Wye Valley NHS Trust

EVIDENCE FOR S106 DEVELOPER CONTRIBUTIONS FOR SERVICES

In relation to planning application for: Proposed Outline application with all matters, save access, reserved for the residential development of 20 open market homes and 10 affordable homes

LPA reference: P202265/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.*
- ***Block Contract:*** *An NHS term of art for 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 instalments by the Healthcare Commissioner in return for providing a defined range of services.*

- ***Clinical Commissioning Group:*** *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*

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

- ***ONS:*** *Office of National Statistics*
- ***OPEL:*** *Operational Pressures Escalation Levels are a way for Trusts to report levels of pressure consistently nationally.*

- ***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.*

- ***Planned 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*

- ***Provider Sustainability Fund (PSF):*** *a fund that supplements the health provider's income*

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 the Trust cannot plan for unanticipated additional growth in the short to medium term. The contribution is being sought 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 Way Valley NHS Trust

1 Wye Valley NHS Trust, ("the Trust" or WVT) 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 accountable to the Secretary of State via NHSI 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.

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

5 Like all other NHS bodies, NHS Trusts are inspected against national standards by the Care Quality Commission (CQC). The Independent Regulator, NHS Improvement, monitors the performance of each NHS Trust. If an NHS Trust finds itself in difficulty, NHS Improvement has a range of intervention powers. In the most serious cases, where NHS Improvement intervention cannot resolve the breach, an NHS Trust can be dissolved.

Who is using the Wye Valley Hospital?

6 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**)** 83.8**%** 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 77**%** 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

7 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 years 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.

8 The Trust is required to provide the commissioned health services to all people that present or who are referred to the Trust. "The Trust must accept any Referral of a Service User however it is made unless permitted to reject the Referral under this Service Condition". 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 services. 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.

- **Activity Based Payment System Funding**

9 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 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. Locally, PbR has also expanded to include community care. 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.

10 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.

11 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**

12 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.

13 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.

14 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.

15 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)

16 **Additional funding- Provider Sustainability Fund (PSF):** a fund that supplements the health provider's income, focused on supporting sustainability of NHS providers

17 In 2019/20, the Trust is due to receive additional PSF funding which supplements the income, subject to the Trust planning and delivering their agreed financial (deficit) plan. In the contract negotiations, it is assumed that the Trust will plan to make a financial deficit. The amount of deficit to be achieved is agreed between the Trust and NHSI.

- If the Trust meets its agreed financial deficit target then it will receive its PSF.

- If the Trust does not achieve its agreed target then the Trust will lose the allocated PSF.

18 In addition, the Trust must not have any 52 week wait breaches for elective care. This means that each patient referred to the Trust for elective care should not wait over 52 weeks for their treatment. If this happens then the Trust will be subject to financial sanctions. The potential amount lost is proportionate to the number of breaches.

19 The development will put an extra pressure on the Trust's ability to achieve the agreed surplus because each additional patient not part of the agreed contract will consume the available funding, and ability to treat all elective patients within the required 52 weeks.

Planning for the Future

20 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.

21 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.

Other possible funding or income

22 As an NHS 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 Trust is expected to generate surpluses for re-investment in maintaining local services. As the Trust is in a deficit position it relies on applications to HM Treasury, via NHSI, for emergency allocations of capital, often in the form of loans.

23 Loan applications would be subject to existing borrowing limits with existing loan providers and would have to be paid back with interest. This would be an unacceptable way of funding the additional expenditure caused by a development, and would result in a serious financial cost pressure to an already pressurised budget.

24 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.

Current Position

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

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 at Wye Valley NHS Trust has seen a 50 % increase in the last 10 years[2]. 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
24,078	2018/19

Figure 1

25 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.

26 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 below 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. 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

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

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

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.

27 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 planned and acute healthcare caused by the proposed development**

28 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. 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.

29 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-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 WV 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.

30 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.

31 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

32 The Trust has identified the following:-.

A development of **30 dwellings** equates to **69 new residents** (based on the current assumption of persons per dwelling as adopted by Herefordshire County Council’s

Education team). Using existing 2016[4] demographic data as detailed in the calculations in Appendix 3 will generate **140** acute interventions over the period of 12 months. This comprises additional interventions by point of delivery for:

- **22** A&E based on % of the population requiring an attendance
- **9** Emergency admissions based on percentage of the population requiring an admission
- **1** Elective admissions based on percentage of the population requiring an admission
- **10** Day-case admissions based on percentage of the population requiring an admission
- **85** Outpatient attendances based on percentage of the population requiring an attendance
- **12** Diagnostic Imaging based on percentage of the population requiring diagnostic imaging

Emergency admissions:

33 For the **9** emergency admissions, representing **12.6%** 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

Premium Costs:

34 For all the **140** anticipated hospital based interventions, the Trust will have no method of recovering the additional Premium Costs needed to ensure the level of service required.

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

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

35 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 is **£19,999.35.** This contribution will be used directly to provide additional health care services to meet patient demand as detailed in Appendix 3.

36 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.

37 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

38 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.

39 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.

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 current Local Plan:

40 ***Herefordshire Local Plan, Core Strategy 2011-2031***

Health and wellbeing

3.61 Health services are being developed through an integrated approach of providing for an increased need for age appropriate services (Understanding Herefordshire). This includes; access to community centres, keeping people

independent in their own home and personalised services such as the provision of extra care homes and supported housing generally. Other objectives of this plan, such as improving the provision of open space to help combat obesity and mental health problems, and the provision of improved broadband technology to facilitate access to services, will all work together to provide for improved health and wellbeing in the future. The place shaping policies and the general policies on community facilities and housing will help to facilitate this approach.

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:

> ***How can the need for health facilities and other health and wellbeing impacts be considered in making planning policies and decisions?***
>
> *Plan-making bodies will need to discuss their emerging strategy for development at an early stage with NHS England, local Clinical Commissioning Groups, Health and Wellbeing Boards, Sustainability and Transformation Partnerships/Integrated Care Systems (depending on local context), and the implications of development on health and care infrastructure.*
>
> *It is helpful if the Director of Public Health is consulted on any planning applications (including at the pre-application stage) that are likely to have a significant impact on the health and wellbeing of the local population or particular groups within it. This would allow them to work together on any necessary mitigation measures. A health impact assessment is a useful tool to use where there are expected to be significant impacts.*
>
> *Information gathered from this engagement will assist local planning authorities in considering whether the identified impact(s) could be addressed through planning conditions or obligations.*
>
> *Paragraph: 005 Reference ID:53-005-20190722*

Conclusion

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.

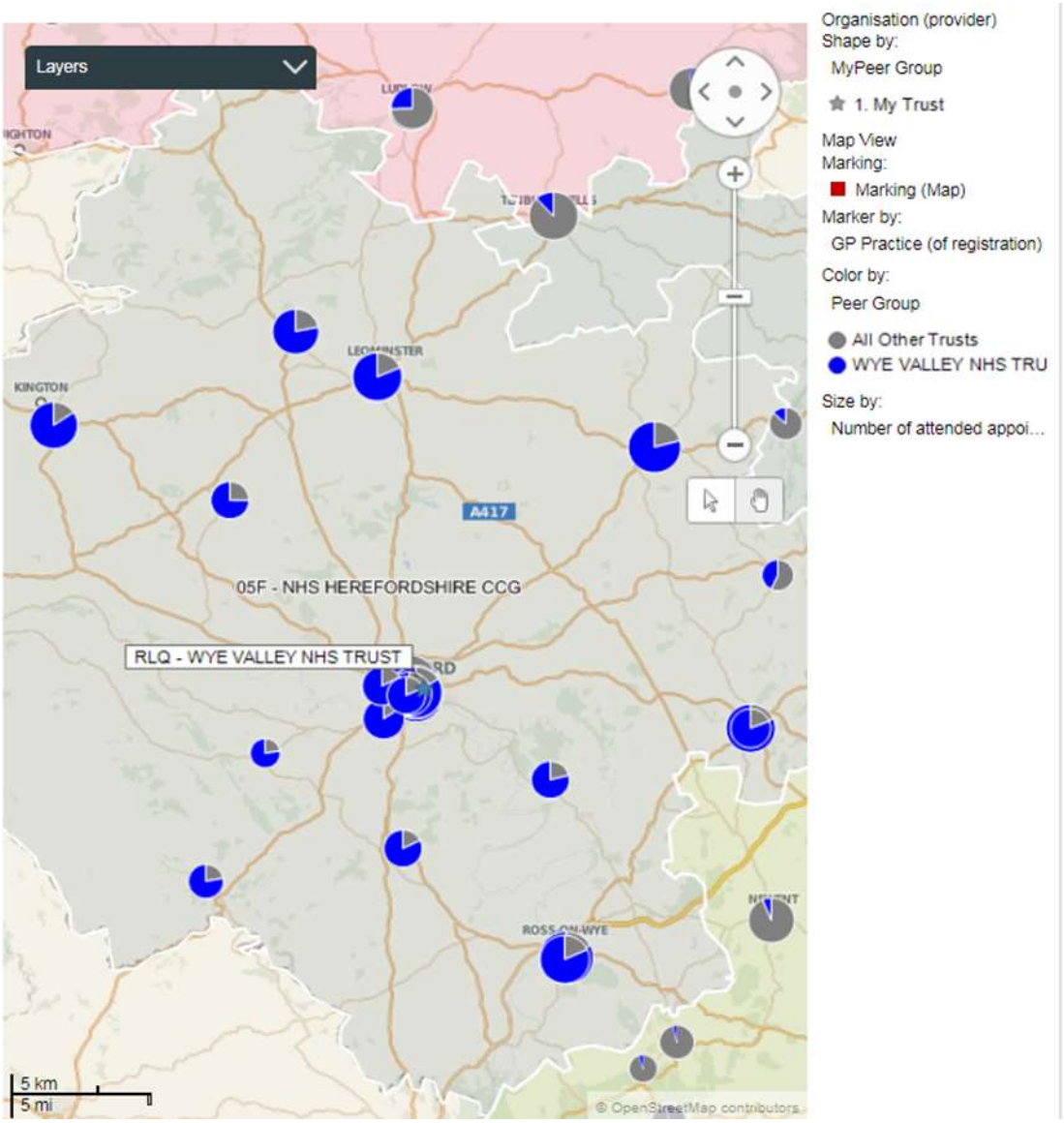
01 September 2020

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



Appendix 3

Ref:		P202265/O						2018/19 Expenditure	
								Pay	140,561,000
Area:		Herefordshire						All other cost	79,682,000
ONS 2017 Population		191,000						Total cost	220,243,000
Estimate population per dwelling		2.29						Marginal rate	30%
Development Dwellings:		30		Development Population:		69		Agency Cap Uplift	55%

Activity Type	Activity 2018/19	% 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	60560	32	0.32	£171.00	22	£3,725		£1,282.46	£1,282
Non Elective Admissions	24078	13	0.13	£2,010.00	9	£17,408	£5,222.29	£5,993.45	£11,216
Elective Admissions	4169	2	0.02	£3,432.00	1	£5,146		£1,771.90	£1,772
Daycase	28650	15	0.15	£622.00	10	£6,410		£2,206.86	£2,207
Outpatients	237110	124	1.24	£103.00	85	£8,784		£3,024.46	£3,024
Diagnostic Imaging	34074	18	0.18	£118.00	12	£1,446		£497.93	£498
Total					140	£42,919	£5,222.29	£14,777.05	£19,999.35

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)