# 5 Year Financial Strategy

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## Executive Summary Paper G

### Context

It has previously been agreed that the Financial Strategy of the organisation will be refreshed twice per year; a full refresh after final audited accounts are reported and operational plans are set and an interim update to account for movement from plan. The last iteration (version 3.1) was approved by IFPIC in August 2016.

Version 4.1 has been produced as a full refresh of the Financial Strategy to incorporate updates for audited 2016/17 final accounts, 2017/18 annual operating plan, STP assumptions, STP UHL capital bids and Interim ICU (Relocation of Level 3 ICU from LGH) Outline Business Case (OBC).

### Questions

1. What are the key assumptions within the Financial Strategy?
2. What are the key changes from the last version of the Financial Strategy?
3. What is the bottom line income and expenditure trajectory?
4. What are the next steps with the financial strategy?

### Conclusion

1. The assumptions used in version 4.1 of the Financial Strategy are largely consistent with the assumptions in the STP refresh in August 2017, STP UHL capital bids and updated for the Interim ICU (Relocation of Level 3 ICU from LGH) Outline Business Case (OBC). This has been modelled in the LTFM and therefore means that QIPP and associated bed reductions, together with site rationalisation savings in 2023/24 are assumed.
2. The key changes in the Financial Strategy from the last iteration are that:
   - The baseline in the LTFM has moved by a year to 2017/18.
   - The completion of the reconfiguration capital programme has been moved to 2022/23, with the Trust returning to a surplus financial position in 2023/24, when the site rationalisation savings are assumed to be delivered.
   - The LTFM also includes 2022/23, which is beyond the scope of the STP and therefore the assumptions applied in that year are consistent with 2021/22. The LTFM is a 5-

year financial model from the base year (2017/18). Therefore, in order to incorporate the site rationalisation savings, the income and expenditure position for 2023/24 has been modelled outside of the LTFM, using the baseline assumptions for 2022/23.

- In 2021/22, the balance of revenue support loans is assumed to be converted into permanent PDC funding. This amounts to £178.7m of debt transfer to PDC funding.

3. The bottom line income and expenditure trajectory associated with this is largely consistent with the STP UHL capital bids and has been updated for the Interim ICU (Relocation of Level 3 ICU from LGH) Outline Business Case (OBC) and has only materially deviated from version 3.1 for the timing of site rationalisation savings.
4. The next formal update is due in six months and is subject to confirmation of the second capital bid for the whole of the reconfiguration programme with any changes to the STP being incorporated along with the 2018/19 annual planning assumptions.

## Input Sought

The Board is asked to **discuss** the content and conclusions of the Financial Strategy and **approve** this for subsequent submission to or engagement with NHS Improvement.

# For Reference

Edit as appropriate:

1. The following objectives were considered when preparing this report:

| | |
|---|---|
| Safe, high quality, patient centred healthcare | [**Yes** /~~No~~ /~~Not applicable~~] |
| Effective, integrated emergency care | [~~Yes~~ /~~No~~ /**Not applicable**] |
| Consistently meeting national access standards | [~~Yes~~ /~~No~~ /**Not applicable**] |
| Integrated care in partnership with others | [~~Yes~~ /~~No~~ /**Not applicable**] |
| Enhanced delivery in research, innovation & ed' | [~~Yes~~ /~~No~~ /**Not applicable**] |
| A caring, professional, engaged workforce | [~~Yes~~ /~~No~~ /**Not applicable**] |
| Clinically sustainable services with excellent facilities | [~~Yes~~ /~~No~~ /**Not applicable**] |
| Financially sustainable NHS organisation | [**Yes** /~~No~~ /~~Not applicable~~] |
| Enabled by excellent IM&T | [~~Yes~~ /~~No~~ /**Not applicable**] |

2. This matter relates to the following governance initiatives:

| | |
|---|---|
| Organisational Risk Register | [**Yes** /~~No~~ /~~Not applicable~~] |
| Board Assurance Framework | [**Yes** /~~No~~ /~~Not applicable~~] |

3. Related Patient and Public Involvement actions taken, or to be taken: **Considered but not applicable**.

4. Results of any Equality Impact Assessment, relating to this matter: **Considered but not applicable**.

5. Scheduled date for the next paper on this topic: **N/A**

6. Executive Summaries should not exceed 1 page. [**My paper** ~~does~~/**does not comply**]

7. Papers should not exceed 7 pages. [**My paper** ~~does~~/**does not comply**]

University Hospitals of Leicester NHS
NHS Trust

# 5 Year Financial Strategy

Financial recovery plan including assumptions & high level long term financial model (LTFM) outputs

Version 4.1

2nd November 2017

# Contents

## 1. Document History

| Version | Date | Summary of change | Author |
|---|---|---|---|
| 1.0 | 08/05/15 | First draft. | Paul Gowdridge |
| 1.1 | 12/05/15 | Conclusions clarified and separated out as distinct section. | Paul Gowdridge |
| 1.2 | 13/05/15 | Final draft produced for Trust Board Thinking day (14/05/15). | Paul Gowdridge |
| 1.3 | 21/05/15 | Development and clarification of further Financial Strategy Development following discussion at Trust Board Thinking Day. | Paul Gowdridge |
| 1.4 | 06/07/15 | Inclusion of outcomes from BCT-UHL Programme Delivery Board, IFPIC and Trust Board. Operational and structural split of income and expenditure deficit added following TDA feedback. | Paul Gowdridge |
| 1.5 | 22/07/15 | Document history added. | Paul Gowdridge |
| 2.0 | 25/11/15 | In year update reflecting revised 2015/16 income and expenditure and capital plans/forecast. | Mohammed Rab/ Paul Gowdridge |
| 3.0 | 04/08/16 | Draft annual full refresh for consideration by Executive Strategy Board 09-08-16. | Mohammed Rab/ Paul Gowdridge |
| 3.1 | 18/08/16 | Annual full refresh incorporating discussions at ESB, explicit reference to more of the assumptions within the modelling for approval by IFPIC. | Mohammed Rab/ Paul Gowdridge |
| 4.0 | 18/08/17 | Annual full refresh incorporating STP assumptions | Mohammed Rab/ Shyam Bhogaita |
| 4.1 | 26/10/17 | Annual full refresh incorporating STP assumptions and updated for the September STP UHL capital bid and Interim ICU Outline Business Case | Mohammed Rab/ Shyam Bhogaita |

## 2. Background

2.1. The Trust is required to clearly articulate its financial strategy for a number of purposes including;

a) Summarising the financial impact of the Integrated Business Plan (IBP), or 'the strategy'
b) Demonstration of timing in which the Trust will execute its financial recovery plan and will return to making a surplus or in the very least breakeven
c) To inform the cash application process for the Trust to seek cash support whilst operating in financial deficit and for external loans to fund the major capital investments not possible from within Trust internally generated resources
d) Aligning internal financial and strategic planning to the Better Care Together (BCT) programme and the LLR Sustainability and Transformation Plan (STP).

2.2. The Trust produced a 5 year Long Term Financial Model (LTFM) in June 2014 as part of a national strategic planning round, production of the organisational 5 year strategy and development of the BCT Strategic Outline Case (SOC) which followed.

2.3. An updated version of this was incorporated in the 5 year Financial Strategy, version 1.0, which was approved by the Integrated Finance, Performance and Investment Committee (IFPIC) in May 2015 and the Trust Board on the 4th June 2015. The recommendation to refresh the Financial Strategy twice annually was approved as part of this.

2.4. Outcomes from the discussions at the Reconfiguration Board, IFPIC and the Trust Board during the approval were captured in version 1.5 of the Financial Strategy. This also captured subsequent discussion with the regulator (National Trust Development Authority) regarding structural and operational drivers of the Trust income and expenditure deficit.

2.5. In November 2015 a partially refreshed Financial Strategy (version 2.0) was produced in line the commitment to do so twice a year, this reflected the revised 2015/16 income and expenditure plan and forecast and the 2015/16 capital plan and forecast. Version 2.0 of the Financial Strategy was used in the BCT Pre Consultation Business Case (PCBC) submission to NHS England in February 2016.

2.6. In August 2016, version 3.0 of the Financial Strategy was produced as full refresh of the 5 year Financial Strategy to incorporate updates for audited 2015/16 final accounts, 2016/17 annual operating plan and draft STP submission made in June 2016. In addition, the changing landscape nationally regarding capital funding and the removal of Public Dividend Capital (PDC) as an option in that regard was reflected in that version. The refresh was timed to facilitate alignment to the 2016/17 final operational plan and the STP.

2.7. The current Financial Strategy contained within this document (version 4.1) has been produced as full refresh of the 5 year Financial Strategy to incorporate updates for audited 2016/17 final accounts, 2017/18 annual operating plan and refreshed STP as at August 2017. This refresh has been timed to facilitate alignment to the 2017/18 final operational plan and the latest version of the STP.

2.8. On April 28th, an initial bid of £30.8m for capital against the £325m announced in the 2017 spring budget was made in order to progress the interim ICU scheme. This is deemed to be the next scheme required to be funded in order to deliver our reconfiguration programme. At the same time that this bid was announced, a deadline of the 24th May was announced for any further capital required within the STP.

2.9. On May 24th, a second capital bid for £397.5m was submitted reflecting the capital required to deliver the whole reconfiguration programme (this includes the £30.8m capital reflected in the first bid). This bid is higher than the capital requested in the original STP submitted in October 2016 STP, due to providing additional ward capacity to reflect the increased bed base and the supporting infrastructure. The capital bid outlines the plan to deliver the clinical reconfiguration strategy of moving from 3 to 2 acute sites. In addition to this, a separate capital bid of £31.3m was submitted for the Electronic Patient Record (EPR) programme.

2.10. On 17th August 2017, the Trust was given the opportunity to update the original capital bid document to ensure complete alignment with the newly released assessment criteria. There was also a compulsory requirement for all capital bids to complete an additional value for money template. The updated bid documents were submitted by the deadline of Wednesday 6th September 2017.

2.11. Our original bid reflected the STP, which was the delivery of a five year Reconfiguration programme first described in the 2014 LLR Better Care Together Strategic Outline Case (SOC); completing by 2020/21. The impact of the STP process and lack of availability of capital has delayed the commencement of this programme, making delivery in this timescale impossible. On further consideration, and having taken advice from senior colleagues at NHS Improvement, the timescales for delivery were revised within our bid to reflect the delays that have been experienced and to ensure that the programme is realistic and deliverable. The capital programme will now conclude in 2022/23, with the Trust returning to a surplus financial position in 2023/24. The capital funding requirements outlined in the capital bids are incorporated within this financial strategy and LTFM update, along with the assumptions in the Interim ICU (Relocation of Level 3 ICU from LGH) Outline Business Case (OBC). These changes will also be reflected in the next refresh of the STP, to ensure consistency with the plan for the wider LLR health economy.

## 3. Baseline Assumptions

3.1. In general terms, the assumptions used in the Financial Strategy to generate the LTFM are consistent with the latest refresh of the STP as at August 2017.

3.2. The assumptions regarding 2022/23 and 2023/24, which were previously not within the scope of the 5 year Financial Strategy and are not within the scope of the STP, have been set consistently with those used for 2021/22.

3.3. The activity growth projections are aligned to the STP; they are based on the latest published version of the Indicative Hospital Activity Model (IHAM), which has been updated to 2015/16 M10 forecast outturn. It gives indicative activity figures up to 2020/21 based on historic trends and local demography projections for activity. However, it has not been locally adjusted at point of delivery (PoD) or speciality level, in order to remain consistent with the STP.

3.4. Activity growth has been applied to Patient Care Income across all PoDs and operational expenditure to deliver the activity growth. This is shown in Table 1 below.

**Table 1** – Activity based volume growth

| | | 2018/19 | 2019/20 | 2020/21 | 2021/22 | 2022/23 |
|---|---|---|---|---|---|---|
| **Patient Care Income** | | | | | | |
| Elective | As Per STP | 2.5% | 2.6% | 2.2% | 2.5% | 2.5% |
| Non elective | As Per STP | 2.5% | 2.6% | 2.2% | 2.5% | 2.5% |
| Outpatient | As Per STP | 2.5% | 2.6% | 2.2% | 2.5% | 2.5% |
| A&E | As Per STP | 2.5% | 2.6% | 2.2% | 2.5% | 2.5% |
| Other clinical - Tariff | As Per STP | 2.5% | 2.6% | 2.2% | 2.5% | 2.5% |
| Other clinical - Non Tariff | As Per STP | 2.5% | 2.6% | 2.2% | 2.5% | 2.5% |
| | | | | | | |
| **Operational Expenditure** | | | | | | |
| Pay | As Per STP | 2.5% | 2.6% | 2.2% | 2.5% | 2.5% |
| Non Pay (operational exp excluding CNST) | As Per STP | 2.5% | 2.6% | 2.2% | 2.5% | 2.5% |

3.5. The inflation and efficiency factors applied are again based on the STP assumptions. They follow the economic assumptions published by NHS Improvement (NHSI) in March 2016. Table 2 below summarises this in headline terms.

**Table 2 –** Headline Income and Expenditure assumptions

| | 2018/19 | 2019/20 | 2020/21 | 2021/22 | 2022/23 |
|---|---|---|---|---|---|
| Income inflation (aggregated impact of income inflation) | 0.1% | 0.0% | 0.9% | 0.1% | 0.1% |
| Cost inflation (aggregated impact of operating cost inflation) | 2.3% | 2.3% | 3.3% | 2.6% | 2.7% |
| LTFM implied efficiency | 2.2% | 2.3% | 2.5% | 2.5% | 2.7% |

3.6. The aggregated cost inflation assumption is further broken down by cost category. The income inflation is the same for each area of PoD and has also 2% efficiency factor applied from 2018/19 to 2022/23. Table 3 below shows a breakdown of this and the breakdown of the cost inflation.

**Table 3 –** Detailed Income and Expenditure change

| **NHS acute activity revenue** | | **2018/19** | **2019/20** | **2020/21** | **2021/22** | **2022/23** |
|---|---|---|---|---|---|---|
| Tariff Inflator | As Per STP | 2.1% | 2.0% | 2.9% | 2.1% | 2.1% |
| Tariff Efficiency Factor | As Per STP | (2.0%) | (2.0%) | (2.0%) | (2.0%) | (2.0%) |
| **Net Tariff inflation** | **As Per STP** | **0.1%** | **0.0%** | **0.9%** | **0.1%** | **0.1%** |
| **Other income** | | | | | | |
| Education & training | As Per STP | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% |
| Research & development | As Per STP | 0.1% | 0.0% | 0.9% | 0.1% | 0.1% |
| Other income | As Per STP | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% |
| Private patients | As Per STP | 0.1% | 0.0% | 0.9% | 0.1% | 0.1% |
| Other non NHS clinical revenue | As Per STP | 0.1% | 0.0% | 0.9% | 0.1% | 0.1% |
| **Operating costs** | | | | | | |
| Pay expenditure | As Per STP | 1.6% | 1.6% | 2.9% | 1.7% | 1.7% |
| Drug expense - high cost | As Per STP | 3.6% | 4.1% | 4.1% | 4.1% | 4.1% |
| Drug expense - other | As Per STP | 3.6% | 4.1% | 4.1% | 4.1% | 4.1% |
| Clinical supplies and services - high cost | As Per STP | 2.1% | 1.9% | 2.0% | 1.9% | 1.9% |
| Clinical supplies and services - other | As Per STP | 2.1% | 1.9% | 2.0% | 1.9% | 1.9% |
| CNST premia | As Per STP | 15.5% | 15.5% | 15.5% | 15.5% | 15.5% |
| Other operating expenditure | As Per STP | 2.1% | 1.9% | 2.0% | 1.9% | 1.9% |

3.7. The operating cost inflation assumptions above can also be represented as a weighted share of the total cost inflation of 2.3% to 3.3% per year. This is shown below in table 4.

**Table 4 –** Headline cost inflation breakdown

| | 2018/19 | 2019/20 | 2020/21 | 2021/22 | 2022/23 |
|---|---|---|---|---|---|
| Pay expenditure | 1.1% | 1.1% | 2.0% | 1.1% | 1.1% |
| Drugs | 0.0% | 0.1% | 0.1% | 0.1% | 0.1% |
| Clinical supplies and services | 0.3% | 0.2% | 0.3% | 0.2% | 0.2% |
| CNST | 0.6% | 0.7% | 0.7% | 0.8% | 1.0% |
| Other | 0.3% | 0.2% | 0.3% | 0.3% | 0.3% |
| **Total** | **2.3%** | **2.3%** | **3.3%** | **2.6%** | **2.7%** |

## 4. Financial Strategy Assumptions

4.1. Following the STP submission in October 2016, it is required for each footprint throughout the country to show how it could close its financial gap and achieve sustainable financial balance in aggregate. Therefore, the main driver in the Financial Strategy refresh is consistency with the STP assumptions, which will show a balanced position for the organisation in 2023/24. The baseline assumptions (above) are important to capture the context of the financial strategy but the assumptions about how the organisational strategy is interpreted for the purposes of the LTFM and STP are crucial in determining the surplus/deficit projection for the Trust. These assumptions are laid out below:

4.1.1. General assumptions

- 2017/18 plan is the baseline position.
- Cost pressures of circa £5m assumed in addition to inflationary cost pressures.
- It is assumed that the estate and facilities transfer from an outsourced service to an internally provided and managed service in May 2016 will remain delivered internally, with services provided to LPT and NHS Property Services.
- The Urgent Care Centre (UCC) is assumed to be recurrent as part of the 2017/18 baseline; this includes both the income and expenditure for UCC.
- Patient care income follows the impact of HRG4+.
- The CIP projections include some of the suggestions from the Carter Review. However, this has not been fully developed at this point in time.
- Transitional costs (with the exception of capital charges) or mitigations for transitional costs have not been included. The transitional costs may include costs resulting from the decision to invest in change, double running and redundancy which may be mitigated by sustainability and transformation funding (STF), additional CIP or pre business case completion savings or staged estate rationalisation.
- No other non-recurrent income or expenditure anticipated.

4.1.2. Income assumptions

- Income is assumed to move in line with activity growth outlined in table 1 above.
- The STF of £11.4m in 2016/17 is non-recurrent in line with existing guidance and will therefore discontinue thereafter.
- The STP contains work streams which include QIPP, reducing UHL income and assuming a reduction in UHL costs in line with it. This has therefore been applied to the LTFM from 2017/18 to 2021/22. The net impact of QIPP income and expenditure changes is a nil I&E benefit cumulatively to 2021/22.

4.1.3. Financing assumptions

- Interest bearing debt (IBD) is used to fund the major business cases, including all estate reconfiguration.
- Interest bearing debt (IBD) is also being used to fund the income and expenditure deficit, plus any further cash shortfall caused by the use of IBD for major business cases. In 2021/22, the balance of revenue support loans is assumed to be converted into permanent PDC funding. This amounts to £178.7m of debt transfer to PDC funding. PDC funding has been assumed to fund the income and expenditure deficits in 2021/22 and 2022/23.
- Operational capital will continue to be aligned to the level of depreciation incurred, with a contribution to the EPR programme. Operational capital is assumed to be utilised for the repayment of capital loans associated with estate reconfiguration.

4.1.4. Estate rationalisation assumptions

- The value of buildings on part of the estate will be impaired as at March 2020 as it transfers to asset held for sale (in line with last business case approval).
- The land becomes an 'asset held for sale' at its current balance sheet value and is then revalued prior to sale, which is assumed to happen in 2023/24 at £28.4m. The land sale receipt is assumed to be used to deliver part of the overall funding requirement for capital expenditure funding.
- Estate reconfiguration business cases will assume impairment of 25% occurs in March of the year the scheme is completed for all new build developments. The 25% impairment assumption is made up of fees and contingency (16.5%) and demolition/refurbishment split (8.5%).
- Rationalisation of estate footprint will not make a saving until full closure of a site occurs.

4.1.5. CIP assumptions

- In general, CIP is modelled at a level between 3.0% and 3.3% from 2018/19 to 2022/23. In 2023/24, CIP is forecasted to deliver 4.7% and this is as a result of the site rationalisation occurring in that year, which is assumed to be part of the CIP delivery target in that year.
- EPR savings assumed as part of the CIP target referenced above, thus making the implementation of EPR an enabler scheme to the Trust delivering year on year saving projected. However, it is important to note that the EPR savings deliver additional opportunity above the baseline requirement of all providers to deliver 2.0% per year.
- Similarly, the site rationalisation business case savings are also assumed to be part of the CIP in addition to the baseline requirement in any given year in the 5 year LTFM. The net benefit of the schemes will contribute to CIP delivery in year, including depreciation and cost of capital on the investment. Where there is an in year deficit in a scheme the CIP contribution is assumed to be zero.

## 5. Key Performance Indicators (KPIs)

5.1. The KPIs captured within the LTFM reflect the impact the strategy has on key drivers of financial performance. These KPIs are therefore considered important when the financial projections of the Trust are reviewed through the financing application processes to test triangulation between financial and non-financial indicators.

5.2. The number of beds forecast is consistent with the STP work streams which include QIPP, and delivering what is now known as an 'integration dividend'. As a result a large driver of achieving improved financial performance and reconfiguration is to reduce the number of beds over the next five years. This is shown in table 5 below. The current Bed Bridge, and therefore our Reconfiguration Programme, is based on the 2020/21 end state of 2048 beds. The revised capital bid recognised that our timelines are now extended by 2 years and therefore work will be required to mitigate an additional 2 years-worth of growth to ensure that the bed number remains valid.

**Table 5 –** Beds Projection

| | **2016/17** | **2017/18** | **2018/19** | **2019/20** | **2020/21** | **2021/22** | **2022/23** |
|---|---|---|---|---|---|---|---|
| Total number of beds | 1975 | 2026 | 2007 | 2013 | 2048 | 2048 | 2048 |

5.3. The level of triangulation and integration of KPIs with the strategy and more specifically the Financial Strategy will be developed as part of on-going refinements.

## 6. 5 year Financial Strategy Trajectory

6.1. The income and expenditure trajectory of the Trust in the LTFM resulting from the assumptions described above is shown below in table 6. It is important to note that the LTFM is a 5-year financial model from the base year (2017/18). Therefore, in order to incorporate the site rationalisation savings, the income and expenditure position for 2023/24 has been modelled outside of the LTFM, using the baseline assumptions outlined in section 3 for 2022/23.

**Table 6 –** Income and expenditure trajectory with comparisons to the previous version and STP

| | 17/18 | 18/19 | 19/20 | 20/21 | 21/22 | 22/23 | 23/24 |
|---|---|---|---|---|---|---|---|
| | £m | £m | £m | £m | £m | £m | £m |
| Patient Income | 814.1 | 820.5 | 830.0 | 844.0 | 855.0 | 877.1 | 899.9 |
| Non Patient Income | 126.9 | 127.4 | 128.6 | 130.4 | 131.6 | 132.9 | 132.0 |
| **Total Income** | **941.1** | **947.9** | **958.6** | **974.4** | **986.6** | **1,010.0** | **1,031.9** |
| Pay Costs | (578.4) | (572.6) | (571.7) | (571.0) | (570.7) | (580.9) | (568.7) |
| Non Pay | (347.2) | (352.0) | (362.2) | (374.0) | (381.7) | (396.3) | (407.6) |
| **Total Operating Expenditure** | **(925.6)** | **(924.6)** | **(933.9)** | **(945.0)** | **(952.4)** | **(977.2)** | **(976.3)** |
| **EBITDA** | **15.5** | **23.3** | **24.7** | **29.4** | **34.2** | **32.9** | **55.6** |
| **Total Non-Operating Expenditure** | **(42.3)** | **(45.0)** | **(120.7)** | **(91.0)** | **(102.6)** | **(94.9)** | **(65.3)** |
| **Net Surplus/(Deficit)** | **(26.8)** | **(21.7)** | **(96.0)** | **(61.6)** | **(68.3)** | **(62.0)** | **(9.7)** |
| Impairments | 0.0 | 0.0 | 74.7 | 41.8 | 48.1 | 41.7 | 14.8 |
| Donated Asset Adjustment | 0.1 | 0.1 | 0.3 | 0.3 | 0.3 | 0.3 | 0.3 |
| **Board Reported Position** | **(26.7)** | **(21.7)** | **(21.0)** | **(19.5)** | **(20.0)** | **(20.0)** | **5.4** |
| **Comparisons** | | | | | | | |
| UHL STP Capital Bid | (26.7) | (21.7) | (21.0) | (19.5) | (20.0) | (20.0) | 5.4 |
| Difference to UHL STP Capital Bid | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| August STP plan | (26.7) | (21.7) | (20.3) | (20.2) | 2.0 | 0.0 | 0.0 |
| Difference to STP plan | 0.0 | 0.0 | (0.7) | 0.7 | (22.0) | (20.0) | 5.4 |
| Version 3.1 trajectory | (26.7) | (24.8) | (23.9) | 2.2 | 3.5 | 0.0 | 0.0 |
| Difference to version 3.1 | (0.0) | 3.1 | 2.9 | (21.7) | (23.5) | (20.0) | 5.4 |

6.2. The comparisons shown here demonstrate alignment between the Trust position and the STP, although it also evidences the difference in planning horizons as the latest STP does not project beyond 2021/22.

6.3. The financial modelling required in the LTFM is very detailed. As a result, the financial strategy will inevitably account for a number of issues, which cannot be directly compared between different versions, not least when baselines change which is part of the most recent refresh. For this reason it is difficult to compare exactly between this iteration and the previous.

6.4. In terms of the comparison to version 3.1 though, there are only material differences between a gross deficit in 2020/21 of £19.5m and the previous trajectory of a £2.2m surplus, resulting in a £21.7m difference. This is a result of moving the site rationalisation benefits to 2023/24.

6.5. It is important to note that the assumption around site reconfiguration being completed in 2023/24 in both this Financial Strategy and the STP is challenging since completion of the building works associated with achieving it are not expected to complete until at least the end of 2022/23. However, as part of the requirement to work towards the delivery of a plan, which balances the health economy within the shortest possible timescale, the optimism here has been required.

6.6. The Trust strategy and the BCT programme/STP are ultimately focused on reducing the inefficiencies built into our service delivery models across 3 sites. The structural deficit we are therefore addressing in the strategy can be separated as distinct from the operational deficit we are addressing in the short term. Similarly, the revenue consequences of investment in our infrastructure begin to be seen prior to the benefits that will be realised by reducing the estate footprint. This is demonstrated in table 7 below.

**Table 7 –** Structural and operational surplus/deficit

| | **2017/18 £m** | **2018/19 £m** | **2019/20 £m** | **2020/21 £m** | **2021/22 £m** | **2022/23 £m** | **2023/24 £m** |
|---|---|---|---|---|---|---|---|
| Structural surplus/(deficit) | (24.5) | (24.5) | (23.5) | (22.5) | (22.5) | (22.5) | - |
| Reconfiguration revenue consequences | - | (0.5) | (2.6) | (5.3) | (7.3) | (8.4) | (7.3) |
| Operational surplus/(deficit) | (2.2) | 3.3 | 5.1 | 8.3 | 9.8 | 10.9 | 12.7 |
| **Total surplus/(deficit)** | **(26.7)** | **(21.7)** | **(21.0)** | **(19.5)** | **(20.0)** | **(20.0)** | **5.4** |

6.7. This shows the operational deficit being reduced from £2.2m 2017/18 to £12.7m surplus in 2023/24, whilst the structural deficit is addressed longer term by the reconfiguration of services resulting in the full benefits realisation of estate reconfiguration. The recurrent operational surplus is then sufficient enough to finance the revenue consequences of reconfiguration on a longer term basis.

6.8. Based on the CIP assumptions outlined above the level of CIP assumed within this trajectory are demonstrated below in table 8.

**Table 8 –** 5 year CIP delivery projection

| | **2017/18** | **2018/19** | **2019/20** | **2020/21** | **2021/22** | **2022/23** |
|---|---|---|---|---|---|---|
| CIP % - Nominal | 3.5% | 3.3% | 3.1% | 3.1% | 3.1% | 3.0% |
| CIP £ - Nominal | 33.0 | 32.0 | 30.0 | 30.0 | 30.0 | 30.0 |

6.9. CIP is modelled at a level between 3.0% and 3.3% from 2018/19 to 2022/23. In 2023/24, CIP is forecast to deliver 4.7 % and this is as a result of the site rationalisation savings occurring in that year, which is assumed to be part of the CIP delivery target in that year. It is important to recognise this reflects the site rationalisation benefit being delivered in this way rather than a staged approach in absence of the benefits from each individual case being known.

6.10. The way in which the financial strategy drives the need for additional external financial support has been shown in the LTFM across 4 different elements: the £12m capital loan received in 2014/15 and the borrowing required to support the Emergency Floor development. These are both within the baseline as an approved funding. The business cases for an EPR and site reconfiguration, including interim ICU schemes, are modelled as 'service developments' within the LTFM. Approval of funding for these business cases is to be confirmed.

6.11. The impact of the reconfiguration plan on the Trust SoFP is shown below in table 9.

**Table 9 –** Statement of Financial Position (SoFP) forecast

| | 17/18 £m | 18/19 £m | 19/20 £m | 20/21 £m | 21/22 £m | 22/23 £m |
|---|---|---|---|---|---|---|
| **ASSETS, NON CURRENT** | | | | | | |
| Property, Plant and Equipment and intangibles | 427.5 | 495.7 | 508.7 | 574.3 | 618.4 | 605.6 |
| Trade and Other Receivables | 2.6 | 2.6 | 2.6 | 2.6 | 2.6 | 2.6 |
| **Assets, Non-Current, Total** | **430.1** | **498.4** | **511.3** | **576.9** | **621.0** | **608.3** |
| | | | | | | |
| **ASSETS, CURRENT** | | | | | | |
| Inventories | 20.0 | 20.0 | 20.0 | 20.0 | 20.0 | 20.0 |
| All Receivables, Current | 84.1 | 76.9 | 70.9 | 45.8 | 46.2 | 46.7 |
| Cash and Cash Equivalents | 1.1 | 1.1 | 1.1 | 1.1 | 1.1 | 1.1 |
| Other Assets, Current | 0.0 | 0.0 | 17.6 | 17.6 | 17.6 | 17.6 |
| **Assets, Current, Total** | **105.2** | **98.0** | **109.6** | **84.6** | **84.9** | **85.4** |
| | | | | | | |
| **ASSETS, TOTAL** | **535.3** | **596.3** | **620.9** | **661.5** | **705.9** | **693.7** |
| | | | | | | |
| **LIABILITIES, CURRENT** | | | | | | |
| Interest-Bearing Borrowings | (3.0) | (5.4) | (13.1) | (192.9) | (18.0) | (19.4) |
| Deferred Income, Current | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Creditors & Other Current Liabilities | (137.6) | (132.3) | (130.8) | (117.9) | (131.1) | (147.0) |
| Finance Leases, Current | (1.9) | (2.8) | (11.4) | (9.9) | (8.0) | (6.0) |
| **Liabilities, Current, Total** | **(142.5)** | **(140.5)** | **(155.2)** | **(320.7)** | **(157.1)** | **(172.4)** |
| | | | | | | |
| **NET CURRENT ASSETS (LIABILITIES)** | (37.3) | (42.6) | (45.6) | (236.0) | (72.2) | (87.0) |
| | | | | | | |
| **LIABILITIES, NON CURRENT** | | | | | | |
| Interest-Bearing Borrowings, Non-Current | (167.7) | (252.5) | (358.3) | (295.1) | (372.7) | (387.2) |
| Provisions, Non-Current | (9.1) | (9.1) | (9.1) | (9.1) | (9.1) | (9.1) |
| Finance Leases, Non-current | (12.0) | (12.0) | (12.0) | (12.0) | (12.0) | (12.0) |
| **Liabilities, Non-Current, Total** | **(188.8)** | **(273.6)** | **(379.4)** | **(316.2)** | **(393.8)** | **(408.3)** |
| | | | | | | |
| **TOTAL ASSETS EMPLOYED** | **204.0** | **182.2** | **86.3** | **24.6** | **155.0** | **112.9** |
| | | | | | | |
| Public dividend capital | 332.0 | 332.0 | 332.0 | 332.0 | 530.6 | 550.6 |
| Retained Earnings (Accumulated Losses) | (205.4) | (227.1) | (323.1) | (384.7) | (453.1) | (515.1) |
| Revaluation reserve | 77.4 | 77.4 | 77.4 | 77.4 | 77.4 | 77.4 |
| **TOTAL TAXPAYERS EQUITY** | **204.0** | **182.2** | **86.3** | **24.6** | **155.0** | **112.9** |

6.12. As a consequence of combining the financing and estate rationalisation assumptions the impact on the forecast Statement of Financial Position (SoFP) in the LTFM is material. By increasing liabilities through loans but only increasing the asset base by the impaired value of assets there is a material weakening of the SoFP.

6.13. The additional external financial support identified to deliver the major capital cases is summarised below in table 10.

**Table 10 –** Borrowings summary

| | 17/18 | 18/19 | 19/20 | 20/21 | 21/22 | 22/23 | 23/24 | Total |
|---|---|---|---|---|---|---|---|---|
| | £m | £m | £m | £m | £m | £m | £m | £m |
| CRL operational capital | 27.8 | 22.4 | 19.2 | 33.4 | 35.4 | 37.0 | 35.3 | **210.5** |
| CRL contribution to EPR | 0.0 | 5.4 | 10.9 | 0.0 | 0.0 | 0.0 | 0.0 | **16.3** |
| Loan Repayments | -2.2 | -2.2 | -3.7 | -10.6 | -15.0 | -18.8 | -20.2 | **-72.7** |
| **Internal capital resource** | **25.6** | **25.6** | **26.4** | **22.8** | **20.4** | **18.2** | **15.1** | **154.1** |
| Donations | 1.0 | 0.3 | 0.3 | 0.3 | 0.3 | 0.3 | 0.3 | **2.8** |
| EF Loan Funding - Agreed | 7.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | **7.0** |
| External borrowing - Reconfiguration | 1.4 | 58.4 | 98.0 | 110.2 | 95.6 | 33.9 | -28.4 | **369.1** |
| Capital receipts | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 28.4 | **28.4** |
| External borrowing - EPR | 5.0 | 10.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | **15.0** |
| **External capital resource** | **14.4** | **68.7** | **98.3** | **110.5** | **95.9** | **34.2** | **0.3** | **422.3** |
| **Total Capital Funding** | **40.0** | **94.3** | **124.7** | **133.3** | **116.3** | **52.4** | **15.4** | **576.4** |

6.14. The borrowings described here are to fund the capital programme which has been summarised in table 11 below.

**Table 11 –** Capital Programme

| | 17/18 | 18/19 | 19/20 | 20/21 | 21/22 | 22/23 | 23/24 | Total |
|---|---|---|---|---|---|---|---|---|
| | £m | £m | £m | £m | £m | £m | £m | £m |
| Interim ICU Projects | 1.4 | 27.4 | 2.0 | - | - | - | - | 30.8 |
| Planned Ambulatory Care Hub | - | 8.0 | 25.0 | 34.3 | 34.4 | 12.8 | - | 114.5 |
| Women's Hospital | - | 6.0 | 18.0 | 25.3 | 25.3 | 9.8 | - | 84.4 |
| Infrastructure | - | 4.0 | 8.0 | 8.0 | 8.0 | 2.2 | - | 30.2 |
| Enabling – LRI & GH | - | 1.6 | 3.0 | 2.4 | - | - | - | 7.0 |
| EMPATH - Cellular Pathology | - | 0.3 | - | - | - | - | - | 0.3 |
| Enhanced ICU facilities - LRI | - | 1.5 | 10.2 | 5.3 | - | - | - | 17.0 |
| Enhanced ICU facilities - GH | - | - | 1.0 | 2.9 | - | - | - | 3.9 |
| Wards - GH | - | 5.0 | 16.7 | 21.9 | 21.9 | 7.6 | - | 73.1 |
| Wards - LRI | - | 2.0 | 2.0 | 3.6 | 3.6 | 0.8 | - | 12.0 |
| Theatres - GH | - | 0.5 | 2.0 | 2.5 | 2.4 | 0.7 | - | 8.1 |
| Extension to Clinical Decisions Unit – GH | - | 1.1 | 2.1 | - | - | - | - | 3.2 |
| Main Entrance - LRI | - | 1.0 | 8.0 | 4.0 | - | - | - | 13.0 |
| **Major reconfiguration projects** | **1.4** | **58.4** | **98.0** | **110.2** | **95.6** | **33.9** | **-** | **397.5** |
| EPR Programme | 5.0 | 15.4 | 10.9 | - | - | - | - | 31.3 |
| **Other major projects** | **5.0** | **15.4** | **10.9** | **-** | **-** | **-** | **-** | **31.3** |
| **TOTAL** | **6.4** | **73.8** | **108.9** | **110.2** | **95.6** | **33.9** | **-** | **428.8** |

## 7. Site Rationalisation

7.1. The savings in 2023/24 associated with rationalising the sites have been summarised in table 12. These assumptions haven't materially changed since version 2.0 of the Financial Strategy and are therefore those reviewed independently by Ernst and Young in 2015.

**Table 12** – Site rationalisation savings

| Cost | Source | Saving £k |
|---|---|---|
| Business Rates | 15-16 budget | 847 |
| Catering | 15-16 budget | 2,687 |
| Cleaning | 15-16 budget | 2,030 |
| Contract Management | 15-16 budget | - |
| Electricity | 15-16 budget | 1,199 |
| Estates Management and Maintenance | 15-16 budget | 1,802 |
| Gas | 15-16 budget | 1,144 |
| Laundry Contract | 15-16 budget | 541 |
| Other | 15-16 budget | 589 |
| Portering | 15-16 budget | 917 |
| Security | 15-16 budget | 283 |
| Switchboard | 15-16 budget | - |
| Water & Sewerage - Charges | 15-16 budget | 321 |
| **Gross estates and facilities costs** | | **12,359** |
| Income from Car Parking and Catering | 15-16 budget | 2,052 |
| **Net estates and facilities costs** | | **10,307** |
| Depreciation | 16-17 Asset register | 2,420 |
| Return on asset | 16-17 Asset register | 2,527 |
| **Capital charges** | | **4,947** |
| **Direct costs & overheads** (see below) | 14-15 costing data | **9,272** |
| **Total costs** | | **24,526** |

7.2. The specific assumptions contained within these savings are as follows:

- Baseline costs not inflated
- Buildings & land capital charges saved, no change to IT & equipment
- Full saving assumed on majority of estates and facilities costs with zero on some others, reality is likely to be somewhere in between

7.3. The direct costs and overheads included contain the following assumptions and calculations:

- Non clinical/management staff reduced as a result of reducing from 3 sites to 2 based on 50% of site share of costs, £4.8m
- Nursing saving based on 33% of theatres pay budget (£1.7m) with other nursing (£0.2m), total £1.9m
- Medical staff savings based on 1 consultant per specialty (£1.3m) with junior doctor savings (£0.4m) in the same proportion, total £1.7m
- CNST saving based on reduction of doctors and activity which drive the cost, total £0.3m
- Pharmacy & imaging savings as a result of reduced site presence based on 50% of site share of costs, total £0.6m

7.4. The net savings from the site rationalisation are offset by additional revenue consequences from capital investment in the estate. The phasing of these costs, alongside the phasing of the total savings associated with the site rationalisation is also important to recognise, as per the current assumptions described above. This is summarised in table 13 below.

**Table 13 –** Net site rationalisation saving and phasing over 6 years

| | 18/19 £k | 19/20 £k | 20/21 £k | 21/22 £k | 22/23 £k | 23/24 £k |
|---|---|---|---|---|---|---|
| Savings on Depreciation | - | - | - | - | - | 2,420 |
| Savings on Return on Asset | - | 1,030 | 2,060 | 2,060 | 2,060 | 2,527 |
| Savings on Estates and Facilities | - | - | - | - | - | 12,359 |
| Loss of income | - | - | - | - | - | (2,052) |
| Other Clinical Savings | - | - | - | - | - | 9,272 |
| **Annual savings from rationalised estate** | **-** | **1,030** | **2,060** | **2,060** | **2,060** | **24,526** |
| | | | | | | |
| **Increase in estate footprint driven costs** | | | | | | |
| | | | | | | |
| **Additional Capital Charges and Interest** | **18/19 £k** | **19/20 £k** | **20/21 £k** | **21/22 £k** | **22/23 £k** | **23/24 £k** |
| Loan Interest | (496) | (1,682) | (3,164) | (4,558) | (5,327) | (5,139) |
| Depreciation | - | (1,023) | (2,882) | (4,849) | (6,557) | (7,162) |
| **Total Additional Capital Charges and Interest** | **(496)** | **(2,705)** | **(6,046)** | **(9,408)** | **(11,883)** | **(12,301)** |
| | | | | | | |
| Additional Facilities Management costs | - | (510) | (765) | (765) | (765) | (8,785) |
| Vascular Savings | - | - | - | - | - | 1,393 |
| Savings from separating emergency and elective activity | - | - | - | - | - | 8,000 |
| Savings on Return on Asset | - | 631 | 1,493 | 2,904 | 4,233 | 4,432 |
| | | | | | | |
| **Total additional costs** | **(496)** | **(2,584)** | **(5,318)** | **(7,269)** | **(8,416)** | **(7,260)** |
| | | | | | | |
| **Net revenue benefit/(cost)** | **(496)** | **(1,555)** | **(3,258)** | **(5,210)** | **(6,356)** | **17,266** |

7.5. The key components of the site rationalisation savings are estates and facilities savings, depreciation and capital charges savings and direct revenue costs and overheads savings. Non-clinical and management staff savings are assumed as a result of reducing from 3 acute sites to 2. Medical and nursing staff efficiency savings are based on more efficient deployment of staff and better alignment of rotas. Pharmacy and other support services savings are assumed as a result of reduced split-site presence. Separating emergency and elective activity will reduce the level of cancellations and a reduction in requirement for Waiting List Initiative (WLI) costs and therefore result in cost savings for the Trust.

7.6. What this analysis shows is the additional costs of the estate reconfiguration strategy beginning to impact prior to the sites being rationalised from 3 to 2. It is therefore recommended that careful consideration is given to the extent to which:

a) Each discrete business case can begin to deliver savings prior to the full estate solution being in place.
b) The phasing of estate related cost savings and whether the cost savings shown in table 13 can be delivered, in part, any earlier than 2023/24.

## 8. Key Risks and Further Financial Strategy Development

8.1. There are a number of key risks associated with delivering the Financial Strategy. These are outlined below:

- CIP delivery is key to delivery of the planned income and expenditure position. The ability for the Trust to deliver year on year saving targets, with EPR as an enabler, is a key assumption, which keeps the Financial Strategy ahead of national guidance in terms of cost saving ambition. However, this is not easily

deliverable. The Trust has an established PMO function and associated governance arrangements in place to mitigate against this risk.

- The financial strategy is dependent on the delivery of the wider STP QIPP demand management schemes, in order to deliver the capacity requirements reflected in the reconfiguration capital programme.
- The capital expenditure required to deliver the reconfiguration programme is dependent on external borrowing that is yet to be approved. Any delay or non-receipt of anticipated funding will delay the reconfiguration programme and so will delay or prevent the delivery of the financial strategy. However, the Trust is engaged in the nationally defined STP capital approvals process to access funding.
- Interest bearing debt (IBD) is currently being used to fund the income and expenditure deficit. In 2021/22, the balance of revenue support loans is assumed to be converted into permanent PDC funding. This amounts to £178.7m of debt transfer to PDC funding. PDC funding has been assumed to fund the income and expenditure deficits in 2021/22 and 2022/23. This assumption is yet to be agreed.

8.2. The Financial Strategy will continue to be developed responding to changes in the wider strategy and health economy planning, particularly the finalisation of the STP towards the end of 2017. In addition, some specific areas are recommended for further consideration:

- Review of site disposal receipt assumption
- Refresh of risk and scenario modelling relating to the sensitivity of baseline and financial strategy assumptions to availability (or not) of capital and consequent slippage on delivery of reconfiguration.
- Modelling the impact of Private Finance Initiative 2 (PF2) as the work in this area develops.
- Responding to the imminent refresh of the Development Control Plan (DCP) and the estates strategy, to incorporate the changes in the level of capacity that may be required as a result of the QIPP planning assumptions within the STP.

## 9. Conclusions

9.1. The current Financial Strategy (version 4.1) trajectory, based on the assumptions given, is largely consistent with the current version of STP.

9.2. Based on the inefficiencies of the current delivery of acute services over 3 sites, the Trust has separated the structural and operational drivers of the income and expenditure deficit. This shows the Trust returning to operational surplus by 2018/19, whilst the strategy is delivered to remove the structural deficit in 2023/24.

9.3. This assumption around site reconfiguration being completed in 2023/24 in both this Financial Strategy and the STP is challenging, since completion of the building works associated with achieving it are not expected to complete until the end of 2022/23. However, as part of the requirement to work towards the delivery of a plan, which balances the health economy within the shortest possible timescale, the optimism here has been required.

9.4. The ability for the Trust to deliver year on year saving targets, with EPR as an enabler, is a key assumption which keeps the Financial Strategy ahead of national guidance in terms of cost saving ambition. However, this is not easily deliverable.

9.5. The requirement for individual business cases to 'pay for themselves' during construction has not been assumed, nor has a phased closure of estate to deliver estate rationalisation savings any earlier. The nature of interim moves means they potentially lead to an increase in cost rather than to cost savings, so introducing each of these factors could have offsetting effects. The benefits of each business case, in addition to the closure of a significant amount of estate, have not been assumed.