The Royal Liverpool and Broadgreen University Hospitals NHS Trust

A New Health Service for Liverpool

World Class Hospitals, World Class Services

Final Confirming Business Case

Royal Liverpool and Broadgreen University Hospitals NHS Trust

January 2014

Contents

Figures

1 Executive Summary

1.1 Introduction

Background

1.1.1 This Confirming Business Case (CBC) *"A New Health Service for Liverpool - World Class Hospitals, World Class Services"*, takes the objective of remodelling and redeveloping Trust services and infrastructure for The Royal Liverpool and Broadgreen University Hospitals NHS Trust a key stage further towards realisation.

1.1.2 The underlying impetus to the project is the increasing risk of business interruption in the existing Royal Liverpool University Hospital due to fire safety issues and deteriorating engineering infrastructure (heating, electrical, ventilation and water).

1.1.3 The CBC follows the Outline Business Case approval in April 2010, the Draft Appointment Business Case approved by DH and Treasury in March 2013 and approval of the Appointment Business Case (ABC) in July 2013.

1.2 Department of Health Approval Conditions

1.2.1 The CBC confirms that conditions attached by the DH to its approval of the ABC have been met.

1.3 Strategic Context

1.3.1 The Trust has considered changes to the NHS nationally, the whole system approach being taken in the local healthcare economy and the Trust's strategy to continue to deliver healthcare of the highest quality. The new Royal Liverpool University Hospital is a critical component to the both the local economy and the Trust.

1.4 Key Changes since the Appointment Business Case

1.4.1 There have been a limited number of changes to the project since the approval of the ABC and these are set out below:

- The inclusion in the design of some features to enable the addition of a helipad
- The DH has reduced the level of PDC being made available to the scheme from £100m to £94m
- An increase of £10m in the amount of funding to be raised from Equity and Senior Debt Funders, to meet the cost of known or potential variations
- The Senior Debt Funding Competition, which has now been concluded, and which has resulted in a lower Unitary Payment than assumed in the ABC.

1.4.2 Post ABC there have been a number of clarifications and fine tuning to the structure of the project and these are described within the summary of Standard Form contract amendments in Chapter 6.

1.4.3 The Trust has kept a tight control over design development and scope changes and there have been no unplanned changes since ABC in the design and scope of the project.

1.5 Design Development

1.5.1 As at ABC, the project will be delivered in three phases:

- Phase 1 - New RLUH handover - March 2017
- Phase 2 - Asbestos Removal and Demolitions - June 2019
- Phase 3 - Landscaping, UGCP, site completion - March 2020.

1.5.2 Following the appointment of The Hospital Company, the Trust has built on the design work delivered throughout the competitive dialogue process and has proceeded to:

- Reaffirm and sign off 1:500 floor by floor plans
- Further develop and sign off 1:200 departmental plans
- Further develop and sign off 1:50 generic and repeatable rooms
- 1:50 loaded plans reviewed for the whole hospital by Financial Close.

1.6 Activity and Capacity

1.6.1 Activity projections have been updated since the ABC to reflect actual outturn for 2012-13. This has not required any amendment to the capacity requirements.

1.7 Procurement Process and Project Documentation

1.7.1 The procurement process followed EU procurement rules using the competitive dialogue process.

1.7.2 The Project Agreement is based on the Department of Health Private Finance Unit Standard Form Version 3, as amended July 2004, February 2006 and November 2006 (SF3). The Project Agreement and Schedules have been refined to reflect project specific matters and have incorporated updates in law and HM Treasury's Standardisation of PFI Contracts (SoPC4) drafting. In addition, amendments have been made to reflect Private Finance 2 drafting as issued by HM Treasury - in particular the transparency provisions have been set out in Schedule 25. All amendments have been agreed with PFU.

1.8 Senior Debt Funding Competition

1.8.1 In accordance with the DH and HM Treasury's funding protocol, The Hospital Company (with the direct involvement of the Trust and with approval from the Private Finance Unit) has undertaken a Preferred Bidder Senior Debt Funding Competition.

1.8.2 The European Investment Bank has committed to meeting 50% of the senior debt requirement.

1.8.3 This was a three-stage process that incorporated preparation, identifying a long list of potential funders and concluding with the selection of a preferred funder from a shortlist of three.

1.8.4 Having submitted the best value for money bid and satisfying the Trust on all other considerations such as deliverability in the required timescale, Legal & General (with Lloyds) was appointed as preferred funder.

1.9 Affordability

1.9.1 The Trust is on target to deliver its financial plan for 2013-14 including the QEP requirement.

1.9.2 At ABC the cash requirement to cover the Unitary Payment and the dividend payable on the Public Dividend Capital had been £25.0m. This has now reduced to £24.2m - a figure that includes a buffer of £0.9m against the potential for adverse financial market movements in the time to Financial Close.

1.9.3 Affordability of the new RLUH had previously relied in part on the achievement in future years of a slightly higher level of efficiency saving than the national requirement. However, the reduction in the Unitary Payment and the use of Trust embedded reserves mean that the only contribution now required from QEP savings will be the £3.4m already achieved.

1.9.4 The project is shown to be affordable under the base case assumptions and the Trust has demonstrated a robust strategy for meeting in full the potential additional costs of an extensive downside case.

1.10 Workforce

1.10.1 The Trust has a clear strategic workforce plan that assesses the potential shape of its workforce on the basis of anticipated changes to service delivery, technology advance and redesigned roles. The plan has been developed by clinical engagement and benchmarking and will be kept under review to ensure it is responsive to changing needs.

1.10.2 Future success is dependent on a flexible workforce, with a mind-set of continuous improvement, responsive to change and affordable. In support of this, the Trust has a team of Service Improvement and Organisational Development practitioners to improve quality and productivity whilst also driving down cost. This team will become a key component of the Trust's Transformation Programme "Journey to 2018".

1.10.3 The Trust believes that leadership exists at every level of the organisation, and includes all staff as leaders, ensuring a fit-for-purpose workforce with the right leadership skills and behaviours, empowered to drive organisational change capable of delivering exceptional services at greater quality and reduced cost.

1.10.4 The training, development and support which has already been put in place for staff (and which continues to be enhanced) provides assurance that the Trust has a forward thinking workforce, fully equipped to deal with the challenges and opportunities in transforming the future of the Trust towards 2018 and beyond.

1.11 Risk Management

1.11.1 The risk matrix has been reviewed and updated and overall remains consistent with that presented in the ABC. Risks continue to be reviewed as the project progresses and major project milestones are completed.

1.11.2 The CBC identifies eight critical risks to the project and their associated mitigation strategies.

2 Introduction

2.1 Purpose of the Confirming Business Case

2.1.1 This is the Confirming Business Case (CBC) for the project "*A New Health Service for Liverpool - World Class Hospitals, World Class Services*", which aims to remodel and redevelop Trust services and infrastructure for The Royal Liverpool and Broadgreen University Hospitals NHS Trust (RLBUHT).

2.1.2 The purpose of the case is to secure final approval for a new hospital to replace the Royal Liverpool University Hospital (RLUH) enabling the procurement process to be completed and Financial Close with The Hospital Company, the consortium appointed as Preferred Bidder to be reached.

2.1.3 The CBC describes developments and key changes that have occurred since the approval of the Appointment Business Case (ABC), highlights any outstanding issues and identifies how these will be resolved prior to Financial Close.

2.1.4 The primary purpose of the CBC is to demonstrate that the project remains within the key parameters set out in the DH approval of the ABC. Accordingly the CBC is limited in its scope and does not provide a history to the scheme, or information that has not changed since approval of the ABC. For full details of the scheme, this CBC should be read in conjunction with the ABC.

2.2 Business Case Approvals

2.2.1 The RLBUHT Board approved this CBC on 29 October 2013.

2.2.2 Stakeholder approval to the Draft Appointment Business Case (DABC) was secured from NHS Merseyside on behalf of all Clinical Commissioning Groups (CCGs) and by North of England Specialised Commissioning Group. For this CBC, commissioners have given formal confirmation of their continued support.

2.3 Planning Approval

2.3.1 The full planning application was approved by Liverpool City Council on 17 September 2013 and Planning Consent was signed on 24 September 2013. The judicial review period is due to end on 5 November 2013.

2.4 Department of Health ABC Approval Conditions

2.4.1 The Trust confirms that the project remains within the parameters set by the DH at ABC:

- The Unitary Payment remains within the ceiling of £21.5m, inclusive of buffer for known risks
- The project remains affordable in terms of its impact on the overall income and expenditure position of the Trust
- The project is positioned to achieve Financial Close within the approved timescale
- The project continues to be supported by the Trust's commissioners
- The Project Agreement and Schedules remain substantially unchanged from those at ABC
- The Trust is confident that the Quality Efficiency Programme for 2013-14 and future financial years will be delivered
- The Trust has worked closely with The Hospital Company to develop a Transition Plan to take the project through construction and into the operational phase
- The Senior Debt Funding Competition has been undertaken with the full approval of PFU and HM Treasury.

3 Strategic Context

3.1 Introduction

3.1.1 The national context has changed considerably over the past twelve months. We have seen the publication of the Francis Report which has called for greater openness and transparency throughout the NHS and the continuing development of a culture where people feel comfortable to raise concerns about the quality of care. As a response to some of the concerns in the Francis report we have seen the Chief Nurse for England publish the 6Cs of nursing care.

3.1.2 In August 2013, the Berwick Report into NHS patient safety made recommendations for the NHS, its regulators and the government in building a robust nationwide system for patient safety rooted in a culture of transparency, openness and continual learning, putting patients firmly at its heart.

3.1.3 We have also seen changes in the organisational structure of the service that look to ensure greater emphasis is placed on monitoring the quality of service provided. This includes the development of multi-agency Quality Surveillance Groups. In addition to this, tremendous activity pressure has destabilised the unscheduled care system, bringing with it increased risk in relation to patient experience.

3.1.4 At a local level, we have made great progress with partner Trusts in discussions around service reconfiguration and are working collaboratively with both NHS and non-NHS partners on the bio-innovation agenda.

3.2 The Local Healthcare Environment

3.2.1 The NHS in Liverpool needs to adapt if it is to face future challenges, such as an ageing population and increases in long-term conditions, while also improving the health of residents. Liverpool CCG's approach is set out in *The Healthy Liverpool Programme*, which has commenced with a detailed examination of the local health service. This process will help to establish what is needed to make sure that the NHS can provide high-quality services now and in the years to come. The Trust is supporting this work in close partnership with the city's other NHS organisations, General Practitioners and Liverpool City Council.

3.2.2 A number of workstreams have now been established under the *Healthy Liverpool Programme* and include:

- Health and Social Care to act as one
- Integrated commissioning
- Self-care and prevention
- Integrated delivery of care
- Neighbourhood delivery of care
- Workforce flexibility.

3.2.3 The CCG is continuing the approach adopted by its predecessor body of a combination of city-wide actions and targeted actions to make a big difference to health. It has placed a strong emphasis on health inequalities and on helping people look after their own health. This includes supporting sensible drinking, reducing the number of people who smoke, tackling obesity and improving mental health and wellbeing. It also includes helping people to find their way around the care system and providing support for self-care.

3.2.4 *The Healthy Liverpool Programme* has now developed *Acting as One*, a blueprint for future service delivery in which co-dependencies of organisations are clear.

3.2.5 The key principles of *Acting as One* include:

- Joint working to avoid duplication
- System (not organisational) incentives to improve health outcomes
- Collective ownership of the healthcare system and solutions
- Vertical and horizontal integration.

3.2.6 Knowsley and South Sefton CCGs have each adopted strategic plans that incorporate many of the objectives included within Liverpool's plan, with an emphasis on improving health inequalities, ensuring access to high quality care provided in the most appropriate settings, moving from unplanned to planned care and moving care closer to home.

3.2.7 It is important to remember that a strong, effective NHS in Liverpool isn't just about health - the NHS employs a huge number of local people and has the potential to attract new jobs and investment. By developing a health service which is fit for the future, real benefits can be brought to the city as a whole.

3.3 Trust Strategy

3.3.1 The Trust's services must have a reputation for high quality in order to attract patients, and it must maintain a financially robust position to sustain its freedom of action and its ability to take advantage of opportunities. The Trust needs to have effective relationships with outside organisations including CCGs, Overview and Scrutiny Committees and partner providers. The Trust also needs to have a good understanding of its competitors.

3.3.2 The Trust is continuing to redesign its services and improve its performance and Outside Hospital services are at the centre of its strategy. This involves close partnership working with Commissioners and Social Services.

3.3.3 Five strategic themes have been developed; all focused on improving health outcomes for patients and underpinned by objectives that are specific, measurable, achievable, relevant and timely. These represent the longer-term objectives to be delivered over a five-year timeframe.

- To improve the quality of life for our patients by providing excellent, safe and accessible healthcare which puts patient wellbeing at the heart of all we do
- To deliver an exceptional patient experience, making the Trust one of the most sought after places to be treated anywhere in the world
- To achieve international recognition for our research and innovation, bringing new therapies from the bench to the bedside
- To develop a world-class workforce, recognised for its skills and level of engagement, and founded on a culture of achievement, education, training and continuous development
- To play a lead role in the development of a sustainable health system for the communities we serve.

3.3.4 Development of the new RLUH underpins the Trust's overall strategy, enabling the Trust to continue to deliver leading-edge clinical services in a more high quality and patient-focused environment. The physical condition of the existing hospital and fire safety risk issues will be eliminated and the associated threat to business continuity will be removed. The new hospital will also contribute to performance improvement and the streamlining of patient care services.

3.3.5 The Trust is preparing to embark on a Transformational Programme "Journey to 2018" to provide an effective means of guiding the delivery of the Trust's strategy over the next few years. It will also ensure that staff and patients are able to move seamlessly into the new hospital in mid-2017 with appropriate staffing structures, models of care and IT capability. A governance structure is being developed which builds on the proven model used for the new hospital.

3.3.6 The development will also enable the relocation of the Clatterbridge Cancer Centre to the RLUH site to facilitate the delivery of integrated cancer care services and offer the potential for a significant increase in cancer research and trials.

3.3.7 Demolition of the existing hospital will provide the potential for further clinical developments, enabling the consolidation of services across the city and for north Merseyside generally.

3.4 Commissioner Support

3.4.1 Appropriate stakeholder approvals to the DABC were secured from NHS Merseyside on behalf of all Clinical Commissioning Groups and North of England Specialised Commissioning Group in respect of the specialist services provided by the Trust.

3.4.2 Amendments to the composition of our contracts arising from changed responsibilities for public health and specialised services have meant that the impact on individual commissioners has also changed. However, the overall impact remains in line with that envisaged at ABC.

3.4.3 Liverpool CCG has confirmed that they understand the work that has taken place to forecast future activity trends which have been built into the CBC.

3.4.4 The CCG is clear that this direction is consistent with the CCG Strategic Commissioning Plans for the city as set out in *The Healthy Liverpool Programme*, and will be working with RLBUHT to refine the detail on an iterative basis in line with changes in demography and clinical practice.

4 Design Development and Delivery Programme

4.1 Introduction

4.1.1 The project is a key component of the delivery of the Trust's Vision and Strategy.

4.1.2 As the Trust and its partners move forward to deliver new healthcare facilities and services, its central vision for the future will remain unchanged – *to be a healthcare provider that is focused on the health and wellbeing of patients, working in partnership with others to deliver the highest quality of care, underpinned by world-class research, innovation and education.*

4.2 Delivery Programme

4.2.1 The project will be delivered in three phases:

- Phase 1 - New RLUH handover - March 2017
- Phase 2 - Asbestos Removal and Demolitions - June 2019
- Phase 3 - Landscaping, UGCP, site completion - March 2020.

4.3 Design Development and Review Process

4.3.1 Following the appointment of The Hospital Company, the Trust has built on the design work delivered throughout the competitive dialogue process and has proceeded to:

- Reaffirm and sign off 1:500 floor by floor plans
- Further develop and sign off 1:200 departmental plans
- Further develop and sign off 1:50 generic and repeatable rooms
- 1:50 loaded plans reviewed for the whole hospital by Financial Close.

4.3.2 The Trust's review and sign off responsibilities for the above has been in accordance with the definition of Clinical Functionality set out in the Project Agreement. The Hospital Company remains responsible for all other design aspects to meet Trust requirements.

4.3.3 The clinical and technical design programme was organised to enable early submission of the detailed planning application.

4.4 Clinical Design Review Status

4.4.1 The post Preferred Bidder refinement and finalisation process has not led to any increase in capital cost except for the consequence of design readiness for a helipad. During the Final Bid process both bidders confirmed that their proposals were capable of refinement to accommodate a helipad ready design.

4.4.2 The Trust can confirm that the 1:200 drawings, through a series of clinical and non-clinical user group meetings, have been signed off at either level A (no Trust comment) or level B status (proceed subject to amendment as noted).

4.4.3 The 1:50 design development process is well advanced and has included input from the project team, technical advisors, clinical and non-clinical representatives. Planned status at Financial Close is set out below:

- 55 generic and repeatable rooms signed off at level A or B
- Groups A (including for example, theatres, clean rooms and outpatients) signed off at Level A or B
- Groups B & C (including for example critical care, generic wards, nuclear medicine) second pass review completed
- Group D first pass review completed (all rooms loaded and reviewed).

4.4.4 The remaining rooms are due for sign off by the end of March 2014.

4.5 Project Co Proposals

4.5.1 The Trust and its technical advisors have been working with The Hospital Company to refine and sign off the technical elements of their Final Bid submission.

4.5.2 The first element of this process was the development and review of all documentation prior to submission of the planning application. The planning application was submitted using a hybrid approach with full permission being sought for the new hospital and outline permission for future development plots. Permission was granted at the Planning Committee meeting on 17 September. The judicial review period runs from the date of the decision notice on 24 September and will expire on 5 November 2013.

4.5.3 As part of the Final Bid, the Hospital Company signed up to a minimum dataset for inclusion within Schedule 8 Part 4 (Project Co Proposals) and this will broadly comprise:

- Site development and masterplan
- Clinical Planning (1:500, 1:200, 1:50 and elevations, Schedule of Accommodation)
- Architectural (Elevations, sections, roof plans, fire compartmentation plans, glazing, interior design & way finding strategies)
- Mechanical & Electrical (Site infrastructure, M & E installations, fire protection systems, security strategy & installations and lift installations)
- Civil & Structural (Foundations, structural floor plans & drainage plans)
- Performance and Sustainability
- Construction phasing and programme.

4.5.4 The documentation is being reviewed and signed off in accordance with the Review Procedure (as defined in Schedule 10), although any comments made by the Trust will not alleviate The Hospital Company from any design responsibilities. The Hospital Company will continue to carry design risk including compliance with HBNs/HTMs and meeting the requirements of the Trust's Construction Requirements (TCRs).

4.5.5 The exception to this is where the Trust has accepted and approved derogations to such requirements and these will be reflected within the TCRs.

4.6 Reviewable Design Data

4.6.1 The Reviewable Design Data (RDD) process (Schedule 8 Part 5) provides the Trust with an opportunity to review and continue to influence and approve the design solution and design development proposals throughout the construction stage.

4.6.2 The level of clinical and technical design data already signed off or due to be signed off by Financial Close and included within the contract is significant and the project is well positioned in terms of readiness and efficiency of the construction programme.

4.6.3 The Trust has agreed a RDD programme for post Financial Close activity, ensuring cohesion with the construction programme and effective resourcing for both The Hospital Company and the Trust. This programme will be included within Project Co's proposals.

5 Activity and Capacity

5.1 Introduction

5.1.1 Activity projections have been updated since the ABC to reflect actual outturn for 2012-13. This has not required any amendment to the capacity requirements.

5.2 Future Service Delivery

5.2.1 The Trust has established a Migration Path setting out the required rate of change for each Clinical Directorate for the activity and performance targets that have informed the Clinical Service Delivery Model (CSDM), Integrated Business Plan (IBP), Long Term Financial Model (LTFM) and the plans for the new RLUH.

5.2.2 To date, forecasts have proven to be robust - and plans continue to be reviewed regularly. The Trust has worked in partnership with its commissioners to develop each element of the plans and to enable a shared understanding of future requirements.

5.2.3 Throughout the development process for the new RLUH, commissioners have undertaken their own activity modelling and have consistently confirmed the Trust's projections. These were an integral part of the ABC and are confirmed in this CBC.

5.3 Activity Projections

5.3.1 The assumptions for future activity show an expectation of little change to inpatients but a significant reduction to outpatient activity in the period to 2017-18, reflecting changes to patient care pathways. The casemix of admitted patients is expected to become more complex.

5.3.2 Activity assumptions are summarised in the figure below:

Figure 1 - Activity Drivers and Projections

	Non-Elective	Elective	Outpatients	A&E
2012-13 Actual	37,327	50,825	631,327	106,166
Demographic Growth	676	998	11,862	1,724
Epidemiology	634	1,335	19,494	-
Demand Management	(1,544)	(824)	(29,018)	(2,864)
Reclassification	-	236	(236)	-
Service Transfers	211	115	(48,423)	-
Independent Sector	-	(585)	(1,340)	-
Potential 2017-18	**37,304**	**52,100**	**583,666**	**105,026**
2018-19	37,435	52,320	586,149	105,352
2019-20	37,601	52,525	588,451	105,641
2020-21	37,720	52,736	590,646	105,943
2021-22	37,977	53,010	593,591	106,254
2022-23	38,242	53,252	596,429	106,600

5.4 Performance Improvement

5.4.1 The Trust has used national benchmarks to identify the potential for performance improvements. The new facilities, changes to working practices and an improved primary care infrastructure will combine to deliver the forecast improvement.

Figure 2 - Key Performance Indicators

Year	Non-Elective ALoS	Elective ALoS	Bed Occupancy	Theatre Utilisation	First to Follow Up Ratio
2008-09	6.6	4.9	87%	68%	2.4
2009-10	6.5	4.8	86%	71%	2.2
2010-11	6.3	4.8	89%	69%	2.4
2011-12	5.7	4.6	91%	78%	2.5
2012-13	5.8	4.8	92%	76%	2.5
2017-18	5.1	5.0	88%	80%	2.1
2022-23	4.9	4.9	88%	80%	2.2

5.4.2 Performance targets are regularly reviewed and may be amended to reflect changes in activity, service transfers or clinical pathways.

5.5 Capacity Requirements

5.5.1 The Trust has used the activity projections and the performance targets set out above to inform its capacity modelling.

Inpatient Bed Complement

5.5.2 Capacity is based on best in class performance at HRG level, benchmarked with university teaching hospitals outside London. At the same time, a range of initiatives are being employed, many already well embedded, to change culture and achieve service improvements ahead of the new hospital opening.

5.5.3 The agreement of activity levels and the establishment of performance targets have enabled the assessment of required inpatient beds. The following figure summarises the requirement and separately identifies changes from the current position:

Figure 3 - Forecast Inpatient Bed Requirement

	Beds
October 2013 inpatient bed complement	768
Activity Growth	57
Model of Care Admission Avoidance	(26)
Services transferring to Independent Sector	(1)
Improvement in day case provision	(1)
Impact of reduced occupancy rate	42
Reduction in length of stay	(88)
Total inpatient bed requirement in 2017-18	**751**

5.5.4 The new RLUH will provide 646 beds, with the balance of 105 located on the Broadgreen Hospital site. The ready availability of capacity at Broadgreen means that the Trust will be able to respond to increases or reductions to actual activity levels.

6 Procurement Process and Contract Documentation

6.1 Introduction

6.1.1 The procurement process followed EU procurement rules using the competitive dialogue process and commenced in March 2010 with the publication of the OJEU notice. The competitive dialogue process was delivered during the period February 2011 through to conclusion in February 2013. Final Bids and the selection of The Hospital Company as Preferred Bidder followed and formalised in the preferred bidder letter signed in April 2013.

6.2 Standard Form Position

6.2.1 The Project Agreement is based on the Department of Health Private Finance Unit (PFU) Standard Form Version 3, as amended July 2004, February 2006 and November 2006 (SF3). The Project Agreement and Schedules have been refined to reflect project specific matters and have incorporated updates in law and HM Treasury's Standardisation of PFI Contracts (SoPC4) drafting. In addition, amendments have been made to reflect Private Finance 2 drafting as issued by HM Treasury - in particular the transparency provisions have been set out in Schedule 25. All amendments have been agreed with PFU.

6.2.2 Project specific matters include:

- Interim Services will be provided by Project Co at the same time as construction
- The Works are to be carried out in three phases and the cost of Phase 2 and Phase 3 will be paid separately by the Trust and not form part of the Unitary Payment
- The Trust will not insure buildings which are to be demolished and will pay directly for insurance of any Retained Facilities
- Hard FM services only are being provided and no Trust staff will transfer to Project Co.

6.2.3 Save for the completion of gaps, minor drafting amendments to reflect project specific issues in the contract and updates to reflect changes in legislation, the amendments made to the Project Agreement are set out in the table below.

Figure 4 - Contract Amendments

Detail	Summary of Contract Amendments
Clause 5.5 / 5.6 (Sustainable Communities)	New clauses inserted dealing with provision by Project Co of a fund to undertake community activities and obligation to refurbish Edwards Building at no cost to the Trust. Details of Edward Building Works set out in Schedule 35
Clause 7 (Warranties)	Sets out warranties given by the Trust relating to Certificate of Title (also amends to Excusing Cause, Relief Event and Compensation Event)
Clause 15A (Project Co Lease and Retail Leases)	New clause inserted setting out process for granting leases to Project Co for areas for its own use and sub-letting as retail
Clause 16.3-16.6 (Consents and Planning Approval)	Wording included setting out obligations on the Trust and in particular obligation to pay for s106/278 Agreements
Clause 17.4 (Thermal & Energy Efficiency)	Additional drafting restricting clause to New Facilities and including reference to CRC Emissions
Clause 22.13 / 22.14 (Completion)	Amendment relating to Snagging Matters being categorised by Independent Tester

Detail	Summary of Contract Amendments
Clause 22.19(b) (Late Completion of the Phase 2 / 3 Works)	If the Phase 3 Works are delayed Project Co pays £2,500 per day to a long stop date of twelve months
Clause 29.13 (Failure to provide Interim Services)	New clause allowing the Trust to step in to Rectify a Fault occurring in the Interim Services
Clause 30 (Employment)	Additional provisions included covering discrimination, promotion of equality and good working practices
Clause 35A (Capital Works Contributions)	New clause inserted setting out mechanism for payment of Capital Works Contributions by the Trust
Clause 36.21A (Material Damage to Demolished Facilities)	New provision setting out process for what happens if a Demolished Facility (which is self-insured by the Trust) is materially damaged or destroyed
Clause 36A (Retained Facility Insurance Cost)	New clause inserted setting out process for the Trust to pay the cost of insurance of the Retained Facilities. Consequential amendments to clause 36
Clause 39 (Change in Law)	Amended to reflect PF2 so Trust takes risk of capex arising from a Change in Law. Also Emissions Specific Change in Law is for the Trust's account
Clause 41.3(c) (Delay Events)	Delay Event includes the execution of works on the Site by a Trust Party to reflect the works that may be carried out by Clatterbridge Cancer Centre Trust in the future
Clause 44 (Project Co Events of Default - Material Breach)	Amends to reflect that the Trust cannot terminate for breach of Interim Services but can require replacement of Service Provider. The Trust cannot terminate for breach in connection with Phase 2 and 3 Works or the carrying out of works to the Edwards Building
Schedule 7 (Land Matters)	Project Specific drafting reflecting the inclusion of Retail Leases and Certificate of Title
Schedule 8, Part 8 (Greenhouse Gas Emissions (CRC Scheme))	Drafting to address the CRC Scheme
Schedule 8, Part 10 (Phase 2 / 3 Works)	Sets out process for the procurement and carry out of Phase 2 Works (removal of asbestos and demolition) and Phase 3 Works (hard/soft landscaping)
Schedule 14 (Service Level Specifications)	Minor drafting amendments to reflect project specific issues and comments raised by the Funders' Due Diligence Technical Advisor. Inclusion of separate Estates Specification for the Retained Facilities
Schedule 16 (Interim Services)	Sets out the services to be provided to the Demolished and Retained Facilities until Completion of Phase 1 Works (or shortly thereafter)
Schedule 18 (Payment Mechanism)	Inclusion of payments/deductions regime for the Interim Services and, after the Phase 1 Completion, for the Retained Facilities
Schedule 21 (Insurance)	Amendments to reflect SoPC4 and project specific issues
Schedule 22 (Variations)	Amendments to limit scope of Project Co to charge funder fee or due diligence costs. Amendments to the Pricing information requirements. Inclusion of Small Works Procedure.

6.3 PF2

6.3.1 A review of PFI was undertaken by HM Treasury in 2012, following which its report *"A new approach to public private partnerships"* was published. This set out the conclusions of the review and the Government's new approach for involving private finance in the delivery of public infrastructure and services.

6.3.2 Although the project for the new RLUH would not be covered by the new guidance, the Trust has considered the main recommendations in the report and has adopted the following approach:

- Public sector equity stake (not able to be adopted at this stage of procurement)
- Exclusion of soft FM services - (already adopted - these services have always been excluded)
- Cost of Small Works (already adopted - Schedule 22 requires fully priced schedule of works)
- Flexibility of maintenance services (not able to be adopted at this stage of procurement)
- Handback Condition (not adopted - Handback Condition will be primarily dictated by maintenance and lifecycle works; these have been benchmarked and The Hospital Company submission is very competitive)
- Lifecycle Risk (not adopted - costs have been benchmarked and The Hospital Company submission is very competitive)
- Greater transparency by the Public Sector (already adopted)
- Greater transparency by the Private Sector (adopted - The Hospital Company has accepted the requirement)
- Change in Law (adopted and provision relating to capital element has been dropped - VfM analysis strongly indicated this course of action)
- Utilities risk (not adopted - retention of risk sharing encourages partnership and Project Co will be managing the Building Maintenance System)
- Insurance risk sharing (not adopted - current market conditions are competitive and this is reflected in The Hospital Company submission).

6.4 Changes Arising From Due Diligence

6.4.1 Funder's due diligence advisors have raised a number of points from their review of the Project Agreement and Schedules and the Trust has accepted that a small number should reasonably be accepted. These are considered minor amendments and include:

- Acceptance of a fast-track Dispute Resolution Procedure in respect of the decommissioning of the facilities to be demolished as the Trust will be certifying this work and there could be implications for Project Co's ability to carry out their subsequent responsibilities
- Acceptance of a security package relating to Phases 2 and 3
- Minor amendments to several performance parameters in Schedule 14 and 16 to provide greater clarity and a better defined measure of required performance
- The introduction of Schedule 35 to set out responsibilities and handover condition in respect of the Edwards Building (an existing Trust facility that Project Co will refurbish and handback at the conclusion of Phase 1)
- Clarification in Schedule 18 in respect of deductions for lifts and pneumatic tube unavailability to make clear that deductions would not be double-counted
- Amendment to Schedule 21 to cover the potential requirement for marine and key supplier insurance
- Clarification of respective responsibilities in respect of S106 and S278 requirements.

6.5 Due Diligence Contracts and Finalisation of Contract Documentation

6.5.1 Immediately following the formal appointment of the senior debt funders, the due diligence advisors will be novated to them. Following novation, the Trust will work closely with The Hospital Company, the senior funders and the due diligence advisors to finalise project documentation, particularly in respect of the funding documents.

7 Senior Debt Funding Competition

7.1 Introduction

7.1.1 In accordance with the DH and HM Treasury's funding protocol, The Hospital Company (with the direct involvement of the Trust and the Private Finance Unit) has undertaken a Preferred Bidder Senior Debt Funding Competition.

7.1.2 The objective of the competition was to obtain competitive proposals for a senior debt funding solution which:

- Are firm, unqualified and deliverable
- Do not undermine the ABC approval
- Deliver the required amount of senior debt funding
- Minimise the Net Present Value of Unitary Payments made by the Trust
- Allow Financial Close to be achieved in a timely manner
- Do not require renegotiation of the project documentation.

7.2 Due Diligence

7.2.1 Due diligence advisors (legal, technical and insurance) were appointed by the Trust (acting in an administrative capacity only and as trustee for the due diligence advisor duty of care to the ultimate funder) in consultation with the shortlisted bidders and PFU. The procurement process was undertaken in January 2011 and appointments were made in the following month. This timing provided for these appointments to be in place prior to the formal commencement of the competitive dialogue process.

7.2.2 The stages within the due diligence scope of services are as follows:

- A first stage due diligence report based on ITPD documentation and allowed early consideration of issues which may be sensitive areas for funders
- A 'fly-over' stage which enabled the Trust to liaise with the due diligence advisors to gain a view on any key concerns raised in the review of Draft Bids or during discussions with bidders
- A second stage in which a due diligence report was commissioned after the Trust had identified the best solution and was minded to appoint a Preferred Bidder. This report informed the funding competition and enabled prospective funders to compete and bid against a known set of commercial terms.

7.3 Funding Competition Process

Approach

7.3.1 The Preferred Bidder Senior Debt Funding Competition has been managed by The Hospital Company and administered by HSBC with full visibility for the Trust and its advisor.

7.3.2 It has been delivered in a three stage process:

- Stage 0 - Preparation
- Stage 1 - Long List
- Stage 2 - Short List.

Objectives

7.3.3 The funding requirement for the new RLUH is £330m, of which the Trust and the DH will provide £24m and £94m respectively. The Sponsors and Senior Debt Funders will provide the balance of £212m.

7.4 European Investment Bank Engagement

7.4.1 Following EIB giving in-principle approval to providing 50% of the senior debt required for the new hospital, approval by EIB Board of Directors was confirmed in July 2013. The funding competition therefore proceeded on this basis.

7.4.2 The tenor of the EIB facility will be equal to that of the Commercial Term Loan Facility of 31 years and 2 months and the EIB and commercial debt will rank pari passu.

7.4.3 The Trust and its advisors have continued to liaise with the EIB during the bidding stage and final approval will be given near to Financial Close.

7.5 Stage Outcomes

Stage 0 - Preparation

7.5.1 A long list of potential funders was considered at the Trust Board meeting in May 2013.

7.5.2 The Trust, its financial advisors (Deloitte) and HSBC subsequently reviewed the list and identified those funders considered to be potentially capable of delivering a competitive funding solution. The list was subsequently considered and approved by the Private Finance Unit and Infrastructure UK (HM Treasury).

Stage 1 - Long List

7.5.3 The long list of funders was invited to participate in the competition and was issued with the following:

- Full unabridged Draft Project Documents (including Project Agreement and three Schedules most relevant to funders, subcontracts and the planning application)
- Full due diligence advisor reports (legal, technical and insurance)
- Base case financial model
- Proposed timetable for the competition
- Summary of response requirements
- Evaluation Criteria.

7.5.4 The objective of this stage was to select a sufficient number of funders and one or more funding products (i.e. bank and capital market) to be progressed to the next stage of the competition.

7.5.5 The selection criteria were set out in the Preliminary Information Memorandum sent to the initial long list of funders. The primary consideration was a quantitative analysis of the funding terms from each submission.

7.5.6 The assessment also considered the following additional criteria:

- Structure of the funding solution
- Ability to meet the required timescale
- Experience of working with EIB.

7.5.7 Stage 2 is very resource intensive for the funders. Following submissions at Stage 1 and having assessed the net present value of each bid, it was therefore felt that just three funders should be shortlisted. These were determined by those giving the lowest net present value. These were also proven solutions that could be delivered in the timescale.

7.5.8 The three options included one bank and two capital market solutions. The Trust Board, the Private Finance Unit and Infrastructure UK approved the shortlist.

7.5.9 The three funders forming the shortlist were as follows:

- A Bank Club consisting of KfW Bankengruppe, Norddeutsche Landesbank and Sumitomo Mitsui Banking Corporation (the three banks that submitted the most competitive bids)
- Legal & General (with Lloyds)
- Municipal and General (with Sumitomo Mitsui Banking Corporation).

Stage 2 - Short List

7.5.10 This stage offered the shortlisted funders an opportunity to:

- Improve on the indicative terms provided in Stage 1
- Participate in clarification meetings with the due diligence advisors, the sponsors and the Trust
- Provide clarity on any matters raised by HSBC, The Hospital Company or the Trust
- Obtain approval to their funding solution from their credit committees (or equivalent approving level of management).

7.5.11 Final submissions by the shortlisted funders were received on 25 September 2013.

7.6 Selection

7.6.1 The first part of the evaluation related to a quantitative analysis of each submission, in which the project Financial Model was populated with each funder's terms.

7.6.2 This analysis revealed a preference for the Legal & General submission on the basis of a lower net present cost to the Trust over the thirty year concession. The differential in the first year Unitary Payment was also significant although this differential narrowed over the concession period due to differential indexation levels.

7.6.3 An assessment was also made of qualitative aspects of each submission such as deliverability, access to additional finance to fund future variations and the interface with EIB. Each submission was thought to be bankable within the Trust's timescale and the qualitative considerations were not therefore a deciding factor.

7.6.4 Following resolution of a small number of conditions attached to the submission, the appointment of Legal & General was approved by PFU and IUK.

8 Finance

8.1 Introduction

8.1.1 This chapter will demonstrate the financial affordability of the project and will provide:

- An overview of future cash releasing efficiency savings
- An analysis of the capital expenditure that will not be included within the PFI
- Outputs from the Foundation Trust Long Term Financial Model, incorporating the early years of operation of the PFI facilities
- Consideration of downside scenarios and mitigation factors.

8.2 Changes since ABC

8.2.1 The most significant changes since ABC are as follows:

- A reduction in the expected 2017-18 Unitary Payment from £21.5m to £21.0m (despite an increase of £0.9m caused by interest rate rises)
- A reduction from £100m to £94m in the Public Dividend Capital provided by the DH
- An increase of £10m in the amount of funding to be raised from Equity and Senior Debt Funders, to meet the cost of known or potential variations
- Changes made to the Trust's financial plans taking account of the new risk rating methodology introduced by Monitor.

8.3 Trust Financial Position

8.3.1 The Trust delivered a surplus of £8.5m for the 2012-13 financial year excluding the impact of impairments. This was a slight improvement on the plan of £8.3m at ABC.

8.3.2 The Trust is on course to deliver its financial plan for 2013-14.

8.4 Activity and Income Assumptions

8.4.1 In conjunction with its commissioners, the Trust has undertaken detailed analysis of future activity and this is detailed in section 5.3.

8.4.2 Using this analysis, income assessments for future years have been calculated for both PbR and non-PbR activity.

8.5 Impact on Commissioners

8.5.1 The anticipated change to income received from each commissioner for the period to 2017-18 (the first full year of operation for the new hospital) is shown in Figure 5. This change is primarily the consequence of increased casemix complexity.

Figure 5 - Commissioner Income 2013-14 to 2017-18

Commissioner	2013-14 SLA	Income change to 2017-18	Income change	Income change per annum
	£m	£m	%	%
Liverpool	186.1	4.2	2.26	0.57
Knowsley	19.3	0.6	3.11	0.78
Sefton	10.1	0.2	1.98	0.50
Halton & St Helens	9.3	0.3	3.23	0.81
Specialist Commissioning	56.2	0.4	0.71	0.18
All Other	47.7	0.8	1.68	0.42
Total	**328.7**	**6.5**	**1.98**	**0.50**

8.5.2 Activity projections were confirmed with CCGs during their review of the DABC and have been re-confirmed for this CBC.

8.5.3 Amendments to the composition of our contracts arising from changed responsibilities for public health and specialised services have meant that the impact on individual commissioners has also changed. However, the overall impact remains in line with that envisaged at ABC.

8.6 Capital Funding Requirement for the PFI

8.6.1 Since selection of The Hospital Company, the Trust has identified a small number of known or potential variations to the design and scope of the new hospital and these are set out in the following figure:

Figure 6 - Design and Scope Variations

	Cost (£m)
Helipad complete	1.8
Conversion of offices to ward accommodation (two wards)	2.5
Site logistics to accommodate CCC	0.5
Design development (1:50 completion)	1.7
Helipad ready (additional costs)	0.3
Section 278	1.3
Brief changes including CT capacity, Interventional Endoscopy, Genome technology	1.4
Equipment	0.5
Total	**10.0**

8.6.2 The Trust has considered the options available to fund these variations and this CBC reflects an increase of £10m in the funding to be raised from Sponsors and Senior Debt funders.

8.6.3 Allowing for the funding required for the variations, the capital funding requirement and sources at ABC and CBC are shown in Figure 7.

Figure 7 - Capital Funding Requirement and Sources

	ABC	CBC
	£m	£m
Construction Cost	264.6	266.3
Variations	-	10.0
Development, financing and other costs	71.3	53.6
Total resource requirement	**335.9**	**329.9**
Trust cash	24.0	24.0
Public Dividend Capital	100.0	94.0
PFI	211.9	211.9
Total funding resources	**335.9**	**329.9**

8.6.4 Construction cost has increased by £1.7m since ABC. This is the combination of £0.9m relating to making the design helipad ready and £0.8m for works on the Underground Car Park previously included in Phase 3 and funded directly by the Trust. A corresponding reduction has been made to the Trust's payment for Phase 3.

8.6.5 Since the ABC, the Trust has secured participation by the EIB in the project. The beneficial funding terms has meant a significant reduction in required funds.

8.6.6 A further change since ABC is a reduction from £100m to £94m in the amount of Public Dividend Capital to be made available by the DH.

8.7 Revenue Implications of the PFI

8.7.1 The Hospital Company's financial model has been updated to reflect the terms of the preferred funder and the annual Unitary Payment at a 2013-14 price base is assessed at £20.4m. (The actual Unitary Payment will be determined by interest rates prevailing at the time of Financial Close).

8.7.2 The variable cost elements of the Unitary Payment, representing just over one third of the total payment, will be subject to inflation. By 2017-18, this would mean the payment would be £21.0m, equivalent to less than 5% of Trust turnover.

8.7.3 At ABC the cash requirement to cover the Unitary Payment and the dividend payable on the Public Dividend Capital had been £25.0m. This has now reduced to £24.2m - even when allowing for the cost of variations set out in Figure 6. The factors that have changed since ABC are set out in the figure below:

Figure 8 - Cash Requirement to fund the Unitary Payment

	£m	£m
Requirement at ABC		**25.0**
Changes since ABC:		
Reduced dividend following reduction to Public Dividend Capital	(0.3)	
External funding to offset reduced Public Dividend Capital	0.5	
Change in market rates	0.9	
Participation of EIB	(1.2)	
Funding terms achieved	(1.6)	
Scope change (Helipad and UGCP)	0.1	
Variations	0.8	(0.8)
Requirement at CBC		**24.2**

8.7.4 Figure 9 provides a reconciliation of how these costs will be funded in 2017-18 in both cash and Income & Expenditure terms.

Figure 9 - Funding the 2017-18 Unitary Payment

	Cash	I&E
	£m	£m
Costs:		
Unitary Payment - Revenue cost (Income & Expenditure Account)	18.4	18.4
Unitary Payment - Capital repayment (Balance Sheet)	2.6	-
Depreciation and dividend payable on Public Dividend Capital	3.2	7.0
Total Costs	**24.2**	**25.4**
Funding:		
Quality Efficiency Programme	3.4	3.4
Embedded reserves	4.0	4.0
Income contribution from increasing complexity of casemix	5.0	5.0
Hard FM savings on demolished buildings	3.0	3.0
Capital and capital charges saved on demolished buildings	5.8	7.0
Sub-total – Resources already secured	**21.2**	**22.4**
Income contribution from increasing complexity of casemix	3.0	3.0
Total Funding	**24.2**	**25.4**

8.7.5 The figure shows that £21.2m of the cash requirement and £22.4m of the income and expenditure requirement can be considered to be secured, either in the Trust's recurrent financial plan or represented by expenditure currently being incurred on buildings to be demolished once the new RLUH opens.

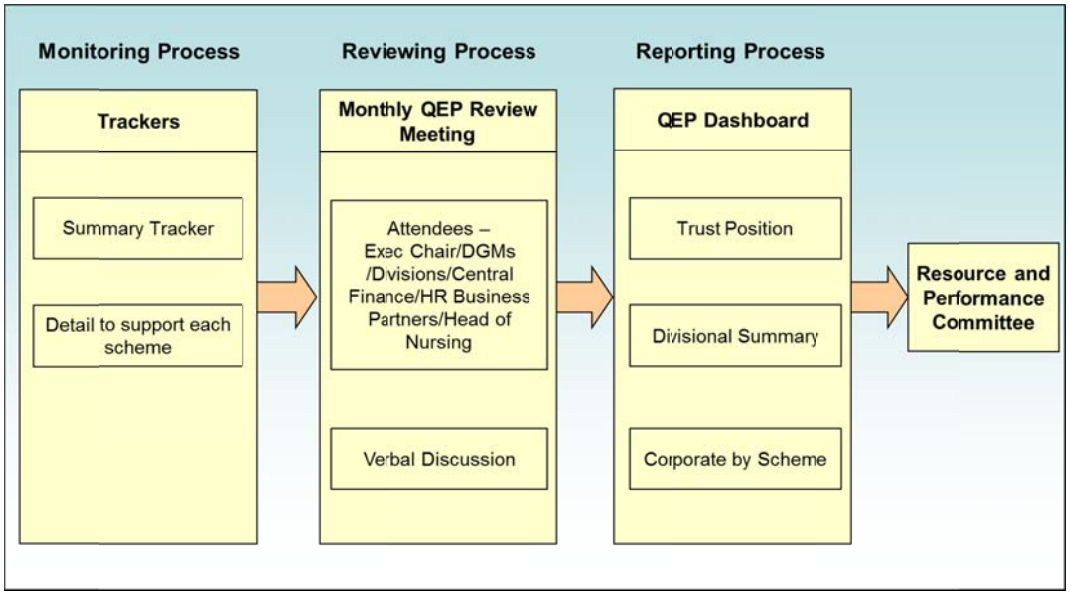
8.8 Quality Efficiency Programme

Governance

8.8.1 The Trust has a strong record in delivering Cost Improvement targets, now known as Quality Efficiency Programme (QEP), and has well-developed monitoring and management systems.

8.8.2 Performance is monitored at monthly QEP meetings and by the Executive Team and is reported in the QEP Dashboard provided on a monthly basis to the Resource and Performance Committee. The reporting structure is shown in the figure below.

Figure 10 - QEP Reporting Structure



8.8.3 Each QEP scheme has an identified lead, accountable for delivery and supported by other Trust resources (e.g. Finance, HR and the Lean Team).

8.8.4 The Trust also has a Programme Management Office to provide monitoring and management of the QEP.

8.8.5 The Trust is aware that to meet the ongoing requirement for delivery of efficiencies, a different transformational approach is needed. The Trust is also approaching the identification and scoping of efficiencies on a continuous basis rather than annually. The Trust has also engaged an outside company (Project I) to look at the overall management of projects and workstreams in the Trust, including the delivery of QEPs. The Trust is confident that the strengthening of the governance processes through a Programme Management Office will support the delivery of all projects, including the QEP Agenda.

Efficiency Requirement

8.8.6 The assumptions made by the Trust in respect of future efficiency requirements are informed by the financial assumptions issued by Monitor and used to assess FT applicant trusts. The base case assumptions are shown in Figure 11.

8.8.7 Affordability of the new RLUH had previously relied in part on the achievement in future years of a slightly higher level of efficiency saving than the national requirement. However, the reduction in the Unitary Payment and the use of Trust embedded reserves mean that the only contribution now required from QEP savings will be the £3.4m already achieved.

Figure 11 - Key QEP Assumptions

Year	QEP In-Year	Recurrent QEP In-Year	QEP Cumulative
	%	£'000	£'000
2013-14	4.80	19,980	19,980
2014-15	4.30	17,548	37,528
2015-16	4.50	18,986	56,514
2016-17	4.20	18,730	75,244
2017-18	3.50	15,628	90,872
2018-19	3.00	14,097	104,969
2019-20	2.40	13,320	118,289
2020-21	1.80	10,251	128,540
2021-22	1.80	10,615	139,155
2022-23	1.90	11,852	151,007

8.8.8 The efficiency improvements implemented in 2013-14 are shown in Figure 12.

Figure 12 - Detailed QEP 2013-14

	2013-14 £'000
Staff:	
Consultants	1,512
Junior Doctors	415
Nursing	2,254
Scientific, Therapies and Technical	1,849
Other Clinical	26
Non-Clinical	4,839
Sub-total Staff	**10,895**
Non-Staff:	
Drugs	1,778
Clinical Supplies	1,047
Other Supplies	4,058
Sub-total Non-Staff	**6,883**
Income	2,202
Total	**19,980**

8.8.9 The Trust is on target to deliver its financial plan for 2013-14 including the QEP requirement.

8.9 Other Capital Investment

8.9.1 Capital investment of just over £94m will be funded outside the PFI. A summary of this investment is shown in the following figure.

Figure 13 - Summary of Trust Funded Capital Investment

Scheme Element	Total	Expended prior to 2013-14
	£m	£m
Multi-Storey Car Park	8.500	1.050
Site completion and landscaping	6.891	-
University embedded accommodation	18.830	-
Development at Broadgreen Hospital	5.110	5.110
Equipment	33.302	-
Demolition of the existing facilities	13.250	-
Existing retail accommodation	1.900	-
Section 106 and 278	0.600	0.100
Reconfiguration of retained facility	0.250	-
Purchase of the Edwards Building	0.120	-
Underground Car Park	5.662	-
Total	**94.415**	**6.260**

8.9.2 These investments will be met from the Trust's capital resources (£66.965m), revenue account (£5.0m), transitional funding (£14.950m) and third party contributions (£7.5m).

8.10 Transitional Costs and Support

8.10.1 The DH recognises that major capital schemes will involve significant expenditure that cannot be met from national tariffs and therefore provides transitional funding.

8.10.2 NHS England has given formal agreement that transitional support of £32.9m will be made available in the period 2013-14 to 2017-18.

8.11 Third Party Funding

8.11.1 The financial plans for the new hospital include £7.5m third party funding to contribute to the purchase of equipment. The Trust intends to utilise £2.5m from existing charitable funds as the first major contribution to this requirement.

8.11.2 Since ABC the Trust has reviewed and updated its fundraising strategy to take account of the timetable for construction and this has been approved by the Board. The strategy now includes a plan for major donor work.

8.11.3 The Trust is now working on the appointment of an Appeal Board and this is expected to be in place by January 2014.

8.12 Base Case

Inflation Assumptions

8.12.1 Inflation assumptions used in the LTFM take account of guidance published by Monitor and the key outputs from the NHS Trust Development Authority 2013-14 Planning Guidance. These are set out in the following figure.

Figure 14 - Inflation Assumptions

Year	Tariff Uplift	Pay Costs	Non-Pay Costs	Drug Costs
	%	%	%	%
2013-14	(1.10)	1.00	1.00	13.00
2014-15	(2.50)	1.00	1.00	13.00
2015-16	(2.00)	1.00	1.00	12.00
2016-17	(2.00)	1.00	2.00	10.00
2017-18	(1.50)	1.00	2.00	10.00
2018-19	0.00	1.00	2.00	9.50
2019-20	0.00	1.00	2.00	9.50
2020-21	0.00	1.00	2.00	9.50
2021-22	0.00	1.00	2.00	9.50
2022-23	0.00	1.00	2.00	9.50

Financial Statements

8.12.2 Summaries of the projected Income & Expenditure Account, Balance Sheet and Cash Flow Statement for the period 2013-14 to 2022-23 are shown in the following figures.

Figure 15 - Projected Income & Expenditure Account 2013-14 to 2022-23

2012-13 £m	Detail	2013-14 £m	2014-15 £m	2015-16 £m	2016-17 £m	2017-18 £m	2018-19 £m	2019-20 £m	2020-21 £m	2021-22 £m	2022-23 £m
338.9	NHS Clinical Income	330.8	329.0	328.6	326.8	327.2	332.0	337.1	342.5	348.7	355.6
3.0	Non NHS Clinical Income	2.7	2.6	2.5	2.5	2.5	2.5	2.5	2.5	2.5	2.5
100.0	Other Income	95.7	95.3	93.4	95.0	102.2	94.1	86.4	86.5	86.5	86.3
441.9	Total Income	429.2	426.9	424.5	424.3	431.9	428.6	426.0	431.5	437.7	444.4
(244.2)	Employee Benefit Expenses	(229.9)	(226.4)	(221.8)	(217.7)	(214.7)	(212.2)	(209.9)	(207.5)	(205.0)	(202.7)
(53.2)	Drug Expenses	(53.3)	(58.9)	(64.6)	(69.7)	(75.5)	(81.9)	(89.3)	(97.9)	(107.4)	(118.0)
(34.7)	Clinical Supplies	(29.4)	(28.6)	(27.6)	(26.6)	(26.0)	(25.6)	(25.3)	(25.5)	(25.6)	(25.8)
(76.4)	Non-Clinical Supplies	(82.2)	(78.1)	(75.0)	(73.8)	(60.2)	(57.1)	(56.6)	(57.2)	(57.3)	(56.2)
(2.1)	PFI Operating Expenses	(2.1)	(1.5)	(1.5)	(4.9)	(11.5)	(10.5)	(3.9)	(4.2)	(4.7)	(4.6)
(410.6)	Total Operating Expenditure	(396.9)	(393.5)	(390.5)	(392.7)	(387.9)	(387.3)	(385.0)	(392.3)	(400.0)	(407.3)
31.3	EBITDA	32.3	33.4	34.0	31.6	44.0	41.3	41.0	39.2	37.7	37.1
7.1%	*EBITDA as % of Income*	*7.5*	*7.8*	*8.0*	*7.4*	*10.2*	*9.6*	*9.6*	*9.1*	*8.6*	*8.3*
0.2	Interest Received	0.2	0.5	1.9	1.4	1.0	0.9	0.9	1.1	1.3	1.5
(1.6)	Interest Expense on Loans and Leases	(1.3)	(1.6)	(1.5)	(1.3)	(16.1)	(15.9)	(15.7)	(15.4)	(15.2)	(14.9)
(14.3)	Depreciation	(14.8)	(15.1)	(14.9)	(14.6)	(18.8)	(17.0)	(16.8)	(16.2)	(15.8)	(15.7)
(7.1)	PDC Dividend	(6.0)	(4.6)	(5.7)	(7.7)	(8.0)	(7.5)	(7.6)	(7.3)	(7.1)	(6.9)
8.5	Net Surplus (Deficit) excluding impairments	10.4	12.6	13.8	9.4	2.1	1.8	1.8	1.4	0.9	1.1
(0.7)	Impairments	(57.9)	(0.9)	(0.9)	-	(43.6)	-	-	-	-	-
7.8	Net Surplus (Deficit) including impairments	(47.5)	11.7	12.9	9.4	(41.5)	1.8	1.8	1.4	0.9	1.1
-	Further Normalising Adjustment	-	(2.5)	(2.5)	(2.5)	-	-	-	-	-	-
8.5	Normalised Net Surplus	10.4	10.1	11.3	6.9	2.1	1.8	1.8	1.4	0.9	1.1

Figure 16 - Projected Balance Sheet Summary 2013-14 to 2022-23

2012-13 £m	Detail	2013-14 £m	2014-15 £m	2015-16 £m	2016-17 £m	2017-18 £m	2018-19 £m	2019-20 £m	2020-21 £m	2021-22 £m	2022-23 £m
	Non-current assets										
230.5	Property, plant and equipment	163.2	154.0	161.1	183.4	173.3	178.8	170.8	163.6	156.8	150.1
-	Property, plant & equipment (PFI)	-	-	-	-	232.9	228.7	224.6	220.5	216.4	212.3
2.1	Trade and other receivables	1.7	1.7	1.7	1.7	1.7	1.7	1.7	1.7	1.7	1.7
232.6	Total Assets: Non-current	164.9	155.7	162.8	185.1	407.9	409.2	397.1	385.8	374.9	364.1
	Current assets										
6.1	Inventories	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0
25.5	Receivables and Other Current Assets	17.1	17.1	17.1	17.0	17.3	17.1	17.0	17.1	17.3	17.5
8.2	Prepayments	0.2	13.9	76.8	118.2	0.2	0.2	0.2	0.2	0.2	0.2
18.6	Cash and cash equivalents	35.9	55.2	74.8	41.0	41.5	30.2	40.1	48.4	55.9	63.4
58.4	Total Assets: Current	59.2	92.2	174.7	182.2	65.0	53.5	63.3	71.7	79.4	87.1
	Current liabilities										
(34.7)	Deferred Income, Provisions and Accruals	(25.9)	(24.1)	(39.5)	(43.6)	(32.1)	(24.8)	(25.0)	(24.7)	(24.5)	(24.0)
(13.9)	Payables	(20.3)	(20.1)	(20.3)	(20.4)	(20.4)	(20.4)	(20.5)	(20.8)	(21.1)	(21.4)
-	PFI Liability	-	-	-	-	(2.7)	(3.0)	(3.0)	(3.0)	(3.2)	(4.0)
(48.6)	Total Liabilities: Current	(46.2)	(44.2)	(59.8)	(64.0)	(55.2)	(48.2)	(48.5)	(48.5)	(48.8)	(49.4)
9.8	Net Current Assets(Liabilities)	13.0	48.0	114.9	118.2	9.8	5.3	14.8	23.2	30.6	37.7
	Non-Current liabilities										
(2.3)	Provisions	(2.3)	(3.6)	(2.8)	(2.5)	(2.3)	(0.8)	(0.6)	(0.3)	-	-
(13.6)	Payables and Other Liabilities	(12.3)	(11.4)	(10.3)	(9.4)	(8.2)	(7.6)	(6.5)	(5.5)	(4.6)	(3.8)
-	PFI Liability	-	-	-	-	(157.3)	(154.4)	(151.3)	(148.3)	(145.2)	(141.2)
(15.9)	Total Liabilities: Non-current	(14.6)	(15.0)	(13.1)	(11.9)	(167.8)	(162.8)	(158.4)	(154.1)	(149.8)	(145.0)
226.5	Total Assets Employed	163.3	188.7	264.6	291.4	249.9	251.7	253.5	254.9	255.7	256.8
	Taxpayers' Equity										
162.8	Public Dividend Capital	162.8	176.5	239.4	256.8	256.8	256.8	256.8	256.8	256.8	256.8
12.5	Retained earnings	(34.9)	(23.2)	(10.2)	(0.8)	(42.3)	(40.5)	(38.7)	(37.3)	(36.5)	(35.4)
51.2	Revaluation reserve	35.4	35.4	35.4	35.4	35.4	35.4	35.4	35.4	35.4	35.4
226.5	Total Taxpayers' Equity	163.3	188.7	264.6	291.4	249.9	251.7	253.5	254.9	255.7	256.8

Figure 17 - Projected Cash Flow Summary 2013-14 to 2022-23

2012-13 £m	Detail	2013-14 £m	2014-15 £m	2015-16 £m	2016-17 £m	2017-18 £m	2018-19 £m	2019-20 £m	2020-21 £m	2021-22 £m	2022-23 £m
31.3	EBITDA	32.3	33.4	34.0	31.6	44.0	41.3	41.0	39.2	37.7	37.1
(0.7)	Exclude non-cash I&E items	(0.1)	-	-	-	-	-	-	-	-	-
30.6	EBITDA (Revised)	32.2	33.4	34.0	31.6	44.0	41.3	41.0	39.2	37.7	37.1
	Movements in Working Capital										
(0.1)	Inventories	0.1	-	-	-	-	-	-	-	-	-
(7.1)	NHS Trade Receivables, Current	5.7	0.1	0.1	(0.1)	-	(0.2)	(0.1)	(0.2)	(0.2)	(0.2)
(0.4)	Non NHS Trade Receivables, Current	1.8	(0.1)	-	0.2	(0.3)	0.3	0.3	-	-	-
(2.4)	Other Receivables	1.3	-	-	-	-	-	-	-	-	-
11.5	Prepayments	8.0	(13.7)	(63.0)	(41.4)	118.0	-	-	-	-	-
7.3	Provisions and Deferred Income	(13.4)	(1.7)	15.0	4.4	(11.7)	(6.8)	(0.2)	(0.2)	(0.2)	(0.3)
0.3	Trade Payables	(0.5)	(0.2)	0.2	0.1	(0.1)	0.1	-	0.3	0.3	0.3
1.3	Other Payables	7.3	-	-	-	-	-	-	-	-	-
(4.4)	Payments on Account	4.7	-	-	-	-	-	-	-	-	-
6.0	Increase/(Decrease) in Working Capital	15.0	(15.6)	(47.7)	(36.8)	105.9	(6.6)	-	(0.1)	(0.1)	(0.2)
(0.2)	Increase/(Decrease) in non-current provisions	-	1.3	(0.8)	(0.2)	(0.2)	(1.4)	(0.3)	(0.3)	(0.3)	-
36.4	Cash Flow from Operations	47.2	19.1	(14.5)	(5.4)	149.7	33.3	40.7	38.8	37.3	36.9
(20.5)	Capital Expenditure	(21.8)	(6.8)	(22.9)	(37.0)	(4.6)	(18.3)	(4.8)	(4.8)	(4.9)	(5.0)
15.9	Cash Flow before Financing	25.4	12.3	(37.4)	(42.4)	145.1	15.0	35.9	34.0	32.4	31.9
-	Public Dividend Capital received	-	13.7	63.0	17.4	-	-	-	-	-	-
(7.2)	Dividends paid	(6.0)	(4.6)	(5.7)	(7.7)	(8.0)	(7.5)	(7.6)	(7.3)	(7.1)	(6.9)
(1.6)	Interest (paid) on loans and Leases	(1.2)	(1.6)	(1.5)	(1.3)	(16.1)	(15.9)	(15.7)	(15.4)	(15.2)	(14.9)
0.2	Interest Received	0.2	0.5	1.9	1.4	1.0	0.9	0.9	1.1	1.3	1.5
(1.3)	Repayment of loans & leases	(1.1)	(1.0)	(0.8)	(1.2)	(121.4)	(3.8)	(3.6)	(4.1)	(3.9)	(4.1)
(9.9)	Net Cash Inflow/(Outflow) from Financing	(8.1)	7.0	56.9	8.6	(144.5)	(26.3)	(26.0)	(25.7)	(24.9)	(24.4)
6.0	Net Cash Inflow / Outflow	17.3	19.3	19.5	(33.8)	0.6	(11.3)	9.9	8.3	7.5	7.5

8.13 Monitor Ratios

8.13.1 Monitor has introduced a new risk rating approach, the "Continuity of Services Risk Rating" based on two financial ratios:

- Liquidity - to indicate whether the Trust can meet its operational cash obligation
- Capital Servicing Capacity - to indicate whether the Trust can service its debts including Private Finance Initiative capital and interest payments.

8.13.2 The overall risk rating is calculated by applying an equal weighting to the two ratios with the outcome being measured against four levels of risk:

- A risk rating of 4 - Sufficient financial headroom and liquidity and Monitor will continue to monitor performance on a quarterly basis
- A risk rating of 3 - Emerging or residual financial concerns resulting in the need for monthly monitoring
- A risk rating of 2 - Financial performance is such that the provider may be subject to investigation to determine whether it is in breach of its Continuity of Services licence condition
- A risk rating of 1 - In extreme cases Monitor may consider the level of risk represents financial distress and initiate contingency planning to ensure continuity of services and access in the event of special administration to indicate whether the provider can meet its operational cash obligation.

8.13.3 A Continuity of Services rating of 4 is projected up to 2016-17. In 2017-18 the Trust commences payments under the PFI scheme and this affects the capital servicing ratio. In addition, in 2017-18 only the ratio is impacted by the bullet payment giving rise to a rating of 1. This will be discussed with Monitor as it is regarded as a technical breach rather than a performance failure.

8.13.4 The Continuity of Services risk ratings are shown in Figure 18.

Figure 18 - Monitor Risk Ratings

Financial Year	Liquidity	Capital Servicing	Continuity of Services
2013-14	4	4	4
2014-15	4	4	4
2015-16	4	4	4
2016-17	4	4	4
2017-18	4	1	3
2018-19	4	2	3
2019-20	4	2	3
2020-21	4	2	3
2021-22	4	2	3
2022-23	4	2	3

8.13.5 The Trust is therefore able to achieve the necessary risk rating.

8.14 Downside Case

8.14.1 Sensitivity analysis has been undertaken to assess the impact on affordability of changes in key variables in the base case.

General

8.14.2 Additional efficiency requirements arising from a broad range of issues have been applied.

Readmissions

8.14.3 This sensitivity provides for an increase in readmissions that would lead commissioners to apply financial penalties.

Length of Stay

8.14.4 This sensitivity provides for the failure to achieve the target length of stay reductions meaning that additional beds would need to be staffed.

Variations to Tariff

8.14.5 Projections of future income assume that the national tariff will reduce (see Figure 14 - Inflation Assumptions). This sensitivity follows Monitor direction and provides for the possibility that other tariff changes may further reduce Trust income.

QEP Delivery

8.14.6 The need to deliver significant year on year cost efficiencies is challenging and this sensitivity recognises that the Trust may fail to achieve the full requirement in any one year.

PFI Funding

8.14.7 The Unitary Payment is strongly influenced by funding terms and the assessment made in this CBC reflects expected market terms with an interest rate buffer of 50 basis points. It is recognised that financial terms available for the development may worsen and this sensitivity provides for a substantial increase.

Activity Projections

8.14.8 Future activity projections anticipate an increase in casemix complexity that will result in increased income. This sensitivity assumes that this income will not be received as activity migrates to other providers.

Training & Education

8.14.9 The Trust is a major provider of undergraduate and postgraduate medical education and consequently receives funding from the SIFT and MADEL levies. This sensitivity recognises the potential for education to be provided in other settings, resulting in an income reduction for the Trust.

Associated Financial Impacts

8.14.10 The specific downsides set out above would have an associated financial impact as cash balances would be substantially reduced. The implications would include increased PDC Dividend payments and reduced interest receivable.

8.15 Trust Mitigation to the Downside

8.15.1 The Trust has identified a number of mitigations available to offset the impact of the sensitivities. Consideration has been given only to areas which the Trust can influence directly and are not dependent on external or fortuitous factors. These are as follows:

Use of Embedded Reserves

8.15.2 In setting its annual budget, the Trust creates a series of reserves in order to both fund pressures expected to arise in year, for example inflation, and as a more general contingency to address risks and unforeseen pressures. The Trust has uncommitted recurrent reserves totalling £12m which could be applied to potential future downside scenarios.

Hold Vacancies

8.15.3 This is a non-recurrent measure, increasing the vacancy factor in specific financial years. Trust turnover rates are typically in excess of 10% per annum and taking action by not filling posts for a particular year will produce savings. The Trust already has an Executive Vacancy Panel in place to review and approve recruitment to vacancies.

Bed Occupancy

8.15.4 The Trust has delivered a substantial bed reduction programme which has seen bed numbers fall from over 1,000 to below 800 in the last four years. In a significant downside scenario the Trust could potentially choose to run with a higher level of bed occupancy in order to allow closure of further beds. A 4% increase in average occupancy would allow a reduction of 28 beds, equivalent to one ward.

Pay Award Review

8.15.5 From 2013-14 onward, the Trust has assumed that an annual pay award of 1% will be made. In the instance that the Trust is facing a future significant downside scenario, it may choose not to award its staff a pay increase on the basis that it would make no commercial sense to allow costs under Board control to increase to unaffordable levels.

8.15.6 The current mitigation is based on an assumption that non-payment of pay awards could be introduced for the 2015-16 and 2016-17 financial years.

Agenda for Change Increment Review

8.15.7 The Trust may choose not to award pay increments on the basis that it would make no commercial sense to allow costs under Board control to increase to unaffordable levels. The current mitigation is based on an assumption that increments would not be paid for the three years commencing with the 2015-16 financial year.

Overtime Payments

8.15.8 Revisions would be made to working practices to ensure that overtime premium payments are eliminated where possible.

Growth in Market Share

8.15.9 The activity projections agreed with commissioners make no judgement on the potential for a new RLUH attracting a greater number of referrals as a consequence of the facilities which would be unrivalled in the city. This mitigation provides for a relatively modest increase in activity.

Review of Non-Core Functions

8.15.10 A number of departments provide services which support the Trust's overall business objectives, without delivering direct patient care and therefore not part of the Trust's core business. A number of these functions could be downsized in response to the level of savings that the Trust would need to identify. As an example this could include elements of the Finance and Information departments.

Review of Sick Leave Payments

8.15.11 The Trust would review the opportunities to reduce the cost of sickness absence.

Estate Rationalisation

8.15.12 The Trust delivers its services from three hospital sites (RLUH, Dental and Broadgreen) with assets totalling some £230m. A level of site rationalisation is already planned in connection with further bed closures and more efficient use of existing space. However, in a downside scenario there are a series of more radical actions that could be taken to generate further savings.

Medical Staff Review

8.15.13 The Trust would undertake a review of local Merit Awards and Consultant sessions for Supporting Professional Activities.

Nursing Shift Patterns

8.15.14 Changes to nursing shift patterns could be introduced.

Staff Contribution

8.15.15 A scheme could be introduced in which staff would contribute four days per annum in unpaid work. A similar scheme has recently been introduced in a local authority. This would be a temporary measure bringing an annual saving of £1.6m and securing job numbers.

PFI Interest Rate Buffer

8.15.16 The Unitary Payment assessment includes an interest rate buffer of 50 basis points against the potential for future interest rate increases, a contingency that amounts to £0.9m per annum.

8.15.17 Whilst the Trust cannot exercise influence over general market conditions, it can influence the date of Financial Close and therefore react to adverse market conditions if necessary.

Associated Financial Impacts

8.15.18 These mitigations would combine to provide a further benefit in respect of interest received and PDC dividend payable as a consequence of the increased cash balances that would result. This is reversing the negative effect included in the downside scenario.

8.16 Downside Case and Mitigations - Outcome

8.16.1 Figure 19 sets out the impact of the downside scenarios and Figure 20 shows the mitigations that the Trust would apply:

Figure 19 - Downside Case

	2014-15 £m	2015-16 £m	2016-17 £m	2017-18 £m	2018-19 £m	2019-20 £m	2020-21 £m	2021-22 £m	2022-23 £m
Base Case Surplus	**10.1**	11.3	6.9	2.1	1.8	1.8	1.4	0.9	1.1
Downside Adjustments									
General	(2.1)	(5.4)	(8.9)	(12.2)	(12.2)	(12.2)	(12.2)	(12.2)	(12.2)
Readmissions	(4.7)	(5.5)	(4.7)	(4.7)	-	-	-	-	-
Length of stay	(1.0)	(1.0)	(1.0)	(1.1)	(1.1)	(1.1)	(1.1)	(1.1)	(1.2)
Variations to Tariff	(1.0)	(2.0)	(3.0)	(3.9)	(3.9)	(3.9)	(3.9)	(3.9)	(3.9)
QEP Delivery	(5.3)	(5.4)	(5.6)	(4.9)	(4.5)	(4.0)	(3.1)	(3.2)	(3.5)
PFI Funding Costs	-	-	-	(0.9)	(0.9)	(0.9)	(1.0)	(1.0)	(1.0)
Activity Projections	(1.3)	(2.4)	(2.8)	(3.5)	(4.0)	(4.0)	(4.0)	(4.0)	(4.0)
Training & Education	(0.4)	(1.0)	(1.6)	(2.3)	(3.3)	(4.4)	(5.6)	(5.7)	(5.7)
Associated Financial Impacts	(0.1)	(0.7)	(1.3)	(2.5)	(3.8)	(5.0)	(6.1)	(7.5)	(8.8)
Total Downside Scenario	**(15.9)**	**(23.4)**	**(28.9)**	**(36.0)**	**(33.7)**	**(35.5)**	**(37.0)**	**(38.6)**	**(40.3)**
Revised Surplus	**(5.8)**	**(12.1)**	**(22.0)**	**(33.9)**	**(31.9)**	**(33.7)**	**(35.6)**	**(37.7)**	**(39.2)**

Figure 20 - Mitigations

	2014-15 £m	2015-16 £m	2016-17 £m	2017-18 £m	2018-19 £m	2019-20 £m	2020-21 £m	2021-22 £m	2022-23 £m
Surplus following downsides	**(5.8)**	**(12.1)**	**(22.0)**	**(33.9)**	**(31.9)**	**(33.7)**	**(35.6)**	**(37.7)**	**(39.2)**
Mitigations									
Embedded Reserves	12.0	12.2	12.4	8.4	8.5	8.7	8.8	9.0	9.1
Hold Vacancies	1.0	-	-	1.0	-	1.0	-	1.0	-
Increased Bed Occupancy	-	-	-	0.9	0.9	0.9	0.9	0.9	0.9
Pay Award Review	-	2.2	4.3	4.3	4.5	4.2	4.1	4.1	4.1
Agenda for Change Increments	-	1.5	3.0	4.6	4.6	4.6	4.6	4.6	4.6
Overtime Payments	-	0.3	0.5	0.5	0.5	0.5	0.5	0.5	0.5
Increased Market Share	1.3	2.4	2.8	3.5	4.0	4.0	4.0	4.0	4.0
Review of Non-Core Functions	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.6
Review of sick leave payments	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5
Estates Rationalisation	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3
Medical Staff Review	-	-	-	1.9	1.9	1.9	3.5	1.9	1.9
Nursing Shift Patterns	-	-	-	2.5	2.5	2.5	2.5	2.5	2.5
Staff contribution	-	1.6	1.6	1.6	-	-	-	-	-
PFI Interest Buffer	-	-	-	0.9	0.9	0.9	0.9	0.9	0.9
Associated Financial Impacts	0.2	0.7	1.4	2.5	3.8	5.0	6.1	7.5	8.8
Total Mitigations	**16.9**	**23.3**	**28.4**	**35.0**	**34.5**	**36.6**	**38.3**	**39.3**	**39.7**
Revised Surplus	**11.1**	**11.2**	**6.4**	**1.1**	**2.6**	**2.9**	**2.7**	**1.6**	**0.5**
Financial Criteria									
Liquidity Ratio	4	4	4	4	4	4	4	4	4
Capital Servicing Ratio	4	4	4	1	2	2	2	2	2
Overall Normalised Risk Rating	**4**	**4**	**4**	**3**	**3**	**3**	**3**	**3**	**3**

8.16.2 The Trust could therefore mitigate the impact of the projected downside.

8.16.3 Whilst the Trust recognises a rating of three would correspond to "emerging or residual financial concerns" and therefore result in monthly monitoring, for the Trust this is more a recognition of the inability to secure a rating in excess of 2 on the Capital Servicing Rating.

8.17 Financial Due Diligence

8.17.1 The Trust can confirm:

- The financial model has been populated with the preferred funder's terms and has been optimised to reduce the cost to the Trust
- The Unitary Payment and its indexation have been calculated correctly
- The preferred funder has agreed to hold its prices until the end of February 2014 subject to a material negative change in market conditions or an unexpected deterioration in the project's final credit risk profile.

8.18 Conclusion

8.18.1 The project is shown to be affordable under the base case assumptions and the Trust has demonstrated a robust strategy for meeting in full the potential additional costs of an extensive downside case.

9 Workforce

9.1 Introduction

9.1.1 This chapter confirms how the Trust Board gains assurance that the workforce is of sufficient size, with the right knowledge and skills to deliver excellent patient care and services, against a backdrop of transformation and efficiency gains, together with assurance on continual progress towards a culture of an engaged and motivated workforce.

9.2 Workforce Planning & Education

9.2.1 The Trust believes that its workforce is its greatest asset and it accounts for over 60% of revenue expenditure. Delivering the required transformational change depends crucially on having a capable workforce of the right capacity. At the same time, significant changes that impact on care delivery and the shape of the future workforce are continuing to emerge locally and nationally such as advances in information management and technology, changing models of care and expectations post Francis.

9.2.2 The Trust has a clear strategic workforce plan developed through high level modelling that assesses the potential shape of its workforce in 2016-17 on the basis of reasonable assumptions, for example changes to service delivery, technology and redesigned roles. The plan has been developed by clinical engagement and benchmarking and will be kept under review to ensure it is responsive to changing needs.

Figure 21 – Potential Impact of Workforce Reductions by Staff Group

Staff Groupings	Current March 2013 wte	Equivalent wte reductions				
		2013-14	2014-15	2015-16	2016-17	Total
Consultants	270	(10)	(10)	(8)	-	(28)
Junior Medical	452	-	-	-	-	-
Nursing	1,666	(35)	(35)	(35)	(41)	(146)
Dental	22	-	-	-	-	-
Scientific, Therapeutic & Technical	983	(25)	(16)	-	-	(41)
Other Clinical Staff	558		-	-	(69)	(69)
Non Clinical Staff	1,413	(190)	(70)	(53)	-	(313)
Total Staff	**5,364**	**(260)**	**(131)**	**(96)**	**(110)**	**(597)**

9.2.3 From this year, the delivery and detail of the future workforce will be driven by dynamic clinical operational workforce planning linked to business planning designed to challenge and refine the shape and distribution of workforce within emerging models of care, activity and impact of the economic climate.

9.2.4 For example, Consultants' increased involvement in leadership, their contributions to innovation and research and their training of junior doctors is crucial to the maintenance and improvement of patient care. The expansion in Consultant numbers over the last six years has now slowed but was necessary to ensure the delivery of specialist services and in moving towards 24/7 delivery of care. Changes in technology and productivity are predicted to impact on overall Consultant workforce by 2016-17, which need to be tested when developing and delivering the following improvements and initiatives.

- The need for a seven-day consultant delivered service
- Consultants delivering full shift resident duties in some specialties
- Continually increasing demand in activity resulting in increased commissioning and related financial resources
- Commitment to achieving national access targets
- Local service development and improvement initiatives
- EWTD requirements where training and education has to be delivered in a shorter time
- Reductions in trainee numbers in some specialties
- Difficulties in recruitment to acute specialties, for example Emergency Medicine.

9.2.5 It is anticipated that workforce reductions and efficiencies will be met mainly by reductions in payroll costs rather than headcount.

9.2.6 The Trust has successfully implemented a Voluntary Redundancy scheme for bands 7-9 during 2013-14 under the new TDA Severance Scheme and is reviewing the structure and skill mix of the clinical administration workforce to drive further efficiencies whilst maintaining quality of clinical services.

9.2.7 National changes to Agenda for Change have been implemented, for example removal of enhancements during sick leave and plans are in place to review all roles at band 8C and above in collaboration with local trusts for consistency.

9.2.8 Implementation of the Sickness Improvement Plan means sickness is at its lowest rate for the last three years (4.38% August 2013) and sickness in nursing has reduced considerably in the last four months to just above the 4% target.

9.2.9 Further work is underway to review overtime, agency and bank costs against vacancies and establishments to identify where efficiencies can be made.

9.2.10 Skilled, competent staff are key to quality and patient safety. As a leading teaching hospital, the Trust is committed to providing the right environment for all learners, to flourish and to embed continuous professional development and life-long learning. Workforce Planning includes ensuring that the Trust continues to provide and/or commissions excellent teaching, education and learning programmes, which stretch students and staff encouraging them to continually improve the quality of patient care.

9.2.11 This year, the Trust has strengthened education governance by formally recognising Board level responsibility for education shared by the Medical Director and HR Director. The Trust has also developed a new Education & Learning Strategy to address the requirements of national education reform and delivery of the Education Outcomes Framework, aiming for an excellent teaching environment, a fully trained and competent workforce, CPD, apprenticeships and vocational learning, whilst developing talent and succession planning.

9.2.12 This year, the Trust piloted a new electronic approach to appraisal and has increased completion rates from 76% to 95%.

9.2.13 The Trust Board has approved a new approach to talent management and succession planning ‘Royal Talent’, which includes a pilot with the Leadership Academy on holding ‘talent’ conversations during appraisal.

9.3 Workforce Transformation

9.3.1 Moving towards the new Royal, the Trust has an opportunity to innovate services to strengthen its position in relation to competitors, and to enter into collaborative ventures to deliver improved services. For example, this year, the Trust has entered into a joint venture with Aintree University Hospitals in forming 'Liverpool Clinical Laboratories', which delivers improved and efficient services at reduced cost with potential for expansion and increased income.

9.3.2 Future success is dependent on a flexible workforce, with a mind-set of continuous improvement, responsive to change and affordable. In support of this, the Trust has a team of service improvement and Organisational Development practitioners to improve quality and productivity whilst also driving down cost.

9.3.3 Service improvement activity follows defined project management principles, to include staff and wider stakeholder engagement, enabling the Trust to embrace and deliver sustainable change. The team provides expertise and training to optimise patient flow and processes, for example notable successes in reducing length of stay, minimising readmissions and maximising theatre capacity. From this year, the team will support the delivery of transformational change on the "Journey to 2018" and the outputs of new clinical service models, together with changed job roles and skill mix will be used to inform and redefine the workforce plan on at least an annual basis.

9.4 Workforce Wellbeing

9.4.1 There is considerable research that a focus on staff health and wellbeing significantly enhances patient outcomes and experience, reduces staff sickness absence and increases staff motivation and engagement. The Trust has offered a range of wellbeing activities for a number of years to include fitness classes, staff choir, book club, walks, fun runs and social events.

9.4.2 Over the last two years the Trust has developed a 'Health and Wellbeing Strategy', linked wellbeing to its sickness improvement plan, introduced a Staff Support Service, including a 24/7 counselling service and introduced training for staff and managers on stress management and mental health.

9.4.3 The Trust is also included in a national health and wellbeing working party under the guidance of Dame Carol Black and has been commended for its success. Further work is underway this year to closely link health and wellbeing to staff engagement to strengthen impact on patient care and outcomes and staff wellbeing.

9.5 Workforce Engagement & Leadership

9.5.1 The Trust Board views staff engagement and empowerment as essential in driving affordable quality and change. Executive and other Directors have taken part in 'back to the floor' programmes, the Chief Executive has regular 'walkabouts' and sessions to meet staff and Executive and Non-Executive Directors regularly attend and participate in staff engagement events.

9.5.2 Implementation of the Trust's 'Every One Matters' strategy puts staff at the heart of improving services for patients and their families and for themselves. Through 'staff conversations', staff are listened to, including what gets in the way of delivery of excellent care, and their ideas to transform services and reduce waste. Ideas are fed back into the 'Every One Matters' implementation plan and progress is reported to the Trust Board.

9.5.3 During 2013, staff engagement success included a 'reward and recognition' scheme led by one of the wards, leading to a reduction of complaints and incidents, reduced sickness, improved appraisal and mandatory training. Improved team work in Pharmacy (Aseptic Service) has reduced time for processing medication and the patient experience has been transformed for patients with a fracture as staff from the Emergency Department to the Fracture Clinic have greater understanding of the entire patient journey.

9.5.4 To embed still further, Divisions and corporate teams are implementing the new Trust model for staff engagement, 'Going Local - Six Steps to the Stars', by hosting their own local staff engagement sessions to continually listen to staff, and setting up 'Star Teams' to address local issues and to implement their own ideas which matter to them and their patients.

9.5.5 During 2013, the Trust joined the National Pioneer Programme for staff engagement with seven other Trusts to strengthen our approach and to learn from other Trusts. Part of the pioneer programme included a 'Pulse Check' based on the NHS staff survey. About 1,500 staff completed the survey in October 2012, which was repeated in August 2013. All but one question had improved and all responses were higher than other Trusts on the programme. The biggest improvement was 'day to day frustrations that get in the way are quickly identified and resolved'. Also last year, the Trust was in the top 20% for our 60% response rate to the NHS Staff Survey 2012, from 51% in 2011.

9.5.6 The Trust believes that leadership exists at every level of the organisation, and includes all staff as leaders, ensuring a fit-for-purpose workforce with the right leadership skills and behaviours, empowered to drive organisational change capable of delivering exceptional services at greater quality and reduced cost.

9.5.7 The Trust has an agreed set of leadership profiles and behaviours at four levels based on Trust values used during appraisal to ensure capability, competence and confidence of managers and staff. Development programmes are in place, with an expectation that managers complete the 'people management' training required of them.

9.5.8 This year, the Trust has introduced a leadership network for the most senior clinicians and managers to meet, share learning, and take part in master classes. The Trust has also reviewed and changed its leadership arrangements at senior level to strengthen decision-making capability and accountability.

9.5.9 Also this year, the Trust has enhanced leadership capability and learning by setting up an external coaching register for senior clinicians and managers and 26 senior leaders are currently in coaching relationships.

9.5.10 During 2013, the Trust developed a 'Care and Concern' programme, which includes a range of scenarios filmed at the RLUH, using actors to depict real issues and complaints for groups of staff in teams to discuss the impact of customer service skills and behaviours.

9.6 Conclusion

9.6.1 The Trust has a clear strategic direction for its workforce. It has constructed an initial high level model that projects the potential shape of its workforce towards 2018 on the basis of reasonable assumptions and has demonstrated that the anticipated pace of change is realistic.

9.6.2 The training, development and support which has already been put in place for staff (which continues to be enhanced) provides assurance that we have a forward thinking workforce, fully equipped to deal with the challenges and opportunities in transforming the future of the Trust towards 2018 and beyond.

10 Risk Management

10.1 Introduction

10.1.1 The Trust's risk management policy requires risks to be identified, evaluated using risk grading criteria and monitored corporately through a Trust risk register.

10.1.2 In addition, the Risk Pooling Scheme for Trusts (RPST), of which the Trust is a member, requires a risk register "for all individual management units…, for significant projects, and for the organisation as a whole;" for all risks requiring treatment, actions to be determined, appropriately recorded and implemented in order of priority using appropriate decision making tools; and continuous reporting to (and where necessary consultation of) the Trust Board.

10.1.3 The approach to project risk management has been designed to fulfil these requirements. In particular, it is based around a project risk register that is embedded within the Trust's overall risk management processes. The identification and management of risk is an integral part of the working ethos within the project.

10.1.4 The focus for project risk reporting is the Redevelopment Committee. In addition, procedures are in place to ensure project risk reporting is integrated into corporate reporting to the Trust Board.

10.2 Methodology

10.2.1 The risk register has been developed in line with the risk management approach approved by the Project Board, including:

- Risk identification, including the maintenance of a project risk register
- The level at which risk will be managed
- Risk analysis, including assessment of likelihood, impact and proximity
- Mitigating actions, including appointing an owner responsible for the management of each risk.

10.3 Reporting

10.3.1 Risks scored in the 'critical' category are reviewed by the Core Team on a monthly basis with the outcome reported to the Redevelopment Committee by exception as part of the monthly Project Update Report.

10.3.2 All risks scored in the 'non-critical' category are reviewed on a quarterly basis.

10.3.3 A report detailing the outcome of the latest review of all risks is presented to the Redevelopment Committee on a quarterly basis.

10.3.4 As the Trust's internal auditor, Mersey Internal Audit Agency has undertaken reviews of the risk process and risk management within the project. These reviews have received a high level of assurance.

10.4 Key Risks

10.4.1 The eight key risks currently identified as critical to the project and their associated mitigation strategies are shown in Figure 22.

10.4.2 The risk matrix has been reviewed and updated and overall remains consistent with that presented in the ABC. Risks will continue to be reviewed as the project progresses and major project milestones are completed.

Figure 22 - Key Risks

Risk	Risk Impact	Mitigation
Approvable Affordable Scheme		
External influences impacting adversely on market terms and the Unitary Payment	▪ The scheme becomes unaffordable ▪ DH ratio would not be met ▪ Potential scheme delay ▪ Requirement for Trust to achieve greater QEP	▪ CBC includes mitigations against adverse market conditions ▪ Maintain overview of market conditions and respond to changes ▪ EIB Board approval received ▪ DH confirmation of £94m capital contribution ▪ ABC approval includes financial buffer ▪ Funding Competition - funder selection within affordability parameters
Clinical Service Delivery Model		
Inability to deliver clinical service redesign	▪ Ability to deliver Trust performance targets is compromised	▪ CCG and NHS Merseyside approval to OBC, DABC and CBC ▪ Delivery of the Outside Hospital infrastructure is well advanced. ▪ Migration Path to plan and track changes ▪ Extended Clinical Design Group engagement on new hospital and service change ▪ Revised governance structure to include service transformation
Activity levels differ from projections (including failure of external stakeholders to agree and deliver on their elements of the CSDM)	▪ Affordability and/or capacity issues	▪ Commissioner support to OBC, DABC and CBC and activity projections ▪ Manage any reductions in the estate through Broadgreen site ▪ Continued development of Trust marketing strategy ▪ Close monitoring of commissioner intentions ▪ Service transformation included as part of project governance and includes *The Healthy Liverpool Programme*
IM&T/Equipment		
Equipment requirements incorrectly stated	▪ Affordability issues	▪ ERM fully developed based on signed off 1:50 drawings for key departments ▪ Table top transfer assessment undertaken ▪ Prioritised work on, IM&T and Category F equipment and top 20 equipment types by value

Risk	Risk Impact	Mitigation
Workforce		
Failure to plan and deliver workforce service change	▪ Industrial relations problems ▪ Staff motivation or recruitment and retention harmed ▪ Management focus on the day to day leaves services unreformed ▪ Services wrong shape/size ▪ Insufficient staff to maintain service quality or unable to achieve workforce QEP	▪ Clarity of workforce planning ▪ Service improvement methodology agreed with weekly executive level scrutiny panel to prioritise and approve projects ▪ Programme Management Office to monitor QEPs ▪ Significant progress in partnership working with Staff Side ▪ Staff engagement strategy ▪ Benchmarking against other Acute Teaching Trusts
Strategic		
Aspects of the project timetable, including stakeholder and planning approval, not delivered	▪ Scheme slippage against key milestones or failure to secure agreement for new hospital ▪ Trust buildings not fit for purpose	▪ Interim measures targeting capital investment to minimise the risk of major facilities failure ▪ Excellent relationships with Liverpool City Council, DH, PFU and Commissioners ▪ Planning Approval secured in September 2013 ▪ Funder selection made in October 2013
Moratorium or slowdown in health spending	▪ Scheme unaffordable ▪ Scheme delay	▪ Scheme costs significantly less at Financial Close than at OBC ▪ Assessed in downside scenario, scheme deliverable without reliance on future growth ▪ Independent assessment has identified significant benefit to the economy
Impact of major service reconfiguration	▪ Funding reductions ▪ Activity impacting on capacity and/or affordability	▪ Stakeholder buy in to CSDM ▪ Commissioner support to DABC & CBC.

10.5 Commercial Risk Profile and Risk Allocation

10.5.1 There have been very limited changes to the project since approval of the ABC and changes to the commercial agreement simply reflect the incorporation of those issues agreed during dialogue and as part of the Final Bid. As such the overall risk profile remains consistent with that at ABC.

11 Timetable and Project Structure

11.1 Introduction

11.1.1 The purpose of this chapter is to confirm that appropriate and effective governance and project controls remain in place, and that ongoing arrangements reflect the shift from procurement to construction, transfer of FM services and operational delivery.

11.2 Organisational Structure and Governance - Current

11.2.1 The overarching governance structure and responsibilities are unchanged from that presented within the ABC and are summarised below:

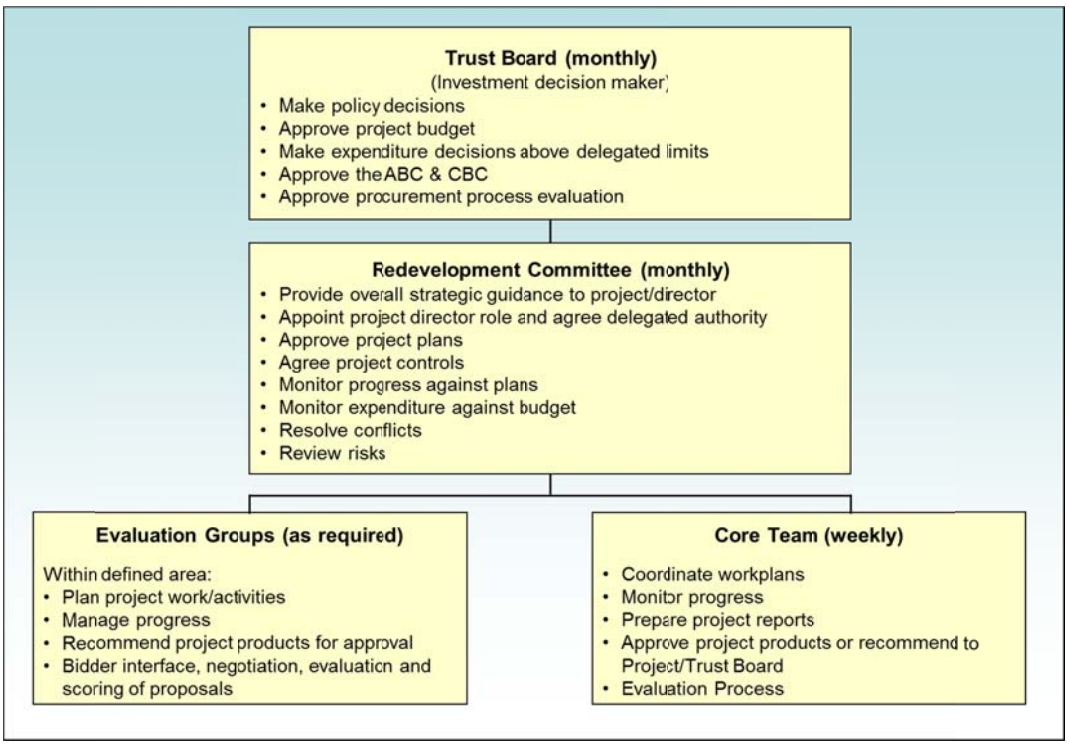
- The *investment decision maker* takes the investment decision for use of resources. This is the *Trust Board.*
- The *Senior Responsible Owner* defines the scope of the project and is the individual who is personally accountable for its success. This is the *Chief Executive.*
- The *Project Director* is responsible for day to day management and decisions on behalf of the Senior Responsible Owner to ensure that the project's objectives are delivered. This is the *Director of Strategy and Redevelopment.*
- The *Project Manager* has a full time commitment to the project managing and coordinating the integrated Project Team on a day to day basis.

Project Governance Model Current to Financial Close

11.2.2 A recent review of the terms of reference of the Project Board has informed the development of an updated structure leading up to and beyond Financial Close and into the construction stage. The Project Board has been constituted as a formal committee of the Trust Board and is now the Redevelopment Committee.

11.2.3 The governance model is set out in the figure below:

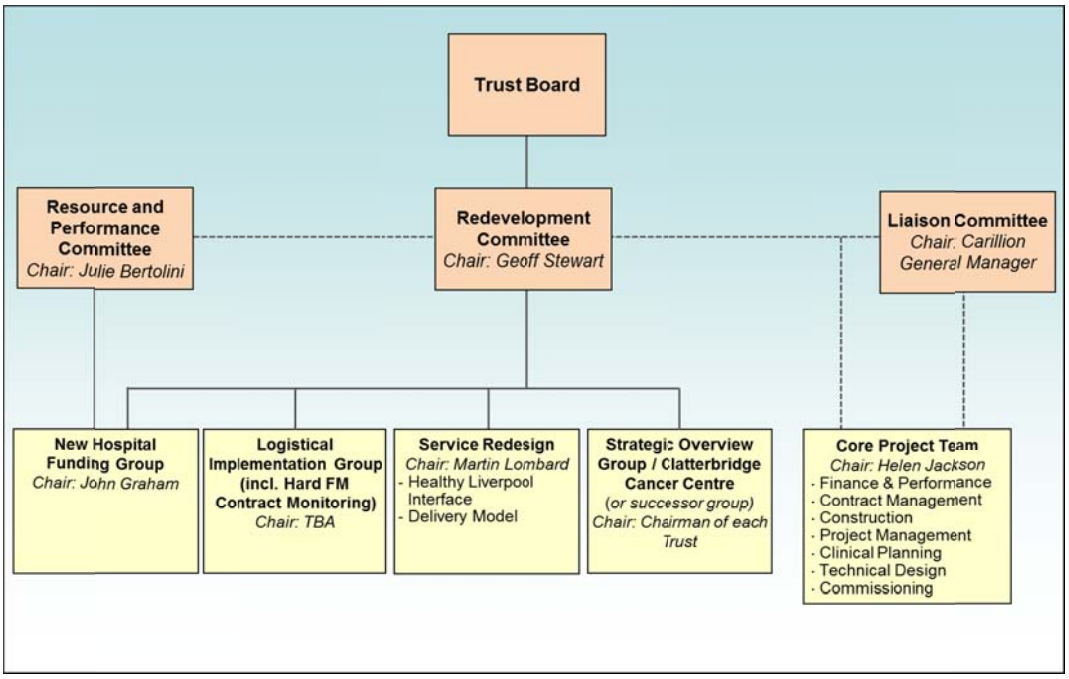
Figure 23 - Current Project Governance Model



11.3 Organisational Structure and Governance - Construction Stage

11.3.1 The revised structure has been developed to steer the project and associated interdependent workstreams through the construction stage of the project and respond to the need to effectively manage not only the construction of the new RLUH, but also to embrace service redesign, transformation and implementation logistics. This structure enables delivery to be better informed and more responsive to operational and strategic decision making.

Figure 24 - Governance Structure from Financial Close to Handover

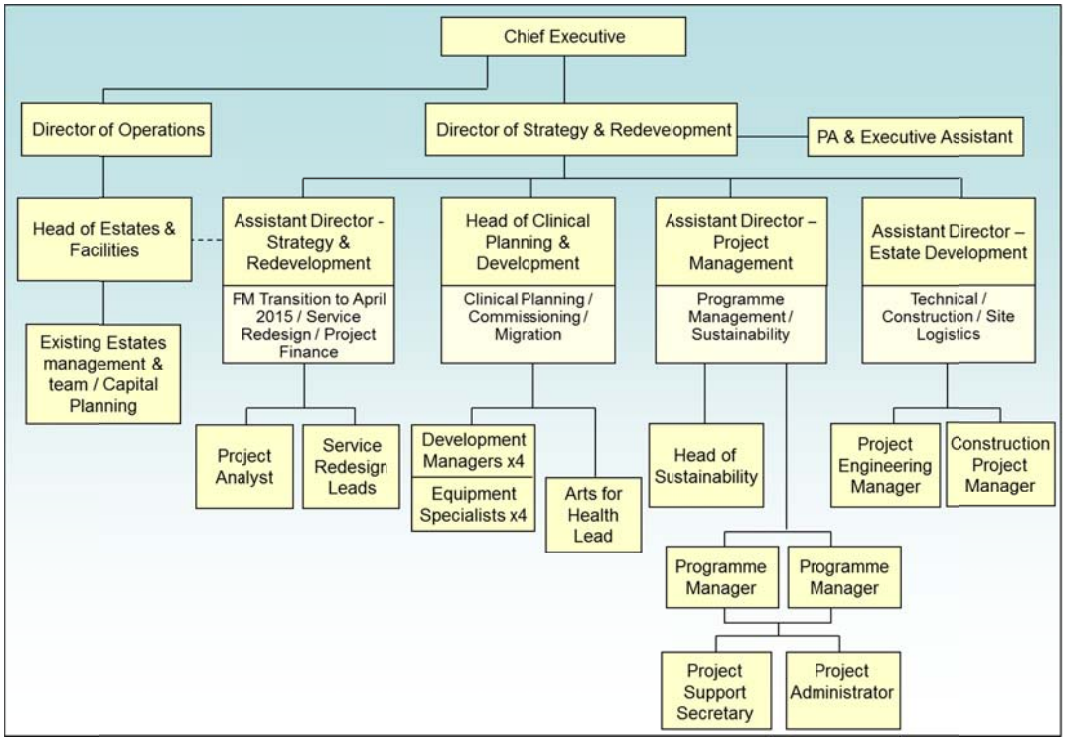


11.4 Project Team Structure - Construction Stage

11.4.1 The project team structure, roles and responsibilities have been reviewed and associated resource requirements have been established taking the project from Financial Close to handover of the new facilities.

11.4.2 The structure provides for consistency of roles and personnel and is set out in the figure below:

Figure 25 - Project Structure Construction Stage to Handover and Service Transfer



11.4.3 The need to work with the existing estate management team is recognised, moving through Financial Close to construction, planning for the implementation and delivery of Interim Services and in the transition to a new operational hospital.

11.4.4 The introduction of new service redesign roles recognises that the Trust needs to plan services and implement change management and workforce redesign prior to the move to the new hospital. The Trust already has a team of Lean-trained, Service Improvement and Organisational Development staff, which will become integral to the design of services, implementing change management and redesigning the workforce; the “Journey to 2018” Transformation Programme.

11.4.5 High level objectives for the construction phase of the project are as follows:

- To plan, organise, manage and deliver, in partnership with the preferred bidder and other stakeholders, the construction of the new RLUH and the redevelopment of the hospital site
- Delivery of service redesign in readiness for the move into the new hospital
- Implement change management to support service redesign
- To actively manage risks associated with the construction and to monitor and report in accordance with governance protocols
- To manage the change control system
- To implement systems for monitoring the scheme within the terms of the Project Agreement
- To oversee the introduction of payments to the preferred bidder for the provision of Interim FM Services in line with the Payment Mechanism
- To monitor incidents arising from the Interim FM services, assess response times and service failures
- To ensure training and induction of FM contract management personnel

- To enforce payment regimes in accordance with the Payment Mechanism and FM service standards
- To develop and implement the practicalities of the small works protocol set out in Schedule 22
- To plan, organise and manage, in partnership with the preferred bidder, the transfer of staff from the existing hard FM service provider, delivering effective staff-mapping through to steady state which minimises any impact on FM staff and cost to the Trust.

11.4.6 From construction through to occupation, to plan and deliver:

- A safe site for patients, visitors and staff
- Management of technical advisors
- Monitor and check Reviewable Design Data, ensuring design and technical issues are dealt with promptly
- Monitoring contractor progress, manage and resolve change requests
- Management of the capital contributions process
- Management and involvement in IT inspections, review IT reports
- The development of operational services commissioning plans
- Technical commissioning of buildings
- The requirements of equipment transfer and procurement
- To develop with the preferred bidder a snagging programme in accordance with the Project Agreement
- Timely and safe transfer of services, staff and patients into the new buildings.

11.4.7 These objectives will be delivered, whilst ensuring that clinical and other services continue uninterrupted.

11.4.8 Project management protocols will provide for:

- Management of the project budget and reporting on a monthly basis
- Internal and external stakeholder consultation and communication
- Post Project Evaluation and Benefits Realisation Planning
- A Gateway review
- A governance structure which enables the progression of interdependent projects including service redesign, logistics and the potential relocation of the Clatterbridge Cancer Centre.

11.5 Transitional Plan Summary

11.5.1 The Trust's Transitional Plan sets out how appropriate planning and preparation for the construction and operational phases will be assured. In accordance with ABC approval requirements, this has been shared with DH.

11.5.2 Contract and construction management is integral to the successful delivery of the project and the Trust has followed recommendations contained in HM Treasury Guidance. This includes adequate resourcing and ensuring continuity throughout the project lifetime.

11.5.3 Estates services at the RLUH site have been outsourced since 1995 and the Trust also has a contract for the provision of Energy Services including a CHP plant, which has been in place since 1993. The Trust has therefore accumulated many years' experience of managing service delivery contracts with private sector contractors and a dedicated team exists.

11.5.4 The hard FM element of the PFI contract replaces the existing estate maintenance service, with staff transferring to the new FM provider under TUPE. The existing Head of Estates & Facilities, who manages the existing contract and has been closely involved in negotiations with bidders and the evaluation of FM proposals, is expected to undertake the contract manager role in the PFI contract.

11.5.5 All senior members of the Trust's project team have previous experience of delivering at least one previous large NHS hospital PFI project. This includes not just the procurement phase of the project but also the construction phase, the management of interim services and the handover to full service delivery. The Trust team therefore has a good understanding of the practical requirements and a track record of satisfying them.

11.5.6 The plan will continue to be developed as the project develops, into the transfer of interim FM services and full service delivery post-handover of the new hospital.

11.6 Gateway 3 Outcome and Close Out of Recommendations

11.6.1 A Gateway 3 was undertaken at the end of October 2012. The overall assessment outcome was amber. The four recommendations have been closed out.

11.7 Key Milestones

11.7.1 The key project milestones are set out in the figure below:

Figure 26 - Key Project Milestones

Milestone	Date Target	Date Achieved
ABC Approval and Preferred Bidder Letter agreed	28 June 2013	1 July 2013
Submission of Planning Application	28 June 2013	27 June 2013
Commence Funding Competition	5 July 2013	4 July 2013
1:200 Clinical Planning sign off	1 August 2013	1 August 2013
Trust to ratify outcome of Stage 1 Funding Competition	27 August 2013	22 August 2013
Stage 1 Funding Competition completed	28 August 2013	29 August 2013
Secure Planning Approval	17 September 2013	24 September 2013
Receive final bids from funders shortlisted in the Funding Competition	25 September 2013	25 September 2013
1:50 design development, clinical and technical documents for – Project Co Proposals	September – March 2014	
Funding Competition – Select funder(s)	4 October 2013	16 October 2013
Trust Board receive completed CBC	29 October 2013	29 October 2013
CBC issued to DH	29 October 2013	
Independent Tester tender outcome approved by Trust Board	29 October 2013	
Expiry of Judicial Review period for Planning Approval	5 November 2013	
CBC DH Approval	27 November 2013	
Contract and Financial Close	16 December 2013	
Commence Mobilisation/Site Clearance	February 2014	
Commence Construction	February 2014	
Transfer of Hard FM – Interim Services	April 2015	
Handover of new RLUH – Phase 1	March 2017	
Trust Commissioning	June 2017	
Service Commencement	June 2017	
Decommissioning and Asbestos Removal	January 2018	
Demolition – Phase 2	June 2019	
Landscaping and UGCP – Phase 3	March 2020	

11.8 Immediate Timetable

11.8.1 Following approval of the CBC, the project can move swiftly to Financial Close.

- Planning approval is in place and judicial review period will have expired
- Funding competition complete and funders selected, EIB fully engaged
- Detailed design completion in accordance with the Financial Close programme
- PA and Schedules agreed, commercial parameters and risk profile unchanged from ABC
- The funding documentation is being assembled in agreement with the preferred funder, the EIB, the legal due diligence advisor, the sponsors and the Trust
- Final Credit Committee approval from the preferred funders.

12 Addendum

12.1 Introduction

12.1.1 This addendum provides an update to the CBC approved by the Department of Health and reflects the actual position achieved at Financial Close on 13 December 2013.

12.2 Department of Health Approval Conditions

12.2.1 The Trust confirms that the project remains within the parameters set by the DH at ABC and those re-affirmed in the Department's letter of approval dated 11 December 2013:

- The Unitary Payment remains within the ceiling of £21.5m
- The project remains affordable in terms of its impact on the overall income and expenditure position of the Trust
- The project achieved Financial Close within the approved timescale
- The project continues to be supported by the Trust's commissioners
- The Project Agreement and Schedules remain substantially unchanged
- The Trust is confident that the Quality Efficiency Programme for 2013-14 and future financial years will be delivered
- The Trust has worked closely with The Hospital Company to develop a Transition Plan to take the project through construction and into the operational phase
- The Senior Debt Funding Competition was undertaken with the full approval of PFU and HM Treasury.

12.3 Contract Documentation

12.3.1 With the exception of the completion of gaps that could not be concluded until Financial Close, the Project Agreement and its Schedules remain as set out in Chapter 6 of this report.

12.4 Finance

Known or Potential Variations

12.4.1 Section 8.6 identifies a number of known or potential variations to the new hospital at an estimated capital cost of £10m. The Trust and the New Hospital Company worked together in the weeks leading up to Financial Close to incorporate any known variations into the base construction cost and this meant that the funding provided for potential variations has reduced to £6.075m.

12.4.2 The final capital funding requirement and its sources is shown in Figure 27:

Figure 27 – Final Capital Funding Requirement and Sources

	CBC	Financial Close
	£m	£m
Construction Cost	266.3	269.3
Variations	10.0	6.1
Development, financing and other costs	53.6	54.0
Total resource requirement	**329.9**	**329.4**
Trust cash	24.0	24.0
Public Dividend Capital	94.0	94.0
PFI	211.9	211.4
Total funding resources	**329.9**	**329.4**

Revenue Implications of the PFI

12.4.3 Terms achieved at Financial Close means that the Trust's forecast financial position is improved from that given in the CBC as the business case had been required to include an interest rate buffer of 50 basis points and this falls away at Financial Close.

12.4.4 Whereas the CBC had used an annual Unitary Payment of £21.0m (at 2017-18 price base), the figure achieved at Financial Close was £19.95m. This annual reduction of just over £1m means that the requirement to secure future resources has also fallen. Adjustment must also be made for a slightly revised valuation for the new hospital incorporating the variation noted above.

12.4.5 Figure 28 provides a reconciliation of how these costs will be funded in 2017-18 in both cash and Income & Expenditure terms.

Figure 28 - Funding the 2017-18 Unitary Payment

	Cash	I&E
	£m	£m
Costs:		
Unitary Payment - Revenue cost (Income & Expenditure Account)	16.4	16.4
Unitary Payment - Capital repayment (Balance Sheet)	3.6	-
Depreciation and dividend payable on Public Dividend Capital	3.3	7.4
Total Costs	**23.3**	**23.8**
Funding:		
Quality Efficiency Programme	3.4	3.4
Embedded reserves	4.0	4.0
Income contribution from increasing complexity of casemix	5.0	5.0
Hard FM savings on demolished buildings	3.0	3.0
Capital and capital charges saved on demolished buildings	5.8	7.0
Sub-total – Resources already secured	**21.2**	**22.4**
Income contribution from increasing complexity of casemix	2.1	1.4
Total Funding	**23.3**	**23.8**

12.5 Risk Management

12.5.1 The CBC identified eight key risks as critical to the project. The achievement of Financial Close and contract signature means the elimination of the risk that external factors might impact adversely on market terms and therefore the Unitary Payment.

12.6 Timetable

12.6.1 Key project milestones are set out in the figure below:

Figure 29 - Key Project Milestones

Milestone	Date Target	Date Achieved
CBC issued to DH	29 October 2013	29 October 2013
Independent Tester tender outcome approved by Trust Board	29 October 2013	29 October 2013
Expiry of Judicial Review period for Planning Approval	5 November 2013	5 November 2013
CBC DH Approval	27 November 2013	11 December 2013
Contract and Financial Close	16 December 2013	13 December 2013
Commence Mobilisation/Site Clearance	February 2014	
Commence Construction	February 2014	
Transfer of Hard FM – Interim Services	April 2015	
Handover of new RLUH – Phase 1	March 2017	
Trust Commissioning	June 2017	
Service Commencement	June 2017	
Decommissioning and Asbestos Removal	January 2018	
Demolition – Phase 2	June 2019	
Landscaping and UGCP – Phase 3	March 2020	