

APP/18/01033, Land East of, Castle Avenue, Havant

**Portsmouth Hospitals NHS Trust's Consultation Response and Regulation 122
CIL compliance statement in respect of the above planning application :**

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.
- **Commissioning for Quality and Innovation payment frame (CQUIN)** is a framework that supports improvements in the quality of services and the creation of new, improved patterns of care. The system was introduced to make a proportion of healthcare providers' income conditional on demonstrating improvements in quality and innovation in specified areas of patient care.
- **Dr Foster:** Dr Foster allows the Trust to understand the patient flow throughout the regions around the hospital and has developed methodologies to support organisations to improve quality and efficiency through the use of data.
- **Emergency care:** Care which is unplanned and urgent.
- **MRET:** Marginal Rate Emergency Threshold, expressed as an agreed historic baseline level of activity and income for emergency admissions. Once the MRET threshold is reached, a marginal rate is applied to the national tariff income the Trust receives for each additional patient. The tariff is reduced to 70% of the value it would have been had the threshold not been exceeded.
- **ONS:** Office of National Statistics.

- **National Tariff Payment System** 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.
- **Planned care:** Medical care that is provided by a specialist or facility upon referral by a primary care physician and that requires more specialised knowledge, skill, or equipment than the primary care physician can provide.
- **Premium Costs:** Premium costs incurred can include the supply of agency staff, Locum Medical Staff and payments to deliver services to meet operational pressures, which exceed the costs incurred when delivering with substantive staff. The Trust also sub-contracts the provision of certain services to third parties to meet demand.

Introduction

As our evidence will demonstrate, Portsmouth Hospitals NHS Trust (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 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. The contract is agreed annually based on previous year's activity plus any pre-agreed additional activity for clinical service development and predicted population growth (this does not include ad-hoc housing developments). The following year's contract does not pay previous year's increased activity. 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. Without the contribution, the development is not sustainable and should be refused.

The Trust (and the wider health system) plans according to demographic demand and changes, along with agreed service changes and/or developments. Additional

significant changes in the system, such as this proposed development, will not have been included within these assumptions.

Emergency and unscheduled care

The Portsmouth and South East Hampshire system is already under considerable strain in keeping up with demographic growth and increased levels of demand. The Trust (PHT) continues to bear a great deal of the burden. This is evidenced by:

Inability to deliver the A&E 4 hour standard

- Pressure in the ability to discharge medically fit patients, due to lack of capacity in the community
- Bed capacity routinely in excess of 95% - providing limited if no flexibility at peak pressure points, thus require the Trust to access additional capacity (at premium cost)
- Community and Primary care support will additionally be put under further pressure by this development, resulting in additional attendances and admissions to the hospital

Planned / Elective care

At the present time the Trust (and system) is unable to deliver the national RTT (18 week) standard, due to capacity and financial constraints. The system very often additional has to already access premium payment and private sector solutions. Any additional growth / demand in the system, which will occur as a result of this development, will result in evitable further deterioration in local waiting times for elective treatment unless there an additional investment in capacity is made.

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

1. Portsmouth Hospitals NHS Trust has an obligation to provide healthcare services.. The Trust has been created pursuant to the National Health Services Act 2006 (as amended) which consolidates the previous Health Service Acts. The Trust has a 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.
2. The Trust is a public sector NHS body and is directly accountable to Parliament 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 (but not limited to) the Clinical Commissioning Groups (CCG):
 - NHS PORTSMOUTH CCG
 - NHS FAREHAM AND GOSPORT CCG
 - NHS SOUTH EASTERN HAMPSHIRE CCG
 - NHS WEST HANTS CCG
 - NHS COASTAL WEST SUSSEX CCG
 - NHS ISLE OF WIGHT CCG
 - NHS SOUTHAMPTON CCG
 - NHS NORTH HAMPSHIRE CCG
 - NHS WILTSHIRE CCG
 - NHS DORSET CCG
 - NHS GUILDFORD AND WAVERLEY CCG

- NHS NORTH EAST HAMPSHIRE AND FARNHAM CCG
 - NHS COASTAL WEST SUSSEX CCG_AUDIOLOGY
 - In addition to the NHSE Military.
3. The Trust is a secondary care and community services provider delivering a range of planned and emergency hospital services to residents of the aforementioned areas. It provides urgent and emergency care services for residents for whom it is the nearest Accident and Emergency (A&E) provider and often for residents from further afield when their closest A&E is under particular pressure.
 4. The Trust works with the Defence Medical Group (South) which has a long standing relationship with the Trust.
 5. The Trust provides planned and emergency hospital and community services, which will be used by the new occupants of this development.
 6. The Trust was established in 1993. The Trusts is subject to NHS standards, performance ratings and systems of inspection. They have a duty to provide NHS services to NHS patients according to NHS quality standards and principles.
 7. Every NHS Trust is authorised to operate by a licence issued by the Independent Regulator. The terms of each NHS Trust's licence sets out the conditions under which they must operate including:
 - The health services that the Trust is authorised and required to provide to the NHS;
 - The standards to which they must operate and against which the Care Quality Commission (CQC) will inspect;
 8. Like all other NHS bodies, NHS Trusts are inspected against national standards by the Care Quality Commission (CQC). The Independent Regulator, NHS Improvement, monitors each NHS Trust to ensure they do not breach the terms of their authorisation. If an NHS Trust significantly breaches the terms of its authorisation, or finds itself in difficulty, NHS Improvement has a range of intervention powers, including powers to:
 - Issue warning notices;

- Require the Board of Governors or Board of Directors to take certain actions;
- Suspend or remove the Board of Governors or members of the Board of Directors.
- In the most serious cases, where NHS Improvement intervention cannot resolve the breach, an NHS Trust can be dissolved.

Funding Arrangements for the NHS Trust

9. The above list of local CCGs commission the Trust to provide acute and community healthcare services to the population of those areas under the terms of the NHS Standard Contract. The Trust also provides services to NHS England for some specialised services across the wider region. This involves identifying the health needs of the population and commissioning the appropriate high quality services necessary to meet these needs within the funding allocated. The CCGs commission planned and emergency acute healthcare from the Trust and agree a service level agreement, including activity volumes and values (on average cost basis) on an annual basis. The Trust directly provides the majority of healthcare services through employed staff but has some staff sub-contracted agency and or locum staff for services when under operational pressure. The Trust is required to provide the commissioned health services to all people that present or who are referred to the Trust. *"The Trust must accept any Referral of a Service User however it is made unless permitted to reject the Referral under this Service Condition"*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 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. The Trust is one of the nearest in regards to this proposed development.

Since 2008, patients have been able to choose which provider they use for their healthcare for particular services. The 2014/15 Choice Framework explains when patients have a legal right to choice about treatment and care in the NHS. The legal right to choice does not apply to all healthcare services, and for acute healthcare it

¹ NHS Standard Contract- Service Condition SC7

only applies to first outpatient appointments, specialist tests, maternity services and changing hospitals if waiting time targets are not met.

Activity Based Payment System Funding – National Tariff Payment System

10. The Trust is paid for the activity it delivers in line with the National Tariff Payment System. Elements of these funding streams are reliant in the activity delivered meeting national and regional quality standards and timeframes. The 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.
11. The Trust had an annual turnover in 2016/17 of £530m. The Trust must find efficiency savings of around of £32.2m.
12. The National Tariff Payment System is published annually via NHS England and NHS Improvement. It is a system of paying NHS healthcare providers a standard average national price or tariff for each patient seen or treated, based on the average cost of delivering that care across all NHS organisation. The cost of providing high quality healthcare rises as systems and organisations near and surpass normal design capacity. Premium rate costs become necessary to overcome issues arising from exceeding design and capacity constraints, and performance is also eroded, increasing fines and penalties due under National Contract terms. The majority of excess costs and fines / penalties at PHT are due to activities which take health systems and organisations near to and beyond their designed capacity, and would be eliminated by reducing capacity overall, lowering the average cost per health episode materially. Conversely, adding more load to the system increases costs at a rate higher than the National average-based tariff system.
13. Although the Trust receives the National Tariff for all eligible activity delivered, in 2010/11 the National Payment guidance mandated a marginal rate for emergency admissions, which exceed a threshold. This rule currently ensures NHS providers are paid only 70% of the National Tariff price for emergency admissions where activity exceeds a baseline linked to 2008/2009 volumes. This penalising system exacerbates the premium costs and penalties issues cited above and experienced by Acute Trust systems working at or above design capacity.
14. 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. CCG funding is finite and is not related in any way to the LPA's housing land supply, need or housing projection.

15. The Commissioning for Quality and Innovation (the "CQUIN") payment framework makes a proportion of NHS healthcare provider income conditional on achieving certain improvement goals. In 2016/2017 the Trust was conditional upon achieving improvement goals. The conditional income for 2015/2016 was £12m and in 2016/17 was £12m. Any impact which interferes with the achievement of the CQUIN's improvement goals will jeopardise the additional income received through the CQUIN. This residential development will have a detrimental impact on the Trust's ability to provide those goals.

Planning for the Future

16. It is evident that the existing, ageing population and future population growth will require additional healthcare infrastructure to enable it to continue to meet the acute and community healthcare needs of the local population.
17. It is not sensible for the Trust to plan strategies to cope with further population growth on a piecemeal basis. The cost and planning implications of so doing are impracticable. Instead, the Trust has considered the anticipated population and demographic growth across our area and looked at the overall impact of the proposed increased population through an internal process which acts as an anticipated healthcare demand forecasting tool to serve the future healthcare needs of the growing population. This process takes into account the trend for the increased delivery of healthcare both in and out of the hospital and into the community and the impact of an aging population on the provision of acute healthcare.

Current Position

18. Across England, the number of acute beds is one-third less than it was 25 years ago², but in contrast to this the number of emergency admissions has seen a 37% increase in the last 10 years³. The number of emergency admissions is currently at an all-time high.
19. The Trust's hospitals are now at full capacity and there are limited opportunities for it to further improve hospital capacity utilisation. The Trust is already experiencing

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

³ Hospital Episode Statistics. www.hesonline.nhs.uk/Ease/servlet/ContentServer?siteID=1937

difficulty in managing to provide the services in a manner that complies with the Quality Requirements of the NHS. Coping systems already incur some premium rate costs, and even so some penalties are inevitable at current activity levels. This is under address currently, and is requiring diversion of resources, as the current pricing mechanism is not sufficient to cover the costs of the marginal rate increases in activity. There are not sufficient resources, services or space within the existing facilities to accommodate more and sudden population growth created by the development, without the quality of the service as monitored under the standards set out in the Quality Requirements dropping further, and ultimately the Trust facing additional costs and inevitable further sanctions for external factors which it is unable to control.

20. In order to maintain adequate standards of care as set out in the NHS Standard Contract quality requirements, it is well evidenced in the Dr Foster Hospital Guide that a key factor to deliver on-time care without delay is the availability of beds to ensure timely patient flow through the hospital. The key level of bed provision should support a maximum bed occupancy of 85%. The 85% occupancy rate is evidenced to result in better care for patients and better outcomes⁴. 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 the treatment of a particular ailment, the patient will be admitted and treated in the best possible alternative location and transferred as space becomes available. Although multiple bed/ward moves 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.
21. Appendix 2 details that the Trust's utilisation of acute bed capacity exceeded the optimal 95.26% average in 2016/17 with escalation beds open. This demonstrates that current occupancy levels are highly unsatisfactory, and the problem will be compounded by an increase in the population, which does not coincide, with an increase in the number of bed spaces available at the Hospital. This is the inevitable result where clinical facilities are forced to operate at over-capacity and is why there is now a very real need to expand the Trust facilities. Any new residential development will add a further strain on the current acute healthcare system.

⁴ British Medical Journal- Dynamics of bed use in accommodating emergency admissions: stochastic simulation model

22. The existing infrastructure for acute and planned health care is unable to meet the additional demand generated because of the proposed development. The population increase associated with this proposed development will significantly impact on the service delivery and performance of the Trust until contracted activity volumes include the population increase. As a consequence of the development and its associated demand for emergency healthcare there will be an adverse effect on the Trust's ability to provide on-time care delivery without delay, this will also result in financial penalties due to the Payment by Results regime.

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

23. The NHS, in common with public health services in many other countries is experiencing staff shortages. The 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 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 the Trust's 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 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 The 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 requirements is that the developer contributes towards the cost of providing the necessary additional capacity for the Trust to maintain service delivery during the first year of occupation of each dwelling. Without securing such contributions, the Trust will have no funding to meet healthcare demand arising from each dwelling during the first year of occupation and the health care provided by the Trust for all patients would be significantly delayed and compromised, putting the local people at risk.

Impact Assessment Formula

- 27 Residents from the area are currently generating significant interventions per head of population per year. This is detailed in full in Appendix 3.

(Development Population x Average Emergency Admission Activity per Head of Population x Tariff x 30% Cost per Emergency Admission Activity (=Total delivery cost)) + (Total Delivery Cost x Trust Pay Costs 30 % x Premium Pay Costs 39 %) = Developer Contribution

- 28 This proposed development comprises of **69 dwellings** and based on the 2011 Census average household size per dwelling being 2.4 we have calculated that this development will accommodate a population of **162 residents**. This means that this residential development will generate **285 interventions** for the Trust based on the average calculation above. The consequences of that number of interventions and the costs of them are set out in **Appendix 3** The contribution requested is based on this calculation 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 that there would be inadequate healthcare services available to support it and it would adversely impact on the delivery of healthcare for other patients in the Trust's area.

- 29 As a consequence of the above and due to the payment mechanisms the Trust is subject to, it is necessary that the developer contributes towards the cost of providing additional designed capacity for the Trust to maintain service delivery during the first year of occupation of each dwelling. The Trust will receive no commissioner funding to meet each dwelling's healthcare demand in the first year of occupation due to the preceding year's outturn activity volume based contract and there is no mechanism for the Trust to recover these costs in subsequent years. Without securing such contributions, the Trust would be unable to support the proposals under the applicable average cost per case payment system 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 requested for this proposed development of **69 dwellings** is **£83,618.00**. This contribution will be used directly to provide additional services to meet patient demand.
- 30 Having considered the cost projections, and phasing of capacity delivery that the Trust requires for this development, it is necessary that the Trust receives 100% of the above figure on the implementation of the planning permission. This will help us to ensure that the services are delivered in a timely manner.

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 ageing population and growth, it will not be able to plan for the growth in a piecemeal manner. 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 homes. The development directly affects the ability to provide the health service required to those who live in the development and the community at large. Without contributions to maintain the delivery of health care services at the required quality standard and to secure adequate health care for the locality the proposed development will put too much strain on the said service infrastructure, putting people at significant risk. This development imposes an additional demand on existing over-burdened healthcare services, and failure to make the requested level of healthcare provision will detrimentally affect safety and care quality for both new and existing local population. This will mean that patients will receive substandard care, resulting in poorer health outcomes and pro-longed health problems. Such an outcome is not sustainable. 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.

- 32 There will be a dramatic reduction in safety and quality as the Trust will be forced to operate over available capacity as the Trust is unable to refuse care to emergency patients. There will also be increased waiting times for planned operations and patients will be at risk of multiple cancellations. This will be an unacceptable scenario for both the existing and new population. The contribution is necessary to maintain sustainable development. Further the contribution is carefully calculated based on specific evidence and fairly and reasonably related in scale and kind to the development. It would also be in the accordance with the Core Strategy and Annual Monitoring Report:

33 **Havant Borough Core Strategy – March 2011**

Policy CS1 Health and Wellbeing

Planning permission will be granted for development which:

- 10. Protects and contributes to the availability of community facilities through refurbishment or new provision which can be justified by needs which are evident in the local district.*

Annual Monitoring Report – December 2017

Planning Obligation

6.7 New development often creates a need for additional infrastructure or improved community services and facilities, without which there could be a detrimental effect on local amenity and the quality of the environment. Planning obligations were traditionally the mechanism used to secure these measures, through Section 106 (S106) Legal Agreements.

- 34 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)

35 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

36 The PPG goes on to suggest that information about the impact of a development on the demand for healthcare services:

... 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

37 In the circumstances, it is evident from the above that the Trust's request for a contribution is not only The contribution will ensure that Health services are maintained for current and future generations and that way make the development sustainable.



Appendix 1
Extract from Fit For the Future,
The Dr Foster Hospital Guide
2012

HOSPITALS UNDER PRESSURE

KEY FINDINGS

FULL TO BURSTING

The peak occupancy rate for NHS beds is 92%. For 48 weeks a year most trusts are more than 90% occupied.

SUPPORT IN THE COMMUNITY

A lack of integration with social care and community services is contributing to the pressure on NHS hospitals.

A WORSENING PROBLEM

Rising numbers of emergency admissions of frail elderly patients have required an additional 10,000 bed days over the past five years. That is equivalent to two new hospitals.

DECREASED AVAILABILITY

The number of acute and general beds in the NHS has decreased by a third in the past 25 years.¹

TECHNICAL BRIEFING

The number of hospital beds has decreased by a third in the past 25 years¹, as hospital stays have become shorter. However, admissions are rising, especially for groups such as the frail elderly (see page 11). This is one of the main causes for the growing pressure on hospital beds.

The NHS publishes figures for NHS trusts giving the average percentage of hospital beds that are occupied. These figures disguise the highs and lows in occupancy that occur week by week and season by season. According to these figures, the NHS has an average occupancy rate of just over 85%².

When occupancy rates rise above 85% it can start to affect the quality of care provided to patients and the orderly running of the hospital.³

Our analysis calculates the number of patients in hospital each day and compares it to the number of beds the hospital says it has available.

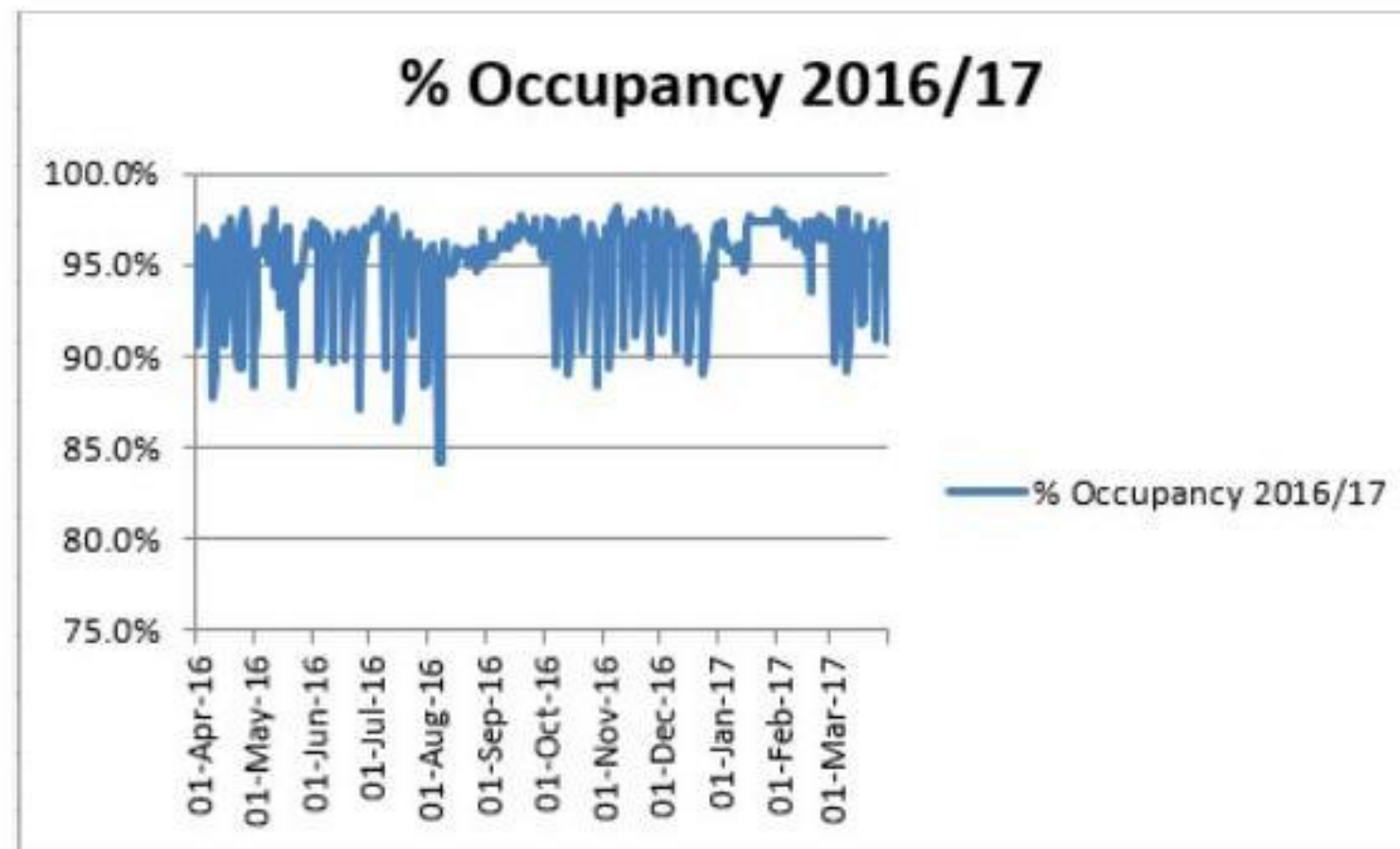
Our figures reveal the extent to which occupancy varies from the low points at weekends and during bank holidays to the high points, when occupancy rates at some hospitals can reach 100%. This analysis shows that the average mid-week occupancy in the NHS is 88%, and that for most of the year most NHS hospitals are experiencing occupancy rates above 90%.

Appendix 2

The chart below details Trust's actual bed occupancy of the general bed base by day during 2016/17,

Significant impact on available bed capacity in the hospital on a day-to-day basis with delays in getting patients transferred from the Emergency Department once it is determined they require admission.

Please note that the percentages shown in the chart below reflect a number of escalation beds open incurring additional costs over and above the Trust's recurrent bed base. Should this provision not have been made, the occupancy level would have been much higher. The average occupancy for 2016/17 was 95.3% however, without the extended capacity the Trust would have been operating at 99.6%.



Appendix 3

Developer's Contribution

Application Reference:	APP/18/01033	Land East of, Castle Avenue, Havant
Local Authority / Area	Havant	
2011 Census Population:	120,684	

Development Dwellings	69
Population Multiplier	2.4
Development Population	162
MRET Threshold %	10%

Expenditure Profile £k	
2017/18*	
Clinical Pay	280,569
All other costs	274,738
Total Costs*	555,307

Staffing cost %	51%
Premium Staff Cost %	38%
Premium Cost Factor	3

* Total Operating Costs Note 8 2017/18 Accounts

Activity Type	Trust Level Activity 2017/18 Reference Costs FCE	Delivery Cost 2017-18 Reference Costs £	Delivery Cost per Activity 2017-18 Reference Costs £	Trust Level Activity 2017/18	Delivery Cost per Activity 2017/18	Annual Local Authority Activity	Annual Local Authority Activity Rate per head of Population	12 months Activity for proposed Population	Delivery Cost for Planned Dwellings £	Marginal Rate (MRET) on Efficiencies £	Premium costs of Delivery £	Cost Pressure (Claim) £
A&E Attendances	151,955	29,972,270	197	148,643	202	24,980	20.7%	34	6,773		3,909	3,909
Non Elective Admissions	94,274	187,143,012	1,985	60,078	3,115	12,692	10.5%	17	53,165	15,950	30,679	46,628
Elective Admissions	11,338	39,629,885	3,495	10,785	3,675	1,966	1.6%	3	9,715		5,606	5,606
Day Case (Elective)	70,929	43,851,069	618	70,906	618	15,694	13.0%	21	13,052		7,531	7,531
Outpatient Appointments	634,624	68,746,309	108	581,829	118	113,952	94.4%	153	18,106		10,448	10,448
Outpatient Appointments (Procedure)	143,053	18,180,523	127	51,558	353	26,391	21.9%	35	12,514		7,221	7,221
Diagnostic Imaging	109,856	9,675,795	88	132,546	73	7,276	6.0%	10	714		412	412
Adult Renal Dialysis	122,439	15,449,581	126	125,459	123	6,440	5.3%	9	1,066		615	615
Ante/Postnatal	124,470	6,877,268	55	12,154	566	2,841	2.4%	4	2,162		1,247	1,247
Total								285		15,950	67,669	83,618

Contribution per Dwelling £	1,212
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