Sandwell and West Birmingham Hospitals NHS Trust
Midland Metropolitan Hospital Project
Outline Business Case

Appendix 8a Superseded Finance Chapters

1 Introduction

This document presents the finance section presented in Version 2.00 of the OBC and covers financial impact at DH Approval in August 2009. It remains unchanged but has been retained to record the position at this first step in the approval process.

2 Finance Chapter of OBC Version 2

2.1 *Comparison of Capital Costs from SOC to OBC*

A comparison of the capital cost and functional content of the scheme at SOC stage, with the current OBC assessments, is based on the following approach:

- Identify capital cost of the acute element of SOC option;
- Reflect impact of change in "approvals" indices:
  - MIPS VOP Index from 385 to 515;
  - Location Factor from -3% to -7%;
  - Equipment (at OB1 base level) from 110 to 120;
- Compare "SOC Adjusted" with OBC estimate for Option 4.

Comparison of SOC and OBC Capital Costs

Capital Costs	Col A SOC MIPS 385	Col B SOC Adjusted MIPS 515	Col C OBC Option 4 MIPS 515	Col D OBC Refresh Option 4 Adjusted MIPS 515	Col E Net Change (Col D – Col B) MIPS 515
Departmental Costs	103.9	139.1	124.4	124.4	-14.7
On-costs	67.6	90.4	109.2	109.2	+18.8
(Location adjustment)	(5.1)	(16.1)	(16.4)	(16.4)	-0.3
Sub-Total Works costs	166.4	213.4	217.2	217.2	+3.8
Fees	24.9	32.0	27.2	27.2	-4.8
Equipment	25.4	27.8	3.5	28.4	+0.6
Non Works	1.0	1.1	5.4	5.4	+4.3
Land Acquisition (net of disposals at SOC stage)	0.0	0.0	19.7	19.7	+19.7

Capital Costs	Col A SOC MIPS 385	Col B SOC Adjusted MIPS 515	Col C OBC Option 4 MIPS 515	Col D OBC Refresh Option 4 Adjusted MIPS 515	Col E Net Change (Col D – Col B) MIPS 515
Planning Contingencies	13.1	15.4	15.2	16.7	+1.3
Optimism Bias	69.2	86.8	38.7	42.5	-44.3
Total Capital Cost exc VAT	300.0	376.5	326.9	357.1	-19.4
VAT	46.8	58.6	50.2	55.5	-3.1
Total Capital Cost inc VAT	300.0	435.1	377.1	412.6	-22.5
Land Disposal	-	-	-	(29.4)	-29.4
Total Capital Cost net of Land Sales	346.8	435.1	377.1	383.2	-51.9

In order to ensure a proper comparison between the costs at SOC and OBC stage, the costs of the PSC have been adjusted in Column D in the table above for the following factors:

- At SOC stage, the capital costs for the project included an allowance for Equipment based on 24.5% of Departmental costs. The Trust has now undertaken a detailed review of Equipment requirements and developed plans for a separate Equipment procurement as part of its Long Term Financial Plan. Equipment provision within the project is now only a nominal £3.5m, and so the costs of the equipment to be financed by the Trust from internal funding has been added in;
- At SOC stage, the prudent assumption made in respect of Land, was that Acquisition costs would not be offset by Land Sales income. The land sales income now expected from the disposal of existing hospital sites has been added in to Column D to offset the acquisition costs.

The main changes between the SOC and OBC Option 4 are:

- A net increase in Works costs of £3.8m, reflecting a clearer articulation of requirements and a more detailed level of design reached at OBC stage, (mitigated as expected by a fall in the provision for Optimism Bias) and comprising:
  - A fall in Departmental Cost Allowance Guidance (DCAG) costs of £14.7m;
  - An increase in On-Costs of £18.8m;
  - An increase of £0.3m in the Location Factor adjustment.

- A net reduction in the cost provision for fees of £4.8m. Although Works costs (above) have increased, at SOC stage a 15% allowance was included for Fees, compared to the current OBC judgement, based on market conditions, of a 12.5% fee level.
- The provision for Non-Works elements has increased by £4.3m, reflecting a more detailed understanding of the site constraints.
- Land Sales income is now expected to exceed the costs of land acquisition by £9.7m.
- The SOC included an overall allowance of 30% for Optimism Bias, a level appropriate for that early stage of the project. The OBC provision of 14.41% reflects the significant advances made in the development of the design and output specifications for the project and comprises:
  - An Upper Bound of 33.5%;
  - Mitigation of 43%.

The net change in capital costs between the “SOC adjusted” and OBC, including land transactions is a reduction of £51.9m, equivalent to 12%. Excluding the impact of land acquisition and disposal, the capital cost reduction is £42.2m, equivalent to 9%.

Further details on capital costs for the proposed solution can be found in paragraph 9.5.2 below.

2.2 *Capital Costs at August 2009 Approval*

The estimated capital costs of the proposed solution have been assessed by the Trust’s capital cost consultants, using a base MIPS index of 515 VOP index for approval purposes.

Outturn costs reflect a start on site in Q2 2012 and a MIPS index of 638 VOP, with inflation from that point assessed on the basis of movements in the Price Adjustment Formula for Building and Specialist Engineering Works to APSAB index.

The resulting capital costs are set out in the table below:

Summary of PSC Capital Costs

Capital Costs	Option 4 Grove Lane £000
At MIPS 515:	
Departmental costs	124,428
On-costs	109,169
(Location adjustment)	(16,352)
Sub-Total Works costs	**217,245**
Fees	27,155
Equipment	3,511
Non Works	5,371
Land Acquisition	19,739
Planning Contingencies	15,197
VAT	44,154
Optimism Bias	44,717
Total Capital Cost at MIPS 515	**377,089**
Total Capital Cost at Outturn	**483,983**
Total Capital Cost at "Current"	**431,985**
Capital Costs (Net of Land Sales):	
At MIPS 515	347,729
At Outturn	454,623
At "Current"	402,625

2.2.1

2.3 *Revenue Costs at August 2009 Approval*

2.3.1 Acute Hospital Services

A detailed analysis of the forecast annual revenue costs for the period up to 2018/19 for the acute hospital related services is shown in ***(Old Appendix Available).***

The projected costs for the first full year of operation in 2015/16 are shown in the table below.

Summary of PSC Revenue Costs – Acute Hospital Services

Revenue Costs	Baseline Costs 2008/09 £000	Projected Costs 2015/16 £000	Change £000
Clinical Services	222,650	167,011	-55,639
Non-Clinical Services	49,459	38,773	-10,686
FM Services	30,224	18,405	-11,819

Revenue Costs	Baseline Costs 2008/09 £000	Projected Costs 2015/16 £000	Change £000
Support Services	16,006	1,760*	-14,246
Capital Charges	25,601	37,823	+12,222
Gross Annual Revenue Costs	**343,940**	**263,772**	**-80,168**

'Support Services' includes a range of services supporting clinical care e.g. Medical Records, Medical Secretaries, Community Midwifery staff and Audiology services.

The cost projections set out in the table above show a reduction of £80.168m compared with the Trust's Financial Plan for 2008/09. The key factors behind this cost reduction are outlined below:

- A&E services reduce in line with activity predictions and the introduction of Urgent Care Centres within Community settings; the costs associated with those Urgent Care facilities co-located with the A&E department in the new hospital are included within the acute quantum of cost;
- Critical Care services are predicted to increase with a planned overall increase in Intensivist Bed requirements;
- Rehabilitation/Stroke and Intermediate Care services are provided in community-based facilities;
- The costs associated with Admitted Patient Care services reduce in line with activity projections, including the anticipated reduction in activity as a result of changes to the catchment population served:
  - The numbers of medical specialty spells reduce by 18.4%;
  - The numbers of surgical specialty spells reduce by 34%, largely because the majority of day case activity will take place in the community facilities from 2015/16;
  - The numbers of spells in Maternity and Paediatrics reduce by 11% and 10% respectively, largely as a result of the predicted change in the catchment population served when the new hospital opens;
- The planned reductions in lengths of stay significantly reduce the forecast bed requirements within the acute hospital and this is reflected within the cost projections;
- A significant reduction in the costs associated with outpatient services as the majority of outpatient activity transfers to community locations;
- Diagnostic services are predicted to grow as demand increases and trends move towards an enriched casemix and an increasing range of tests/scans, although significant work will also be undertaken within Community facilities;
- Non-Clinical Support functions are modelled to fit within the new service configuration recognising efficiencies will be achieved through service integration within one Acute hospital site;
- The costs of Hard and Soft FM services have been individually modelled taking into account the reduction of 45% in the overall space requirement for acute hospital services compared to the current position;

- Capital Charges for the New Hospital site and associated equipment needs are predicted to rise significantly reflecting the capital cost of the new build and the need to equip the facilities to appropriate standards.

2.3.2 Summary of PSC Revenue Costs – Community Based Services

A detailed analysis of the forecast revenue costs for the services to be delivered by the Trust in other community based settings is shown in ***(Old Appendix Available).*** and summarised in the table below. The projected costs shown are for the first full year of operation of the new acute hospital (2015/16).

Summary of PSC Revenue Costs – Community Based Services

Revenue Costs	Baseline Costs 2008/09 £000	Projected Costs 2015/16 £000	Change £000
Clinical Services	-	43,103	+43,103
Non-Clinical Services	-	10,020	+10,020
FM Services	-	2,747	+2,747
Support Services	-	9,342*	+9,342
Capital Charges	-	6,500	+6,500
Gross Annual Revenue Costs	**-**	**71,712**	**+71,712**

'Support Services' includes a range of services supporting clinical care e.g. Medical Records, Medical Secretaries, Community Midwifery staff and Audiology services.

The projected costs of those services which will be delivered by the Trust in alternative settings reflect the following key factors:

- The transfer of a significant proportion of outpatient activity to community based facilities;
- The transfer of the majority of surgical day case activity to the community facilities based on the City Hospital and Sandwell Hospital sites;
- The transfer of Community Midwifery services to community locations;
- In-patient facilities for Intermediate Care and Stroke are provided by the Trust within the community facilities; and
- The costs of non-clinical support functions and FM services are included within the cost projections to reflect an estimated full cost for service provision, consistent with the full income expected to accrue for services provided.

2.3.3 Summary of PSC Revenue Costs – Total

The Trust's total projected cost base for 2015/16 for all of the services to be provided by it is set out in the table below:

Summary of PSC Revenue Costs - Total

Revenue Costs	Baseline Costs 2008/09 £000	Projected Costs 2015/16 £000	Change £000
Clinical Services	222,650	210,114	-12,536
Non-Clinical Services	49,459	48,793	-666
FM Services	30,224	21,152	-9,072
Support Services	16,006	11,102	-4,904
Capital Charges	25,601	44,323	+18,722
Gross Annual Revenue Costs	**343,940**	**335,484**	**-8,456**

'Support Services' includes a range of services supporting clinical care e.g. Medical Records, Medical Secretaries, Community Midwifery staff and Audiology services.

Overall, the Trust's revenue costs are projected to reduce by £8.456m by 2015/16.

The projected revenue costs over the period up to 2026/27 are set out in ***(Old Appendix Available).*** and summarised in the table below:

Revenue Cost Profile 2008/09 – 2026/27 (PSC)

	2010/11 £000	2011/12 £000	2012/13 £000	2013/14 £000	2014/15 £000	2015/16 £000	2017/18 £000	2026/27 £000
Pay	230,744	232,806	230,041	229,523	225,375	207,566	209,034	222,682
Non-Pay	85,621	88,271	89,562	90,465	86,860	76,775	78,057	83,102
Capital Charges	24,567	26,835	25,296	25,224	26,254	44,323	44,323	44,723
Total Recurring Costs	**340,932**	**347,912**	**344,899**	**345,212**	**338,489**	**328,664**	**331,414**	**350,507**
Non-Recurring Costs	5,118	2,566	1,132	700	6,679	6,819	2,023	-
Total Gross Costs	**346,050**	**350,478**	**346,031**	**345,912**	**345,168**	**335,483**	**333,437**	**350,507**

2.4 *Income at August 2009 Approval*

The Trust's levels of income have been modelled in detail over the period up to 2026/27.

For Patient-Related income, the income model uses as its starting point the Trust's 2008/09 contract income baselines for 2008/09 and applies judgments endorsed by the *Right Care, Right Here Programme* to determine future activity levels and resultant income levels based upon 2008/09 national and local PbR tariff prices.

Non-patient related income is largely divided into two categories:

- Education & Training related, including national levies; and
- General Category C income for activities or services provided by various departments within the Trust to internal and external customers.

Each area has been individually considered to determine the likely impact of the planned changes on individual income streams.

Training income streams have been assumed to generally remain stable across the period, while Category C income accruing to service departments fluctuates depending on individual circumstances. For example, some services like Catering and Nursery income is judged to cease as service provision will cease. Other areas such as Diagnostics are assumed to grow in line with national trends.

The Trust's projected income profile for the period up to 2026/27 is set out in the table below:

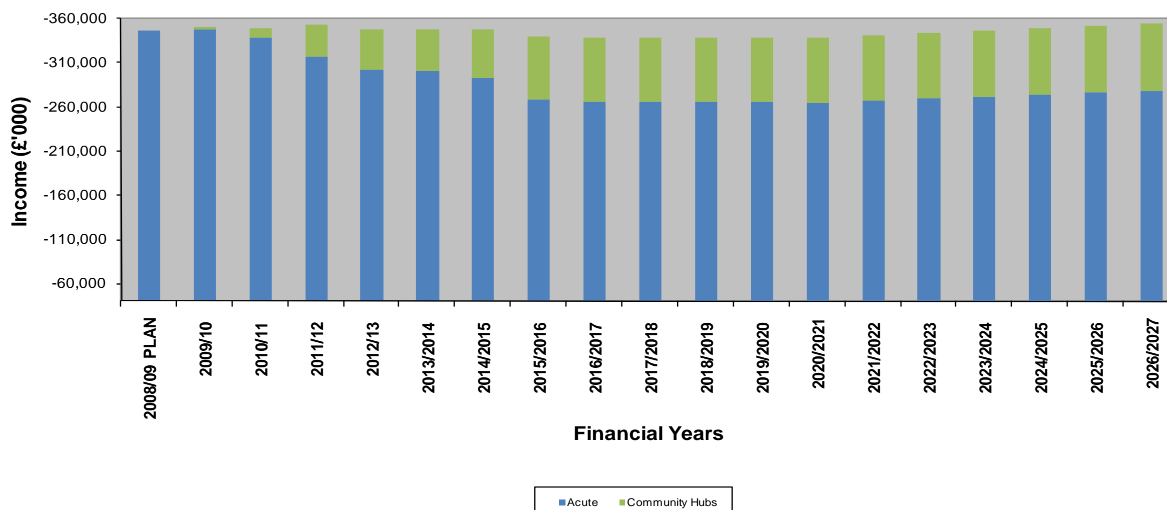
Income Profile 2008/09 – 2026/27

	2008/09 £000	2009/10 £000	2010/11 £000	2011/12 £000	2012/13 £000	2013/14 £000	2014/15 £000	2015/16 £000	2017/18 £000	2026/27 £000
Admitted Patient Care	152,815	153,110	153,699	154,582	155,759	156,140	146,172	120,629	122,944	135,946
Outpatients	54,514	51,302	44,877	35,240	22,391	22,459	22,821	22,370	22,506	22,976
A&E	15,740	15,786	14,853	13,453	11,586	12,183	12,183	14,455	14,608	16,042
Special Categories	63,803	63,120	62,636	52,703	50,261	51,401	49,429	50,595	50,595	53,863
Out of Hospital Services	-	2,817	9,469	35,383	46,651	47,429	54,582	71,737	72,147	76,666
PBR MFF	20,743	20,522	20,038	18,626	17,519	17,730	16,949	15,384	15,572	16,920
Other NHS	4,989	6,016	5,934	5,528	5,342	5,377	3,327	3,118	2,333	2,333
Category C	34,004	33,175	33,214	32,846	33,278	34,073	32,970	29,898	30,261	30,261
Total Recurring Income	**346,609**	**345,817**	**344,720**	**348,362**	**342,787**	**346,792**	**338,433**	**328,187**	**330,966**	**355,007**
PFI Tapering Relief	-	-	-	-	-	-	-	12,100	7,260	-
PCT Transitional Support	-	4,417	3,888	4,653	5,626	1,430	8,986	-	-	-
Total Income	**346,609**	**350,264**	**348,608**	**353,015**	**348,413**	**348,222**	**347,419**	**340,287**	**338,226**	**355,007**

The table above shows that income associated with acute hospital services reduces as services are transferred to other settings, and is projected to reduce from £346m in 2008/09 to £269m by 2015/16. Conversely, the income accruing to the Trust from the provision of services in community-based settings rises to £71m by 2015/16.

The figure below shows the levels of income over the transitional period up to 2017/18 analysed between income accruing from those services delivered by the Trust from the new hospital and that accruing from the provision of services in community based settings.

Income Profile 2008/09 – 2026/27



2.5 *Affordability at August 2009 Approval*

The Trust's Income and Expenditure position over the period to 2026/27 is set out in the table below:

Overall I & E Position 2008/09 – 2026/27 (PSC)

	2008/09 £000	2009/10 £000	2010/11 £000	2011/12 £000	2012/13 £000	2013/14 £000	2014/15 £000	2015/16 £000	2017/18 £000	2026/27 £000
Income	346,609	350,264	348,608	353,015	348,413	348,222	347,419	340,287	338,226	355,007
Expenditure	343,940	347,700	346,050	350,478	346,031	345,912	345,168	335,483	333,437	350,507
I&E Surplus	**2,669**	**2,564**	**2,558**	**2,537**	**2,382**	**2,310**	**2,251**	**4,804**	**4,789**	**4,500**

The overall I & E projections demonstrate that the Trust maintains a surplus consistent with approximately 1% of its turnover up to 2014/15, and would achieve a significantly greater surplus from 2015/16 onwards. This position includes the following key features:

2.5.1 Cost Improvement Savings

The Trust's plans at present include a baseline CIP requirement of 3%, which is consistent with central government expectations, financial planning within the Trust as part of its Foundation Trust application, and the likely impact implicit within future tariff pricing under PbR.

In recent years, the Trust has demonstrated a strong track record of cost reductions, managing to identify efficiencies of approximately £45m during the final 3 years of its 5 year recovery period. The Trust completed its recovery plan on 31 March 2008 and in turn met its statutory breakeven requirement.

The Trust has already commenced work on identifying its cost efficiency programme for 2010/11. The approach and areas to be pursued are summarised below:

- Service redesign - the Trust is planning to achieve 50% of its savings from service redesign and vacancy management. Reference to vacancy management should not be interpreted to mean 'vacancy freeze', but rather the development over time of enhanced roles and changes to the workforce, which can be engineered during a period when vacancies occur;
- 25% of the required savings will be sought from a critical analysis of non-pay spending levered from national and regional procurement initiatives and steps the Trust can take internally to improve its use of non-pay items, including materials management, pharmacy robotics and exploitation of available technologies, e.g. e-procurement;
- 25% of the required savings will be sought from increased turnover. This should not be interpreted as meaning that the Trust is looking to increases in activity as a solution to its savings targets without consideration of the referral trends, commissioner intentions, strength of competitive position etc. These savings reflect the natural benefit occurring from a degree of acute sector growth and the ability to become more efficient as income rises by a full cost factor and the Trust delivers the work from an established base which includes fixed costs; in other words, marginal income exceeding marginal costs. A strict discipline has been applied in previous years that prevents operating divisions from promoting excessive CIP plans from income sources.

The table below identifies examples of specific areas for cost improvement under each of the themes summarised above, with the relative proportion of the programme applied to each area:

Outline CIP 2010/11

Area of Saving/Example	Proportion of Savings Required
Service Re-Design/Vacancy Management	**50%**
Bed Reductions - 30 beds pa	
Ward nurse skill mix	
Clinical productivity - efficient use of consultant capacity via a review of premium rate working/PAs/numbers	
Reduction in Theatre capacity/skill mix (1 Theatre pa) requiring improvement throughput theatre stock	
Streamline diagnostic capacity through service redesign and skill-mix	
Better use of OP capacity - service redesign and skill-mix, DNAs, working times	
Clinical administration reductions – Connecting for Health (CfH)	
Administration reductions – Electronic Staff Record (ESR) and CfH	
Agency costs - absolute reduction in hours and achieved through Bank and recruitment	
Service redesign - LEAN, day-case rates, outpatient plus procedure expansion	
Procurement	**25%**
General procurement through contracts - regional/national	
In house procurement initiatives through standardisation and rationalisation	
Energy savings	
Drug savings	
Equipment management	

Area of Saving/Example	Proportion of Savings Required
Capital charges/rates CNST premiums - increasing general and maternity by 1 level each over 2 years	
Turnover/Activity LDP growth benefit, modest assumption of 1% GP access increase Other income - commercial and market share	**25%**

The Trust has a strong track record of delivering sustainable cost improvements. It is recognised that performance in the past is no guarantee of the impact in future, but what the Trust has done to strengthen delivery is to retain the systems and infrastructure in place during formal financial recovery so that the monitoring of the CIP plan does not occur during a 'crisis period' but rather becomes fully embedded and part of the culture of strong financial management.

2.5.2 Transitional Funding

A Transitional Funding Framework (TFF) agreement has been developed with the two local PCTs to address the financial impact of the *Right Care, Right Here Programme* activity plan (in the years leading up to the opening of new healthcare facilities). This section describes the local health economy's Transitional Financial Framework supporting this project and the wider programme.

The activity trajectories create situations where income is redirected from the Trust in the short-term leading to a full tariff reduction in value terms. Conversely, the cost base of the organisation contains lags owing to the time required to reduce semi-fixed and fixed costs. The partnership has concluded that a resourcing mechanism should be identified to enable delivery of the wider strategy.

The assessment of transitional costs is not confined to the Acute Trust alone. The substance of transitional costs across the Health Economy shows that:

- SWBH must address:
- The difference between the cost reductions achievable by the Trust as it reduces in size and its loss of income (some costs are fixed in the short term whilst income is lost at 100% of tariff rates);
- The acquisition costs of the new hospital; and
- The costs of landholding prior to the opening of the new hospital.
- The two PCTs must address:
- The double-running costs associated with the commissioning of new community and primary care premises in advance of activity transfers;
- Decanting costs associated with refurbishment schemes; and
- Revenue to capital transfers to fund the new community capital developments.

In addition, the health economy is likely to incur additional costs as part of the process of workforce restructuring.

2.5.3 Principles

Four principles underpin the Transitional Financial Framework:

- All plans, costs and transactions will be shared on an 'open-book' basis;
- The agreement should neither inappropriately disadvantage any of the partners nor create perverse incentives that might compromise the implementation or spirit of *Right Care, Right Here*;
- Risks should be shared in a manner which enables individual organisations to assess the likelihood and scale of future commitments; and
- Any cost pressures incidental to the transition arrangements shall fall outside the scope of the agreement.

The Trust and the PCTs have agreed that:

- The PCTs shall fund their own transition costs;
- The PCTs shall make a contribution towards SWBH's costs; and
- SWBH shall maximise its own contribution to its costs, recognising the need to generate internal efficiencies and to meet the requirements of Foundation Trust status.

2.5.4 Transitional Costs

At present there is approximately £87m of transition related costs between the three partners. The Trust's share of this is £61m made of up two key elements. The table below presents the Transitional Financial Framework impact.

Transitional Financial Framework Impact

	Costs 2008/09 – 2014/15 £m
TRANSITIONAL COSTS	
Loss of income in advance of cost reductions	40
Enabling costs	21
Total Costs	61
FINANCED BY:	
PCT Transitional Funding	29
Internal Trust Savings (0.5% per annum 2009/10 – 2014/15)	32
Total Funding	61

The loss of income in advance of cost reductions of £40m is the result of a detailed analysis of the income and expenditure model as linked to activity assumptions combined with cost behaviour analysis. This has been shared in detail with PCT partners as part of the 'open book' analysis of the programme.

The enabling costs of £21m include assessed provisions for land holding, non-capital land acquisition costs, workforce-related restructuring, and a contingency for unforeseen elements or slippage in the internal Trust savings of £32m.

The PCTs have set aside transitional funding of £29m within their financial plans to 2014/15. The additional cost improvement savings of £32m over the period are embedded in the Trust's financial planning assumptions and its LTFM. It is not therefore a separate scheme but rather added to the productivity targets of the organisation. The additional savings are recurrent in nature, amounting to £9.4m on a recurring basis, and are available for use on a non-recurrent basis during the transition period.

All of the £61m and the offsetting financing sources have been included within the income and expenditure projections shown in Table 97 above.

2.5.5 Future Service Level Agreements and LDP Planning

The Transitional Financial Framework has been developed so that it can feature as part of future service level agreements irrespective of NHS Trust or Foundation Trust status. It caters for annual reviews especially where activity in the intervening years deviates from plan (up or down) and this creates additional flexibilities or financial pressures for the Trust.

As stated it is intended that the framework and the associated funds flow will be explicitly set out in future service agreements and articulated within the non-PbR section of these agreements. The protocol is being amended and will be incorporated into the funding agreements as part of the LDP process. It is important to note that funds have been set aside by the PCTs as part of their long term planning ahead of the detailed LDP discussions for 2009/10 onwards.

2.6 *Risks and Sensitivity Analysis at August 2009 Approval*

2.6.1 Risks

The Trust's Integrated Business Plan and application for NHS Foundation Trust status is currently being finalised and identifies the key risks to the delivery of the Trust's business model. The risks have been categorised into:

- Long-term risks: risks to the success of our long-term strategy for our services (the "Right Care, Right Here" strategy);
- Transitional risks: risks to the successful transition from current models of care and facilities to new ones;
- Generic risks: risks inherent in the day to day operation of a large acute trust irrespective of the wider strategic agenda.

Twelve key risks have been identified and mitigation plans prepared for each of them:

- Affordability and/or deliverability of the new acute hospital;
- Lower levels of future demand for the Trust's services than forecast;
- Higher levels of future demand for the Trust's services than forecast;
- Loss of activity to competitors before the new hospital opens;
- Inability to reduce costs sufficiently as activity shifts to primary care;
- Destabilisation of one of the two existing acute hospitals before the new hospital opens;
- Inability to deliver a workforce that is fit for purpose for new models of care;
- Maintaining key national access targets (18 weeks and A&E);
- Increase in hospital acquired infection rates;
- Inflation in the PBR Tariff not matching real cost inflation;
- Inability to fully deliver future CIPs;
- Significant service interruption due to major incident.

2.6.2 Sensitivity Analyses

As part of the preparation of its Integrated Business Plan, the Trust has modelled the impact on its financial plans of a number of alternative scenarios based upon the identified key business risks. The scenarios which are being modelled are as follows:

- Downside Scenarios
- Delay in opening of the new hospital;
- Unitary Payment for the new hospital is higher than forecast;
- Lower level of activity/income for acute hospital services than forecast;
- Trust not commissioned to run the community facilities as forecast;
- Loss of activity/income during the transitional period;
- Failure to reduce costs as activity shifts during the transitional period;
- Inflation higher than assumed in the Long Term Financial Model;
- Part of future CIP not delivered successfully.
- Upside Scenarios
- Higher level of activity/income for new hospital than forecast;
- Trust commissioned to run greater proportion of community facility services;
- Increased elective activity/income during the transitional period.

The results of the modelling undertaken to date indicate that the financial risk to the Trust from the downside scenarios is much greater during the transitional period up to 2014/15 than the risk from 2015/16 onwards. The Trust has robust mitigation strategies in place and the available cash balances and working capital facility are sufficient to manage the identified period of greatest risk on a cash liquidity basis.