Sent: 17 May 2022 10:27
Subject: FW: Updated Consultation Reports: Royal Devon University Healthcare NHS Foundation Trust (ROY91/1)
Attachments: 22.0236.FUL - Exeter - Part 1.docx; 22.0236.FUL - Exeter - Part 2.docx

From: Sandra Horne <shorne@wilkes.co.uk>
Sent: 13 May 2022 11:47
To: Planning <Planning@exeter.gov.uk>
Cc: Leenamari Aantaa-Collier <laantaa-collier@wilkes.co.uk>
Subject: Updated Consultation Reports: Royal Devon University Healthcare NHS Foundation Trust (ROY91/1)

Dear Sirs,

Further to previous correspondence, please attached updated consultation reports in relation to the following applications:

- 22/0236/FUL

We have updated our client's consultation reports following a merger of Royal Devon & Exeter NHS Foundation Trust and Northern Devon NHS Trust on 1 April 2022 to form the **Royal Devon University Healthcare NHS Foundation Trust**.

We should be grateful if you would confirm receipt of the attached.

Kind regards,

Sandra Horne
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A list of members is available for inspection at our registered office at 41 Church Street, Birmingham B3 2RT

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Royal Devon
University Healthcare
NHS Foundation Trust

This is a consultation response to the planning application ref: 22/0236/FUL in relation to Royal Clarence Hotel Cathedral Yard Exeter Devon EX1 1HD

Introduction

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. Access to health services is a fundamental part of sustainable healthy community.

As the attached document demonstrates, Royal Devon University Healthcare NHS Foundation Trust (the Trust) is currently operating at full capacity in the provision of acute and planned healthcare.

It is further demonstrated that this development will create potentially long term impact on the Trust ability provide services as required.

The Trust's funding is based on previous year's 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.

The contract is agreed annually based on previous year's activity plus any pre-agreed additional activity for clinical services. The Trust is unable to take into consideration the Council's housing land supply, potential new developments and housing trajectories when the contracts are negotiated. Further, the following year's contract does not pay previous year's deficit retrospectively. This development creates an impact on the Trust's ability provide a services required due to the funding gap it creates. The contribution sought is to mitigate this direct impact.

CIL Regulation 122

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 4
(c) fairly and reasonably related in scale and kind to the development."

S 106

S 106 of the Town and Country Planning Act 1990 (as amended) allows the Local Planning Authority to request a developer to contribute towards the impact it creates on the services. The contribution in the amount £22,661.00 sought will go towards the gap in the funding created by each potential patient from this development. The detailed explanation and calculation are provided within the attached document.

Without the requested contribution, the access to adequate health services is rendered more vulnerable thereby undermining the sustainability credentials of the proposed development due to conflict with NPPF and Local Development Plan policies as explained in the attached document.

Royal Devon University Healthcare NHS Foundation Trust

10 May 2022

Royal Devon
University Healthcare
NHS Foundation Trust

EVIDENCE FOR S106 DEVELOPER CONTRIBUTIONS FOR SERVICES

Application reference: 22/0236/FUL

In relation to planning application: Royal Clarence Hotel Cathedral Yard Exeter Devon EX1 1HD

Definitions

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

- ***Acute care:*** *This is a branch of hospital healthcare where a patient receives active but short-term treatment for a severe injury or episode of illness, an urgent medical condition, or during recovery from surgery. In medical terms, care for acute health conditions is the opposite from chronic care, or longer-term care.*

- ***Block Contract:*** *An NHS term 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 a fixed annual fee in installments by the Clinical Commissioning Groups in return for providing a defined range of services.*

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

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

- ***NHSI:*** *NHS Improvement: Regulatory body for NHS Trusts in England*

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

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

- ***Primary Care:*** *services that provide the first point of contact in the healthcare system, including general practice, community pharmacy, dental, and optometry (eye health) services.*

- ***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.*

- ***Sustainability and Transformation Fund (STF):*** *a fund that supplements the health provider's income, linked to specific delivery targets*

Introduction

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 urgent and elective 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 and capacity 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."

Evidence

Introduction to Royal Devon University Healthcare NHS Foundation Trust

1 On 1 April 2022 Royal Devon & Exeter NHS Foundation Trust merged with Northern Devon Healthcare NHS Trust to create the Royal Devon University Healthcare NHS Foundation Trust. The data provided in this evidence is provided by Royal Devon & Exeter NHS Foundation Trust prior to the merger. As the development in question does not affect Northern Devon Healthcare NHS Trust, the merger has not affected any calculations.

2 Royal Devon University Healthcare 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.

3 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.

4 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 and community health care services for a core population of around 450,000, with 350,000 of those residents living in Exeter, East and Mid Devon. This population grows, particularly in the summer months.

5 Royal Devon & Exeter NHS Foundation Trust has an estimated turnover of around £500 million and employs around 8000 staff.

Who is using the Royal Devon University Healthcare NHS Foundation Trust?

6 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. Activity data analysis shows, that on average, approximately 70% of the Trust's patient activity is from residents within Exeter, East and Mid Devon.

Funding Arrangements for the NHS Trust

7 Northern, Eastern and Western Devon Clinical Commissioning Group and South Devon and Torbay Clinical Commissioning Group (CCGs) commission the Trust to provide acute healthcare services to the population of Exeter and East and Mid Devon under the terms of the NHS Standard Contract. This commissioning activity involves identifying the health needs of the respective populations and commissioning the appropriate high quality services necessary to meet these needs within the funding allocated. The commissioners commission planned and emergency acute hospital (medical &surgical) and community health care from Royal Devon University Healthcare NHS Foundation Trust. They agree service level agreements, including activity volumes and values annually based on last year's performance plus any known national initiatives. The CCGs have no responsibility for providing healthcare services. They commission (specify, procure and pay for) services, which provides associated income for the Trust.

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.

9 The Trust has an annual turnover of c£500m per annum, and c£297m is received from the Northern, Eastern and Western Devon Clinical Commissioning Group and South Devon and Torbay Clinical Commissioning Group (CCG) within Block Contracts. The majority of the remainder of the Trust's funding is through other NHS services contracts. The Trust has to find efficiency savings of around 4% each year.

10 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.

11 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. **The commissioning is not related to Local Planning Authorities' housing needs, projections, existing planning permissions or land supply**.

12 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 maintaining local services.

[1] NHS Standard Contract- Service Condition SC7

13 As a Foundation Trust, there is eligibility to request a commercial loan to fund capital development proposals.

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

Performance Trajectory

15 The Trust is asked to submit monthly performance data in relation to certain waiting times standards in order to receive money from the Sustainability and Transformation Fund. One of the waiting time standards which Trusts are required submit performance data in relation to is the 4-hour A & E waiting time standard. Failure to deliver services in accordance with the performance trajectory agreed, results in withdrawal of an element of the STF.

16 Operational Pressures Escalation Levels are a way for Trusts nationally to report levels of pressure consistently. Under OPEL, there are 4 escalation levels, where Level 1 shows the Trust is maintaining patient flow and able to meet anticipated demand. In contrast, escalation to Level 4 shows the Trust is unable to deliver comprehensive care and there is a greater risk on patient care and safety being compromised.

17 Please see **Appendix 6** which demonstrates the Trust's performance in relation to the national standard described above. It can be clearly seen that the Trust is frequently experiencing major pressures and its inability to cope with the increasing patient demand. New development within the regions will inevitably add to the already over-burdened NHS and will put the Trust at a serious risk of losing the STF funding. For Q4 2018/19 the penalty for failing to achieve the 4 hour waiting time standard by March 2019 was £1.3m.

Planning for the Future

18 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.

19 It is **not** possible for the Trust to predict when planning applications are made and delivered and, therefore, it 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. However, the commissioning operates based on previous year's performance and does not take into account potential increase in population created by a prospective development, housing projections or housing land supply.

Current Position

- **A & E Attendances and the direct impact on emergency health care services**

20 Across England, the number of acute beds is one-third less than it was 25 years ago[2]. A&E attendances have also grown dramatically in the last 10 years. The growth is shown in the table below.

A & E Attendances	Year
64110	2007/8
104977	2019/20

Figure 1

21 The Trust runs at over 89 % bed occupancy, 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's ability to keep up with the required quality of the service. The Trust will face sanctions if it is unable to provide the required service at the required standard.

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

Acute Adult Bed Occupancy

22 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[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.

23 Appendix 4 shows monthly details of the Trust's utilisation of acute bed capacity for the two financial years. This shows that the Trust exceeded the optimal 85% occupancy rate for all of 2016/17 and 2017/18. 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 healthcare caused by the proposed development**

24 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

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

adverse effect on the Trust's ability to provide on-time care delivery without delay increasing capacity demand.

25 During 2019/20, the equivalent of 104,977 residents of Exeter and East and Mid Devon attended the Trust's A&E Department. In addition to this, the equivalent of more than every resident attended an outpatient appointment and 206,744 uses of the Community Health Services were made by Exeter and East and Mid Devon residents. This is equivalent to the average Exeter and East and Mid Devon resident generating 2.1 acute hospital interventions per year at the Royal Devon University Healthcare NHS Foundation Trust[4].

26 There is no way to reclaim any additional cost for un-anticipated activity within Devon. 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 the 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. Without the contribution, 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 **23 dwellings** equates **56 new residents** (based on the current assumption of 2.43 persons per dwelling as per ONS figures). Using existing 2016[5] demographic data as detailed in the calculations in Appendix 4 will generate **112.92** acute interventions over the period of 12 months. This comprises additional interventions by point of delivery for:

- **14.27** A&E based on 25.6% of the population requiring an attendance
- **10.98** Non Elective admissions based on 19.7% of the population requiring an admission

[4] Updated figures for 19/20 not available
[5] ONS 2016 Population Estimates (June 2016 base)

- **1.03** Elective admissions based on 1.8% of the population requiring an admission
- **3.71** Day-case admissions based on 6.6% of the population requiring an admission
- **1.97** Regular attendances based on 3.5% of the population requiring to attend regularly
- **37.52** Outpatient attendances based on 67.2% of the population requiring an attendance
- **9.26** Outpatient attendances based on 16.6% of the population requiring procedure
- **34.09** Community health services based on 61% of the population requiring the delivery of Community based Services.

Formula:

Increase in Service Demand:

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

The final figure – Affordable housing deduction

The total impact of the development is abated to 65% of total cost pressure. This abatement recognises that, according to the Exeter housing policy 35% will be affordable housing so will be intra migration.

28 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 **23 dwellings** is **£22,661.00.** This contribution will be used directly to provide additional health care services to meet patient demand as detailed in Appendix 5.

29 The contribution requested (see Appendix 5) 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.

30 Having considered the cost projections, and phasing of capacity delivery we require for this development it is necessary that the Trust receives 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 increased delays for patients and dissatisfaction with NHS services.

Summary

31 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, for one year only, 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.

32 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 risk of significant delays in accessing care. Such an outcome is not sustainable.

33 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.

34 There will be a dramatic reduction in the Trust's ability to provide timely and high quality care for the local population as it will be forced to operate over available capacity and as the Trust is unable to refuse care to emergency patients. There will also be increased waiting times for planned operations and patients will be at risk of multiple cancellations. This will be an unacceptable scenario for both the existing and new population. The contribution is necessary to maintain sustainable development. Further the contribution is carefully calculated based on specific evidence and fairly and reasonably related in scale and kind to the development. It would also be in the accordance with Council's current Coe Strategy:

35 Exeter City Council – Core Strategy (up to 2026)

4. Providing for growth: Spatial strategy

Objective 7 - Promote development that contributes to a healthy population

Policy CP18 - New development must be supported by appropriate infrastructure provided in a timely manner. The City Council will continue to work in partnership with infrastructure providers and other delivery agencies to keep an up to date infrastructure delivery plan that will enable proposals, in accordance with the spatial strategy, to be brought forward. ***Developer contributions will be sought to ensure that the necessary physical, social, economic and green infrastructure is in place to deliver development****.* ***Contributions will be used to mitigate the adverse impacts of development*** *(including any cumulative impact). Where appropriate, contributions will be used to facilitate the infrastructure needed to support sustainable development.*

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) … .*

Conclusion

36 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 the impact that this development will create is adequately mitigated and that the capacity provide health services is maintained for the population of this proposed development and the population of the existing community.

10 May 2022

Appendix 1

Services at Royal Devon and Exeter NHS Foundation Trust

We are focused on providing safe, high-quality services, delivered with courtesy and respect

The Royal Devon and Exeter NHS Foundation Trust (RD&E) provides integrated health and care services across Exeter and East and Mid Devon. With about 8,000 staff, it manages a large acute teaching hospital, twelve community hospitals and provides community services to a core population of over 450,000.

The RD&E has a long and proud history, dating back over 250 years. The Trust has earned an international reputation as a recognised provider of high-quality healthcare services, innovation, research and education. The Trust is nationally and internationally recognised for excellence in a number of specialist fields, including the Princess Elizabeth Orthopaedic Centre, the Centre for Women's Health (maternity, neonatology and gynaecology services), cancer services, renal services, Exeter Mobility Centre, and Mardon Neuro-Rehabilitation Centre.

As a teaching hospital, the RD&E delivers undergraduate education for a full range of clinical professions, is established as a leading centre for high-quality research and development in the South West peninsula, and is the lead centre for the University of Exeter Medical School. The RD&E became one of the first foundation trusts in 2004 and this status, with accountability to local citizens through our membership and governors, is an important way of connecting with the people and communities we serve.

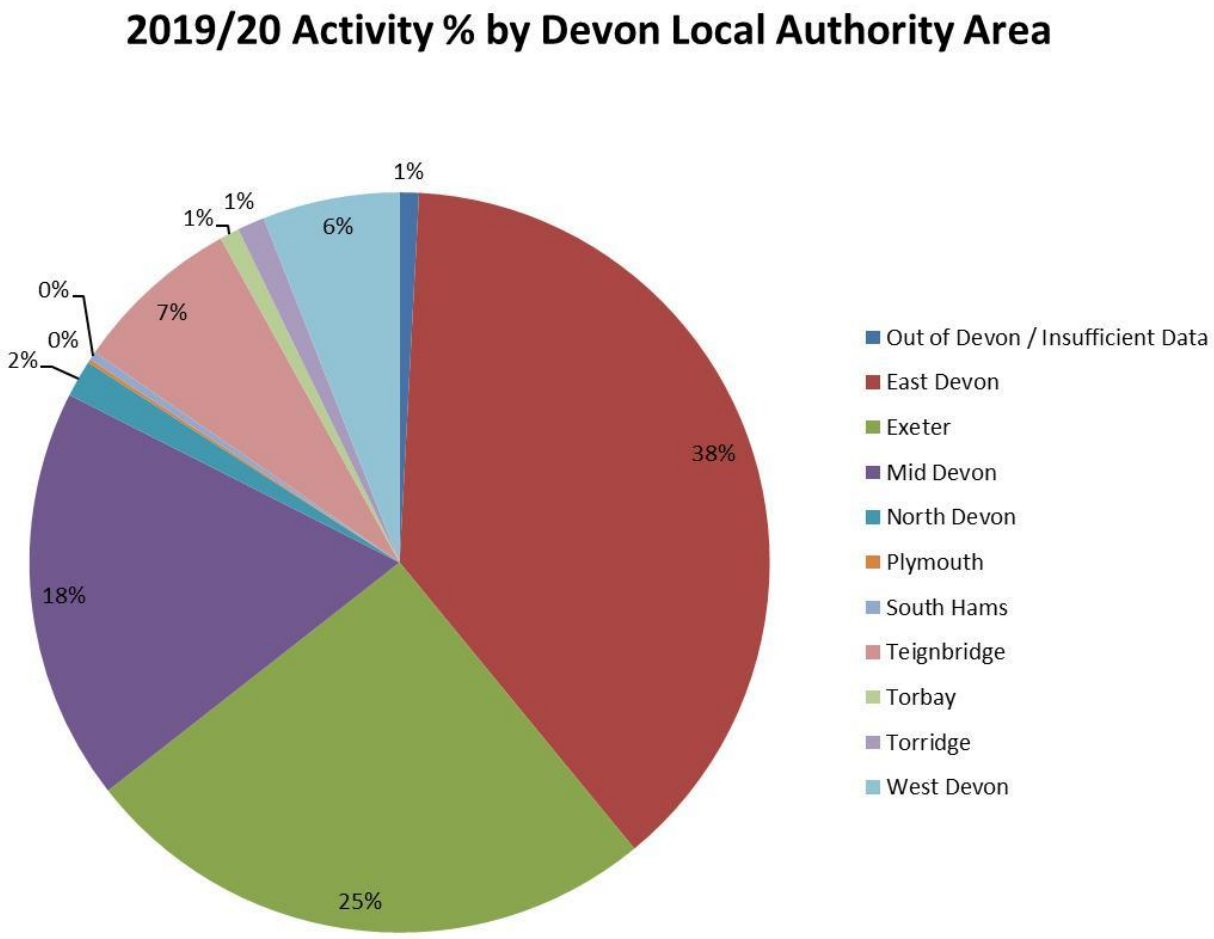
The Trust's strategy is focused on ensuring that it provides safe, high-quality services, delivered with courtesy and respect. This was reflected in the Care Quality Commission's (CQC) inspection in November 2015, which praised the Trust's culture as "strongly focused on quality, with patients being the absolute priority." Rated as good overall – the first in the South West – the CQC also rated seven out of eight services at the Wonford site as either outstanding or good, including outstanding for caring services, urgent and emergency care, and critical care.

The Trust has responsibility for Eastern community services, with many of the services run in the community hospitals in East Devon. By bringing acute and community services together under one organisation in Eastern Devon, we are able to offer more efficient and joined-up integrated care. Working together with health and social care partners and local communities, we are better placed to meet people's needs and keep more people well at home and supported within their community, ensuring a hospital stay only happens when acutely necessary.

The integration of care services is part of a wider ambition to establish a place-based system of care which promotes independence, prevention and wellbeing. This system places the needs of the individual firmly at the centre, supporting them to live the life they want to lead.

Source: Royal Devon and Exeter NHS Foundation Trust website

Appendix 2 – Activity market share by Local Authority Area for Devon for Royal Devon and Exeter NHS Foundation Trust 2019/20.



Note: "Activity" in the above graph is those activity types that make up this claim (shown in Appendix

Appendix 3

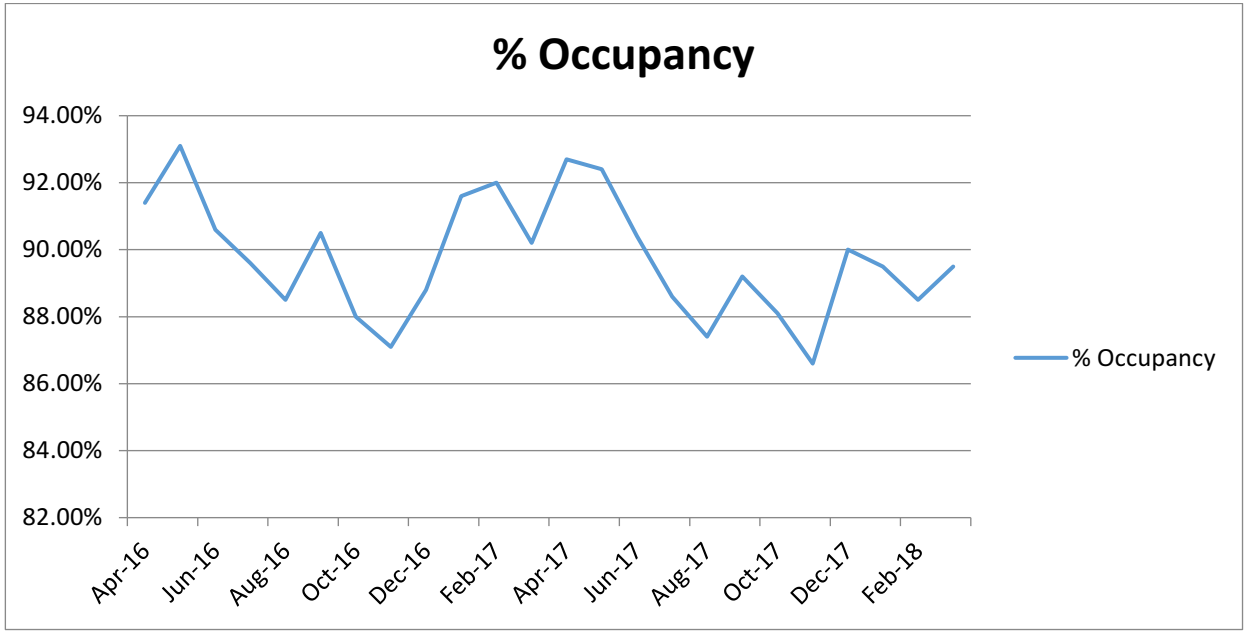
2019/20 Activity	2019-20 total activity
Admitted patient care	560
Cancer multi-disciplinary teams	15,103
Chemotherapy and radiotherapy	93,181
Critical care	7,437
Diagnostic imaging & nuclear medicine	25,966
High cost drugs and devices	1,159
Rehabilitation	3,787
Renal	86,137
Direct access diagnostic services	40,823
Direct access pathology	2,060,534
Community health services	464,182
Daycase, non-elective short stay and regular day/night	180,410
Elective and non-elective	111,223
Emergency care	104,977
Outpatients attendances	504,602
Outpatients procedures	105,969
Total	3,806,050

Source: from standard return to NHS Improvement – Reference Cost Return

Appendix 4

Adult Acute Bed occupancy rate (Wonford site)

Note: excludes maternity, paediatrics, rehabilitation beds, community hospitals.



	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Occupied	18,449	19,619	18,357	18,468	18,195	18,055	18,079	16,806	17,678	18,352	16,555	17,926	18,955	17,084	18,483	16,843	17,352	17,173	17,488	17,055	17,225	17,801	17,023	17,771
Available	20,178	21,063	20,251	20,610	20,561	19,956	20,538	19,284	19,906	20,028	18,000	19,872	20,438	18,488	20,454	19,007	19,861	19,246	19,856	19,683	19,144	19,881	19,226	19,850
% Occupancy	**91.40%**	**93.10%**	**90.60%**	**89.60%**	**88.50%**	**90.50%**	**88.00%**	**87.10%**	**88.80%**	**91.60%**	**92.00%**	**90.20%**	**92.70%**	**92.40%**	**90.40%**	**88.60%**	**87.40%**	**89.20%**	**88.10%**	**86.60%**	**90.00%**	**89.50%**	**88.50%**	**89.50%**

Appendix 5 Contribution Requested

Exeter District Council	Exeter						
Ward	St David's						
ONS Mid 2019 Population Estimate for Ward:	11,421						
Development Dwellings:	23						
Population Multiplier for Exeter District Council:	2.43						
Is the development a Student one?	No						
Is the development a Extra Care one?	No						
Is the development a Retirement Village/Housing one?	No						
Development Population:	56						

Activity Type	**Activity 2019/20 for Ward Area**	**% Activity rate per annum per head of population**	**Delivery cost per activity (spell) £**	**12 months Activity for 23 Dwellings**	**Delivery cost for 23 Dwellings £**	**Migration reduction 35% £**	**Cost Pressure (Claim) £**
A&E Attendances	2,919	25.6%	133	14.27	1,894	663	1,231
Critical care	21	0.2%	10,005	0.10	1,027	360	668
Non Elective Admissions & Short Stays	2,245	19.7%	1,508	10.98	16,556	5,795	10,761
Elective Admissions	210	1.8%	3,142	1.03	3,226	1,129	2,097
Day Case Admissions	758	6.6%	814	3.71	3,015	1,055	1,960
Regular Attendances	402	3.5%	241	1.97	473	166	308
Outpatient Appointments	7,674	67.2%	140	37.52	5,247	1,836	3,411
Outpatient Appointment Procedures	1,893	16.6%	152	9.26	1,406	492	914
Community Nursing Visits	6,971	61.0%	59	34.09	2,018	706	1,312
Total				**112.92**	**34,863**	**12,202**	**22,661**
Per Head of Population:					£624		£406
Per Dwelling:					£1,516		£985

Explanatory note: Data used to calculate contribution

Clinical activity recording
All activity undertaken by the Trust is traceable to a patient through the patient's address, NHS number and registered GP which are recorded each time a patient is treated. This data is anonymised, validated and submitted annually for the National Cost Collection exercise that is done by every trust so that it is available nationally and publicly.

Calculating the Trust's claim
The data table above calculates the impact of the development on the Trust's capacity and mitigates this by creating a financial claim to meet additional costs.

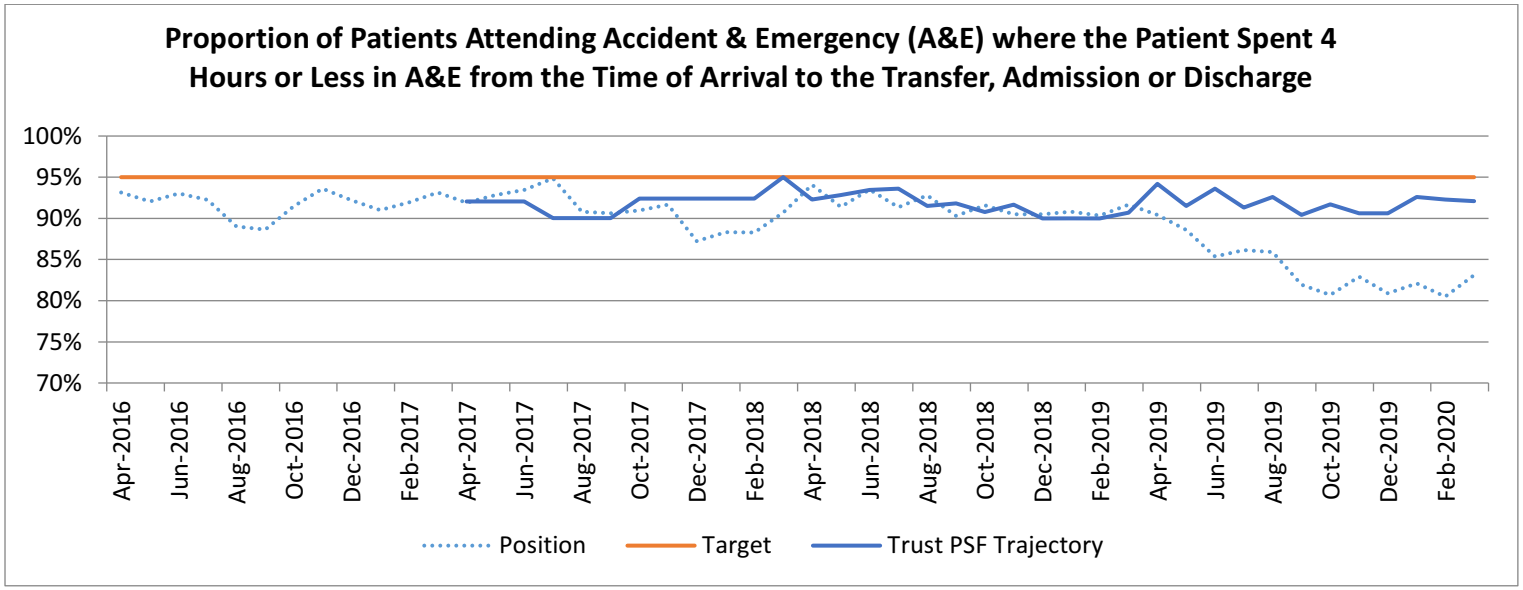
Assumptions and explanations
The Trust's calculation establishes the additional impact the new development will impose on the Trust's resources. To start the calculation, the total population of the development is calculated by multiplying the number of dwellings by the average number of people expected to live in each house. The Trust uses an average number of people per household published by the local council to make this calculation.
However, the total impact of the development is abated to 65% of total cost pressure. This abatement recognises that, according to the Exeter housing policy 35% will be affordable housing so will be intra migration, 65% of people moving into the development are new to the county (migration factor) and therefore are not included in the funding allocation with which the county's clinical commissioning groups buy the Trust's services. In this way, the calculation avoids double counting the impact from existing county residents' demands already anticipated in the Trust's annual plans.

The calculation's steps
Column 1 shows the different types of activity undertaken by the Trust. Column 2 shows the amount of activity undertaken by the Trust that originated from the LSOA/ward in which the new development is being constructed. Column 3 shows the percentage rate of provision for that LSOA. All of this data is derived from the Trust's records of patients seen over the 12 month period used for the calculation.
Each activity undertaken by the Trust has an average cost associated with it. These costs are calculated by using the national guidance that all trusts must use when preparing their 'National Cost Collection' (NCC) submission, which are published annually. **The Trust uses their own average figure for each activity type to calculate the financial impact of caring for new people housed in the development. The NCC can be found in column 4, entitled "Delivery cost per activity".**
The additional activity anticipated as a result of the new population column 5 is derived from a multiplication of the development's new population by the historical percentage rate of provision for that Ward column 3.

The additional impact that will result from the new population column 6 is a product of multiplying the delivery cost (column 4) by the additional activity (column 5).To adjust for the migration factor the cost is reduced by multiplying the migration factor (column 7) and the final cost pressure claim is shown in column 8.

Appendix 6

Proportion of Patients attending A&E where the patient spent 4 hours or less in A&E from the time of arrival to transfer, admission or discharge



Excerpt of figures in the above graph

	Jan-2019	Feb-2019	Mar-2019	Apr-2019	May-2019	Jun-2019	Jul-2019	Aug-2019	Sep-2019	Oct-2019	Nov-2019	Dec-2019	Jan-2020	Feb-2020	Mar-2020
Total Breaches	1055	1054	1045	1116	1437	1738	1763	1775	2228	2363	1981	2172	1984	2061	1318
Total Attendances	11494	10925	12552	11645	12597	11877	12715	12606	12339	12244	11594	11366	11081	10565	7811
Position	90.82%	90.35%	91.67%	90.42%	88.59%	85.37%	86.13%	85.92%	81.94%	80.70%	82.91%	80.89%	82.10%	80.49%	83.13%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Trust PSF Trajectory	90.0%	90.0%	90.7%	94.2%	91.5%	93.6%	91.3%	92.6%	90.4%	91.7%	90.6%	90.6%	92.6%	92.3%	92.1%