University Hospitals Coventry and Warwickshire NHS Trust

EVIDENCE FOR S106 DEVELOPER CONTRIBUTIONS FOR SERVICES

LPA reference: OUT/2018/3080

In relation to planning application for: Rookery Farm (field adjacent to Pumping Station) Watery Lane Coventry - Proposed residential development of up to 40 dwellings.

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.*

- ***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.*

University Hospitals Coventry and Warwickshire NHS Trust

- ***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.*

- ***Tertiary care:*** *Highly specialised medical care usually over an extended period of time that involves advanced and complex procedures and treatments performed by medical specialists in state-of-the-art facilities. (For example; cancer treatment).*

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 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.

Introduction to University Hospitals Coventry and Warwickshire NHS Trust

1 University Hospitals Coventry and Warwickshire NHS Trust, ("the Trust") has an obligation to provide healthcare services and manages two hospitals in Coventry and Rugby, being the Hospital of St. Cross, Rugby, and University Hospital, Coventry. Although run independently, 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 as an NHS Trust in 1993. 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.

2 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 to the population of Coventry and Warwickshire and works as a University Teaching Hospital alongside Warwick Medical School. Acute healthcare services incorporate activities delivered in a hospital setting.

3 The Trust provides a wide range of planned and emergency services to patients across its two hospital sites in Coventry and Rugby (see Appendix 1) It is the major provider of secondary care services to the population of Coventry City and Rugby Borough, and specialist tertiary services including cancer, renal transplant and other specialist services to patients across Coventry, Warwickshire (including Rugby Borough) and further afield, and is the sole, capable provider of major trauma services in Coventry and Warwickshire and beyond.

4 The facilities at University Hospital, Coventry and the Hospital of St Cross, Rugby will be used by the new occupants of this development.

Who is using the University Hospital?

5 Since 2008, patients have been able to choose which provider they use for their healthcare for particular services. The current NHS Choice framework, published in April 2016 explains when patients have a legal right to choice about treatment and care in the NHS. The legal right to choice 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 2017/18 (the most recent data available to UHCW Trust) **84%** of Coventry and Warwickshire residents chose UHCW for their first outpatient appointment and UHCW delivered over **91%** of Coventry and Warwickshire's 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. Coventry and Rugby Clinical Commissioning Group (CCG) commissions the Trust to provide acute healthcare services to the populations of Coventry and Rugby under the terms of the NHS Standard Contract. Likewise, South Warwickshire CCG and Warwickshire North CCG commission the Trust to provide acute healthcare services to the populations of their respective geographies in Warwickshire. NHS England (Specialised Commissioning) commissions the Trust to provide certain specialist and tertiary services to the people of Coventry and Warwickshire and beyond. 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 (activity arising from major trauma and A&E), acute hospital medical and surgical care and specialist and tertiary healthcare from UHCW and agree service level agreements, including activity volumes and values on an annual basis. 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 2017/19 with which the Trust is compliant states “Nothing in this SC7 allows the Provider to refuse to provide or to stop providing a Service if that would be contrary to the Law.” 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 who receive their trauma within the boundaries of the UHCW major trauma service (including the whole of

Coventry & Warwickshire) will be taken to the University Hospital major trauma centre facilities.

- **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 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 2016/17 activity levels (latest available); 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 2017-18, 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. The net change tariff prices over the previous 12 years can be seen in Appendix 4.

- **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 2015/16 baseline. There is no ability to reclaim the 30% of tariff above the baseline for additional activity.

13 The Trust has an annual turnover of c. £658m per annum (2017/18). Of this amount, £558m relates to Commissioner income and £396m of this relates to activity reimbursed at the National Tariff. The remainder of the Trust's funding is through other sources, including education, training and research monies and contracts with other providers.

14 The Trust is expected to generate surpluses for re-investment to develop local services, or alternatively must seek to secure external financing in the form of loans (although due to the current financial constraints in the NHS, access to such funds is extremely limited). This development will directly impact on the service capacity requirements of the Trust to meet additional demand, against which the Trust will have no means of fully recouping the funds required for reinvestment

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 CCG is negotiated on a yearly basis and this will eventually catch up with population growth, but 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[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. UHCW growth is shown in Figure 1.

Emergency Admissions	Year
52,706	2014/15
57,642	2015/16
58,434	2016/17
61,372	2017/18

Figure 1

19 The Trust's hospitals are now at full capacity 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 no 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.

The Trust's current ability to cope with the number of A&E attendances and it's responsiveness to emergency admissions has been specifically commented on by the Care Quality Commission as "Requiring Improvement" in its most recent inspection report (April 2018). Stating 'Patients waiting for admission to a ward spent longer in the Emergency Department than in most other hospitals in England.' In

[1] Older people and emergency bed use, Exploring variation. London: King's Fund 012
[2] Hospital Episode Statistics.www.hesonline.nhs.uk/Ease/servlet/ContentServer?siteID=1937

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 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 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.

20 Appendix 5 details the Trust's utilisation of acute bed capacity, which exceeded the optimal 85% occupancy rate for the majority of the year. (UHCW exceeds 100% when required to bed patients in non-inpatient areas, for example, bedding emergency patients overnight in the day surgery unit.) 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**

23 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.

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

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

24 The NHS, in common with public health services in many other countries is experiencing staff shortages. UHCW 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 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 staff play 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 can be cost effective, because they are only hired when needed and don't carry the same longer-term costs, as directly employed staff – such as pensions, sick pay and holiday pay. They are an essential part of UHCW 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 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. To engage agency staff is the only option to keep up with the required standard.

25 For the additional **177** acute interventions, 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.

26 UHCW 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

27 The Trust has identified the following:-.

A development of **40 dwellings** equates to **94** new residents. Using existing 2017/18 demographic data as detailed in the calculations in Appendix 3 will generate **177** acute interventions over the period of 12 months This comprises additional interventions by point of delivery for:

- **28** A&E based on % of the population requiring an attendance
- **2** Elective admissions based on % of the population requiring an admission
- **10** Day-case admissions based on % of the population requiring an admission
- **14** Emergency admissions based on % of the population requiring an admission
- **107** Outpatient admissions based on % of the population requiring an admission
- **16** Diagnostic Imaging based on % of the population requiring diagnostic imaging

Emergency admissions:

28 For the **14** emergency admissions, representing **15**% 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:

29 For all the **177** 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 (60%) x NHSI Agency Premium Cap (55%) = Developer Contribution.

30 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 **40 dwellings** is **£20,482.00.** This contribution will be used directly to provide additional health care services to meet patient demand as detailed in Appendix 3.

31 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.

32 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

33 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.

34 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.

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 care and patients will be at increased 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 developments. Without the contribution the Trust considers that the development is not a sustainable development.

36 **Local Plan Adopted December 2017 - Health Impact Assessment - Policy HW1: Health Impact Assessments (HIA)**

1. All major development proposals will be required to demonstrate that they would have an acceptable impact on health and wellbeing. This should be demonstrated through a:

a) HIA where significant impacts on health and wellbeing would arise from that proposal; or

b) HIA Screening Report which demonstrates that the proposed development would not overall give rise to negative impacts in respect of health and wellbeing.

2. All HIA's shall be undertaken in accordance with the Council's HIA Supplementary Planning Document.

3. Where a development has significant negative or positive impacts on health and wellbeing the Council may require applicants to provide for the mitigation or provision of such impacts through planning conditions and/or financial/other contributions secured via planning obligations and/or the Council's CIL Charging Schedule.

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

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

[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.

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.

12 December 2018

Appendix 1

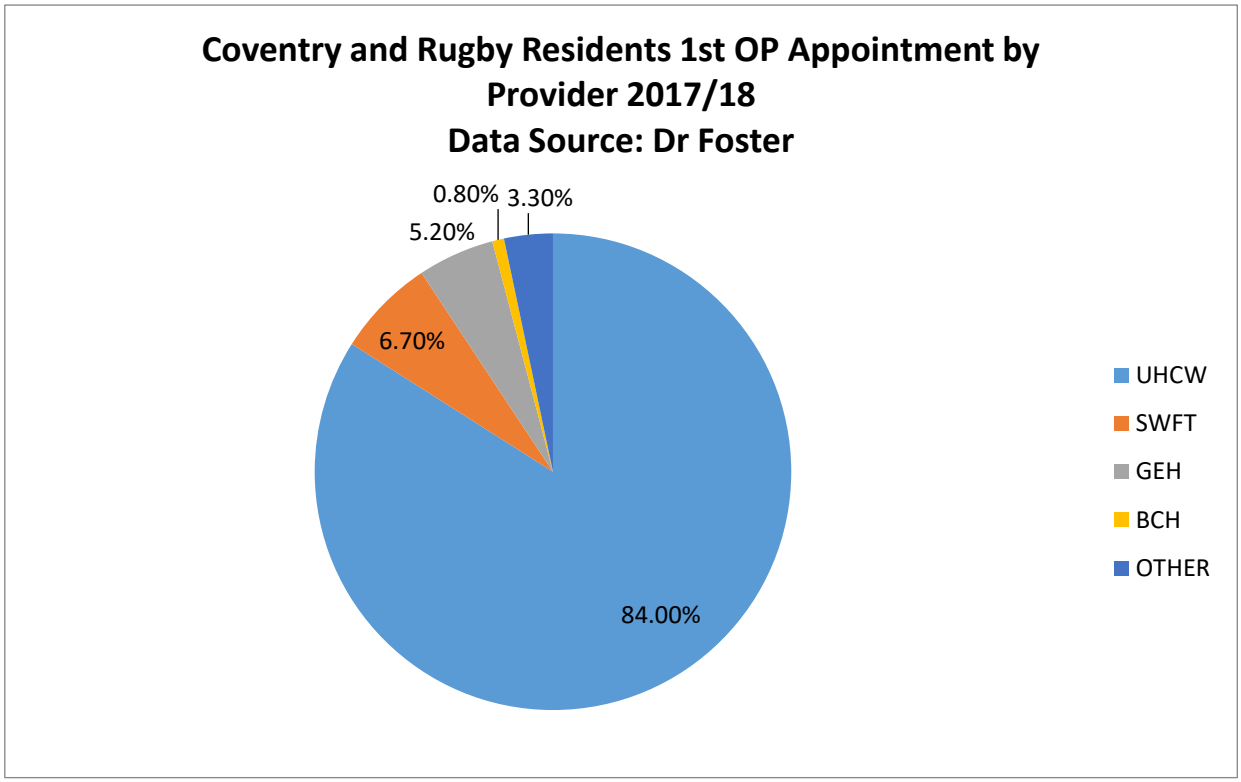
Services provided at University Hospital

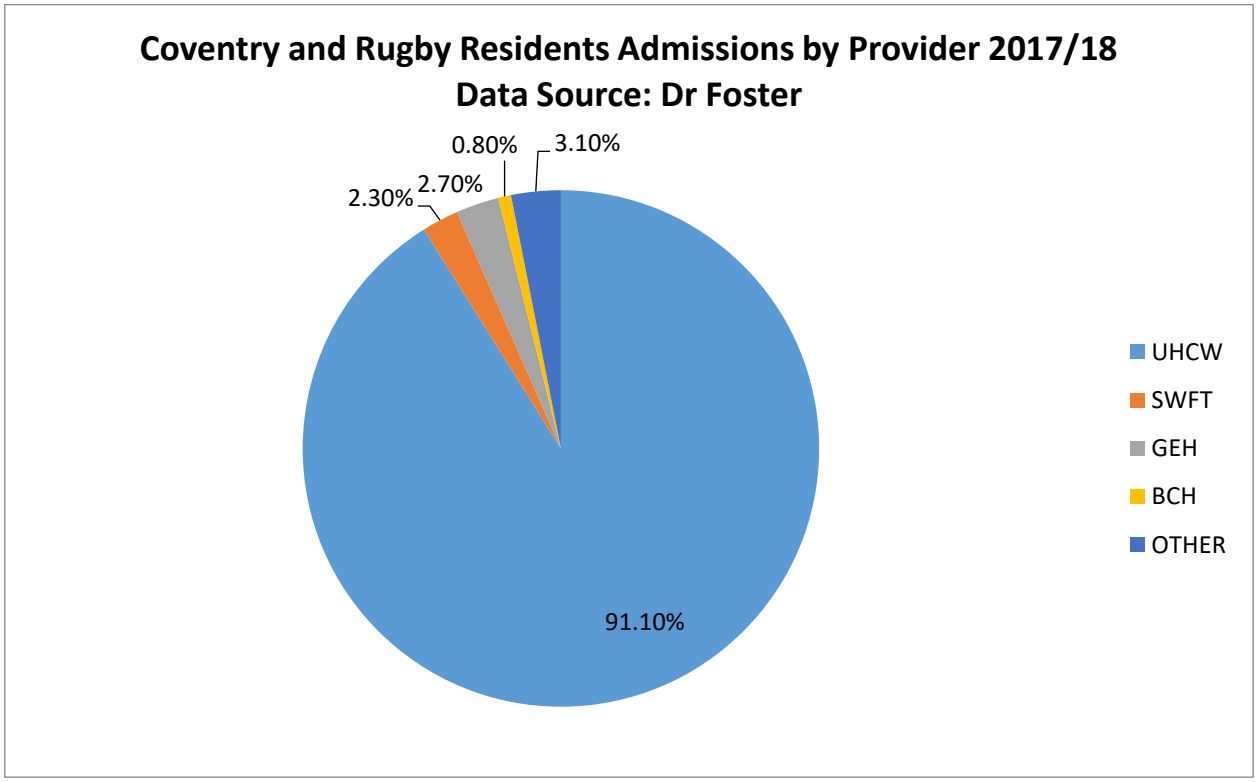
General Acute Services:
Acute Medicine
Accident and Emergency
Age Related Medicine and Rehabilitation
Anaesthetics
Assisted Conception
Audiology
Breast Surgery
Cardiology Critical Care
Colorectal Surgery
Dermatology
Diabetes and Endocrinology
Ear, Nose and Throat
Gastroenterology
General Medicine
General Surgery
Gynaecology
Haematology
Hepatobiliary and Pancreatic Surgery
Upper Gastrointestinal Surgery
Maxillo Facial Surgery
Neurology and Neurophysiology
Obstetrics
Ophthalmology
Optometry
Orthodontics
Orthopaedics Trauma
Orthoptics
Paediatrics
Pain Management
Plastic Surgery
Renal Medicine
Reproductive Medicine
Respiratory Medicine
Rheumatology
Urology
Vascular Surgery
Specialised Services:
Bone Marrow Transplantation
Cardiothoracic Surgery
Clinical Physics
Haemophilia
Invasive Cardiology
Neonatal Intensive Care and Special Care
Neuro Imaging
Neurosurgery
Oncology and Radiotherapy
Plastic Surgery
Renal Dialysis and Transplantation
Diagnostic and Clinical Support Services:
Biochemistry
Dietetics
Echo Cardiography
Endoscopy
Haematology
Histopathology
Medical Physics/Nuclear Medicine
Microbiology
Occupational Therapy
Pharmacy
Physiotherapy
Respiratory Function Testing
Ultrasound
Vascular Investigation

Services provided at Hospital of St Cross

Acute Medicine:
Acute Medicine
Acute Surgery
Ambulatory Care
Breast Screening
Colorectal Cancer Screening Centre
Day Surgery, Overnight Stay / 23 hour Surgery
Endoscopy
Laboratory Services
Macular Unit
Magnetic Resonance Imaging (MRI) Scanning
Outpatients Services
Satellite Renal Dialysis Unit
Scanning, Bone Density
Urgent Care Centre
X-ray including Ultrasound
Inpatient Medical Services
Inpatient Elective Surgery
Inpatient Rehabilitation Service
Intermediate Care

Appendix 2


Coventry and Rugby Residents 1st OP Appointment by Provider 2017/18
Data Source: Dr Foster
0.80%
3.30%
5.20%
6.70%
84.00%
UHCW
SWFT
GEH
BCH
OTHER


Coventry and Rugby Residents Admissions by Provider 2017/18
Data Source: Dr Foster
0.80%
3.10%
2.30%
2.70%
91.10%
UHCW
SWFT
GEH
BCH
OTHER

Appendix 3 - LPA ref: OUT/2018/3080 Rookery Farm (field adjacent to Pumping Station) Watery Lane Coventry

Application Ref:

Coventry Please Select

ONS 2017 Population Estimate: 359945

Development Dwelllings: 40 **Development Populatior** 94

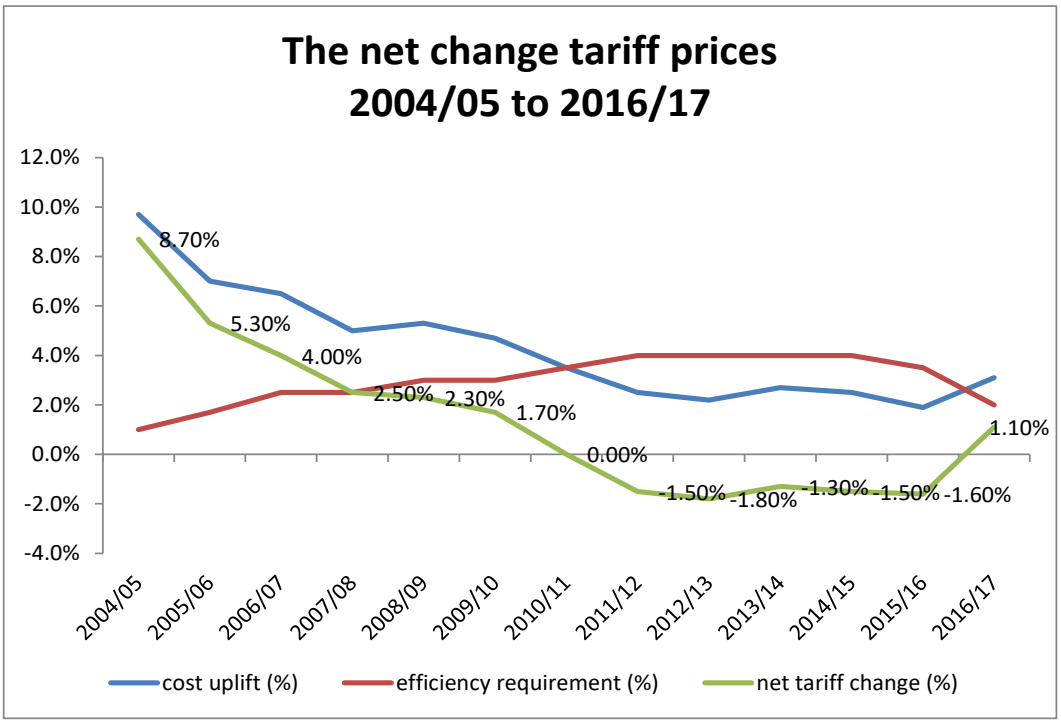
2016/17 M11

Pay	**60%**
All Other Cost	
Total Cost	
Marginal Rate on Emergency Admissions	**30%**
Agency Cap Uplift	**55%**

Activity Type	Activity 2017	% Activity rate per annum per head of	Activity rate per annum per head	Avg Tariff	12 mths Activity for 40 Dwellings	Delivery Cost for 40	Marginal Rate on	Premium Cost of Delivery	Cost Pressure (Claim)
A&E Attendances	107,518	30%	11:36	£ 133.12	28	£ 3,738		£ 1,233.45	£ 1,233
Non Elective Admissions	53,123	15%	5:36	£ 1,307.80	14	£ 18,143	£ 5,443.00	£ 5,987	£ 11,430
Elective Admisisons	6,702	2%	1:36	£ 3,077.31	2	£ 5,386		£ 1,777	£ 1,777
DC Admissions	37,401	10%	1:9	£ 584.77	10	£ 5,712		£ 1,885	£ 1,885
Outpatient appointments	411,085	114%	41:36	£ 105.48	107	£ 11,324		£ 3,737	£ 3,737
Diagnostic Imaging	62,952	17%	1:6	£ 77.29	16	£ 1,271		£ 419	£ 419
Total					**177**	**£ 45,573**	**£ 5,443**	**£ 15,039**	**£ 20,482**

Appendix 4

The net change tariff prices



Appendix 5

Bed occupancy rate