Royal United Hospitals Bath
NHS Foundation Trust

Royal United Hospitals Bath NHS Foundation Trust

Consultation Response and Regulation 122 CIL compliance statement

Application Reference: 2021/1675/EOUT

Application Description: Land South Of Frome Bounded By Marston Road, B3092/railway Line And A361 (Frome Bypass) And Including Land To The South Of The A361 Frome Somerset

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) 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
   - 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.

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, as the funding model the Trust operates within does not pre-empt growth in activity or population.

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

[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

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 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 2 – Workforce Issues

24. Provision of safe hospital-based services relies on sufficient capacity within a suitably sized and skilled clinical workforce and within appropriate physical assets.

25. 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.

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

26. 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 **1700 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. As a consequence of the development and its associated demand for acute and planned health care there will be an adverse effect on the Trust's ability to provide on-time care delivery without delay.

27. 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

28. 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 Estate and Improvement, which in turn allocate the funds to the CCGs.

29. Bath and North East Somerset (BaNES), Wiltshire, Somerset and Bristol, North Somerset and South Gloucestershire (BNSSG) Clinical Commissioning Groups (CCGs) and NHS England commission the Trust to provide acute healthcare services to the local population.

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

31. 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.

32. 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.

33. 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

34. 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.

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

36. A&E attendances and the majority of the Trust's non-elective admissions are covered by a blended payment system. This consists of an agreed threshold; if the threshold is exceeded, up to 3% of the total value is charged at a 20% marginal rate, and above 3% is charged at full tariff.

37. 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.

38. 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.

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

40. 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.

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

Other Possible Funding or Income

42. 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.

43. 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.

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

45. 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.

46. In its modest but effective mitigation, the Trust has carefully considered its funding from the CCGs and is requesting only the amount that it cannot obtain through its contracts with CCGs 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.

47. 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.

48. 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.

49. This proposed development comprises of **1,700 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 **3,910 residents**.

50. As detailed in the calculations in Appendix 4, **3,910 residents** are currently generating an average of **3,304 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.

51. 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.

52. 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.

53. Therefore, the contribution requested for this proposed development of **1700 dwellings** is **£1,805,285.00.** This contribution will be used directly to provide additional services to meet patient demand as indicated in Appendix 4

54. 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.

55. The Trust is happy to work with the Council and provide any further information it requires.

Policy support

56. 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".

57. 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 NNPF).

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, 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) …

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

58. Mendip Local Plan (adopted 2014)

DP19: Development Contributions

The Council will support the delivery of local infrastructure in line with new development and mitigate or compensate for the effects that new development may have:

1. *Through the introduction and operation of a Community Infrastructure Levy (CIL) which will enable the collection of money with the objective of investing in local infrastructure - as detailed in the Infrastructure Delivery Plan – in order to support new development set out in this plan and in response to other agreed priorities as set out in an annual statement.*

2. *By the use of legal agreements (or other appropriate mechanism) where the implementation of a development would result in:*
   - *specific or direct impacts on a site, its surrounding area or local infrastructure (including amenities and facilities), or*
   - *a need to compensate for loss or damage caused by a development.*

Contributions will be directly, fairly and reasonably related in scale and kind to the proposed development

Summary

59. 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 not to support a government body but rather to enable that body 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. Without contributions to maintain the delivery of health care services at the required quality standard and to secure adequate health care for the locality the proposed development will 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.

60. In the circumstances, without the requested contributions to support the service delivery the planning permission should not be granted.

04 January 2022

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.

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

- **Community care:** long-term care for people who are elderly or disabled which is provided within the community rather than in hospitals, especially as implemented in the UK under the National Health Service and Community Care Act of 1990

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

- **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

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]

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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%

**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		Activity Costs	
	Activity 2019/20	% Activity Rate per Annum	Total Delivery Cost Trust-wide	Delivery Cost per Activity 2019.20 Reference Costs
A&E Attendances	95,274	19.1%	£19,395,746	£203.6
Non Elective Admissions	28,915	5.8%	£97,921,441	£3,386.5
Non Elective (Short Stay)	55,406	11.1%	£30,240,389	£545.8
Outpatient Appointments	414,005	82.8%	£54,928,604	£132.7
Outpatient Appointments (Procedure)	87,950	17.6%	£16,863,755	£191.7
Diagnostic Imaging	36,338	7.3%	£3,417,697	£94.1
Community	19,307	3.9%	£2,631,442	£136.3
Total	**737,195**		**£225,399,074**	

Royal United Hospitals Bath
NHS Foundation Trust

Appendix 4: Impact of Development Calculation

Application Reference:	**2021/1675/EOUT**
Local Authority / Area	**Mendip**
Population Estimate (LSOAs):	**2,386**
Population Estimate (Trust wide):	**500,000**

LSOA: E01029053 - Mendip 001D

Development Dwellings	**1,700**
Population Multiplier	**2.30**
Development Population	**3,910**
Deduction of existing population	**TBC**
Final population	

	Expenditure Profile £	
	2018/19	2019/20
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 pressure
A&E Attendances	95,274	19.1%	277	11.6%	£ 19,395,746.3	£ 203.6	454	£ 92,409.8	£ 3,678.0	£ 96,087.8
Non Elective Admissions	28,915	5.8%	236	9.9%	£ 97,921,440.6	£ 3,386.5	387	£ 1,309,703.3	£ 52,128.0	£ 1,361,831.3
Non Elective (Short Stay)	55,406	11.1%	-		£ 30,240,389.2	£ 545.8		£ -	£ -	£ -
Outpatient Appointments	414,005	82.8%	1,044	43.8%	£ 54,928,604.0	£ 132.7	1,711	£ 226,986.4	£ 9,034.0	£ 236,020.4
Outpatient Appointments (Procedure)	87,950	17.6%	227	9.5%	£ 16,863,755.0	£ 191.7	372	£ 71,326.5	£ 2,839.0	£ 74,165.5
Diagnostic Imaging	36,338	7.3%	232	9.7%	£ 3,417,697.0	£ 94.1	380	£ 35,757.5	£ 1,423.0	£ 37,180.5
Total	**717,888**		**2,016**		**£222,767,632**		**3,304**	**1,736,183**	**69,102**	**1,805,285**

Impact per Dwelling	**£ 1,061.93**
Total Mitigation Request	**£ 1,805,285**