Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	10 Year LTFM, planning assumptions and outputs
SPONSOR (EXECUTIVE DIRECTOR):	Robert White, Director of Finance & Performance Management
AUTHOR:	Robert White, Director of Finance & Performance Management
DATE OF MEETING:	28th November 2013

EXECUTIVE SUMMARY:

The purpose of this paper is to provide the Trust Board with a description of the assumptions and estimates which support the Trust's 10 year financial model and to present the resultant output. One of the key planning parameters concerns attaining a score of 3 out of a possible 4 within Monitor's Continuity of Risk Rating system. At its meeting on 31 October 2013, the Board considered the acceptability of a rating of 3 and based on the circumstances of the Trust's plans concluded that a 3 was an acceptable. For completeness, this paper reiterates components of the October Board paper and how the regulator's risk rating is influenced by plans being tested by the Trust, not the least of which is the inclusion of MMH within the model.

Particular attention is needed to the assumptions regarding income forecasts, efficiency levels, cost behaviour, internal capital expenditure and the inclusion of £100m of non-repayable PDC funding as part of an overall funding/affordability position which includes the reconfiguration of acute services incorporating MMH. Similar to the base case, consideration and agreement is required to this set of plans. The paper forms part of a composite set of documents in support of future strategic aims. Should the board conclude that it is in a position to progress with its plan, this document and others will be submitted to the Trust Development Authority to enable it to undertake its assessment work in conjunction with the Department of Health.

REPORT RECOMMENDATION:

The Board is asked to:

- RECEIVE the paper and detailed appendices
- NOTE and AGREE the assumptions supporting the base case including Revenue estimates (income & expenditure), MMH capital planning values and resultant annual unitary payment, year on year efficiency requirements, cash flows and balance sheet forecasts.
- CONCLUDE that the successful delivery of the planning assumptions and management of key issues and challenges when reflected within a 10 year LTFM returns a sustainable financial result and a pre-consulted upon and agreed Continuity of Risk Rating of 3.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:
The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
	X	

KEY AREAS OF IMPACT *(Indicate with 'x' all those that apply):*					
Financial	**X**	Environmental		Communications & Media	
Business and market share		Legal & Policy	**X**	Patient Experience	
Clinical		Equality and Diversity		Workforce	
Comments:					
ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:					
Strategic Objectives – 21st century facilities & FT readiness					
PREVIOUS CONSIDERATION:					
May 2013 and previous updates at Trust Board during planning period, F&I 22.11.13					

Sandwell & West Birmingham Hospitals NHS Trust

Trust Board

Long Term Financial Model – incorporating MMH

28th November 2013

Sandwell & West Birmingham Hospitals NHS Trust

Trust Board

Long Term Financial Model – incorporating MMH

28th November 2013

1.0 Introduction

The purpose of this paper is to provide the Trust Board with a description of the assumptions and estimates which support the Trust's 10 year financial model and to present the output from that model.

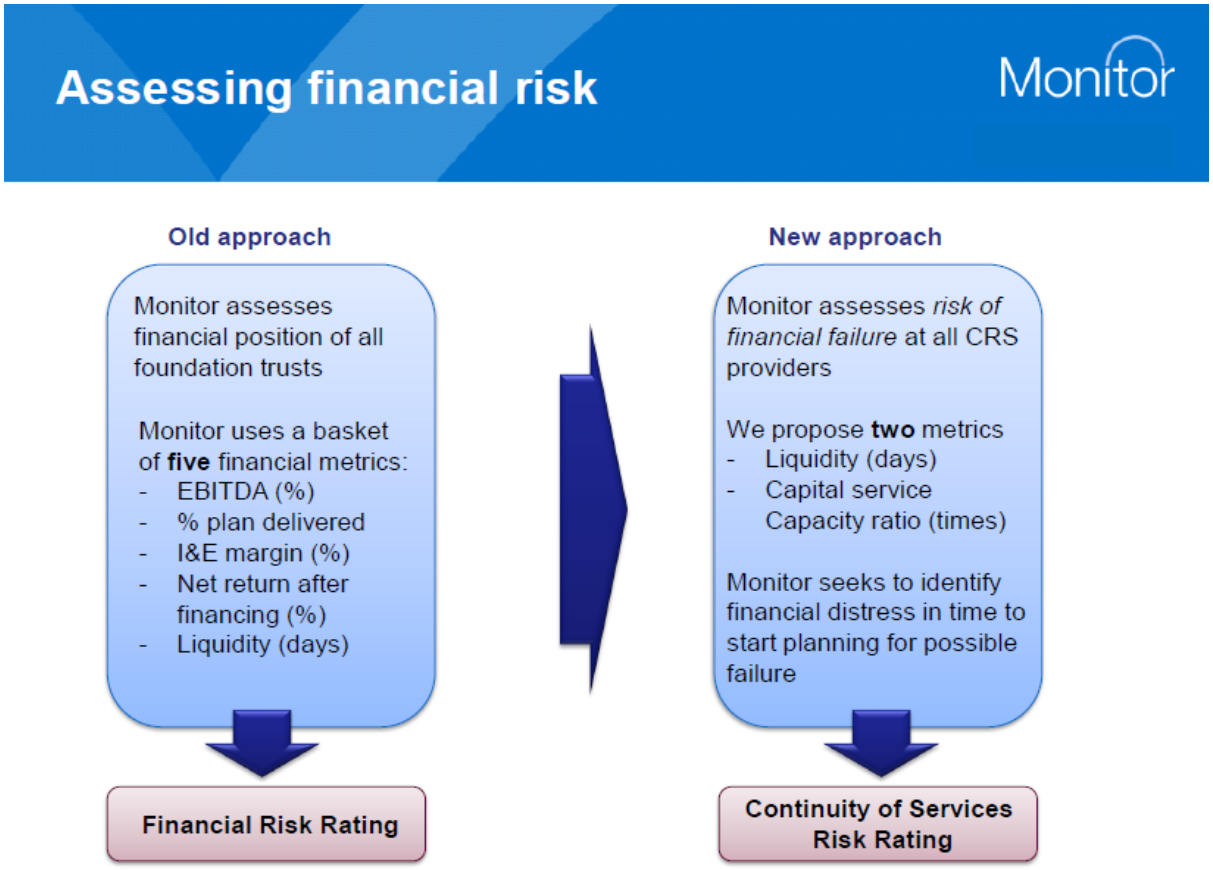
One of the key planning parameters concerns attaining a score of 3 out of a possible 4 within Monitor's Continuity of Risk Rating system. At its meeting on 31 October 2013, the Board considered the acceptability of a rating of 3 and based on the circumstances of the Trust's plans concluded that a 3 was an acceptable. For completeness, this paper reiterates components of the October Board paper and how the regulator's risk rating is influenced by plans being tested by the Trust, not the least of which is the inclusion of MMH within the model.

2.0 Summary of the Risk Rating System

The Trust will be familiar with the previous Monitor 5 point rating scheme which incorporated a number of financial hurdles linked to I&E performance, operating surpluses and achievement of plans. Sitting alongside the previous system was the PBC (prudential borrowing code) which, depending upon the presence of material PFI assets, calculated certain ratios for debt servicing.

The new regime published in September 2013 and previous Monitor documents make it clear that the prudential borrowing code and prudential borrowing limits no longer apply. Both the previous Financial Risk Ratings and PBLs have been replaced with a Continuity of Risk Rating based on 2 component parts of equal weight, i.e. Liquidity (effectively number of days of operating cash) and Debt Servicing (the extent to which the operating surplus and the resultant free cash flow is capable of covering debt repayments inclusive of both principal and interest).

A slide borrowed from explanatory materials from Monitor highlights the differences between the previous and new regimes.



The monthly Trust Board finance reports have included 'shadow' risk ratings under the new system. There is a range of variables or outputs being tested in the LTFM (long term financial model) one of which being the achievable rating given the parameters within the model. Alongside the risk rating, tests were applied to the level of efficiency savings arising from the Trust's plans. These two output variables, along with all other assumptions currently point to a risk rating of 3.

Metric	Weight	Definition	Rating categories 1	2	3	4
Liquidity ratio (days)	50%	Working capital balance x 360 / Annual operating expenses	<-14	-14	-7	0
Capital servicing capacity (times)	50%	Revenue available for capital service / Annual debt service	<1.25x	1.25x	1.75x	2.5x

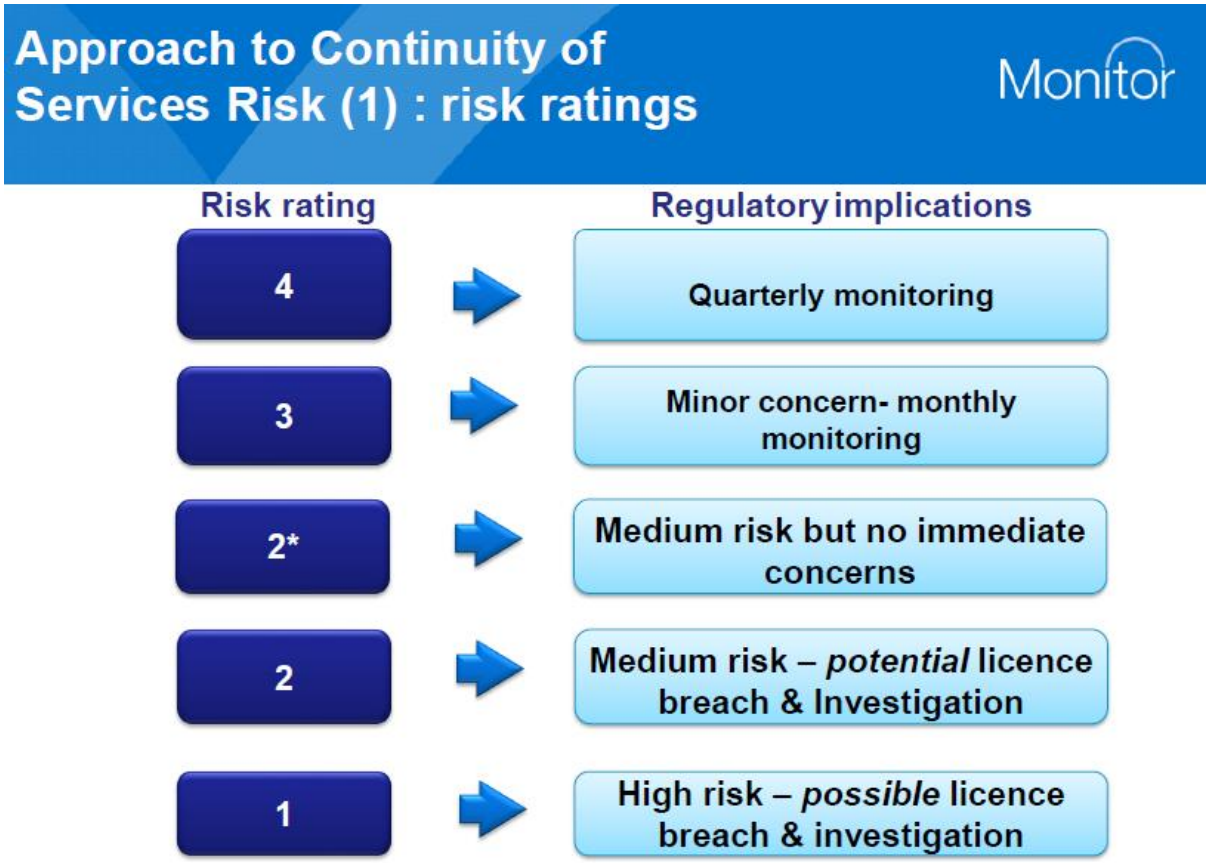
continuity of services risk rating

The application guidance for aspirant Foundation Trusts does not explicitly state the risk rating necessary to enter the process. However, the Trust Board has concluded that a rating of 3 should be attained within the model inclusive of the new hospital plans.

Presentation of the LTFM is being used to satisfy information requirements laid down by the Department of Health – capital branch and the TDA. This assists their work in assessing the affordability of the Trust's reconfiguration plans. It is at this point that certain goals become congruent insofar as the LTFM producing acceptable risk ratings in each of the years (as part of supporting acute reconfiguration affordability) and the TDA's FT preparatory application process.

There are implications of future regulation for each of the risk rating levels.

The latter point is important as the commencing risk rating for any year can change. Where this occurs, the level of intervention varies.



As can be seen, only the top level (or least risky) attracts a light touch regulatory response. Therefore, reaching a '3' should in most cases be regarded as a minimum acceptable level by most Trusts. The 2* rating is we believe a response to concerns from relatively stable FTs with large PFI assets. When the new rating system was being consulted upon, it was thought a number of these Trusts would be placed in the category of 2, thus prompting risk concerns from potential commercial partners aside from the inevitable involvement from the regulator. The Trust is not planning for this rating, but it is worth bearing in mind the context that most likely brought it about.

Current forecasts indicate that moving beyond a 3 within a model inclusive of a major privately financed infrastructure project, would push efficiency savings levels well beyond achievable levels and/or require a funding settlement from commissioners that goes beyond available resources. The risk regime in any event forces the Trust to produce surpluses that may appear counter-intuitive to commissioners (i.e. between 2-3% in some years).

3.0 The LTFM Model Outputs: BASE CASE

In preparation for its meeting on 28th November 2013, Trust Board members were given opportunities to consider planning documents in more detail especially given the 'decision point' regarding the affordability of a PF2 funded new hospital. In reaching a risk rating of 3, the draft LTFM continues to reflect the receipt of non-repayable PDC (public dividend capital) of £100m in order to satisfy the debt serving component of the CsRR. This is in addition to the original and on-going assumption regarding PFI tapering relief of 7.5% of capital value arising at the point of opening on a declining 5 year period (i.e. year 1 - 2.5%, year 2 – 2.0% and so on). These major variables together with CCG supported income assumptions, the Unitary Payment, revenue cost modelling and overall year on year cost reduction plans comprise the major components of the model. The next sections describe the content and output of the model and comprise the core information which supports future financial plans.

3.1 A summary of Income and surplus margins across the period

A significant part of the Trust's plans are based on income forecasts grounded in RCRH trajectories and planning assumptions by commissioners. These can be seen in Appendix 12 which shows Trust income and activity for the years 2013/14 and 2018/19 by CCG.

Sandwell and West Birmingham CCG together with the two Birmingham CCGs make up 80% of the Trusts clinical income. Sandwell & West Birmingham CCG is 65%, Birmingham Cross City CCG (11%), Birmingham South & Central CCG (4%), with the balance from other CCGs. This is an important metric in terms of securing strategic alignment and/or support from commissioning bodies.

The table below summarises the surplus margins which are required to deliver a Continuity of Service Risk Rating of, at least, a 3 in every year. The summarised I&E statement can be seen in Appendix 1 later in the document.

Future Years Forecast from 2013/14 I&E	2013/14 £m	2014/15 £m	2015/16 £m	2016/17 £m	2017/18 £m	2018/19 £m	2019/20 £m	2020/21 £m	2021/22 £m	2022/23 £m
Income	431.0	429.5	429.2	430.9	431.7	442.9	451.3	462.4	474.0	483.5
Pay	(289.9)	(284.8)	(278.0)	(271.3)	(265.2)	(258.0)	(258.1)	(266.6)	(273.9)	(277.4)
Non Pay	(115.1)	(118.3)	(122.1)	(121.9)	(123.4)	(137.1)	(140.9)	(146.3)	(151.0)	(156.0)
Non Recurrent Flexibility	-	(1.4)	(2.2)	(6.1)	(9.0)	(2.8)	(2.0)	-	-	-
EBITDA	25.9	25.0	26.9	31.6	34.2	45.1	50.4	49.4	49.1	50.1
Non Operating Costs	(21.3)	(21.9)	(23.4)	(25.5)	(25.5)	(38.5)	(44.3)	(45.2)	(45.8)	(44.8)
Technical Adjustments	-	-	-	-	(66.3)	(44.0)	-	-	-	-
Position Discounting Technical Issues	**4.6**	**3.1**	**3.5**	**6.0**	**8.7**	**6.5**	**6.1**	**4.2**	**3.3**	**5.3**
Surplus margin to Turnover	1.08%	0.73%	0.81%	1.40%	2.01%	1.48%	1.35%	0.91%	0.70%	1.10%

The Trust is required to grow its annual surpluses before and during the transfer to MMH as its liquidity position must improve in order to deliver a 3 rating. Thereafter, once a 3 rating is established, surpluses can reduce as long as working capital is managed and the capital programme requirements do not increase.

3.2 Inflation and Implied efficiency levels

Appendix 2 shows the implied efficiency levels that meet the Monitor Assessor Case levels and include prudent assumptions in respect of inflationary pressure on both income and expenditure. Section 4.2.1.5 outlines the rationale for the inflation assessment and resultant efficiency assumptions.

3.3 Efficiency savings

Appendix 3 shows the efficiency savings that reflect the challenge facing the organisation split between nationally driven efficiency targets / MMH affordability driven CIP requirements and changes required in accordance with RCRH transformation. Savings levels are measured against turnover and controllable costs, which is how the LTFM judges the relative proportion of savings required.

3.4 Confirmation of the Continuity of Service Risk Rating

Appendix 4 below shows the base case Continuity of Service Risk Rating (CsRR). The Trust delivers a minimum of a 3 rating in every year. However, the score relies upon a strong Capital Service Capacity rating across the years to MMH and thereafter, as this component of the metric becomes more difficult to achieve, the liquidity component must strengthen to enable a score of 3 to be achieved.

3.5 Forecast Balance Sheet

The Trust Balance sheet forecasts may be viewed within appendix 5. A number of events are occurring which impact across the timeline, including

- Impairing fixed assets relating to the existing estate.
- Introducing PDC support and treating the £100m as a prepayment to be released once practical completion occurs.
- Introducing MMH on to the balance sheet
- Reducing provisions over the timeline as project resources etc. are committed.

3.6 Cash balances

The Table below shows the cash balance positions which are anticipated to remain positive during the planning period. The summarised Cash Flow statement can be seen in Appendix 6. Improving cash balances are also a function of the strategy to improve annual cash backed surpluses to strengthen liquidity and thus sustain a 3 risk rating.

Cashflow	Future years forecasts								
	2014/15 £m	2015/16 £m	2016/17 £m	2017/18 £m	2018/19 £m	2019/20 £m	2020/21 £m	2021/22 £m	2022/23 £m
Net cash inflow / (outflow)	(5.0)	(4.0)	5.5	8.9	2.5	4.5	0.5	4.7	8.8
Cash Balance	21.8	17.8	23.3	32.2	34.7	39.1	39.6	44.3	53.1

3.7 Reserves, established to support service reconfiguration.

Reserves have been established to accommodate unforeseen events and to address costs associated with service reconfiguration. These vary over the period and range between 1.4% to 4.2% of turnover, although the upper level provides for post configuration double running cost.

3.8 Confirmation of the financial assumptions underpinning the shadow unitary charge and other payments

The Unitary Charge modelled within this position represents a ceiling in costs which the Trust is intending to refresh its Public Sector Comparator against. Therefore, the results contained within the LTFM represent the maximum considered affordable. It is envisaged that updated cost estimates will be contained within this planning envelope.

The Unitary Charge is forecast to be c£27m in the first full year of concession at the equivalent of 2019-2020 prices. These results are predicated against

- A capital build cost of c£285m
- Hard fm cost of c £30 per sqm
- Lifecycle cost of c £20 per sqm
- A 30 year concession
- Receiving the £100m PDC support on a non-repayable basis
- The current estimates are developed around 74,000 sqm's but depending upon options considered and other parameters within the calculations, c 79,000 may be affordable
- Funding terms consistent with recent PFI deals
- Index-able element of c.35% , indexed at 2.5% per annum from a 2013-2014 base.

The first 5 years accounting treatment of the baseline unitary payment can be seen within Appendix 7.

3.9 PDC and tapering relief assumption including an assessment of the impact on the unitary charge of not receiving PDC funding

Appendix 8 demonstrates the impact of non-receipt of the £100m PDC support. This is forecast to add c£9m to the annual unitary payment charge above current baseline levels. Additional funding streams including CIP would be needed to offset this additional cost. Part of the contribution to this would be avoiding the PDC dividend of c £3.5m

3.10 Confirmation of the affordable workforce numbers underpinning all financial forecasts.

Workforce volume changes are a function of the overall affordability modelling. Papers were presented to the October Trust Board outlining how the workforce transformation would need to be approached.

The changes that affect the cost base also impact on the number of staff employed by the trust. The table within Appendix 9 analyses changes to the workforce numbers arising from the base activity changes resulting from RCRH initiatives and demographic change, the impact of developments and the impact of future efficiency savings.

Key headlines show that WTE's reduce in the base position and cumulative developments increase the Trusts workforce by 586 by 2022/23 which lessens the impact of the required cumulative CIP reductions of 2,170 over the period.

Overall, WTEs reduce from 7048 to 5483. It should be noted that further workforce modelling is being undertaken which may repair some of this reduction when the impact of skill mix change is applied. It expected that this piece of work will be on-going to determine the future workforce service models that are sustainable and safe.

3.11 The Internal Capital Programme

There are many competing pressures within the capital programme. The Trust is seeking to invest beyond its traditional funding levels identified by its depreciation in most years. This investment requirement is reflected by,

- substantial Community estate refurbishment,
- investment in the IM&T/HIS strategy *(complimented by c£14 in revenue implementation)*
- Completing the acquisition of the Grove Lane site,
- Routine equipping needs,
- Minimising the investment required for statutory standards estate work.
- Initiating an Imaging managed service contract to alleviate pressure on the Capital Programme.

Appendix 10 shows the investment profile across the timeline.

3.12 The 12.5% Test

This test has received scrutiny following the NAO report into Peterborough's PFI scheme. The test seeks to confirm that "estates costs" do not exceed 12.5% of the Trust annual normalised income.

It remains unclear as to what the precise definition of "estates costs" represents. Therefore, two measures have been developed in consideration of the test.

Firstly, to assess the proportion of the full unitary charge compared to normalised turnover, and secondly, to include the unitary charge, non-MMH depreciation, PDC dividend and estates hard fm costs in comparison to normalised turnover. In both instances the Trust is able to meet the test successfully.

Appendix 11 demonstrates the components of the test and the result of the two approaches.

4.0 Background Financial Information

This section presents the historic financial performance and provides context to the inclusion of MMH within the financial strategy. The financial strategy itself is designed to:

- Provide flexibility to respond to changing patterns of demand and commissioner requirements.
- Enable risks and variations to the plan to be managed.
- Ensure compliance with the parameters set by Monitor for NHS Foundation Trusts.
- Incorporate the Trust's plan to acquire a new acute hospital by utilising the recently developed PF2 finance model.
- Support the operational management of the organisation.

As previously stated, the financial information and assumptions used within the Long-Term Financial Model (LTFM) are based upon the activity and capacity planning assumptions supporting the health economy wide Right Care Right Here (RCRH) programme. The model incorporates the main QiPP themes which seek to improve efficiency and productivity within healthcare.

4.1 Historical financial overview and financial strategy

Since 2006/07 the Trust has been delivering strong 'bottom line' surpluses (after adjusting for impairments and IFRS issues where appropriate) while meeting all other primary financial targets. Moreover, it has fully achieved cost improvement programme (CIP) targets, at least to the level assumed within national tariff efficiency expectations. Over the period 2010/11 to 2012/13 annual normalised surpluses (as measured against the DoH break even target) of £2.9m, £2.3m and £5.4m were delivered with a forecast £4.8m normalised surplus in 2013/14.

The Trust will endeavour to meet statutory standards in all of its premises; however, long-term investment will continue to reflect the plan for the new hospital and the complimentary estate. The Trust is planning for a significant refurbishment of its retained estate during the lifetime of its LTFM. The Trust intends to deliver The Midland Metropolitan Hospital (MMH) at Grove Lane assisted by the revised PFI scheme known as PF2, along with a supporting contribution of £100m of Public Dividend Capital (PDC) resources.

The following sections review in more detail the historic income and expenditure position, commencing in 2010/11, and include the current financial year forecasts to 31 March 2014. The tables included throughout this paper are extracts from the draft Long-Term Financial Model (LTFM).

4.1.1 Summary Income and expenditure statement

Table 1 shows the summarised income and expenditure statement for the period 2010/11 to 2012/13. The 2013/14 result is produced based upon the reported outturn position.

Table 1 – Summary Income and expenditure statement

Income and Expenditure	Actual 2010/11 £m	Actual 2011/12 £m	Actual 2012/13 £m	Forecast 2013/14 £m
Income				
NHS Clinical income	337.5	382.8	391.4	390.9
Non NHS Clinical income	0.2	0.3	0.6	0.5
Other Operating income	49.3	41.1	41.0	39.6
Total Operating Income	**386.9**	**424.1**	**433.0**	**431.0**
Expenditure				
Pay	(258.6)	(285.7)	(284.9)	(289.9)
Non Pay	(104.5)	(115.5)	(121.3)	(115.1)
Total Operating Expenses	**(363.1)**	**(401.2)**	**(406.3)**	**(405.1)**
Operational Surplus	**23.8**	**23.0**	**26.7**	**25.9**
Profit / loss on asset disposal	(0.2)	(0.2)	(0.1)	(0.2)
Impairment losses	(9.5)	2.4	(8.7)	-
Depreciation	(13.3)	(13.1)	(14.2)	(14.0)
Total interest receivable / (payable)	0.1	0.1	0.1	0.1
Total interest payable on loans / leases	(2.0)	(2.1)	(2.1)	(2.2)
PDC Dividend	(5.7)	(5.6)	(5.2)	(5.0)
Non Operating Costs	**(30.7)**	**(18.4)**	**(30.2)**	**(21.3)**
Surplus / (deficit) before tax	**(6.9)**	**4.5**	**(3.4)**	**4.6**
Add back technical adjustments	9.5	(2.4)	8.7	-
Revised Surplus / (deficit) before tax	**2.6**	**2.1**	**5.3**	**4.6**
Net Margin %	**-1.78%**	**1.07%**	**-0.79%**	**1.08%**

Earnings before interest, taxation, depreciation and amortisation (EBITDA) show a surplus from operations that ranges from £23.8m in 2010/11 to £27.9m in 2013/14. Impairment losses of £9.5m in 2010/11 and £8.7m in 2012/13 arose from a revaluation of the Trust's estate in line with national policy, which resulted in the reduction of the net book value of the assets on the balance sheet. This created technical deficits following the requirement to charge the value of the reduction to income and expenditure for the period. This has the effect of converting the operating surplus into a deficit for each of the years. However, if the effect of the impairments and exceptional items (Profit / (Loss) on asset disposals) was excluded, as it is an allowable offset within NHS accounting policy for measuring performance against DH targets, the Trust would have still achieved a net surplus across all years. In 2011/12, the Trust had the benefit of an impairment gain which increased the net surplus; however, by applying the same technical adjustment methodology as with impairment losses, the surplus was reduced to £2.4m.

On 1st April 2011, the Trust acquired community services previously provided by Sandwell PCT under the Transforming Community Services (TCS) programme. This resulted in an annual increase to turnover of £34.7m. The acquisition represented c.9% of turnover and was therefore below materiality thresholds. The effect of the transfer has marginally diluted the surplus margin, as the services were transferred on a break even basis.

4.1.2 Summary Statement of Financial Position

A summary of the Statement of Financial Position for the period 2010/11 to 2013/14, together with some explanatory commentary, is set out below.

Table 2 – Summary Statement of Financial Position

Statement of Financial Position	Actual 2010/11 £m	Actual 2011/12 £m	Actual 2012/13 £m	Forecast 2013/14 £m
Assets, Non Current	**218.2**	**229.5**	**219.0**	**224.9**
Assets Current				
Inventories	3.5	4.1	3.6	3.8
Receivables	11.6	12.9	9.4	9.0
Cash & cash equivalents	20.7	34.5	42.5	26.8
Other Financial Assets, Current (e.g. accrued income)	0.1	-	-	4.5
Prepayments, Current, non-PFI related	0.7	1.0	0.6	2.4
Assets, Current, Total	**36.6**	**52.5**	**56.2**	**46.4**
Assets Total	**254.8**	**282.0**	**275.2**	**271.3**
Liabilities Current				
Trade and other payables	(12.2)	(23.9)	(32.0)	(14.1)
Other	(27.6)	(26.4)	(24.5)	(37.8)
Liabilities, Current, Total	**(39.8)**	**(50.4)**	**(56.5)**	**(51.8)**
Net Current Assets / Liabilities	**(3.3)**	**2.1**	**(0.3)**	**(5.5)**
Borrowings	-	(7.0)	(3.0)	(1.0)
Other	(33.4)	(32.7)	(32.3)	(30.4)
Liabilities, Non-Current, Total	**(33.4)**	**(39.7)**	**(35.3)**	**(31.4)**
Total Assets Employed	**181.5**	**191.9**	**183.4**	**188.0**
Taxpayers Equity				
Public dividend capital	160.2	160.2	160.2	160.2
Retained earnings (Accumulated Losses)	(28.1)	(18.6)	(20.3)	(15.6)
Donated asset reserve	2.1	-	-	-
Revaluation reserve	36.6	41.2	34.4	34.4
Other reserves	10.7	9.1	9.1	9.1
Net Surplus	**181.5**	**191.9**	**183.4**	**188.0**

Non-current asset values have increased by £6.7m over the period reflecting the net impact of additions, depreciation, disposals and impairments. Large investments in recent years include purchasing land in Grove Lane for Midland Metropolitan Hospital and reconfiguration of maternity, neonatal and pathology services.

4.1.3 Current assets and liabilities

Current assets have increased over the period, from £36.6m in 2010/11 to £46.4 in 2013/14. The largest impact being the increase in our cash balances resulting from a combination of generation of surpluses providing cash benefit and a Department of Health loan to fund land purchase taken in 2011/12.

This is partially offset by a reduction in receivables which represents an improvement in our debtor collection processes. This has shortened average debtor days as income is received earlier than in previous years.

Current liabilities increased from £39.8m to £51.8m in 2013/14, £2m of which is in interest bearing borrowings relating to the £8m Department of Health loan which is repayable over four years.

The Trust recognises that it has historically operated with net current liabilities. This does create a Monitor risk factor, but indicates that it has converted its working capital into cash benefit, by collecting receipts due while managing payments to creditors.

Non-current liabilities have remained relatively static over the period. They did increase in 2011/12 due to the aforementioned receipt of the Department of Health capital loan to fund the purchase of the Grove Lane site. Additionally the liability in respect of the PFI for the Birmingham Treatment Centre is reducing in line with the contractual agreement and capital repayments occurring over the period.

Taxpayers' equity has fluctuated due to changes in retained earnings arising from the generation of surpluses and changes to the revaluation reserve arising from asset revaluations. The overall balance of taxpayers' equity has increased from £181.5m in 2010/11 to £188.0m in 2013/14.

4.1.4 Summary Cash Flow Statement

The Trust has seen a positive cash inflow from operating activities due to surplus generation and the improvement in working capital to 2012/13 with additional positive cash flow from the loan proceeds.

The forecast for 2013/14 is a cash outflow of £15.7m due in part to the capital programme which includes the continuation of the land purchase programme and a forecast reduction in provisions.

Table 3 – Summary Cash flow Statement

Cashflow	Actual 2010/11 £m	Actual 2011/12 £m	Actual 2012/13 £m	Forecast 2013/14 £m
Operational Surplus	23.8	23.0	26.7	25.9
Non Cash adjustments	(0.2)	0.4	0.6	(0.1)
Movement in Working Capital	10.5	4.1	6.4	(6.5)
Movement in Long term provisions	0.1	0.3	0.6	(0.6)
Net Cash Outflow from Operating Activities	**34.3**	**27.7**	**34.4**	**18.7**
Cash flow from investing activities				
Capital expenditure	(21.3)	(11.9)	(15.9)	(24.0)
Asset Sale proceeds	0.6	0.1	0.0	-
Cashflow before financing	**13.5**	**15.9**	**18.5**	**(5.3)**
Cashflow from financing activities				
Dividends paid	(5.0)	(5.6)	(5.6)	(5.0)
Interest paid	(2.0)	(2.1)	(2.1)	(2.2)
Interest received	0.1	0.1	0.1	0.1
Drawdown on loans and leases	-	8.0	-	-
Repayment of loans and leases	(1.8)	(2.6)	(3.0)	(3.3)
Net cashflow from financing	**(8.7)**	**(2.1)**	**(10.5)**	**(10.4)**
Net cash inflow / (outflow)	**4.8**	**13.8**	**8.0**	**(15.7)**
Cash Balance	**20.7**	**34.5**	**42.5**	**26.8**

4.2 Introduction to Financial Assumptions for future period

The previous section described the Trust's track record over the previous three, and current year in terms of income and expenditure, balance sheet and cash flow. This section is forward-looking insofar as it highlights some of the assumptions that are being used in the formulation for the draft LTFM.

The forward financial plan has been prepared recognising the 2013/14 Monitor Compliance Regime. This regime lays down criteria which identifies well performing, financially viable and sustainable service delivery and creates a discipline required to achieve successful compliance.

The Trust should seek to ensure a healthy balance sheet is maintained as well as delivery of a cumulative surplus on income and expenditure to allow flexibility in the coming years. Consequently, there is an intention to stabilise annual operational surpluses and to ensure they are cash backed. This approach will assist the Trust in funding MMH, coping with unforeseen circumstances, enable a period of consolidation and also provide flexibility as emerging clinical innovation requires. Furthermore, the financial planning parameters include a tight non PF2 internal capital programme covering MMH equipment and retained estate refurbishment.

The financial models and assumptions used in support of the LTFM derive much of their input from the 'Right Care Right Here' (RCRH) activity trajectories. These in turn, are linked to operational plans for wider healthcare activities. The Trust plans to maintain its surpluses and develop reserves, which would be aimed at levering in change and transition. By utilising these resources on a non-recurrent basis, funding any additional costs of the Grove Lane scheme is enhanced. From 2018/19, the costs associated with the new hospital and in particular the PFI unitary payment, are included within the

model and are funded from within internally generated sources. However, the LTFM is seeking to demonstrate that the new hospital is recurrently affordable and that the overall CIP requirement is marginally greater than current Monitor CIP assumptions.

The model assumes new revised PF2 funding mechanisms along with £100m of PDC support via Department of Health (DH) and Treasury approvals.

4.2.1 Future Income

Forecast future income is mainly driven by the factors outlined below and the Income by CCG is shown in Appendix 12.

4.2.1.1 Activity volumes

The activity model developed jointly with the Trust's SWBH-facing CCGs has been used to predict base future income projections.

Table 4 below shows future activity at Point of Delivery (POD) level.

Table 4 – Activity Trajectory

	10 Year Timeline											
	Forecast Outturn	Future Years									LTFM	2014/15 to
	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	Lifespan	2022/23
	000's	000's	000's	000's	000's	000's	000's	000's	000's	000's	000's	000's
Elective	50.3	50.8	50.7	50.1	50.2	50.7	51.3	51.9	52.5	53.1	2.7	2.2
Non elective	60.9	60.8	60.8	61.1	60.4	59.2	59.3	60.3	61.1	61.7	0.7	0.9
Outpatient	712.6	671.3	624.6	605.0	586.1	587.5	591.7	596.1	600.2	606.2	(106.4)	(65.0)
A&E	212.8	219.0	222.4	225.9	227.1	226.3	227.2	230.4	231.8	234.1	21.4	15.2
Other clinical - Tariff	-	-	-	-	-	-	-	-	-	-		
Other clinical - Non Tariff	16.5	17.2	18.1	18.1	18.1	18.1	18.1	18.1	18.1	18.1	1.6	0.9
Community Core Contacts	735.9	740.5	745.2	750.3	755.5	762.8	770.2	777.7	785.5	793.3	57.4	52.8
Community Contacts Developments	-	9.3	20.9	32.2	42.1	48.1	50.8	51.7	52.4	52.9	52.9	43.6

The Trust maintains an activity and capacity database which assists in analysing forecast movements occurring over the planning period.

Activity modelling combines:

- Amendments to model results across the future timeline, reflecting latest LDP contract performance (2013/14) compared with historic modelled expectations for this period. In effect, restating the activity baseline and thus any impact across the future nine year period.
- Some growth in activity as a result of increasing demand for the Trust's population, i.e. assumption of increased demand for short stay emergencies and as a result of demographic change.
- An anticipated transfer (loss) of activity (especially outpatient activity) to new primary care-based provider organisations. However a proportion is assumed to be retained by the Trust, but in a community rather than an acute setting.
- A loss of catchment to other local acute providers in line with health economy strategy, e.g. maternity births.

- A loss of catchment to other local acute providers reflecting the change in location due to transfer to the MMH new hospital.
- A prudent view of inpatient elective catchment loss from elective competition commencing in 2016/17.
- Decommissioning of inpatient Vascular, IR and major Trauma services to alternative acute providers.
- The provision by the Trust of a range of services (outpatients, diagnostics, day surgery, urgent care and intermediate care) in settings outside of an acute hospital. Many of these services will be covered by national PBR arrangements (e.g. outpatients, day surgery) and where appropriate national tariff has been used to forecast future income. Others (e.g. intermediate care, urgent care) have been the subject of local discussions and the Trust's base case includes income assumptions agreed with the Trust's main commissioners
- The development of alternative treatment pathways in community services to avoid hospital bed days and outpatient follow up attendances within the acute setting. This is a service model which is intended to grow over time to avoid work in the acute setting and enable on-going treatment closer to patients' homes. This mirrors national and local commissioning strategies
- The inclusion of community services integrated within the Trust should lead to long-term investment in this area as an enabling strategy to change/reduce demand on secondary care.
- The inclusion of health economy wide QiPP schemes to reflect commissioning intent, e.g. improving new to review follow up ratios, decommissioning certain elective procedures and minimising the impact of future emergency admissions by targeting reductions in average length of stay.
- Modest development growth in respect of new service provision. This covers service areas where we are confident, and have received commissioner agreement that resources will be targeted, e.g. health visitor growth, Behçet's Centre, Gynae-oncology and Stroke. Future development investment levels can be found within the development section of the LTFM and represent c.1% of annual contracted turnover.

4.2.1.2 Tariff assumptions

Tariff assumptions within the LTFM suggest a period of deflation will continue until 2019-2020 as part of the delivery of annual efficiency. Thereafter, tariff will stabilise and start to increase towards the end of the trajectory.

4.2.1.3 CQUIN funding

CQUIN funding is assumed to remain broadly in line with 2013/14 percentage levels and not exceed 2.5% over the plan period. The operating framework alluded to increases in the rate, to as much as 10% over time, however the phasing of the increase is not readily available. Therefore the Trust has been prudent in its assumptions and made no adjustment for growth.

4.2.1.4 Cost inflation

Pay-related inflation is modelled at relatively low levels, reflecting current trends. The Trust assumes the national pay award will grow but remain below the underlying rate of RPI until 2019-2020. Thereafter pay award may increase more in line with a c2.5% RPI expectation. Other pay increases associated with incremental uplift and consultant discretionary awards are modelled as cost pressure adjustments and therefore do not feature in the inflationary calculations, but do feature in consideration of the implied efficiency. This typically adds c 1% per annum to the annual pay bill.

Although the "Health Service Cost Index", (HSCI), suggests minimal inflationary pressure on drugs (September 2013 compared with September 2012) the Trust has modelled a growth of 5% per annum. This is additional to a volume growth of 2-3% built into baseline income forecasts. Taken together, this represents a material annual increase in income and cost to cover inflation, volume and latest NICE prescribing guidance.

Other areas of non-pay cover a broad spectrum of non-pay costs with differing component judgments of cost inflation. For example,

- Medical and Surgical purchases are running at an annual rate of c4% growth,
- Utilities, a growth of c8%
- x-ray films, a reduction of c-1%

The Trust has modelled a blended position which takes these elements into account. Future years assumptions predict reductions in non-pay cost inflation, although, levels remain relatively high.

PFI-estimated inflation has been applied to the unitary charge for expenditure in respect of the Birmingham Treatment Centre, as contractually the Trust is obliged to pay RPI indexation each year. Future RPI levels of between 3 and 2.5% have been modelled for the Unitary Payment (UP).

4.2.1.5 Implied efficiency metrics

The Trust is required to form its own view of future inflation trends / indices. Guidance is issued at the end of quarter 3, each year, indicating expectations for the forthcoming year. The inflation / deflation assessments must deliver an overall implied efficiency rate consistent with national expectations. The Trust is working to long range implied efficiency levels as directed by Monitor in April 2012. It is expected that updated guidance is imminent for 2014-2015 and may suggest a reduced implied efficiency requirement of c1% , to 4%.

Until this guidance is confirmed the Trust is working within the parameters of Monitor's 2012-2013 instruction. In effect this position may create a degree of "inflation contingency" in 2014-2015 , as judgments around tariff deflation and cost inflation have been developed to meet higher implied efficiency requirements than may prove to be required.

The existing assumptions and rationale is outlined below.

Table 5 - Monitor Implied Efficiency Requirements

	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
Monitor Stated Base Case Assumptions (April 2012)	5.0%	4.2%	4.2%	4.2%					
Monitor Stated Downside Case Assumptions (April 2012)	5.5%	5.5%	5.0%	5.0%					

Table 5 shows the net implied efficiency targets outlined by Monitor in early 2012-2013. These have been used as a baseline expectation for the period to 2017-2018. Thereafter no guidance has been issued and therefore the Trust has taken a view. The Trust has modelled implied efficiency reducing in the future years to 3.2% by the end of the period.

The method of calculation to determine the efficiency target applies the inflation / tariff deflation assumptions to the Trust's weighted-average normalised cost base. Table 6 below represents the inflationary assumptions incorporated within the LTFM.

The Trust has noted the contents of the Monitor letter dated April 2012 referring to the possibility of additional pressures which may reach 2% in any given period. However, after consideration of each of the examples provided within the letter, the Trust has formed the following view:

- The potential for non-reimbursement for emergency readmissions within 30 days of discharge following an initial episode of elective care: The Trust considers that this risk is inherent within the base case and therefore is already accounted for within the financial model. The Trust has not incurred penalties associated with this risk in the past and aims to maintain this position.

- The 30% marginal tariff for non-elective procedures: In opposition to national trends, the Trust has successfully adopted RCRH themes and strategies which have reduced emergency activity. The Trust therefore considers that as actual levels of activity currently fall well below the threshold that was set in previous years, it is protected against the risk of over performing to the extent that it breaches the threshold, and therefore the risk of attracting the 30% marginal cost rate are mitigated and the risk is very small.

- Tariff flexibility that allows providers and commissioners to agree in exceptional circumstances variations from tariff prices below the national published price: The Trust has considered this risk and believes that this issue is already reflected within the base case model. The health economy-wide RCRH strategy already provides for local agreements to levels of activity and local pricing, and is already integral to current contracting negotiations and risk sharing arrangements with main commissioners.

Any further future flexibility will always be achieved by a process of negotiation, and the relationship with our commissioners is well established in consideration of the overall health-economy strategy.

Table 6 – Summary Inflation Assumptions

	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
Income									
Elective	-2.1%	-1.5%	-1.3%	-1.3%	-1.0%	0.0%	0.3%	0.5%	0.5%
Non Elective	-2.1%	-1.5%	-1.3%	-1.3%	-1.0%	0.0%	0.3%	0.5%	0.5%
Outpatients	-2.1%	-1.5%	-1.3%	-1.3%	-1.0%	0.0%	0.3%	0.5%	0.5%
A&E	-2.1%	-1.5%	-1.3%	-1.3%	-1.0%	0.0%	0.3%	0.5%	0.5%
Other Clinical Non Tariff	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Other Block Cost & Volume (Community	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Other Income - Private Patients	-2.1%	-1.5%	-1.3%	-1.3%	-1.0%	0.0%	0.3%	0.5%	0.5%
Other Income - Education & Training	-2.1%	-1.5%	-1.3%	-1.3%	-1.0%	0.0%	0.3%	0.5%	0.5%
Other Income - Research & Development	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Other Income - Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Expenditure	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Pay	1.0%	1.0%	1.3%	1.3%	1.5%	2.5%	2.5%	2.8%	2.8%
Drugs	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
Clinical Supplies & Services	5.5%	4.0%	4.0%	4.0%	3.0%	3.0%	3.0%	3.0%	3.0%
Shared Services	5.5%	5.5%	5.3%	5.0%	4.8%	4.0%	4.0%	4.0%	4.0%
CNST Premium	5.5%	5.5%	5.3%	5.0%	4.8%	4.0%	4.0%	4.0%	4.0%
Other Costs	5.5%	5.5%	5.3%	5.0%	4.8%	4.0%	4.0%	4.0%	4.0%
PFI Indexation	3.0%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%
Capex Inflation	3.0%	3.0%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%

There are indications that efficiency assumptions set for 2014-2015 will be slightly less onerous than the ones assumed above. Consultation suggests the overall efficiency target set for 2014-2015 will be set at a net 4% with tariff deflation at c1.9% and cost inflation averaging c2%. If this is represented in the guidance for 2014-2015 then the indices currently in the base position suggest some contingency may exist in the future or flexibility may exist to reduce cost inflation estimates. However, if the overall implied levels of efficiency modelled in the LTFM is maintained and cost inflation indices going forward reduce to a weighted average around 2%, then it is likely tariff deflation may be greater than modelled. In this case, adjustment between cost inflation and income deflation will approximately "net off" and the underlying position will remain the same.

4.2.2 Transformational Saving Plans (TSPs)

The Trust has planned to make efficiency savings which incorporate three elements:

- Marginal cost variations associated with the RCRH activity changes.
- Cost reductions required to offset the impact of the implied national efficiency assumptions outlined above.
- Cost reductions against existing fixed costs to fund the costs associated with MMH.

The Trust does not operationally separate out the three elements, in recognition that the cost reductions required under the elements need the same processes and principles applied in order to be effective. The Trust therefore refers to its overall efficiency programme as the Transformation Plan (TP) in recognition that the programmes are transformational in nature.

The detail of the TP can be found in individual schemes referred to as TSPs (Transformation Savings Plans). These are commonly known as line by line CIPs.

The LTFM however, deals with the elements in different ways:

- The marginal cost variations are shown within base case expenditure, and the annual change associated with activity movement is identified as average growth/reduction. This is then identifiable within the bridge analysis.
- The national CIP element is reported separately as this is an area that Monitor focuses on and is a key output from the financial model.
- Cost reductions in existing Estate and infrastructure costs to enable the transfer of the funds to fund the future PFI costs associated with the new hospital.
- Additional CIP to meet the shortfall associated with the new hospital is treated the same as national CIP.

During the planning period there are changes in levels of activity in particular areas, e.g. outpatients where significant reductions in levels of activity is forecast. However, these are offset by growth in other areas so the overall impact of RCRH activity/income changes in net terms are minimal.

The LTFM has been produced using the assumption that all TP targets will be met. The Trust recognises that the scale of CIPs required is a significant challenge, albeit no more than that facing many other NHS organisations over the next few years. It further recognises that financial flexibility has been squeezed in previous years and that the challenge becomes more difficult in the future because savings cannot be achieved in the same way that they have been previously. Therefore, future CIPs must come from service reconfiguration and service redesign with significant input, and indeed ownership from clinicians to ensure that safety and quality are not compromised. To demonstrate the Trust's recognition of the scale of the challenge, it has invested in a Transformation Support Office to facilitate and co-ordinate the process and develops systems for measuring the impact of each of the schemes in both financial and non-financial measures. Only when schemes are able to satisfy the tests may they proceed.

Historic achievement of CIPs provides assurance that systems and processes are in place to manage the challenge.

5.0 Challenges and Key Deliverables that support LTFM results

In general terms the areas of significant challenge, but challenges that must be met in reaching a conclusion regarding the deliverability of the plan and hence affordability of the acute reconfiguration plans are:

- Delivering the transformational savings to the levels required.
- Maintaining high quality care through the transformation whilst workforce numbers are reducing.
- Growing sufficient surpluses to deliver a base case 3 rating.
- Minimising the capital spend (or remaining within planned levels) to maximise liquidity.
- Managing the change in clinical activities and the new service models.
- Managing the PSC review to ensure updated unitary charge assessments are contained within the financial envelope set within the LTFM.
- Minimising the cost of MMH to maximise affordability, including assuming a 15% impairment on the MMH asset and accounting for the asset over 60 years.
- Developing arrangements with CCG partners for long term investment levels and risk sharing arrangements
- National efficiency assumptions are assumed to reduce over the LTFM timeline.
- Introducing an Imaging MES service.
- Mitigating a downside position by additional savings and deferring capital programme needs without destabilising service provision.

6.0 Conclusions

This paper seeks to highlight the regulatory risk factors applicable to the 10 year model, present the output from the model, describe historical financial results, and summarise key planning assumptions and challenges/key deliverables.

The Trust Board is asked to:

RECEIVE the paper and detailed appendices

NOTE and AGREE the assumptions supporting the base case including Revenue estimates (income & expenditure), MMH capital planning values and resultant annual unitary payment, year on year efficiency requirements, cash flows and balance sheet forecasts.

CONCLUDE that the successful delivery of the planning assumptions and management of key issues and challenges when reflected within a 10 year LTFM returns a sustainable financial result and a pre-consulted upon and agreed Continuity of Risk Rating of 3.

Robert White, Director of Finance & Performance Management

Appendix – 1- Headline SOCI, discounting technical adjustments.

Statement of Comprehensive Income	Forecast 2014/15 £m	Forecast 2015/16 £m	Forecast 2016/17 £m	Forecast 2017/18 £m	Forecast 2018/19 £m	Forecast 2019/20 £m	Forecast 2020/21 £m	Forecast 2021/22 £m	Forecast 2022/23 £m
Income									
NHS Clinical income	389.2	389.9	391.6	392.6	395.6	406.2	418.8	432.0	443.0
Non NHS Clinical income	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5
Other Operating income	39.9	38.8	38.8	38.6	46.8	44.7	43.1	41.6	40.1
Total Operating Income	**429.5**	**429.2**	**430.9**	**431.7**	**442.9**	**451.3**	**462.4**	**474.0**	**483.5**
Expenditure									
Pay	(284.8)	(278.0)	(271.3)	(265.2)	(258.0)	(258.1)	(266.6)	(273.9)	(277.4)
Non Pay	(119.7)	(124.3)	(128.0)	(132.4)	(139.9)	(142.9)	(146.3)	(151.0)	(156.0)
Total Operating Expenses	**(404.5)**	**(402.3)**	**(399.3)**	**(397.5)**	**(397.8)**	**(400.9)**	**(413.0)**	**(424.9)**	**(433.3)**
Operational Surplus	**25.0**	**26.9**	**31.6**	**34.2**	**45.1**	**50.4**	**49.4**	**49.1**	**50.1**
Profit / loss on asset disposal	-	-	-	-	-	-	-	-	-
Impairment losses	-	-	-	(66.3)	(44.0)	-	-	-	-
Depreciation	(14.4)	(14.8)	(15.6)	(15.9)	(14.0)	(15.8)	(16.7)	(17.0)	(16.4)
Total interest receivable / (payable)	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Total interest payable on loans / leases	(2.1)	(2.1)	(2.2)	(2.1)	(18.6)	(23.4)	(23.2)	(23.3)	(23.1)
PDC Dividend	(5.5)	(6.5)	(7.8)	(7.6)	(6.0)	(5.2)	(5.4)	(5.5)	(5.4)
Non Operating Costs	(21.9)	(23.4)	(25.5)	(91.8)	(82.5)	(44.3)	(45.2)	(45.8)	(44.8)
Surplus / (deficit) before tax	3.1	3.5	6.0	(57.6)	(37.4)	6.1	4.2	3.3	5.3
Add back technical adjustments	-	-	-	66.3	44.0	-	-	-	-
Revised Surplus / (deficit) before tax	**3.1**	**3.5**	**6.0**	**8.7**	**6.5**	**6.1**	**4.2**	**3.3**	**5.3**
Net Margin %	**0.73%**	**0.81%**	**1.40%**	**2.01%**	**1.48%**	**1.35%**	**0.91%**	**0.70%**	**1.10%**

Appendix – 2- Inflation and Implied Efficiency Expectations.

Future Inflation Assumptions	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
Income									
Tariff Behaviour	-2.10%	-1.50%	-1.30%	-1.30%	-1.00%	0.00%	0.25%	0.50%	0.50%
Other	0	0	0	0	0	0	0	0	0
Pay	1.00%	1.00%	1.30%	1.30%	1.50%	2.50%	2.50%	2.75%	2.75%
Drugs	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%
Clinical Supplies	5.50%	4.00%	4.00%	4.00%	3.00%	3.00%	3.00%	3.00%	3.00%
Other Costs	5.50%	5.50%	5.25%	5.00%	4.75%	4.00%	4.00%	4.00%	4.00%
Capital Costs	3.00%	3.00%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%

	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
LTFM Implied Efficiency Assessment (Annual)	4.9%	4.2%	4.2%	4.2%	3.9%	3.6%	3.3%	3.2%	3.2%

Appendix - 3 – Transformational Savings Trajectory.

TSP TRAJECTORY	2013/14 £m	2014/15 £m	2015/16 £m	2016/17 £m	2017/18 £m	2018/19 £m	2019/20 £m	2020/21 £m	2021/22 £m	2022/23 £m
Income	5.5	1.7	2.0	-	-	-	-	-	-	-
Pay	8.8	13.1	11.7	13.8	13.9	14.0	14.4	9.4	9.4	9.4
Non Pay	5.1	5.2	4.3	5.2	5.4	5.5	5.6	3.6	3.6	3.6
Sub Total	**19.3**	**20.0**	**18.0**	**19.0**	**19.3**	**19.5**	**20.0**	**13.0**	**13.0**	**13.0**
Other Movements inc RCRH / Bed Plan Disinvestment / EDAT,Agency Reductions and Tariff Adjustment	**0.2**	**0.0**	**3.7**	**2.5**	**2.4**	**2.6**	**0.1**	**0.1**	**-**	**-**
Baseline View of TSP Implications	**19.6**	**20.0**	**21.7**	**21.5**	**21.7**	**22.1**	**20.1**	**13.1**	**13.0**	**13.0**
% of Turnover	**4.5%**	**4.7%**	**5.0%**	**5.0%**	**5.0%**	**5.0%**	**4.5%**	**2.8%**	**2.7%**	**2.7%**

LTFM says										
CIP Value	**19.3**	**20.0**	**18.0**	**19.0**	**19.3**	**19.5**	**20.0**	**13.0**	**13.0**	**13.0**
Total in-year CIPs as a percentage of turnover	**4.5%**	**4.7%**	**4.2%**	**4.4%**	**4.5%**	**4.4%**	**4.4%**	**2.8%**	**2.7%**	**2.7%**
Total in-year CIPs as a percentage of costs	**4.6%**	**4.9%**	**4.5%**	**4.9%**	**5.2%**	**5.4%**	**5.6%**	**3.7%**	**3.7%**	**3.7%**
LTFM considers CIP (Not TSP) v Controllable Operating Costs)										

Appendix – 4: Continuity of Service Risk Rating- (Base Case).

CsRR in the base case LTFM	Outturn 2013/14	Forecast 2014/15	Forecast 2015/16	Forecast 2016/17	Forecast 2017/18	Forecast 2018/19	Forecast 2019/20	Forecast 2020/21	Forecast 2021/22	Forecast 2022/23
Liquidity ratio (days)										
Current assets	56.2	46.4	41.1	70.4	107.9	149.6	51.9	56.5	57.1	61.9
Inventories	3.6	3.8	3.8	3.8	3.8	3.8	3.3	3.3	3.3	3.3
PFI prepayments and assets held for sale	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Current liabilities	(55.5)	(51.8)	(49.9)	(52.2)	(52.0)	(79.1)	(56.2)	(59.2)	(58.5)	(56.3)
Days	360.0	360.0	360.0	360.0	360.0	360.0	360.0	360.0	360.0	360.0
Operating expenses	(405.1)	(404.5)	(402.3)	(399.3)	(397.5)	(397.8)	(400.9)	(413.0)	(424.9)	(433.3)
Fully Committed Working Capital Facility (+)										
Liquidity ratio (days) - opening liquidity	**(2.6)**	**(8.2)**	**(11.3)**	**13.0**	**47.2**	**60.3**	**(6.9)**	**(5.3)**	**(3.9)**	**1.9**
Capital servicing capacity (times)										
Interest payable (-ve)(£m)	(2.2)	(2.1)	(2.1)	(2.2)	(2.1)	(18.6)	(23.4)	(23.2)	(23.3)	(23.1)
Debt repayment (-ve)(£m)	(3.3)	(3.0)	(2.0)	(1.3)	(0.9)	(102.2)	(3.2)	(3.0)	(3.5)	(3.4)
PDC dividend (-ve)(£m)	(5.0)	(5.5)	(6.5)	(7.8)	(7.6)	(6.0)	(5.2)	(5.4)	(5.5)	(5.4)
PDC repayment (-ve)(£m)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Surplus/(Deficit) from operations	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Adjustment for donated asset income	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
EBITDA	25.8	25.0	26.8	31.5	34.1	45.0	50.3	49.3	49.0	50.0
Interest receivable (+ve)(£m)	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Surplus available	25.9	25.1	26.9	31.5	34.2	45.1	50.4	49.4	49.1	50.2
Capital servicing capacity (times)	**2.5**	**2.4**	**2.5**	**2.8**	**3.2**	**0.4**	**1.6**	**1.6**	**1.5**	**1.6**
Scoring - (uses opening liquidity)										
Liquidity ratio score	**3**	**2**	**2**	**4**	**4**	**4**	**3**	**3**	**3**	**4**
Capital servicing capacity score	**3**	**3**	**4**	**4**	**4**	**1**	**2**	**2**	**2**	**2**
OVERALL Continuity of Service Risk Rating (CSRR)	**3**	**3**	**3**	**4**	**4**	**3**	**3**	**3**	**3**	**3**

Appendix -5- Balance Sheet

Statement of Financial Position	Forecast 2014/15 £m	Forecast 2015/16 £m	Forecast 2016/17 £m	Forecast 2017/18 £m	Forecast 2018/19 £m	Forecast 2019/20 £m	Forecast 2020/21 £m	Forecast 2021/22 £m	Forecast 2022/23 £m
Assets, Non Current	**229.4**	**237.9**	**238.6**	**163.3**	**413.2**	**414.7**	**413.9**	**406.9**	**399.8**
Assets Current									
Inventories	3.8	3.8	3.8	3.8	3.3	3.3	3.3	3.3	3.3
Receivables	8.7	8.6	7.3	6.8	7.1	7.2	7.4	7.4	7.6
Cash & cash equivalents	21.8	17.8	23.3	32.2	34.7	39.1	39.6	44.3	53.1
Other Financial Assets, Current (e.g. accrued income)	4.5	4.5	4.5	4.5	4.5	4.5	4.5	4.5	4.5
Prepayments, Current, non-PFI related	2.4	35.7	69.0	102.4	2.4	2.4	2.4	2.4	2.4
Assets, Current, Total	**41.1**	**70.4**	**107.9**	**149.6**	**51.9**	**56.5**	**57.1**	**61.9**	**70.8**
Assets Total	**270.5**	**308.3**	**346.6**	**312.9**	**465.1**	**471.1**	**471.1**	**468.8**	**470.6**
Liabilities Current									
Trade and other payables	(14.2)	(17.2)	(18.0)	(18.3)	(19.0)	(22.2)	(21.5)	(19.9)	(20.3)
Other	(35.7)	(35.0)	(34.0)	(60.8)	(37.3)	(37.0)	(37.0)	(36.4)	(35.9)
Liabilities, Current, Total	**(49.9)**	**(52.2)**	**(52.0)**	**(79.1)**	**(56.2)**	**(59.2)**	**(58.5)**	**(56.3)**	**(56.2)**
Net Current Assets / Liabilities	**(8.8)**	**18.2**	**55.9**	**70.5**	**(4.3)**	**(2.7)**	**(1.3)**	**5.6**	**14.5**
Borrowings	-	-	-	-	-	-	-	-	-
Other	(29.4)	(28.1)	(27.2)	(2.5)	(215.0)	(212.0)	(208.5)	(205.1)	(201.6)
Liabilities, Non-Current, Total	**(29.4)**	**(28.1)**	**(27.2)**	**(2.5)**	**(215.0)**	**(212.0)**	**(208.5)**	**(205.1)**	**(201.6)**
Total Assets Employed	**191.2**	**228.0**	**267.3**	**231.3**	**193.8**	**199.9**	**204.1**	**207.5**	**212.8**
Taxpayers Equity									
Public dividend capital	160.2	193.6	226.9	260.2	260.2	260.2	260.2	260.2	260.2
Retained earnings (Accumulated Losses)	(12.5)	(9.0)	(3.0)	(60.6)	(98.0)	(91.9)	(87.7)	(84.4)	(79.1)
Donated asset reserve	-	-	-	-	-	-	-	-	-
Revaluation reserve	34.4	34.4	34.4	22.6	22.6	22.6	22.6	22.6	22.6
Other reserves	9.1	9.1	9.1	9.1	9.1	9.1	9.1	9.1	9.1
Net Surplus	**191.2**	**228.0**	**267.3**	**231.3**	**193.8**	**199.9**	**204.1**	**207.5**	**212.8**

Appendix – 6- Cashflow.

Cashflow	Future years forecasts								
	2014/15 £m	2015/16 £m	2016/17 £m	2017/18 £m	2018/19 £m	2019/20 £m	2020/21 £m	2021/22 £m	2022/23 £m
Operational Surplus	25.0	26.9	31.6	34.2	45.1	50.4	49.4	49.1	50.1
Non Cash adjustments	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.2)	(0.1)	(0.1)	(0.1)
Movement in Working Capital	(0.7)	(33.3)	(28.7)	(29.4)	98.8	0.1	(0.4)	(0.2)	(0.2)
Movement in Long term provisions	-	-	-	-	-	-	-	-	-
Net Cash Outflow from Operating Activities	**24.3**	**(6.5)**	**2.7**	**4.6**	**143.8**	**50.3**	**49.0**	**48.8**	**49.8**
Cash flow from investing activities									
Capital expenditure	(18.8)	(20.2)	(19.3)	(18.6)	(14.6)	(14.2)	(16.9)	(11.9)	(9.2)
Asset Sale proceeds	-	-	-	-	-	-	-	-	-
Cashflow before financing	**5.5**	**(26.7)**	**(16.6)**	**(14.0)**	**129.1**	**36.1**	**32.1**	**36.9**	**40.6**
Cashflow from financing activities									
PDC capital received	-	33.3	33.3	33.3	-	-	-	-	-
Dividends paid	(5.5)	(6.5)	(7.8)	(7.6)	(6.0)	(5.2)	(5.4)	(5.5)	(5.4)
Interest paid	(2.1)	(2.1)	(2.2)	(2.1)	(18.6)	(23.4)	(23.2)	(23.3)	(23.1)
Interest received	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Drawdown on loans and leases	-	-	-	-	-	-	-	-	-
Repayment of loans and leases	(3.0)	(2.0)	(1.3)	(0.9)	(102.2)	(3.2)	(3.0)	(3.5)	(3.4)
Net cashflow from financing	**(10.5)**	**22.8**	**22.1**	**22.8**	**(126.6)**	**(31.7)**	**(31.5)**	**(32.2)**	**(31.8)**
Net cash inflow / (outflow)	**(5.0)**	**(4.0)**	**5.5**	**8.9**	**2.5**	**4.5**	**0.5**	**4.7**	**8.8**
Cash Balance	**21.8**	**17.8**	**23.3**	**32.2**	**34.7**	**39.1**	**39.6**	**44.3**	**53.1**

Appendix -7- Baseline Shadow Unitary Charge Estimate.

The Shadow Base Unitary Charge

			First Five Years of MMH Concession				
BASE CASE			**2018/19**	**2019/20**	**2020/21**	**2021/22**	**2022/23**
			£m	**£m**	**£m**	**£m**	**£m**
MMH Revised Size: 74,300m2							
MMH Revised Capex Target: £293.2 million, £285m plus bidder costs.							
PDC Contribution £100m							
Indexable %		35%					
Interest Rate Buffer Margin		0.05%					
Memorandum - unitary charge allocation							
	Unitary charge		(20.1)	(27.0)	(27.3)	(27.5)	(27.8)
	Finance lease creditor repayment		0.9	2.1	2.3	2.5	2.7
	Finance lease creditor interest		16.4	21.2	21.2	21.1	21.1
	Operating costs		2.7	3.7	3.8	3.9	4.0
	MMH Depreciation charge		3.1	4.2	4.2	4.2	4.2
	First Full Year Variance						
	I&E Element						
	Capital Repayment						
Construction Start Date		01/02/2016					
Construction End Date		30/07/2018					
Services Start Date		01/08/2018					
Services End Date		31/07/2048					

Appendix -8- Downside Shadow Unitary Charge Estimate.

The Shadow Downside Unitary Charge

First Five Years of MMH Concession

DOWNSIDE CASE	2018/19	2019/20	2020/21	2021/22	2022/23
	£m	£m	£m	£m	£m
MMH Revised Size: 74,300m2					
MMH Revised Capex Target: £293.2 million, £285m plus bidder costs.					
NO PDC Contribution £100m					
Indexable %	35%				
Interest Rate Buffer Margin	0.05%				
Memorandum - unitary charge allocation					
Unitary charge	(26.8)	(36.0)	(36.4)	(36.7)	(37.1)
Finance lease creditor repayment	4.5	2.9	3.1	3.4	3.7
Finance lease creditor interest	19.5	29.4	29.4	29.4	29.4
Operating costs	2.7	3.7	3.8	3.9	4.0
MMH Depreciation charge	3.1	4.2	4.2	4.2	4.2
Full Year Var to Base		(9.0)			
I&E Element		8.2			
Capital Repayment		0.8			

Appendix 9 – Workforce (WTE) forecasts.

Pay Related Movements	10 Year Timeline: WTE Workforce									
	Outturn	Future Years								
	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
	Wte's	Wte's	Wte's	Wte's	Wte's	Wte's	Wte's	Wte's	Wte's	Wte's
Base Position										
Consultants	279	287	287	281	279	270	267	267	265	261
Junior Medical Staff	474	466	453	438	425	408	415	406	398	388
Nursing - Acute	2,454	2,487	2,384	2,237	2,113	1,986	1,980	1,953	1,893	1,850
Nursing - Community	517	492	479	458	434	409	380	367	357	337
Scientific / Prof & Tech	1,119	1,083	1,041	1,002	958	935	907	892	875	851
Non Clinical	2,083	1,973	1,859	1,739	1,622	1,430	1,341	1,286	1,246	1,181
Agency	121	74	58	53	50	47	40	36	33	30
Sub Total	**7,048**	**6,862**	**6,561**	**6,208**	**5,882**	**5,485**	**5,330**	**5,206**	**5,066**	**4,897**
Developments										
Consultants	-	2	4	6	10	12	14	16	20	23
Junior Medical Staff	-	2	4	7	11	14	17	19	23	27
Nursing - Acute	-	16	34	55	84	103	119	138	168	188
Nursing - Community	-	-	19	41	68	97	127	156	189	223
Scientific / Prof & Tech	-	8	17	28	42	52	60	70	85	95
Non Clinical	-	3	6	9	14	17	19	22	27	30
Agency	-	-	-	-	-	-	-	-	-	-
Sub Total	**-**	**31**	**84**	**146**	**229**	**295**	**356**	**422**	**511**	**586**
Combined										
Consultants	279	289	290	287	289	282	281	283	285	284
Junior Medical Staff	474	468	458	446	436	422	431	425	421	415
Nursing - Acute	2,454	2,504	2,418	2,291	2,197	2,089	2,099	2,091	2,061	2,037
Nursing - Community	517	492	498	499	502	506	507	523	546	560
Scientific / Prof & Tech	1,119	1,091	1,058	1,029	1,001	987	968	962	959	946
Non Clinical	2,083	1,976	1,865	1,748	1,636	1,447	1,360	1,308	1,273	1,211
Agency	121	74	58	53	50	47	40	36	33	30
Sub Total	**7,048**	**6,893**	**6,645**	**6,354**	**6,111**	**5,780**	**5,686**	**5,628**	**5,577**	**5,483**
Indicative CIP Impact Annual		**(258)**	**(226)**	**(271)**	**(288)**	**(284)**	**(246)**	**(205)**	**(199)**	**(194)**
Indicative CIP Impact Cumulative		**(258)**	**(484)**	**(755)**	**(1,043)**	**(1,327)**	**(1,573)**	**(1,777)**	**(1,976)**	**(2,170)**

Appendix 10 – The Internal Trust Capital Programme

Maximum Capital Investment Trajectory	**2013/2014 MMH Modelled**	**2014/2015 MMH Modelled**	**2015/2016 MMH Modelled**	**2016/2017 MMH Modelled**	**2017/2018 MMH Modelled**	**2018/2019 MMH Modelled**	**2019/2020 MMH Modelled**	**2020/2021 MMH Modelled**	**2021/2022 MMH Modelled**	**2022/2023 MMH Modelled**	**Period**
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Land	2.89	2.02	2.46	1.48	0.45	0.00	0.00	0.00	0.00	0.00	9.29
Capitalised Salaries & Slippage	0.50	0.50	0.50	0.50	0.50	0.50	0.50	0.50	0.50	0.50	5.00
Statutory Standard	4.37	3.00	3.00	1.60	1.60	0.55	0.55	0.55	0.55	0.55	16.32
Strategic Investment	4.28	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	4.28
Contingency	1.99	1.50	1.40	1.58	0.75	0.75	0.00	0.00	0.00	0.00	7.97
Sub Total	**14.02**	**7.02**	**7.36**	**5.17**	**3.30**	**1.80**	**1.05**	**1.05**	**1.05**	**1.05**	**42.86**
Retained Estate Refurbishment	0.00	2.00	3.29	2.09	2.09	2.74	7.88	6.22	0.00	0.00	26.30
Site Demolitions	0.00	0.78	0.78	0.78	1.83	0.78	0.00	0.00	1.05	0.00	6.00
City Site Demolitions before Sale.	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Sub Total Retained Estate	**0.00**	**2.78**	**4.07**	**2.87**	**3.92**	**3.52**	**7.88**	**6.22**	**1.05**	**0.00**	**32.30**
IM&T Investment Routine	1.83	2.00	2.00	2.00	2.00	2.00	1.80	2.00	2.00	2.00	19.63
IM&T-EPR & MMH	0.00	3.49	5.56	2.02	4.03	0.64	0.00	0.00	0.00	0.00	15.74
Sub Total IM&T	**1.83**	**5.49**	**7.56**	**4.02**	**6.03**	**2.64**	**1.80**	**2.00**	**2.00**	**2.00**	**35.38**
Medical Equipment	4.65	3.00	3.00	3.00	3.51	2.93	4.05	4.05	4.05	4.35	36.59
MMH Specifics (Inc Imaging)	0.00	0.00	0.00	0.00	16.00	2.00	0.00	0.00	0.00	0.00	18.00
Discount for Imaging MSC	0.00	0.00	0.00	0.00	-16.00	0.00	0.00	0.00	0.00	0.00	-16.00
Sub Total Medical Equipment	**4.65**	**3.00**	**3.00**	**3.00**	**3.51**	**4.93**	**4.05**	**4.05**	**4.05**	**4.35**	**38.59**
Revised Capital Programme Position	**20.51**	**18.29**	**21.98**	**15.05**	**16.75**	**12.89**	**14.78**	**13.32**	**8.15**	**7.40**	**149.12**

Appendix 11 – The 12.5% Test

Analysis of Estates cost against 12.5% Maximum Target

	13/14	14/15	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Turnover:										
Recurrent	430,977	429,545	429,173	430,866	431,741	442,910	451,316	462,387	474,007	483,477
Non Recurrent	-	-	-	-	-	-	-	-	-	-
Total	**430,977**	**429,545**	**429,173**	**430,866**	**431,741**	**442,910**	**451,316**	**462,387**	**474,007**	**483,477**
Maximum value of estates costs (12.5% of Total Turnover)	*53,872*	*53,693*	*53,647*	*53,858*	*53,968*	*55,364*	*56,414*	*57,798*	*59,251*	*60,435*
Maximum value of estates costs (12.5% of Recurrent Turnove	*53,872*	*53,693*	*53,647*	*53,858*	*53,968*	*55,364*	*56,414*	*57,798*	*59,251*	*60,435*
Total Estates Costs										
Group 1 : PFI Specific Costs										
PFI Interest	2,115	2,120	2,138	2,243	2,096	18,628	23,353	23,183	23,312	23,104
Capital Repayment	1,029	998	1,017	1,306	903	2,151	3,207	3,037	3,514	3,419
Facilities Management (Operating Charge)	1,100	1,232	1,303	1,021	1,685	4,084	5,363	6,087	5,872	6,577
Total PFI Charges	**4,244**	**4,350**	**4,458**	**4,570**	**4,684**	**24,863**	**31,923**	**32,307**	**32,698**	**33,100**
Expressed as a % of turnover	***0.98%***	***1.01%***	***1.04%***	***1.06%***	***1.08%***	***5.61%***	***7.07%***	***6.99%***	***6.90%***	***6.85%***
In Excess of recommended 12.5%	-	-	-	-	-	-	-	-	-	-
Group 2 : Estates Costs Excl Soft FM										
PFI Interest	2,115	2,120	2,138	2,243	2,096	18,628	23,353	23,183	23,312	23,104
Capital Repayment	1,029	998	1,017	1,306	903	2,151	3,207	3,037	3,514	3,419
Facilities Management (Operating Charge)	1,100	1,232	1,303	1,021	1,685	4,084	5,363	6,087	5,872	6,577
Depreciation Excluding MMH Build	13,405	13,852	14,325	15,066	15,413	10,398	11,164	12,054	12,368	11,745
PDC Dividend	5,027	5,480	6,477	7,763	7,598	5,966	5,203	5,441	5,521	5,445
Estates Building Related	956	956	956	956	956	956	367	367	367	367
Estates Engineering Related	2,561	2,561	2,561	2,561	2,561	2,561	1,176	1,176	1,176	1,176
Estates General Related	564	564	564	564	564	564	169	169	169	169
Estates Grounds Related	192	192	192	192	192	192	171	171	171	171
Total Group 2 : Estates Costs Excl Soft FM	**26,949**	**27,955**	**29,534**	**31,672**	**31,968**	**45,500**	**50,173**	**51,685**	**52,470**	**52,173**
Expressed as a % of turnover	***6.25%***	***6.51%***	***6.88%***	***7.35%***	***7.40%***	***10.27%***	***11.12%***	***11.18%***	***11.07%***	***10.79%***
In Excess of recommended 12.5%	-	-	-	-	-	-	-	-	-	-

Appendix - 12 – Income by CCG.

SANDWELL & WEST BIRMINGHAM HOSPITALS NHS TRUST
HIGH LEVEL SUMMARY OF INCOME & ACTIVITY BY CCG

Category	Sandwell & West Birmingham CCG		Bham Cross City CCG		Bham South & Central CCG		All Other CCGs		ALL CCGs Total	
	£m		£m		£m		£m		£m	
	13/14	18/19	13/14	18/19	13/14	18/19	13/14	18/19	13/14	18/19
INCOME										
A&E Incl Urgent Care	13.8	15.7	2.6	2.9	1.1	1.2	1.9	2.3	19.4	22.1
Day Cases	18.3	23.0	3.9	4.7	1.4	1.7	5.6	6.9	29.2	36.3
Elective IP	15.2	12.5	3.0	2.6	0.9	0.8	3.4	2.7	22.6	18.6
Elective Sub total	*33.5*	*35.5*	*6.9*	*7.4*	*2.3*	*2.5*	*9.1*	*9.6*	*51.8*	*54.9*
Non Electives	77.2	81.3	10.2	11.5	3.6	4.1	8.5	9.3	99.5	106.2
OCL	39.1	46.1	8.8	9.7	2.4	2.7	44.9	49.7	95.2	108.1
OP First	15.5	15.4	4.1	4.2	1.3	1.3	4.2	4.7	25.0	25.6
OP Follow Up	20.4	16.6	5.3	4.6	1.7	1.6	7.1	7.1	34.4	29.9
OPPROC	3.9	4.6	1.0	1.2	0.4	0.4	0.6	0.7	5.8	6.9
Maternity - Total	13.2	15.1	1.9	2.2	0.5	0.6	0.1	0.1	15.8	18.0
Outpatient Sub total	*52.9*	*51.7*	*12.3*	*12.2*	*3.8*	*3.9*	*12.0*	*12.6*	*81.0*	*80.4*
Community (TCS)	28.5	33.1	1.4	2.1	0.0	0.3	9.1	10.9	39.1	46.4
TOTAL INCOME EXCLUDING MFF	**245.0**	**263.3**	**42.2**	**45.8**	**13.2**	**14.6**	**85.5**	**94.4**	**386.0**	**418.0**
Adjustments to the above										
MFF	6.5	4.2	1.1	0.7	0.4	0.2	1.9	1.2	10.0	6.4
Adjustment for Drugs (re LAT)	3.9	3.9	-	-	-	-	(3.9)	(3.9)	-	-
TOTAL INCOME	**255.4**	**271.4**	**43.4**	**46.5**	**13.6**	**14.8**	**83.6**	**91.7**	**396.0**	**424.4**
Net Tariff Deflator Estimate	*(3.3)*	*(14.6)*	*(0.5)*	*(2.4)*	*(0.2)*	*(0.9)*	*(1.1)*	*(10.9)*	*(5.1)*	*(28.7)*
INCOME AFTER TARIFF DEFLATOR	**252.1**	**256.7**	**42.8**	**44.1**	**13.4**	**14.0**	**82.5**	**80.8**	**390.9**	**395.6**
	000's		000's		000's		000's		000's	
Activity										
A&E Incl Urgent Care	151.7	161.7	28.3	29.9	11.4	12.1	21.4	22.6	212.8	226.3
Day Cases	24.9	27.5	5.7	6.2	1.9	2.1	7.7	8.2	40.2	43.9
Elective IP	6.9	4.5	1.4	0.9	0.4	0.3	1.4	1.0	10.1	6.7
Elective Sub total	31.8	32.0	7.1	7.1	2.3	2.4	9.1	9.2	50.3	50.7
Non Electives	85.6	84.5	14.2	13.9	5.1	5.0	8.0	7.7	112.9	111.2
OCL	55.0	57.8	10.6	11.0	3.3	3.4	34.2	35.2	103.2	107.5
OP First	129.7	121.3	35.8	34.8	9.9	9.5	26.9	26.5	202.2	192.1
OP Follow Up	286.8	203.3	69.3	51.2	19.9	16.4	74.8	62.0	450.9	332.9
OPPROC	30.4	32.2	6.1	6.5	2.3	2.4	3.9	4.1	42.7	45.2
Maternity - Total	14.1	14.6	2.1	2.2	0.4	0.4	0.2	0.2	16.8	17.3
Outpatient Sub total	461.0	371.4	113.4	94.7	32.5	28.7	105.8	92.8	712.6	587.5
Community (TCS)	524.0	595.0	21.5	22.7	0.5	0.5	190.0	195.4	735.9	813.6
TOTAL ACTIVITY	**1,309.1**	**1,302.4**	**195.1**	**179.4**	**55.1**	**52.1**	**368.5**	**363.0**	**1,927.8**	**1,896.9**

Appendix – 13 – Model Detailed Assumptions and Risks

1. Activity

1a. Assumptions

Forecast changes to activities across all currencies are embedded from partnership work undertaken under the umbrella of the RCRH Partnership. This has been updated by historic Better Care Better Value indicators and top decile peer performance indicators from 2011-2012.

These assumptions were refined in 2012-2013 resulting in Version 5.7A of the Activity & Capacity model. The results were shared with commissioners as the Trust developed its application for Foundation status in 2012-2013.

The 2013-2014 baseline LDP proposal has updated the new base for the outturn year in the LTFM. The future year's trajectory has taken this base and adjusted the results to proportionally align with the modelling principles in the version 5.7A model.

The analysis below provides a more in-depth explanation of the modelling approach and inherent assumptions,

Taking each year in turn,

2012-2013

Income and activities have been generated from year to date actual performance to December, 2012. A forecast has been developed on this performance to reflect a year end view.

2013-2014

Working papers, developed by colleagues in preparation for the 2013-2014 contracting round, have been used to predict the 2013/2014 contractual expectations. These also represent the changes in tariff currencies and structures. These assumptions have replaced the previous v5.7 RCRH Activity Model assumptions for this year.

2014-2015 through to 2021-2022

The baseline for future years stems from version 5.7 of the Activity & Capacity Model, as broadly agreed with Commissioners in April 2012(detailed assumptions will be outlined below). However, where actual performance / anticipated contract proposals for 2013/14 are materially different an adjustment has been made to the future trajectory to reflect an updated informed view of the future.

This is most noticeable in a number of areas,

- New Tariff Structures have been introduced for all Maternity Services in 2013-2014 so their impact has been mapped as best possible,
- 2012-2013 actual performance is generally greater than contracts/ RCRH models expected and thus the overall baselines were raised slightly moving into 13/14 thus creating a ripple effect across the trajectory,
- New Contract Lines have been introduced (e.g. Unbundled Imaging , c£4.8m) but some lines have been reduced or removed,
- No TFF (Transitional Support) is currently within the updated position.

RCRH Modelling Principles

Core clinical practice modelling changes are kept stable, building upon the historic RCRH principles/rules and refining them for latest knowledge, recognising progress has already been made over the last few years which effects assumptions moving forward.

SWBH remains committed to a long-term strategy of a new acute hospital solution and retaining ownership of the BTC, BMEC (including Sheldon Block), residual core Sandwell Treatment Centre facilities and Rowley Regis Hospital. It is intended to consolidate services provided by SWBH largely within these locations.

V5.7 Modelling assumes the following:

- Catchment loss/Choice associated with the new acute hospital has been deferred to start in 2017/18 through to 2019/20.
- Demography data has been updated to 2010/11 ONS statistics.
- Future demand across categories follows previous RCRH assumptions, notably minimal growth in elective cases and only emergency growth in short length of stay patients.
- All rules relating to the creation of Intermediate care or the avoidance of bed days have remained, with minor adjustments in recognition that some progress has already been made in reducing length of stay or removing bed days by successful bed closure initiatives.
- Existing Outpatient devolution rules are retained but are now based upon updated baseline outpatient volumes forecast for 2013/2014.
- Historic Top decile review of new outpatient targets is retained reflecting a target for transformation savings consistent with work undertaken by the Trust and ATOS in 2011/2012.
- New rules have been developed to reflect the transfer of vascular inpatients and major trauma services to UHB.
- Specific outpatient growth has been applied consistent with previous modelling.
- Rules have been developed around community bed day alternatives attributing a proportion of this avoided bed related activity to additional community related contacts provided by SWBH SCHS.
- Rules regarding Urgent Care and A&E attendances have been refined. Urgent Care currently not performed by SWBH is assumed to remain outside of SWBH remit. However, SWBH has reclassified minor A&E casemix as Urgent Care undertaken by SWBH in Sandwell and Rowley locations.
- Assessment of “Other Contract lines” has removed no longer contracted for elements and added new ones based upon 2013/2014.
- Some growth has been applied to Community service to reflect a view of selective growth in Health Visiting etc.

Category Specific Assumptions/Rules

Admitted Patient Care

Admitted Patient Care is made up of Elective Inpatients and Day Cases, Emergencies and a new category, Intermediate Care, denoting cases moving into community beds. Listed below are the key Stages that make up the hierarchy for Admitted Patient Care and a summary of the modelling assumptions currently applied.

Demography

Demography assumptions have been updated to reflect the latest ONS data forecasts at PCT level until 2020/21. HOB and Sandwell have specifically applied judgements at age range level. All other PCT's have had Sandwell's demography changes applied as a default.

Generally, the overall impact of applying demography is 1% per annum uplift to activity for the modelling period.

Growth Assumptions

Growth has been specifically applied as follows:

- Emergencies: A 2% per annum increase has been applied to short stay emergency spells staying less than 2 days. No increase has been applied to emergency cases staying longer than 2 days
- Electives: No elective growth is applied to most specialties as the judgment on demographic change is assumed to cover any increase.
- Ophthalmology, Orthopaedics, Neurology and Rheumatology and Gynae-Oncology all have an annual increase of 3% applied in recognition of past activity trends.
- Generally growth assumptions have been kept low consistent with previous RCRH agreements.

Efficiency & Community Driven Initiatives

Avoided Admissions

With the recent change in HRG casemix from version 3.5 to 4 a review has been undertaken of the potential HRG's which may be avoided in the acute setting in the future. In some instances 87% of grouped HRG's may be avoided with a reducing scale to grouped HRG's where around 3% may be avoided.

The modelling assumes that approximately 100% of the acute avoided admissions are cared for in and by Primary care providers.

Elective Inpatients to Day Cases

Further acute efficiency measures target patients with less than two day lengths of stay and aims to move them to day cases thus reducing bed requirements. Judgements of target percentage that can transfer are defined by HRG.

Excess Bed Days

A significant element of SWBH efficiency measures is represented by the target to reduce excess bed days for patients staying less than 30 days by 50% over the modelling period once rehabilitation patients have been transferred to community locations.

Best Practice LOS

HRG's have been targeted through work previously undertaken by Teamwork, where there is potential to reduce LOS to national standards. Modelling assumes best practice standards are achieved over the period.

Bed day savings in the acute hospitals are re-provided proportionately, 37.5% as Beds, 37.5% as Alternative Initiatives (Community Contacts) and 25% as planned to not be re-provided.

Rehabilitation and Intermediate Care

All inpatient care at Rowley Regis site is reclassified as Intermediate Care as the site is reclassified a community location. In addition to this, all acute cases with a length of stay over 28 days are assumed to transfer to community locations from day 21. Of this cohort of activity, it is assumed for non Hob related patients,

- 60% of historic bed days will be re-provided in the form of community beds,
- 15% would be re-provided by bed alternative measures in community,
- 25% would not be re-provided.
- For what were HoBtPCT related patients no bed days are re-provided as beds as they are all assumed to go into primary care.

Choice / Elective Competition

A prudent judgement has been applied over the period 2015/16 to 2018/19 where, with the exception of Gynae-oncology and Ophthalmology, an assumption of a 10% reduction to elective inpatients has been modelled, assuming an impact of lost work through patient choice, competition or catchment change.

Catchment Changes to Emergency Activities

Specialties have been assessed to consider the impact of catchment changes as acute services move from City and Sandwell sites.

With the exception of Obstetrics and Ophthalmology, 11% of emergency adult activity from the City site is assumed to transfer to other providers once the new acute site is available. All specialties are assumed to lose 11% of emergency activity as Sandwell acute activity is re-sited to the new acute site.

Activity Trend Results: Admitted Patient Care

APC - Electives

The overall impact of RCRH change on electives over the period is minimal and the activity shows a stable trajectory. Any loss in activity (i.e. services for T&O and Vascular) and best practice LOS assumption is offset by demography growth. The cumulative change over the period is an increase of 1007 cases.

APC – Emergencies

Similarly with emergencies the overall net impact of RCRH change is minimal and the activity shows a stable trajectory with almost no net growth in Spells per annum from 13/14 onwards. Any loss in activity and best practice LOS assumption is offset by demography growth. The overall movement in activity over the period is 81 cases, driven from the forecast outturn for 12/13. However, any increased volumes of activity is predicted to be seen in the short stay casemix, rather than longer stay patients, as improvements in services available for clinical decision making are enhanced. Investment levels rise though, due to the increase in new investment in respect of the separation of Intermediate care services.

In summary RCRH principles plan to stem the impact of growth in future years, rather than making significant reductions to existing activity levels.

However, catchment loss from 2017/18 to 2019/20 does reflects a reduction of c12,975 spells, approximately half of which are offset by other growth assumptions and by 2021/22 growth assumptions have completely repaired the loss witnessed over the three years.

Outpatients

Demography/Growth Assumptions

Demography assumptions are consistent with Admitted Patient Care and thus most specialties assume a circa 1% growth per annum.

Some specialties have seen much greater demand over recent years and receive the same growth as elective inpatients, circa 3%. Ophthalmology has an annual increase of 5%. Cardiology and Paediatrics assume a 4% growth on new outpatients.

For some specialties new to review ratios are less efficient than best practice performance. Where this is the case reductions have been made to follow up's assuming efficiencies will be achieved during the modelling period, consistent with targets assessed within the Transformation agenda.

Some specialties have been re-sited fully in the latest rules in one year rather than applying a tapering effect.

Activity Trend Results: Outpatients

Outpatients including OPPROCs show a decline in attendances over the period 2013/14 to 2018/19. The cumulative reduction over the period is 125,116 attendances, of which 118,025 are review attendances, largely driven by the need to improve new to review ratios and the rules written in the modelling to assume efficiencies through transformation. The total reduction in attendances has been offset to some extent by demography growth. Some of these attendances are expected to become a new demand for SCHS, approximately 40,000 are assumed to become new community contacts.

A&E / Urgent Care

Growth Assumptions

A standard growth assumption of 2% per annum has been applied additional to the 1% growth for demography.

Urgent Care

Activities currently classified as Urgent Care and no longer provided by SWBH are assumed to remain provided in that manner. Any subsequent movements between A&E and Urgent Care are assumed to be within the control and remit of SWBH. All SWBH provided Urgent Care is then assumed to be provided within Community locations owned by the Trust over time.

Activity Trend Results: A&E

Growth is c18,186 attendances across the LTFM period. From 2014/15 through to 2016/17 annual growth is c3000 attendances, but catchment loss occurs and nullifies growth over the period of MMH implementation.

Community Services

Growth Assumptions

Minor demography changes and a growth in Health Visitors investment have been applied.

One area of growth applied reflects a judgment of the impact of “community bed alternatives” bed day avoidance on SCHS. It is assumed every avoidable bed day considered by SCHS would lead to one contact priced at c£110 per contact. Furthermore, significant existing review outpatient volumes are targeted to be channelled towards SCHS to provide on-going community support.

Activity Trend Results: Community Services

The community contacts show gradual increase in the number of contacts of c4.6k to 7.9k per annum. The cumulative increase over the period is c57k contacts on a base of 736,000 contacts. This growth is attributable to demography. The activity presented here excludes development growth in community contacts for Outpatients and alternative bed day initiatives

1b. Risks and Mitigations

The future activity changes are generated by reference to historic benchmarks and RCRH partnership definition. Risks include,

- Benchmark standards suggest all specialties will be performing to top decile standards.
- Capacity is determined by achieving these transformations in performance.
- Benchmark standards are subject to change.
- Transformational change is central to affording the change and coping within the capacity identified, in particular,
    i. Reducing length of stay
    ii. Converting elective inpatients to day cases
    iii. Transforming outpatient activities into alternative pathway treatments
    iv. Comprehensively integrating acute into community care
    v. Managing demand on the Trust along with CCG partners.
- Developing new approaches to contracting for Intermediate Care and alternatives to outpatient care need to mature with commissioner support.

Mitigations

Activity modelling will continue with annual updates to baselines and assumptions. Thus variances from plan will be understood and remedial action where appropriate will be identified.

As part of the Assurance process consideration has been given to how the Trust might cope if actual delivery differs from assumed delivery. In most cases the Trust has sufficient flexibility to handle these results.

2. COSTS

The Cost forecasts included in the model are derived by a combination of top down cost modelling and specific cost calculations for known events. The approach is outlined below,

a. **2013-2014 Forecast Outturn:** A forecast outturn, based upon year to date performance to the end of June forms the base for future cost forecasts. This outturn has been reviewed at the end of quarter 2 and the Trust remains on course to deliver the outturn predicted at quarter 1.

b. **2014-15 to 2022-23 Core Operation Costs:** The Trust has developed cost modelling which predicts future behaviour by department based largely upon changes to activities. This creates a view of functional (departmental) costs required for given levels of activity. This is described in LTFM format.

c. **Specific strategic decisions**: Additional to the Trust's baseline operation costs are investments planned and approved annually for a fixed term or permanent basis. These investment decisions are profiled separately and include,

   i. **Investment in flexible bed provision:** this is assumed to be temporary with a tapering withdrawal of bed provision as average length of stay reduces.

   ii. **Investment in EDAT services:** new investment has occurred in 2013-2014, with a full year impact in 2014-2015. It is assumed to be withdrawn once MMH is operational.

   iii. **Investment in IM&T support systems and networks**: increases annual running cost for IM&T but areas are still assumed to make their share of efficiency savings

   iv. **Investment in Community services including Health Visiting**

d. **Service Developments:** The Trust has modelled new income growth and has assigned assumed costs to this growth. These assumptions have been shared with commissioners. A significant margin is assumed which is directed to support the additional cost of the MMH PF2 scheme.

e. **PFI Costs:** The existing BTC PFI costs are increased by the introduction of MMH mid-year in 2018-2019**.** The calculation of the components of the Unitary Charge for MMH is based upon a reduced footprint of MMH compared with the 2010-11 position and unit costs for hard fm and lifecycle have been reduced to align with obtained benchmarks. Funding terms are taken from the latest schemes to achieve Financial Close, but enclose a small buffer of 0.5%. Inflation indices have been used to forecast the Unitary Payment from 2018-2019 onwards. Given the number of variables, certainty surrounding the Unitary Charge value will only be determined around Financial Close. Hence the values must be viewed as indicative.

f. **Dual Running Costs**: A provision for dual running costs is included across 2018-19 to 2020-21. The provision is funded by the assumption that taper relief, traditionally available under PFI, will continue to be available under PF2. The provision earmarks support for estate related costs as infrastructure changes.

3. CIP /TSP

Delivery of the TSP programme across the trajectory is fundamental to affordability. The cumulative savings levels are historically unprecedented and are driven by national efficiency expectations, changes required through RCRH changes and additional savings to afford the MMH additional overhead costs.

General risks include,

a. CIP Income: CCG's may not commit to affording these additional income levels on a recurrent basis or may stage investment over a longer time frame. This income level is additional to the service developments element in the above section.

b. CIP Costs levels remain around 5% per annum over a significant part of the timeline. The Trust has detailed plans for 2014/15 and 2015-2016 TSPs but whilst the Trust is showing significant increases in the level of savings from 2016/17, there are no details in place which detail how these savings will be achieved.

c. National efficiency expectations are assumed to reduce as the timeline progresses. TSP levels remain high to afford additional MMH costs.

d. Workforce reductions have been modelled and consideration has been given to areas where opportunities exist to make savings as services consolidate through MMH.

e. Agency spend is expected to reduce significantly, partly offset by conversion to substantive posts.

4. **Workforce**: assumptions within the LTFM show a net reduction of c1,300 WTEs over the timeline. The transparency of where these reductions will be achieved and the impacts arising from the reductions is contained with the Workforce Redesign paper submitted to Trust Board in October 2013. The impact of workforce change is determined within the TSP plans for the next two years. Thereafter, the definition focuses on the impact MMH will have on consolidated services. Work is on-going to develop approaches to workforce re-design.

5. **PDC Support £100m:** The case builds in the support of £100m PDC to assist with financing the new hospital development. The downside impact of not achieving the funding place an additional annual financial impact of c£9m on the Trust.

6. **Commissioner Support**: The Trust is sighted on the clinical case for change and remains committed to the RCRH partnership strategy. The Trust's main Commissioner has indicated that there are significant financial constraints on future funding arrangements and whilst this risk has been reflected in the RCRH assumptions within the model, the landscape for these RCRH assumptions is changing.

7. **Risk Rating (CsRR):** The Trust can remain within the financial governance parameters set by the NHS Foundation Trust regime through a period of major service change – the base case LTFM achieves a CsRR rating of at least a 3 over the plan period. However there is limited room for manoeuvre in terms of the strength of the rating. In the early trajectory years the Trust is reliant upon a strong Capital Service Capacity score to deliver the overall rating. As the MMH scheme comes on line the Trust needs to improve its Liquidity score as delivery through Capital Service Capacity is harder to achieve. Improving liquidity requires strong surpluses and careful timing of investments in the capital programme. If this criterion is not met, the Trust will struggle to deliver a 3 rating.

8. **Capital costs for MMH:** have changed significantly over the recent months, arising from increases in the assumptions relating to inflation, financing and Vat. These changing assumptions have resulted in significant changes to the scheme and Community Estate as follows:

- a reduction in the size of the car park.
- retention of the Education Centre at the Sandwell site facilities, negating the requirement for a MMH build.
- re-aligning hard FM and lifecycle costs per sqm.
- further aspirational cost reductions seeking to solve for a capex value around £285m.

1. **Capital Programme:** An assumption of an Imaging MES scheme to cover c £16m Imaging capital need has been introduced from 2018-2019. This avoids the need for this to be funded from the Trust's capital but this remains an assumption at this point. The MES scheme has been treated as an operating lease, however, there is a risk that the accounting treatment may change requiring the creation of a finance lease and a higher resultant charge to expenditure.

10. **MMH Asset Life and Valuation:** An assessment of 15% impairment has been included in modelling. Work is on-going to validate this view with the District Valuer. Given the nature of the PFI contract and the condition of the building envisaged at the end of 30 years an asset life of 60 years has been adopted. No future indexation has been applied to the asset post opening as recent experience suggests any indexation is offset by the Trust's annual request for an asset revaluation process.

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Midland Metropolitan Hospital Monitoring and Status Report**
SPONSOR (EXECUTIVE DIRECTOR):	**New Hospital Project Director**
AUTHOR:	**Graham Seager Director of Estates/New Hospital Project Director**
DATE OF MEETING:	**November 2013**

EXECUTIVE SUMMARY:

Sandwell and West Birmingham Hospitals NHS
NHS Trust

Midland Metropolitan Hospital Status Report
November 2013

Activities Last Period

- Long term work force assurance work completed
- Long term financial modelling completed
- Architectural refresh being finalised
- Further engagement with DH /NHSTDA
- Plan for procurement phase developed
- Nearing vacant possession of Grove Lane site
- Demolition of contaminated/ unsafe structures in progress
- PF2 Value for Money assessment being undertaken

Planned Next Period

- Initiate approval process with NHSTDA
- Achieve vacant possession of Grove Lane
- Progress Grove Lane site demolition plan
- Agree PF2 commercial documentation with HMT
- Initiate bidders for pre market engagement
- Refresh procurement documentation
- Agree final approval process

Issues for Resolution/Risks for Next Period

Final approvals and commissioner support before agreement advertise scheme in OJEU

REPORT RECOMMENDATION:

Discuss and Accept status report

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:
The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
X		X

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***

Financial	X	Environmental	X	Communications & Media	
Business and market share		Legal & Policy		Patient Experience	X
Clinical		Equality and Diversity		Workforce	

Comments:

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

21st Century Facilities

PREVIOUS CONSIDERATION:

None

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	**Foundation Trust Programme Monitoring and Status Report**
SPONSOR (EXECUTIVE DIRECTOR):	**Mike Sharon, Director of Strategy and Organisational Development**
AUTHOR:	**Mike Sharon, Director of Strategy and Organisational Development**
DATE OF MEETING:	**28 November 2013**

EXECUTIVE SUMMARY:

The report gives an update on:

- Activities this period
- Activities next period
- Issues for resolution and risks in next period

REPORT RECOMMENDATION:

To review the planned activities and issues that require resolution as part of the FT Programme

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
x		

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***

Financial	x	Environmental	x	Communications & Media	x
Business and market share	x	Legal & Policy	x	Patient Experience	x
Clinical	x	Equality and Diversity	x	Workforce	x

Comments:

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

'Becoming an effective organisation' and 'Achieving FT Status'

PREVIOUS CONSIDERATION:

Routine monthly update

FT Programme Monitoring Status Report

Amber

Activities Last Month

- Final cut detailed CIPs for 2014/15 & 2015/6 including evidence of QIAs
- External consultant commenced review of Groups' governance procedures
- Board to Board with Deloitte
- Information sessions (for members) scheduled on the roles & responsibilities of Governors and the formation of a Shadow Council of Governors
- Individual Board member coaching commenced

Planned Next Month

- Commence redevelopment of IBP
- Commence refresh of Membership, Workforce and Clinical strategies
- Board undertake BGAF & QGAF self-assessment
- Outcome of strategic communications review

Issues for Resolution/Risks for Next Month

- Continue to make progress on A&E target in line with rectification plan to NTDA
- Plan agreed to address 18 weeks performance

Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD

DOCUMENT TITLE:	Monitor Risk Assessment Framework
SPONSOR (EXECUTIVE DIRECTOR):	Robert White, Director of Finance and Performance Mgt
AUTHOR:	Mike Harding, Head of Performance Management
DATE OF MEETING:	28 November 2013

EXECUTIVE SUMMARY:

Monitor introduced its Risk Assessment Framework for NHS Foundation Trusts with effect from 1 October 2013. This replaces its previous Compliance Framework. The range of indicators utilised by Monitor within this framework feature within the Access, Outcomes and Quality Governance categories of the Corporate Performance Report. The Access and Outcome metrics used by Monitor have thresholds identified and weightings attributed, and are reflected in the attached. The principal differences between the Access and Outcome metrics aligned to the Risk Assessment Framework, compared with the 'Service Performance' metrics within the previous Compliance Framework, is that meeting the MRSA Bacteraemia objective no longer features and weightings assigned to Cancer 31-day waits and Access to Healthcare for People with a Learning Disability have been increased.

Monitor will also track indicators of quality governance; trends in a number of staff/patient metrics, e.g. satisfaction ratings, turnover and absenteeism. An overall Governance Rating is generated by:

- Performance against selected national access and outcomes standards
- CQC judgements on quality of care
- Third Party information
- Other information available to reflect quality governance
- Degree of risk to continuity of services and other aspects of risk relating to financial governance

Access and Outcome metrics will be formally monitored quarterly. A potential governance concern is triggered by; an aggregate weighted score is 4.0 or more, or by failing the same indicator for at least 3 consecutive quarters or by breaching the A&E waiting times target in two quarters over any four-quarter period and in any additional quarter over the subsequent three quarters.

During the month the Trust underperformed against the Emergency Care 4-hour wait target, but met the required thresholds for each of the other weighted Access and Outcomes indicators. As such the overall weighted score for the month is 1.0, which attracts an AMBER / GREEN Governance Rating. The Trust is projected to meet performance thresholds for all high level RTT and Cancer targets for the month.

REPORT RECOMMENDATION:

The Trust Board is asked to NOTE the report.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:

The receiving body is asked to receive, consider and:

Accept	Approve the recommendation	Discuss
x		

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***

Financial	x	Environmental	x	Communications & Media	
Business and market share		Legal & Policy	x	Patient Experience	x
Clinical	x	Equality and Diversity		Workforce	

Comments:

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

High Quality Care and An Effective NHS Foundation Trust.

PREVIOUS CONSIDERATION:

Performance Management Committee, Clinical Leadership Executive and Finance & Investment Committee

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST - MONITOR RISK ASSESSMENT FRAMEWORK ACCESS AND OUTCOME METRICS 2013/2014 (w.e.f. October 2013)

INDICATOR	MEASUREMENT	WEIGHT		Metrics Effective October 2013 mapped to earlier performance: July 2013 / 14	August 2013 / 14	September 2013 / 14	Quarter 2 2013 / 14	October 2013 / 14	November 2013 / 14	December 2013 / 14	Quarter 3 2013 / 14	NARRATIVE
Clostridium Difficile	No. of Infections	1.0	Actual	5	3	4	12	2				There were 2 cases of C Diff reported during the month of October, compared with a trajectory for the month of 4. During the year to date 24 cases have been reported, below the trajectory for the period of 28.
			[Target]	[4]	[4]	[4]	[12]	[4]	[4]	[4]	[12]	
				■	■	▼	■	▲				
Cancer - 2 weeks; either												
All Cancers	% patients	1.0	Actual	94.0	95.5	93.9	94.4					Performance since April 2010 has met the 93.0% operational threshold, and is expected to have been maintained at this level.
			[Target]	[93.0]	[93.0]	[93.0]	[93.0]	[93.0]	[93.0]	[93.0]	[93.0]	
				▲	▲	▼	▲	■				
or		or										
Symptomatic breast patients	% patients	1.0	Actual	96.2	96.6	97.8	96.8					Performance since July 2011 has met the 93.0% operational threshold, and is expected to have been maintained at this level.
			[Target]	[93.0]	[93.0]	[93.0]	[93.0]	[93.0]	[93.0]	[93.0]	[93.0]	
				▲	▲	▲	▲	■				
Cancer - 31 days	% patients	1.0	Actual	100	100	99.4	99.8					Performance since April 2010 has met the 96.0% operational threshold, and is expected to have been maintained at this level.
All Cancers: 31-day wait from diagnosis to first treatment			[Target]	[96.0]	[96.0]	[96.0]	[96.0]	[96.0]	[96.0]	[96.0]	[96.0]	
				▲	■	▼	▲	■				
Cancer - 31 days; either												
Wait for second / subsequent treatment	% patients	1.0	Actual	100	100	99.0	99.7					Performance since April 2010 has met the 94.0% operational threshold, and is expected to have been maintained at this level.
- surgery			[Target]	[94.0]	[94.0]	[94.0]	[94.0]	[94.0]	[94.0]	[94.0]	[94.0]	
				▲	■	▼	▲	■				
or		or										
Wait for second / subsequent treatment	% patients	1.0	Actual	100	100	100	100					Performance since January 2013 has met the 98.0% operational threshold and is expected to be maintained at this level.
- anti cancer drug treatments			[Target]	[98.0]	[98.0]	[98.0]	[98.0]	[98.0]	[98.0]	[98.0]	[98.0]	
				■	■	■	■	■				
or		or										
Wait for second / subsequent treatment	% patients	1.0	Actual	n/a	n/a	n/a	n/a					Performance since April 2010 has met the 94.0% operational threshold, and where appropriate is expected to be maintained at this level.
- radiotherapy			[Target]	[94.0]	[94.0]	[94.0]	[94.0]	[94.0]	[94.0]	[94.0]	[94.0]	
				■	■	■	■	■				
Cancer - 62 days; either												
from urgent GP referral to treatment	% patients	1.0	Actual	86.2	85.3	85.2	85.5					Performance since October 2012 has met the operational threshold of 85.0%, and is expected to be maintained at this level.
			[Target]	[85.0]	[85.0]	[85.0]	[85.0]	[85.0]	[85.0]	[85.0]	[85.0]	
				■	▼	▼	▼	■				
or		or										
Cancer - 62 days	% patients	1.0	Actual	96.0	100	93.8	96.9	100.0				Performance since April 2010 has met the 90.0% operational threshold, and is expected to have been maintained at this level.
from consultant screening service referral			[Target]	[90.0]	[90.0]	[90.0]	[90.0]	[90.0]	[90.0]	[90.0]	[90.0]	
				▼	▲	▼	▼	■				
Referral to Treatment Waiting Times	% patients	1.0	Actual	92.5	92.3	90.1	91.6	92.2				Performance continues to be meet the 90% operational threshold and is expected to be maintained at this level.
Admitted			[Target]	[90.0]	[90.0]	[90.0]	[90.0]	[90.0]	[90.0]	[90.0]	[90.0]	
				▲	▼	▼	▼	■				
Referral to Treatment Waiting Times	% patients	1.0	Actual	96.9	96.6	95.1	96.2	97.8				Performance continues to be meet the 95% operational threshold and is expected to be maintained at this level.
Non - Admitted			[Target]	[95.0]	[95.0]	[95.0]	[95.0]	[95.0]	[95.0]	[95.0]	[95.0]	
				▼	▼	▼	▼	■				
Referral to Treatment Waiting Times	% patients	1.0	Actual	92.8	92.2	92.6	92.5	95.6				Performance continues to be meet the 92% operational threshold and is expected to be maintained at this level.
Incomplete Pathway			[Target]	[92.0]	[92.0]	[92.0]	[92.0]	[92.0]	[92.0]	[92.0]	[92.0]	
				▼	▼	▲	▼	■				
Emergency Care Waits less than 4-hrs	% patients	1.0	Actual	94.70	95.50	94.70	95.00	92.60				Performance during October was 92.60%, beneath the 95.00% operational threshold.
			[Target]	[95.00]	[95.00]	[95.00]	[95.00]	[95.00]	[95.00]	[95.00]	[95.00]	
				▲	■	■	■	▼				
Data Completeness Community Services	% complete	1.0	Actual	>50.00	>50.00	>50.00	>50.00	>50.00				The Trust remains compliant with all requirements.
(RTT Information, Referral Information and Treatment Activity Information)			[Target]	[50.00]	[50.00]	[50.00]	[50.00]	[50.00]	[50.00]	[50.00]	[50.00]	
				■	■	■	■	■				
Patient Experience	Certification against compliance with requirements regarding access to healthcare for people with a learning disability	1.0	Actual	Compliant	Compliant	Compliant	Compliant	Compliant				The Trust remains compliant with all requirements.
			[Target]	[Compliant]	[Compliant]	[Compliant]	[Compliant]	[Compliant]	[Compliant]	[Compliant]	[Compliant]	
				■	■	■	■	■				
Score for Access & Outcome Metrics				**2.0**	**0.0**	**1.0**	**0.0**	**1.0**				

Governance Rating									
	GREEN	<1.0	■						
	AMBER/ GREEN	1.0 - 1.9	■	■					
	AMBER/ RED	2.0 - 3.9	■	■					
	RED	>3.9	■						
					2.0	**0.0**	**1.0**	**0.0**	**1.0**