Statement of	:	Daniel Gilks
On behalf of	:	Interested Party
Number	:	2
Dated		20.11.2023

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 Warwickshire NHS of Clifford Bridge Road, Coventry, CV2 2DX **WILL STATE** as follows:

1. This is my second witness statement and is in response to the Senior Major Projects officer Ella Casey's (EC) evidence (reference CD18.14).

1. In the previous statement I had explained in detail how the funding cascades down from the Government to the NHS Trust. The detailed explanation in my previous statement and in this statement is for the purposes to demonstrate that the contribution requested is carefully calculated, is directly related to this development, that there is no double funding and is therefore reasonable request from the Developer to mitigate the impact that this development will create on the Trust's health infrastructure capacity. In the following paragraphs I will further clarify those issues raised by the Council.

2. In Para 4.3 it is contended that the ONS information used to adjust ICB populations and hence funding allocations do take into account specific housing developments. In addition to paragraphs 6 to 7 of my first statement, I can confirm that the target allocations to ICBs are based on the numbers and demographic breakdown of patients registered to the General Practices linked to that ICB which are adjusted annually using ONS projections. ONS Projections do not take into account housing developments (we have a statement from the ONS to this effect) but rather use 10 yearly census data and then project using birth rates and mortality rates and pre-existing migration patterns. The ONS projection figure used for the purposes of the allocating of funds to ICB is not in direct correlation to the ONS figures used for housing allocations as many other factors will influence the final funding figure. The factors are different to those that are dictated by housing allocation figures. Please see paragraphs 6.2- 6.7 of my first statement.

3. As explained the ICB allocation of funds to the Trust does not include ONS population projections as explained in detail paragraph 7.1 of my first statement. Please note that the Trust is independent legal entity to the ICB and is providing health services to the local population. The ICB does not provide any health services to the local population.

4. In Para 4 and 5.4 of the Officer's statement it is suggested that the Trust can negotiate a contract with its commissioners which is sensitive to population growth due to inward migration relating to a housing development and existing planning permissions including lead time.

5. The contracting regime under the NHS currently is the Aligned Payment and Incentive (API) Contract. Under this contract, some elements are blocks and do not vary in relation activity levels (unplanned care, critical care, obstetrics – c 80% by value of services).

6. The remaining 20% (for planned care- outpatients and planned inpatient treatments) comes under the Elective Recovery Fund (ERF) which varies directly with activity levels – money follows the patient. The ERF is a relatively recent change in policy by the Dept of Health to provide an incentive for providers to increase their throughput to address the post-pandemic waiting list backlog. In its updated response, the Trust has reduced its funding proposal by 20% to reflect the ERF.

7. For the remaining 80%, there is no mechanism to increase funding in the year in which the net inward migration takes place regardless of whether the Trust is aware of it or not (existing planning permissions. The API contract is a matter of national policy – not something that can be negotiated-away locally. In any event, the ICB itself does not have the funding to pay to the Trust because as set out previously, the formula which drives its allocation does not factor in housing development and the population arising from these developments until the people are registered with their GP Practice.

8. Para 4.5 quotes Holgate J that any funding gap may be due to inadequacies in the NHS funding arrangements and moving funding between regions.

9. This may or may not be correct, but in an era of net inward migration nationally, it may be academic anyway as this is not a matter of a cost-neutral shifting around of resource, but an increase in demand due to increases in population numbers and demographics which is felt nation-wide. Even if it is correct that the funding formula is not fit for purpose, these are the rules, set nationally, within which UHCW and its commissioners must operate within.

10. This same argument could be said about any contribution which is paid through taxation.

11. As to the Paragraph 5.8 of the statement and expected five-year housing land supply I can confirm that this has absolutely no relevance to the funding formula between the Trust and the ICB. There are no rules allowing the Trust to include population projections arising from the existing planning applications or five-year land supply. There is not enough funding available that could be allocated based on population projections or applications that may or may not be implemented.

12. A hospital is a patient-facing service. Demand for hospital services is multifactorial – age, lifestyle, expectation, gaps in other services such as social care, weather and infection-load are all factors – but the single biggest factor is the number of people in the hospital's catchment. If the population increases, there will be an incremental increase in emergency department attendances, GP referrals and births. As explained in paragraph 10 of my first statement the impact is on the existing infrastructure capacity and not an impact on the 'funding scheme' as asserted in paragraph 5.2 and 5.10 of EC's statement.

13. The mitigation formula calculation is based on an average incremental increase pf the activity levels which creates a direct impact on the health infrastructure capacity created by the development. The real impact can easily be greater than the anticipated clinical activity based on the existing activity related to this development area. One patient with substantial health problems or a flu outbreak in this development area can create significantly bigger impact on the health infrastructure capacity than anticipated and therefore the costs to the Trust may be considerably more.

14. There is no potential that the Trust is somehow double funded for the impact that this development will create on the Trust's health infrastructure capacity.

15. Finally, as explained the in the consultation response according to Dr Foster the safe bed occupancy rate (OR) is 85%. The current NHS England recommended OR is 92%. The Trust is consistently over 98% OR. This means that any additional patient from this development will worsen and/or exacerbate the Trust's ability to provide safe health care service. In particular, rising admissions, whether emergency or not, will increase pressure on available resources, including hospital beds. This in turn has a knock-on effect on all the departments. For an example, when hospital bed capacity is full, patients wait longer in A&E for a hospital bed. When A&E capacity is full, patients wait longer in an ambulance. This is in turn will affects the ambulance service itself as waiting time for responding to a 999 call will increase. It is evident that this will not have the best outcome for a patient. More complex the health issue more severe health outcome for the patient. At the moment the clinical standard requires a person suffering from stroke to have a brain imaging within an hour of having arrived at the hospital. Any longer waiting time may mean that the patient does not receive the required treatment in time. This in turn means that the health outcomes may be considerably different. It could mean difference between a patient recovering, being wheelchaired or loss of life.

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