation is to provide NHS services to NHS patients and users according to NHS principles and standards - free care, based on need and not ability to pay. The Trust was established in 2011.

2 NHS 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, principles and the NHS Constitution. Like all other NHS bodies, NHS Trusts are inspected against national standards by the Care Quality Commission, NHS Improvement and other regulators/accrediting bodies.

3 The Trust is a public sector NHS body and is directly accountable to the Secretary of State for the effective use of public funds. The Trust is funded from the social security contributions and other State funding, providing services free of charge to affiliated

persons of universal coverage. The Trust is commissioned to provide acute healthcare services at Hereford County Hospital which is based in the city of Hereford, along with a number of community hospitals and community services for Herefordshire and its borders. The Trust was England's first integrated provider of acute, community and adult social care services bringing together Hereford Hospital NHS Trust, NHS Herefordshire provider services (excluding mental health) and Herefordshire Council's Adult Social Care Services. The Adult Social Care Services have now transferred back to Herefordshire Council.

4 The Trust has an estimated turnover of around £180 million and employs around 3,000 staff.

Who is using the Wye Valley Hospital?

5 Since 2008, patients have been able to choose which provider they use for their healthcare for particular services. The 2014/15 Choice Framework explains when patients have a legal right to choice about treatment and care in the NHS. The legal right to choose does not apply to all healthcare services (for example emergency care), and for hospital healthcare it only applies to first outpatient appointments, specialist tests, maternity services and changing hospitals if waiting time targets are not met. In 2016/17 (most recent published population data**) 83.84 %** of Herefordshire and its borders including Ross on Wye, Leominster and Bromyard residents chose Wye Valley NHS Trust for their first outpatient appointment and Wye Valley NHS Trust delivered over 74% of Herefordshire and its borders including Ross on Wye, Leominster and Bromyard residents' total admissions, including admissions for specialised services (see Appendix 2). The calculations in this evidence base are based upon this percentage share.

Funding Arrangements for the NHS Trust

6 NHS Herefordshire Clinical Commissioning Group (HCCG) commissions the Trust to provide acute healthcare services to the population of Herefordshire under the terms of the NHS Standard Contract. This commissioning activity involves identifying the health needs of the respective populations and commissioning the appropriate high quality services necessary to meet these needs within the funding allocated. These commissioners commission planned and emergency acute hospital medical and surgical care from Wye Valley NHS Trust and agree service level agreements, including activity volumes and values on annually based on last year's performance. The commissioners have no responsibility for providing healthcare services. They commission (specify, procure and pay for) services, which provides associated income for the Trust. The Trust directly provides the majority of healthcare services through employed staff but has sub-contracted some non-clinical services through its PFI arrangements.

7 The Trust is required to provide the commissioned health services to all people that present or who are referred to the Trust. The NHS Standard Contract for Services, condition SC7 for 17/18 and with which the Trust is compliant states "The Trust must accept any Referral of a Service User however it is made unless permitted to reject the Referral under this Service Condition"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. This obligation extends to all services from emergency treatment at Accident and Emergency (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. In respect of major trauma, all patients receive their trauma within the boundaries of the major trauma service.

- **Activity Based Payment System Funding**

8 The Trust is paid for the activity it delivers in line with the National Tariff Payment System. In 2003 the Department of Health introduced the National Tariff Payment by Results (PbR) system, an activity based payment system, initially for a small number of common elective care procedures. Over the past decade the scope of services

[1] NHS Standard Contract- Service Condition SC7

covered by this activity-based payment approach of setting prices for specified treatments has expanded to include Outpatient, Elective, Emergency, Diagnostic and A&E activity. Under the Payment by Results regime, the Trust is paid at a set rate for each PbR-eligible activity it delivers, subject to quality and access time standards being met. Failure to deliver on-time intervention without delay presents the Trust with a risk of financial penalties being imposed by its Commissioners.

9 Payment for emergency admissions is set at the 2008/09 activity levels; with any activity over and above this level only attracting 70% of the tariff value. This represents a marginal cost of delivery only. This means that for each patient receiving emergency care that is above the agreed activity level, the Trust will only receive 70 % of funding towards the costs of the services delivered. Therefore, any activity above this level will not receive the funding to support increased demand for service delivery.

10 The National Tariff is set by the Department of Health, NHS England and NHS Improvement. The process for deriving the tariff involves taking the national average cost base for the delivery of hospital care and factoring in a number of adjustments to take account of cost inflation, efficiency and the Clinical Negligence Scheme for Trusts (CNST). Between 2011-12 and 2015-16, the National Tariff was reduced, on average, by 1.5% per year, due to the fact that the uplift for cost inflation was less than the efficiency factor.

- **Payment By Results**

11 The Trust is paid for the 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.

12 As stated above for emergency admissions the Trust will only be paid a marginal cost of 70% for activity above the 2016/17 baseline. There is no ability to reclaim the 30% of tariff above the baseline for additional activity.

13 Under our contract with our main commissioner Herefordshire CCG, the Trust has agreed a level of activity for emergency admissions (MRET). Once the MRET

threshold is reached a marginal rate is applied to the income we receive for each additional patient is reduced to 70% of the value it would have been had the threshold not been exceeded. Since the national tariff is designed to cover the costs a provider incurs having succeeded in making expected efficiencies this implies that even after we have made efficiencies we only recover 70% of the cost of treating these additional patients until an adjustment is made to the threshold baseline under the annual contracting process.

14 The MRET threshold was introduced in 2010/11 and breached the Contract threshold in every year since, which resulted in the following loss of income:

- 2010/11 - £1,068,687 (first year)
- 2016/17 - £1,471,698 (most recent year)

Planning for the Future

15 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.

16 It is **not** possible for the Trust to predict when planning applications are made and delivered and, therefore, cannot plan for additional development occupants as a result. The Trust has considered strategies to address population growth across its area and looked at the overall impact of the known increased population to develop a service delivery strategy to serve the future healthcare needs of the growing population. This strategy takes into account the trend for the increased delivery of healthcare out of hospital and into the community.

17 The funding from the HCCG is negotiated on an annual basis with contracted activity levels and MRET thresholds agreed annually. Contracted activity levels cannot take into account the increased service requirement created by the increase in population due to development, including that from this development, in the first year of occupation.

Current Position

- **Emergency admissions and the direct impact on emergency health care services**

18 Across England, the number of acute beds is one-third less than it was 25 years ago[2], but in contrast to this the number of emergency admissions at Wye Valley NHS Trust has seen a 50 % increase in the last 10 years[3]. The number of emergency admissions (including ambulatory care) is currently at an all-time high. The growth is shown in the table below.

Emergency Admissions	Year
14,361	2006/07
21,977	2016/17

Figure 1

19 The Trust runs at over 90% bed occupancy, one of the highest rates in England, and there are limited opportunities for it to further improve hospital capacity utilisation. Whilst the Trust is currently managing to provide the services in a manner that complies with the quality requirements of the NHS and its regulators, there are not sufficient resources or space within the existing facilities to accommodate population growth 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 maximum bed occupancy of 85%. The 85% occupancy rate is evidenced to

[2] Older people and emergency bed use, Exploring variation. London: King's Fund 2012

result in better care for patients and better outcomes[4]. 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. 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. Consequently, when hospitals run at occupancy rates higher than 85%, patients are at more risk of delays to their treatment, sub-optimal care and being put at significant risk.

21 Appendix 4 details that the Trust's utilisation of acute bed capacity which exceeded the optimal 85 % occupancy rate for the majority of 2016/17. This demonstrates that current occupancy levels are highly unsatisfactory, and the problem will be compounded by an increase in need created by the development 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. Any new residential development will add a further strain on the current acute healthcare system.

- **The direct impact on the provision of emergency healthcare caused by the proposed development**

22 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. As a consequence of the development and its associated demand for emergency healthcare there will be an adverse effect on the Trust's ability to provide on-time care delivery without delay, this will also result in financial penalties due to the Payment by Results regime.

- **The direct impact on the delivery of suitably and safely staffed hospital services, caused by the proposed development**

23 The NHS, in common with public health services in many other countries is experiencing staff shortages. Wye Valley NHS Trust has a duty to provide high-

[4] British Medical Journal- Dynamics of bed use in accommodating emergency admissions: stochastic simulation model

quality services for all and ensure that it is appropriately and safely staffed in order to manage both the unpredictable demand for major trauma and emergency care and diagnostic and elective care. Rising unplanned demand for care in a hospital setting, often paid for at a Premium Cost, has detrimentally impacted on the financial position of the Trust. To ensure the continuing provision of the highest standard of patient care, the need will arise for the Trust to employ both medical and non-medical agency staff where prospective cover arrangements are not in place. Agency staffing plays a vital role in the NHS, giving hospitals the flexibility to cope with fluctuating staff numbers and helping Trusts to avoid potentially dangerous under-staffing. Agency staff are an essential part of Wye Valley staffing resources. They are an essential part of Wye Valley staffing resources presently and with current vacancy rates any expansion in service will require agency staffing at premium cost. As an NHS Trust we are required to manage the value of agency costs within a threshold set by our regulator NHSI. The Trust needs to ensure that the level of services is delivered as required, by the NHS Standard Contract for Services regardless of the increased demand due to the development. The engagement of agency staff is the only option to keep up with the required standard.

24 For the additional emergency admissions, the Trust will be required to source additional, suitably qualified agency based staff to work alongside the permanent workforce in order to meet this additional demand, until it is in receipt of CCG funding to enable recruitment of substantive posts to manage the additional demand. The normal funding arrangement is only related to the existing staff levels. It does not include the additional staffing demand required to address the required additional service levels.

25 Wye Valley NHS Trust has a duty to provide high-quality care for all and ensure that it is appropriately and safely staffed in order to manage both the unpredictable demand for both emergency as well as required elective care. There is no way to reclaim this additional premium cost for un-anticipated activity. The only way that the Trust can maintain the “on time” service delivery without delay and comply with NHS quality, constitutional and regulatory requirements is through developer funding (requiring the developer to meet the 30% funding gap directly created by the development population) due to the nature of the marginal rate operation of the

emergency tariff and Premium Cost requirement, thus enabling the Trust to reinvest this to provide the necessary capacity for the Trust to maintain service delivery during the first year of occupation of each unit. Without securing such contributions, the Trust will have no funding to meet healthcare demand arising from the development during the first year of occupation and the health care provided by the Trust would be significantly delayed and compromised, putting the residents and other local people at potential risk.

Impact Assessment Formula

26 The Trust has identified the following:-.

A development of **17 dwellings** equates to **38.93** new residents (based on the current assumption of 2.29 persons per dwelling as adopted by Herefordshire County Council's Education team). Using existing 2016[5] demographic data as detailed in the calculations in Appendix 3 will generate **74** acute interventions over the period of 12 months. This comprises additional interventions by point of delivery for:

- **11** A&E based on 29% of the population requiring an attendance
- **5** Emergency admissions based on 11% of the population requiring an admission
- **1** Elective admissions based on 2% of the population requiring an admission
- **5** Day-case admissions based on 13% of the population requiring an admission
- **45** Outpatient attendances based on 136% of the population requiring an attendance
- **7** Diagnostic Imaging based on 18% of the population requiring diagnostic imaging

[5] ONS 2016 Population Estimates (June 2016 base)

Emergency admissions:

27 For the **5** emergency admissions, representing **13%** of the residents, the Trust will have no method of recovering the 30% of tariff needed to invest in the stepped change needed for services.

Formula:

Emergency admissions - Development Population x Average Emergency Admission Activity Rate per Head of Population x Average Emergency Tariff x 30% Cost per Emergency Admission Activity = Developer Contribution £2,260.89

Premium Costs:

28 For all the **74** anticipated hospital based interventions, the Trust will have no method of recovering the additional Premium Costs needed to ensure the level of service required.

Formula:

Development Population x Average Admission Activity Rate per Head of Population x Average Tariff x proportion of Trust staff cost of total cost (62.6 %) x NHSI Agency Premium Cap Uplift (55 %) = Developer Contribution = £6,751.65

29 As a consequence of the above and due to the payment mechanisms and constitutional and regulatory requirements the Trust is subject to, it is necessary that the developer contributes towards the cost of providing capacity for the Trust to maintain service delivery during the first year of occupation of each unit of the accommodation on/in the development. The Trust will not receive the full funding required to meet the healthcare demand due to the baseline rules on emergency funding and there is no mechanism for the Trust to recover these costs retrospectively in subsequent years as explained. Without securing such contributions, the Trust would be unable to support the proposals and would object to the application because of the direct and adverse impact of it on the delivery of

health care in the Trust's area. Therefore the contribution required for this proposed development of **17 dwellings** is **£9,012.54.** This contribution will be used directly to provide additional health care services to meet patient demand as detailed in Appendix 3.

30 The contribution requested (see Appendix 3) is based on these formulae/calculations, and by that means ensures that the request for the relevant landowner or developer to contribute towards the cost of health care provision is directly related to the development proposals and is fairly and reasonably related in scale and kind. Without the contribution being paid the development would not be acceptable in planning terms because the consequence would be inadequate healthcare services available to support it, also it would adversely impact on the delivery of healthcare not only for the development but for others in the Trust's area.

31 Having considered the cost projections, and phasing of capacity delivery we require for this development it is necessary that the Trust receive 100% of the above figure prior to implementation of the planning permission for the development. This will help us to ensure that the required level of service provision is delivered in a timely manner. Failure to access this additional funding will put significant additional pressure on the current service capacity leading to patient risk and dissatisfaction with NHS services resulting in both detrimental clinical outcomes and patient safety.

Summary

32 As our evidence demonstrates, the Trust is currently operating at full capacity in the provision of acute and planned healthcare. It is further demonstrated that although the Trust has plans to cater for the known population growth, it cannot plan for unanticipated additional growth in the short to medium term. The contribution is being sought not to support a government body but rather to enable that body to provide services needed by the occupants of the new development, and the funding for which, as outlined above, cannot be sourced from elsewhere. The development directly affects the ability to provide the health service required to those who live in the development and the community at large.

33 Without contributions to maintain the delivery of health care services at the required quality, constitutional and regulatory standards and to secure adequate health care for the locality, the proposed development will put too much strain on the said services, putting people at significant risk. Such an outcome is not sustainable.

34 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.

35 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 current development plan:

36 **Current development plan**

Policy ID1- Infrastructure Delivery

"Provision for new and/or the enhancement of existing infrastructure, services and facilities to support development and sustainable communities, will be achieved through a co-ordinated approach.

Where necessary, in addition to planning conditions for essential on-site design requirements and critical infrastructure, developer contributions towards strategic infrastructure through s106 agreements and/or a future Community Infrastructure Levy (CIL), will be secured in accordance with national planning policies and other relevant legislation.

A Planning Obligations Supplementary Planning Document (SPD) will provide details of the type and scale of obligations that may apply."

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) … .*

Further, the Planning Practice Guidance ('PPG') provides that:

> *Local planning authorities should ensure that health and wellbeing, and health infrastructure are considered in local and neighbourhood plans and in planning decision making. Public health organisations, health service organisations, commissioners and providers, and local communities should use this guidance to help them work effectively with local planning authorities in order to promote healthy communities and support appropriate health infrastructure.*
>
> *Paragraph: 001 Reference ID: 53-001-20140306*

The PPG goes on to suggest that information about the impact of a development on the demand for healthcare services[1]:

> *… should assist local planning authorities consider whether the identified impact(s) should be addressed through a Section 106 obligation or a planning condition.*
>
> *…Paragraph: 004 Reference ID: 53-004-20140306*

[1] It is acknowledged that this arises in the context of a discussion of consultation with Clinical Commissioning Groups and NHS England, but plainly it would also apply with equal force to information provided by the Trust.

Conclusion

37 In the circumstances, it is evident from the above that the Trust's request for a contribution is not only necessary to make the development acceptable in planning terms it is directly related to the development; and fairly and reasonably related in scale and kind to the development. The contribution will ensure that Health services are maintained for current and future generations and that way make the development sustainable.

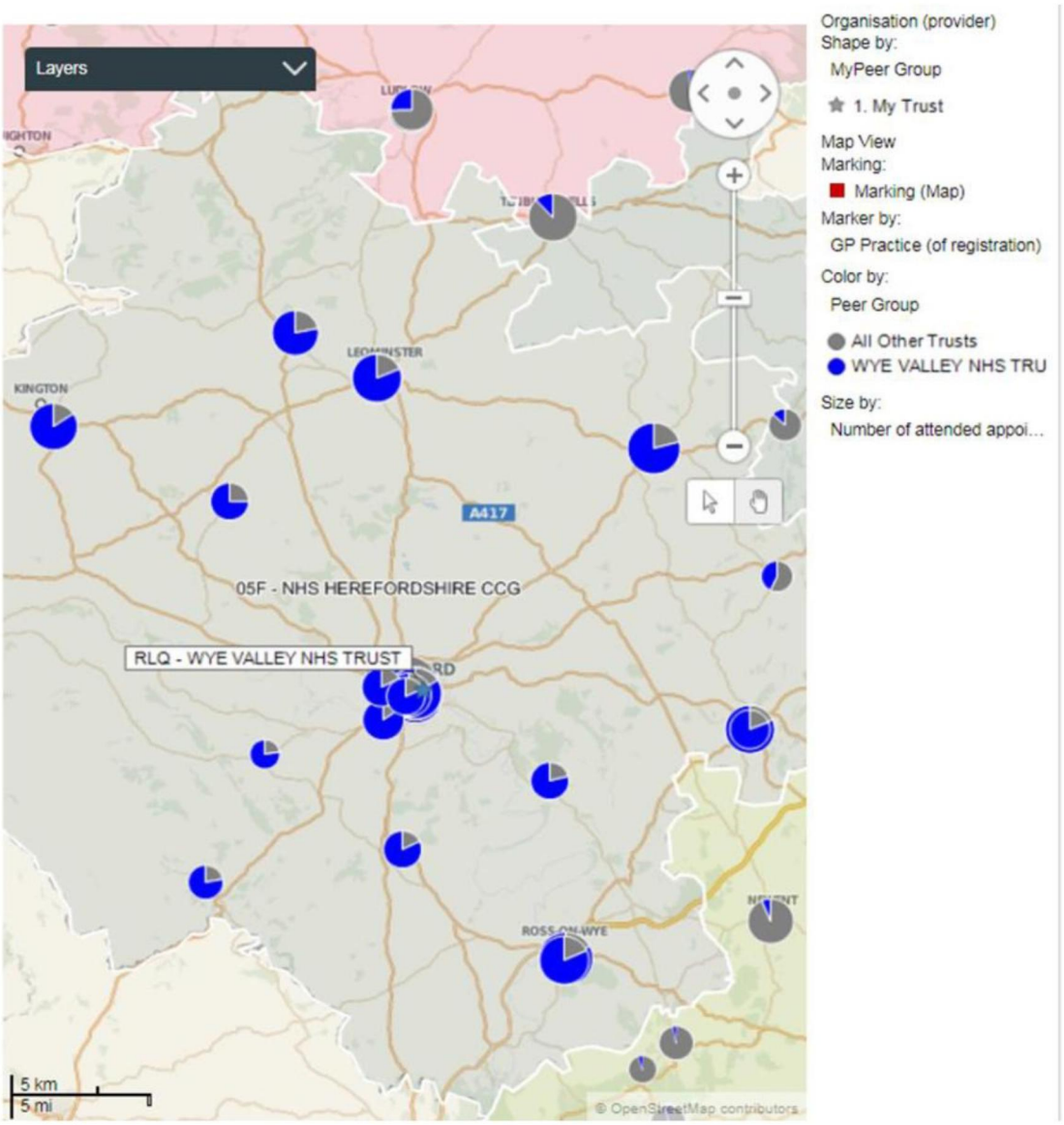
30 January 2019

Appendix 1

Services at Wye Valley NHS Trust

Audiology	Abdominal Aortic Aneurysm screening
A&E	Acquired Brain Injuries (HABIT)
Breast surgery	Bladder and bowel health service
Cancer services	Child Safeguarding
Children's and adolescents' services	Children's Community Nursing
Cardiology	Children's Hearing Service
Ear, Nose and Throat services	Community Hospitals
Dermatology	Community Palliative Care
Diabetology	Community Stroke Rehabilitation
Endocrinology and metabolic medicine	Dental Access Centres
Gastroenterology and hepatology	Dietetics
General surgery General medicine	District Nursing
Geriatric medicine	Expert Patients Programme (long-term health conditions)
Gynaecology	Falls
Haematology	Health Psychology
Maternity/ obstetrics	Health Visiting
Neurology	Lymphoedema
Ophthalmology	Multiple Sclerosis
Oral and maxillofacial services	Paediatricians
Pathology	Paediatric occupational therapy
Palliative care service	Paediatric Physiotherapy
Plastic surgery	Pain Management
Podiatric Surgery	Parkinsons Disease Nurse
Radiology	Physiotherapy
Renal services	Podiatric Surgery
Rheumatology	Podiatry
Respiratory medicine	School Nursing
Special Care Baby Unit	Speech and Language Therapy
Trauma and orthopaedics	
Urology	
Vascular surgery	
Audiology	

Appendix 2 – First OP appointment market share for Wye Valley NHS Trust 2017/19



NHS
Wye Valley
NHS Trust

Appendix 3

Ref:		P184662/O	Holmer House Farm					2017/18 Expenditure	
								Pay	135,200,000
Area:		Herefordshire						All other cost	86,300,000
ONS 2017 Population		191,000						Total cost	221,500,000
Estimate population per dwelling		2.29						Marginal rate	30%
Development Dwellings:		17		Development Population:		38.93		Agency Cap Uplift	55%

Activity Type	Activity 2017/18	% Activity rate per annum per head population	Activity rate per annum per head of population (Indicative based on Hfds)	Avg. tariff	12 months activity for dwellings	Delivery cost for dwellings	Marginal rate on emergencies	Premium cost of delivery	Cost pressure (claim)
A&E	55603	29	0.29	£126.18	11	£1,430		£492.35	£492
Non Elective Admissions	23695	12	0.12	£1,560.45	5	£7,536	£2,260.89	£2,594.75	£4,856
Elective Admissions	3303	2	0.02	£2,567.85	1	£1,729		£595.20	£595
Daycase	22810	12	0.12	£731.36	5	£3,400		£1,170.69	£1,171
Outpatients	222439	116	1.16	£103.35	45	£4,686		£1,613.27	£1,613
Diagnostic Imaging	34074	18	0.18	£119.35	7	£829		£285.39	£285
Total					74	£19,610	£2,260.89	£6,751.65	£9,012.54

Appendix 4

Bed occupancy rate

Q1 from each year

Year	WVT G&A Occ %	England G&A Occ %	WVT G&A beds available
10/11	97.9	86.3	241
11/12	93.9	86.9	239
12/13	97.7	87.9	239
13/14	97.1	88.5	222
14/15	96.0	88.1	222
15/16	94.2	88.4	222
16/17	92.3	90.2	265
17/18	90.4	89.1	265

(G&A – General and Acute)