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23 April, 2015, updated
1. Introduction and context

1.1 Oxford University Hospitals NHS Trust’s Board agreed an Integrated Business Plan in October 2014. This set out plans for services, staffing and finances and was underpinned by a five-year Long Term Financial Model (LTFM).

1.2 In accordance with planning guidance issued by the NHS Trust Development Authority (NTDA) and Monitor, the Trust is developing a Business Plan for 2015/16 for consideration by its Board on 13 May.

1.3 Following a pause to the completion of Monitor’s assessment of its foundation trust application, the Trust has agreed with Monitor that it will submit in late April an updated LTFM based on Month 10 trading; updated downside planning and mitigating actions taking account of latest commissioning intentions; and an update on the handling of income risk, cost improvement plans, the prioritisation and management of interdependencies with the capital programme, and workforce and organisational issues.

1.4 This document aims to summarise developments in these areas. It can be seen as a ‘bridge’ between the October 2014 Integrated Business Plan and the 2015/16 Annual Plan to be considered by the Board in May. It should be read alongside the updated LTFM, downside and mitigations, and information submitted to the NTDA as part of the planning process for 2015/16.

1.5 OUH has worked closely with its main commissioners to agree activity assumptions and service plans for 2015/16 and beyond. This work has taken place against a backdrop of uncertainty about the tariffs payable for care and, after a proposed tariff was rejected nationally, the Board decided against supporting revised options proposed by NHS England and Monitor.

1.6 The Board expects to conduct a fuller update of its strategy during 2015/16.
2. Strategic overview

2.1 The Trust’s operational plan for 2015/16 is shaped by the Trust’s five year strategy as set out in the Integrated Business Plan published in October 2014.

2.2 The operational plan seeks to advance the achievement of the Trust’s six strategic objectives which are:

SO1: To be a patient-centred organisation, providing high quality, compassionate care with integrity and respect for patients and staff – “delivering compassionate excellence”

SO2: To be a well-governed organisation with high standards of assurance, responsive to members and stakeholders in transforming services to meet future needs - “a well-governed and adaptable organisation”

SO3: To meet the challenges of the current economic climate and changes in the NHS by providing efficient and cost-effective services – “delivering better value healthcare”

SO4: To provide high quality general acute healthcare to the people of Oxfordshire, including more joined-up care across local health and social care services – “delivering integrated local healthcare”

SO5: To develop extended clinical networks that benefit our partners and the people they serve. This will support the delivery of safe and sustainable services throughout the network of care that we are part of and our provision of high quality specialised care for the people of Oxfordshire and beyond - “excellent secondary and specialised care through sustainable clinical networks”

SO6: To lead the development of durable partnerships with academic, health and social care partners and the life sciences industry to facilitate discovery and implement its benefits - “delivering the benefits of research and innovation to patients”

2.3 The overall strategic context in which OUH has developed its plan continues to be one of growing demand for health services, driven in particular by the needs of the ageing population, the implications of unhealthy lifestyle choices and increased patient expectations. At the same time healthcare continues to change with developments in treatments, technologies and care delivery.

2.4 For 2015/16 the Government has allocated an extra £1.83 billion to the NHS, but the financial context in which these demands must be met remains challenging. Monitor, NHS England and independent analysts have previously calculated that a combination of growing demand, if met by no further annual efficiencies and flat real terms funding, would produce a mismatch between resources and patient needs of nearly £30 billion a year in England by 2020/21.

2.5 OUH, in common with the rest of the NHS, must meet these demands without compromising the safety and quality of its services, implementing the recommendations of the Francis, Berwick and Winterbourne View reviews.

2.6 The particular challenges for Oxfordshire’s health and social care system are the continued growth of its population due to inward migration, including to new developments such as the planned development of Bicester as a “Garden City”, and increasing life expectancy, caused in part by the development of successful treatments for cancer and cardiac disease, coupled with an ageing population. Oxfordshire’s 65 and over population grew by 18% from 2001 to 2011, while the number of people aged 85 and over rose by 30%. This growth is predicted to continue and is coupled with age-associated co-morbidity, with an ‘epidemic’ of frailty, cognitive impairment, such as dementia, and ‘frailty syndromes’, such as falls and immobility.

2.7 The ability of its local commissioner, Oxfordshire Clinical Commissioning Group (OCCG), to fund the growing demand for healthcare is constrained by its underlying deficit position, distance from target funding and the requirement to transfer funds to Oxfordshire County Council to protect social care as part of the national Better Care Fund initiative.
2.8 These demographic factors are already placing considerable strain on Oxfordshire Health and Social Care providers. Despite a number of initiatives, the number of patients whose transfers are delayed across the Oxfordshire system remains high. In 2014/15 (as at the end of February 2015), an average of 10.5% of OUH acute beds were occupied by people whose transfer to an alternative care setting was delayed. These issues have contributed to the Trust’s difficulty meeting national performance standards, particularly the Emergency Department standard (that patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department).

2.9 The Trust’s plan has also been informed by the Five Year Forward View, published in October 2014, and subsequent detailed planning guidance. The key elements of OUH’s response to the vision set out for how the NHS should address the demands on it are:

**A radical upgrade in prevention and public health** – continued implementation of the Trust’s Public Health Strategy, recognising its potential to play a broader role in improving and maintaining the health of the population, including the well and its own staff and thereby contribute to addressing the current rising rates of demand for its services. Key achievements during 2014/15 included the launch of an innovative drop-in health improvement advice centre at the John Radcliffe Hospital, training for staff in how to provide health improvement advice and work with food providers to increase healthy choices during meal times. Areas of focus for 2015/16, include ‘pop up’ health improvement centres on the Trust’s other sites; more training for staff on health promotion, including both physical and mental health, and the identification of ‘health champions’; development of a food and drink strategy; promotion of increased opportunities for active travel and other physical activity; and the promotion and support of mental wellbeing and resilience in the Trust’s staff. The health and wellbeing of staff is also an important theme of its Organisational Development and Workforce Strategy and progress to date was evidenced by the high scores achieved in the latest national audit of implementation of the NICE Public Health Guidance for the Workplace.

**Greater control for patients of their own care** - the Electronic Patient Record (EPR) allows clinicians to share more information with patients about their care. OUH is working towards achieving fully interoperable digital health records from 2018, as well collaborating through both the Academic Health Science Centre (AHSC) and the Academic Health Science Network (AHSN) to develop innovative ways of increasing patients’ control and monitoring of their condition, using technology, e.g. a gestational diabetes smartphone app.

**Engagement of communities** - this is described in Part Seven. In response to the call for NHS organisations to lead the way as progressive employers, with particular reference to the equality and diversity agenda, OUH is seeking to “widen participation” in underrepresented groups, with the support of Health Education Thames Valley (HETV), building on the success of the care support worker academy launched in 2012.

**Removal of barriers between organisations which hamper care provision and the development of new and diverse models of care** - OUH is collaborating with Oxford Health NHS FT and commissioners to explore new models to address the challenges to the local health economy described above. OUH and Oxford Health NHS FT are working jointly on an Alliance Programme to transform urgent healthcare services for older people and adults who have complex health problems across Oxfordshire. This aligns with Oxfordshire CCG’s strategic commissioning intentions to redesign services to achieve an integrated model, make major transformational changes in urgent care and move towards an outcomes based model of commissioning. In February 2015 OCCC determined OUH and Oxford Health NHS FT to be the Most Capable Provider.

For specialised and cancer services the Trust’s clinical strategy describes a model where the OUH takes on a leadership role as one of a smaller number of specialist providers at the centre of a portfolio of inter-connected clinical networks, supported by its role within the AHSC and AHSN. During 2014/15, the Trust has continued to extend its provision of local services throughout the Thames Valley and in Swindon and Milton Keynes, including joint consultant appointments and the
continued implementation of the vascular network. In 2015/16 key elements of this work will be the progression of business cases for the provision of satellite radiotherapy units at Swindon and Milton Keynes; continued implementation of the vascular network; work with the Royal Berkshire NHS FT to establish a joint Bone Marrow Transplant (BMT) service; continuing discussions with commissioners about the establishment of a network for the treatment and management of Sickle Cell patients; and responding to decisions about the future provision of urological cancer services.

**Exploiting the information revolution** – OUH has followed an accelerated pace for the introduction of its Electronic Patient Record, recently moving into joint first position in the Clinical Digital Maturity Index and seeks to continue to realise the benefits of EPR through its Transformation programme. During 2015/16 OUH will undertake the prioritisation of work in this area through its Information Management and Technology strategy. ‘Building the Digital Hospital’ is also a theme of the NIHR Oxford Biomedical Research Centre (BRC), with areas of work including electronic prescribing, linked to robotic dispensing: asset tracking using wireless and radiofrequency technology; the Oxfordshire Care Summary; SEND – an electronic system for recording and displaying patient vital signs; and ‘Big Data’ – linking disparate sources of data to understand better patient journeys through the hospital (also a theme of the AHSC). The Oxford AHSN has established a multi-partner E-Health Lab, a coordinating hub for e-health activity.

**Acceleration of useful healthcare innovation** – Oxford has been designated as an NHS Genomic Medicine Centre, while a major part of the Oxford AHSN’s work is Clinical Innovation Adoption, aiming to select ten innovations a year to adopt at scale across the region. Internally, innovation is nurtured through the Trust’s Transformation programme and during 2015/16 a framework will be developed to encourage and develop innovation within the Trust.

**Driving efficiency and productive investment** – this is coordinated through the Trust’s Transformation programme, which includes initiatives to streamline clinical pathways; implement E-procurement and barcoding; introduce demand management diagnostics and reduce non-attendances.

2.10 Other strategic developments which affect the Trust are:

**The Better Care Fund** which will total £37.5m in Oxfordshire from 2015/16 onwards. The proposed plan is focused on addressing the issues with system performance in relation to the ED target and delayed transfers, described above. The whole system has signed up to a 2% reduction in non-elective care, which for OUH means a reduction of 3,400 non-elective admissions in 2015/16.

**The Big Plan** – Oxfordshire’s joint Learning Disability Strategy for 2015-18, which is being developed jointly by Oxfordshire County Council and OCCC, proposes the integration of provision of mental and physical health care for people with learning disabilities into mainstream health services. During 2015/16 OUH will seek to continue the policy of moving services for people from the north of the county and neighbouring communities to its Horton site where this is clinically and financially sustainable.

2.11 Over the coming year the Trust plans to refresh its long term strategy, taking into consideration the Five Year Forward View, in particular the new ways of working and models of care described in it. Consideration of how the Trust can best collaborate with other care providers will be key to this. The strategy review will also examine the sustainability of the Trust’s services, particularly the sustainability of its specialised services portfolio, in the light of likely tariff changes and the review of specialised services planned by NHS England. A review of the underpinning strategies of Workforce, Estates and IT will be important to this, particularly to determining any constraints.

2.12 Since October 2014, progress has been made with local stakeholders towards the delivery of integrated care and on the development of plans for radiotherapy provision in Swindon and Milton Keynes, described below.
Local services: Oxfordshire Alliance Programme

2.13 The *NHS Five Year Forward View* published in October 2014 outlined the need to move to new models of care and emphasised that the NHS will increasingly need to dissolve traditional boundaries and focus on long term conditions, rather than providing single, unconnected episodes of care.

2.14 OUH and Oxford Health NHS Foundation Trust are working together on an Alliance Programme to transform urgent healthcare services for older people and adults who have complex health problems across Oxfordshire. The two Trusts are in the process of developing an Alliance agreement to enable transformational changes to be put in place that will ensure that patient care is provided in a more coordinated, effective and patient centred way.

2.15 These proposals are, in part, a response to historical problems with infrastructure and the configuration of services across Oxfordshire. They are also a response to well-known challenges facing the NHS and social care, such as growing demand and an ageing population with more complex health care needs.

2.16 The Alliance is focused on the provision of urgent care services for people who fall into four main categories (as illustrated in the diagram overleaf):

- Those who are acutely unwell and require acute admission and a focus on supported discharge.
- Those who require rapid assessment, treatment and stabilisation and who would be treated in an Emergency Multidisciplinary Unit, with possible admission to a community hospital bed.
- Those who are complex elderly patients where proactive support to primary care is crucial.
- The general older adult population where services provided within the Alliance can support primary care and integrated locality teams to enable patients to ‘age well’.

2.17 The Board agreed a process in May 2014 to achieve the ambitions and aspirations of a proposed integrated care delivery model. In September 2014, the Board considered a Most Capable Provider Assessment, required under procurement law by Oxfordshire Clinical Commissioning Group. In February 2015, Oxfordshire CCG deemed OUH and Oxford Health to be the Most Capable Provider and agreed that contract negotiation with the Alliance should proceed.

2.18 Achieving the aims of the Alliance will require significant changes to the way care is organised and managed and to the infrastructure supporting it. It will also require a rethinking of roles and reskilling of staff to provide more responsive and coordinated care.

2.19 Governance arrangements for the Alliance are being developed with both Trusts’ Boards in order to meet regulatory requirements and effectively to manage risks of service delivery, income and liabilities.

2.20 OUH and Oxford Health have made a joint commitment to provide the resources and staff required to deliver the work programmes for the start-up phase and continuation of the Alliance, once formally established.

Specialised services: radiotherapy developments

2.21 Two business cases are being developed for satellite radiotherapy units - in Swindon and Milton Keynes.

2.22 An Outline Business Case for the Swindon radiotherapy unit was approved by the Board and by the NHS TDA in 2014 and estimated capital costs at £14.7m. A Full Business Case is nearing completion and shows expected capital costs of £16.4m. Charitable funding and potential changes to prostate fractionation rates and specialised tariffs remain as financial risks and are being acknowledged appropriately in the financial modelling. The FBC for the Swindon scheme is to be considered by the Trust Board during 2015 after which, prior to authorisation, it would progress to the NHS TDA. A revised programme timetable, subject to the necessary approvals, sees the new building open in June 2017. These costs and this timetable have informed this scheme’s inclusion in the LTFM base case.

2.23 The Milton Keynes radiotherapy scheme has not yet been approved at Outline Business Case level, so is not modelled in the LTFM. This scheme is under review following the latest Malthus predictions for radiotherapy needs and the OBC is to be considered by the Trust’s Board early in 2015/16.
1. Acutely unwell
- Hospital admission to acute bed for assessment and treatment in agreed pathways;
- Admission when required for the shortest time necessary with early supported discharge to the most appropriate post-acute setting.

2. Unstable frail elderly
- Rapid access assessment, treatment and stabilisation through Emergency Medical Unit model of care;
- Admission when required through ‘fit for purpose’ community hospitals;
- Focus upon early supported discharge.

3. Complex elderly patients
- Proactive support to a federated primary care model to recognise complexity and manage patients prior to crisis occurring;
- Delivered in conjunction with IFD and ‘outreach function’ from Emergency Medical Unit.

4. General elderly care patient
- Support, advice and clinical supervision to primary care and integrated locality teams to enable patients to ‘age well’.

Oxfordshire Alliance Programme
3. Measures to assess and address risks to quality

3.1 Monitor’s review of the Trust’s quality governance arrangements in 2014 identified some issues on which action was needed. These are summarised in the table below, referencing questions in Monitor’s Quality Governance Framework.

3.2 Progress is reported through the Quality Committee. At its meeting on 13 May 2015, the Board will be asked to consider progress made and a revised self-assessment against the QGF ratings, informed by discussion at the Quality Committee during April.

<table>
<thead>
<tr>
<th>QGF question</th>
<th>Rating</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>3B: Are there clearly defined, well understood processes for escalating and resolving issues and managing quality performance?</td>
<td>Amber/Red</td>
<td>Actions to improve reporting to the Board’s Quality Committee and amend the role of the Clinical Governance Committee; to improve the timeliness and effectiveness of actions to address risks sustainably, especially addressing performance against plans to address failures to meet access and outcomes standards; and to improve the escalation and reporting of serious incidents and demonstrate shared learning from them.</td>
</tr>
<tr>
<td>1A: Does quality drive the trust’s strategy?</td>
<td>Amber/Green</td>
<td>The development of more explicit and measurable quality goals, translated to Divisional level and, where possible, to ward level.</td>
</tr>
<tr>
<td>1B: Is the Board sufficiently aware of potential risks to quality?</td>
<td>Amber/Green</td>
<td>Actions to gain assurance on the quality impact of Cost Improvement Programme schemes in progress, and to improve the efficacy and consistency of the use of risk registers at Divisional level.</td>
</tr>
<tr>
<td>2B: Does the Board promote a quality-focused culture throughout the Trust and 3C: Does the Board actively engage patients, staff and other key stakeholders on quality?</td>
<td>Amber/Green</td>
<td>Actions to support staff to undertake training and appraisals, and to improve engagement with the Trust’s consultant body.</td>
</tr>
<tr>
<td>3A: Are there clear roles and accountabilities in relation to quality governance?</td>
<td>Amber/Green</td>
<td>Actions to clarify the role and functioning of Clinical Governance Committee and Trust Management Executive in relation to quality governance.</td>
</tr>
<tr>
<td>4B: Is the Board assured of the robustness of quality information?</td>
<td>Amber/Green</td>
<td>Actions to improve the robustness and consistency of information on access, outcomes and quality at the Board and its committees, and to gain assurance from clinical audit. Clarification of formal links between the Board’s Quality and Audit Committees.</td>
</tr>
<tr>
<td>4C: Is quality information used effectively?</td>
<td>Amber/Green</td>
<td>Actions to use a wider group of benchmark peers than the Shelford Group, and to improve Divisional quality reports.</td>
</tr>
</tbody>
</table>
4. **Workforce**

4.1 To deliver the levels of activity required by its commissioners whilst achieving quality improvements and operational performance standards, OUH must maintain sufficient levels of staffing and skills.

4.2 OUH’s workforce capacity profile is aligned with planned service activity levels and LTFT assumptions. However, variations will exist which will require the use of contingent staffing to meet unplanned or short-term increases in activity and to respond to particular recruitment and retention issues.

**Safe staffing levels**

4.3 OUH is committed to providing care of the highest quality, with respect to safety, outcomes and the experience of patients and carers.

4.4 Central to the Trust’s workforce plan is to maintain safe staffing levels for clinical staff groups and to work towards achieving optimum capacity and capability across all staff groups.

4.5 Nurse staffing levels and skill mix are regularly reviewed at ward level using the Safer Nursing Care Tool advocated by the Shelford Group of teaching hospitals. Real time ward staffing levels are monitored on each hospital site through twice-daily staff and bed capacity reviews, led by a sister or matron. Where necessary, staff members are moved and/or temporary staff secured to address any identified shortfalls in capacity. Following a rise in funded staffing numbers on some wards during 2014/15, work continues to recruit and retain to establishment levels.

**Organisational culture and values**

4.6 The Trust’s values of Excellence, Compassion, Respect, Delivery, Learning and Improvement guide and inform attitudes, behaviours, interactions and performance, and so underpin organisational culture. These values are being integrated into all aspects of the Trust’s workforce processes, policies and practice which govern every step of the employee journey with OUH, from recruitment to exit interview.

4.7 The Trust will continue to promote and embed a culture and climate where its core values will be evident in its leadership and in the day-to-day behaviours of staff. The aim is to create a distinctive, authentic and sustainable values-based culture which:

- promotes trust, openness and engagement;
- engenders a ‘can do’ and flexible approach by all staff, encouraged by supportive working processes;
- fosters authentic leadership;
- builds effective partnership working;
- expects personal responsibility and accountability at all levels.

4.8 Values Based Interviewing continues to be used across all staff groups and greater numbers of line managers will be equipped with the skills required to conduct Values Based Conversations with staff, to enhance the value of annual appraisal and to help to further strengthen good people management practices within the organisation.

**Outstanding nursing and midwifery**

4.9 At its meeting in March 2015, the Board...
agreed a Nursing and Midwifery Strategy for 2015-2018. This set out an aim to develop outstanding nursing and midwifery practice with an internationally recognised reputation for excellence, to be achieved through five strategic themes (see box).

Roles and service redesign
4.10 Alongside its actions to maintain appropriate staffing levels, the Trust will continue to flex established workforce models to include the introduction of redesigned roles better suited to meeting service needs and new models of care.

4.11 Examples of recent successes include the Supported Hospital Enhanced Discharge Service; the development of a Community Support Worker role; and the introduction of new roles in Emergency Departments to enable the more effective distribution of tasks between nursing and medical staff.

4.12 Similarly, and in order to reduce waste, greater consideration will be given to the more innovative use of those professions where there is a current and predicted workforce oversupply, such as Pharmacy. The influence of such workforce considerations on service redesign will be included within a refreshed Workforce Strategy later in 2015/16.

Staff turnover and vacancy
4.13 Despite achieving an increase in its substantive workforce of 400WTE in 2014/15, the overall turnover rate of 13.2% in early 2015 reflected an upward trend and an increase of 1.9% in the year.

4.14 An analysis of turnover by pay band highlighted that staff retention is a more significant problem across clinical staff groups, particularly within band 5 (predominantly qualified nursing, midwifery, theatres and therapies staff). For both clinical and non-clinical staff groups, turnover at band 2 level is also high compared with other bands, which in part reflects competition within the local economy for lower skilled labour.

4.15 Within the context of the prevailing national and local economic climate, controlling staff turnover will remain challenging. The Trust will continue to strive towards reducing its overall turnover rate to 10.5% in 2015/16, and thereafter to maintain this level. As a consequence of reducing turnover, combined with the achievement of greater efficiencies in recruitment and selection processes, the Trust aims to reduce the overall vacancy rate to 5%, or below.

Recruitment and retention
4.16 The recruitment and retention of staff remains a significant challenge for the Trust. In common with most other NHS provider organisations, staff turnover at OUH depends on a variable number of risk factors such as the work environment, demographic variables, individuals’ personal responses to situations, and alternative options and opportunities for employment.

4.17 Recent focus group work, including a recruitment and retention ‘summit’, combined with the analysis of local staff survey and exit interview responses, has served to provide greater insight into the key factors influencing the Trust’s ability to attract, recruit and retain staff in sufficient numbers, and with the right level of skill and experience. Feedback consistently highlights the significance of local cost of living in influencing the decision by individuals to leave the organisation, either to relocate to areas of the country which are deemed more affordable, or to other trusts where salary bands are higher and/or a salary weighting is applied.

4.18 Staff retention is adversely affected by OUH’s relative proximity to the London NHS ‘market’, where movement within the NHS is high and where salaries attract a weighting (high cost area supplement) equating to as much as 20% of basic pay. Outside central London, Oxford is officially recognised as being the least affordable town/city in which to live, with an average property costing over eleven times local average earnings. Oxford rental costs are also regarded as being higher than elsewhere in the country, with tenants typically spending over half of their salaries on property charges.

4.19 Staff commentary also confirms that pressures associated with the local high cost of living are worsened by the relative difficulty encountered by many employees in their daily commute, whether by car or
public transport, combined with frequent problems associated with site access, parking and egress. These particular pressures cause additional stress and anxiety, which impacts on the overall health and wellbeing of OUH staff and is often significant enough to prompt individuals to leave the organisation.

4.20 There is no single or simple solution to the challenges associated with staff recruitment and retention. However, actions are being taken in six key areas:

- Increasing substantive workforce capacity
- Mitigating high cost of living
- Applying targeted recruitment and retention incentives
- Widening participation
- Improving professional development opportunities and career advancement
- Creating and sustaining the right environment

4.21 In support of continued UK recruitment activity, an overseas recruitment programme is proving successful in attracting qualified and experienced nursing staff from Northern Europe. This programme will continue until the target recruitment numbers are achieved.

Education, training and development

4.22 Access to professional development opportunities and career advancement are important issues for staff, particularly those occupying professional roles. A Trust Education and Training Strategy is being developed, recognising that OUH must provide opportunity and support in these areas and across all professional groups so that, as far as possible, individuals are able to develop and sustain their careers locally in order to benefit both staff and patient care.

4.23 Protected time for education and training is a particular issue for clinical staff, reinforcing the need to increase substantive staff capacity and reduce reliance on the contingent workforce. A comprehensive review will examine the effectiveness of existing shift patterns within wards and other clinical areas. A particular concern is the impact of long (i.e. twelve hour) shifts on handover time and the ability of staff to undertake all categories of training, or to effectively engage in regular appraisal and personal development planning.

Attendance management

4.24 Consistent with expectations for the wider NHS, OUH is committed to reducing staff sickness absence and maintaining an overall rate of 3% or below. Implementation of the FirstCare absence management system has proved beneficial in providing more accurate and timely data, assisting staff and line managers, and more efficiently and effectively facilitating individuals' return to work following a period of absence.

Contingent workforce

4.25 As a consequence of sustained high levels of staff turnover and increases in planned activity levels, the Trust is over-reliant upon the use of the contingent workforce (i.e. bank and agency), and in particular agency staff. Current expenditure in this area represents 8.3% of the total pay bill.

4.26 This level of reliance upon additional bank and agency capacity is costly and can have an impact on the continuity of care provided to patients and on the experience of the Trust’s substantively employed staff. In 2015/16 the Trust plans to reduce its expenditure on the contingent workforce by 14% from 2014/15 levels.

Widening participation

4.27 With the support of Health Education Thames Valley, OUH is exploring opportunities to widen participation, particularly of disengaged young people, those without qualifications, low skilled, part-time and temporary workers, those on low incomes and/or working age benefits, older adults, those with literacy, numeracy or learning difficulties and some minority ethnic groups.
4.28 An important aspect of the Trust’s activities to widen participation is the support provided for care support workers through OUH’s Care Support Worker Academy. All care support workers are able to undertake a programme of education which leads to the award of the higher certificate of fundamental care. Thereafter, those individuals who demonstrate the ability to progress into a professional education programme are provided with support to do so. Launched in 2012, the CSW Academy is also active in recruiting care support workers; developing competency frameworks; promoting and supporting assistant practitioner development (in partnership with Oxford Brookes University); providing career and progression advice; and promoting apprenticeship opportunities within the Trust.

**Leadership and Talent Development**

4.29 Faced with the challenges of a changing and ever more demanding operating environment, continued success will require the application of authentic and thoughtful leadership which has service quality, patient-centred care and efficiency at its heart.

4.30 A systematic approach to spotting, developing and growing talent is under development within a Leadership and Talent Development Strategic Framework endorsed by the Trust Board in 2014/15.

5. **Governor development and membership**

5.1 As required during the Monitor assessment phase, the Trust has established and begun to prepare its Council of Governors to fulfil its functions from the date of authorisation.

5.2 Elections were conducted for the Trust by UK Engage. All public and staff governor seats were contested and results were declared on 20 February 2015. With the exception of one nominated governor, all governors are in place and induction has been conducted with input from NHS Providers’ GovernWell team.

5.3 Action continues to deliver the Trust’s Membership Strategy, agreed by the Board in January 2014. The number of members exceeded the target set for the start of elections. Work will take place during 2015 with the Council of Governors to develop the Strategy and associated action plan, against which progress was reported to the Board in September 2014.
6. Financial Plans

Introduction
6.1 The purpose of this section is to:
• Review the historical financial performance of the Trust for 2011/12 to 2013/14.
• Outline in-year financial forecast for 2014/15.
• Detail the financial plans for the Trust for the five years from 2015/16 to 2019/20.

6.2 Key points are that:

6.2.1 OUH has used the Long Term Financial Model (LTFM) to forecast its future financial performance over five years to 2019/20. The LTFM incorporates appropriate assumptions on activity, inflation, service development, capital and cost improvement programmes and supports the Trust’s strategy as described above.

6.2.2 The LTFM incorporates plans for service expansion in Radiotherapy as part of its strategy to continue developing as a key regional provider of specialised services.

6.2.3 The plans include significant capital investment with larger schemes including JR theatres, Adult Critical Care and Radiotherapy satellite units. The plans include £38.5m of capital loan finance over the period to help fund these capital investments.

6.2.4 It includes the Default Tariff Rollover (DTR) position for the Trust in 2015/16, along with updated assumptions on NHS tariffs from 2016/17.

6.2.5 It demonstrates that the Trust is financially viable and will generate revenue and cash surpluses from the planned first full year of licence in 2016/17.

6.2.6 It shows that the Trust will achieve an overall Continuity of Service Risk Rating (CSRR) of 3 from the planned first full year of licence in 2016/17. This includes the benefit of a £22m FT liquidity loan planned for draw down at the anticipated point of licence in 2015/16.

Historical financial position
6.3 The tables in this section provide a historical analysis of income and expenditure from 2011/12 to 2013/14. The financial statements for 2011/12 were prepared on a merger accounting basis for the year, following the merger in November 2011 of the former Oxford Radcliffe Hospital and Nuffield Orthopaedic Centre Trusts to form the Oxford University Hospitals NHS Trust.

6.4 The information includes the income and expenditure results, the underlying earnings position, the Balance Sheet and Cash Flows, with narrative on the key changes and movements between each year. The historical delivery of savings each year is also set out here.
Historical financial performance

Income and expenditure statement

6.5 The tables below summarise the trading position for 2011/12 to 2013/14, setting out the main components of annual income and expenditure over this period.

<table>
<thead>
<tr>
<th>Statement of Comprehensive Income - OUH</th>
<th>2011/12 £000s</th>
<th>2012/13 £000s</th>
<th>2013/14 £000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income from activities</td>
<td>643,758</td>
<td>684,673</td>
<td>739,652</td>
</tr>
<tr>
<td>Other operating income</td>
<td>144,462</td>
<td>137,030</td>
<td>128,695</td>
</tr>
<tr>
<td><strong>Total income</strong></td>
<td><strong>788,220</strong></td>
<td><strong>821,704</strong></td>
<td><strong>868,346</strong></td>
</tr>
<tr>
<td>Operating expenses</td>
<td>-718,705</td>
<td>-752,888</td>
<td>-795,080</td>
</tr>
<tr>
<td><strong>EBITDA</strong></td>
<td><strong>69,515</strong></td>
<td><strong>68,815</strong></td>
<td><strong>73,267</strong></td>
</tr>
<tr>
<td>EBITDA margin %</td>
<td>8.8%</td>
<td>8.4%</td>
<td>8.4%</td>
</tr>
<tr>
<td>Depreciation and amortisation</td>
<td>-34,850</td>
<td>-36,758</td>
<td>-36,706</td>
</tr>
<tr>
<td><strong>Operating surplus/ (deficit)</strong></td>
<td><strong>34,664</strong></td>
<td><strong>32,058</strong></td>
<td><strong>36,561</strong></td>
</tr>
<tr>
<td>Profit/ (loss) on the disposal of fixed assets</td>
<td>-159</td>
<td>-17</td>
<td>394</td>
</tr>
<tr>
<td>Fixed asset impairments</td>
<td>2,327</td>
<td>-4,568</td>
<td>8,426</td>
</tr>
<tr>
<td>Interest receivable</td>
<td>135</td>
<td>189</td>
<td>243</td>
</tr>
<tr>
<td>Interest payable and financing costs</td>
<td>-20,471</td>
<td>-20,477</td>
<td>-20,633</td>
</tr>
<tr>
<td><strong>Surplus/ (deficit) for the financial year</strong></td>
<td><strong>16,497</strong></td>
<td><strong>7,186</strong></td>
<td><strong>24,991</strong></td>
</tr>
<tr>
<td>Dividends payable on public capital</td>
<td>-8,894</td>
<td>-8,502</td>
<td>-7,559</td>
</tr>
<tr>
<td><strong>Retained surplus / (deficit)</strong></td>
<td><strong>7,603</strong></td>
<td><strong>-1,316</strong></td>
<td><strong>17,432</strong></td>
</tr>
<tr>
<td>Adjustments for impairments and IFRIC 12</td>
<td>-2,327</td>
<td>4,568</td>
<td>-8,426</td>
</tr>
<tr>
<td>Adjustments for donated asset reserve elimination</td>
<td>1,882</td>
<td>394</td>
<td>1,889</td>
</tr>
<tr>
<td><strong>Breakeven duty surplus / (deficit)</strong></td>
<td><strong>7,157</strong></td>
<td><strong>3,646</strong></td>
<td><strong>10,895</strong></td>
</tr>
<tr>
<td>Adjusted surplus / (deficit) %</td>
<td>0.9%</td>
<td>0.4%</td>
<td>1.3%</td>
</tr>
</tbody>
</table>

6.6 The next section identifies the key income and cost drivers over the three year period and sets these out for the last financial year 2013/14 in the bridge chart at 6.14 below.

6.7 Income from activities increased between 2011/12 and 2013/14. The main reasons for this were increases in volume of activity (£83.0m) with significant growth in areas such as critical care and chemotherapy, increased pass-through drugs and devices income (£17.4m) and developments and other increases (£14.4m). These were partly offset over the period by the increasing impact of the national non-elective threshold marginal rates rule (£7.9m) and deflation to national tariffs for Payment by Results (£22.1m).
Income from activities (patient related income)

<table>
<thead>
<tr>
<th>Changes in Income From Activities - OUH</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Movement to 2012/13 £000s</td>
</tr>
<tr>
<td>Activity volume</td>
<td>32,972</td>
</tr>
<tr>
<td>Pass through drugs and devices</td>
<td>8,717</td>
</tr>
<tr>
<td>CQUIN</td>
<td>10,281</td>
</tr>
<tr>
<td>Developments and other (includes readmission penalties)</td>
<td>7,664</td>
</tr>
<tr>
<td>National non-elective threshold marginal rates</td>
<td>-7,484</td>
</tr>
<tr>
<td>Deflation to national tariffs</td>
<td>-11,234</td>
</tr>
<tr>
<td><strong>Total change in income from activities</strong></td>
<td><strong>40,916</strong></td>
</tr>
</tbody>
</table>

(Excludes non-recurrent patient care income)

Other operating income

6.8 Other operating income was stable over the period once non-recurrent income items are excluded. The main changes were as follows:

6.8.1 Increasing research and development income (£12.5m) and non-patient care services income (£1.5m). These were offset by reductions in MPET income of £2.0m and other income reductions.

6.8.2 Non-recurring income relating to the ORH and NOC merger are being included in other income within the financial model. These are set out in the table below on normalised earnings, including £15.2m of non-recurrent income in 2011/12.

<table>
<thead>
<tr>
<th>Other operating income - OUH</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2011/12 £000s</td>
</tr>
<tr>
<td>Education and training</td>
<td>46,769</td>
</tr>
<tr>
<td>Research and development</td>
<td>39,177</td>
</tr>
<tr>
<td>Other income</td>
<td>58,517</td>
</tr>
<tr>
<td><strong>Total other operating income</strong></td>
<td><strong>144,462</strong></td>
</tr>
</tbody>
</table>

(Includes non-recurrent income)

Operating expenses

6.9 Pay costs increased over the period. The main reasons for this were:

6.9.1 Pay increases linked to volume growth in activity of £44.9m.

6.9.2 Increased research and development and trust wide pay expenditure (funded by a corresponding increase in income) of £17.3m.

6.9.3 Service development investment in pay of £2.6m.
6.9.4 Incremental pay increases (including a 1% pay award for staff in 2013/14) of £10.7m. These increases have been in line with national policy.

6.9.5 Other increases including investment to deliver increased CQUIN income and the impact of non-recurrent pay savings from 2011/12 and 2012/13.

6.10 These increases were offset by pay savings of £34.5m.

<table>
<thead>
<tr>
<th>Employee benefit expenses - OUH</th>
<th>2011/12 £000s</th>
<th>2012/13 £000s</th>
<th>2013/14 £000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultants</td>
<td>90,064</td>
<td>90,904</td>
<td>97,667</td>
</tr>
<tr>
<td>Junior medical</td>
<td>59,097</td>
<td>62,871</td>
<td>63,581</td>
</tr>
<tr>
<td>Nursing and midwifery</td>
<td>123,922</td>
<td>126,665</td>
<td>133,575</td>
</tr>
<tr>
<td>Scientific, therapeutic and technical</td>
<td>55,520</td>
<td>54,858</td>
<td>60,407</td>
</tr>
<tr>
<td>Other staff</td>
<td>87,265</td>
<td>97,884</td>
<td>104,109</td>
</tr>
<tr>
<td>Temporary and agency staff (excluding bank)</td>
<td>12,131</td>
<td>17,636</td>
<td>24,327</td>
</tr>
<tr>
<td><strong>Total employee benefit expenses</strong></td>
<td><strong>427,999</strong></td>
<td><strong>450,818</strong></td>
<td><strong>483,666</strong></td>
</tr>
</tbody>
</table>

(Excludes non-recurrent employee benefit expense)

6.11 Non-pay costs increased during the period. The main reasons for this were:

6.11.1 Increases linked to volume growth of activity of £32.3m.

6.11.2 Inflationary increases of £23.0 million (including £9.5m on drugs and £7.2m on clinical supplies and services).

6.11.3 Increased pass-through drugs and devices expenditure of £17.4m.

6.11.4 CNST premium increases of £2.5m.

6.11.5 Service development investment of £1.1m.

6.11.6 Increased depreciation and amortisation £1.9m.

6.11.7 Other increases including investment to deliver increased CQUIN income and the impact of non-recurrent non-pay savings from 2011/12 and 2012/13.

6.12 These increases were offset by non-pay savings of £38.4m. A number of non-recurring items were included in non-pay, as shown in the table overleaf. These included £8.1m of non-recurring items in 2011/12.
Other Operating Expenses - OUH

<table>
<thead>
<tr>
<th></th>
<th>2011/12 £000s</th>
<th>2012/13 £000s</th>
<th>2013/14 £000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drugs, blood products and medical gases</td>
<td>75,893</td>
<td>79,891</td>
<td>86,823</td>
</tr>
<tr>
<td>Clinical supplies and services expenses</td>
<td>86,391</td>
<td>92,500</td>
<td>96,232</td>
</tr>
<tr>
<td>General supplies and services expenses</td>
<td>7,311</td>
<td>6,274</td>
<td>6,342</td>
</tr>
<tr>
<td>Establishment expenses</td>
<td>7,428</td>
<td>6,909</td>
<td>8,395</td>
</tr>
<tr>
<td>Premises expenses</td>
<td>29,505</td>
<td>34,041</td>
<td>31,503</td>
</tr>
<tr>
<td>PFI operating expenses</td>
<td>29,103</td>
<td>30,739</td>
<td>31,857</td>
</tr>
<tr>
<td>Depreciation and amortisation of assets</td>
<td>34,850</td>
<td>36,758</td>
<td>36,706</td>
</tr>
<tr>
<td>Impairment of fixed assets (non-recurring)</td>
<td>-2,327</td>
<td>4,568</td>
<td>-8,426</td>
</tr>
<tr>
<td>Other operating expenses</td>
<td>55,077</td>
<td>51,717</td>
<td>50,262</td>
</tr>
<tr>
<td><strong>Total other operating expenses in financial statements</strong></td>
<td><strong>323,230</strong></td>
<td><strong>343,395</strong></td>
<td><strong>339,694</strong></td>
</tr>
</tbody>
</table>

Remove impairments and exceptional items

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2,327</td>
<td>-4,568</td>
<td>8,426</td>
</tr>
<tr>
<td><strong>Total other operating expenses (after adjusting impairments)</strong></td>
<td><strong>325,557</strong></td>
<td><strong>338,828</strong></td>
<td><strong>348,120</strong></td>
</tr>
</tbody>
</table>

(Includes non-recurrent expenditure)

Income and expenditure – normalised earnings

6.13 The Trust improved its underlying financial position, moving from a normalised net deficit of (£1.6m) in 2011/12 to a normalised net surplus of £8.6m in 2013/14. This is after adjusting for agreed non-recurrent or “exceptional” items, as set out in the table below, that are not part of the normal course of operations for the Trust.1

Normalised earnings – OUH

<table>
<thead>
<tr>
<th></th>
<th>2011/12 £000s</th>
<th>2012/13 £000s</th>
<th>2013/14 £000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retained surplus / (deficit)</td>
<td>7,603</td>
<td>-1,316</td>
<td>17,432</td>
</tr>
<tr>
<td>Less impairments</td>
<td>-2,327</td>
<td>4,568</td>
<td>-8,426</td>
</tr>
<tr>
<td>(Profit)/loss on asset disposals</td>
<td>159</td>
<td>17</td>
<td>-394</td>
</tr>
<tr>
<td>Less non-recurring income</td>
<td>-15,200</td>
<td>0</td>
<td>8,997</td>
</tr>
<tr>
<td>Less non-recurring expenditure</td>
<td>8,122</td>
<td>0</td>
<td>-8,997</td>
</tr>
<tr>
<td><strong>Normalised net surplus / (deficit)</strong></td>
<td><strong>-1,643</strong></td>
<td><strong>3,269</strong></td>
<td><strong>8,612</strong></td>
</tr>
</tbody>
</table>

Bridge analysis of 2012/13 normalised surplus to 2013/14 normalised surplus

6.14 The bridge chart overleaf shows the main changes in the normalised position in the year 2013/14.

---

1 Non-recurrent items agreed with the Monitor assessment team as part of “locking down” the Base Case LTFM.
Statement of Financial Position

6.15 The table below shows the year-end Statement of Financial Position from 2011/12 to 2013/14.

<table>
<thead>
<tr>
<th>Statement of Financial Position - OUH</th>
<th>2011/12 £000s</th>
<th>2012/13 £000s</th>
<th>2013/14 £000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-current assets</td>
<td>707,513</td>
<td>693,266</td>
<td>710,202</td>
</tr>
<tr>
<td>Current assets:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inventories</td>
<td>12,761</td>
<td>11,353</td>
<td>11,807</td>
</tr>
<tr>
<td>Receivables and prepayments</td>
<td>36,391</td>
<td>26,296</td>
<td>24,361</td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>43,884</td>
<td>65,657</td>
<td>86,448</td>
</tr>
<tr>
<td><strong>Total current assets</strong></td>
<td><strong>93,036</strong></td>
<td><strong>103,306</strong></td>
<td><strong>122,616</strong></td>
</tr>
<tr>
<td>Current liabilities</td>
<td>-108,189</td>
<td>-121,401</td>
<td>-131,187</td>
</tr>
<tr>
<td><strong>Net current assets (liabilities)</strong></td>
<td><strong>-15,153</strong></td>
<td><strong>-18,095</strong></td>
<td><strong>-8,571</strong></td>
</tr>
<tr>
<td><strong>Total assets less current liabilities</strong></td>
<td><strong>692,360</strong></td>
<td><strong>675,171</strong></td>
<td><strong>701,631</strong></td>
</tr>
<tr>
<td>Provisions for liabilities and charges</td>
<td>-1,426</td>
<td>-1,602</td>
<td>-2,447</td>
</tr>
<tr>
<td>Loans</td>
<td>-12,541</td>
<td>-7,811</td>
<td>-5,003</td>
</tr>
<tr>
<td><strong>Total assets employed</strong></td>
<td><strong>371,960</strong></td>
<td><strong>371,386</strong></td>
<td><strong>409,826</strong></td>
</tr>
<tr>
<td>Financed by:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public dividend capital</td>
<td>206,873</td>
<td>207,673</td>
<td>208,935</td>
</tr>
<tr>
<td>Revaluation reserve</td>
<td>147,744</td>
<td>147,362</td>
<td>164,735</td>
</tr>
<tr>
<td>Other reserves</td>
<td>1,743</td>
<td>1,743</td>
<td>1,743</td>
</tr>
<tr>
<td>Retained earnings</td>
<td>15,600</td>
<td>14,608</td>
<td>34,413</td>
</tr>
<tr>
<td><strong>Total taxpayers’ equity</strong></td>
<td><strong>371,960</strong></td>
<td><strong>371,386</strong></td>
<td><strong>409,826</strong></td>
</tr>
</tbody>
</table>

(Loans for 11/12 and 12/13 include amounts due within one year – due to categorisation in the LTFM).

Non-current assets

6.16 The Trust’s non-current assets predominantly consist of land, property, plant and equipment across its four main sites: the John Radcliffe, Churchill and Nuffield Orthopaedic Centre sites in Oxford and the Horton General Hospital in Banbury.

6.17 Over the last decade the Trust has invested in the renewal and improvement of its estate, including a new hospital including a Cancer Centre on the Churchill site, a new West Wing, Children’s Hospital and Heart Centre on the John Radcliffe site, and a new hospital on the Nuffield Orthopaedic Centre site. Much of this investment was procured under the Private Finance Initiative (PFI) and was included under fixed assets on conversion to IFRS accounting in 2008/09.
6.18 Capital investment has also included an expansion of cardiac capacity and newborn intensive care capacity on the John Radcliffe site; two additional operating theatres on the NOC site; and investment in medical equipment and in the Electronic Patient Record system.

6.19 The net value of non-current assets increased over the period by £2.7m. This was due to asset investment, asset revaluations and reversals of previous valuation impairments exceeding depreciation.

Current assets

6.20 Cash balances increased by £42.6m over the three year period. Cash increases have been driven by an improved underlying financial position since 2010/11, reduced capital expenditure in 2011/12, and improved cash management from 2012/13, especially around NHS debt and the invoicing and collection of settlements from commissioners.

6.21 The decrease in inventories values over the period by £1.0m was primarily caused by simplified stock management.

6.22 Receivables balances reduced by £9.3m in 2012/13, due to factors including prompt billing and settlement of all 2012/13 income to avoid legacy debts resulting from commissioning system changes (£2.9 million) and a reduction in sales ledger debts (£1m) and assets no longer being held as a debtor pending leasing (£2.2m). Receivables balances reduced by £2.7m in 2013/14 due to several factors including a reduction in private patient debt.

Current liabilities

6.23 Trade payables and accruals balances have increased due to increases in patient care activity over the three year period as well as increased amounts of research and development income held. The level of this deferred research income is one of the drivers behind the Trust’s net current liability position on the Statement of Financial Position. There was also a £1.1 million increase in capital creditors by March 2014 relating to the phasing of expenditure in the capital programme in 2013/14.

Non-current liabilities

6.24 Long term liabilities are predominantly the three OUH PFI scheme liabilities which are accounted for under IFRS on the Balance Sheet (with the assets under fixed assets), along with existing medical equipment finance leases that the Trust has in place, deferred income (mainly relating to research), and loans. The long term PFI scheme liabilities have reduced gradually each year as capital repayments against the outstanding lease liability are made.

6.25 The loan liabilities were for a working capital loan and two capital investment loans (see detail below), which have reduced as scheduled repayments have been made. OUH repaid the final instalment on its working capital loan in March 2013.

Taxpayers’ equity

6.26 There has been an overall increase of £37.8m in the level of taxpayers’ equity over the period. This is predominantly driven by asset revaluations of £19.9m in the last year and the £17.4m retained surplus generated over the last year.
**Better Payment Practice Code (BPPC) performance**

6.27 The table below sets out BPPC performance over the last three years.

<table>
<thead>
<tr>
<th>BPPC Performance - OUH</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2011/12</td>
</tr>
<tr>
<td>Non NHS Invoices Paid Within Policy (Value)</td>
<td>84%</td>
</tr>
<tr>
<td>Non NHS Invoices Paid Within Policy (Number)</td>
<td>86%</td>
</tr>
<tr>
<td>NHS Invoices Paid Within Policy (Value)</td>
<td>81%</td>
</tr>
<tr>
<td>NHS Invoices Paid Within Policy (Number)</td>
<td>72%</td>
</tr>
</tbody>
</table>

6.28 The Trust is working to achieve the NHS policy on BPPC which requires payment of 95% of invoices within 30 days of receipt of invoice. For the last year (on NHS payables) the Trust achieved 96% by value of invoices paid (increased from 81% in 2011/12). It achieved 92% by volume (increased from 74% in 2012/13). The Trust has previously struggled to meet the 95% target, but is now moving more purchasing onto its electronic purchase order system in order to streamline the authorisation process. This should guarantee delivery of the 95% target.

**Working capital ratios**

6.29 In 2013/14 NHS trade receivable days averaged five days for receipt of payment, while non-NHS trade receivable days averaged 27 days.

6.30 Trade payable days averaged 35 days for payment to be made. The stock turnover ratio was five days.

**Repaying the working capital and capital loans**

6.31 ORH took out a working capital loan of £19.986m in March 2007 from the Department of Health to finance the impact of a deficit accumulated in 2005/06 and 2006/07. The Trust repaid this loan over an agreed six year schedule and paid back the final instalments in 2012/13. These repayments were financed partly by income and expenditure surpluses generated since 2006/07 and partly by constraining the size of the Trust’s capital programme.

6.32 Two capital investment loans of £6.141m in 2007/08 and £7.900m in 2008/09 were taken out to help fund the capital programme. The capital repayments made (and the remainder due to be made) on the loans are shown in the schedule overleaf.
### Loan repayment schedule

<table>
<thead>
<tr>
<th>Loan repayments - OUH (£000s)</th>
<th>Working capital loan repayments</th>
<th>Capital loan repayments</th>
<th>Total loan repayments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007/08</td>
<td>3,332</td>
<td>0</td>
<td>3,332</td>
</tr>
<tr>
<td>2008/09</td>
<td>3,332</td>
<td>614</td>
<td>3,946</td>
</tr>
<tr>
<td>2009/10</td>
<td>3,332</td>
<td>1,404</td>
<td>4,736</td>
</tr>
<tr>
<td>2010/11</td>
<td>3,332</td>
<td>1,404</td>
<td>4,736</td>
</tr>
<tr>
<td>2011/12</td>
<td>3,332</td>
<td>1,404</td>
<td>4,736</td>
</tr>
<tr>
<td>2012/13</td>
<td>3,326</td>
<td>1,404</td>
<td>4,730</td>
</tr>
<tr>
<td>2013/14</td>
<td>0</td>
<td>1,404</td>
<td>1,404</td>
</tr>
<tr>
<td>2014/15</td>
<td>0</td>
<td>1,404</td>
<td>1,404</td>
</tr>
<tr>
<td>2015/16</td>
<td>0</td>
<td>1,404</td>
<td>1,404</td>
</tr>
<tr>
<td>2016/17</td>
<td>0</td>
<td>1,404</td>
<td>1,404</td>
</tr>
<tr>
<td>2017/18</td>
<td>0</td>
<td>1,405</td>
<td>1,405</td>
</tr>
<tr>
<td>2018/19</td>
<td>0</td>
<td>790</td>
<td>790</td>
</tr>
<tr>
<td>2019/20</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>19,986</strong></td>
<td><strong>14,041</strong></td>
<td><strong>34,027</strong></td>
</tr>
</tbody>
</table>

### Summary Statement of Cash Flows

6.33 The table below summarises the Trust’s cash flow for 2011/12 to 2013/14.

<table>
<thead>
<tr>
<th>Summary Statement of Cash Flows - OUH</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2011/12 £000s</td>
</tr>
<tr>
<td>Net cash inflow/ (outflow) from:</td>
<td></td>
</tr>
<tr>
<td>- operating activities</td>
<td>86,954</td>
</tr>
<tr>
<td>- returns on investments and servicing of finance</td>
<td>-20,291</td>
</tr>
<tr>
<td>- capital expenditure</td>
<td>-17,438</td>
</tr>
<tr>
<td>- dividend payments</td>
<td>-8,983</td>
</tr>
<tr>
<td>Net cash inflow/ (outflow) before financing</td>
<td>40,241</td>
</tr>
<tr>
<td>Net cash inflow/ (outflow) from financing</td>
<td>-15,834</td>
</tr>
<tr>
<td><strong>Increase/ (decrease) in cash</strong></td>
<td><strong>24,407</strong></td>
</tr>
<tr>
<td>Opening cash balance April 1st</td>
<td>19,477</td>
</tr>
<tr>
<td><strong>Closing cash balance March 31st</strong></td>
<td><strong>43,884</strong></td>
</tr>
</tbody>
</table>

6.34 The level of cash held increased by £42.6m over the period.
6.35 Cash outflows from financing included the interest element of PFI unitary payments as well as interest payable on the Trust’s loans.

6.36 Capital expenditure reflected a reduction in capital investment in 2011/12 following a prolonged period of fixed asset investment. Capital expenditure increased in 2012/13, driven by increased investment in medical equipment (£1.8m), developments in vascular and trauma services (£1.6m) and increased donated asset expenditure (£2.4m).

6.37 The dividend payments decreased by £3.0m during 2013/14. This was primarily due to a change in the calculation methodology in the NHS to reflect the average value of daily cash balances rather than simply using the opening and closing cash balances for the year.

6.38 There was a net outflow of cash from financing each year as capital repayments were made on loans and leases and on PFI scheme liabilities.

**Capital expenditure**

6.39 Historical levels of capital expenditure are shown in the table below.

<table>
<thead>
<tr>
<th>Capital expenditure - OUH</th>
<th>2011/12 £000s</th>
<th>2012/13 £000s</th>
<th>2013/14 £000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and Surgical Equipment</td>
<td>3,060</td>
<td>4,810</td>
<td>3,754</td>
</tr>
<tr>
<td>NOC theatres</td>
<td>153</td>
<td>2,190</td>
<td>660</td>
</tr>
<tr>
<td>Estates maintenance</td>
<td>2,452</td>
<td>1,663</td>
<td>1,968</td>
</tr>
<tr>
<td>Other</td>
<td>305</td>
<td>4,435</td>
<td>4,081</td>
</tr>
<tr>
<td><strong>Total maintenance</strong></td>
<td><strong>5,970</strong></td>
<td><strong>13,098</strong></td>
<td><strong>10,463</strong></td>
</tr>
<tr>
<td>Neonatal Intensive Care</td>
<td>3,017</td>
<td>2,328</td>
<td>945</td>
</tr>
<tr>
<td>IT / EPR</td>
<td>4,044</td>
<td>3,689</td>
<td>5,942</td>
</tr>
<tr>
<td>Head &amp; neck cancer relocation</td>
<td>559</td>
<td>663</td>
<td>0</td>
</tr>
<tr>
<td>IMRT: Rapid arc installation (2 machines), upgrade (2 machines)</td>
<td>0</td>
<td>0</td>
<td>2,218</td>
</tr>
<tr>
<td>PET/CT Scanner</td>
<td>0</td>
<td>0</td>
<td>2,660</td>
</tr>
<tr>
<td>Trauma Centre business case</td>
<td>0</td>
<td>607</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>7,460</td>
<td>6,808</td>
<td>4,166</td>
</tr>
<tr>
<td><strong>Total non-maintenance</strong></td>
<td><strong>15,080</strong></td>
<td><strong>14,095</strong></td>
<td><strong>15,931</strong></td>
</tr>
<tr>
<td><strong>Total capital expenditure</strong></td>
<td><strong>21,050</strong></td>
<td><strong>27,193</strong></td>
<td><strong>26,394</strong></td>
</tr>
</tbody>
</table>

6.40 Maintenance expenditure includes buildings maintenance and medical equipment replacement. The increase in maintenance expenditure in 2012/13 was due to a focus on renewal and replacement of assets in the capital programme, including medical equipment, the estate and theatres capacity on the NOC site. Non-maintenance expenditure includes the strategic expansion of cardiac, trauma and newborn intensive care capacity over the last three years, as well as investment in IT infrastructure to support implementation of the Electronic Patient Record (EPR) system.

6.41 2013/14 also saw investment in rapid arc radiotherapy equipment and a PET scanner in the Oxford Cancer Centre on the Churchill site.
6.42 The level of cost improvement achieved by the Trust in this period is shown below.

![Cost Improvement Programme - OUH](chart)

### Cost Improvement Programme - OUH

<table>
<thead>
<tr>
<th></th>
<th>2011/12 £000s</th>
<th>2012/13 £000s</th>
<th>2013/14 £000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target CIPs</td>
<td>58,373</td>
<td>49,500</td>
<td>44,730</td>
</tr>
<tr>
<td>CIPs achieved - recurrent</td>
<td>53,002</td>
<td>41,270</td>
<td>40,353</td>
</tr>
<tr>
<td>CIPs achieved - non-recurrent</td>
<td>4,215</td>
<td>4,250</td>
<td>2,343</td>
</tr>
<tr>
<td>% of plan achieved</td>
<td>98%</td>
<td>92%</td>
<td>95%</td>
</tr>
<tr>
<td>% of savings achieved recurrently</td>
<td>91%</td>
<td>83%</td>
<td>90%</td>
</tr>
</tbody>
</table>

6.43 The Trust has sought to generate savings above the nationally expected levels of implied efficiency.

6.44 This was driven by the need to strengthen the underlying financial position of the Trust, and by cost pressures in addition to those included in the national implied efficiency, for instance the RPI inflation increases on the three PFI schemes.

6.45 In 2011/12 OUH delivered a cost improvement programme of £57.2m, of which £53m was delivered recurrently and £4.2m non-recurrently, with a 2.0% shortfall against target. This shortfall was offset by additional patient activity.

6.46 In 2012/13 OUH delivered a cost improvement programme of £45.5m, of which £41.3m was delivered recurrently and £4.2m non-recurrently, with an 8.0% shortfall against target.

6.47 In 2013/14 OUH delivered a cost improvement programme £42.7m of which £40.4m was recurrent and £2.3m non-recurrent, with a shortfall against target of £2.0m. This 4.5% shortfall was offset by additional activity. The main schemes are shown overleaf.
Cost Improvement Summary for 2013/14

<table>
<thead>
<tr>
<th>Cost Improvement Programme - OUH</th>
<th>Target £000s</th>
<th>Actual £000s</th>
<th>Variance £000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Divisional General Efficiency</td>
<td>19,630</td>
<td>20,851</td>
<td>1,221</td>
</tr>
<tr>
<td>Procurement</td>
<td>4,279</td>
<td>3,467</td>
<td>-812</td>
</tr>
<tr>
<td>Medicines Management</td>
<td>1,535</td>
<td>2,027</td>
<td>492</td>
</tr>
<tr>
<td>Trust-wide Capacity and Redesign</td>
<td>3,679</td>
<td>2,479</td>
<td>-1,200</td>
</tr>
<tr>
<td>Workforce Initiatives</td>
<td>7,789</td>
<td>4,877</td>
<td>-2,912</td>
</tr>
<tr>
<td>Reduction in Waiting List Initiatives</td>
<td>1,000</td>
<td>1,000</td>
<td>0</td>
</tr>
<tr>
<td>Research and Development</td>
<td>5,700</td>
<td>5,700</td>
<td>0</td>
</tr>
<tr>
<td>Other Miscellaneous Schemes</td>
<td>1,118</td>
<td>2,295</td>
<td>1,177</td>
</tr>
<tr>
<td>Total</td>
<td><strong>44,730</strong></td>
<td><strong>42,696</strong></td>
<td><strong>-2,034</strong></td>
</tr>
</tbody>
</table>

6.48 The high level of bed occupancy in the Trust meant that planned savings from ward closures were not realised in the year. The failure to deliver the £1.2m capacity reduction saving was partly offset by tariff income from additional non-elective activity.

6.49 Divisional general efficiency savings comprised projects that were delivered within the clinical Divisions and exceeded the target by £1.2m.

6.50 Workforce initiatives included targeting agency cost reductions, consultant job planning, targeting reduction in sickness absence, introduction of enhanced salary sacrifice schemes and a rationalisation of the number of clinical Divisions.

Reference Costs Index

6.51 The Trust’s reference costs benchmark indicates that its costs run at 3% above the national average. The Reference Costs Index (RCI) for the Trust reduced from 108 in 2011/12 to 103 in 2013/14.

6.52 OUH has taken an active role in initiatives to improve the quality of reference cost submissions and is one of four trusts to work with the Department of Health on a national exercise to test changes to the reference cost pools and the reference cost system. The Trust submitted an additional set of 2012/13 reference cost data at patient level to facilitate national development of patient level reference costs.

6.53 OUH uses reference cost information as part of setting savings targets for Divisions. In 2013/14 an element of the target was applied differentially to each Division according to how it ranked against the others when measured in terms of 2011/12 reference cost scores. Divisions with relatively high reference costs are asked to find proportionately greater savings relative to their expenditure base than Divisions with lower reference cost scores. The Trust has a Clinical Costing Development Group (CCDG) which promotes the use of reference cost data, together with patient-level costing (PLICS) and Service Line Reporting, to improve the understanding of costs and income at specialty and patient level and so drive improvements in cost performance.
Current financial performance and forecast

6.54 This section sets out the Trust’s forecast outturn for the current financial year 2014/15 and its modelled future financial plans for the five subsequent financial years 2015/16 to 2019/20. This is based upon the Trust’s strategy and service development plans to establish OUH as a strong, financially viable Foundation Trust that is able to continue to develop services and deliver its other objectives. Alongside this long term model, the Trust sets out its key assumptions and trends, and details of the cost improvement programme upon which these plans are built.

Forecast outturn for 2014/15

6.55 The Trust is forecasting delivery of its planned £11.5m surplus (against the breakeven duty), representing a £8.7m retained surplus (1.0% of turnover), as set out in the table below.

6.56 Income from activities includes £747.9m\(^2\) of NHS clinical activity and £11.2m of non-NHS clinical revenue, which includes private patient income and Road Traffic Act income. NHS clinical activity reflects the forecast outturn for the Trust’s principal commissioners of £354.8m of activity for NHS England (Wessex) and £292.9m for Oxfordshire CCG\(^3\).

6.57 Expenditure forecast control totals for 2014/15 have been agreed with the clinically-led Divisions to deliver the activity and income levels included in the Trust’s forecast. These control totals reflect Divisions’ business plans, devised to deliver OUH’s strategic objectives for the year as set out in this Integrated Business Plan.

<table>
<thead>
<tr>
<th>Statement of Comprehensive Income</th>
<th>Prior year</th>
<th>Forecast outturn</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2013/14 £000s</td>
<td>2014/15 £000s</td>
</tr>
<tr>
<td>Income from activities</td>
<td>739,652</td>
<td>759,074</td>
</tr>
<tr>
<td>Other operating income</td>
<td>128,695</td>
<td>147,328</td>
</tr>
<tr>
<td><strong>Total income</strong></td>
<td><strong>868,346</strong></td>
<td><strong>906,402</strong></td>
</tr>
<tr>
<td>Operating expenses</td>
<td>-795,080</td>
<td>-831,164</td>
</tr>
<tr>
<td>EBITDA</td>
<td>73,267</td>
<td>75,238</td>
</tr>
<tr>
<td>EBITDA margin %</td>
<td>8.4%</td>
<td>8.3%</td>
</tr>
<tr>
<td>Depreciation and amortisation</td>
<td>-36,706</td>
<td>-38,007</td>
</tr>
<tr>
<td><strong>Operating surplus/ (deficit)</strong></td>
<td><strong>36,561</strong></td>
<td><strong>37,231</strong></td>
</tr>
<tr>
<td>Profit/ (loss) on the disposal of fixed assets</td>
<td>394</td>
<td>-200</td>
</tr>
<tr>
<td>Fixed asset impairments</td>
<td>8,426</td>
<td>0</td>
</tr>
<tr>
<td>Interest receivable</td>
<td>243</td>
<td>304</td>
</tr>
<tr>
<td>Interest payable and financing costs</td>
<td>-20,633</td>
<td>-20,688</td>
</tr>
<tr>
<td><strong>Surplus/ (deficit) for the financial year</strong></td>
<td><strong>24,991</strong></td>
<td><strong>16,647</strong></td>
</tr>
</tbody>
</table>

\(^2\) This includes non-recurrent Resilience income of £2.3m as well as additional Referral to Treatment (RTT) funding of £5.3m.

\(^3\) The Oxfordshire CCG contract is capped in 2014/15 at £284.6m. The OCCG forecast outturn figure includes £2.2m variance to plan on pass through drugs as well as additional Resilience and RTT income. The capped contract includes the agreement not to apply CQUIN denials or penalties in the current financial year. After 2014/15 the financial modelling assumes compliant contracts with commissioners.
Dividends payable on public capital | -7,559 | -7,945

**Retained surplus / (deficit)** | 17,432 | 8,702
Adjustments for impairments and IFRIC 12 | -8,426 | 0
Adjustments for donated asset reserve elimination | 1,889 | 2,780
**Breakeven duty surplus / (deficit)** | 10,895 | 11,482
Adjusted surplus / (deficit) % | 1.3% | 1.3%

**Normalised net surplus 2014/15**

6.58 OUH’s forecast normalised position for 2014/15 is a surplus of £8.9m, calculated as follows:

<table>
<thead>
<tr>
<th>Normalised Surplus</th>
<th>Prior year</th>
<th>Forecast outturn</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retained Surplus</td>
<td>17,432</td>
<td>8,702</td>
</tr>
<tr>
<td>Normalising adjustment - profit/(loss) on asset disposals</td>
<td>-394</td>
<td>200</td>
</tr>
<tr>
<td>Impairments</td>
<td>-8,426</td>
<td>0</td>
</tr>
<tr>
<td>Less non-recurring income</td>
<td>8,997</td>
<td>0</td>
</tr>
<tr>
<td>Less non-recurring expenditure</td>
<td>-8,997</td>
<td>0</td>
</tr>
<tr>
<td><strong>Normalised Net Surplus</strong></td>
<td>8,612</td>
<td>8,902</td>
</tr>
</tbody>
</table>

**Bridge chart – 2014/15**

6.59 The bridge analysis overleaf shows movements between the normalised opening 2014 position and the normalised forecast outturn position at the close of the financial year 2014/15. Key components of the bridge chart include:

- Activity related growth of £19.4m, with marginal cost growth of £16.5m.
- Income (tariff, non-tariff and other) deflation of £11.2m and pay and non-pay cost inflation of £13.8m (both net of pass-through drugs inflation).
- National pressures of £13.3m (relating to the increased Marginal Rate Emergency Tariff (MRET) impact on non-elective income, incremental pay drift and additional pay quality related costs following internal peer review).
- A 1% contingency level (£9.0m included in Quality and other local pressures).
- Forecast savings of £42.4m.
OUH Normalised Surplus Bridge 2013/14 outturn to 2014/15 forecast outturn (£ million)

- £19.4M NHS Activity
- £6.0M Other NHS
- £5.8M Non-NHS Activity
- £5.1M B/Cs
- £0.4M R&D
- £1.8M AHSN
- £23.7M Pay
- £11.0M Non-Pay
- £7.7M Contribution
- £13.8M Pay
- £11.3M Non-Pay
- £2.5M Pay
- £13.3M Pay
- £6.9M Pay
- £6.4M Income
- £8.0M Pay
- £1.0M Non-Pay
- £5.4M Income
- £8.8M NHS
- £2.4M Other

Opening Balance (Mar 14): £8.6
Baseline income: £31.2
Baseline activity expenditure: £19.8
Service development income: £8.1
Service development expenditure: £7.3
Depreciation, financing, etc: £1.7
Expenditure inflation (net of PT drugs): £42.4
CIP: £13.8
National pressures: £13.3
Income deflation (net of PT drugs): £11.2
Quality & Other local pressures: £14.4
Closing Balance (Mar 15): £8.9
Statement of Financial Position

6.60 The table below sets out the forecast outturn Statement of Financial Position at 31 March 2015, as well as the prior year outturn balances.

<table>
<thead>
<tr>
<th>Statement of Financial Position</th>
<th>Prior year</th>
<th>Forecast outturn</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2013/14 £000s</td>
<td>2014/15 £000s</td>
</tr>
<tr>
<td><strong>Non-current assets</strong></td>
<td>710,202</td>
<td>719,391</td>
</tr>
<tr>
<td>Current assets:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inventories</td>
<td>11,807</td>
<td>11,808</td>
</tr>
<tr>
<td>Receivables and prepayments</td>
<td>24,361</td>
<td>29,612</td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>86,448</td>
<td>75,886</td>
</tr>
<tr>
<td><strong>Total current assets</strong></td>
<td>122,616</td>
<td>117,306</td>
</tr>
<tr>
<td>Current liabilities</td>
<td>-131,187</td>
<td>-126,860</td>
</tr>
<tr>
<td><strong>Net current assets (liabilities)</strong></td>
<td>-8,571</td>
<td>-9,554</td>
</tr>
<tr>
<td><strong>Total assets less current liabilities</strong></td>
<td>701,631</td>
<td>709,836</td>
</tr>
<tr>
<td>Non-current liabilities</td>
<td>-284,355</td>
<td>-273,113</td>
</tr>
<tr>
<td>Provisions for liabilities and charges</td>
<td>-2,447</td>
<td>-2,385</td>
</tr>
<tr>
<td>Loans</td>
<td>-5,003</td>
<td>-3,599</td>
</tr>
<tr>
<td><strong>Total Assets Employed</strong></td>
<td>409,826</td>
<td>430,740</td>
</tr>
<tr>
<td>Financed by:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public dividend capital</td>
<td>208,935</td>
<td>208,115</td>
</tr>
<tr>
<td>Revaluation reserve</td>
<td>164,735</td>
<td>177,767</td>
</tr>
<tr>
<td>Other reserves</td>
<td>1,743</td>
<td>1,743</td>
</tr>
<tr>
<td>Retained earnings</td>
<td>34,413</td>
<td>43,115</td>
</tr>
<tr>
<td><strong>Total Taxpayers’ Equity</strong></td>
<td>409,826</td>
<td>430,740</td>
</tr>
</tbody>
</table>

Non-current assets

6.61 Non-current assets are forecast to increase by £9.2m, resulting principally from capital expenditure additions of £34.3m for 2014/15 (including new finance leases, donations and PFI lifecycle and Managed Equipment Service payments) and an increase in asset valuations of £13.0m, being offset by forecast depreciation of £38.0m.

6.62 Capital expenditure includes £18.5m of maintenance including replacement of medical equipment assets, buyouts of previously leased medical equipment, investment in major radiological and ultrasound equipment and preparatory work for ward relocations to exit some of the oldest buildings.

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4 A Managed Equipment Service (MES) is included within the Churchill Cancer Centre PFI contract for radiotherapy and radiology equipment maintenance and replacement in the Cancer Centre.
on the Churchill site. Non-maintenance expenditure is also included for the development of the Full Business Case on the radiotherapy satellite development at Great Western Hospital in Swindon and for planning a radiotherapy development in Milton Keynes. In addition, £4.8m of expenditure is included for investment in the EPR system and the IT infrastructure, along with £1.3m for the re-procurement of the EPR system. More details on capital plans are set out in Capital expenditure plans below.

**Current assets and liabilities and a new working capital loan**

6.63 Cash balances are forecast to decrease by £10.6m to £75.9m at 31 March 2015. This is primarily driven by a forecast reduction in working capital this year of £9.8m and a net £0.8m repayment of PDC.

**Better Payment Practice Code**

6.64 The Trust is achieving 90% of non-NHS (and 97% of NHS) invoices paid within 30 days (by value as at 31st January 2015) and is working to improve this, as explained at paragraph 6.28 above.

**Non-current liabilities**

6.65 Long term creditors are forecast to reduce by £12.7m in 2014/15 due to capital repayments against the PFI and finance lease liabilities and loan repayments.

**Taxpayers’ equity**

6.66 The forecast increase in Taxpayers’ equity is due to the increase in Retained Earnings from the forecast surplus for the year of £8.7m and an increase of £13.0m in the revaluation reserve (from the estimate of increases in asset valuations). There is also a £0.7m increase in Public Dividend Capital relating to successful bids against the Safer Hospitals, Safer Wards Technology Fund, and a £0.3m planned increase in PDC for Improving Maternity Care Settings, offset by a repayment of £1.8m of PDC.

**Summary Statement of Cash Flows**

6.67 The table overleaf sets out the forecast cash flow for 2014/15 with a closing cash balance of £75.9m.

6.68 The forecast cash flow for 2014/15 shows an overall £10.6m decrease in OUH’s cash balance during the year. This is driven by a planned decrease in working capital levels (driven by a reduction in Trade payables and an increase in accrued income) and a net £0.8m repayment of PDC.

6.69 The significant items affecting the cash flow during 2014/15 are:

- Cash inflow from operating activities of £64.6m.
- Cash outflows relating to capital expenditure of £31.4m and PFI lifecycle and Managed Equipment Service payments of £1.3m.
- Payments for PFI and lease liabilities and repayment of the capital loans, and interest on these, totalling £33.6m.
- Payment of the dividend of £8.4m.
Summary Statement of Cash Flows

<table>
<thead>
<tr>
<th>Net cash inflow/ (outflow) from:</th>
<th>Prior year</th>
<th>Forecast outturn</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2013/14 £000s</td>
<td>2014/15 £000s</td>
</tr>
<tr>
<td>- operating activities</td>
<td>82,323</td>
<td>64,556</td>
</tr>
<tr>
<td>- returns on investments and servicing of finance</td>
<td>-20,255</td>
<td>-20,394</td>
</tr>
<tr>
<td>- capital expenditure</td>
<td>-21,904</td>
<td>-32,681</td>
</tr>
<tr>
<td>- dividend payments</td>
<td>-6,382</td>
<td>-8,364</td>
</tr>
<tr>
<td>Net cash inflow/ (outflow) before financing</td>
<td>33,782</td>
<td>3,116</td>
</tr>
<tr>
<td>Net cash inflow/ (outflow) from financing</td>
<td>-12,991</td>
<td>-13,678</td>
</tr>
<tr>
<td>Increase/ (decrease) in cash</td>
<td>20,791</td>
<td>-10,562</td>
</tr>
</tbody>
</table>

Opening cash balance April 1st: 65,657, 86,448

Closing cash balance March 31st: 86,448, 75,886

Cost Improvement Programme (CIP) plans in 2014/15

6.70 The CIP for 2014/15 is forecast to have delivered savings totalling £42.4m. The programme content was developed by the clinical Divisions of the Trust working on local Divisional efficiency schemes and working collaboratively on cross-Divisional efficiency improvement plans. Trust support services also worked closely with clinical Divisions on plans for reduced non pay costs through procurement and medicines management. A combined team of clinical Divisional leaders and corporate leaders designed and agreed workforce initiatives to save on agency, medical and non-medical staff costs. The programme content is summarised in the table below.

6.71 A major component of 2014/15 delivery was the impact of schemes commenced in 2013/14. This applies to workforce schemes and management of sickness absence where a new system of reporting sickness through a third party provider including enhanced support for staff and managers was put in place.

6.72 The Trust has continued to pursue a range of workforce initiatives designed to improve staff productivity and is focusing on ‘transformation’ programme activities to ensure that cross-Divisional opportunities are fully realised. This includes programmed activities to improve theatre utilisation and productivity and improve non-elective patient pathway flow.

6.73 The Trust will continue to ensure that it realises appropriate financial benefits from its large scale teaching and research programmes.

6.74 Electronic Patient Record and other IT modernisation projects will result in opportunities to improve productivity and supersede outdated processes.
<table>
<thead>
<tr>
<th>Cost Improvement Programme schemes, 2014/15</th>
<th>Plan</th>
<th>Forecast outturn</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2014/15 £000s</td>
<td>2014/15 £000s</td>
</tr>
<tr>
<td>Divisional efficiency savings - pay</td>
<td>9,975</td>
<td>10,002</td>
</tr>
<tr>
<td>Divisional efficiency savings - non-pay</td>
<td>3,857</td>
<td>8,668</td>
</tr>
<tr>
<td>Divisional efficiency savings - income</td>
<td>5,602</td>
<td>3,265</td>
</tr>
<tr>
<td>Workforce initiatives - medical</td>
<td>4,279</td>
<td>3,792</td>
</tr>
<tr>
<td>Workforce initiatives - non-medical</td>
<td>1,995</td>
<td>1,515</td>
</tr>
<tr>
<td>Resource alignment</td>
<td>3,141</td>
<td>942</td>
</tr>
<tr>
<td>National pay deal</td>
<td>1,608</td>
<td>1,609</td>
</tr>
<tr>
<td>Outpatients – phase 2</td>
<td>400</td>
<td>0</td>
</tr>
<tr>
<td>Procurement and partnerships</td>
<td>1,634</td>
<td>1,634</td>
</tr>
<tr>
<td>Research and development and training and education income</td>
<td>3,150</td>
<td>3,150</td>
</tr>
<tr>
<td>Private patients and overseas income</td>
<td>1,650</td>
<td>1,310</td>
</tr>
<tr>
<td>Medicines management</td>
<td>1,350</td>
<td>968</td>
</tr>
<tr>
<td>Estates</td>
<td>700</td>
<td>300</td>
</tr>
<tr>
<td>Theatres phase 2 – remodelling of JR theatres</td>
<td>800</td>
<td>690</td>
</tr>
<tr>
<td>Average Length of Stay</td>
<td>1,200</td>
<td>1,793</td>
</tr>
<tr>
<td>Electronic Patient Record</td>
<td>1,000</td>
<td>310</td>
</tr>
<tr>
<td>Service Line Reporting / Service Line Management portfolio optimisation</td>
<td>1,000</td>
<td>0</td>
</tr>
<tr>
<td>Procurement</td>
<td>800</td>
<td>180</td>
</tr>
<tr>
<td>Other schemes</td>
<td>1,898</td>
<td>2,283</td>
</tr>
<tr>
<td><strong>Total Cost Improvement Programme</strong></td>
<td><strong>46,039</strong></td>
<td><strong>42,411</strong></td>
</tr>
</tbody>
</table>

**Quality Impact Assessment**

6.75 A tiered assessment process is in place to judge any impact on quality from the implementation of the programme. All schemes are quality assessed within the clinically-led Divisional management structures. After assessment at Divisional level, schemes are assessed for quality impact by the Trust’s Director of Nursing, Medical Director and Director of Clinical Services as well as the other Divisional Directors. All schemes are signed off by the relevant clinical lead in the service, the Divisional Director of the relevant clinical Division and the Chief Nurse, Medical Director and Director of Clinical Services.

**Delivery process and governance**

6.76 The process for ensuring delivery of the programme revolves around the Cost Improvement Committee of the Trust Management Executive.

6.77 The Cost Improvement Committee is chaired by the Director of Clinical Services and its members include the clinician Divisional Directors (by invitation), Divisional General Managers (by invitation), the Director of Finance and Procurement, the Medical Director, the Chief Nurse, Director of
Development and the Estate, Director of Planning and Information, and Director of Organisational Development and Workforce. At each of its meetings it receives updated forecasts of actual savings against planned schemes. It agrees actions to address any shortfalls and supports project leads to overcome any obstacles to delivery.

6.78 The Cost Improvement Committee oversees working groups responsible for delivery of individual schemes within the overall programme.

6.79 Programme content consists of a balance of Divisional general efficiency, procurement and medicines management savings plans, workforce measures and operational efficiency improvements.

6.80 The Divisional general efficiency and full year effect of previous year schemes are the responsibility of individual Divisions. Divisions meet formally as part of the reporting cycle between steering group meetings to take forward their schemes and update forecasts of delivery with support from the programme management office.

**Contingency planning**

6.81 Where gaps in the delivery of the originally planned schemes are not fully resolvable the Cost Improvement Committee agrees measures to close these gaps through:

- Managing over-delivery against target for some schemes to offset any under-delivery in other schemes.
- Bringing forward the start date of schemes in the programme to ensure overall delivery.
- Bringing forward schemes from 2015/16 to start in 2014/15.

6.82 This approach to contingency planning on CIP delivery supplements the approach to risk management and mitigation set out in the Risk section below.

**Programme scrutiny and performance management**

6.83 The Board and its Finance and Performance Committee receive reports on CIP progress at each of their meetings. Schemes are reflected in Divisional budgets and Divisions are performance managed against these budgets at performance reviews each month.

**Medium term financial plans**

6.84 OUH will generate revenue and cash surpluses to achieve an overall Continuity of Service Risk Rating (CSRR) of 3 from the planned first full year of licence (2016/17), including CSRR ratings of 3 for each quarter.

6.85 The Trust has made assumptions about activity growth based on detailed activity modelling work undertaken with the clinical divisions and assumptions have been made on inflation and implied efficiency to take account of Monitor’s 2015/16 tariff consultation guidance as well as the previous planning update on the difficult economic climate in the NHS. This is illustrated by five-year Income and Expenditure projections and the projected bridge analysis to 2019/20.

**Five year summary Income and Expenditure projections**

6.86 The Trust will continue to strengthen its financial performance through the following:

6.86.1 Planning to generate retained surpluses of 1% of turnover each year, after a planned deficit in 2015/16. Retained surpluses from 2016/17 to 2019/20 average £9.5m per year (after

excluding donations income receipts which distort the retained surplus position, particularly in 2016/17 and 2017/18).

6.86.2 Maintaining a normalised EBITDA margin level of between 7.0%-8.5% each year. This is driven by planned efficiency improvements of £218.9m (in real terms) over the five year period.

6.86.3 No cost growth in real terms, with a net reduction in real terms operating costs (above EBITDA) of 5.3% by 2019/20.

6.86.4 Delivering additional activity at a marginal cost to generate a benefit to margins of an average £7.8m each year.

6.86.5 Maintaining strong cash balances for each of the five years, with average year end cash balances of £71.9m over the period.

<table>
<thead>
<tr>
<th>Statement of Comprehensive Income</th>
<th>Forecast outturn</th>
<th>Forward Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2014/15 £000s</td>
<td>2015/16 £000s</td>
</tr>
<tr>
<td>Income from activities</td>
<td>759,074</td>
<td>771,765</td>
</tr>
<tr>
<td>Other operating income</td>
<td>147,328</td>
<td>143,784</td>
</tr>
<tr>
<td>Total income</td>
<td>906,402</td>
<td>915,550</td>
</tr>
<tr>
<td>Operating expenses</td>
<td>-831,164</td>
<td>-851,449</td>
</tr>
<tr>
<td>EBITDA</td>
<td>75,238</td>
<td>64,101</td>
</tr>
<tr>
<td>EBITDA margin %</td>
<td>8.3%</td>
<td>7.0%</td>
</tr>
<tr>
<td>Depreciation and amortisation</td>
<td>-38,007</td>
<td>-37,800</td>
</tr>
<tr>
<td>Operating surplus/ (deficit)</td>
<td>37,231</td>
<td>26,301</td>
</tr>
<tr>
<td>Profit/ (loss) on the disposal of fixed assets</td>
<td>-200</td>
<td>-200</td>
</tr>
<tr>
<td>Fixed asset impairments</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Interest receivable</td>
<td>304</td>
<td>238</td>
</tr>
<tr>
<td>Interest payable and financing costs</td>
<td>-20,688</td>
<td>-20,870</td>
</tr>
<tr>
<td>Surplus/ (deficit) for the financial year</td>
<td>16,647</td>
<td>5,468</td>
</tr>
<tr>
<td>Dividends payable on public capital</td>
<td>-7,945</td>
<td>-8,774</td>
</tr>
<tr>
<td>Retained surplus / (deficit)</td>
<td>8,702</td>
<td>-3,306</td>
</tr>
<tr>
<td>Adjustments for impairments and IFRIC 12</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Adjustments for donated asset reserve elimination</td>
<td>2,780</td>
<td>3,306</td>
</tr>
<tr>
<td>Break even duty surplus / (deficit)</td>
<td>11,482</td>
<td>0</td>
</tr>
<tr>
<td>Adjusted surplus / (deficit) %</td>
<td>1.3%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

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6 2016/17 includes £2m of charitable donations for the Swindon Radiotherapy satellite unit and 2017/18 includes a further £0.5m of donations relating to Swindon and £1.3m of charitable donations for the Milton Keynes Radiotherapy satellite unit.
### Normalised surplus / (deficit)  

<table>
<thead>
<tr>
<th></th>
<th>Forecast outturn</th>
<th>Forward Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2014/15 £000s</td>
<td>2015/16 £000s</td>
</tr>
<tr>
<td>Retained surplus</td>
<td>8,702</td>
<td>-3,306</td>
</tr>
<tr>
<td>Normalising adjustment - profit/(loss) on asset disposals</td>
<td>200</td>
<td>200</td>
</tr>
<tr>
<td>Impairment</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Normalised Net Surplus / (deficit)</td>
<td>8,902</td>
<td>-3,106</td>
</tr>
</tbody>
</table>

**Bridge chart – projections to 2019/20**

6.87 The first bridge chart below shows forecast movements from 2014/15 forecast outturn normalised surplus to 2015/16 normalised surplus. The second shows the forecast movement over the remaining four future years, from 2016/17 to 2019/20.

6.88 The projections take into account assumptions for inflation and implied efficiency levels, income growth, cost pressures and savings, as set out below.

6.89 These projections show that OUH expects to deliver sustainable Retained Surpluses from 2016/17 and for the remainder of the period, enabling it to strengthen its Balance Sheet, improve its underlying liquidity and create capacity for service investment (primarily) through internally generated resources to deliver its strategic objectives.

6.90 Costs increase during the five year period due to the following factors:

- Pay costs increase £41.3m. These are associated with activity (£29.8m), national pressures (incremental drift £12.4m), quality and other local pressures (£23.1m), contingency (£6.0m), the radiotherapy development (£1.0m) and NMET investment (£0.4m). There are also recurrent pay pressures relating to pensions changes in 2015/16 (£1.4m) and 2016/17 (£9.0m). Pay inflation adds £51.6m over the five year period (assumptions on pay inflation rates are set out below). These cost increases are partly mitigated by pay savings totalling £97.0m (real terms including agency and non-recurrent savings).

- Non-pay operating costs increase by £53.5m. These are associated with activity (£25.1m), quality and other local pressures (£10.7m), EPR pressures (£4.0m), loss of the CNST risk management discount (£3.2m), contingency (£2.0m) and the radiotherapy development (£0.7m). Non-pay inflation (including pass-through drugs) adds £87.4m over the five year period (assumptions on non-pay inflation rates are set out below). These cost increases are partly mitigated by non-pay savings totalling £94.9m (real terms including non-recurrent savings).

- A net increase of £5.6m relating to depreciation, interest and Public Dividend Capital.

6.91 Commissioner income increases during the five year period in relation to the following factors:

- £90.0 million net growth in activity and case-mix income and a £23.8m increase due to additional contribution derived from income. These are based on the Trust’s current activity forecasts and savings plans, and are broken down in the section below.

- The growth in activity is offset by the MRET impact on new non-elective activity growth, which reduces the income growth by £5.5m over the period. This impact is offset by the assumption on the change in MRET rate from a 70% deduction to 30% deduction from 2016/17 onwards (£9.8m).

---

7 Monitor Guidance for the Annual Planning Review 2014/15. Pension pressures in 2015/16 relate to the 0.3% pay cost impact from the revaluation of public sector pension contributions. In 2016/17 the pension pressure arises from reforms to the state pension (with the potential impact assessed by the Trust).
- Offsetting the MRET rate change benefit in 2016/17 is the assumption that a specialist marginal rate 30% deduction is applied from 2016/17 onwards to specialist income growth (including pass through income) above the 2014/15 forecast outturn level. This has an adverse impact over the period of £13.9m.
- Pass-through drugs inflation adds £31.0m to commissioner income.
- Tariff deflation (excluding the pass-through drugs) reduces income by £26.5m (assumptions on income deflation rates are set out below).
- No tariff deflation is applied in the plan in 2015/16, as the Trust is operating under the Default Tariff Rollover (DTR) regime. Instead no CQUIN income is included in the plan for 2015/16, per the DTR rules.\(^8\)
- The Radiotherapy satellite unit service development adds £2.0m to commissioner income.
- Non-recurrent winter resilience funding of £2.3m (in the forecast outturn for 2014/15) is removed from commissioner income from 2015/16 onwards.

\(^8\) Tariff arrangements for your 2015/16 activity, Monitor, February 2015.
OUH Normalised Surplus Bridge 2014/15 forecast outturn to 2015/16 plan (£ million)

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount (£ million)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opening Balance (Mar 15)</td>
<td>8.9</td>
</tr>
<tr>
<td>Baseline income</td>
<td>16.6</td>
</tr>
<tr>
<td>Service development expenditure</td>
<td>10.1</td>
</tr>
<tr>
<td>Depreciation, Financing, etc</td>
<td>0.6</td>
</tr>
<tr>
<td>Expenditure inflation (net of PT drugs)</td>
<td>0.4</td>
</tr>
<tr>
<td>CIP</td>
<td>1.4</td>
</tr>
<tr>
<td>National pressures</td>
<td>51.8</td>
</tr>
<tr>
<td>Expenditure inflation (net of PT drugs)</td>
<td>16.6</td>
</tr>
<tr>
<td>£19.8M Pay</td>
<td></td>
</tr>
<tr>
<td>£21.5M Non-Pay</td>
<td></td>
</tr>
<tr>
<td>£10.5M Contribution</td>
<td></td>
</tr>
<tr>
<td>£16.2M NHS Activity</td>
<td></td>
</tr>
<tr>
<td>£9.7M NHS Activity</td>
<td></td>
</tr>
<tr>
<td>£0.4M Other</td>
<td></td>
</tr>
<tr>
<td>£1.6M B/Cs</td>
<td></td>
</tr>
<tr>
<td>£0.2M AHSN (£1.6M) R&amp;D</td>
<td></td>
</tr>
<tr>
<td>£0.1M Strat SD</td>
<td></td>
</tr>
<tr>
<td>£1.7M B/Cs</td>
<td></td>
</tr>
<tr>
<td>£0.2M AHSN (£1.6M) R&amp;D</td>
<td></td>
</tr>
<tr>
<td>£1.4M Pay</td>
<td></td>
</tr>
<tr>
<td>£21.5M Non-Pay</td>
<td></td>
</tr>
<tr>
<td>£10.5M Contribution</td>
<td></td>
</tr>
<tr>
<td>£13.5M Non-Pay</td>
<td></td>
</tr>
<tr>
<td>£3.1M Pay</td>
<td></td>
</tr>
<tr>
<td>£14.3M Pay</td>
<td></td>
</tr>
<tr>
<td>£7.9M Non-Pay</td>
<td></td>
</tr>
<tr>
<td>£1.0M Income</td>
<td></td>
</tr>
<tr>
<td>£1.2M CNST Discount</td>
<td></td>
</tr>
<tr>
<td>£2.7M A4C/Med Cont</td>
<td></td>
</tr>
<tr>
<td>£1.4M Pensions</td>
<td></td>
</tr>
<tr>
<td>£14.2M CQUIN (DTR)</td>
<td></td>
</tr>
<tr>
<td>£2.7M MRET</td>
<td></td>
</tr>
<tr>
<td>£1.9MSIFT/MADEL</td>
<td></td>
</tr>
<tr>
<td>£nil NHS</td>
<td></td>
</tr>
<tr>
<td>£3.0M Other</td>
<td></td>
</tr>
<tr>
<td>Closing Balance (Mar 16)</td>
<td>23.3</td>
</tr>
</tbody>
</table>
OUH Normalised Surplus Bridge 2015/16 plan to 2019/20 plan (£ million)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Activity</td>
<td>£70.2M</td>
<td>£44.7M</td>
<td>£77.1M</td>
<td>£48.5M</td>
<td>£47.0M</td>
</tr>
<tr>
<td>Pay</td>
<td>£16.6M</td>
<td>£4.7M</td>
<td>£24.3M</td>
<td>£10.3M</td>
<td>£26.5M</td>
</tr>
<tr>
<td>Non-Pay</td>
<td>£53.6M</td>
<td>£43.9M</td>
<td>£52.8M</td>
<td>£37.2M</td>
<td>£20.3M</td>
</tr>
<tr>
<td>Contribution</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>£1.7M</td>
</tr>
<tr>
<td>Income</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>£0.1M</td>
</tr>
<tr>
<td>NIC Change</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>£1.7M</td>
</tr>
<tr>
<td>MRET net</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>£0.1M</td>
</tr>
<tr>
<td>CQUIN</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>£0.1M</td>
</tr>
<tr>
<td>AHSN</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>£0.1M</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>£0.1M</td>
</tr>
</tbody>
</table>

Total Surplus: £200 million
NHS clinical income

6.92 The elements of clinical income growth are broken down in the table below. The assumptions underlying these projections are set out below.

<table>
<thead>
<tr>
<th>Breakdown of NHS clinical income growth and efficiencies - real terms</th>
<th>Forward Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2015/16 £000s</td>
</tr>
<tr>
<td>Demographic growth</td>
<td>2,406</td>
</tr>
<tr>
<td>Underlying demand growth</td>
<td>18,238</td>
</tr>
<tr>
<td>KPI - reduction</td>
<td>-1,290</td>
</tr>
<tr>
<td>Contestability - income reduction</td>
<td>-403</td>
</tr>
<tr>
<td>Patients Choice - income growth</td>
<td>793</td>
</tr>
<tr>
<td>CQUIN loss - net (per DTR)</td>
<td>-14,199</td>
</tr>
<tr>
<td>Income efficiency savings / other</td>
<td>4,245</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>9,790</strong></td>
</tr>
</tbody>
</table>

Private patient and other income

6.93 Private patient and overseas income is planned to increase in real terms by £0.5m in 2015/16, due to planned additional contribution derived from income saving plans in that year’s CIP.

6.94 Education and Training income is planned to reduce in real terms by a net £1.5m on Education and Training income in 2015/16 (with a planned further reduction in Service Increment for Teaching (SIFT) and Medical and Dental Education Levy (Madel) income of £1.9m, partially offset by Non-Medical Education and Training (NMET) income increases of £0.4m). This follows reductions to these income streams since 2013/14 for the Trust, following changes in education and training funding being implemented by the Department of Health, with overall funding reductions to OUH anticipated to be phased in over a three year period from 2013/14 to 2015/16.

6.95 Research and development income is planned to increase in real terms by £2.6m in 2015/16 due to planned schemes to increase contribution levels from these income streams. Plans to increase this income contribution include increasing research trials income, and leveraging the Trust’s AHSN and AHSC status and its close working relationship with the University of Oxford to increase research and development income. There is a planned reduction of £1.6 million in Biomedical Research Centre (BRC) income in 2015/16 (year four of the existing five-year award).

6.96 Oxford AHSN income and expenditure is forecast to reduce over the five year contract period to £1.4m (real terms) by 2017/18, reflecting the income profile in the AHSN business plan.

6.97 Cash generated from operating activity surpluses will be used to:

- Fund remaining repayments on the existing two capital loans.

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9 The reduction is mainly due to additional non-recurrent income received by the BRC in 2014/15. Total BRC / BRU income in 2015/16 and 2016/17 is planned to be £22.4 million each year from the existing five year award. The financial model includes the assumption that the BRC / BRU status is retained after 2016/17 at the same level of funding.

10 This income reduces due to decreased NHS England funding. The LTFM does not assume the gap being made up by additional membership contributions as is shown in the business plan. AHSN income includes Health Education Thames Valley income.
• Fund repayments on the new FT working capital loan proposed in 2015/16 to strengthen underlying liquidity.
• Fund annual capital expenditure from internally generated cash.
• Fund repayments on the planned capital investment loans for the theatres modernisation and adult critical care business cases on the John Radcliffe site and the Milton Keynes radiotherapy satellite unit.
• Service repayments on lease liabilities.
• Strengthen the Statement of Financial Position and liquidity.

**Income and activity assumptions on growth and demand management**

6.98 Activity and income projections are underpinned by assumptions which include changing demand and market share. Assumptions overall indicate annual commissioning income growth averaging 2.5% in real terms for each year from 2015/16 to 2019/20. These assumptions take specific account of the following:

• Forecast demographic changes based on ONS statistics\(^{11}\) for the ten most significant commissioners, adding an average £2.2m per annum.
• Underlying demand changes based upon historical trends, such as increasing cancer survival rates raising activity levels for chemotherapy and radiotherapy. This adds an average £16.9m per annum. The demand projections reflect the Trust’s strategy to develop further as a regional centre of specialised acute care, for example including a 3.0% annual growth in medical oncology, and 4.6% growth each year in colorectal cancer surgery (driven by the national extension of the age range for bowel screening and by additional bowel scoping) as treatment continues to be centralised in specialist treatment centres such as the Oxford Cancer Centre.
• The Trust’s modelling includes 3.2% annual growth in demand for geriatric care based on information from a study conducted jointly by Oxfordshire CCG and the Trust\(^{12}\).
• Demand changes take account of increasing demand for cardiology, due to an increase in the incidence of heart failure in the ageing population and increased ability to intervene to treat heart rhythm defects. Annual growth of 6.2% in cardiology and 5.6% in cardiac surgery has been modelled. This reflects increases in recent years and incorporates projected market growth based on discussions with the Division and supported by an analysis of Dr Foster data. Continuing centralisation of vascular intervention and cardiac surgery in Oxford is taking place.
• Demand changes also reflect OUH’s strategic partnership with the University of Oxford, with research activity in areas such as diabetes medicine predicted to drive an annual growth of 7.8% in diabetes medicine outpatients activity in the Trust.
• The requirement to deliver national performance targets for access is reflected in the LTFM by including elective activity required to meet and sustain waiting times within the 18 week standard\(^{13}\).
• An annual reduction of £1.3m has been included, based upon the delivery of Key Performance Indicators. This assumes a year-on-year 5% reduction in excess bed days (length of stay) across all specialties. A year-on-year reduction in outpatient follow-ups of 2% across all specialties has also been assumed.

\(^{11}\) ONS statistics: 2010-based subnational population projections for health geographies, SHAs and PCOs by sex and five-year age group for SHAs and PCTs in England.

\(^{12}\) OUHT emergency department attendances and emergency admissions 2008/9 to 2012/13, Mant et al, Oxfordshire CCG/Oxford University Hospitals NHS Trust, October 2013.

\(^{13}\) RTT funding of £5.3m (with associated expenditure) is included recurrently in the LTFM in the 2014/15 baseline to reach and maintain a sustainable position for 18 week waits.
• Income increases by £2.1m by 2019/20 from the radiotherapy satellite centre development at the Great Western Hospital site in Swindon.

• Centralisation of specialist care, supported by the Safe and Sustainable programme, is increasing demand for paediatric subspecialty services. For example, OUH’s modelling predicts annual growth of 6.0% for paediatric diabetes medicine and 3.2% for paediatric neurology. As with cancer services, OUH’s strategic response to this is to work with partner trusts to develop a model which provides as much care as possible locally and has recently extended the range of paediatric specialties providing services at the Horton General Hospital.

• Modelling has also incorporated patient choice (focussing on the potential for an increase in activity in surgical specialties based on obtaining a greater proportion of workload from commissioners on the borders of the Trust’s catchment area) and competition from a Treatment Centre in Banbury and an independent endoscopy service in Witney.

• Plans include a number of technical adjustments to the way in which activity is counted and allocated with maximum take now fully implemented. Income has been modelled at current 2014/15 tariffs.

• The modelling includes the assumption that the 30% Marginal Rate Emergency Tariff (MRET) for non-elective activity (above 2008/09 levels) continues to be applied under DTR in 2015/16, with the overall MRET income reduction rising to £19.9m by next year. After 2015/16 the LTFM includes the assumption that the MRET rate is increased to 70%, with a corresponding in year benefit of £10.3m in 2016/17. MRET continues to then be applied to non-elective income growth at this higher rate in the plans to 2019/20, with an additional average annual adverse impact on income of £1.1m.

• However, alongside the assumption included in the plans of an improved MRET rate after 2015/16, the LTFM includes an assumption that a marginal rate of 70% payment is also applied to (NHS England Wessex) specialist activity growth (above the 2014/15 forecast outturn level), including pass-through drugs and devices growth, from 2016/17 onwards, after the DTR regime in 2015/16. This has a marginal rate impact of £5.8m in 2016/17 and builds up to an impact of £13.9m by 2019/20.

6.99 The impact of these factors on activity is shown in the table below.

### Activity changes over the five year period

<table>
<thead>
<tr>
<th>Changes in acute activity</th>
<th>Forward Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective - spells (000s)</td>
<td>100.8</td>
</tr>
<tr>
<td>Elective - % change</td>
<td>4.1%</td>
</tr>
<tr>
<td>Non-Elective - spells (000s)</td>
<td>81.5</td>
</tr>
<tr>
<td>Non-Elective - % change</td>
<td>2.4%</td>
</tr>
<tr>
<td>Outpatient - FA &amp; FU (000s)</td>
<td>862.2</td>
</tr>
<tr>
<td>Outpatient - % change</td>
<td>1.7%</td>
</tr>
<tr>
<td>A&amp;E - attendances (000s)</td>
<td>142.0</td>
</tr>
<tr>
<td>A&amp;E - % change</td>
<td>3.5%</td>
</tr>
</tbody>
</table>
6.100 The bridge chart overleaf breaks down the movements modelled on elective and non-elective activity spells over the period.

6.101 From 2015/16 to 2019/20 activity increases by an average of 5,756 spells each year.

Changes modelled in elective and non-elective spells over the period

![Activity chart]

**Income and expenditure projections and assumptions**

6.102 The bridge chart and tables below break down the impact of the different components of activity changes modelled upon NHS clinical income levels over the five year period, along with the impact of additional MRET marginal payments, specialist marginal rates and tariff deflation and pass-through drugs inflation.

6.103 In real terms, income from NHS commissioners is expected to grow by a net £101.3 million over the next five years (net of the additional MRET and specialist marginal impacts), tariff deflation is expected to decrease income by £26.5 million, while pass-through drugs are inflated by £31.0 million over the period.
### Total NHS Clinical Income

<table>
<thead>
<tr>
<th></th>
<th>2014/15 £000s</th>
<th>2015/16 £000s</th>
<th>2016/17 £000s</th>
<th>2017/18 £000s</th>
<th>2018/19 £000s</th>
<th>2019/20 £000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total NHS clinical income</td>
<td>747,871</td>
<td>760,252</td>
<td>794,828</td>
<td>814,501</td>
<td>834,105</td>
<td>853,675</td>
</tr>
<tr>
<td>Net change (year to year) - all factors</td>
<td>-</td>
<td>1.7%</td>
<td>4.5%</td>
<td>2.5%</td>
<td>2.4%</td>
<td>2.3%</td>
</tr>
<tr>
<td>Total NHS clinical income excluding inflation</td>
<td>747,871</td>
<td>755,321</td>
<td>795,047</td>
<td>813,214</td>
<td>831,495</td>
<td>849,168</td>
</tr>
<tr>
<td>Net real terms change (year to year) - all factors</td>
<td>-</td>
<td>1.0%</td>
<td>5.3%</td>
<td>2.3%</td>
<td>2.2%</td>
<td>2.1%</td>
</tr>
</tbody>
</table>

### Changes in NHS Clinical Income

<table>
<thead>
<tr>
<th></th>
<th>2015/16 £000s</th>
<th>2016/17 £000s</th>
<th>2017/18 £000s</th>
<th>2018/19 £000s</th>
<th>2019/20 £000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deflation</td>
<td>0</td>
<td>-10,658</td>
<td>-4,628</td>
<td>-5,511</td>
<td>-5,686</td>
</tr>
<tr>
<td>Drugs inflation</td>
<td>4,931</td>
<td>5,508</td>
<td>6,134</td>
<td>6,834</td>
<td>7,583</td>
</tr>
<tr>
<td>Service developments</td>
<td>387</td>
<td>216</td>
<td>231</td>
<td>891</td>
<td>359</td>
</tr>
<tr>
<td>Growth and efficiencies</td>
<td>9,790</td>
<td>34,986</td>
<td>21,748</td>
<td>21,204</td>
<td>21,107</td>
</tr>
<tr>
<td>MRET impact on new non-elective growth</td>
<td>-2,727</td>
<td>10,306</td>
<td>-1,085</td>
<td>-1,090</td>
<td>-1,088</td>
</tr>
<tr>
<td>Specialist marginal rate on growth after 2015/16</td>
<td>0</td>
<td>-5,782</td>
<td>-2,727</td>
<td>-2,724</td>
<td>-2,705</td>
</tr>
<tr>
<td><strong>Total net real terms growth</strong></td>
<td><strong>7,450</strong></td>
<td><strong>39,726</strong></td>
<td><strong>18,167</strong></td>
<td><strong>18,281</strong></td>
<td><strong>17,673</strong></td>
</tr>
<tr>
<td><strong>Overall change in NHS clinical income</strong></td>
<td>12,381</td>
<td>34,576</td>
<td>19,673</td>
<td>19,604</td>
<td>19,570</td>
</tr>
</tbody>
</table>
Income assumptions

6.104 The financial plan is based upon a detailed activity model for the Trust. This includes activity growth with an average financial value of £18.0 million per annum which in turn includes the effect of modelled demographic changes, underlying demand, KPI improvements and efficiency savings.

6.105 Potential affordability issues from Oxfordshire commissioners are assessed and included as a risk in the Downside scenario LTFM. The Risk section below provides further detail on this.

6.106 Income is modelled at 2014/15 tariff levels. The LTFM reflects the DTR regime for the full year for 2015/16, following the national rejection of the 2015/16 tariff consultation. The Trust did not opt for either the Enhanced Tariff Option (ETO) or DTR and therefore was defaulted into the DTR regime. This continues to apply 2014/15 tariff prices to activity with no tariff deflator. The Trust continues to only be paid a 30% marginal rate for emergency hospital admissions and the Trust is not eligible for CQUIN income in 2015/16.

6.107 After 2015/16 the LTFM includes the assumption that the MRET rate is increased to 70%, with a corresponding in year benefit of £10.3m in 2016/17. MRET continues to then be applied to non-elective income growth at this higher rate in the plans to 2019/20, with an additional average annual adverse impact on income of £1.1m.

6.108 However, alongside the assumption included in the plans of an improved MRET rate after 2015/16, the LTFM includes an assumption that a marginal rate of 70% payment is also applied to (NHS England Wessex) specialist activity growth (above the 2014/15 forecast outturn level), including pass-through drugs and devices growth, from 2016/17 onwards, after the DTR regime in 2015/16. This has an adverse impact of £5.8m in 2016/17, and builds up to an adverse impact of £13.9m by 2019/20.

<table>
<thead>
<tr>
<th>NHS clinical income</th>
<th>Forecast outturn</th>
<th>Forward Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2014/15 £000s</td>
<td>2015/16 £000s</td>
</tr>
<tr>
<td>Elective</td>
<td>160,316</td>
<td>167,361</td>
</tr>
<tr>
<td>Non-Elective</td>
<td>172,996</td>
<td>176,891</td>
</tr>
<tr>
<td>Outpatient</td>
<td>107,449</td>
<td>109,574</td>
</tr>
<tr>
<td>A&amp;E</td>
<td>15,776</td>
<td>16,324</td>
</tr>
<tr>
<td>Other NHS</td>
<td>291,335</td>
<td>290,102</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>747,871</strong></td>
<td><strong>760,252</strong></td>
</tr>
</tbody>
</table>

Implied efficiency levels, inflation assumptions and national pressures

6.109 The plan makes assumptions on the level of deflation in tariff and non-tariff income and inflation in other income, along with the Trust’s cost inflation assumptions, that determines the overall implied efficiency requirement each year, as set out in the next section. A summary of the deflation and inflation assumptions included within the forecasts is shown in the table below.

---

14 This includes a potential affordability impact from 2015/16 of the Better Care Find transfer from OCCG to the Local Authority.
15 The levels of MFF (Market Forces Factor) funding uplift to tariffs is assumed to remain at current % levels over the forecast period.
### Inflation assumptions

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Income</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHS clinical income *</td>
<td>0.0%</td>
<td>-1.2%</td>
<td>-0.6%</td>
<td>-0.7%</td>
<td>-0.7%</td>
</tr>
<tr>
<td>Non NHS clinical income</td>
<td>-1.9%</td>
<td>0.4%</td>
<td>-0.6%</td>
<td>-0.7%</td>
<td>-0.7%</td>
</tr>
<tr>
<td>Other income - Education and Training</td>
<td>-1.9%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Other income - Research and Development</td>
<td>-1.9%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Other income - Other</td>
<td>-1.9%</td>
<td>1.2%</td>
<td>1.3%</td>
<td>1.3%</td>
<td>1.3%</td>
</tr>
<tr>
<td><strong>Expenditure</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee benefit expenses</td>
<td>0.6%</td>
<td>2.0%</td>
<td>2.5%</td>
<td>2.5%</td>
<td>2.5%</td>
</tr>
<tr>
<td>Drug expenses</td>
<td>7.0%</td>
<td>7.0%</td>
<td>7.0%</td>
<td>7.0%</td>
<td>7.0%</td>
</tr>
<tr>
<td>Clinical supplies and services expenses</td>
<td>1.6%</td>
<td>1.9%</td>
<td>1.9%</td>
<td>2.0%</td>
<td>2.0%</td>
</tr>
<tr>
<td>Other expenses</td>
<td>2.9%</td>
<td>3.2%</td>
<td>3.2%</td>
<td>3.3%</td>
<td>3.3%</td>
</tr>
<tr>
<td>CNST insurance</td>
<td>31.0%</td>
<td>15.0%</td>
<td>15.0%</td>
<td>15.0%</td>
<td>15.0%</td>
</tr>
<tr>
<td>Unitary charge</td>
<td>2.5%</td>
<td>2.5%</td>
<td>2.5%</td>
<td>2.5%</td>
<td>2.5%</td>
</tr>
<tr>
<td>Capital expenditure</td>
<td>3.5%</td>
<td>3.5%</td>
<td>3.5%</td>
<td>3.5%</td>
<td>3.5%</td>
</tr>
</tbody>
</table>

* There is no tariff deflator under DTR in 2015/16.

6.110 Tariff and non-tariff NHS clinical income deflation resumes from 2016/17 (after DTR in 2015/16). For 2016/17 the Trust has calculated the deflator that would have applied under ETO in 2015/16 and then added to that the deflator for 2016/17 projected in accordance with previous guidance from Monitor\(^\text{17}\), as such the tariff deflator catches up in 2016/17.

6.111 Education and Training income inflation and Research and Development inflation is assumed to be nil after 2015/16. This is based upon detailed weighted analysis of the components in each income stream and the evidence that inflationary increases have been flat recently in these areas.

6.112 Other income - Other reflects a weighted average inflation increase of 1.3% per annum after 2015/16. This is based upon a weighted analysis of the different income components in this category, which include sale of drugs income and energy fees, where income inflation has been matched to the relevant cost inflation.

6.113 Cost inflation reflects the Trust’s own analysis of cost inflation levels on the pay and non-pay expenditure categories as described below (this includes taking into account Monitor’s assessment of overall annual input cost inflation pressures\(^\text{18}\)). The employee benefit expense inflation assumptions reflect the recent NHS pay award inflation announcement for 2015/16\(^\text{19}\), after this pay inflation is assumed to increase to 2% in 2016/17 and 2.5% thereafter as the Trust has assessed that there are

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\(^{17}\) *Guidance for the Annual Planning Review 2014/15*, Monitor, updated in January 2014. Tariff deflator is the difference between the expected tariff efficiency factor (page 12 Table 3) and the input cost inflation (page 8 Table 1).

\(^{18}\) *Ibid.* – page 8 Table 1.

\(^{19}\) Department of Health NHS pay award announced in March 2015 for 2015/16. Staff on Agenda for Change grades up to spine point 42 are to receive a 1% uplift. Staff above this spine point will receive no pay inflation uplift. Some lower bands of staff will receive a greater pay uplift. For medical staff, those at the top of a pay band with no access to incremental pay progression will receive a non-consolidated, non-recurrent payment worth 1% of basic pay in 2015/16. The Trust has assessed the overall impact of this to be 0.62% on staff costs in 2015/16.
likely to be additional pay pressures that arise in the future years after a prolonged period of supressed pay levels in the NHS.

6.114 The drugs expense inflation assumption of 7.0% per annum is based upon the Trust’s analysis of Pharmacy drugs expenditure data in the Baxter’s database for the three years 2011/12-2013/14, which shows a weighted average inflationary increase of 4.5% per annum. An additional 2.5% has been allowed for inflationary pressures for new drugs coming on stream (including those from NICE decisions), giving the total inflation assumption of 7.0%.

6.115 The clinical supplies inflation assumption of an average 1.9% per annum is based upon the OBR’s GDP deflator forecast figures for 2015/16 to 2018/1920 (and extrapolated for a further year to 2019/20). This reflects the approach to calculating other operating costs inflation in the National Tariff consultation guidance for 2015/16.21

6.116 The Other expenses assumption of an average 3.2% growth per annum is based upon the current OBR GDP deflator forecasts for 2015/16 to 2018/1922 (extrapolated for a further year to 2019/20), but adjusted for the Trust’s own assessment of utilities inflation rates (based upon recent historical experience) for electricity, gas and other fuels, to produce an overall weighted average inflationary uplift each year based upon the different expenditure items within this category in the LTFM.

6.117 The Clinical Negligence Scheme for Trusts (CNST) insurance inflation assumption includes the actual increase notified to the Trust of a 31% rise in 2015/16 (excluding the additional £3.2m cost impact from the loss of the risk management discount, which has been reflected separately as a cost pressure in 2015/16 in the LTFM). Taken together these two factors have led to a 53% increase in notified CNST premiums for the Trust in 2015/16. After 2015/16 continued inflationary pressures are expected on CNST premiums for large acute teaching Trusts such as OUH and 15% per annum inflationary increases have been included in the LTFM.

6.118 Private Finance Initiative (PFI) unitary payment inflation is modelled at 2.5% forecast RPI across the period, reflecting future assumptions in the three PFI IFRS financial models.

6.119 The capital expenditure inflation assumption of 3.5% is based upon the capital costs inflation within the 2015/16 National Tariff consultation guidance, extrapolated forward for the future years.

6.120 The LTFM includes national pressures relating to pay incremental drift of 0.5% per annum. This is based upon the Trust’s own calculations on the financial impact on permanent staff costs in 2013/14 of incremental drift of 0.6%, but allowing for a small offset for staff turnover levels mitigating the incremental drift impact.

6.121 The LTFM also includes a national pressure for pension changes in 2015/16 and 2016/17 with an overall impact on weighted average input cost inflation of 0.2% and 1.2% respectively. These relate to the revaluation of public sector pension contributions in 2015/16 (a 0.3 employers contribution increase) and reforms to the state pension planned in 2016/17 (with an increase in employer NICs, the impact of which has been assessed by the Trust).

6.122 As stated by Monitor23, these are cost pressures for providers and assumed to be funded through tariff, and so have been included in the implied efficiency calculation in the LTFM for those two years as set out in the table below. The Trust has run a downside risk that these pension pressures are not recognised through the tariff (and are therefore in addition to the indicative efficiency requirement) and this is set out in the Risk section below.

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20 GDP deflator figures from the Quarterly National Accounts update in June 2014.
22 GDP deflator figures from the Quarterly National Accounts update in June 2014.
6.123 The LTFM includes an overall implied efficiency level of 5.0% for 2015/16, reducing to an average of 4.2% per annum after that for the years 2016/17 to 2019/20 (excluding local cost pressures). The financial impact of the overall weighted income deflation, cost inflation and national cost pressures (as described above) is shown in the table overleaf, and shows for each year the total indicative efficiency built into the LTFM as a percentage.
### Implied efficiency each year in the LTFM

<table>
<thead>
<tr>
<th></th>
<th>2015/16 %s</th>
<th>2016/17 %s</th>
<th>2017/18 %s</th>
<th>2018/19 %s</th>
<th>2019/20 %s</th>
<th>Average Weighting %</th>
<th>2015/16 weighted %s</th>
<th>2016/17 weighted %s</th>
<th>2017/18 weighted %s</th>
<th>2018/19 weighted %s</th>
<th>2019/20 weighted %s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income deflation (weighted average - excluding pass-through drugs)</td>
<td>(see separate breakdown of deflation by income type)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-0.4%</td>
<td>-1.1%</td>
<td>-0.4%</td>
<td>-0.5%</td>
<td>-0.5%</td>
</tr>
<tr>
<td>Loss of CQUIN (DTR) - instead of national tariff deflator</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-1.7%</td>
<td>1.6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee benefit expense Inflation and incremental drift</td>
<td>1.2%</td>
<td>2.5%</td>
<td>3.0%</td>
<td>3.0%</td>
<td>3.0%</td>
<td>69%</td>
<td>0.8%</td>
<td>1.7%</td>
<td>2.1%</td>
<td>2.1%</td>
<td>2.1%</td>
</tr>
<tr>
<td>Pensions - national cost pressure</td>
<td>0.3%</td>
<td>1.7%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>69%</td>
<td>0.2%</td>
<td>1.2%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Drugs inflation (excluding pass-through drugs)</td>
<td>7.0%</td>
<td>7.0%</td>
<td>7.0%</td>
<td>7.0%</td>
<td>7.0%</td>
<td>3%</td>
<td>0.2%</td>
<td>0.2%</td>
<td>0.2%</td>
<td>0.2%</td>
<td>0.2%</td>
</tr>
<tr>
<td>Clinical supplies and services expenses inflation</td>
<td>1.6%</td>
<td>1.9%</td>
<td>1.9%</td>
<td>2.0%</td>
<td>2.0%</td>
<td>13%</td>
<td>0.2%</td>
<td>0.3%</td>
<td>0.3%</td>
<td>0.3%</td>
<td>0.3%</td>
</tr>
<tr>
<td>CNST insurance inflation</td>
<td>31.0%</td>
<td>15.0%</td>
<td>15.0%</td>
<td>15.0%</td>
<td>15.0%</td>
<td>6%</td>
<td>1.3%</td>
<td>0.7%</td>
<td>0.8%</td>
<td>1.0%</td>
<td>1.1%</td>
</tr>
<tr>
<td>Other expenses inflation</td>
<td>2.9%</td>
<td>3.2%</td>
<td>3.2%</td>
<td>3.3%</td>
<td>3.3%</td>
<td>9%</td>
<td>0.3%</td>
<td>0.3%</td>
<td>0.3%</td>
<td>0.2%</td>
<td>0.2%</td>
</tr>
<tr>
<td><strong>Total implied efficiency impact %</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>5.0%</strong></td>
<td><strong>3.9%</strong></td>
<td><strong>4.1%</strong></td>
<td><strong>4.3%</strong></td>
<td><strong>4.4%</strong></td>
</tr>
</tbody>
</table>

* From O_Efficiency in the LTFM, but adjusted for pensions national cost pressures and factoring in loss of CQUINs in 2015/16 (per DTR) in lieu of a tariff deflator being applied in that year only.
Expenditure assumptions

6.124 The expenditure projections reflect costs associated with the growth in activity set out above. This cost growth has been calculated from the Trust’s PLICS data on semi-fixed and variable cost profiles to calculate marginal cost growth at Point of Delivery (POD) and specialty level. This enables differential marginal costs to be modelled depending on which POD and specialty the activity growth is in (as set out in the LTFM). This results in an overall average marginal cost rate of 61% for future years in the LTFM (including the impact of pass through drugs and devices).

6.125 A separate service development sheet has been modelled in the LTFM for the development of a satellite Radiotherapy unit at Great Western Hospital in Swindon.

6.126 Forecast pay expenditure includes cost pressures for pay incremental drift for staff on Agenda for Change terms and conditions (0.5% per annum) and medical staff incremental drift (0.5% per annum), based upon detailed analysis of recent incremental drift impact on the Trust’s pay expenditure (as set out in the inflation and national pressures section above).

6.127 Additional recurrent cost pressures of a further 1% each year have been included on pay and non-pay operating expenditure, this includes allowing for investment in new national quality and standards and safety issues.

6.128 A cost pressure (totalling £4.0m) is included in the plans over the two years 2015/16 and 2016/17 to reflect the impact of Department of Health (DH) support for the ICT costs of the Cerner Electronic Patient Record (EPR) system being withdrawn.

6.129 A cost pressure of £3.2m has been included from 2015/16 on CNST insurance costs as a result of the removal of the risk management discount the Trust previously received, as part of wider national changes to the CNST scheme.

Projected expenditure

<table>
<thead>
<tr>
<th>Operating expenses (nominal)</th>
<th>Forecast outturn</th>
<th>2014/15 £000s</th>
<th>2015/16 £000s</th>
<th>2016/17 £000s</th>
<th>2017/18 £000s</th>
<th>2018/19 £000s</th>
<th>2019/20 £000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee benefit expenses</td>
<td></td>
<td>-500,700</td>
<td>-508,747</td>
<td>-524,037</td>
<td>-530,017</td>
<td>-535,780</td>
<td>-541,996</td>
</tr>
<tr>
<td>Drug expenses</td>
<td></td>
<td>-96,383</td>
<td>-100,808</td>
<td>-108,071</td>
<td>-115,845</td>
<td>-124,296</td>
<td>-133,408</td>
</tr>
<tr>
<td>Clinical supplies and services expenses</td>
<td></td>
<td>-101,192</td>
<td>-98,641</td>
<td>-100,962</td>
<td>-102,485</td>
<td>-104,352</td>
<td>-105,999</td>
</tr>
<tr>
<td>PFI specific expenses</td>
<td></td>
<td>-31,731</td>
<td>-32,854</td>
<td>-33,744</td>
<td>-34,377</td>
<td>-35,105</td>
<td>-36,238</td>
</tr>
<tr>
<td>Other expenses</td>
<td></td>
<td>-81,129</td>
<td>-79,729</td>
<td>-68,373</td>
<td>-62,196</td>
<td>-57,534</td>
<td>-50,995</td>
</tr>
<tr>
<td>Operating Expenses</td>
<td></td>
<td>-831,164</td>
<td>-851,449</td>
<td>-871,090</td>
<td>-886,900</td>
<td>-906,132</td>
<td>-925,976</td>
</tr>
</tbody>
</table>

Cost Improvement Programme (CIP)

6.130 In nominal (cash) terms annual cost and performance improvements are expected to realise an average of £46.8m per annum over the five years of the IBP, which equates to an average saving requirement of 5.2% of each year 24. Savings are higher in 2015/16 and 2016/17 than in subsequent years. In 2015/16 this is due to the higher implied efficiency requirement in that year and a higher level of cost pressures, including CNST increases and EPR cost pressure. In 2016/17 the requirement is

---

24 CIP expressed as a percentage of recurrent controllable costs each year (excluding PFI and non-recurrent costs) as shown in I_CIP – summary in the LTFM.
higher than subsequent years to bring the retained surplus back up to 1% surplus from the planned deficit position in 2015/16.

6.131 Total savings of £218.9m (in real terms) are planned over the five year period. The Trust recognises that the delivery of this programme is crucial to delivering the financial projections in its LTFM.

<table>
<thead>
<tr>
<th>CIPs (nominal terms)</th>
<th>Forward Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff and pay savings</td>
<td>£000s</td>
</tr>
<tr>
<td>Drugs savings</td>
<td>12,059</td>
</tr>
<tr>
<td>Clinical supplies</td>
<td>6,010</td>
</tr>
<tr>
<td>Other costs</td>
<td>8,770</td>
</tr>
<tr>
<td>Other (including agency and income CIPs)</td>
<td>18,468</td>
</tr>
<tr>
<td>Total CIPs (nominal terms)</td>
<td>52,624</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CIPs (real terms)</th>
<th>Forward Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff and pay savings</td>
<td>£000s</td>
</tr>
<tr>
<td>Drugs savings</td>
<td>11,985</td>
</tr>
<tr>
<td>Clinical supplies</td>
<td>5,617</td>
</tr>
<tr>
<td>Other costs</td>
<td>8,632</td>
</tr>
<tr>
<td>Other (including agency and income CIPs)</td>
<td>18,474</td>
</tr>
<tr>
<td>Total CIPs (real terms)</td>
<td>51,817</td>
</tr>
</tbody>
</table>

Cost Improvement Programme (CIP) for 2015/16 and 2016/17

6.132 The table below summarises the expected delivery programme for the period to March 2017.
6.133 The programme for 2015/16 has been subject to a similar planning process as for the 2014/15 CIP, with project documentation and quality impact assessments.

6.134 Programme content consists of Divisional and cross-Divisional schemes. The cross-Divisional programme includes three main areas; workforce initiative savings, transformation savings and other savings. The workforce initiatives include a major focus on efficient deployment of clinical staff through improved job planning and other workforce change. The transformation programme savings include measures to reduce length of stay and did not attend rates. It also includes schemes relating to the EPR system to work to realise the benefits of this major modernisation process, converting these to cash releasing savings plans by 2015/16. Other savings include Medicines Management and Procurement schemes, which will continue to deliver cost reductions.

6.135 The Cost Improvement Committee is overseeing the development of mechanisms to deliver these changes to ensure that actions are being taken to a timescale that recognises the lead times for these more significant changes. The committee receives regular workforce and quality indicator reports.

6.136 The design of schemes has taken place according to the processes established in previous years. Assessment has occurred of the quality impact of these schemes. The approach to delivery will evolve during the year as the programme begins to emphasise transformation themes.
6.137 The Trust will be implementing a Carbon and Energy Fund (CEF) scheme to reduce its energy running costs. Other energy savings will be secured through the use of more environmentally-friendly low energy lighting across the Trust.

**Key Performance Indicators (KPIs)**

6.138 A summary of principal KPI projections is set out below.

6.139 Bed numbers are forecast to decrease by 5 from 1,465 in 2014/15 to 1,460 by 2019/20. This forecast decrease is driven by modelled activity increases from demography and underlying growth offset by assumptions on reduced delays in patient transfer and 7 day working increasing the number of days that beds are available.

6.140 Average non-elective length of stay is forecast to improve as transformational efficiencies are realised in some specialties and the impact of delayed transfers of care gradually reduces. Theatre utilisation is forecast to gradually improve reaching 85% by 2019/20 as benefits are realised from further efficiency schemes.

<table>
<thead>
<tr>
<th>KPIs</th>
<th>Forecast outturn</th>
<th>Forward Projections</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Units</td>
<td>2014/15 15/16 16/17 17/18 18/19 19/20</td>
</tr>
<tr>
<td>Bed numbers</td>
<td>Beds</td>
<td>1.465 1.470 1.468 1.468 1.464 1.460</td>
</tr>
<tr>
<td>Average length of stay (elective)</td>
<td>Days</td>
<td>4.31 4.23 4.16 4.09 4.03 3.97</td>
</tr>
<tr>
<td>Average length of stay (non elective)</td>
<td>Days</td>
<td>4.31 4.21 4.12 4.04 3.96 3.88</td>
</tr>
<tr>
<td>Theatre utilisation</td>
<td>%</td>
<td>76% 78% 80% 81% 83% 85%</td>
</tr>
<tr>
<td>Catchment population (excluding tourists)</td>
<td>000's</td>
<td>628.6 630.3 632.0 633.5 635.6 637.0</td>
</tr>
</tbody>
</table>
## Projected Statement of Financial Position

6.141 Statement of Financial Position projections for 2014/15-2019/20 are summarised as follows:

<table>
<thead>
<tr>
<th>Statement of Financial Position</th>
<th>Forecast</th>
<th>Outturn</th>
<th>Forward Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2014/15 £000s</td>
<td>2015/16 £000s</td>
<td>2016/17 £000s</td>
</tr>
<tr>
<td>Non-current assets</td>
<td>719,391</td>
<td>726,538</td>
<td>758,263</td>
</tr>
<tr>
<td>Current assets:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inventories</td>
<td>11,808</td>
<td>11,808</td>
<td>11,808</td>
</tr>
<tr>
<td>Receivables and prepayments</td>
<td>29,612</td>
<td>29,612</td>
<td>29,612</td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>75,886</td>
<td>69,103</td>
<td>69,632</td>
</tr>
<tr>
<td>Total current assets</td>
<td>117,306</td>
<td>110,523</td>
<td>111,052</td>
</tr>
<tr>
<td>Net current assets (liabilities)</td>
<td>-9,554</td>
<td>1,793</td>
<td>-2,622</td>
</tr>
<tr>
<td>Total assets less current liabilities</td>
<td>709,836</td>
<td>728,331</td>
<td>755,641</td>
</tr>
<tr>
<td>Total Assets Employed</td>
<td>430,740</td>
<td>428,076</td>
<td>439,769</td>
</tr>
<tr>
<td>Financed by:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public dividend capital</td>
<td>208,115</td>
<td>208,757</td>
<td>208,757</td>
</tr>
<tr>
<td>Revaluation reserve</td>
<td>177,767</td>
<td>177,767</td>
<td>177,767</td>
</tr>
<tr>
<td>Other reserves</td>
<td>1,743</td>
<td>1,743</td>
<td>1,743</td>
</tr>
<tr>
<td>Retained earnings</td>
<td>43,115</td>
<td>39,809</td>
<td>51,502</td>
</tr>
<tr>
<td>Total Taxpayers’ Equity</td>
<td>430,740</td>
<td>428,076</td>
<td>439,769</td>
</tr>
</tbody>
</table>

### Non-current assets

6.142 Non-current assets increase overall in net terms over the five years, reflecting the impact of planned capital expenditure (see detail on the content of the capital plans below) being partly offset by annual depreciation of assets. Asset revaluations have not been assumed in the LTFM after the revaluation in the current year, due to the uncertainty over asset valuation movements over the period.

### Current assets

6.143 Inventory levels are projected to remain consistent over the period, in line with forecast levels at March 2015. NHS Trade Receivables days are forecast to be broadly constant and consistent with current performance at an average of four days. Non-NHS Trade Receivables days are forecast to be consistent over the period, averaging 24 days.

6.144 Cash balances at each year end are expected to be maintained at between £69.1m and £75.0m over the five years, after allowing for the Trust’s capital financing strategy. This includes a modelled FT
working capital loan draw down of £22.0m in July 2015 to strengthen the Balance Sheet net current asset position of the Trust at the planned point of authorisation as a Foundation Trust. This is the forecast loan level necessary to achieve sufficient headroom on the liquidity score on Monitor’s Continuity of Service Risk Rating (CSRR) in future years against the base case and downside scenarios (see page 59). This loan is forecast to be repaid over ten years.

Current liabilities

6.145 Trade Payables days currently average 27 days and are forecast to reduce over the five years, as payment performance improves, bringing these down to 23 days by the end of the period. This is driven by planned improvements to the Trust’s Accounts Payable systems, including increasing the use of purchase orders and enhancing workflow for creditor invoices.

6.146 Equipment lease liabilities (due within one year) are projected to increase over the period, principally because the Carbon Energy Fund (CEF) scheme (£18.0m capital value in real terms over two years) is included in the plans as a new finance lease. A new lease of £0.8m has been included in 2014/15 for the microbiology automation scheme.

6.147 PFI liabilities (due within one year) are projected to increase until 2017/18 in line with the planned proportion of unitary payment elements going against repayment of the outstanding liabilities. From 2018/19 they drop due to the higher level of PFI lifecycle and MES payments planned from that point.

6.148 Accruals are forecast to be consistent from the 2015/16 planned level over the five year period in the LTFM.

Non-current liabilities

6.149 Non-current liabilities initially increase due to the planned £22m FT working capital loan drawdown in 2015/16, the planned drawdown of capital investment loans for JR theatres, adult critical care and radiotherapy in 2015/16 and 2016/17 and the new Carbon Energy scheme finance leases (as outlined above under current liabilities). After this non-current liabilities are planned to reduce each year as repayments continue to be made against the PFI liabilities, medical equipment and energy scheme leases and the loans.

6.150 Deferred income increases in 2015/16 (by £3.1m) as a result of the Welcome Centre scheme.

Taxpayers’ equity

6.151 Taxpayers’ equity is forecast to increase due to the retained earnings reserve growing as surpluses are generated over the period from 2016/17 (after the retained deficit of £3.3m planned in 2015/16), averaging £10.9m each year, including donations income.

International Financial Reporting Standards (IFRS)

6.152 The financial information in this document has been produced according to International Financial Reporting Standards (IFRS). The main impact of the introduction of IFRS was to bring the Trust’s three PFI schemes onto the Trust’s Statement of Financial Position. IFRS also had an impact on the accounting treatment of equipment operating leases which were re-categorised as finance leases.

25 JR theatres capital loan £24m (planned draw down in two tranches in March 2017 and March 2018). Adult critical care capital loan £6m (planned draw down in March 2017). Milton Keynes radiotherapy satellite unit capital loan £8.5m (planned draw down in two tranches in March 2017 and March 2018).
Projected Statement of Cash Flows

6.153 The table below forecasts the Trust’s cash flow to 2019/20. Projections for 2014/15 were described at 6.55 above. In 2015/16 a £22.0m FT working capital loan\(^{26}\) has been included in the financial plans to strengthen the liquidity CSRR position from 2015/16 as the planned year of authorisation.

6.154 These projections show the Trust maintaining a strong cash position over the period (after the £6.8m reduction in cash in 2015/16), driven by generation of EBITDA surpluses, and indicate that the Trust will generate a cash balance of £73.5m by the end of 2019/20.

6.155 This cash position includes funding capital expenditure to address maintenance and backlog investment requirements. Capital expenditure is financed from internally generated sources of funds, as set out below along with capital expenditure plans, with the exception of the JR theatres modernisation scheme, the adult critical care scheme and the Milton Keynes radiotherapy satellite unit scheme\(^{27}\).

6.156 The main cash outflows over the period are on capital expenditure, dividends, interest and liability repayments on the three PFI schemes, and interest and repayments on the loans.

6.157 OUH has a treasury management policy which provides a framework for managing its cash position and the use of any surplus cash. The Trust has developed a policy to reflect the duties and freedoms of a Foundation Trust, which will be approved prior to authorisation.

<table>
<thead>
<tr>
<th>Summary Statement of Cash Flows</th>
<th>Forecast outturn</th>
<th>Forward Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2014/15 £000s</td>
<td>2015/16 £000s</td>
</tr>
<tr>
<td>EBITDA</td>
<td>75,238</td>
<td>64,101</td>
</tr>
<tr>
<td>Excluding non-cash I&amp;E items</td>
<td>-839</td>
<td>-269</td>
</tr>
<tr>
<td>Increase/(decrease) in working capital</td>
<td>-9,781</td>
<td>-14,944</td>
</tr>
<tr>
<td>Increase/(decrease) in non current provisions</td>
<td>-62</td>
<td>0</td>
</tr>
<tr>
<td>Net cash inflow from operating activities</td>
<td>64,556</td>
<td>48,888</td>
</tr>
<tr>
<td>Proceeds on disposals</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Cash flow before financing</td>
<td>31,874</td>
<td>13,775</td>
</tr>
<tr>
<td>Public dividend capital received</td>
<td>980</td>
<td>642</td>
</tr>
<tr>
<td>Public dividend capital repaid</td>
<td>-1,800</td>
<td>0</td>
</tr>
<tr>
<td>Dividends paid</td>
<td>-8,364</td>
<td>-8,774</td>
</tr>
<tr>
<td>Interest (paid) on loans and leases</td>
<td>-20,698</td>
<td>-20,870</td>
</tr>
<tr>
<td>Interest received on cash and cash equivalents</td>
<td>304</td>
<td>238</td>
</tr>
<tr>
<td>Drawdown of loans and leases</td>
<td>0</td>
<td>22,000</td>
</tr>
<tr>
<td>Repayment of loans and leases</td>
<td>-12,858</td>
<td>-13,794</td>
</tr>
<tr>
<td>Net cash (outflow) / inflow</td>
<td>-10,562</td>
<td>-6,784</td>
</tr>
<tr>
<td>Closing Cash Balance</td>
<td>75,886</td>
<td>69,103</td>
</tr>
</tbody>
</table>

\(^{26}\) The planned level of the FT liquidity loan has increased from the £10m level planned last autumn due to the retained deficit planned now in 2015/16.

\(^{27}\) JR theatres capital loan £24m (planned draw down in two tranches in March 2017 and March 2018). Adult critical care capital loan £6m (planned draw down in March 2017). Milton Keynes radiotherapy satellite unit capital loan £8.5m (planned draw down in two tranches in March 2017 and March 2018).
Working capital facility

6.158 No working capital facility is included in the financial plan as the Trust has taken the view that it is not prudent to include one in the LTFM after taking account of Monitor’s tightened guidelines\(^\text{28}\) that a facility should be included only if it is a fully committed working capital facility with no clauses preventing their use should a Trust be under financial strain.

Loans

6.159 A new FT working capital loan of £22.0m is included in the modelling to be drawn down in July 2015 and planned to be repaid over ten years from 2015/16. This strengthens the Trust’s liquidity position and cash balance and hence the liquidity rating at the planned point of authorisation. The balances outstanding on the two existing capital investment loans and the new FT working capital loan are paid down each year.

6.160 Three capital investment loans have been included as part of the overall financing strategy for the capital programme, which includes some significant schemes to modernise theatres and adult critical care provision at the John Radcliffe Hospital as well as two new satellite Radiotherapy units.

6.161 A £24.0m capital investment loan to fund the JR theatres modernisation capital business case is included in plans for drawdown in two tranches in March 2017 and March 2018 (to match the profile of the expenditure) and is planned to be repaid over fifteen years from 2017/18. A £8.5m capital investment loan is also included to fund the Milton Keynes satellite radiotherapy unit for drawdown in two tranches in March 2017 and March 2018 (to match the profile of the expenditure) and is planned to be repaid over fifteen years from 2017/18. A £6m capital investment loan is also included to fund the adult critical care scheme at the JR in March 2017 and is planned to be repaid over fifteen years from 2017/18.

Capital investment and financing strategy

Capital expenditure plans

6.162 In the period to 2019/20, the Trust plans capital investment of £182.8m. This includes planned expenditure to address the backlog investment required to ensure buildings and equipment in use are in a good condition and to improve facilities for care delivery on each site. These include schemes to modernise the operating theatres in the main building on the JR site, and to modernise and expand the adult critical care unit adjacent to the JR theatres.

6.163 Investment plans are also included in some of the older ward areas including Infectious Diseases, Renal Inpatients and Respiratory Medicine on the Churchill site.

6.164 Capital investment is also included for two radiotherapy satellite units.

6.165 Ongoing commitments to invest in replacing medical equipment and IT infrastructure are also included in the capital plans for each year.

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\(^{28}\) Risk Assessment Framework, Monitor, August 2013.
## Capital Expenditure Plans - (Nominal)

<table>
<thead>
<tr>
<th></th>
<th>Forecast outturn</th>
<th>Forward Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2014/15 £000s</td>
<td>2015/16 £000s</td>
</tr>
<tr>
<td>Medical equipment</td>
<td>12,139</td>
<td>7,063</td>
</tr>
<tr>
<td>Estates maintenance</td>
<td>2,079</td>
<td>2,568</td>
</tr>
<tr>
<td>JR theatre remodelling</td>
<td>50</td>
<td>104</td>
</tr>
<tr>
<td>Adult critical care</td>
<td>0</td>
<td>62</td>
</tr>
<tr>
<td>Ward relocations</td>
<td>50</td>
<td>1,784</td>
</tr>
<tr>
<td>Other maintenance</td>
<td>4,227</td>
<td>492</td>
</tr>
<tr>
<td><strong>Total maintenance capital expenditure</strong></td>
<td><strong>18,545</strong></td>
<td><strong>12,073</strong></td>
</tr>
<tr>
<td>Radiotherapy (satellite centres) - excluding donations</td>
<td>895</td>
<td>4,191</td>
</tr>
<tr>
<td>IT/EPR</td>
<td>4,750</td>
<td>3,364</td>
</tr>
<tr>
<td>EPR Re-procurement</td>
<td>1,296</td>
<td>4,048</td>
</tr>
<tr>
<td>Horton Endoscopy</td>
<td>130</td>
<td>2,070</td>
</tr>
<tr>
<td>JR Welcome Centre - embedded lease</td>
<td>0</td>
<td>3,105</td>
</tr>
<tr>
<td>Other schemes</td>
<td>5,785</td>
<td>4,005</td>
</tr>
<tr>
<td><strong>Non Maintenance Capex</strong></td>
<td><strong>12,856</strong></td>
<td><strong>20,782</strong></td>
</tr>
<tr>
<td><strong>Total Capital Expenditure</strong></td>
<td><strong>31,401</strong></td>
<td><strong>32,855</strong></td>
</tr>
</tbody>
</table>

* Includes JR Welcome Centre embedded lease. Excludes expenditure relating to PFI lifecycle/Managed Equipment Service, donated assets and new finance leases (including Carbon Energy Fund).

6.166 The financing strategy is to primarily use cash from depreciation and the annual surpluses generated (after making scheduled loan and lease liability repayments) to finance the five year capital investment plan. These internally generated funds finance 79% of the capital programme over the next five years. The remaining 21% of the programme is financed by three planned capital investment loans for the JR theatres and adult critical care modernisations and the Milton Keynes radiotherapy satellite unit (as set out in the section on loans above). The funding of the capital programme is set out below.
Funding of capital investment plans

<table>
<thead>
<tr>
<th></th>
<th>Forecast outturn</th>
<th>Forward Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2014/15 £000s</td>
<td>2015/16 £000s</td>
</tr>
<tr>
<td>Total capital investment (nominal)</td>
<td>31,401</td>
<td>32,855</td>
</tr>
<tr>
<td>Financed by:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retained surplus</td>
<td>8,702</td>
<td>0</td>
</tr>
<tr>
<td>(exclude donations income to fund donated capex)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Depreciation (including PFI)</td>
<td>38,007</td>
<td>37,800</td>
</tr>
<tr>
<td>New capital investment loans</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>New PDC capital</td>
<td>980</td>
<td>642</td>
</tr>
<tr>
<td>Embedded lease - deferred income</td>
<td>0</td>
<td>3,105</td>
</tr>
<tr>
<td>Less: PFI and finance lease repayments of capital</td>
<td>-11,454</td>
<td>-10,190</td>
</tr>
<tr>
<td>Less: PFI lifecycle and MES payments</td>
<td>-1,281</td>
<td>-2,258</td>
</tr>
<tr>
<td>Less: repayment of loans</td>
<td>-1,404</td>
<td>-3,604</td>
</tr>
<tr>
<td>Internally generated financing available for capital investment</td>
<td>33,550</td>
<td>25,495</td>
</tr>
<tr>
<td>Difference</td>
<td>2,149</td>
<td>-7,360</td>
</tr>
</tbody>
</table>

**Capital investment criteria applied to developments**

6.167 All business cases and associated capital investment requirements go to the Trust Management Executive for approval. Each is assessed against strict criteria including overall fit with the Trust’s strategy, alignment with its business plan, and the requirement to deliver a positive net financial contribution on income and expenditure.

**Private Finance Initiative schemes**

6.168 The Trust has three PFI projects: the West Wing and Children’s Hospital at the John Radcliffe (for which payments started in January 2007), the Nuffield Orthopaedic Centre (for which payments started in February 2007), and the new Cancer Centre at the Churchill Hospital (for which payments started in January 2009).

6.169 The contracts are for 30 years, except for the NOC contract which is for 37 years. All three contracts are inflated annually by Retail Prices Index.

6.170 The PFI buildings make up 29.1% of the property on OUH’s sites.

6.171 As well as the buildings, the contracts include hard and soft facilities management services, including estate management and maintenance and soft facilities management services including domestics, portering, and catering. The Churchill Hospital PFI also includes the provision of a Managed Equipment Service (MES) for regular upgrade and replacement of radiotherapy and radiology equipment in the Cancer Centre.

6.172 Unitary payments for the three schemes totalled £62.4m in 2013/14 (including contract variation payments). This sum included the services outlined above, capital repayments of the liabilities and interest. This represented 7.2% of OUH turnover for that year.
Private patients

6.173 The Trust expects its private patient income to be stable from 2015/16 at an average of 1.1% of clinical income for the remainder of the period after some planned growth in 2015/16.

Trading accounts, Service Line Reporting (SLR) and Service Line Management (SLM)

6.174 OUH is a clinically-led organisation supported by Service Line Management. OUH has used SLM to facilitate and support its management of specialist clinical areas as distinct operational units. It has been used to help these operational units to better understand their performance and organise their services in a way that benefits patients and delivers efficiencies for the trust.

6.175 The Trust has taken steps to develop SLR. These include devolving management responsibility for some theatre areas to the clinical Divisions using those theatres and implementing the Prodacapo costing system to facilitate the production of Patient Level Information Costing (PLICS) and SLR. Prodacapo is an activity based costing system that is considered to give the best opportunity to capture the cost of the various clinical interactions in a Trust of this size and complexity. The Trust has devolved all income to Divisions, developed internal trading for Radiology and Pathology services and plans to implement internal charging for Theatre services and space costs, to support SLR and clinical Divisions in their use of clinical support services.

6.176 SLR reports draw primarily on the same data as reference costs and are reported to managers and clinicians in each of the Trust’s clinical Divisions to inform them of the profitability position for each Division and specialty. Reports allow Divisional management to understand the drivers of reference cost benchmarks and to identify areas for cost and productivity improvement and so reduce reference costs and increase financial contributions.

6.177 The Trust has taken steps to promote the use of SLR and reference cost information, including establishing a Clinical Costing Advisory Development Group with significant clinical membership. This group takes a lead role in driving the adoption of Service Line Management and the use of PLICS and SLR to improve the understanding of costs and income at a specialty and patient level. The group makes the clinically-led Divisions accountable for business management and ensures they continue to embed PLICS and SLR/SLM in the organisation.

Continuity of Service Risk Rating

6.178 The following table summarises the Trust’s forecast performance against Monitor’s revised Continuity of Service Risk Rating (CSRR) for each of the next five years. It shows that from the planned first full year of licence (2016/17) onwards, OUH will generate sufficient revenue and cash surpluses to achieve a CSRR of 3.

6.179 The liquidity rating averages -5.0 days over the five year period, which is above the threshold of -7.0 days for a score of 3 on liquidity. As previously noted no working capital facility is included in the LTFM due to Monitor’s tightened guidelines that a facility should only be included if it is a fully committed working facility with no clauses preventing their use should a Trust be under financial strain. The Trust has included a £22.0m FT working capital loan in the plans to allow headroom of an average 4.3 days over the period on the liquidity rating. (Without this the Trust would score a 2 on liquidity in 2016/17, at -11.3 days and only increase to a score of 3 on liquidity in 2019/20).

6.180 The capital servicing capacity rating is close to the threshold of 1.75 times cover to score 3, and therefore scores a 2 in some years and a 3 in 2016/17 and 2019/20 (these years have larger PFI lifecycle and MES payments due, reducing the amount classified as PFI debt liability repayable in those years).
years and increasing the capital servicing rating score). The measure compares the surplus available to service capital repayments with capital repayments (which include interest payable, debt repayments, PDC dividend and PDC repayments).

### Continuity of Service Risk Rating (CSRR)

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Liquidity ratio (days) – uses opening liquidity</td>
<td>-8.8</td>
<td>-9.0</td>
<td>-4.1</td>
<td>-5.9</td>
<td>-5.4</td>
<td>-0.7</td>
</tr>
<tr>
<td>Liquidity ratio score</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
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<tr>
<td>Capital servicing capacity (times)</td>
<td>1.73</td>
<td>1.47</td>
<td>1.87</td>
<td>1.66</td>
<td>1.56</td>
<td>2.00</td>
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<tr>
<td>Capital servicing capacity score</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Overall Continuity of Service Risk Rating</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>

### Conclusion

6.181 After excluding the impact of technical accounting adjustments, the Trust has achieved a financial surplus in each of the last seven years\(^{30}\). The creation of OUH in 2011 put the combined organisation in a stronger financial position to operate successfully as a Foundation Trust.

6.182 The Trust has strengthened its underlying financial position in the last three years. It is focused on continuing to strengthen its financial position and Balance Sheet by delivering a 1% retained surplus in 2014/15 through good financial management and the delivery of cost improvements.

6.183 This base allows it to produce a financial plan that, in an increasingly challenging financial environment, delivers surpluses from the planned first full year of licence in 2016/17, with improved liquidity and risk ratings, and finances service improvements in areas of development to support its strategic goals.

6.184 The Trust recognises that there are risks to the delivery of this financial plan. These are examined in the Risk section below with measures that the Trust can adopt to control or manage these risks.

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\(^{30}\) This enabled the Trust to reach a cumulative break-even duty surplus position in 2013/14 of £6.7m.
7. Risk

7.1 The Board of Directors has overall responsibility for managing risk. It recognises the importance of monitoring and managing those risks which have the potential to threaten the achievement of its strategic goals proactively.

7.2 The Board has established effective arrangements to do this and to ensure that prompt and proportionate action is taken at the first sign that a risk may be materialising or where there is evidence that the mitigating action it has sanctioned is not proving effective.

7.3 OUH aims to operate a mature and structured approach to risk that strikes a balance between being excessively risk averse and exposing the organisation to risks that are insufficiently controlled. The former could prevent the Trust from being able to seize strategic opportunities for improvement, whilst the latter could allow threats to its strategy and performance to materialise. Achieving this balance is based on a process of setting the Trust’s level of appetite for a particular risk based on its risk maturity, agreeing an appropriate tolerance for this, delegating the authority to manage within this tolerance and ensuring that appropriate on-going monitoring is in place.

7.4 Risks are clearly linked to the Trust’s strategic objectives and, with the progressive implementation of its Risk Management Strategy, the organisation intends to increase the sophistication with which it assesses, manages and monitors risk.

7.5 This section sets out OUH’s overall approach to risk management and summarises the systems and processes employed. It provides an overview of the latest assessment of key risks facing the Trust’s business plan and the sensitivity of its financial projections to these risks if they were to materialise.

Summary of principal risks

7.6 The Trust reviews its strategic objectives each year as part of its business planning cycle. The strategic objectives are supported by a set of annual corporate objectives.

7.7 At Board level, the Trust monitors the principal risks to the delivery of its strategic objectives through its Board Assurance Framework (BAF) and by regular reviews of a Corporate Risk Register (CRR). Divisions and corporate departments monitor and manage risks against the corporate objectives, escalating any risk which may impact at Trust level.

7.8 The seven risk areas identified are outlined below. These relate to the delivery of OUH’s business plan following authorisation as a Foundation Trust. Each represents a broad set of related risks which are elaborated upon in text which also describes the mitigating actions which are currently being implemented, planned or considered. Risks are assessed for likelihood and consequence.

7.9 It is important to note that only some of these risks would have a direct impact on income, cost and liquidity. The remaining risks would only be likely to have an adverse financial impact in the medium to long term if no action was taken to address them.

7.10 The Board has agreed on the articulation of the overarching risk headings contained within the BAF and CRR. It has been agreed that the principal risks identified concern the maintenance of the quality of patient services, operational performance and financial stability; and that the majority of the other risks described in the BAF or CRR have an effect or impact on these principal risks. For example, the Trust’s ability to transform services through the positive engagement of its workforce or to engage with its stakeholders and partners has a direct impact on the quality of its services.

7.11 It should be noted that the chart above is not a comprehensive list of every risk within the Trust’s Corporate Risk Register (CRR). Rather, it provides a summary of those issues that present a significant long term risk to the achievement of the Trust’s strategic objectives.

7.12 The CRR also includes risks escalated from divisional or corporate directorate risk registers that have been included for specific implementation and active monitoring by the Trust Management Executive over a shorter time period with the intention that they will be de-escalated once Trust-wide issues have been resolved.
<table>
<thead>
<tr>
<th>Risk</th>
<th>Modelled In Downside?</th>
<th>Risk Score at 14/4/15</th>
<th>Target Risk Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failure to maintain quality of patient services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loss of income from CQUIN targets</td>
<td>Risk 1a / 1b</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Failure to maintain safe staffing levels and skill mix</td>
<td>Risk 1c</td>
<td>12</td>
<td>3</td>
</tr>
<tr>
<td>Impact on quality of services as a result of excessive use of agency staff</td>
<td>No</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>Adult ICU capacity pressure</td>
<td>No</td>
<td>12</td>
<td>6</td>
</tr>
<tr>
<td>Failure to maintain financial sustainability</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Failure to deliver the required levels of cost improvement</td>
<td>Risk 2a</td>
<td>16</td>
<td>9</td>
</tr>
<tr>
<td>Pension cost pressures not funded in tariff</td>
<td>Risk 2b</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adverse impact on balance sheet from calls on R&amp;D income</td>
<td>Risk 2c</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Negative impact of changes to marginal rates for specialist and emergency tariffs</td>
<td>Risk 2d</td>
<td>16</td>
<td>8</td>
</tr>
<tr>
<td>Negative impact of introduction of marginal rates for non-specialist activity</td>
<td>Risk 2e</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Failure to maintain operational performance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Failure to reduce delayed transfers of care</td>
<td>Risk 3a</td>
<td>20</td>
<td>12</td>
</tr>
<tr>
<td>Failure to deliver national A&amp;E standard</td>
<td>Risk 3b</td>
<td>16</td>
<td>6</td>
</tr>
<tr>
<td>Failure to deliver national 18 week referral to treatment standards</td>
<td>Risk 3b</td>
<td>9</td>
<td>3</td>
</tr>
<tr>
<td>Failure to deliver national access standards for cancer</td>
<td>Risk 3b</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>Failure to achieve sustainable contracts with commissioners</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Above plan non-elective and A&amp;E activity</td>
<td>Risk 4a</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Activity plans prove unaffordable to commissioners</td>
<td>Risk 4b</td>
<td>16</td>
<td>6</td>
</tr>
<tr>
<td>Failure to sustain an engaged and effective workforce</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Failure to recruit and retain high quality staff in specific areas</td>
<td>Risk 5</td>
<td>16</td>
<td>8</td>
</tr>
<tr>
<td>Failure to effectively control pay and agency costs</td>
<td>Included in Risk 5</td>
<td>16</td>
<td>9</td>
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<tr>
<td>Inadequate staffing levels in maternity service</td>
<td>Included in Risk 5</td>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td>Failure to achieve midwife supervision ratios</td>
<td>No</td>
<td>12</td>
<td>4</td>
</tr>
<tr>
<td>Insufficient provision of training, appraisals and development</td>
<td>No</td>
<td>9</td>
<td>3</td>
</tr>
<tr>
<td>Failure to achieve the required transformation of services</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Failure to deliver improvements to out of hours care – Care 24/7</td>
<td>Risk 6</td>
<td>9</td>
<td>4</td>
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<tr>
<td>Inability to meet Trust need for capital investment</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Failure to obtain capital financing loans</td>
<td>Risk 7a</td>
<td>12</td>
<td>6</td>
</tr>
<tr>
<td>Shortfall in charitable donations for radiotherapy developments</td>
<td>Risks 7b</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Failure to maintain quality patient services

7.13 This encompasses risks that threaten the delivery of agreed patient safety, patient experience and effectiveness priorities as set out in the Quality Strategy, with a consequent impact on clinical care, patient safety and reputation. Poor service quality would include failure to deliver the quality aspects of contracts with commissioners and potential breaches of CQC regulations.

7.14 The need to deliver and maintain safe staffing levels, including out of hours cover, is at the forefront of maintaining a high quality of care to patients. OUH has focused on using the most appropriate evidence-based tool (Safer Nursing Care Tool) to calculate patients' levels of acuity and dependency. The Trust triangulates these data with professional judgement from its senior nursing teams to determine the appropriate safe levels of staff for its clinical areas. Daily real time monitoring of safe staffing levels on all sites is being implemented with an electronic tool in use by ward staff and reporting of staffing levels occurs at meetings on all four sites with twice daily email escalation. The above supports reporting to the Board which includes the status of nurse staffing levels. Future plans include the development of an electronic tool to measure acuity.

7.15 Linked to safe staffing levels is the risk that excessive use of agency staff may pose a risk to the quality of service delivered as a result of a failure to provide adequate staffing trained at an appropriate level and to achieve continuity in the standard of care. Both local and overseas recruitment campaigns are underway to reduce the Trust’s reliance on agency staffing. To mitigate risks the Trust uses only recognised agencies to ensure competencies are assessed and the local induction of agency staff is documented according to Trust policy.

7.16 Non-attainment of CQUIN targets represents deficiencies in the quality of the Trust’s services as well as exposing it to financial risk through the loss of CQUIN payments. During 2015/16, the Trust is not eligible for CQUIN payments under the DTR (Default Tariff Rollover) arrangement. In future years, however, the Trust’s downside model reflects the risk of non-achievement of CQUIN targets and the possibility that these payments are not reintroduced after the DTR period ends.

7.17 The existing capacity of Adult/Cardiac ICU has been recognised as not meeting the level of demand experienced. Benchmarking against equivalent trusts suggests that capacity at OUH is 50% lower. The service often runs at over 100% capacity and patients requiring critical care may be unable to access it, resulting in the cancellation of elective surgery. Development of a business case to fund additional beds was approved by TME in February 2015. Mitigating actions include processes to ensure that the bed management team are able to discharge patients from ICU in a timely manner and the use of supplementary staffing.

7.18 The risk that delivery of cost improvement programmes (CIPs) may impact on service quality has also been considered. This risk was de-escalated from the Corporate Risk Register as the current process was felt to be robust. The Trust requires that an assessment is made of the potential impact of workforce plans and CIPs on quality through review and agreement by the Chief Nurse and the Medical Director to ensure that deleterious proposals are rejected. This process is fully embedded and working across the Trust. In addition the Trust has now developed a process for assessing the aggregate risk of CIPs across the Trust with this information presented to the Quality Committee.

7.19 Failure to manage risks in relation to quality could also increase the likelihood of other risks being realised. Failures to maintain quality and their impact on reputation could lead to a loss of activity through patient choice if patient experience deteriorates, and could also affect the recruitment and retention of staff. The latter could in turn increase the requirement for bank and agency usage which presents a risk to the quality of care delivered by these temporary staff as well as increased costs. Similarly, a financial impact may be felt should lapses in service quality result in a failure to achieve CQUIN targets and a resultant loss of income, although this risk is excluded from the Oxfordshire contract for the 2014/15 financial year only.

7.20 Overall mitigations to quality risks include a focus on meaningful benchmarks for quality with regular review at Trust and Divisional levels. Specifically, the NHS Operating Framework notes the need for trusts to examine, understand and explain their Summary Hospital Mortality Indicator (SHMI) figures.
and to act where performance is falling short. Mortality figures are regularly considered by the Clinical Effectiveness Committee with mortality review arrangements within the Trust under review.

7.21 Work on Delivering Compassionate Excellence and Listening into Action acts alongside the delivery of the Trust’s Quality Strategy to mitigate risks to quality. These will also facilitate cultural change to reinforce the actions and policies that sustain high quality services. Implementation of a Trust-wide patient feedback management system will also provide a mechanism to identify and prompt timely action to address emerging issues.

7.22 The Trust has worked with local partners to create the Oxford AHSC and Oxford AHSN. Its active engagement in operational clinical networks and a network for innovation will deliver benefits in maintaining and improving quality of outcomes and patient experience whilst assisting in sustaining and developing specialist services.

**Failure to maintain financial sustainability**

7.23 A significant element of the risk of failure to maintain financial sustainability is that of not achieving a level of cost improvement plans (CIPs) sufficient to make the financial plans viable. This includes a failure to control pay and agency costs as well as the risk that CIPs deliver an insufficient proportion of savings recurrently.

7.24 There exists a financial risk relating to pension cost pressures (through increased employers NI contributions) from pension scheme changes in 2016/17 that may not be funded in the national tariff, requiring additional mitigating measures in the future to meet an increased implied efficiency. This is considered to be a low probability since Monitor guidance suggests that this will be reflected in the tariff deflator calculation as was the case for 2015/16.

7.25 A risk also exists that the timing of calls upon Research and Development funding could impact upon the Trust’s cash balances on the Statement of Financial Position.

7.26 The Trust’s base case now assumes a tariff in future years that closely resembles the 15/16 ETO (Enhanced Tariff Option). The risk has therefore been assessed of a proposed tariff which is more aligned with the initial 2015/16 tariff consultation and its likely impact on the Trust’s specialist services. The downside includes modelling of a 50% specialist marginal rate as well as a 50% Marginal Rate Emergency Tariff (MRET) level compared with 70% on each within the base case, from 2016/17 onwards.

7.27 The risk of a move towards a 50% marginal rate for non-specialist commissioner activity growth has also been considered separately.

7.28 Mitigation of these risks is mainly underpinned by ensuring the development of a robust, long term CIP programme with divisional ownership and sufficient programme office support. This should include service redesign to make pathways more efficient and is likely to move delivery of some services outside the Trust and these larger scale changes are now supported by the Trust’s Transformation Programme. This programme is subject to a rigorous performance management regime and quality impact assessment process.

7.29 A set of more radical mitigation plans will need to be applied to mitigate these financial risks, including ‘radical’ strategic disinvestments such as site rationalisation and the sale of assets.

**Failure to maintain operational performance**

7.30 Failures to meet national access standards have a significant impact on patient experience and on the Trust’s income and expenditure. Penalties for breaches of contractual standards increased significantly in value from 1 April 2014. Although this risk was excluded from the Oxfordshire contract for the
2014/15 financial year and the same is likely to be the case for 2015/16, this is not anticipated for future years and penalties remain in place for specialised services.

7.31 In 2014/15, OUH did not meet several national access standards which form part of Monitor’s Risk Assessment Framework. The Trust made progress during 2014/15 through the delivery of plans agreed with its commissioners and the NHS TDA, supported by input from the national elective and emergency care intensive support teams.

7.32 OUH began 2015/16 not meeting three access and outcomes standards:

- Maximum time of 18 weeks from point of referral to treatment: Admitted pathways.
- A&E maximum waiting time of four hours from arrival to admission/transfer/discharge.
- All cancers: 62-day wait for first treatment from urgent GP referral for suspected cancer.

7.33 Updated plans and trajectories for all three areas were considered by the Board’s Finance and Performance Committee in April 2015 in the context of staffing, ward and theatre capacity available to the Trust for 2015/16 and the availability of financial resources resulting from discussions with lead commissioners.

7.34 Oxfordshire’s high number of delayed transfers of care has presented a long-standing challenge and has a significant impact on the flow of patients through the acute system. This has a direct effect on the Trust’s performance in relation to the national Emergency Department four hour waiting time target.

7.35 Mitigations include targeted work within the Trust to improve patient flow, strengthen leadership and to release downstream beds. OUH has set up a Discharge Assurance Group to review its own operational processes to support the best possible flow of patients through its services. The Trust also intends to further develop its Supported Hospital Discharge Service.

7.36 Detailed work is under way with Oxfordshire CCG, Oxfordshire County Council and Oxford Health NHS FT with a focus on removing delays to support patient flow. The Trust will also undertake further collaborative work with Oxford Health on integrated care pathways as described in section 2 above.

7.37 The Trust must also maintain rapid access to cancer treatment and meet the national referral to treatment time standards for elective care. The Trust’s plans to meet all cancer standards and address its waiting list backlog will see performance continue to recover against Trust-wide standards. These plans are intended to meet the national standards and to maintain waits at a sustainable level for the future.

**Failure to achieve sustainable contracts with commissioners**

7.38 Failure to agree sustainable contracts with commissioners in future years would impact on the assumptions in the LTFM and the affordability of services for the health economy as a whole. Contracts will need to be affordable for commissioners whilst also including activity levels sufficient for OUH and its commissioners to meet waiting time standards.

7.39 This requires clear and consistent plans across the healthcare system and that the Trust is able to respond nimbly to requirements to flex its capacity upwards or downwards. Dialogue continues to identify, agree and progress actions that reduce risks for commissioners and to address issues of demand management and affordability. However, the Trust has continued to see an increase in activity levels that has a financial impact on its commissioners.

7.40 It is recognised that Oxfordshire CCG’s constrained financial position will continue to present a challenge in delivering sustainable contracts and that the ‘Better Care Fund’ further reduces commissioner flexibility in allocating funding although this could act as a mitigating factor should plans be successful in reducing delayed transfers within the acute sector.

7.41 During 2014/15 the ‘cap and collar’ contract arrangement agreed with Oxfordshire CCG presented a risk to OUH if activity grew beyond the point where it becomes unfunded whilst protecting the Trust against exposure to the risk of performance and CQUIN penalties for Oxfordshire. A similar position for 2015/16 is anticipated. Trends from recent years indicate a continuing risk that non-elective and A&E
activity levels will rise ahead of commissioner plans, creating continuing financial pressure for the local healthcare economy.

7.42 Progress made with the Oxfordshire Alliance Programme (described in section 2) is expected to support the development of sustainable local services and sustainable funding arrangements for them.

7.43 Significant pressures also exist in specialised service contracting with NHS England, OUH’s largest commissioner by contract value.

7.44 Mitigations include internal performance controls and continuing liaison with commissioners to develop contingencies where required. The relationship with commissioners is actively monitored through commissioner alignment meetings.

7.45 Where demand management successfully reduces activity, the Trust needs to be prepared to actively remove stranded costs. OUH recognises that delays in removing any stranded fixed costs pose a risk to its own financial performance.

Failure to sustain an engaged and effective workforce

7.46 Risks related to workforce include the failure to secure a high quality workforce supply in an international job market. This applies particularly to areas where recruitment has proved difficult. It is recognised that relatively high levels of local employment may necessitate an increase in pay costs if such a workforce is to be retained. Failure to manage this will impact on other risks such as the maintenance of quality and the patient experience, the successful delivery of CIPs and the Trust’s ability to provide activity levels that meet its income plans.

7.47 Challenges in relation to recruitment and retention will also impact on the risks of high agency usage outlined above. As well as presenting a risk to quality of care this also threatens the Trust’s ability to control pay costs.

7.48 The continuation of a sustained recruitment programme, combined with targeted international campaigns will mitigate these risks. Increased recruitment must be supported by a continuous focus on staff retention. To this end, a range of strategic interventions is being pursued, including mitigating high cost of living; applying targeted recruitment and retention incentives; widening participation; improving professional development opportunities and career advancement, and creating and sustaining the right environment.

7.49 A specific risk is the potential for poor staffing levels within the Maternity Service. Peaks in workload are managed using on call hospital and community staff creating an impact on the community service such that postnatal visits and clinics are delayed or cancelled and continuity of care is affected. Staff may also be at increased risk of stress and related issues as a result.

7.50 A related issue is failure to recruit Supervisors of Midwives at a ratio of 1:15 as recommended by the Nursing and Midwifery Council which generates a risk of inadequate support to junior midwifery staff.

7.51 Recruitment of midwives is under way, with a specific campaign to recruit more midwives to the 2014-15 intake. Interim mitigating actions are the use of staff on zero hours contracts to cover shifts and the use of Birth Rate+ to monitor the acuity of patients against staffing levels.

7.52 A further risk highlighted through the staff survey is insufficient provision of effective appraisals and of appropriate education and development opportunities. This is likely to reduce staff motivation and morale whilst increasing turnover, exacerbating issues outlined above. An electronic process for recording appraisals is now in place to ensure consistency of approach with a multi-professional Education and Training Strategy to be established.

7.53 OUH will need to be aware of the risk that a failure to engage staff and trade unions in change management could result in increased industrial action, and so to engage in effective communication and partnership working with trade union representatives and staff.

7.54 Mitigation plans to deal with these risks include an active staff engagement programme and the implementation of the Trust’s values through recruitment and appraisal processes. Strong Board and
Divisional leadership will be supported by leadership development and education to enable effective working and change orientation.

**Failure to deliver the required transformation of service delivery**

7.55 Transforming the way in which the Trust delivers services is essential to ensuring its success over the coming years. OUH recognises that there is a range of risks to delivering the required transformation.

7.56 A specific example is the need to deliver the Care 24/7 Project to improve out of hours care to address the risks that exist due to multi-site working and super-specialisation should there be inadequate team working out of hours. This can result in poor patient experience and suboptimal clinical outcomes. Risk summits have been held to agree principles and identify solutions for each site with the Care 24/7 Programme in place and monitored via the Trust Management Executive.

7.57 In order to achieve the level of change that will be necessary, the Trust will develop a flexible, open and innovative organisational culture consistent with its values and maintain a focus on longer term planning, removing barriers to the implementation of new models of care. It will also be important that the Trust maximises clinical advantages from EPR, where possible.

7.58 The risks of not doing so impact on the patient experience and on operational performance and could affect the ability of services to achieve long term sustainability. Mitigation will require the delivery of a phased programme of change, with active staff engagement, with clear accountability and management arrangements built around strong governance and assurance processes.

7.59 Transformation of service delivery within OUH should also be seen in the context of system-wide transformation, with work on the Oxfordshire Alliance Programme described above and in section 2.

**Failure to deliver required capital investment**

7.60 In order to provide safe and high quality services and deliver its other strategic goals, the Trust needs to maintain and develop its infrastructure. A significant level of capital investment has been identified as being necessary over the period covered by the Integrated Business Plan. It is recognised that there is a risk that the organisation will have insufficient capital funds to finance these requirements.

7.61 Specific risks underlying this concern include a failure to obtain capital loans to the required level and the failure to obtain charitable funding to support projects where this is anticipated.

7.62 This risk is mitigated by a prudent approval process to ensure that investment is based on a strong service and financial case. The Board will maintain a clear overview of capital investments to ensure that these are appropriately scheduled to ensure affordability over time.

**Financial implications**

7.63 The Trust works to mitigate each of the key risks described above in specific terms. The following assessment focusses on those elements of the risks which have a clear and measurable financial component and therefore have similarly quantifiable mitigations.

7.64 The first table overleaf summarises the financial impact of each Downside risk (that has a clear and measurable financial component) on the combined Downside scenario.

7.65 The second table summarises the impact of applying individual mitigations specific to each risk (where they can be applied) on the mitigated Downside scenario.

7.66 The third table summarises the impact on the mitigated Downside scenario of applying a set of further, more radical, global mitigation measures.
Summary of impact on Base Case of each individually modelled risk after applying probabilities in the Downside scenario

<table>
<thead>
<tr>
<th>Base case</th>
<th>Retained Surplus</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Individual Impact of Unmitigated Downsides</strong> *</td>
<td></td>
</tr>
<tr>
<td>Failure to maintain quality of patient services - CQUIN partial loss</td>
<td>-</td>
</tr>
<tr>
<td>Failure to maintain quality of patient services - CQUIN total loss</td>
<td>-</td>
</tr>
<tr>
<td>Failure to maintain quality of patient services - Staff ratios</td>
<td>-</td>
</tr>
<tr>
<td>Failure to maintain financial sustainability - CIP</td>
<td>-</td>
</tr>
<tr>
<td>Failure to maintain financial sustainability - Pension costs (tariff)</td>
<td>-</td>
</tr>
<tr>
<td>Failure to maintain financial sustainability - R&amp;D</td>
<td>-</td>
</tr>
<tr>
<td>Failure to maintain financial sustainability – Specialist tariff and MRET 50%</td>
<td>-</td>
</tr>
<tr>
<td>Failure to maintain financial sustainability - Non-Specialist tariff 50%</td>
<td>-</td>
</tr>
<tr>
<td>Failure to maintain operational performance – Delayed Transfers of Care (DTOC)</td>
<td>-</td>
</tr>
<tr>
<td>Failure to maintain operational performance - Penalties</td>
<td>-</td>
</tr>
<tr>
<td>Failure to achieve sustainable contracts with commissioners – Over-performance</td>
<td>-</td>
</tr>
<tr>
<td>Failure to achieve sustainable contracts with commissioners - Affordability</td>
<td>-</td>
</tr>
<tr>
<td>Failure to sustain an engaged and effective workforce - R&amp;R (agency pressures)</td>
<td>-</td>
</tr>
<tr>
<td>Failure to deliver required transformation of services - Care 24/7</td>
<td>-</td>
</tr>
<tr>
<td>Inability to meet Trust need for capital investment - capital loans</td>
<td>-</td>
</tr>
<tr>
<td>Inability to meet Trust need for capital investment - Radiotherapy donations</td>
<td>-</td>
</tr>
<tr>
<td>Interest receivable/(payable) on adjusted cash balance</td>
<td>-</td>
</tr>
<tr>
<td>Other combining effects</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total impact of all downsides</strong></td>
<td>-</td>
</tr>
<tr>
<td><strong>Total downside case</strong></td>
<td>8.7</td>
</tr>
</tbody>
</table>

*After applying a probability for each risk crystallising in the Downside scenario as set out on para 7.8.
Summary of impact on Downside Case after applying specific mitigations against each risk in the mitigated Downside scenario

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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Retained Surplus</td>
<td>8.7</td>
<td>(18.1)</td>
<td>(37.4)</td>
<td>(49.0)</td>
<td>(61.7)</td>
<td>(75.2)</td>
</tr>
</tbody>
</table>

**Impact of individual Mitigations** *

- **Failure to maintain quality of patient services - CQUIN partial**
  - 2015/16: (0.3)
- **Failure to maintain quality of patient services - CQUIN total**
  - 2015/16: 0.3
- **Failure to maintain quality of patient services - Staff ratios**
  - 2015/16: 0.3
- **Failure to maintain financial sustainability - CIP**
  - 2015/16: 1.8
  - 2016/17: 6.3
  - 2017/18: 8.8
  - 2018/19: 11.6
  - 2019/20: 15.2
- **Failure to maintain financial sustainability - Pension costs (tariff)**
  - 2015/16: -
  - 2016/17: -
  - 2017/18: -
  - 2018/19: -
  - 2019/20: -
- **Failure to maintain financial sustainability - R&D**
  - 2015/16: -
  - 2016/17: -
  - 2017/18: -
  - 2018/19: -
  - 2019/20: -
- **Failure to maintain financial sustainability - MRET 50%**
  - 2015/16: -
  - 2016/17: -
  - 2017/18: -
  - 2018/19: -
  - 2019/20: -
- **Failure to maintain financial sustainability - Non-Spec Tariff**
  - 2015/16: -
  - 2016/17: -
  - 2017/18: -
  - 2018/19: -
  - 2019/20: -
- **Failure to maintain operational performance - DToC**
  - 2015/16: -
  - 2016/17: -
  - 2017/18: -
  - 2018/19: -
  - 2019/20: -
- **Failure to maintain operational performance - Penalties**
  - 2015/16: (0.5)
  - 2016/17: 0.9
  - 2017/18: 0.9
  - 2018/19: 0.8
  - 2019/20: 0.8
- **Failure to achieve sustainable contracts with commissioners – Over-performance**
  - 2015/16: -
  - 2016/17: 0.4
  - 2017/18: 0.6
  - 2018/19: 0.8
  - 2019/20: 1.1
- **Failure to achieve sustainable contracts with commissioners - Affordability**
  - 2015/16: -
  - 2016/17: -
  - 2017/18: -
  - 2018/19: -
  - 2019/20: -
- **Failure to sustain an engaged and effective workforce - R&R (agency pressures)**
  - 2015/16: (0.3)
  - 2016/17: 0.5
  - 2017/18: 1.3
  - 2018/19: 2.2
  - 2019/20: 3.1
- **Failure to deliver required transformation of services - Care 24/7**
  - 2015/16: (0.4)
  - 2016/17: 0.7
  - 2017/18: 1.5
  - 2018/19: 2.4
  - 2019/20: 3.3
- **Inability to meet Trust need for capital investment - capital loans**
  - 2015/16: -
  - 2016/17: -
  - 2017/18: -
  - 2018/19: -
  - 2019/20: -
- **Inability to meet Trust need for capital investment - Radiotherapy donations**
  - 2015/16: -
  - 2016/17: -
  - 2017/18: -
  - 2018/19: -
  - 2019/20: -
- **Interest receivable/(payable) on adjusted cash balance**
  - 2015/16: (0.0)
  - 2016/17: 0.0
  - 2017/18: 0.5
  - 2018/19: 1.0
  - 2019/20: 1.6
- **Combining effects**
  - 2015/16: 0.6
  - 2016/17: (0.0)
  - 2017/18: (0.1)
  - 2018/19: (0.3)
  - 2019/20: (1.1)

**Total impact of all individual mitigations**

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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>8.7</td>
<td>(17.5)</td>
<td>(28.7)</td>
<td>(34.5)</td>
<td>(42.1)</td>
<td>(50.2)</td>
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</table>

*After applying a probability for each risk crystallising in the Downside scenario as set out in the table on para 7.8.*
Summary of impact on mitigated Downside Case after applying wider global mitigations in the Downside scenario

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</tr>
</thead>
<tbody>
<tr>
<td>- staffing measures</td>
<td>13.4</td>
<td>17.6</td>
<td>20.8</td>
<td>21.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- telemedicine</td>
<td>1.5</td>
<td>1.5</td>
<td>1.6</td>
<td>1.6</td>
<td>1.7</td>
<td></td>
</tr>
<tr>
<td>- estates rationalisation</td>
<td>2.4</td>
<td>4.7</td>
<td>7.1</td>
<td>7.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- sale of premises</td>
<td>2.5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- car parking charges</td>
<td>0.6</td>
<td>0.6</td>
<td>0.6</td>
<td>0.6</td>
<td>0.6</td>
<td></td>
</tr>
<tr>
<td>- commercialization of partnerships</td>
<td>0.5</td>
<td>1.6</td>
<td>1.7</td>
<td>2.9</td>
<td>3.0</td>
<td></td>
</tr>
<tr>
<td>- demand management</td>
<td>2.3</td>
<td>2.3</td>
<td>2.3</td>
<td>2.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- other operating expenditure measures</td>
<td>7.4</td>
<td>7.6</td>
<td>7.9</td>
<td>8.2</td>
<td>10.8</td>
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<tr>
<td>- deferred income</td>
<td>2.0</td>
<td>2.0</td>
<td>2.0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- capital expenditure (and depreciation)</td>
<td>1.3</td>
<td>3.3</td>
<td>3.7</td>
<td>3.7</td>
<td>3.7</td>
<td></td>
</tr>
<tr>
<td>- Interest receivable/(payable) on adjusted cash balance</td>
<td>0.0</td>
<td>0.1</td>
<td>0.9</td>
<td>2.3</td>
<td>3.9</td>
<td></td>
</tr>
<tr>
<td>- combining effects (movement of accounts receivable/payable, etc.)</td>
<td>0.0</td>
<td>0.0</td>
<td>0.1</td>
<td>0.1</td>
<td>(0.3)</td>
<td></td>
</tr>
<tr>
<td><strong>Total global mitigations</strong></td>
<td>-</td>
<td>13.4</td>
<td>37.5</td>
<td>43.0</td>
<td>51.8</td>
<td>60.1</td>
</tr>
</tbody>
</table>

| Total downside with global mitigations | 8.7 (4.1) | 8.8 | 8.5 | 9.7 | 9.9 |
Sensitivity analysis on the key risks

7.67 This section examines the potential sensitivity of the Trust’s income, cost and cash projections to the risk management of the scenarios set out above. The financial model that underpins this IBP is posited on the Base Case scenario. This represents the Trust’s assessment of the most likely future outlook and is built on:

- Growth and inflation assumptions that seek to recognise the difficult current economic climate.
- Current views on changing demand and market share, including forecast demographic changes, commissioner plans, and specific targeted growth in some defining and specialist service developments as set out in Chapters 5 and 6.

7.68 Sixteen sensitivities have been modelled to examine key aspects of financial risk within the seven risk areas outlined earlier in this chapter. These sensitivities are described in the tables below along with the impact each has, before mitigations are applied, on the income and expenditure position, cash balances, liquidity and the Continuity of Service Risk Rating (CSRR).

<table>
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<tr>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Retained surplus £M</td>
<td>8.7</td>
<td>-3.3</td>
<td>11.7</td>
<td>11.7</td>
<td>9.9</td>
<td>10.1</td>
</tr>
<tr>
<td>Cash at bank at year-end £M</td>
<td>75.9</td>
<td>69.1</td>
<td>69.6</td>
<td>72.2</td>
<td>75.0</td>
<td>73.5</td>
</tr>
<tr>
<td>Liquidity days</td>
<td>-8.8</td>
<td>-9.0</td>
<td>-4.1</td>
<td>-5.9</td>
<td>-5.4</td>
<td>-0.7</td>
</tr>
<tr>
<td>Continuity of Service Risk Rating 1–4</td>
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<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>I&amp;E surplus margin %</td>
<td>1.0%</td>
<td>-0.4%</td>
<td>1.2%</td>
<td>1.2%</td>
<td>1.0%</td>
<td>1.0%</td>
</tr>
</tbody>
</table>

1a. Failure to maintain quality of patient services - partial loss of CQUIN

Description of sensitivity
Failure to maintain quality of patient services (reduction CQUIN)

Impact on LTFM
Additional loss of CQUIN income of £2M per annum from 2016/17, over and above the £4M provision included in Basecase. This represents a total loss of £6M against a £16.2M gross plan (37.0%)
NB: no impact in 2015/16 as CQUIN excluded from DTR

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</tr>
</thead>
<tbody>
<tr>
<td>Retained surplus £M</td>
<td>8.7</td>
<td>-3.3</td>
<td>9.7</td>
<td>9.8</td>
<td>8.0</td>
<td>8.2</td>
</tr>
<tr>
<td>Cash at bank at year-end £M</td>
<td>75.9</td>
<td>69.1</td>
<td>67.7</td>
<td>68.3</td>
<td>69.0</td>
<td>65.6</td>
</tr>
<tr>
<td>Liquidity days</td>
<td>-8.8</td>
<td>-9.0</td>
<td>-4.1</td>
<td>-6.7</td>
<td>-7.0</td>
<td>-3.0</td>
</tr>
<tr>
<td>Continuity of Service Risk Rating 1–4</td>
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<td>3</td>
<td>3</td>
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<td>3</td>
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<tr>
<td>I&amp;E surplus margin %</td>
<td>1.0%</td>
<td>-0.4%</td>
<td>1.0%</td>
<td>1.0%</td>
<td>0.8%</td>
<td>0.8%</td>
</tr>
</tbody>
</table>
### 1b. Failure to maintain quality of patient services - permanent loss of CQUIN

#### Description of sensitivity
Exclusion of CQUIN revenue after 2015/16

#### Impact on LTFM
Permanent loss of £16M CQUIN gross revenue assumed to be restored from 2016/17 in Basecase results in a reduction of income from 2016/17 of £12M (£4M is already included as a provision against partial loss in Basecase)

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</thead>
<tbody>
<tr>
<td>Retained surplus</td>
<td>£M</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>8.7</td>
<td>-3.3</td>
<td>-0.2</td>
<td>-0.1</td>
<td>-1.9</td>
<td>-1.6</td>
</tr>
<tr>
<td>Cash at bank at year-end</td>
<td>£M</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>75.9</td>
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<td>57.8</td>
<td>48.6</td>
<td>39.5</td>
<td>26.3</td>
</tr>
<tr>
<td>Liquidity</td>
<td>days</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-8.8</td>
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<td>-4.1</td>
<td>-10.7</td>
<td>-14.9</td>
<td>-14.5</td>
</tr>
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<td>Continuity of Service Risk Rating</td>
<td>1–4</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>I&amp;E surplus margin</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.0%</td>
<td>-0.4%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>-0.2%</td>
<td>-0.2%</td>
</tr>
</tbody>
</table>

### 1c. Failure to maintain quality of patient services - staff ratios

#### Description of sensitivity
Failure to maintain quality of patient services (CQC staffing ratios and specialist derogations pressures)

#### Impact on LTFM
Pressure to invest in additional pay costs (at agency premium rates) of £7.0M pa, being 1.4% of staff costs (1% WTE + 40% premium), for each year from 2016/17.

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</thead>
<tbody>
<tr>
<td>Retained surplus</td>
<td>£M</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>8.7</td>
<td>-3.3</td>
<td>4.5</td>
<td>4.3</td>
<td>2.3</td>
<td>2.3</td>
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<tr>
<td>Cash at bank at year-end</td>
<td>£M</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>75.9</td>
<td>69.1</td>
<td>62.4</td>
<td>57.6</td>
<td>52.8</td>
<td>43.5</td>
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<tr>
<td>Liquidity</td>
<td>days</td>
<td></td>
<td></td>
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<tr>
<td>Continuity of Service Risk Rating</td>
<td>1–4</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I&amp;E surplus margin</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.0%</td>
<td>-0.4%</td>
<td>0.5%</td>
<td>0.4%</td>
<td>0.2%</td>
<td>0.2%</td>
</tr>
</tbody>
</table>
### 2a. Failure to maintain financial sustainability - CIP

**Description of sensitivity**
Failure to maintain financial sustainability - risk of failure to deliver the required level of Divisional savings

**Impact on LTFM**
Failure in each forward year of half the CIP plans and a one-year delay in other half of CIP plans in clinical Divisions resulting in a reduction in EBITDA of £6.9M in 2015/16 accumulating to £50M in 2019/20.

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</tr>
</thead>
<tbody>
<tr>
<td>Retained surplus (£M)</td>
<td>8.7</td>
<td>-10.3</td>
<td>-13.2</td>
<td>-23.0</td>
<td>-35.4</td>
<td>-47.4</td>
</tr>
<tr>
<td>Cash at bank at year-end (£M)</td>
<td>75.9</td>
<td>62.5</td>
<td>38.1</td>
<td>6.3</td>
<td>-36.2</td>
<td>-95.0</td>
</tr>
<tr>
<td>Liquidity (days)</td>
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<td>-9.0</td>
<td>-6.9</td>
<td>-18.2</td>
<td>-30.6</td>
<td>-42.0</td>
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<tr>
<td>I&amp;E surplus margin (%)</td>
<td>1.0%</td>
<td>-1.1%</td>
<td>-1.4%</td>
<td>-2.4%</td>
<td>-3.6%</td>
<td>-4.7%</td>
</tr>
</tbody>
</table>

### 2b. Failure to maintain financial sustainability - pension costs (tariff downside)

**Description of sensitivity**
Failure to maintain financial sustainability - pensions pressures not funded in tariff 16/17 (Monitor tariff downside)

**Impact on LTFM**
A reduction in the Base case tariff assumption by 1.3% in 2016/17, being the value associated with expected additional employers’ NIC costs due to proposed pension changes (if not funded as a national pressure in tariff), resulting in a nominal reduction of patient care activity income of £9.5M from 2016/17 (growing in line with turnover to £10.0M in 2019/20)

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### 2c. Failure to maintain financial sustainability - R&D

**Description of sensitivity**
Failure to maintain financial sustainability - timing of calls on R&D income impacts on Balance Sheet

**Impact on LTFM**
A reduction in the cash balance of £13M in September 2015 due to the release of deferred income (> 1 year) in respect of R&D, resulting in a reduction in cash & working capital of £13M.

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### 2d. Failure to maintain financial sustainability - 50% specialist tariff

**Description of sensitivity**
Failure to maintain financial sustainability - potential impact of 50% MRET & specialist tariff rate from 2016/17 onwards

**Impact on LTFM**
Net loss of income totalling £10.3M in 2016/17 rising to £17.9M in 2019/20, due to rebasing of MRET & specialist discount from 70:30 (assumed in Basecase) to 50:50. This includes £4.9M rebasing of historical MRET discount, the balance being due to forward growth in Non-Elective and Specialist.

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2e. Failure to maintain financial sustainability - non-specialist tariff

**Description of sensitivity**
Failure to maintain financial sustainability - potential impact of adoption of a 50% non-specialist marginal rate from 2016/17 onwards

**Impact on LTFM**
Net loss of income of £4.6M in real terms in 2016/17 rising to £16.8M in 2019/20, being 50% of forward growth of Non-Specialist activity from a 2014/15 base.

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3a. Failure to maintain operational performance - DToC

**Description of sensitivity**
Additional operating costs due to continuing activity for delayed transfers of care (risk that plans to reduce these delayed transfers do not succeed)

**Impact on LTFM**
Additional operating costs equivalent to 80 beds (resulting from failure to reduce delayed transfers) £4.8M pa unfunded; additional capital costs of £10M in 2015/16 to address resultant ward capacity requirements on the Churchill site, resulting in additional depreciation of £1M pa from 2015/16.

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### 3b. Failure to maintain operational performance - penalties

**Description of sensitivity**  
Failure to maintain operational performance (consequent impact of penalties regime)

**Impact on LTFM**  
Doubling of potential impact of penalties from £6M pa provision in Basecase to £12M reduces income by £6M from April 2015. This relates to risk of failure against the A&E, 18 week RTT and national cancer access standards.

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### 4a. Failure to achieve sustainable contracts with commissioners - overperformance

**Description of sensitivity**  
Failure to achieve sustainable contracts with commissioners - cost impact if demand exceeds our activity plan

**Impact on LTFM**  
Doubling of non-elective and A&E growth from 2015/16 resulting in £3.8M additional marginal expenditure at premium agency rates (including 40% premium on pay costs), accumulating to £18.4M in 2019/20, partly offset by additional income of £1.7M in 2015/16 accumulating to £15.6M (at 70:30 marginal rates for non-elective activity from 2016/17 - 30:70 in 2015/16).

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4b. Failure to achieve sustainable contracts with commissioners - commissioner affordability

**Description of sensitivity**
Failure to achieve sustainable contracts with commissioners - financial risk of fiscal constraints on NHS budgets from 2016/17 leaving an affordability gap with commissioners.

**Impact on LTFM**
Income due to forward growth after 2015/16 is halved (due to commissioner affordability pressures); cost of delivery remains. This results in a reduction of income of £20M in 2016/17, rising to £46M in 2019/20.

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5. Failure to sustain an engaged and effective workforce - recruitment and retention (agency pressures)

**Description of sensitivity**
Failure to improve recruitment and retention rates results in higher agency premium expenditure and impacts on the ability to deliver workforce CIP schemes

**Impact on LTFM**
Continuing levels of turnover and other workforce issues result in increased agency staffing pressures, preventing achievement of workforce CIP schemes, increasing pay cost by £5.6M in 2015/16 accumulating to £17.6M in 2019/20.

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### 6. Failure to deliver the required transformation of services - Care 24/7

**Description of sensitivity**
Failure to deliver Care 24/7 changes resulting in failure to achieve transformational CIP plans

**Impact on LTSM**
Reduction to EBITDA by £10.6M in 2015/16 accumulating to £23M in 2019/20, due to failure of transformational CIP schemes (except EPR/Cris & Depth of Coding schemes).

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**Impact before mitigation**

### 7a. Inability to meet Trust needs for capital investment - capital loans finance

**Description of sensitivity**
Inability to meet Trust needs for capital investment - due to failure to obtain capital financing loans for the theatres and adult critical care schemes at the JR and the MK Radiotherapy satellite unit

**Impact on LTSM**
Failure to secure capital loans in 2016/17 and 2017/18 required to finance three capital schemes totalling £38.5M results in corresponding reduction in cash balances and working capital. (I&E is slightly improved as the as the reduction in interest payable exceeds loss of income receivable from positive cash balance but the liquidity rating is severely impaired).

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<td>£M</td>
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<td></td>
<td>8.7</td>
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<td>10.8</td>
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<tr>
<td>Cash at bank at year-end</td>
<td>£M</td>
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<td></td>
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</tr>
<tr>
<td>I&amp;E surplus margin</td>
<td>%</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>1.0%</td>
<td>-0.4%</td>
<td>1.2%</td>
<td>1.3%</td>
<td>1.1%</td>
<td>1.1%</td>
</tr>
</tbody>
</table>
## 7b. Inability to meet Trust needs for capital investment - Radiotherapy donations shortfall

### Description of sensitivity

Inability to meet Trust needs for capital investment - risk of charitable donations shortfalls on the two Radiotherapy schemes.

### Impact on LTFM

Shortfall of donations requires acquisition of assets through capital expenditure. This results in a loss of donations income against the retained surplus of £3.8M over 2016–18 (in real terms) and reduced cash balances. [The break-even surplus would be reduced by the additional depreciation cost over the economic life of the asset]

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</thead>
<tbody>
<tr>
<td>Retained surplus</td>
<td>£M</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>£M</td>
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<td>-3.3</td>
<td>9.5</td>
<td>9.7</td>
<td>9.9</td>
<td>10.1</td>
</tr>
<tr>
<td>Cash at bank at year-end</td>
<td>£M</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>£M</td>
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<td>-9.0</td>
<td>-4.1</td>
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<td></td>
</tr>
<tr>
<td>I&amp;E surplus margin</td>
<td>%</td>
<td>1.0%</td>
<td>-0.4%</td>
<td>1.0%</td>
<td>1.0%</td>
<td>1.0%</td>
</tr>
</tbody>
</table>
Downside scenario analysis

7.69 The sensitivities set out above to model the impact of the seven key risk areas in the Trust’s assumptions are aggregated together to form the Downside scenario.

7.70 In aggregating the sensitivities a percentage probability has been applied to each to reflect the Trust’s assessment of the likelihood of each risk crystallising in a combined Downside scenario. The probabilities against each risk arising in the combined Downside scenario are set out in the table below.

<table>
<thead>
<tr>
<th>Risk</th>
<th>Probability of risk crystallising in downside case (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failure to maintain quality of patient services - CQUIN partial</td>
<td>90%</td>
</tr>
<tr>
<td>Failure to maintain quality of patient services - CQUIN total</td>
<td>10%</td>
</tr>
<tr>
<td>Failure to maintain quality of patient services - Staff ratios</td>
<td>50%</td>
</tr>
<tr>
<td>Failure to maintain financial sustainability - CIP</td>
<td>50%</td>
</tr>
<tr>
<td>Failure to maintain financial sustainability - Pension costs (tariff)</td>
<td>50%</td>
</tr>
<tr>
<td>Failure to maintain financial sustainability - R&amp;D</td>
<td>10%</td>
</tr>
<tr>
<td>Failure to maintain financial sustainability - Tariff 50%</td>
<td>50%</td>
</tr>
<tr>
<td>Failure to maintain financial sustainability - Non-Spec Tariff</td>
<td>10%</td>
</tr>
<tr>
<td>Failure to maintain operational performance - DToC</td>
<td>75%</td>
</tr>
<tr>
<td>Failure to maintain operational performance - Penalties</td>
<td>50%</td>
</tr>
<tr>
<td>Failure to achieve sustainable contracts with commissioners - Overperformance</td>
<td>25%</td>
</tr>
<tr>
<td>Failure to achieve sustainable contracts with commissioners - Affordability</td>
<td>25%</td>
</tr>
<tr>
<td>Failure to sustain an engaged and effective workforce - R&amp;R (agency pressures)</td>
<td>25%</td>
</tr>
<tr>
<td>Failure to deliver required transformation of services - Care 24/7</td>
<td>25%</td>
</tr>
<tr>
<td>Inability to meet Trust need for capital investment - capital loans</td>
<td>50%</td>
</tr>
<tr>
<td>Inability to meet Trust need for capital investment - Radiotherapy donations</td>
<td>100%</td>
</tr>
</tbody>
</table>

7.71 This Downside case is summarised, before any mitigation, in the following table.
7.72 As can be seen, if this Downside scenario were to materialise the Trust would need to implement a number of mitigation plans so that it retained:

- its capacity to generate annual surpluses from its operations;
- cash balances at a level allowing it to operate efficiently and meet all of its cash obligations, while maintaining some cash flexibility; and
- a Continuity of Service Risk Rating of 3.

7.73 To achieve this, the Trust would, where possible, implement a set of risk mitigation measures against each key risk. These mitigating actions are shown in the tables below.

7.74 The risk relating to failure to maintain quality of patient services has been modelled firstly through a sensitivity assessing failure to deliver all of the CQUIN targets (1a), resulting in an increase in the loss to 37% of the planned CQUIN for 2016/17 (£6.0m). This risk does not impact on 2015/16 due to the DTR tariff arrangements in that year.

<table>
<thead>
<tr>
<th>Combined Downside - before mitigations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retained surplus £M</td>
</tr>
<tr>
<td>Cash at bank at year-end £M</td>
</tr>
<tr>
<td>Liquidity days</td>
</tr>
<tr>
<td>Continuity of Service Risk Rating 1–4</td>
</tr>
<tr>
<td>I&amp;E surplus margin %</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Impact after mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retained surplus £M</td>
</tr>
<tr>
<td>Cash at bank at year-end £M</td>
</tr>
<tr>
<td>Liquidity days</td>
</tr>
<tr>
<td>Continuity of Service Risk Rating 1–4</td>
</tr>
<tr>
<td>I&amp;E surplus margin %</td>
</tr>
</tbody>
</table>

1a. Failure to maintain quality of patient services - partial loss of CQUIN

**Description of sensitivity**
Failure to maintain quality of patient services (Reduction CQUIN)

**Impact on LTFM**
Additional potential loss of CQUIN revenue of £2m pa over existing annual provision (£4M) in the Basecase from 2016/17. Mitigation: additional investment to address areas of shortfall increases pay cost recurrently from April 2016 by £1.3M and eliminates ongoing downside CQUIN loss from October 2016, restoring CQUIN income to its Basecase value. The part-year loss of £1M to September 2016 remains unremitted.

<table>
<thead>
<tr>
<th>Impact after mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retained surplus £M</td>
</tr>
<tr>
<td>Cash at bank at year-end £M</td>
</tr>
<tr>
<td>Liquidity days</td>
</tr>
<tr>
<td>Continuity of Service Risk Rating 1–4</td>
</tr>
<tr>
<td>I&amp;E surplus margin %</td>
</tr>
</tbody>
</table>

33 From the CQUIN provision of £4.0m already in the Base case from 2016/17.
7.75 A second sensitivity (1b) has been modelled on CQUIN from 2016/17, on the risk of not regaining the CQUIN income after the period of DTR in 2015/16 comes to an end.

1b. Failure to maintain quality of patient services - permanent loss of CQUIN

**Description of sensitivity**
Exclusion of CQUIN revenue after 2015/16

**Impact on LTFM**
Permanent loss of £16M CQUIN gross revenue assumed to be restored from 2016/17 in Basecase results in a reduction of income from 2016/17 of £12M (£4M is already included as a provision against partial loss in Basecase). Mitigated by reducing investment to achieve CQUIN by £5.3M (1/3 of total value) annually, with effect from October 2016.

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</thead>
<tbody>
<tr>
<td>Retained surplus £M</td>
<td>8.7</td>
<td>-3.3</td>
<td>2.4</td>
<td>5.3</td>
<td>3.6</td>
<td>4.0</td>
</tr>
<tr>
<td>Cash at bank at year-end £M</td>
<td>75.9</td>
<td>69.1</td>
<td>60.4</td>
<td>56.6</td>
<td>53.1</td>
<td>45.5</td>
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<tr>
<td>Liquidity days</td>
<td>-8.8</td>
<td>-9.0</td>
<td>-4.2</td>
<td>-9.7</td>
<td>-11.7</td>
<td>-9.3</td>
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<tr>
<td>Continuity of Service Risk Rating</td>
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<td>3</td>
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<td>3</td>
</tr>
<tr>
<td>I&amp;E surplus margin %</td>
<td>1.0%</td>
<td>-0.4%</td>
<td>0.3%</td>
<td>0.6%</td>
<td>0.4%</td>
<td>0.4%</td>
</tr>
</tbody>
</table>

7.76 A third sensitivity (1c) has been modelled on failure to maintain appropriate safe staffing ratios and to meet specialist derogations with a consequent impact on patient services, with a consequent impact on pay costs of £7.0m (at premium agency rates) to address the impact on patient care.

1c. Failure to maintain quality of patient services - staff ratios

**Description of sensitivity**
Failure to maintain quality of patient services (CQC staffing ratios and specialist derogations pressures)

**Impact on LTFM**
Pressure to invest in additional pay costs (at agency premium rates) of £7.0M pa, being 1.4% of staff costs (1% WTE + 40% premium), for each year from 2016/17. No direct mitigation (see global mitigation measures).

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</thead>
<tbody>
<tr>
<td>Retained surplus £M</td>
<td>8.7</td>
<td>-3.3</td>
<td>4.5</td>
<td>4.3</td>
<td>2.3</td>
<td>2.3</td>
</tr>
<tr>
<td>Cash at bank at year-end £M</td>
<td>75.9</td>
<td>69.1</td>
<td>62.4</td>
<td>57.6</td>
<td>52.8</td>
<td>43.5</td>
</tr>
<tr>
<td>Liquidity days</td>
<td>-8.8</td>
<td>-9.0</td>
<td>-4.1</td>
<td>-8.7</td>
<td>-11.1</td>
<td>-9.2</td>
</tr>
<tr>
<td>Continuity of Service Risk Rating</td>
<td>1–4</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I&amp;E surplus margin %</td>
<td>1.0%</td>
<td>-0.4%</td>
<td>0.5%</td>
<td>0.4%</td>
<td>0.2%</td>
<td>0.2%</td>
</tr>
</tbody>
</table>

7.77 Failure to meet all of the CQUIN targets would be mitigated by making an additional recurrent investment of £1.3m in 2016/17 in additional staffing to tackle the areas causing the CQUIN targets to be missed. It is anticipated that this would see standards met from Quarter 3 of 2016/17.
The risk of failure to regain CQUIN income, after the DTR regime ends, would need to be mitigated by the Trust reducing its expenditure to achieve CQUIN targets to offset the financial impact. It has been assumed that only one third of the CQUIN income loss could be released in costs under this scenario.

The increased pay costs of £7.0m (at agency premium rates) required to address the risk of failure to maintain appropriate staffing ratios and to meet specialist derogations would need to be mitigated through further Trust wide (global) mitigating measures to offset the financial impact, as described later in this section.

Risks relating to failure to maintain financial sustainability have been modelled firstly (2a) through a sensitivity on failure to deliver a proportion of the Divisional general efficiency savings for each of the five future years. The risk modelling is based on a 12 month delay in implementing schemes and then only making 50% of the originally planned CIP value.

### 2a. Failure to maintain financial sustainability - CIP

#### Description of sensitivity
- Failure to maintain financial sustainability - risk of failure to deliver the required level of Divisional savings

#### Impact on LTFM
- Failure in each forward year of half the CIP plans and a one-year delay in other half of CIP plans in clinical Divisions resulting in a reduction in EBITDA of £6.9M in 2015/16 accumulating to £50M in 2019/20. This is mitigated by accelerating transformational and other cross-cutting schemes to halve the downside impact from October 2015.

#### Impact after mitigation

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</thead>
<tbody>
<tr>
<td>Retained surplus</td>
<td>£M</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Cash at bank at year-end</td>
<td>£M</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Liquidity</td>
<td>days</td>
<td>-8.8</td>
<td>-9.0</td>
<td>-5.5</td>
<td>-12.1</td>
<td>-18.2</td>
</tr>
<tr>
<td>Continuity of Service Risk Rating</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I&amp;E surplus margin</td>
<td>%</td>
<td>1.0%</td>
<td>-0.7%</td>
<td>-0.1%</td>
<td>-0.6%</td>
<td>-1.2%</td>
</tr>
</tbody>
</table>
7.81 A second sensitivity (2b) has been modelled on the pension cost pressures in 2016/17 included in the Base Case not being funded within the tariff leading to an increased implied efficiency (downside tariff) requirement within a Downside case in that year.

<table>
<thead>
<tr>
<th>Description of sensitivity</th>
<th>Failure to maintain financial sustainability - pensions pressures not funded in tariff 16/17 (Monitor tariff downside)</th>
</tr>
</thead>
</table>

**Impact on LTFM**

A reduction in the Base case tariff assumption by 1.3% in 2016/17, being the value associated with expected additional employers’ NIC costs due to proposed changes (if not funded as a national pressure in tariff), resulting in a nominal reduction of patient care activity income of £9.5M from 2016/17 (growing in line with turnover to £10.0M in 2019/20). No direct mitigation (see global mitigation measures).

<table>
<thead>
<tr>
<th>Impact after mitigation</th>
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</thead>
<tbody>
<tr>
<td>Retained surplus £M</td>
</tr>
<tr>
<td>2014/15: 8.7</td>
</tr>
<tr>
<td>2015/16: -3.3</td>
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<tr>
<td>2016/17: 2.1</td>
</tr>
<tr>
<td>2017/18: 2.0</td>
</tr>
<tr>
<td>2018/19: 0.0</td>
</tr>
<tr>
<td>2019/20: 0.1</td>
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<table>
<thead>
<tr>
<th>Cash at bank at year-end £M</th>
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<tbody>
<tr>
<td>2014/15: 75.9</td>
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<tr>
<td>2015/16: 69.1</td>
</tr>
<tr>
<td>2016/17: 60.1</td>
</tr>
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<td>2017/18: 53.0</td>
</tr>
<tr>
<td>2018/19: 45.9</td>
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<td>2019/20: 34.3</td>
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<table>
<thead>
<tr>
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<td>2014/15: -8.8</td>
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<td>2015/16: -9.0</td>
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<td>2017/18: -9.7</td>
</tr>
<tr>
<td>2018/19: -13.1</td>
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<td>2019/20: -12.0</td>
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<table>
<thead>
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<td>2015/16: 2</td>
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<td>2016/17: 3</td>
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<tr>
<td>2017/18: 2</td>
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<tr>
<td>2018/19: 2</td>
</tr>
<tr>
<td>2019/20: 3</td>
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</table>

<table>
<thead>
<tr>
<th>I&amp;E surplus margin %</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014/15: 1.0%</td>
</tr>
<tr>
<td>2015/16: -0.4%</td>
</tr>
<tr>
<td>2016/17: 0.2%</td>
</tr>
<tr>
<td>2017/18: 0.2%</td>
</tr>
<tr>
<td>2018/19: 0.0%</td>
</tr>
<tr>
<td>2019/20: 0.0%</td>
</tr>
</tbody>
</table>

7.82 A third sensitivity (2c) has been run to examine the impact on financial sustainability of bringing forward the timing of calls on deferred research and development income (of £13m) in the Statement of Financial Position, with the consequent impact on cash balances and the liquidity rating.

<table>
<thead>
<tr>
<th>Description of sensitivity</th>
<th>Failure to maintain financial sustainability - timing of calls on R&amp;D income impacts on Balance Sheet</th>
</tr>
</thead>
</table>

**Impact on LTFM**

A reduction in the cash balance of £13M in September 2015 due to the release of deferred income (> 1 year) in respect of R&D, resulting in a reduction in cash & working capital of £13M. Liquidity rating risk; no direct mitigation (see global mitigation measures).

<table>
<thead>
<tr>
<th>Impact after mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retained surplus £M</td>
</tr>
<tr>
<td>2014/15: 8.7</td>
</tr>
<tr>
<td>2015/16: -3.3</td>
</tr>
<tr>
<td>2016/17: 11.7</td>
</tr>
<tr>
<td>2017/18: 11.7</td>
</tr>
<tr>
<td>2018/19: 9.9</td>
</tr>
<tr>
<td>2019/20: 10.1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cash at bank at year-end £M</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014/15: 75.9</td>
</tr>
<tr>
<td>2015/16: 56.1</td>
</tr>
<tr>
<td>2016/17: 56.6</td>
</tr>
<tr>
<td>2017/18: 59.1</td>
</tr>
<tr>
<td>2018/19: 61.8</td>
</tr>
<tr>
<td>2019/20: 60.3</td>
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<table>
<thead>
<tr>
<th>Liquidity days</th>
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<tbody>
<tr>
<td>2014/15: -8.8</td>
</tr>
<tr>
<td>2015/16: -9.0</td>
</tr>
<tr>
<td>2016/17: -9.5</td>
</tr>
<tr>
<td>2017/18: -11.2</td>
</tr>
<tr>
<td>2018/19: -10.6</td>
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<tr>
<td>2019/20: -5.8</td>
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<table>
<thead>
<tr>
<th>Continuity of Service Risk Rating 1–4</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014/15: 2</td>
</tr>
<tr>
<td>2015/16: 2</td>
</tr>
<tr>
<td>2016/17: 3</td>
</tr>
<tr>
<td>2017/18: 2</td>
</tr>
<tr>
<td>2018/19: 2</td>
</tr>
<tr>
<td>2019/20: 3</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>I&amp;E surplus margin %</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014/15: 1.0%</td>
</tr>
<tr>
<td>2015/16: -0.4%</td>
</tr>
<tr>
<td>2016/17: 1.2%</td>
</tr>
<tr>
<td>2017/18: 1.2%</td>
</tr>
<tr>
<td>2018/19: 1.0%</td>
</tr>
<tr>
<td>2019/20: 1.0%</td>
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</tbody>
</table>
7.83 A fourth sensitivity (2d) has been run to examine the impact on financial sustainability of a less favourable marginal rate on specialist services marginal rates and also MRET, at only 50% marginal rate for each, compared to the 70% assumed for each from 2016/17 in the Base Case, with a consequent financial impact on the Trust’s income position and margin.

2d. Failure to maintain financial sustainability - 50% specialist tariff

<table>
<thead>
<tr>
<th>Description of sensitivity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failure to maintain financial sustainability - potential impact of 50% MRET &amp; specialist tariff rate from 2016/17 onwards.</td>
</tr>
</tbody>
</table>

### Impact on LTFM

Net loss of income totalling £10.3M in 2016/17 rising to £17.9M in 2019/20, due to rebasing of MRET & specialist discount from 70:30 (assumed in Basecase) to 50:50. This includes £4.9M rebasing of historical MRET discount, the balance being due to forward growth in Non-Elective and Specialist. No direct mitigation (see global mitigation measures).

#### Impact after mitigation

<table>
<thead>
<tr>
<th>Year</th>
<th>Retained surplus (£M)</th>
<th>Cash at bank at year-end (£M)</th>
<th>Liquidity (days)</th>
<th>Continuity of Service Risk Rating</th>
<th>I&amp;E surplus margin (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014/15</td>
<td>8.7</td>
<td>75.9</td>
<td>-8.8</td>
<td>2</td>
<td>1.0%</td>
</tr>
<tr>
<td>2015/16</td>
<td>-3.3</td>
<td>69.1</td>
<td>-9.0</td>
<td>2</td>
<td>-0.4%</td>
</tr>
<tr>
<td>2016/17</td>
<td>1.4</td>
<td>59.4</td>
<td>-4.1</td>
<td>3</td>
<td>0.1%</td>
</tr>
<tr>
<td>2017/18</td>
<td>-1.1</td>
<td>49.2</td>
<td>-10.0</td>
<td>2</td>
<td>-0.1%</td>
</tr>
<tr>
<td>2018/19</td>
<td>-5.4</td>
<td>36.6</td>
<td>-14.6</td>
<td>2</td>
<td>-0.6%</td>
</tr>
<tr>
<td>2019/20</td>
<td>-7.7</td>
<td>17.4</td>
<td>-15.7</td>
<td>2</td>
<td>-0.8%</td>
</tr>
</tbody>
</table>

7.84 A fifth sensitivity (2e) has been run to examine the impact on financial sustainability of the risk of movement towards a marginal rate of 50% from 2016/17 on non-specialist activity growth.

2e. Failure to maintain financial sustainability - non-specialist tariff

<table>
<thead>
<tr>
<th>Description of sensitivity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failure to maintain financial sustainability - potential impact of adoption of a 50% non-specialist marginal rate from 2016/17 onwards.</td>
</tr>
</tbody>
</table>

### Impact on LTFM

Net loss of income of £4.6M in real terms in 2016/17 rising to £16.8M in 2019/20, being 50% of forward growth of Non-Specialist activity from a 2014/15 base. No direct mitigation (see global mitigation measures).

#### Impact after mitigation

<table>
<thead>
<tr>
<th>Year</th>
<th>Retained surplus (£M)</th>
<th>Cash at bank at year-end (£M)</th>
<th>Liquidity (days)</th>
<th>Continuity of Service Risk Rating</th>
<th>I&amp;E surplus margin (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014/15</td>
<td>8.7</td>
<td>75.9</td>
<td>-8.8</td>
<td>2</td>
<td>1.0%</td>
</tr>
<tr>
<td>2015/16</td>
<td>-3.3</td>
<td>69.1</td>
<td>-9.0</td>
<td>2</td>
<td>-0.4%</td>
</tr>
<tr>
<td>2016/17</td>
<td>1.4</td>
<td>65.1</td>
<td>-4.1</td>
<td>3</td>
<td>0.7%</td>
</tr>
<tr>
<td>2017/18</td>
<td>-1.1</td>
<td>58.8</td>
<td>-7.7</td>
<td>2</td>
<td>0.3%</td>
</tr>
<tr>
<td>2018/19</td>
<td>-5.4</td>
<td>48.9</td>
<td>-10.8</td>
<td>2</td>
<td>-0.3%</td>
</tr>
<tr>
<td>2019/20</td>
<td>-7.7</td>
<td>30.8</td>
<td>-10.9</td>
<td>2</td>
<td>-0.7%</td>
</tr>
</tbody>
</table>

7.85 The savings shortfall (in risk 2a) would need to be mitigated by bringing forward strategic transformational savings plans from future years. It has been assumed that bringing forward these transformational plans this will only mitigate 50% of the shortfall.
If the pensions pressures were not funded in tariff (in risk 2b), leading to a higher implied efficiency requirement, then the Trust would need to advance some of the global mitigation plans described at paragraph 7.41 on the mitigated Downside case.

No individual risk specific mitigations have been run against the third sensitivity (in risk 2c) on calls on deferred research and development income, on the fourth sensitivity on specialist services marginal rates (risk 2d), or against the fifth sensitivity on non-specialist marginal rates (2e). In these scenarios the Trust would need to bring forward cash preservation measures included in the global mitigation plans set out from paragraph 7.41.

If the pensions pressures were not funded in tariff (in risk 2b), leading to a higher implied efficiency requirement, then the Trust would need to advance some of the global mitigation plans described at paragraph 7.41 on the mitigated Downside case.

No individual risk specific mitigations have been run against the third sensitivity (in risk 2c) on calls on deferred research and development income, on the fourth sensitivity on specialist services marginal rates (risk 2d), or against the fifth sensitivity on non-specialist marginal rates (2e). In these scenarios the Trust would need to bring forward cash preservation measures included in the global mitigation plans set out from paragraph 7.41.

Risk relating to failure to maintain operational performance has been modelled firstly through a sensitivity relating to additional costs of £4.8m per annum from 2015/16 to continue to operate the equivalent of an additional 80 beds (four wards of patients) due to the failure to reduce delayed transfers of care (in risk 3a).

The consequence of having to continue running an additional 80 beds to provide care for patients awaiting transfer would also require an estimated £10m one-off capital investment in ageing building stock on the Churchill site and consequent revenue implications. This expenditure would be required to maintain patient treatment within a safe ward environment that meets modern standards. No specific mitigation has been modelled but this scenario would need to be addressed by the global set of mitigation plans outlined from paragraph 7.103.

A second sensitivity (risk 3b) has been run assessing failure to maintain performance standards in patient care with the resultant impact from the harsher contractual penalties regime from 2015/16 with an additional £6.0m impact compared to the Base case. This is based upon risks against delivery on components of penalties in the current financial year, including delivery of the A&E standard, delivery of RTT access targets and delivery of cancer targets.

Failure to maintain performance standards with consequent financial penalties would require decisive mitigating action with a recurrent investment of £4.0m in 2015/16 in additional staffing to improve the quality of patient services. This rapid action would be necessary to decisively tackle the potential

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34 From the penalties provision of £6.0m already in the Base case from 2015/16.
35 RTT targets for 18 weeks and also zero tolerance RTT waits over 52 weeks.
reputational risk and associated loss of income at an early stage. This mitigating action would then turn around performance from Q3 of 2015/16, reducing the levels of penalties applied against performance standards back to the level in the Base case from that point.

3b. Failure to maintain operational performance - penalties

<table>
<thead>
<tr>
<th>Description of sensitivity</th>
<th>Impact on LTFM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failure to maintain quality of patient services (consequent impact of penalties regime)</td>
<td>Doubling of potential impact of penalties from £6M pa provision in Basecase to £12M reduces income by £6M from April 2015. This relates to failure against the A&amp;E, 18 week RTT and national cancer access standards. Mitigation: additional investment increases pay cost recurrently from April 2015 by £4.0M and eliminates ongoing downside penalties with effect from October 2015. The part-year loss due to penalties of £3M to September 2015 remains unremitting.</td>
</tr>
</tbody>
</table>

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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Retained surplus</td>
<td>£M</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash at bank at year-end</td>
<td>£M</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Liquidity</td>
<td>days</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continuity of Service Risk Rating</td>
<td>1–4</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>I&amp;E surplus margin</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7.92 The risk shown below of failure to achieve sustainable contracts with Commissioners has been modelled firstly (4a) to examine the impact of OUH’s activity plans being exceeded, with a doubling of planned growth in non-elective and A&E activity from 2015/16 to 2019/20, compared to the Base Case LTFM, with consequent impact from marginal cost increases on pay at premium agency rates.

4a. Failure to achieve sustainable contracts with commissioners - overperformance

<table>
<thead>
<tr>
<th>Description of sensitivity</th>
<th>Impact on LTFM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failure to achieve sustainable contracts with commissioners - cost impact if demand exceeds our activity plan</td>
<td>Doubling of non-elective and A&amp;E growth from 2015/16 resulting in £3.8M additional marginal expenditure at premium agency rates (including 40% premium on pay costs), accumulating to £18.4M in 2019/20, partly offset by additional income of £1.7M in 2015/16 accumulating to £15.6M (at 70:30 marginal rates for non-elective activity from 2016/17 - 30:70 in 2015/16). Mitigation is to increase recruitment of substantive staff to eliminate premium costs from 2016/17.</td>
</tr>
</tbody>
</table>

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</tr>
</thead>
<tbody>
<tr>
<td>Retained surplus</td>
<td>£M</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash at bank at year-end</td>
<td>£M</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Liquidity</td>
<td>days</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continuity of Service Risk Rating</td>
<td>1–4</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>I&amp;E surplus margin</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Secondly, the risk of a failure to achieve sustainable contracts with commissioners has been modelled to examine the risk of a financial gap after 2015/16 for the next four years with commissioners (including the potential affordability gap arising from the commissioner’s Better Care Fund (BCF) obligations resulting in a transfer away from acute provider funding to local authorities). This risk has been modelled as a 50% reduction on the activity growth paid for by all commissioners (the Trust still incurs the marginal cost impacts of the Base case activity growth projections in full). This risk would have to be mitigated by the Trust taking demand management cost reduction measures to eliminate the marginal cost impact of this unpaid activity, this mitigation is included within the global mitigation measures set out below.

While this risk has been modelled as part of a downside scenario, the Trust expects a compliant contract to apply in future years, with all commissioners, in which we would continue to be paid for activity that did not move to a community or local authority setting. The Base case reflects this compliant contract assumption with OUH’s commissioners.

### 4b. Failure to achieve sustainable contracts with commissioners - commissioner affordability

**Description of sensitivity**

Failure to achieve sustainable contracts with commissioners - financial risk of fiscal constraints on NHS budgets from 2016/17 leaving an affordability gap with commissioners.

**Impact on LTFM**

Income due to forward growth after 2015/16 is halved; cost of delivery remains. This results in a reduction of income of £20M in 2016/17, rising to £46M in 2019/20. A demand Management mitigation has been included under global mitigations.

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</thead>
<tbody>
<tr>
<td>Retained surplus</td>
<td>£M</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash at bank at year-end</td>
<td>£M</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Liquidity</td>
<td>days</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continuity of Service Risk Rating</td>
<td>1–4</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>I&amp;E surplus margin</td>
<td>%</td>
<td>1.0%</td>
<td>-0.4%</td>
<td>-0.8%</td>
<td>-1.8%</td>
<td>-2.8%</td>
</tr>
</tbody>
</table>

The risk relating to failure to sustain an engaged and effective workforce (risk 5) has been modelled through a sensitivity reflecting a potential financial impact from failure to reduce staff turnover levels and improve recruitment and retention of staff, resulting in continuing high levels of agency premium pay costs impacting on our ability to make future planned workforce related pay savings (accumulating to a £17.6m impact by 2019/20).
5. Failure to sustain an engaged and effective workforce - recruitment and retention (agency pressures)

**Description of sensitivity**
Failure to improve recruitment and retention rates results in higher agency premium expenditure and impacts on the ability to deliver workforce CIP schemes.

**Impact on LTFM**
Continuing levels of turnover and other workforce issues result in increased agency staffing pressures, preventing achievement of workforce CIP schemes, increasing pay cost by £5.6m in 2015/16 accumulating to £17.6m in 2019/20.

Mitigated by investing £1.0M recurrently from 2015/16 to resolve workforce issues and restore workforce CIP achievement from 2016/17.

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</tr>
</thead>
<tbody>
<tr>
<td>Retained surplus</td>
<td>£M</td>
<td>8.7</td>
<td>-10.0</td>
<td>4.9</td>
<td>4.7</td>
<td>2.7</td>
</tr>
<tr>
<td>Cash at bank at year-end</td>
<td>£M</td>
<td>75.9</td>
<td>62.4</td>
<td>56.2</td>
<td>51.7</td>
<td>47.3</td>
</tr>
<tr>
<td>Liquidity</td>
<td>days</td>
<td>-8.8</td>
<td>-9.0</td>
<td>-6.8</td>
<td>-11.2</td>
<td>-13.5</td>
</tr>
<tr>
<td>Continuity of Service Risk Rating 1–4</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I&amp;E surplus margin</td>
<td>%</td>
<td>1.0%</td>
<td>-1.1%</td>
<td>0.5%</td>
<td>0.5%</td>
<td>0.3%</td>
</tr>
</tbody>
</table>

7.96 This financial risk has been mitigated by a recurrent investment of £1.0m in implementing improved recruitment and retention measures, including increased training and exit interviews, to address causes of the high turnover level and reduce the consequent agency usage. This then enables planned workforce savings to be made from 2016/17.

7.97 The risk relating to failure to deliver the required transformation of services has been modelled as a sensitivity relating to failure to deliver the Care 24/7 transformation project (risk 6). A lack of capacity to focus on the delivery of the planned transformational efficiency savings (£10.6m in 2015/16 rising to £22.6m by 2019/20). This has been mitigated by a recurrent investment in transformation capacity of £0.5m (and an additional non-recurrent £1.0m of expenditure to establish the transformation team in 2015/16 and gain initial impact). This then ensures the capacity is in place to deliver the transformational efficiency savings after a one year delay from 2016/17.

6. Failure to deliver the required transformation of services - Care 24/7

**Description of sensitivity**
Failure to deliver Care 24/7 changes resulting in failure to achieve transformational CIP plans

**Impact on LTFM**
Reduction to EBITDA by £10.6M in 2015/16, due to failure of transformational CIP schemes (except EPR/CRIS & Depth of Coding schemes). Further failure from 2016/17 is mitigated by a non-recurrent investment of £1.0M in 2015/16 plus additional transformational support of £500k pa from 2015/16 onward. This restores achievement of transformation CIP schemes from 2016/17.

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</tr>
</thead>
<tbody>
<tr>
<td>Retained surplus</td>
<td>£M</td>
<td>8.7</td>
<td>-15.5</td>
<td>0.3</td>
<td>0.2</td>
<td>-1.8</td>
</tr>
<tr>
<td>Cash at bank at year-end</td>
<td>£M</td>
<td>75.9</td>
<td>57.1</td>
<td>46.2</td>
<td>37.2</td>
<td>28.3</td>
</tr>
<tr>
<td>Continuity of Service Risk Rating 1–4</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>I&amp;E surplus margin</td>
<td>%</td>
<td>1.0%</td>
<td>-1.7%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>-0.2%</td>
</tr>
</tbody>
</table>
The risk of inability to meet the Trust’s needs for capital investment has been modelled in the Downside case firstly (7a) as a sensitivity relating to failing to get the three capital investment loans included in the Base case, totalling £38.5m. The impact on cash and liquidity from failing to obtain the capital investment loans would have to be addressed by cash preservation plans within the global mitigation measures set out below.

### 7a. Inability to meet Trust needs for capital investment - capital loans finance

**Description of sensitivity**
Inability to meet Trust needs for capital investment - due to failure to obtain capital financing loans for the theatres and adult critical care schemes at the JR and the MK Radiotherapy satellite unit

**Impact on LTFSM**
Failure to secure capital loans in 2016/17 and 2017/18 required to finance three capital schemes totalling £38.5M results in corresponding reduction in cash balances and working capital. (I&E is slightly improved as the reduction in interest payable exceeds loss of income receivable from positive cash balance but the liquidity rating is severely impaired). Liquidity risk with no direct mitigation (see global mitigation measures).

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</thead>
<tbody>
<tr>
<td>Retained surplus (£M)</td>
<td>8.7</td>
<td>-3.3</td>
<td>11.7</td>
<td>12.2</td>
<td>10.7</td>
<td>10.8</td>
</tr>
<tr>
<td>Cash at bank at year-end (£M)</td>
<td>75.9</td>
<td>69.1</td>
<td>47.6</td>
<td>35.6</td>
<td>41.7</td>
<td>43.5</td>
</tr>
<tr>
<td>Liquidity (days)</td>
<td>-8.8</td>
<td>-9.0</td>
<td>-4.1</td>
<td>-14.2</td>
<td>-19.0</td>
<td>-12.6</td>
</tr>
<tr>
<td>Continuity of Service Risk Rating 1–4</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I&amp;E surplus margin (%)</td>
<td>1.0%</td>
<td>-0.4%</td>
<td>1.2%</td>
<td>1.3%</td>
<td>1.1%</td>
<td>1.1%</td>
</tr>
</tbody>
</table>

The risk of inability to meet the Trust’s needs for capital investment has been modelled secondly (7b) as a sensitivity relating to failing to raise the £2.5m of charitable donations included in the business case for the Radiotherapy satellite unit in Swindon and also failing to raise the £1.3m of charitable donations included in the base case for the Radiotherapy satellite unit in Milton Keynes. No specific mitigation has been modelled against this and global mitigation plans set out below would need to be brought forward to offset this financial impact.

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36 These relate to JR theatres (£24m), adult critical care (£6m) and Milton Keynes radiotherapy satellite unit (£8.5m).
Mitigated Downside case

7.100 The risk-specific mitigations shown above against each identified risk have then been combined in the partially mitigated Downside case after applying the percentage probabilities of each risk crystallising, shown at 7.70 above.

7.101 The partially mitigated Downside case is summarised in the table below.

<table>
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<tr>
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</thead>
<tbody>
<tr>
<td>Retained surplus £M</td>
<td>8.7</td>
<td>-3.3</td>
<td>9.5</td>
<td>9.7</td>
<td>9.9</td>
<td>10.1</td>
</tr>
<tr>
<td>Cash at bank at year-end £M</td>
<td>75.9</td>
<td>69.1</td>
<td>67.5</td>
<td>68.0</td>
<td>70.8</td>
<td>69.3</td>
</tr>
<tr>
<td>Liquidity days</td>
<td>-8.8</td>
<td>-9.0</td>
<td>-4.1</td>
<td>-6.7</td>
<td>-7.1</td>
<td>-2.3</td>
</tr>
<tr>
<td>Continuity of Service Risk Rating 1–4</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>I&amp;E surplus margin %</td>
<td>1.0%</td>
<td>-0.4%</td>
<td>1.0%</td>
<td>1.0%</td>
<td>1.0%</td>
<td>1.0%</td>
</tr>
</tbody>
</table>

7.102 This partially mitigated Downside case (after specific mitigations against each individual risk modelled) leaves a requirement for further more radical recurrent mitigation plans to sustain a surplus each year, and return to a Continuity of Service Risk Rating of 3 in future years.

7.103 Any organisation needs to have a set of more radical risk mitigation schemes in reserve, in the event of a Downside scenario arising. The Trust is actively pursuing a set of further, more radical risk mitigations, such as taking further staffing measures, telemedicine, site rationalisation, reduction in space utilisation and sale of premises.

7.104 Specific mitigations would be required in the Downside scenario to preserve cash, particularly from the risks with a significant cash impact such as the risk of not obtaining the capital loans finance. These mitigations would include cutting and deferring other areas of capital expenditure and firm working capital management to maintain cash in the Downside scenario.
7.105 These more radical mitigations have been modelled in the combined Downside case (after specific mitigations against each individual risk have been included). The result is summarised below.

### Combined Downside - fully mitigated. After global mitigations (in addition to risk specific mitigations) have been applied

<table>
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</tr>
</thead>
<tbody>
<tr>
<td>Retained surplus £M</td>
<td>8.7</td>
<td>-4.1</td>
<td>8.8</td>
<td>8.5</td>
<td>9.7</td>
<td>9.9</td>
</tr>
<tr>
<td>Cash at bank at year-end £M</td>
<td>75.9</td>
<td>75.4</td>
<td>75.9</td>
<td>66.9</td>
<td>67.1</td>
<td>63.0</td>
</tr>
<tr>
<td>Liquidity days</td>
<td>-8.8</td>
<td>-9.0</td>
<td>-1.1</td>
<td>-2.5</td>
<td>-6.8</td>
<td>-3.0</td>
</tr>
<tr>
<td>Continuity of Service Risk Rating 1–4</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>I&amp;E surplus margin %</td>
<td>1.0%</td>
<td>-0.4%</td>
<td>0.9%</td>
<td>0.9%</td>
<td>1.0%</td>
<td>1.0%</td>
</tr>
</tbody>
</table>

7.106 This Downside case after global mitigations have been applied shows that OUH can deliver a sustainable financial position over the five-year period with cash balances of between £63.0m and £75.9m, surpluses each year from 2016/17 averaging 1.0% of income and a Continuity of Services Risk Rating of 3 for each year from 2016/17, the planned first full year of licence.

**Conclusion**

7.107 This analysis presents a prudent set of sensitivities modelling the potential financial impacts of the seven key risk areas for OUH which are outlined in this chapter. These are combined into a Downside case which, when mitigations are applied, illustrates that the Trust would still achieve a stable financial position in a Downside scenario over the five year period to 2019/20.