The Royal Bournemouth and Christchurch Hospitals
NHS Foundation Trust

EVIDENCE FOR S106 DEVELOPER CONTRIBUTIONS FOR SERVICES

8/19/0943/OUT

Land at Jesmond Avenue, Highcliffe, Christchurch, Dorset, BH23 5AY

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/Managed Contract:*** *An NHS Term 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 range of defined 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.*

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

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

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

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

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

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

- ***Provider Sustainability Fund (PSF):*** *a fund that supplements the providers income.*

- ***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.*

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

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

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

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

(a) necessary to make the development acceptable in planning terms;

(b) directly related to the development; and

(c) fairly and reasonably related in scale and kind to the development.”

Regulation 123 does not apply to this s 106 Contribution. The request is not to fund infrastructure as defined by S 216 of the Planning Act 2008.

Evidence

Introduction to Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust

1 Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust, (“the Trust”) has an obligation to provide healthcare services. 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.

2 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, 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. The Trust secured Foundation Trust status on the 1st April 2015.

3 The Trust is a public sector NHS body and is directly accountable to the Secretary of State for the effective use of public funds. The Trust is funded from the social security contributions and other State funding, providing services free of charge to affiliated persons of universal coverage. The Trust is commissioned to provide acute healthcare services for the residents of Bournemouth, Christchurch, East Dorset and part of the New Forest with a total population of around 550,000, which rises during the summer months. Some specialist services cover a wider catchment area, including Poole, the Purbecks and South Wiltshire. The Trust is the Hub in relation to the Dorset and Wiltshire Vascular Network.

4 The Trust has a turnover in 2017/18 of £295 million and employs around 4,500 staff.

Who is using the Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust?

5 Since 2008, patients have been able to choose which provider they use for their healthcare for particular services. The 2016 NHS 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 2018/19 (most recent published population data**) the following proportions of residents** within Bournemouth, Christchurch, East Dorset, Poole and the New Forest chose Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust for their first outpatient appointment and admissions,

Locality	Outpatients	Elective	Emergency	A&E
Bournemouth	74.1%	86.7%	70.2%	80.7%
Christchurch	84.4%	92.5%	78.0%	89.8%
East Dorset	59.4%	69.1%	50.9%	59.3%
Poole	24.8%	40.7%	14.7%	20.6%
New Forest	39.0%	39.0%	39.0%	39.0%

6 The calculations in this evidence base are based upon this percentage share.

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Funding Arrangements for the NHS Trust

7 Dorset and West Hampshire Clinical Commissioning Group (CCGs) are the main commissioners who commission the Trust to provide acute healthcare services to the population of Bournemouth, Christchurch, East Dorset and part of the New Forest 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 constraints.. Commissioners commission planned and emergency acute hospital medical and surgical care from Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust and agree service level agreements, including activity volumes and values on annually based on last year's performance. The commissioners have no responsibility for providing healthcare services. They commission (specify, procure and pay for) services, which provides associated income for the Trust. The Trust directly provides the majority of healthcare services through employed staff but has sub-contracted some non-clinical services through its PFI arrangements. The Trust is contracted on a block contract fixed income basis from both Dorset and West Hampshire CCG.

8 The Trust is required to provide the commissioned health services to all people that present or who are referred to the Trust. The NHS Standard Contract for Services, condition SC7 for 17/18 and with which the Trust is compliant states "*The Trust must accept any Referral of a Service User however it is made unless permitted to reject the Referral under this Service Condition"*[1]. There is no option for the Trust to refuse to admit or treat a patient on the grounds of a lack of capacity to provide the service/s. This obligation extends to all services from emergency treatment at Accident and Emergency (A&E) to routine/non-urgent referrals. Whilst patients are able in some cases to exercise choice over where they access NHS services, in the case of an emergency they are taken to their nearest appropriate A&E Department by the ambulance service. In respect of major trauma, all patients who receive their trauma within the boundaries of the Trust the major trauma service will be taken to the Trust Major trauma centre facilities.

[1] NHS Standard Contract- Service Condition SC7

- **Activity Based Payment System Funding**

9 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, A 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. RBCHFT is funded through block contract arrangements by both Dorset and West Hampshire CCG and as such any in year activity is not funded through the PbR payment system.

10 The Trust has an annual turnover of c. £295m per annum and is paid both through Block and PbR contracts. The majority of the Trusts income is blocked and fixed for the financial year. The Trust has to find efficiency savings of around 4.5% or £12.697 million each year and the Trust is subject to marginal payments for a proportion of our annual work.

11 The Department of Health dictates the costs they think NHS health services should be priced at. The tariff is broken down with 65% for staffing costs, 21% other operational costs, 7% for drugs, 2% for the clinical negligence scheme and 5% for capital maintenance costs

<u>Payment by Result</u>

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 if care and intervention and are evidenced by best clinical practice to ensure optimal outcomes for patients. Each patient referred to the Trust for treatment should not wait over 52 weeks for an appointment. If any patient does, then the Trust is subject to a penalty of £2,500 in respect of those patients who have not been seen within the required 52 weeks.

13 This development will create additional pressure on the Trust to provide appointments within the required timescales.

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

14 The Trust receives additional funding which supplements the income. In the contract negotiations, it is assumed that the Trust in its financial plan makes a profit (control total). The amount of profit to be achieved is agreed between the Trust and the CCG.

15 If the Trust meets its control total, quarterly payments will be made in arrears subject to delivering the planned year to date financial performance. If not the will lose this payment which is in region of £7 million for 2019/20.

16 The development will put an extra pressure on the Trust's ability to achieve the agreed profit because each additional patient not part of the agreed contract will consume the available funding.

17 None of the additional expenditure spent outside the current year's funding is ever recovered in the following year's funding. The new funding is only based on the previous year's activity. It is not related to LPA housing projections, need or land supply.

Other possible funding

18 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 Trust is expected to generate surpluses for re-investment in capital infrastructure and maintenance through its annual planning process.

19 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. Loan applications are subject to borrowing limits and Monitor approval of our repayment proposals. Loans are repaid to the Department at the same rate of interest that was payable by the Government Protected Assets needed to provide NHS services cannot be used as security for borrowing.

20 A loan would be subject to borrowing limits and external authorisation processes and would have to be paid back with interest. This would be 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.

Planning for the Future

21 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.

22 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.

Current Position

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

23 Across England, the number of acute beds is one-third less than it was 25 years ago[2], but in contrast to this the number of emergency admissions at Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust has seen an increase in the last 10 year[3]. The number of emergency admissions (including ambulatory care) is currently at an all-time high. The growth is shown in the table below.

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

Emergency Admissions	Year
24,450	2006/07
36,307	2016/17

Figure 1

24 The Trust runs on average at 93% bed occupancy with peaks during winter months at 100%, amongst 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, this development will have a direct impact on the Trust ability to keep up with required quality of the service. The Trust will face sanctions due to dropping ability to provide the required service.

25 In order to maintain adequate standards of care as set out in the NHS Standard Contract quality requirements, it is well evidenced in the Dr Foster Hospital Guide that a key factor to deliver on-time care without delay is the availability of beds to ensure timely patient flow through the hospital. The key level of bed provision should support maximum bed occupancy of 85%. The 85% occupancy rate is evidenced to result in better care for patients and better outcomes[4]. This enables patients to be placed in the right bed, under the right team and to get the right clinical care for the duration of their hospital stay. Where the right capacity is not available in the right wards for treatment of his/her particular ailment, the patient will be admitted and treated in the best possible alternative location and transferred as space becomes available, but each ward move increases the length of stay for the patient and is known to have a detrimental impact on the quality of care. Consequently, when hospitals run at occupancy rates higher than 85%, patients are at more risk of delays to their treatment, sub-optimal care and being put at significant risk.

26 Appendix 1 details that the Trust's utilisation of acute bed capacity which exceeded the optimal 85 % occupancy rate for the majority of 2016/17. This demonstrates that

current occupancy levels are highly unsatisfactory, and the problem will be compounded by an increase in need created by the development which does not coincide with an increase in the number of bed spaces available at the Hospital. This is the inevitable result where clinical facilities are forced to operate at over-capacity. Any new residential development will add a further strain on the current acute healthcare system.

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

27 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 development 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.

28 During 2017/18 95,148 residents of Bournemouth, Christchurch, East Dorset and part of the New Forest attended the Trust's A&E Department. In 2017/18 113,124 of Bournemouth, Christchurch, East Dorset and part of the New Forest residents were admitted to the Hospital alongside 251,070 Outpatient follow ups and 130,317 new out-patient attendances.

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

29 The NHS, in common with public health services in many other countries is experiencing staff shortages. Royal Bournemouth & Christchurch Hospitals NHS Foundation 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 the Trust's staffing resources 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 CCGs 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 Royal Bournemouth & Christchurch Hospitals NHS Foundation 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 to meet the funding gap directly created by the development population. 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 **54 dwellings** equates to **89 new residents** (based on the current assumption of 1.65 persons per dwelling as adopted by Council's calculation). Using existing 2018 demographic data as detailed in the calculations in Appendix 2 will generate **174** acute interventions over the period of 12 months. This comprises additional interventions by point of delivery for the following. This is based on 2017/18 Reference Cost information submitted to NHS England and subject to external audit scrutiny.

- A&E based on the equivalent percentage of the population requiring an attendance
- Emergency admissions based on the equivalent percentage of the population requiring an admission
- Elective admissions based on the equivalent percentage of the population requiring an admission
- Day-case admissions based on the equivalent percentage of the population requiring an admission
- Outpatient attendances based on the equivalent percentage of the population requiring an attendance
- Diagnostic Imaging based on the equivalent percentage of the population requiring diagnostic imaging

33 Formula:

Development Population x % Development Activity Rate per head of Population x Cost per Activity = Developer Contribution

Premium Costs

34 For the **174** 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 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 **£53,716.00.** This contribution will be used directly to provide additional health care services to meet patient demand as detailed in Appendix 2.

36 The contribution requested (see Appendix 2) 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.

40 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.

41 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.

42 It would also be in the accordance with Council's Core Strategy:

Christchurch and East Dorset Councils Health Improvement Statement – 2014-2016

1.5. Our Contributions Towards Improving Health and Wellbeing The functions and responsibilities of the Councils Partnership ensure we are well placed as a key partner in delivering health interventions and improving the health and wellbeing of our communities. The contributions of the Partnership are much more than providing exercise facilities at our leisure centres. Services have an impact on the wider determinates of health, including the effects of living in poor housing conditions, providing access to facilities, distribution of benefits, access to safe food and healthy workplaces. Allowing individuals to improve their health and wellbeing no matter what condition their health is or issues of inequality they face.

Christchurch and East Dorset Corporate Plan – 2016-2020

SC2 Promote healthy and active lifestyles:

- *Support initiatives that contribute to the wellbeing of residents*
- *Support and promote the health and wellbeing of our residents through the delivery of our wider corporate priorities*
- *Promote the benefits of pursuing health and wellbeing improvements amongst our partners and stakeholders*

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*

In the circumstances, without the requested contributions to support the services infrastructure the planning permission should not be granted.

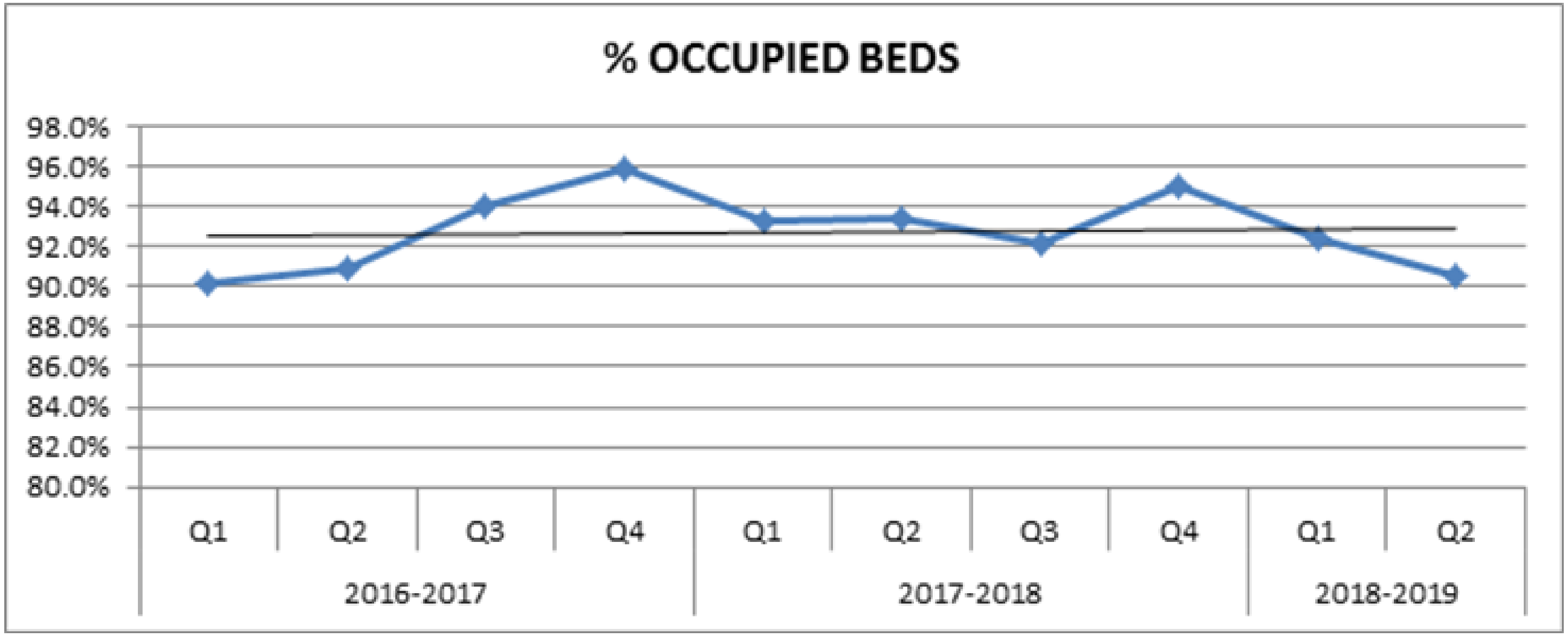
Conclusion

43 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.

Date: 10 October 2019

The Royal Bournemouth
and Christchurch Hospitals
NHS Foundation Trust

Appendix 1 - Bed occupancy rate



NHS

The Royal Bournemouth and Christchurch Hospitals

NHS Foundation Trust

Appendix 2 -

Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust

Application Reference:	8/19/0943/OUT	Land at Jesmond Avenue		
Local Authority / Area	Christchurch BC			
Activity Type	EL & DC	OP & Diag	Non El	A&E
Trust Population Catchment Estimate	420,846	359,112	348,310	363,705
Population Estimate of Planned Scheme	1			
Deprivation Weighting % (Public Health England)	0.00%	0.00%	0.00%	0.00%
Development Dwellings	54	54	54	54
Population Multiplier	1.65	1.7	1.7	1.7
Development Population	89	89	89	89

	Expenditure Profile £	
	2017/18*	2018/19**
Clinical Pay	135,063	146,172
All other costs	157,922	163,807
Total Costs*	292,985	309,979
Staffing cost %	46.10%	47.16%
Premium Staff Cost %	5.87%	6.60%

Used Bank & Agency Costs / Total Costs from NHSI return

* Total Operating Costs Note 5.1 2017/18 Accounts

** Total Operating Costs from 2018/19 accounts

Activity Type	Trust Level Activity 2017/18 Reference Costs	Delivery Cost Quantum 2017/18 Reference Costs £	Delivery Cost per Activity 2017/18 Reference Costs £	Scheme Specific Deprivation Weighting £	% of Resident Population profile attending at POD	Delivery Cost for Planned Population £	Acute Interventions (Activity)	Deliver Cost for Specific Scheme Deprivation Weighted	Premium costs of Delivery £	Cost Pressure (Claim) £
A&E Attendances	95,223	14,779,590	155.21	0.00	26.18%	41	24	3,621	113	3,733
Non Elective Admissions	30,797	61,767,725	2005.64	0.00	8.84%	177	8	15,801	492	16,292
Non Elective (Short Stay)	28,964	11,977,762	413.54	0.00	8.32%	34	8	3,064	95	3,159
Elective Admissions	7,887	34,344,833	4354.61	0.00	1.87%	82	2	7,271	226	7,498
Day Case (Elective)	53,292	34,855,789	654.05	0.00	12.66%	83	12	7,380	230	7,609
Outpatient Appointments	360,628	43,323,573	120.13	0.00	100.42%	121	92	10,749	334	11,083
Outpatient Appointments (Procedure)	55,218	10,146,444	183.75	0.00	15.38%	28	14	2,517	78	2,596
Diagnostic Imaging	55,153	6,821,639	123.69	0.00	15.36%	19	14	1,693	53	1,745
Total	687,162	218,017,355					174		1,621	53,716

Contribution per Dwelling £	995