HHCT-PSHFT Merger Programme

Assessment of Transaction LTFM in relation to proposed transaction

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14 September 2016

KPMG LLP
8th Floor
15 Canada Square
London
E14 5GL

Tel +44 (0)20 7311 1559
Fax +44 (0)20 7311 4077
richard.mills@kpmg.co.uk

Private and confidential

14 September 2016

The Directors
Peterborough and Stamford Hospitals
NHS Foundation Trust
Peterborough City Hospital
Bretton Gate
Peterborough
PE3 9GZ

The Directors
Hinchingbrooke Health Care NHS Trust
Hinchingbrooke Hospital
Hinchingbrooke Park
Huntingdon
Cambridgeshire
PE29 6NT

Attention: Mark Avery, Deputy Director – System Transformation

Ladies and Gentlemen

Hinchingbrooke Health Care NHS Trust ('HHCT') and Peterborough and Stamford Hospitals Foundation Trust ('PSHFT') proposed merger – Transaction LTFM assessment

In accordance with the terms of reference set out in our Contract Letter dated 11 July 2016, as amended by our Variation Letter dated 19 August 2016 (together 'our Contract Letter'), we enclose our report on the transaction LTFM assessment in relation to the proposed merger of HHCT and PSHFT.

The scope of work set out in our Contract Letter is attached as Appendix 1 to the report. This details the agreed scope of our enquiries. The important notice overleaf should be read in conjunction with this letter.

Our report is for the benefit and information only of those Parties who have accepted the terms and conditions of our Contract Letter and should not be copied, referred to or disclosed, in whole or in part, without our prior written consent, except as specifically permitted in our Contract Letter. To the fullest extent permitted by law, we will not accept responsibility or liability to any other party (including those Parties' legal and other professional advisers) in respect of our work or the report.

Yours faithfully

KPMG LLP

KPMG LLP

Important notice

- This document has been prepared in accordance with our contract letter dated 11 July 2016, as amended by our Variation Letter dated 19 August 2016. It is subject to the terms and conditions of that contract.
- Our fieldwork for Part 1 (the initial assessment of the standalone Long Term Financial Models ('LTFM') commenced on 18 July 2016 and was completed on 21 July 2016. A draft report outlining our initial findings and recommendations from Part 1 was issued dated 22 July 2016. Our fieldwork for Part 2 (update to the assessment of the standalone LTFMs) commenced on 22 August and was completed on 30 August 2016. The final version of the report dated 14 September covering Part 1 and Part 2 should be read in conjunction with this report.
- Our fieldwork for Part 3 (assessment of the Transaction LTFM) commenced on 1 September 2016 and was completed on 7 September 2016. We have not undertaken to update our report for events or circumstances arising after that date
- Our report is for the benefit and information of the addressees only and should not be copied, referred to or disclosed, in whole or in part, without our prior written consent. The scope of work for this report, included in Appendix 1, has been agreed by the addressees and to the fullest extent permitted by law we will not accept responsibility or liability to any other party (including the addressees' legal and other professional advisers) in respect of our work or the report.
- In preparing our report, our primary source of information has been information supplied by Hinchingbrooke Health Care NHS Trust ('HHCT') and Peterborough and Stamford Hospitals Foundation Trust ('PSHFT'). We do not accept responsibility for such information and have not in this stage of our work sought to establish its reliability through reference to other evidence.
- The scope and assessment procedures carried out are limited and substantially less than those which would have been performed in a due diligence exercise. You should note that our findings do not constitute recommendations to you as to whether or not you should proceed with the potential merger of HHCT and PSHFT. Instead, they are intended to highlight key issues and further required actions to be considered as HHCT and PSHFT further advance their LTFMs and proceed towards drafting a Full Business Case for the merger.
- Our report makes reference to 'KPMG Analysis'; this indicates only that we have (where specified) undertaken certain analytical activities on the underlying data to arrive at the information presented; we do not accept responsibility for the underlying data.
- The analysis of underlying surplus/deficit is for indicative purposes only. We have sought to illustrate the effect on reported surplus/deficit of adjusting for those items identified by management in the course of our work that may be considered to be 'non-recurring' or 'exceptional'. However, the selection and quantification of such adjustments is necessarily judgmental. Because there is no authoritative literature or common standard with respect to the calculation of 'underlying' surplus/deficit, there is no basis to state whether all appropriate and comparable adjustments have been made. In addition, while the adjustments may indeed relate to items which are 'non-recurring' or 'exceptional' or otherwise unrepresentative of the trend, it is possible that the surplus/deficit for future periods may be affected by such items, which may be different from the historical items.
- The information contained herein is of a general nature and is not intended to address the circumstances of any particular individual or entity. Although we endeavour to provide accurate and timely information, there can be no guarantee that such information is accurate as of the date it is received or that it will continue to be accurate in the future. No one should act on such information without appropriate professional advice after a thorough examination of the particular situation.
- We must emphasise that the realisation of the prospective financial information set out within our report is dependent on the continuing validity of the assumptions on which it is based. We accept no responsibility for the realisation of the prospective financial information. Actual results are likely to be different from those shown in the prospective financial information because events and circumstances frequently do not occur as expected, and the differences may be material.
- This report has been reviewed by the management of Hinchingbrooke Health Care NHS Trust or Peterborough and Stamford Hospitals Foundation Trust, who have provided comments on the factual accuracy of its contents.

Glossary of terms

A&E	Accident and Emergency
APR	Annual Plan Return
BPPC	Better Payments Practice Code
C&P CCG	Cambridge and Peterborough CCG
CCG	Clinical Commissioning Group
CFO	Chief Financial Officer
CIP	Cost Improvement Programme
EBITDA	Earnings Before Interest, Tax, Depreciation and Amortisation
FYxx	Financial Year xx
HHCT	Hinchingbrooke Health Care NHS Trust
ITFF	Independent Trust Financing Facility
LIFT	Local Improvement Finance Trust
LTFM	Long Term Financial Model
MFF	Market Forces Factor
MRI	Magnetic Resonance Imaging
NHSI	NHS Improvement
OBC	Outline Business Case
PAS	Patient Administration System
PDC	Public Dividend Capital
PFI	Private Finance Initiative
PLICS	Patient Level Information Costing System
PPE	Property, Plant and Equipment
PSHFT	Peterborough and Stamford Hospitals NHS Foundation Trusts
QIPP	Quality, Innovation, Productivity and Prevention
SEP	Strategic Estates Partnership
SLR	Service Line Reporting
SOCI	Statement of Comprehensive Income
SOFP	Statement of Financial Position
STF	Sustainability Transformation Funding
STP	Sustainability and Transformation Plan
TPB	Transition Programme Board

Contents

The contacts at KPMG in connection with this report are:

Richard Mills
Healthcare Advisory Director,
Tel: 020 7311 1559
richard.mills@kpmg.co.uk

Sue Day
Healthcare Advisory Partner,
Tel: 020 7311 4831
susan.day@kpmg.co.uk

Craig Morton
Healthcare Advisory Manager,
Tel: 020 7896 4961
craig.morton@kpmg.co.uk

Edward Aronson
Healthcare Advisory Manager,
Tel: 020 7311 8783
edward.aronson@kpmg.co.uk

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Executive Summary

Executive Summary - Introduction

Introduction

Background

- The Boards of Peterborough and Stamford Hospitals NHS Foundation Trusts ('PSHFT') and Hinchingbrooke Health Care NHS Trust ('HHCT') approved the Outline Business Case ('OBC') recommending the merger of the two organisations in May 2016.
- The current timetable is geared towards the merged organisation being operational from 1 April 2017. As a result, the two organisations are running an accelerated transaction process, committed to the following timetable:
  - 30 September 2016: Completion of final business case ('FBC'), subject to public engagement
  - 30 September 2016: Submission of FBC to NHS Improvement ('NHSI'); and
  - 1 April 2017: Transaction completion
- Both organisations are working closely to complete as much of the pre-transaction requirements as possible, utilising an internal PHFT/HHCT programme team.
- A Transition Programme Board ('TPB') is overseeing the work of the programme team. Membership includes members of the programme team, both boards, local commissioners (Cambridge and Peterborough CCG), and NHSI.

Context of this report

- HHCT, PSHFT and the TPB are seeking independent assessment of the certain key elements of the merger programme are key points throughout the process, to provide a degree of comfort to both Trust Boards.
- KPMG has therefore been engaged to independently assess the standalone Long Term Financial Model ('LTFM') that each of the organisations are in the process of developing, as well as the merger/transaction LTFM that will support the FBC for the merger.
- KPMG undertook an initial Part 1 assessment of the standalone LTFMs in July 2016, with a draft report outlining our initial findings and recommendations issued dated 22 July 2016. In late August prior to the completion of the transaction LTFM we undertook a further review of the standalone LTFMs and produced a progress report following our July findings dated 6 September 2016.
- We have subsequently undertaken an assessment of the Transaction LTFM in early September 2016, with the main areas of focus covered in this report covering:
  - Assess the assumptions alignment between HHCT and PSHFT
  - Assess the combined LTFM for the merger of HHCT and PSHFT
  - Summarise and comment on the combined Trust downside and mitigated downside scenarios.

Executive Summary - Key findings

The following pages summarise the key findings contained within this report as a result of our work to date, reflecting our Part 3 assessment of the Transaction LTFM. For each of the areas identified we have provided our comments and recommendations, as well as our view of the relative importance of each area for consideration by the TPB, HHCT and PSHFT in assessing the next steps required going forwards in terms of further advancement of the Transaction LTFM and with respect to drafting the FBC for the merger.

The relative importance allocated to each area is based on the perceived importance for the TPB to address in advancing the merger programme, as well as on our experience of how NHS Improvement carry out its transaction reviews and where they will look to probe and challenge the LTFM and FBC.

Area	Description	KPMG Comment and Recommendation	Import-ance
Preparation of the Transaction LTFM	▪ The Trusts have made significant progress in the development of the Transaction LTFM in a short space of time. ▪ We note that the Transaction LTFM we assessed has been populated using the two standalone LTFMs as of 10 August 2016. Changes and corrections following this date are being documented in a register so that all recommendations and changes can be made at once to a master version. ▪ The preparation of the Transaction LTFM reflects the aggregation of the HHCT and PSHFT baselines, with adjustments overlaid for: – Alignment of common assumptions; – Merger synergies; – Transaction costs; – Funding assumptions; and – Other transaction level adjustments (e.g. PDC dividend calculation).	▪ We note that the approach to constructing the Transaction LTFM has been carried out within a short timespan (approximately one month). ▪ Whilst the work to make the two standalone LTFMs as consistent as possible has likely simplified the process, we would typically expect the Transaction LTFM to take much longer to develop. ▪ We have highlighted specific observations in the detail of the report around the Transaction LTFM set up and modelling that require addressing prior to submission to NHSI. This includes three false error checks that have been identified on the 'control tab'. These we believe are substantive errors, not just rounding, and should be corrected before submission to NHSI. ▪ We recommend that the modelling team should continue to refine and develop the Transaction LTFM in the coming weeks as the FBC is further developed, including the development of workforce modelling as recommend in our report on the standalone LTFMs.	**M**
Clinical synergies	▪ Savings from clinical collaboration are currently under development, with further detailed work in this area planned over the coming months and beyond the proposed transaction date as the clinical strategy and operating model is further developed.	▪ We would typically expect the clinical benefits from merger (including detailed worked up financial benefits) to be clearly set out in a business case as merger synergies, rather than CIP. ▪ In our experience, NHSI's view is that the primary driver for merging NHS Trusts is increased quality of patient care and clinical synergies, with back-office savings as an additional benefit.	**H/M**

Executive Summary - Key findings (cont.)

Area	Description	KPMG Comment and Recommendation	Import-ance
Clinical synergies (Cont.)	▪ We understand that the TPB and both Boards wish to present a public message that back-office (non-clinical) synergies will result from the merger and that savings from clinical collaboration will be treated as delivering against forecast CIP targets, rather than as merger synergies.	▪ However, we understand that the TPB has discussed the treatment of clinical savings as CIP with NHSI. ▪ In addition, we recognise that the draft FBC explains that all financials savings achieved from clinical integration will be used to reinvest in services, and to meet the improvements in efficiency and cost reduction that are required of all services annually to offset the pressure of annual cost inflation. ▪ We recommend that the Trust continues to work on the detailed financial benefits that will arise from clinical collaboration. ▪ Where clinical synergies cannot yet be quantified, we recommend that that these are included in the FBC as qualitative clinical synergies. An initiative such as putting best practise in place across both trusts may not yet be quantifiable, but will yield greater quality of care for patients and is therefore still a clinical synergy. ▪ We recommend that both Trusts continue to engage with clinicians in the development of these synergies, as strong clinical engagement is a key factor in developing quality plans and in maximising the chances of a successful implementation.	**H/M**
Back-office synergies	▪ The Trusts are targeting £9.0 million of back-office synergies, with £6.7 million planned from reduction in WTE and which is supported by the production of bottom up merged operating models for the back-office functions. ▪ However, there is currently a unidentified savings gap of £642k, predominantly relating to non-pay. ▪ We understand that the phasing of the current worked up pay savings have not yet been worked through in full, as these will be subject to staff consultation.	▪ We recommend that the Trusts continue to work on the development of additional back-office savings to fill the current gap to the LTFM and that this is reflected in the Transaction LTFM prior to submission, as appropriate. This should include a detailed assessment of corporate CIP schemes against planned merger synergies to avoid potential double counting. ▪ We recommend that if savings cannot be identified to close the gap, this should be reflected in an adjustment to the Transaction LTFM baseline or through further sensitivity analysis for delaying or reducing synergies. ▪ We also recommend that further work be completed on the detailed plans for delivery of synergies as part of further development of integration planning. ▪ We recommend that the TPB reassess the phasing of both pay and non-pay savings, as well as considering this as part of sensitivity analysis.	**H/M**

Executive Summary - Key findings (cont.)

Area	Description	KPMG Comment and Recommendation	Import-ance
Transaction costs	■ £13.8 million of transaction costs have been estimated and reflected in the Transaction LTFM. ■ At present we understand that the transaction costs identified have been worked up for the period leading up to the transaction date and that transaction costs for FY18-FY20 have been based on estimates and are subject to change following agreement of the merger and subsequent setting up of the different transition workstreams. ■ For redundancy these costs have been worked up from the back-office synergy calculations and are at present based on midpoint.	■ We recommend that the transaction costs are further developed in detail to determine the quantum and phasing of costs focusing on post merger as the current plans are primarily worked up in detail to the merger date. ■ In addition, specific workstreams should focus on further developing the robustness of transitional cost assumptions that have been factored into the Transaction LTFM. ■ We recommend that to ensure the redundancy costs are robust that a workforce review be completed to establish whether the midpoint assumption is correct. ■ We understand that the trust has undertaken an external IT/IS review. The findings for the recent review should also be factored in to the working paper for IT costs to ensure these are robust.	**H/M**
Funding	■ The Transaction LTFM assumes that the merged Trust will be financed by the draw down of additional loans to support the merged Trust's cash position across the forecast period given the operating deficits that are projected. ■ Additional funding from loans has been factored into the Transaction LTFM to reflect this, given no transitional or central funding has yet been agreed for the merger with commissioners, DH or NHSE.	■ We recommend that the TPB continue to progress its conversations and negotiations with commissioners and central bodies regarding transitional or central funding, updating this into the Transaction LTFM when available to assess the impact on both the I&E and cash position. ■ The TPB should consider an additional sensitivity analysis to reflect a potential change in interest rate above forecast and how this will affect the surplus/deficit position of the merged Trust.	**H/M**
Risks and sensitivities	■ The TPB has considered and modelled six key sensitivities to the Transaction LTFM, including: – Assumption of no growth; – Non-delivery of income CIPs; – CIP delivery at 2%; – SEP – only 50% of income and delayed by one year; – Potential transaction costs/implementation – 50% increase; and – Non achievement of merger savings by 10% and delayed by one year	■ While the sensitivities that have been considered are broadly in line with our expectations, we recommend that the TPB reach agreement on the level of the SEP, standalone CIP and income CIP, and merger synergies to be included in the base case of the FBC and also in any downside sensitivity analysis. ■ This includes the TPB considering a realistic level of CIP to include in the base case across both PSHFT and HHCT, based on the internal due diligence that has been completed and when assessing against the Trusts' historical track record of delivering CIP, the current development of detailed plans underpinning forecast CIP and the financial grip and governance arrangements that are in place.	**H/M**

Executive Summary - Key findings (cont.)

Area	Description	KPMG Comment and Recommendation	Import-ance
Risks and sensitivities (cont.)	▪ A number of upside sensitivities have also been considered and modelled.	▪ In our experience, 10% non-achievement of merger synergies is a mild downside case. We recommend that the TPB consider the possibility of up to a 25% sensitivity, which might provide the TPB and the Boards with a better indication of what underachievement of synergies might look like. ▪ We recommend that the TPB consider a more prudent position with respect to the SEP sensitivity (given it is still uncommitted) to present a downside case that assumes the SEP does not happen at all. This would demonstrate that the TPB and Boards are aware of the risks of delivery and are not relying on this as a fundamental part of making the merger sustainable. ▪ We recommend that that CIP schemes and merger synergies are developed in further detail to give NHSI greater confidence that the schemes can be achieved on time and to the level included in the LTFM. ▪ We recommend that the Trusts' sensitivity analysis is further modelled to include the impact on the cash flow position of the downside case. ▪ We recommend that, following updates to the HHCT standalone LTFM with respect to the re-categorisation of income CIP, that the CIP sensitivity modelling is updated to reflect this change.	**H/M**
Mitigations	▪ We understand that the Trusts' mitigations are currently work in progress, based upon discussions that have taken place at the TPB and at Board level. ▪ However, we have not had sight of these as part of our assessment as they are still under development.	▪ We recommend that mitigations for the downside case are developed in detail to offset the deterioration in both the merged Trusts surplus/deficit and cash position. ▪ In our experience, best practice indicates that mitigations should be developed to a similar level of detail as to CIP plans, with supporting detailed financial analysis and implementation plans.	**H/M**

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Financial Overview

Financial overview - Transaction LTFM SOCI

SOCI overview - Transaction LTFM							
£m	FY17 Outturn	FY18 Forecast	FY19 Forecast	FY20 Forecast	FY21 Forecast	FY22 Forecast	CAGR FY18-22
Income							
Tariff income	241	347	355.7	363.9	375.6	387.8	2.25%
Other block or Cost and Volume contract	0	3.8	3.8	3.8	3.8	3.9	0.52%
Total NHS clinical Income	241	350.8	359.5	367.7	379.5	391.7	2.23%
Private patient revenue	0.7	2.2	2.5	2.8	2.9	3	6.40%
Other non protected revenue	0	0.7	0.7	0.7	0.7	0.7	
Other Operating revenue	42.8	41.9	42.8	45.2	48.2	48.8	3.10%
Total Income	**284.4**	**395.5**	**405.4**	**416.3**	**431.3**	**444.2**	**2.35%**
Expenses							
Employee benefit expenses	-174.6	-251.9	-244.4	-246	-251.9	-256.9	0.39%
Drug expenses	-18	-29.9	-30.7	-31.6	-32.9	-34	2.60%
Clinical supplies and services expenses	-25.1	-35.5	-35.2	-34.9	-35.5	-36	0.28%
Other expenses	-58.5	-86.1	-86.4	-86.3	-90	-93.7	1.71%
Total Expenses	**-276.2**	**-403.5**	**-396.8**	**-398.9**	**-410.3**	**-420.6**	**0.83%**
EBITDA	**8.2**	**-8**	**8.7**	**17.4**	**20.9**	**23.6**	**-224.16%**
Non-operating items							
Gain/(loss) on asset disposals	-	-	-	-	-	-	
Net interest expense	0	0	0	0	0	0	
Depreciation and Amortisation	-13.7	-18.8	-19.1	-19.1	-19.6	-19.9	1.14%
PDC Dividend	0	-2	-0.7	0	0	0	-100.00%
Impairment of fixed assets	-	-	-	-	-	-	
Surplus/(Deficit)	**-20.2**	**-46.7**	**-29.8**	**-21.3**	**-19.2**	**-17.6**	**-17.73%**
KPIs							
EBITDA margin	2.87%	-2.02%	2.14%	4.19%	4.85%	5.30%	-221.28%
Net margin	-7.11%	-11.81%	-7.35%	-5.11%	-4.46%	-3.97%	-19.59%

Source: Management information: HHCT LTFM

Source: Management Information: Transaction LTFM

Increases in clinical income year on year post merger are driven by inflation and income CIP. In FY18 these include specific targets for coding and repatriation of elective activity from STP.

Other operating revenue is projected to increase in FY21022 driven by the contribution from the SEP.

Expenditure growth increases in the first year driven by the inclusion of transaction costs. Expenditure in future years rises driven by the marginal cost of delivering further income. This is offset somewhat by CIP and merger synergies for pay and non-pay.

The absence of HHCT gain/loss on disposal was identified in our previous report as being a £2.1m gain to the surplus/deficit.

Post merger there will be a PDC dividend payable in FY18 and FY19 but no further payments are forecast due to the negative net asset position.

The merged Trust's deficit peaks in FY18 driven by the transaction costs including redundancies and double running. The deficit is projected to improve thereafter for the delivery of assumed CIP, merger synergies and the impact of SEP.

Financial overview - Transaction LTFM SOFP

SOFP overview - Transaction LTFM							
£m	FY17 Outturn	FY18 Forecast	FY19 Forecast	FY20 Forecast	FY21 Forecast	FY22 Forecast	CAGR FY18-22
Non Current Assets							
PPE, intangibles & other	431	528.5	523.2	529	523.8	518.8	-0.37%
Current Assets							
Inventories	3.5	5.2	5.2	5.2	5.2	5.2	0.00%
NHS trade receivables	13.1	20.1	20.1	20.1	19	19.6	-0.50%
Non-NHS trade receivables	0	0	0	0	0	0	
Other assets	15.4	15.4	15.4	15.4	15.4	15.4	0.00%
Cash	20.1	1.9	2.1	2.1	2.2	3.0	9.57%
Total current assets	**52.1**	**42.7**	**42.9**	**42.8**	**41.9**	**43.2**	**0.23%**
Total assets	**483.2**	**571.1**	**566.1**	**571.8**	**565.7**	**562.1**	**-0.32%**
Current liabilities							
Trade Payables, Current	-31	-42.5	-42.5	-42.5	-44	-45.5	1.37%
Other Payables, Current	-21.3	-21.7	-21.7	-21.7	-21.7	-21.7	0.00%
Capital Payables, Current	-9.9	-10.4	-10.4	-10.4	-10.4	-10.4	0.00%
Accruals, Current	0	0	0	0	0	0	
Other liabilities	-13.3	-31.2	-17.9	-17.9	-15	-4.5	-32.11%
Total current liabilities	**-75.5**	**-105.7**	**-92.4**	**-92.4**	**-91.1**	**-82.1**	**-4.93%**
Net current assets	**-23.4**	**-63**	**-49.6**	**-49.5**	**-49.2**	**-38.8**	**-9.24%**
Non-current liabilities	**-376.3**	**-436.2**	**-474.2**	**-501.3**	**-515.7**	**-538.7**	**4.31%**
Net assets	**31.4**	**29.2**	**-0.6**	**-21.9**	**-41.1**	**-58.7**	**-214.99%**
Taxpayer's equity							
Public dividend capital	283.2	283.2	283.2	283.2	283.2	283.2	0.00%
Retained Earnings	-347.1	-469.2	-499	-520.2	-539.5	-557.1	3.49%
Revaluation reserve	95.3	120.9	120.9	120.9	120.9	120.9	0.00%
Misc Other Reserves	0	94.2	94.2	94.2	94.2	94.2	0.00%
Total taxpayer's equity	31.4	29.2	-0.6	-21.9	-41.1	-58.7	-214.99%
KPIs							
NHS Trade receivable days	19.6	20.6	20.1	19.7	18	18	-2.66%
Trade payable days	110	100.8	100.3	100	100	100	-0.16%

Non Current Asset are projected to decrease across the forecast period, driven by a decrease in the level of planed capital expenditure (net of depreciation).

We recommend that the requirement for the capital programme for the merged Trust be assessed prior to submission of the transaction LTFM to NHSI to ensure level of capital expenditure can be supported.

A cash surplus in projected in each year across the forecast period, reflecting assumptions regarding funding of cash shortfalls through the drawing down of loans.

Increased non-current liabilities from additional loan financing taken out to fund cash deficits.

The net asset position is negative from FY18 onwards. No further payments of PDC are forecast following FY19.

The LTFM calculates working capital movements using different method from year 4 (FY20), but there is a decrease in receivable days to manage the transaction cash position. We recommend that the Trusts develop an explanation for assumed improvement in WC days.

In this period trade creditor days appear to be extremely high, well outside of BPPC guidance.

Source: Management Information: Transaction LTFM

Financial overview - Transaction LTFM Cash Flow

Cash flow overview - Transaction LTFM							
£m	FY17 Outturn	FY18 Forecast	FY19 Forecast	FY20 Forecast	FY21 Forecast	FY22 Forecast	CAGR FY18-22
Surplus/(Deficit) from operations	**8.2**	**-8**	**8.7**	**17.4**	**20.9**	**23.6**	**-224.16%**
Non cash adjustments	0	0	0	0	0	0	
Operating cash flows before movements in working capital	8.2	-8	8.7	17.4	20.9	23.6	-224.16%
Movement in working capital:	**0.1**	**0**	**0**	**0**	**0**	**0**	
Increase/(decrease) in working capital	18.2	0	0	0	2.7	0.9	
Increase/(decrease) in Non Current Provisions	0	0	0	0	0	0	
Net cash inflow/(outflow) from operating activities	**26.3**	**-8**	**8.7**	**17.4**	**23.6**	**24.4**	**-224.99%**
Cash flow from investing activities							
Property, plant and equipment expenditure	-20.8	-15.6	-13.9	-24.9	-14.5	-14.9	-0.91%
Proceeds on disposal of property, plant and equipment	0	0	0	0	0	0	
Net cash inflow/(outflow) from investing activities	**-20.8**	**-15.6**	**-13.9**	**-24.9**	**-14.5**	**-14.9**	**-0.91%**
CF before Financing	5.5	-23.6	-5.2	-7.5	9.1	9.5	-183.36%
Cash flow from financing activities							
Public Dividend Capital received	19	0	0	0	0	0	
Public Dividend Capital repaid	0	0	0	0	0	0	
Dividends paid	0	0	0	0	-2.7	0	
Interest (paid) on Loans and Leases	-14.7	-17.9	-18.6	-19.6	-20.6	-21.3	3.54%
Interest (paid) on bank overdrafts and working capital facilities	0	0	0	0	0	0	
Interest received on Cash and Cash Equivalents	0	0	0	0	0	0	
Drawdown of Loans and Leases	28.9	33.5	48.7	37.7	25	23	-7.25%
Repayment of Loans and Leases	-10.2	-11.2	-24.7	-10.7	-10.7	-10.5	-1.28%
Other cash flows from financing activities	0	0	0	0	0	0	
Net cash inflow/(outflow) from financing	**23.1**	**4.4**	**5.4**	**7.4**	**-8.9**	**-8.8**	**-214.87%**
Net cash outflow/inflow	**28.6**	**-19.2**	**0.2**	**0**	**0.2**	**0.7**	**-151.57%**

Source: Management Information: Transaction LTFM

Other than the 4th floor conversion at PSHFT in FY20, there is a decrease in levels of capital expenditure post merger. We recommend that this can be justified prior to submission to NHSI.

PDC Dividend payable for FY18 and FY19 deferred payment to FY21.

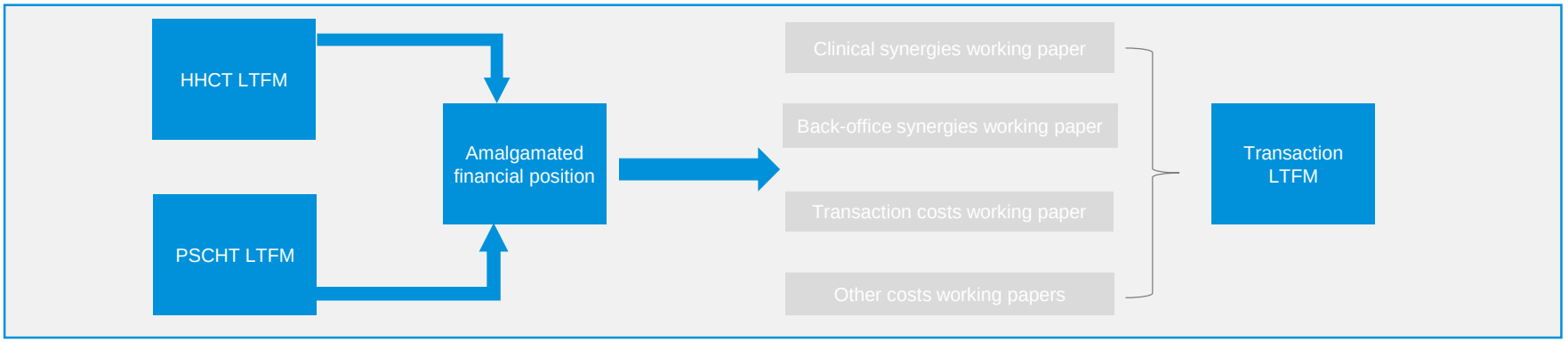
Increase in the drawdown of loans initially post merger to fund the transaction costs. We recommend that while this is prudent, other sources of funding should be explored to part fund this, including commissioners and NHSE.

Small net cash inflows are projected in each financial year (due to the draw down of loan financing), with the exception of FY18 where there is a cash outflow of £(19.2) million driven by the operating deficit in that financial year.

KPMG

Supporting analysis

Basis of preparation - Transaction LTFM



Basis of preparation

- The Transaction LTFM has been developed on the basis of the amalgamated financial positions from the two standalone LTFMs, overlaid with adjustments for synergies, transaction costs and other transaction adjustments. Both HHCT and PSHFT have worked alongside each other to make assumptions as consistent as possible and the stand alone LTFMs have been largely updated based on our previous recommendations.
- A number of working papers were identified which feed the Transaction LTFM, which are not linked into the standalone LTFM; these include working papers for transaction costs and synergies. This is normal practice as part of the Transaction LTFM development process; however, we recommend that external links are removed from the Transaction LTFM prior to submitting for NHSI review to prevent reference errors.
- Three false error checks have been identified on the 'control tab'. These we believe are substantive errors, not just rounding and should be corrected before submission to NHSI – see overleaf.
- The 2016/17 financial outturn forecast continues to be based on the PSHFT annual plan. Projections from 2017/18 onwards are calculated based the amalgamated inputs from HHCT and PSHFT LTFM and inflated based on aligned assumptions to derive the Transaction LTFM.
- Additional costs have been entered for the transaction costs in the first two years of the forecast with cost savings from the identified synergies being delivered in subsequent years.

Basis of preparation (cont.)

- We had previously identified some assumptions regarding the treatment of NHS trade payable days that improved the HHCT cash position in FY20. While this issue has been partly addressed in the Transaction LTFM, we recommend this should be reassessed as there remains an improved Trade Receivables Days position from FY19 onwards that should be explained.
- We have highlighted specific observations overleaf around the Transaction LTFM set up and modelling that require addressing prior to submission to NHSI.
- At present the LTFM continues to have been modelled based on costs, with workforce being calculated based on the total costs. We continue to recommend that more detailed workforce modelling is carried out to provide a better understanding of future workforce requirements.

Approach to consolidating into Transaction LTFM

- We note that the approach to constructing the Transaction LTFM has been carried out within a short timespan (approximately one month).
- Whilst the work to make the two standalone LTFMs as consistent as possible has likely simplified the process, we would typically expect the Transaction LTFM to take much longer and the modelling team should continue to refine the Transaction LTFM in the coming weeks as the FBC is further developed.
- Finally we note that the Transaction LTFM has been populated using the two standalone LTFMs as of 10 August 2016. Changes and corrections following this date are being documented in a register so that all changes can be made at once.

Basis of preparation - Transaction LTFM (cont.)

We have identified the following technical issues in our assessment of the Transaction LTFM. The priority rating is an indicator of urgency prior to submission to NHSI.

Area	Comments	Priority
Three false error checks on the 'Control' tab: • Year end cash balance • Cashflow check • Outturn Reconciliation Check	These are substantive errors, not just rounding and should be corrected before submission to NHSI. The control tab picks up errors in an “Audit checklist”, all of these should read as TRUE prior to submission to NHSI to ensure that the LTFM elements balance.	H
"No" responses in the Checklist should be explained.	The checklist tab questions should all be Yes prior to submission to NHSI. Where the answer is "no" and will remain so for the submission for NHSI, an explanatory note should be added to justify the answer..	M
'I_Activity (memo)', 'I_KPI' and 'I_KPI (Target) (Memo)' not completed	These are memo input sheets, so don't drive financial movements in the model, but NHSI may use this for further analysis. We recommend you enquire with NHSI as to whether this needs to be completed.	M
Units missing from 'C_Incme (Sum - Detailed)' tab	Duplicate the corresponding units from the 'I_Incme (Target)' tab. These figures should match with the “I_Incme (Target)’ tab.	L
Historical capex numbers missing from 'I_Cost (Existing)' tab	NHSI are likely to analyse these inputs when considering sensitivities. We recommend you complete this or confirm with NHSI that an alternative presentation is acceptable.	M
Agency staff numbers missing from 'I_Cost (Existing)' and 'I_Cost (Target)' tabs	NHSI are likely to analyse these inputs when considering sensitivities. We recommend you complete this or confirm with NHSI that an alternative presentation is acceptable.	M
Unattributed £4m non-maintenance capex 'I_Cost (Consolidated)'	Currently there is capital expenditure cost populating this tab. A brief description of what this relates to should be added for clarity prior to final submission.	L
'S_Input' is populated	This tab should not be populated as this does not drive anything within the LTFM and should be cleared before submitting to NHSI.	L
PDC dividend payment showing on cash flow statement in FY21. PDC dividend was payable	PDC dividend payment showing on cash flow statement in FY21. PDC dividend was payable in FY18 and FY19. We recommend that this is reviewed as PDC dividend should not be deferred.	M

Overview of Transaction adjustments

The table below shows the aggregated position of the standalone LTFMs of both HHCT and PSHFT, splitting out the impact for adjustments applied to the Transaction LTFM. There are a number of movements between the aggregated HHCT/PSHFT position and the Transaction LTFM, which are due the alignment of assumptions and adjustments applied in the Transaction LTFM that are explained below.

SOCI - HHCT & PSHFT vs Transaction LTFM					
£m	**FY18 Forecast**	**FY19 Forecast**	**FY20 Forecast**	**FY21 Forecast**	**FY22 Forecast**
Clinical Income	0.1	0.1	0.1	0.1	1.2
Other Revenue	0.0	0.0	0.0	-0.1	-0.1
Total Income	**0.1**	**0.1**	**0.1**	**0.0**	**1.1**
Employee benefit expenses	-2.7	6.2	6.9	7.1	7.2
Other expenses	-3.7	-1.4	2.4	2.5	2.5
Total Expenses	**-6.4**	**4.8**	**9.3**	**9.6**	**9.8**
EBITDA	**-6.3**	**4.9**	**9.4**	**9.6**	**10.9**
Net interest expense	-0.1	0.1	0.5	0.4	0.6
Depreciation and Amortisation	0.0	0.0	0.2	0.0	0.0
PDC Dividend	0.0	0.0	0.4	0.3	0.3
Changes from aggregated standalone LTFMs for HHCT and PSHFT	**-6.4**	**4.9**	**10.5**	**10.3**	**11.8**

Source: KPMG working based on: Transaction LTFM, HHCT LTFM and PSHFT LTFM

The main movements in income and expenditure relate to:

- **Income** – an overlay of PSHT inflation assumptions for income categories has led to an increase across tariff based income, particularly in FY22 due to the inflation percentage being omitted in the HHCT standalone LTFM. An overlay of PSHFT inflation assumptions for Education and Training income has led to a minor difference in Other Revenue.
- **Pay expenditure** – a significant increase in expenditure in FY18 in the Transaction LTFM reflects the inclusion of transaction costs, including a large redundancy pot. The subsequent benefit to expenditure in future years is the impact of back-office pay synergies identified from the merger.
- **Other expenses –** similar to pay expenditure there is an increase in expenditure in the first two years compared to the stand alone position, driven by the inclusion of transaction costs. The subsequent benefit to expenditure in future years is the impact of back-office non-pay synergies identified from the merger
- **Net Interest Expense –** reduction in interest expense due to the assumption of funding for the merger being drawn down from long term loans.
- **PDC Dividend** – the merger of HHCT and PSHFT create a position where only the first two years have positive net assets. As a result there is a net saving on PDC Dividend payments created through the merger.

Key assumptions - Transaction LTFM

We set out below the key assumptions that have been applied to the Transaction LTFM, showing where there have been changes to the underlying assumptions in the standalone LTFMs of HHCT and PSHFT or where additional Transaction assumptions have been applied.

Area	Description	KPMG Comment and Recommendation
Alignment of assumptions		
Cost Inflation	▪ Cost inflation is in line with NHSI guidance. ▪ For areas identified in our previous report where inflation assumptions did not match; HHCT inputs have been overlaid with the PSHFT inflation assumptions in the Transaction LTFM.	▪ None.
Sustainability and Transformation Funding ('STF')	▪ As per the recommendations in our previous report both PSHFT and HHCT have aligned their assumptions regarding receipt of STF funding, so that it is only available in the FY17 outturn year and is not recurrent thereafter.	▪ None
Activity growth	▪ Following recommendations made in our previous report, the impact of QIPP on activity growth has been aligned across PSHFT and HHCT – QIPP has now been consistently applied. ▪ However, additional activity growth in FY18 and FY19 Elective is being driven by £3.2 million of specific income CIP schemes developed by HHCT based on coding and the other based on STF repatriation of elective activity.	▪ We understand that the HHCT income CIP included in FY18 and FY19 has not been agreed with commissioners. The TPB should agree on the level of income CIP (amongst other areas) to be included in the base case of the FBC and also in any downside sensitivity analysis. ▪ We also recommend that that further development be made on the detailed plans that underpin any income CIPs for FY18 and FY19 to ensure these are robust. NHSI will scrutinise the level of CIP and robustness of plans in determining their view on the LTFM.
Contingency and Property Rental Increases	▪ Both HHCT and PSHFT have built in contingency and property rental increases into their standalone LTFM. ▪ For PSHFT the contingency is more explicitly identified from the base line.	▪ We recommend that HHCT clearly separate out the contingency and rental increases in the stand alone LTFM to show this in the same way as PSHFT, so that this can be jointly reflected within the transaction LTFM. ▪ Within the LTFM this should be labelled and easily identified by NHSI to reflect that the LTFM has been weighted to reflect a prudent forecast.
PFI	▪ Following recommendations in our previous report, both HHCT and PSHFT have working papers to demonstrate the PFI calculations of the individual Trusts.	▪ We recommend a joint working paper is developed prior to submission to NHSI detailing the merged trust calculation.

Key assumptions - Transaction LTFM (cont.)

Area	Description	KPMG Comment and Recommendation - August
Transaction assumptions		
Synergy savings See pages 23 and 25 with respect to additional detail on clinical and back-office synergies	■ The total value of synergies which are built into the transaction LTFM is £8,961k, relating to back office synergies. ■ Following the population of the transaction LTFM, there have been further developments of the supporting detail for identified areas for synergies – however, there is a current gap to the LTFM figure is £642k. ■ Savings from clinical collaboration are currently under development, with further detailed work in this area planned over the coming months and beyond the proposed transaction date. ■ We understand that the TPB and both Boards wish to present a public message that back-office (non-clinical) synergies will result from the merger and that savings from clinical collaboration will be treated as delivering against forecast CIP targets rather than merger synergies.	■ We would typically expect the clinical benefits from merger (including detailed worked up financial benefits) to be clearly set out in a business case as merger synergies, rather than CIP. ■ In our experience, NHSI's view is that the primary driver for merging NHS Trusts is increased quality of patient care and therefore clinical synergies, with back-office savings as an additional benefit. ■ However, we understand that the TPB has discussed the treatment of clinical savings as CIP with NHSI. ■ We recommend that the Trust continues to work on the detailed financial benefits that will arise from clinical collaboration. ■ We recommend that the Trusts continue to work on the development of additional back-office savings to fill the current gap to the LTFM and that this is reflected in the transaction LTFM prior to submission, as appropriate. ■ We also recommend that further work be completed on the detailed plans for delivery of synergies as part of further development of integration planning, including the likely phasing of benefits.
Transaction costs See page 27 with respect to Transaction costs	■ Estimated costs related to the transaction have been modelled into the LTFM, split into four categories: – Redundancy (£3.4 million) – Internal Transition Costs (£5.1 million) – External Costs (Legal and Due Diligence £1.3 million); and – IT Integration Costs (£4 million).	■ We have been advised that no additional transaction costs have been identified following the internal due diligence process recently undertaken. ■ However, we have not yet been provided with the detail workings supporting the transaction costs. ■ We recommend that the detail continue to be worked up detailing the breakdown of the transaction costs, as well as the phasing of expenditure across the forecast period. ■ We recommend that IT integration costs are aligned with the detail being provided by the TPB's external IM&T advisor. ■ We recommend that IT costs be further analysed between I&E and capital costs and therefore split out in the LTFM, with capital expenditure being capitalised as an asset on the SOFP and treated separately from the I&E.

Key assumptions - Transaction LTFM (cont.)

Area	Description	KPMG Comment and Recommendation - August
Transaction assumptions		
Capital expenditure	■ Capital expenditure in the Transaction LTFM is assumed to be in line with the standalone capital plans of the standalone Trusts. ■ Excluding the 4th floor conversion in PSHFT in FY20, capital expenditure within the Transaction LTFM is less than historical spend. ■ There is currently no separately identified capital expenditure within the transaction costs across the forecast period, despite a significant spend on IT for the merged organisation.	■ We recommend that the merged Trust develop a combined capital programme and estates strategy for the forecast period, to enable the merged Trust to justify the reduction in capital expenditure across the forecast period. ■ It is recommended that any capital expenditure be removed from the SOCI to the SOFP to reflect the increase in assets.
PDC Dividend	■ Following the merger of the two organisations there are forecast dividend payments of £2 million in FY18 and £0.7 million in respectively. ■ The cash payment of PDC is assumed to be deferred until FY21.	■ We recommend that the deferral of the cash payment of PDC dividend to FY21 be re-assessed. We have highlighted this point to the finance team and been advised this will be addressed in the final submission.
Funding	■ The Transaction LTFM assumes that the merged Trust will be financed by the draw down of additional loans to support the Trust's cash position across the forecast period given the operating deficits that are projected. ■ Additional funding from loans has been factored into the LTFM to reflect this view, given no transitional or central funding has yet been agreed for the merger with commissioners, DH or NHSE.	■ We recommend that the TPB continue to progress its conversations and negotiations with commissioners and central bodes regarding transitional or central funding, updating this into the Transaction LTFM when available to assess the impact on both the I&E and cash position. ■ The TPB should consider an additional sensitivity analysis to reflect a potential change in interest rate above forecast and how this will affect the surplus/deficit position of the merged organisation.

Clinical synergies

Savings from clinical collaboration are currently under development, with further detailed work in this area planned over the coming months and beyond the proposed transaction date as the merged Trust's clinical model is worked up in more detail. At the current stage of development of the merger FBC we would typically expect clinical synergies to be have been worked up in further detail, including the financial benefits that would arise from clinical collaboration. At present clinical synergies have been identified but the benefits at present are represented as qualitative rather than quantitative in the draft FBC.

Areas Identified for Clinical Synergies	**Areas Identified** ▪ Reduction in agency spend through improved likelihood of being able to recruit to clinical roles as a consequence of larger teams, more varied case-mix, better peer support, opportunities for sub-specialisation, training etc. ▪ Conversion of one existing Haematology consultant role (vacancy) to a staff grade doctor ▪ Likely reduction in payments for clinical roles as a result of reduced need for duplicated on-call rotas for some specialties (not directly required for acute take e.g. ENT), and in time, clinical leadership payments may be able to come down. ▪ Potential areas for growth in profitable areas where demand is evidenced e.g. radiotherapy, cardiology and thoracic medicine **Further Areas identified for Consideration** ▪ Pharmacy – This workshop is due to take place soon. ▪ Imaging – Potential to bring more reporting back in-house following capital investment in IT. ▪ Pathology – This area is currently on hold due to TPP uncertainty ▪ Research – The track record for being able to recruit to trials at HHCT is understood to be good, so PSHFT stand to benefit from integration. HHCT research has dropped in recent times due to locum teams being unable to maintain this record; an area that would benefit from merged teams.
Assessment of current synergies	Savings from clinical collaboration are currently at a relatively early stage of development, with most being dependant upon the post merger clinical model that is to be worked up and with others dependant upon the impact of the ongoing STP work. A full clinical strategy has not been developed at this stage apart from the identified synergy within Haematology, although this too requires further development. Both Trusts have given the public message that of the £9 million of projected synergies from the merger, these do not include any that arise from integrating clinical services. The merger has been communicated to the public as a way of making back-office savings while ensuring that any clinical savings are reinvested in services; therefore no clinical resources will be reduced. For example, in order to be sustainable, Neurology and Stroke services will need more medical staff in order to provide safe, sustainable services locally even though they will be working as part of a larger team. As such, clinical savings will contribute towards forecast level of CIP included in the Transaction LTFM and have not been identified as clinical synergies within the FBC.
Recommend-ations	To ensure that the plans underpinning the FBC are robust we recommend that: ▪ The TPB confirm its approach to the description and positioning of clinical savings arising from merger. Typically, clinical savings are recognised as merger synergies as opposed to contributing towards the merged organisations future CIP target. In our experience NHSI consider that mergers should not be undertaken purely for back-office synergies, but that there should be a clinical benefit to the patient in terms of better value and better quality of treatment. Recently we have worked on another merger where NHSI required a clear plan of clinical synergies before approving the transaction. ▪ However, we understand that the TPB has discussed the treatment of clinical savings as CIP with NHSI. In addition, we recognise that the draft FBC explains that all financials savings achieved from clinical integration will be used to reinvest in services, and to meet the improvements in efficiency and cost reduction that are required of all services annually to offset the pressure of annual cost inflation.

Clinical synergies (cont.)

Recommend-ations	▪ Clinical pathways need to be developed further into a post merger operating model at a departmental and trust wide level. As well as clinical pathways, additional clinical synergies may be identified from a clear imaging strategy. In our experience synergy opportunities are frequently identified in Pharmacy, Genetics and Pathology through post merger working. ▪ In addition, we would expect to see the opportunity for additional income in areas such as R&D. With the merger the merger Trust's footprint will grow, which may lead to greater opportunities to attract R&D funding. ▪ Where clinical synergies cannot yet be quantified, we recommend that that these are included in the FBC as qualitative clinical synergies. An initiative such as putting best practise in place across both trusts may not yet be quantifiable, but will yield greater quality of care for patients and is therefore still a clinical synergy. ▪ We recommend that both Trusts continue to engage with clinicians in the development of these synergies, as strong clinical engagement is a key factor in developing quality plans and in maximising the chances of a successful implementation.

Back-office synergies

The Trusts are targeting £9.0 million of back-office synergies, with £6.7 million planned from reduction in WTE and which is supported by the production of bottom up merged operating models for the back-office functions. However, there is currently a unidentified savings gap of £642k, predominantly relating to non-pay.

We recommend that if savings cannot be identified to close the gap, this should be reflected in the Transaction LTFM baseline or through sensitivity analysis for delaying or reducing synergies.

We recommend further work to ensure that the identified categories are worked up to thorough detailed implementation plans, which can be enacted post merger.

Back Office Saving (£'000)	HR	Finance	Corporate	CEO	Nursing	Facilities	IM&T	Clinical Support	OPS	Total	Non-Pay
Combined current WTE	117.8	94.0	20.3	21.8	130.2	115.8	154.5	9.6	372.0	**1036.0**	
Combined current Pay budgets (inc agency)	£4,439	£2,980	£342	£3,206	£5,128	£41,239	£4,957	£742	£15,870	**£78,902**	
New WTE	94.3	77.5	13.5	14.0	118.6	17.0	151.9	4.8	333.5	**825.1**	
New Cost	£3,279	£2,762	£448	£1,495	£4,551	£40,565	£4,503	£371	£14,065	**£72,040**	
Saving wte	-23.5	-16.5	-6.8	-7.8	-11.6	-98.8	-2.6	-4.8	-38.5	**-167.6**	
wte reduction %	-20%	-18%	-33%	-36%	-9%	-85%	-2%	-50%	-10%	**-16%**	
Pay reduction %	-26%	-7%	31%	-53%	-11%	-2%	-9%	-50%	-11%	**-9%**	
Current worked up savings	**-£1,160**	**-£218**	**£106**	**-£1,710**	**-£577**	**-£674**	**-£453**	**-£371**	**-£1,805**	**-£6,862**	**-£1,457**
Targeted savings - Recurrent	-£1,163	-£1,081	-£365	-£1,129	-£522	-£1,185	-£509	-£371	-£373	**-£6,698**	**-£2,263**
Variance (Final Savings vs LTFM)	**-£4**	**-£864**	**-£471**	**£581**	**£55**	**-£511**	**-£55**	**£0**	**£1,433**	**£164**	**-£806**

Pay budgets used to calculate savings as opposed to actual cost for FY17. We recommend that any material variance be reflected in these numbers.

Overall 9% recurrent pay reductions.

Planned savings in facilities savings in pay does not match reduction in WTE, due to requirement for increase in non-pay post merger due to planned outsourcing.

Does not include the £874k corporate reductions identified in HHCT CIPs.

Under identification of against synergy target. We recommend that a more prudent view be entered into the LTFM if the gap cannot be closed.

Source: Management Information: FBC Cost Synergies and Sensitivities working paper

- The table above shows the identified categories for the back-office function synergies.

Pay synergies

- At present pay synergies represent 9% of current pay costs despite a drop in WTEs of 16%. In our experience from other mergers we have seen a range of back-office pay savings of between approximately 8% and 20%, but this is dependent on the relevant existing, and target, operating models.

Back-office synergies (cont.)

Pay synergies (cont.)

- The current calculations for pay synergies have been derived from the new operating models for the merged Trust that have been worked up using the Carter review recommendations. The calculations use the midpoint for each band, plus on costs (averaging 26%) less the combined current pay budgets (inc. agency). The assumptions around on costs appears in line with our expectations, but the use of midpoints to calculate pay costs under the future operating model could result in overstatement of the pay synergies.
- We recommend that a workforce review is carried out by both HHCT and PSHFT to determine whether the midpoint assumption is realistic for the bands across the back-office functions.
- A simple sensitivity for a change in assumption for 1 point above or 1 point below the midpoint could result in the value of savings identified being increased or decreased by 10%.

Non-pay synergies

- Non-Pay savings currently identified are £806k below the targeted savings of £2.3 million of recurrent savings, with the majority of savings identified being in estates, contracts and IT/IS costs.
- In our experience we would expect to see potential savings identified from procurement. Procurement spend is an area with potential for significant synergies, but further information and detailed planning would be needed (e.g. on detailed expenditure categories) before an estimation of savings can be made.
- As a estimate, if 1% if savings per year were to be made to non-drugs, non-PFI expenditure beginning in FY18, then this would represent savings of approximately £1.3 million, which could close the current gap in non-pay synergy savings.

Phasing of Back-Office Synergies

- The phasing of the current worked up savings have not yet been worked through as these will be subject to staff consultation.
- The targeted recurrent savings are phased heavily in FY18, with CEO department delivering the full targeted saving in that year. There is a significant risk that synergy savings may not deliver to this profile given the potential complexity of implementing some of these initiatives.
- In our experience we would expect non-pay savings to be phased at an earlier stage than FY20, with specific schemes such as IT and Estates already being developed.

We recommend that the TPB reassess the phasing of both pay and non-pay savings, as well as considering this as part of sensitivity analysis.

	16/17	17/18	18/19	19/20
CEO department	£0.0	£1,129.0	£0.0	£0.0
Corporate Governance	£0.0	£292.2	£73.1	£0.0
Finance	£0.0	£865.2	£216.3	£0.0
HR	£0.0	£930.6	£232.6	£0.0
Nursing	£0.0	£417.5	£104.4	£0.0
Facilities	£0.0	£592.3	£592.3	£0.0
IT/IS	£0.0	£406.9	£101.7	£0.0
Ops	£0.0	£298.0	£74.5	£0.0
Clinical Support	£0.0	£297.0	£74.2	£0.0
Non-pay	£0.0	£0.0	£0.0	£2,263.1
Savings	**£0.0**	**£5,228.6**	**£1,469.1**	**£2,263.1**

Source: Management Info: FBC Cost Synergies and Sensitivities working paper

Transaction Costs

The table below shows the high level summary of the forecast transaction costs assumed within the Transaction LTFM. We understand that the breakdown of these costs has moved on significantly following the population of the Transaction LTFM with redundancy and transaction costs up to the merger date worked up in full.

We recommend that the transaction costs are further developed in detail to determine the quantum and phasing of costs focusing in particular on post merger. In addition, specific workstreams should focus on further developing the robustness of cost assumptions that have been factored into the Transaction LTFM.

	Costs				Total Costs	
Transaction Costs (£000's)	**16/17 Yr0**	**17/18 Yr1**	**18/19 Yr2**	**19/20 Yr3**	**Recurrent £'000**	**One off £'000**
Redundancy	£0	-£2,943	-£486	£0	£0	-£3,429
Internal transition costs	-£1,715	-£3,284	-£116	£0	£0	-£5,115
External costs (legal + due diligence)	-£1,275	£0	£0	£0	£0	-£1,275
IT integration costs	-£1,000	-£1,500	-£1,500	£0	£0	-£4,000
Total Costs	**-£3,990**	**-£7,727**	**-£2,102**	**£0**	**£0**	**-£13,819**

Source: Management Information: FBC Cost Synergies and Sensitivities working paper

- **Redundancy** – The value of the redundancy pot is based upon the back-office post merger operating models which have been developed for the specific areas identified as releasing synergies. These costs have been calculated using midpoint and are subject to consultation around the operating models for each area. It is recommended that workforce models be used to establish whether the assumption of midpoint is correct.
- **Internal Transition Costs** – The internal transition costs include the cost of the transitional team as well as an element for clinical backfill. We understand that at present these costs are worked through based on the 2015/16 OBC.
- **External Costs** – Pre-merger the trusts have incurred transaction expenditure for external consultancy in terms of due diligence, legal arrangements and independent accounting opinions and assurance boards which are part of the work undertaken leading up to the merger.
- **IT Integration Costs** – We understand that at present an IT/IS review is taking place to assess the requirements for the merged organisation. We would expect that some of this IT cost is capital expenditure related to transitioning the two organisations onto one system. We would also expect to see recurrent cost in terms of IT licences for the new system and ongoing maintenance.

At present we understand that the detail of specific workstreams have not been formalised beyond the anticipated transaction date, but that in the lead up to the transaction date these workstreams will be formalised with specific workstream leads.

Risks and sensitivities

The TPB has considered and modelled six key sensitivities to the Transaction LTFM, as set out in the table below. While these are broadly in line with our expectations, we recommend that the TPB reach agreement on the level of the SEP, standalone CIP and income CIP and merger synergies to be included in the base case of the FBC and also in any downside sensitivity analysis.

We understand that the Trusts' mitigations are currently work in progress – we recommend that these are further developed in detail to respond to the downside case if some or all of the risks identified were to materialise.

Downside Modelling of Transaction LTFM	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Transaction LTFM Surplus/Deficit	**-20.2**	**-46.7**	**-29.8**	**-21.3**	**-19.2**	**-17.6**
Assume no growth	0.0	-1.3	-4.0	-7.3	-9.6	-13.6
No income CIP's i.e. no cost margin saving on growth	-1.8	-2.0	-2.5	-2.7	-2.7	-2.7
CIPs at minimum 2% requirement	-9.0	-12.5	-14.0	-16.7	-18.9	-20.0
SEP assume only 50% of income and delayed by one year	0.0	0.0	-0.5	-2.2	-3.8	-2.6
Potential transaction cost/ Implementation assume 50% increase	-2.0	-3.9	-1.1	0.0	0.0	0.0
Non achievement of savings by 10% and delayed by one year	0.0	-5.2	-0.5	-0.7	-0.9	-0.9
Adjusted Transaction LTFM Surplus/Deficit	**-33.0**	**-71.6**	**-52.3**	**-50.8**	**-55.1**	**-57.4**

Source: Management Information: FBC Cost Synergies and Sensitivities working paper

Commentary on sensitivities:

Downside Sensitivities	Comments and Recommendations
Assume No growth	▪ The Trusts have modelled a sensitivity whereby all growth and a "flat cash" scenario is assumed. ▪ This is a likely area for NHSI to challenge (i.e. why growth generates a margin) and therefore we believe that it is a good area to sensitise.
No income CIPs i.e. no cost margin saving on growth	▪ The Trusts have modelled a sensitivity whereby income CIPs are removed. ▪ Whilst this is a prudent assumption, the TPB may wish to consider if there are specific income CIPs that are more risky than others (e.g. unconfirmed or not agreed with commissioners) and sensitise these specifically.
CIPs at 2%	▪ The Trusts have modelled a sensitivity whereby CIP are delivered at 2%. ▪ This is a common and reasonable area for sensitivity. However, we recommend that the TPB and Trusts consider the realistic level of CIP to include in the base case across both PSHFT and HHCT, based on the internal due diligence that has been completed and when assessing against the Trusts' historical track record of delivering CIP, the current development of detailed plans underpinning forecast CIP and the financial grip and governance arrangements that are in place. ▪ This is a highly subjective area and NHSI may be more or less severe in their sensitivity. ▪ We understand that the level of HHCT CIP has been updated since the date of the August LTFM to reclassify the marginal rate generated by assumed additional demographic income CIP in the latest HHCT standalone LTFM – previously just the marginal rate was shown as income CIP within the LTFM, while the latest version of the LTFM reclassifies the full amount of additional demographic income as an income CIP. This results in an increase in the level of overall HHCT CIP, taking the percentage range year on year to between 4.6% and 4.9%. ▪ . We recommend that the sensitivities are remodelled to take this into account.

Risks and sensitivities (cont.)

Downside Sensitivities	Comments and Recommendations
SEP assume only 50% of income and delayed by one year	▪ This appears to be a reasonable area for sensitivity given the risks previously highlighted. ▪ However, we recommend that the TPB consider a more prudent position (given it is still uncommitted) to present a downside case that assumes the SEP does not happen at all. This would demonstrate that the TPB and Boards are aware of the risks of delivery and are not relying on this as a fundamental part of making the merger work.
Potential transaction costs/implementation – 50% increase	▪ The Trusts have modelled a sensitivity whereby transaction costs increase by 50%. ▪ This is a typical area of sensitivity and appears to be reasonable, but TPB should continue to monitor this against the detail of the transaction costs and assumptions as these were still under development at the time of our review.
Non achievement of merger savings by 10% and delayed by one year	▪ The Trusts have modelled a sensitivity whereby synergies are underachieved by 10% and delayed by one year. ▪ This is a typical area of sensitivity, with typical sensitivities in this area around post transaction implementation plans delaying the benefits realised. However, this depends on the level of confidence in the merger synergies and the detail available around implementation plans. ▪ In our experience, 10% non-achievement is a mild downside case. We recommend that the TPB consider the possibility of up to a 25% sensitivity, which might provide the TPB and the Boards with a better indication of what underachievement of synergies might look like. ▪ In addition, a more detailed approach would include sensitising specific, more risky elements of the merger synergies at a higher rate, rather than applying a single rate to all.
Upside Sensitivities	**Comments and Recommendations**
Assume QIPP is not achieved	▪ In our experience, NHSI are unlikely to accept this as a upside or a mitigation, but we believe this is reasonable upside case given known pressures and continuing demand in the local health economy. ▪ In addition, we recognise that it is a difficult area to model, but commissioners typically assume that QIPPs are going to improve their financial positions, or at least supress increases in demand that Trusts cannot deliver.
Assume S&T funding is recurrent	▪ In our experience, NHSI are unlikely to accept this as a upside or a mitigation as there is no clarity on such funding, but this appears to be a reasonable scenario to consider. .
Assume receipt of additional £15m PFI support at PSHFT	▪ In our experience, NHSI are unlikely to accept this as a upside or a mitigation, but we understand discussions between PSHFT and NHSE/NHSI are ongoing in this area, so this is a reasonable scenario to consider. ▪ However, it would appear to be more the case that if other savings/income generation fail to deliver then this may be an interim funding mechanism.

Other potential sensitivities to consider:

- **Capital expenditure** – the Trusts have assumed forecast capital expenditure at annual levels that are below historical levels. The TPB should consider whether this should be an area of sensitivity if a detailed capital programme has not been worked up for the merged Trust.
- **Interest rate on borrowings** – the TPB should consider whether interest rates are fixed for existing or planned borrowings, as the risk of rising interest could have a significant impact on the merged Trust. For example, the TPB should undertake scenario analysis as to what would be the impact if new loans obtained were charged at 1% more than existing loans?

Risks and sensitivities Cont.

Mitigations

- We understand that the Trusts' mitigations are currently work in progress, based upon discussions that have taken place at the TPB and at Board level. However, we have not had sight of these as part of our assessment as they are still under development.
- We recommend that mitigations for the downside case are developed in detail to offset the deterioration in both the merged Trusts surplus/deficit and cash position. In our experience, best practices indicate that mitigations should be developed to a similar level of detail as to CIP plans, with supporting detailed financial analysis and implementation plans.
- We also recommend that TPB consider further mitigations. For example, if the SEP did not happen, what other schemes may be developed instead to take advantage of the surplus estate?

An overview of NHSI's high level approach to sensitivity analysis

1. Take the submitted LTFM as the merged Trust's "Base case";
2. Make adjustments to bring in line with national guidance or where there is strong case for applying sensitivities (e.g. non-achievement of CIP, non-delivery of the SEP), as NHSI's "Assessor case"
3. Consider "reasonable downside" sensitivities (i.e. not worst case), present this to the merged Trust to present mitigations. NHSI will then assess which mitigations to accept, producing the "downside case"

A key point to highlight is that there is no consideration of "upside" sensitivities by NHSI. In the sensitivity comments slide we have therefore considered the upside case as potential mitigations on the downside case.

In addition the sensitivity analysis should detail the impact on the net surplus/deficit position and also on the cash position. A key question for NHSI is "how long until they run out of cash in a downside case?".

Alongside NHSI's work on reviewing the financial cases, will be consideration of the governance of the merging Trusts. It will expect the Boards to be aware of what a downside case may look like and what actions it may take to mitigate it. Part of this is done by the finance team's presentation of the downside case, but it is also expected that strong boards will engage with this and challenge this.

NHSI's approach to assessing CIP sensitivities is to review the CIP programme and governance, assessing any analysis of CIPs available and reviewing a sample in detail (e.g. PIDs, QIAs and interviewing CIP leads). Using this as a basis, it will:

1. Fully sensitise out any CIPs identified as unlikely to be achieved; and
2. Based on governance, historical achievement and level of detailed plans and benchmarking, determine a R/A/G rating for the overall programme and sensitise at 15% non-achievement and 5% delay unless high quality plans are in place.

If plans are significantly underdeveloped (principally in year 1) then a greater sensitivity may be applied.

Additional recommendations

- We recommend that the Trusts' sensitivity analysis is further modelled to include the impact on the cash flow position of the downside case; and
- We recommend that that CIP schemes are further developed in detail to give NHSI greater confidence that the schemes can be achieved on time and to the level included in the LTFM.

Appendices

1. **Scope of work**
2. **Sources of information**

Appendix 1 - Part 1 and 2 Scope of work

Scope of work

Part 3 – Combined LTFM

Assess assumptions alignment between HHCT & PSHFT

— Comment on the application of revised assumptions to the HHCT LTFM

— Comment on the application of revised assumptions to the PSHFT LTFM

Assess combined LTFM

— Summarise and comment on the modelled impact of the proposed transaction:

- Clinical and back office operating model changes
- Recurrent costs associated with operating an enlarged Trust
- Non recurrent transaction and integration costs (capital and I&E)
- Capital expenditure requirements
- Due diligence findings
- Funding arrangements

Model the downside scenario – Summarise and comment on the combined Trust downside and mitigated downside scenarios.

Appendix 2 - Sources of information

PSHFT	HHCT
Long Term Financial Model	Long Term Financial Model
PSHFT Forward Plan Financial Return (IFRS) Final - Plan for YE March 2017	2015/16 Financial Monitoring and Accounts
PSHFT Trust Annual Plan FY17	2016/17 Financial Monitoring (Full plan)
Board Reports FY15-FY17	STP Provider workings
Capital Programme for APR	CIP Tracker 2016/17-2017/18
CIPs 2013/14-2015/16	SEP outlying presentation
STP Provider workings	Activity workings
Mini LTFM summary	CIP 3 year opportunities
PFI workings	SEP high level financial forecasts
FBC to OBC reconciliation	Loan workings
Other underlying working papers	

Transaction LTFM
Long Term Financial Model
Sensitivity analysis of modelled downside and upside
Synergies high level workings – clinical and back-office
Synergies working papers for back-office work stream