Statement of	:	Daniel Gilks
On behalf of	:	Interested Party
Number	:	1
Exhibit	:	None
Dated	:	21 September 2023

Appeal No: AA/K3715/W/23/3322013

RUGBY BOROUGH COUNCIL

BRANDON ESTATES LIMITED

Appellant

and

RUGBY BOROUGH COUNCIL

Respondent

and

UNIVERSITY HOSPITALS & WARWICKSHIRE NHS TRUST

Interested Party

WITNESS STATEMENT OF DANIEL GILKS

I, Daniel Gilks, the Associate Director of Finance for the University Hospitals Coventry and Warwickwhire NHS of Clifford Bridge Road, Coventry CV2 2DX **WILL STATE** as follows:

1. I am a Chartered Accountant and have worked within the NHS for more than 20 years. I have professional experience in both NHS providers and commissioning organisations. I have been in my current role, Associate Director of Finance – Commercial, at University Hospital Coventry and Warwickshire for 4 years. The content of this statement is within my own knowledge and belief unless expressly stated to the contrary, in which case I believe it to be true to the best of my information, knowledge and belief.

2. This is a response to the Rugby Borough Council's CIL Compliance Statement in relation to the Appeal by Brandon Estates at Coventry Stadium, Rugby Road, Coventry CV8 3GL Appeal reference AA/K3715/W/23/3322013.

3. I have the following comments/ observations in relation to the CIL Compliance statement as follows.

4. In the last five years the Rugby Council has never before raised the issue of how the Trust negotiate contracts with the Clinical Commissioning Group (now called Integrated Care Board, the ICB). This is it the first time the Council suddenly considers that it is difficult to accept the way the Contract have been negotiated.

5. The fact that part national taxation is used to fund part of health services including primary care services and infrastructure is no different to funding of schools, highways, and local authorities.

6. How the NHS funding is done including how ONS projections (growth) is cascading down to the Trust including why the Trust cannot take into consideration an application that it is known to the Trust when negotiating its contract with ICB can be explained as follows:

   6.1. HM Treasury has a ring-fenced budget supporting health and the total amount monies available is therefore constrained. It is then distributed between the ICBs.

   6.2. The ONS population growth does not determine how much each ICB is to receive towards the increase in the capacity of health service due to population increase through housing development and population increase in general.

   6.3. The ONS projections are only part of the calculation as to what proportion of the monies (i.e. what size of the slice of the cake) are given to each ICB. There are many other factors that are taken into consideration when the limited amount is allocated between the ICBs, for example, levels of deprivation, health inequalities and population health profiles.

   6.4. The allocations of funds to ICBs are based on a weighted capitation formula WCF (i.e., distribute resources based on the relative need of each area for health services), multiplied by the total of GP-registered patients within the ICB. The weightings are dependent on a number of factors such as age, health inequalities, and deprivation levels as mention above.

6.5. This is ICB's target allocation, which is not the same as the actual allocation – which is subject to a distance from target and pace of change adjustment (the difference between its de facto allocation and the WCF, and a policy about how quickly it should move to the target).

6.6. The populations relevant to ICBs are registered GP populations rather than ONS populations projections (because ICBs are built up from GP practices mapping to ICBs rather than geographical boundaries) .Population growth estimates are built into the ONS, but this does not necessarily translate directly – e.g., just because the ONS may say your population has grown by 1% (and it's not just your total numbers which are important – it's the demographics -e.g., if your population overall has stayed stable but the over 65s have grown by 2%, that will cause additional pressure on health services (the same as if the population aged 5-18 had increased would have a pressure on education). In addition, growth funding is a political decision ultimately – so even though everyone may agree that there is demographic growth of 2%, it does not automatically follow that commissioners will have a real-terms funding increase of 2%.

6.7. Consequently, the growth through the ONS figures do not translate into or correlate additional funds that are created by the actual population increase in the ICB area or indeed population increase created by a prospective housing development.

7. The ICB then divides further the limited funding received between multiple health providers like primary care (it is noted that the Council has accepted the primary care contribution for which the funding comes from the same source) ambulance service, community health service and mental health service in addition to the acute services.

7.1. The yearly or two-yearly negotiations between the Trust and the ICB on the size of the limited funds that has been allocated to the ICB by the Government is based on the NHS Payment Scheme (NHSPS). The NHSPS replaces the Tariff system but the costs element as to how much is activity will costs has not changed just the distribution of the total funds between the providers. The estimated level of population is based on previous year's GP patient population registration list. The funding does not include any funding which would be directly related to the increase of population through prospective housing development or anticipated population increase through permissions granted or through local plans and those who are not registered with the GP practice in the local area. Other factors like weather conditions, epidemics, capacity constraints in other parts of the system, and other socio/economic/health related aspects such mental health, employment, education and training will form part of the consideration.

7.2. Simply, even if the Trust could go back to request more funding, there is just not enough of the limited funds to add for prospective developments whether they are known or not to the Trust or to the ICB. It is for this reason that the ICB has no funding to hold back in the same way as the department of education. In addition to that the Trust could include prospective housing or projected housing through local plans into the negotiations.

7.3. It is not until the new population is registered with the GP practice that last year's local population increase is taken into consideration. Once people have registered at the GP practice they will be part of the funding but the Trust is not paid back retrospectively for those patients residing at the development who have already used the services during the first year of occupation. This is also explained in the consultation response. The "gap" in the funding is not a lag in the funding. The funding does not follow the patient other than in one respect: the Elective Recovery Fund. This equates to approximately 20% of total turnover and relates to planned care and creates a direct link between activity carried out and income received - if a provider carries out more planned care activity, then money follows the patient and the provider would be paid more. The reverse also applies – if the provider carries out less planned care activity then deductions to income will result. So, as a housing development were to result in net inward migration and some of those additional patients had planned NHS care (an outpatient consultation or an inpatient procedure) then we will receive more income than we otherwise would have done. This arrangement does not apply to the remaining 80% by value of services provided by the hospital – which includes emergency care – A&E attendances, emergency admissions and adult and pediatric critical care, but also other services such as obstetrics, renal dialysis, , pathology tests, rehabilitation, radiotherapy and community based services such as virtual wards. Funding for these services is fixed for the year and only subject to renegotiation on an annual basis. Any additional funding which may be successfully negotiated by a provider in reflection of activity growth in any of these services is never retroactive – so there is no other recourse for funding to address any gap in funding arising as a result of in-year unplanned additional demand associated with net inward migration.

8. Importantly, this arrangement is not the product of a local negotiation; this is national policy, as set out under the NHS Standard Contract and is known as the Aligned Payment and Incentive (API) contract.

9. The Trust is not asking funding for the acute services in general terms as suggested by the CIL compliance statement . The obligation requested is carefully calculated and directly related to the development and prospective patients from a specific site as follows:

9.1. Clinical activity recording:

9.1.1. 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 monthly to a national data warehouse so that it is available nationally and publicly. Note this activity count does not represent discrete patients, but the amount of activity undertaken.

9.1.2. Column A shows the different types of activity undertaken by the Trust. Column B provides the Trust's total activity in a 12-month period and column 3 is the activity rate per annum per head of population.

9.1.3. Columns C and D shows the amount of activity undertaken by the Trust that originated from the LSOA/ward in which the new development is being constructed. All of this data is derived from the Trust's records of patients seen over the 12-month period used for the calculation.

9.1.4. Each activity undertaken by the Trust has a nationally determined cost associated with it. These costs are an average cost of activity across the NHS, established annually. The Trust uses this average figure for each activity type to calculate the financial impact for new people housed in the development. The costs can be found in the Column G, entitled "Delivery cost for the dwellings".

9.2. However, over and above the reference cost of delivery, due to long-standing, national, workforce shortages, the Trust will face additional cost pressure from employing premium rate staff to meet the additional demand. The cost of this is shown in Column J, "Premium staffing". The additional costs is only related to the agency uplift not the full costs. Thus, to demonstrate total impact, Columns I and J have been added together to show the cost pressure created by the new population from a development.

9.3. The costs of each activity will include equipment and maintenance of the premises in addition to the other costs that the health service will provide to the patient. However, if the Trust have to provide a service outside of its existing capacity (such as running additional outpatient clinics at weekends, or opening a so called surge ward to accommodate additional unexpected urgent care demand, this inevitably costs more than standard because it involves use of agency staffing or payment of premium rates for weekend or evening working.

10. The costs pressure is directly linked to the development and the additional costs arising from a new development during the first year of occupation is not received back retrospectively and is a genuine gap in the funding. The Trust is independent legal cooperation providing acute health service to the local community and the funding available is a limited amount as explained. The options available to the Trust is to either increase efficiency to utilise the land available effectively or build new infrastructure. It has chosen to utilise the space available because at this moment in time, this is the most efficient and cost-effective way of dealing with the land and space available. Access to health services is paramount to a sustainable development. Without the mitigation towards the health infrastructure requested, the development will have a detrimental socioeconomic impact and will not meet the health needs of the present without compromising the ability of future generations to meet their own needs.

11. In short, the increase of population through housing development has a negative impact on the Trust's capacity to provide services within its existing infrastructure. (This is not dissimilar to an impact created on school places). The options available to the Trust is to either increase efficiency to utilise the land available effectively or build new infrastructure. It has chosen to utilise the space available because at this moment in time, this is the most efficient and cost-effective way of dealing with the current land use. The mitigation calculation is carefully formulated and explained in the consultation response and above. The contribution is directly linked to this development. The ICB does not withhold monies like in the case of education, so there is no double funding**.**

12. The University Hospitals Coventry and Warwickshire NHS Trust welcomes the opportunity to discuss this request further with the case officer and/or applicant and wish to be involved throughout the S106 wording process to ensure that contributions are allocated in the most appropriate way.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings for contempt of court may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth.

Signed …… ….

Daniel Gilks

Dated ……21ST September 2023……..