East Lancashire Hospitals NHS Trust

East Lancashire Hospitals NHS Trust

Consultation Response and Regulation 122 CIL compliance statement

3/2020/0309 - Spout Farm Preston Road Longridge PR3 3BE

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 of art 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 installments by the Healthcare Commissioner 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.*

- ***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.*

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

- ***NHSI:*** *NHS Improvement are a health services regulator, they are responsible for overseeing NHS foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care.*

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

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

- ***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*

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

Evidence

Background

1 East Lancashire Hospitals NHS Trust (the "Trust") is a major provider of acute and planned health services for the people of East Lancashire and Blackburn with Darwen. The Trust provides services from the following hospitals:

- Royal Blackburn Teaching Hospital
- Burnley General Teaching Hospital
- Clitheroe Community hospital
- Accrington Victoria Hospital
- Pendle Community Hospital

2 Although run independently, the Trust has been set up in law under the National Health Services Act 2006 which consolidates the previous Health Services Acts. The primary obligation is to provide NHS services to NHS patients and users according to NHS principles and standards - free care, based on need and not ability to pay. NHS Trusts are part of the NHS and subject to NHS standards, performance ratings and

systems of inspection. They have a duty to provide NHS services to NHS patients according to NHS quality standards, principles and the NHS Constitution. Like all other NHS bodies, NHS Trusts are inspected against national standards by the Care Quality Commission, NHS Improvement and other regulators/accrediting bodies.

3 East Lancashire Hospitals NHS 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 East Lancashire and Blackburn with Darwen. Acute healthcare services incorporate activities delivered in a hospital setting. The Trust is a secondary care provider delivering a range of planned and emergency hospital services and is the sole, capable provider of major emergency care.

Funding Arrangements

4 NHS East Lancashire Clinical Commissioning Group (CCG) is the lead commissioner for the population for of East Lancashire and Blackburn with Darwen and commissions East Lancashire Hospitals NHS Trust to provide acute and planned healthcare services under the terms of the NHS Standard Contract. The Trust is also commissioned by the following CCGs:

NHS AIREDALE, WHARFDALE AND CRAVEN CCG
NHS BLACKBURN WITH DARWEN CCG
NHS BLACKPOOL CCG
NHS BOLTON CCG
NHS BURY CCG
NHS CALDERDALE CCG
NHS CHORLEY AND SOUTH RIBBLE CCG
NHS EAST LANCASHIRE CCG
NHS FYLDE & WYRE CCG
NHS GREATER PRESTON CCG
NHS HEYWOOD, MIDDLETON AND ROCHDALE CCG
NHS WEST LANCASHIRE CCG
NHS WIGAN BOROUGH CCG
NHS MORECAMBE BAY CCG

5 This involves identifying the health needs of the population and commissioning the appropriate high quality services necessary to meet these needs within the budget allocated. CCGs commission planned and emergency acute healthcare from East Lancashire Hospitals NHS Trust and agree a service level agreement, including activity volumes and values on an annual basis. CCGs have no responsibility for providing healthcare services – this would be a conflict of interests. The Trust directly provides the majority of healthcare services through employed staff but has sub-contracted some non-clinical services through competitive procurement to secure better value for money.

6 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.

7 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 only applies to first outpatient appointments, specialist tests, maternity services and changing hospitals if waiting time targets are not met. Over the past 4 years, the majority of residents have chosen East Lancashire Hospitals NHS Trust for their first outpatient appointment (66%) and The Trust has delivered over 70% of 's residents' total admissions, including admissions for specialised services (see Appendix 1). The calculations in our formula in paragraph 24 and Appendix 4 are based on our current

[1] NHS Standard Contract- Service Condition SC7

share of patients in this area as opposed to our share, and assume we will receive the same share of patients from the new development population.

Payment system

8 The Department of Health dictates the costs they think NHS health services should be priced at. The tariff is broken down with 66.9% for staffing costs, 20% other operational costs, 3.7% for drugs, 2.5% for the clinical negligence scheme and 6.9% for capital maintenance costs.

9 The non-elective admissions, A&E attendances and ambulatory / same day emergency care payment is contracted through an aligned contract rather than an activity based contract. If activity increases during the year, the commissioners may not recompense the Trust for any over performance. Further, the contract does not cover the whole of the actual costs of the patient treatment.

10 Each activity (treatment) has a standard price. However, the price does not cover the total costs of the activity.

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 or land supply.

12 In 2019/20, the Trust is due to receive additional PSF funding which supplements the income, subject to the Trust planning and. In the contract negotiations, it is assumed that the Trust will plan to make a financial surplus. The amount of surplus to be achieved is agreed between the Trust and NHSI.

13 If the Trust meets its agreed surplus target then it will receive its PSF, otherwise the trust will not be able to access their PSF allocation.

14 In addition the Trust has to achieve 52 week wait requirement for elective care. This means that each patient referred to the Trust for elective care should not wait over 52 weeks for their treatment. If this happens then the Trust will be subject to financial sanctions. The potential amount lost is proportionate to the number of breaches.

15 The development will put an extra pressure on the Trust's ability to achieve the agreed surplus because each additional patient not part of the agreed contract will consume the available funding. It will also put an extra pressure on the Trust's ability to achieve the required 52-week wait.

Other possible funding or income

16 Charitable Donations are managed in line with the provisions of the Charities Act. The Charity Trustee oversees the use of any donated funds and in doing so fulfils its responsibility to ensure that all expenditure demonstrates 'Additionality', i.e. that charitable funds are not used to pay for items of equipment or facilities which are needed to deliver day-to-day services.

17 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 2019-20 the Trust is conditional upon achieving improvement goals. The conditional income for 2019-20 is £5.9m. 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.

Impact

Current Position

18 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 has seen a 37% increase in the last 10 years[3]. 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. This development will have an impact on resources/ space within the existing facilities to accommodate sudden population growth created by the development without the quality of the service as monitored

[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

under the standards set out in the Quality Requirements dropping, and ultimately the Trust facing sanctions for external factors which it is unable to control. The new development will create an impact on the service delivery which will have a long term impact.

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 (see Appendix 3) that a key factor to deliver on-time care without delay is the availability of beds to ensure timely patient flow through the hospital. The key level of bed provision should support a maximum bed occupancy of 85%. The 85% occupancy rate is evidenced to result in better care for patients and better outcomes[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 (see Appendix 2.) Where the right capacity is not available in the right wards for treatment of his/her particular ailment, the patient will be admitted and treated in the best possible alternative location and transferred as space becomes available, but each ward move increases the length of stay for the patient and is known to have a detrimental impact on the quality of care. Consequently, when hospitals run at occupancy rates higher than 85%, patients are at more risk of delays to their treatment, and sub-optimal care and being put at significant risk.

21 Appendix 2 details that the Trust's utilisation of acute bed capacity exceeded the optimal 85% occupancy rate for the majority of 2018/19. 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.

22 During 2018/19, 174,462 residents attended the Trust's A&E Department and 64,185 residents were admitted to one of the Trust's hospitals. In addition to this, nearly 52,570 had an operation, the equivalent of 4 in 5 residents attended an outpatient

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

appointment and 192,620 had a radiological examination or scan. This is equivalent to the average resident generating 1.6 acute hospital interventions per year at East Lancashire Hospitals NHS Trust (see Appendix 4).

The direct impact on the provision of planned and acute healthcare caused by the proposed development

23 The existing service delivery infrastructure for acute and planned health care is unable to meet the additional demand generated as a result of the proposed development. The population increase associated with this proposed development will significantly impact on the service delivery and performance of the Trust until contracted activity volumes include the population increase. As a consequence of the development and its associated demand for acute and planned health care there will be an adverse effect on the Trust's ability to provide on-time care delivery without delay due to inadequate funding to meet demand.

24 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 capacity for the Trust to maintain service delivery during the first year of occupation of each dwelling. Without securing such contributions, the Trust will have no or limited funding to meet healthcare demand arising from each household during the first year of occupation. The health care provided by the Trust would be significantly delayed and compromised, putting the local people at risk. This deficit created by this development will have a long term impact on the ability to provide required services.

Impact Assessment Formula

25

Formula

(New Development Population x % Development Activity Rate per head of New Population x Cost per Activity X 80%) = Developer Contribution

This proposed development comprises of up to **34 dwellings** and based on the 2011 Census average household size per dwelling, we have calculated that this development will accommodate a population of **82 residents**. This means that this residential development will generate **184 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 4. 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 others in the Trust's area.

26 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 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 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.

27 Therefore, the contribution requested for this proposed development is **£47,058.00.** This contribution will be used directly to provide additional services to meet patient demand as detailed in Appendix 4.

28 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 on the implementation of the planning permission. This will help us to ensure that the healthcare services are delivered in a timely manner.

Summary

29 As our evidence demonstrates, the Trust is currently operating at full capacity in the provision of acute and planned healthcare. The contribution is being sought not to support a government body but rather to enable that body to provide 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.

30 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. 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 Council's Core Strategy:

East Lancashire Hospitals NHS Trust

Ribble Valley Borough Council's Core Strategy 2008-2028

8 DELIVERY MECHANISMS AND INFRASTRUCTURE-

…..In terms of delivery, The Council will lead the implementation of the Core Strategy, however this cannot be done in isolation from other services and service providers. Others that may be involved in the implementation include:

- *Local Partnerships*
- *Individuals, land-owners and private developers*
- *Parish Councils*
- *Community Groups*
- *Lancashire County Council*
- *Relevant government departments and agencies such as, the Environment Agency, the Highways Agency, Natural England and English Heritage*
- *Statutory Undertakers (gas, water, sewerage, electricity,*
- *Telecommunications) and Public Transport Operators*

Health Providers

The Council is committed to ensure the necessary infrastructure is brought forward to meet the needs of the area resulting from proposed growth and development. *The Council will continue to work with relevant authorities, public bodies and agencies to secure the delivery of infrastructure in a timely and effective manner. In providing a policy framework through this Core Strategy and the use of its Planning powers relevant infrastructure can be delivered. Statutory undertakers such as United Utilities and relevant authorities such as Lancashire County Council, and NHS England will need to meet their legal responsibilities for the provision of water and water treatment,* ***health services*** *to meet the needs of the areas and school facilities. However much of this provision will be dependent upon the timing of development, the emerging needs to be addressed at the time and capacity of existing provision.*

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) … .

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

Date: 29 May 2020

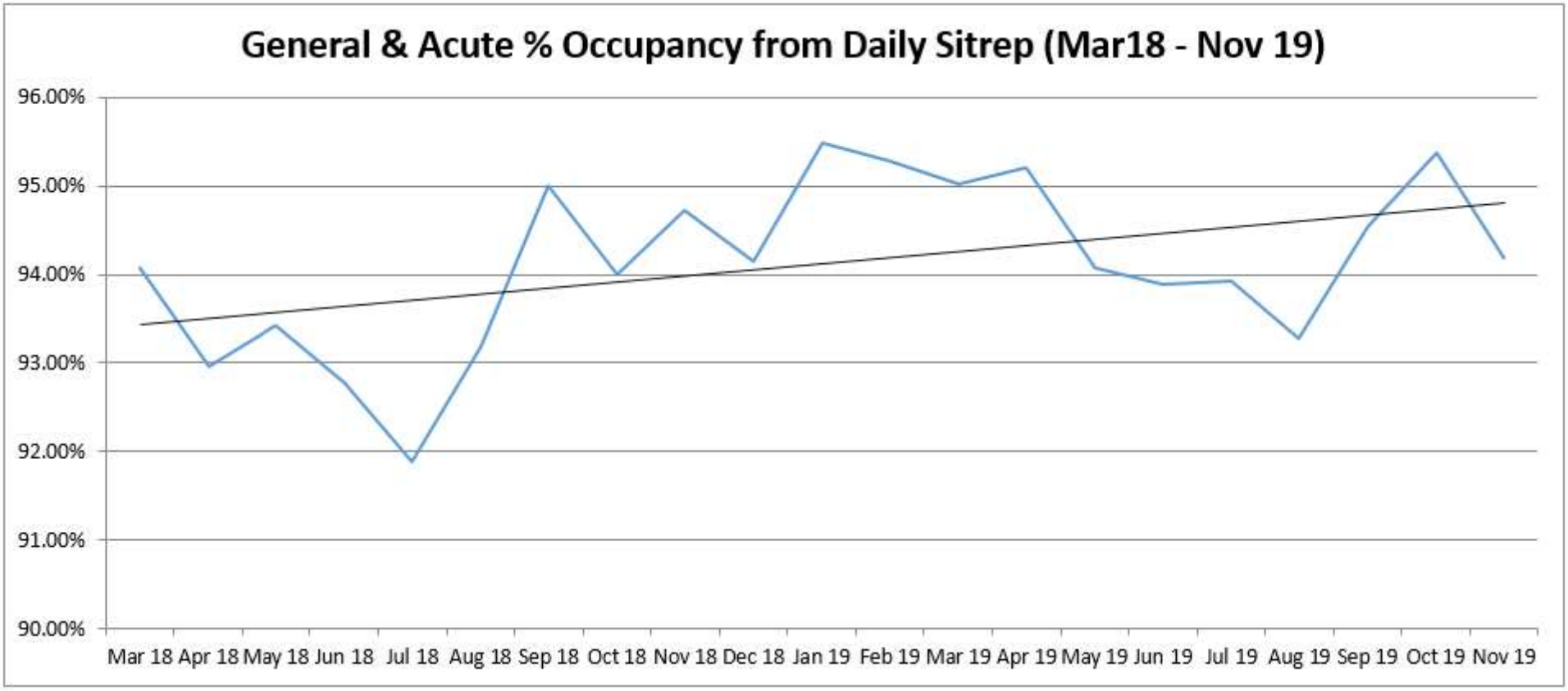
East Lancashire Hospitals NHS Trust

Appendix 1 – Services offered by East Lancashire Hospitals NHS Trust

Accident and Emergency (A&E)		
Acute Medical Unit (AMU)	Diabetes Service (Integrated)	Lymphedema
Ambulatory Emergency Care Unit	Dietetics	Macmillan Information Service
Anaesthetics	Discharge Lounge	Magnetic Resonance Imaging (MRI)
Antenatal Care	District Nurses	Major Trauma Unit
Audiology (Adult)	Domestic Services (Patient Services)	Maternity Services
Audiology (Hearing and Balance)	DVT Clinic	Medicines Support Team
Audiology (Paediatric)	Ear, Nose and Throat (ENT)	Mortuary Services
Bereavement Care Service	Early Pregnancy Assessment Unit	Musculoskeletal service
Blackburn Birth Centre	East Lancashire Child and Adolescent Services (ELCAS)	Neonatal Intensive Care Unit
Bladder and Bowel Service	East Lancashire Community Parkinsons Service	Neuro Rehabilitation
Bowel Cancer Screening	Elective Centre	Nuclear Medicine
Breast Imaging (Screening) Service	Emergency Department	Occupational Therapy
Breast Services	Endoscopy	Oral and Maxillofacial Surgery (OMFS)
Breast Surgery/Treatments	Eyes	Orthodontics
Burnley Birth Centre	Falls	Orthotics
Cancer Services	Fracture Clinic	Overseas Visitors
Cardiac Rehabilitation Service	General Office	Paediatrics
Cardiology	General Outpatients	Pain Management Service
Central Birth Suite	General Paediatrics	Palliative Care
Chaplaincy (Spiritual Care Centre)	Gynaecology	Pancreas and Liver Service
Chemotherapy Unit Blackburn	Hearing (Children)	Patient Transport Service
Chest Clinic	Heart Failure Nursing Service	Pharmacy
Child Development Centres	Hepato-Pancreatic-Biliary (Liver and Pancreas)	Physiotherapy
Children's Diabetes Service	Hospital Transport Service	Podiatry Service
Children's Community Nursing	Infant Feeding	Rossendale Birth Centre
Children's Day Case - Ward 27	Infection Prevention and Control	Speech and Language Therapy
Children's Minor Illness Unit	Integrated Eye Service (Ophthalmology)	Spinal Clinic
Children's Observation and Assessment Unit	Integrated MSK, Pain and Rheumatology Service	STEADY On!
Children's Outpatients	Integrated Respiratory Service	Stroke Therapy
Children's Services	Integrated Therapy Service	Stroke Unit
Children's Ward	Intensive Home Support Service	Surgical Ambulatory Emergency Care Unit (SAECU)
Clinical Laboratory Medicine (Pathology)	Intermediate Care Allocation Team	Termination of Pregnancy (Abortion) Service
Clinical Outpatients	Laundry and Linen Service	Tissue Viability Service
Colonoscopy	Liver and Pancreas Service	Tongue Tie Service
Colorectal Service – Bowel Surgery	Lower Limb Vascular Service	Trauma and Orthopaedics
Community and Neurodevelopmental Paediatrics		Treatment Rooms
Community Heart Failure Nursing Service		Ultrasound
Community Stroke Rehabilitation Team		Uro-gynaecology
Coronary Care Unit (CCU)		Urology
Critical Care Unit		Wound Care Team
Dementia Care		X-ray
Dermatology Service		

East Lancashire Hospitals
NHS Trust

Appedix 2 – Bed occupancy



East Lancashire Hospitals NHS Trust

Appendix 3
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 years[1], as hospital stays have become shorter. However, admissions are rising, especially for groups such as the frail elderly (see page 11). This is one of the main causes for the growing pressure on hospital beds.

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

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

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

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

East Lancashire Hospitals NHS Trust

Appendix 4

EAST LANCASHIRE HOSPITALS NHS TRUST

Application Reference:	3/2020/0309
Local Authority / Area	Ribble Valley Borough Council
Description	Spout Farm Preston Road Longridge PR3 3BE

Population Estimate:	557,658
Development Dwellings	34
Population Multiplier	2.4
Development Population	82

	Expenditure (£k)
	2018-19
Pay	241,865
Non Pay	103,758
Total Costs	345,623
Staffing cost %	70%
Premium Staff Cost %	30%

Activity Type	Trust Level 2018-19 Reference Costs Cost £	Trust Level Activity 2018-19 Reference Costs	% Activity Rate per Annum - Trust wide	Activity Rate per Annum per head of Population	Delivery Cost per Activity 2018-19 Reference Costs £	12 months Activity for proposed Population	Delivery Cost for Planned Dwellings £	Premium costs of Delivery £	Cost Pressure (Claim) £
A&E Attendances	33,604,578	181,843	32.6%	18:55	185	27	4,917	1,032	5,950
Non Elective Admissions	132,516,446	37,011	6.6%	1:18	3,580	5	19,391	4,071	23,461
Non Elective (Short Stay)	28,795,540	49,991	9.0%	4:55	576	7	4,214	885	5,098
Elective Admissions	30,827,368	9,629	1.7%	0:55	3,202	1	4,511	947	947
Day Case (Elective)	43,624,634	55,430	9.9%	0:1	787	8	6,383	1,340	1,340
Outpatient Appointments	54,426,631	671,897	120.5%	67:55	81	98	7,964	1,672	9,636
Outpatient Procedures	10,661,762	150,381	27.0%	1:6	71	22	1,560	328	328
Diagnostic Imaging	9,719,321	100,102	18.0%	5:27	97	15	1,422	299	299
Total	**344,176,280**	**1,256,284**				**184**	**50,362**	**10,573**	**47,058**
					Contribution per Dwelling £				**1,384**