ITEM: 09/045
DOC: 9

MEETING: Trust Board – 18 March 2009

TITLE: 2009/10 Annual Plan and Annual Budget

SUMMARY:
As an NHS Trust the Whittington is required to submit its 2009/10 annual plan to NHS London. The Board will be aware that the Whittington submitted its draft annual plan on 19 January 2009. It is usual for NHS London to require Trusts to provide additional information following NHS London analysis and the Whittington has provided additional information on a number of items including:

- Patient experience measures
- Staff satisfaction actions
- Workforce planning
- Updated financial information

The Trust provided NHS London with a final submission on 23 February 2009 which included the new information that had been provided through the weeks following initial submission.

Although the plan focuses on 2009/10 NHS London requires that narrative and financial detail is provided for the two successive financial years. The narrative included in the annual plan has been taken from the integrated business plan which was seen and approved by the Trust Board in December 2008.

The Trust's strategy, corporate objectives, governance risks and mitigations and service development plans are in line with those expressed in the IBP. The major performance issue that has been highlighted in the plan is the Trust's incidence of MRSA bacteraemia infection and the actions to address this are detailed.

The Financial Plan for 2009/10 to 2011/12 is discussed along with the assumptions, risks and mitigations and is based upon the initial annual plan submission. The income values for the plan are currently being negotiated and consequently the position presented represents work in progress.

Details of the financial plan have been summarised in the executive summary along with the recommended next steps.

ACTION: For discussion and approval

REPORT FROM:
Fiona Elliott, Director of Planning & Performance
Richard Martin, Director of Finance

SPONSORED BY: David Sloman, Chief Executive

Financial Validation Lead: Director of Finance	Richard Martin

Compliance with statute, directions, policy, guidance Lead: All directors	**N/a**

Compliance with Healthcare Commission Core/Developmental Standards Lead: Director of Nursing & Clinical Development	**Reference:** N/a

Compliance with Auditors' Local Evaluation standards (ALE) Lead: Director of Finance	**Reference:** Financial management – planning and risk management

Compliance with requirements of FT application and monitoring regime Lead: Director of Strategy & Performance	**Reference:** Key component of application process in order to support Board Memorandum

1.0 Executive Summary

1.1 The plan for 2009/10 is a deficit of £3m with deficits of £7.4m and £6.7m in the following two years
1.2 No contingency is included
1.3 Only £0.8m is assumed from potential release of provisions
1.4 CIP in 2009/10 has been reduced from £8m to £5.9m
1.5 DTC income targets have been reduced by £1.5m in 2009/10 recurrently
1.6 Income from Out-patients and imaging consistent with NHS London directive
1.7 Partial inclusion of performance penalties within planned deficit
1.8 Significant risk to position as PCT SLA proposal not agreed or received
1.9 Significant risk re coding of patient data in time
1.10 Budget setting process may produce cost pressures following detailed bottom up analysis
1.11 Future years may receive a lower tariff increase and future CIP requirements will need to increase along with a return to the original CIP target for 2008/09.
1.12 PCT affordability is variable and possibly an issue
1.13 Activity projections require further review
1.14 Measures have yet to be agreed for the CQUIN payment and a degree of risk exists
1.15 Loans for working capital will be required in 2010/11 and 2011/12 and these will breach the PBL in 2011/12
1.16 Risk rating of 2 applies across the three years
1.17 There is the risk of a breach of the statutory break-even duty in the future subject to firming up on the numerous variables
1.18 There are implications for setting an imbalanced plan that is not recovered and rebalanced in the short term.
1.19 The Trust is not currently in a position to re-activate its FT application

2.0 Next steps

2.1 Approve the deficit budget of £3m for 2009/10
2.2 The Executive team to prepare proposals to balance the 2009/10 plan by the end of May
2.3 Achieve the best possible outcome on the 2009/10 SLA – March 2009
2.4 Review all activity projections and confirm feasibility – March 2009
2.5 Create replacement proposals to return to a CIP target of £8m on a recurrent basis in 2009/10 – April 2009
2.6 CIPs in 2010/11 should rise to £9.3m from £4.1m – April 2009
2.7 Reconcile and agree to the annual plan control total the outcome of the detailed budget setting process or realistically adjust income or CIP plans – April 2009.
2.8 Ensure that there is an effective action plan in place to code patient data within one month of the month end correctly and fully – March 2009
2.9 Re assemble the long term financial model and identify size of problem – May 2009
2.10 External assurance of financial model to confirm size of problem - June 2009.
2.11 Use financial data as part of the due diligence process for assessing options for future viability – Second quarter onwards

A) 2009/10 Annual Plan Narrative

1.0 Introduction

NHS London provides a structured template for the development of the annual plan and this is coherent with the required content of the Integrated Business Plan (IBP) and long term financial model (LTFM). Although the plan focuses on 2009/10 NHS London requires that narrative and financial detail is provided for the two successive financial years. The narrative included in the annual plan has been taken from the integrated business plan which was seen and approved by the Trust Board in December 2008.

The Trust's strategy, corporate objectives, service development plans and governance risks and mitigations are in line with those expressed in the IBP. The major performance issue that has been highlighted in the plan is the Trust's incidence of MRSA bacteraemia infection and the actions to address this are detailed.

2.0 Trust Strategy

The annual plan confirms the Trust's strategy to be "the hospital of choice for local people", providing a core range of services and having a special focus on day treatment and one stop care, maternity and neonatal services, and the management of long term conditions in partnership with primary and community providers. It describes the Whittington's niche in the market place as providing a range of acute services, which complement those of the major acute and specialist hospitals within the local health economy and that the portfolio of services provides a basis on which to develop, in partnership with both commissioners and providers of healthcare. Consideration for the implications of the Healthcare for London strategy are outlined and demonstrate that this is consistent with the Whittington's proposed model for the provision of primary, community, secondary and specialised care.

3.0 Corporate objectives

i) The annual plan outlines the Trust's strategic goals of: patient focus, operational excellence and financial strength and the ten strategic objectives, again taken from the IBP, which provide the building blocks for delivering the vision.

4.0 Service developments

A summary of the SWOT analysis from the IBP was provided and detail of seven key service development areas presented with high level income and expenditure and workforce planning information. The seven service development areas in the 2009/10 annual plan are as follows:

- Reducing health care associated infections (HCAIs)
- Investing in neonatal care and maternity services
- Utilisation of Day Treatment Centre capacity
- Working in partnership with primary and community care to provide seamless services in the most appropriate setting
- Responding to the recommendations of Healthcare for London
- Continuing the programme of improved bed utilisation
- Transformational Redesign Programme - improving the non-clinical systems for planned care services

5.0 Governance

The annual plan provides detail of the Whittington's integrated governance framework and risk management structure. The Risk Management Strategy was included and the function of the Board Assurance Framework and Risk Register, mapped to the corporate objectives, was outlined. Commentary was provided on key strategic, quality and safety, operational, IM&T, and human resources risks and the actions that are being taken to mitigate these.

A full copy of the annual plan is available for inspection by the Trust Board through the Director of Planning and Performance.

B) Three-Year Financial Plan 2009/10 to 2011/12

1.0 Introduction

The 2009/10 annual plan that submitted on the 23 February 2009 to NHS London preceded completion of the SLA negotiations. At this time the assumptions made, which are outlined in more detail below, resulted in a deficit of £3m. The annual plan is a three year document, and on this basis future years are also in deficit. This position may change as a result of the outcome of the SLA negotiations.

This report covers the following aspects of the development of the financial plan:

- Methodology
- Assumptions
- Risks & Mitigations
- New Information
- Changes to earlier Annual Plan submission
- Summary Financial Statements
- Capital
- Cash
- Risk Rating
- Cost Improvement Plan
- Budget setting
- SLA Negotiations
- Implications of a deficit plan
- What would help improve the position?
- Implications for the FT application
- Conclusions and next steps

2.0 Methodology

2.1 The annual plan submission to NHS London is a three-year document with a series of financial templates and takes the form of a smaller version of the IBP and LTFM. The requirements for submitting the document stipulated the expectation that HRG4 and IFRS should be reflected along with the inclusion of a contingency and a minimum position of break-even in each year.

2.2 The IBP/LTFM as assembled and presented to the December Trust Board, did not reflect HRG4 or IFRS and nor did it reflect more recent information such as the increase in the CNST premium. The new information has been overlaid onto the earlier LTFM values and a best/likely/worst-case scenario developed.

2.3 The annual plan shows a base case and a downside case, with the base case representing what the Trust believes may happen in terms of SLA settlement. The base case is equivalent to the likely case and generally reflects more up to date information on the 38 variables that are facing the Trust than was included in the annual plan that was submitted in January.

2.4 The expenditure and activity assumptions were assembled with reference to activity and expenditure trends, budget holder views, approved cost pressures, and updates to the forecast CIP plus new information as detailed within this report.

3.0 Assumptions

3.1 The following key assumptions have been used:

Income

- HRG4 Tariff used
- MFF reductions reflected
- No further MFF smoothing assumed
- Non-face to face contacts and Audiology (specifically highlighted) are paid at the non-mandatory tariff
- The capping approach, as directed by NHS London has been followed for Unbundled Imaging and Out-patient procedures. These are no longer assumed to be reimbursed in line with the non-mandatory tariff resulting in a £4m reduction in income.
- CQUIN quality payment of 0.5% is not fully received, instead 0.4% within likely case.
- That PCT proposed performance penalties are not fully reflected in the likely case deficit for 2009/10.
- No disruption to current critical care funding
- Coding of data can be final within one month – although £0.7m risk included in likely case
- Patient transport services are reimbursed as per the SLA proposal
- That the tendering of urgent care for minor ED attendances slips by 6 months
- Lower ED price for minors following re-tendering
- Paediatric ED opened in 2008/09 with activity growth as per IBP Maternity deliveries increase to 4,400 from 3,700 in 5 years based on trend
- That the additional Maternity funding received in 2008/09 is made recurrent £0.7m
- Income and expenditure of NICU and maternity interim development reflected
- Day treatment target included within IBP is reduced by £1.5m
- That income reduces by £0.5m due to the ISTC (50% of PCT expectation)
- Risk adjusted demand management expectations incorporated – Out-patients and ED
- Impact of HFL – trauma & cardiac although stroke loss is shown under risks
- Additional HDU activity coded (part of CIP)
- R&D reduction incorporated
- SIFT rebasing in 2010/11 does not result in any change
- Population growth of 7.3% over 10 years as per IBP
- Non-recurrent income negligible from 2009/10

Expenditure

- CNST Premium increase reflected of £1m
- IFRS reflected in expenditure and balance sheet.
- Drugs inflation of 7% including NICE as per local provider analysis
- 2009/10 includes an estimated net impairment of the estate of £0.4m following revaluation.
- Pay awards - 2.5% for agenda for change staff with 2.1% for other staff.
- EWTD and increments have been included separately.
- Cost pressures are specific validated proposals that have been discussed with divisions alongside other assumptions such as activity, roll forward budgets and CIP.
- From 2010/11 onwards a budget has been set aside for as yet un-presented pressures on a recurrent and cumulative basis. The value is 0.97% or approximately £1.6m per annum and is based upon the level planned in 2009/10.
- Non- pay inflation of 2.8% reducing to 2.3% in subsequent years and is based upon Treasury forecasts.

- Roll forward and funding of any unavoidable levels of net over-spending.
- Additional provision made for drugs and clinical consumables based upon the movement in patient activity from year to year from 2009/10 on a recurrent basis.
- Working capital assumptions – NHS Debtors 81% within the month collected with 10% collected within one and two months. Non NHS Debtors 87% are settled within 30 days.
- Trade creditors 83% to 91% within 30 days
- Asset revaluation in the first quarter of 2009/10 to move to the revised basis of "modern equivalent asset" – expected to generate a reduction of at least £7.6m on a total buildings valuation of £52.4m excluding PFI.
- 2009/10 initial cost improvement programme set at £8m. £5.9m of this has been identified on a recurrent basis. It is further assumed that £1.1m of the shortfall is temporary and can be achieved from 2010/11, in addition to the standard requirement of £4.2m on a recurrent basis thereafter.
- Temporary borrowing now included from 2010/11 in order to maintain cash balance at £3m.
- No contingency included

4.0 Risks and mitigations

4.1 A degree of risk and prudence has been reflected in the likely case deficit of £3m in 2009/10, although the potential for further adverse changes exists. Key changes within the planned deficit of £3m include:

- Reduce the CIP target from £8m to £5.9m of which £1m reduction is recurrent and £1.1m reduction is non recurrent
- Recurrently reduce DTC income target by £1.5m
- Lower level of demand management as per PCT revised assumptions £0.2m
- Loss of ISTC income at 50% of PCT expectation - £0.5m
- Loss of ED tender for urgent care – further £0.2m
- Unexpected cost pressures of £0.5m – allowance made
- Performance metrics of £2.0m included but not agreed

4.2 Specific mitigations against the risks include:

- Non-recurrent measures such as review of provisions to deal with non-recurrent problems. Very limited scope in 2009/10 compared to 2008/09.
- Lease space to other organisations
- Charge rent to third party provider of urgent care
- Extract a marginal cost saving of 25% if the ISTC is successful

4.3 By far the greatest risk concerns the agreement of the SLAs in 2009/10 and the need to avoid any further move towards the worst case. Key risks are as follows:

- CQUIN shortfall £650k at stake with £500k achievement assumed in likely case
- Critical care/block SLA funding
- Coding of patient activity in time – risk of £1.5m
- Performance penalties such as follow up ratios and other metrics
- Further CIP slippage and scope to identify replacement schemes in 2009/10
- Activity projections requiring further reduction
- ISTC is more successful than assumed

- Budget setting process reveals further pressures that cannot be managed back to the proposed overall budget control total.
- PCT affordability
- From 2010/11 lower tariff uplifts of 0.7% and SIFT rebasing along with assumptions of 4.5% CIP instead of the 2.3% assumed

5.0 New Information

5.1 Since the submission of the draft annual plan to NHS London on the 19th January, the Trust was contacted on the 5th February by commissioners. The following performance metrics were outlined with a financial penalty for non-compliance:

- Non-payment for re-admissions within 28 days
- Non-payment for consultant to consultant referrals without GP approval
- Non-payment for elective work if day case rate too low
- Non-payment for pre-admission bed days >2% of admissions
- Non-payment for low priority procedures without prior approval
- Non-payment for "S22" activity – procedure not carried out
- Dispute over paying for HDU activity carried out on the wards

5.2 The previous plan submission prudently assumed a proportion of the income that could have been charged for Out-patient procedures and unbundled imaging. New instructions from NHS London have outlined a revised methodology for charging that does not use the indicative tariff that was published for 2009/10. The consequence is to reduce our income expectation by approximately £1.2m although had the full entitlement been previously assumed the reduction would have been circa £4m.

5.3 The quality top up to the tariff of 0.5% is not seen by the PCT as being an automatic pass through payment and instead expects to retain a proportion of the £650k at stake. Measures have yet to be agreed.

5.4 The PCT is challenging some historic block items of funding and some risk has been reflected in the likely case scenario.

5.5 More prudent provision has been made in respect of income activity and CIP achievement and no contingency is now being held.

5.6 The previous plan showed a break-even position although a £4.5m unallocated contingency was being held. The submitted plan now shows a £3m deficit with no contingency held and therefore there has been an adverse movement of £7.5m between the two plans.

6.0 Changes to earlier Annual Plan submission

6.1 The following table summarises the change between the two annual plan submissions to date for the first two years:

	2009/10 Annual original plan	2009/10 new plan	2009/10 change
	£m	£m	£m
Surplus as per latest IBP(Base case)	2.900	2.900	0
Adjustments			
HRG4/MFF Mandatory	2.374	2.374	0
CNST & IFRS Pressures	3.000	3.000	0
HRG4 (Non mandatory issues)	6.848	3.757	-3.091
Other contractual issues	2.450	1.900	-0.550
Performance metrics and new information	0	-1.855	-1.855
Other pressures/adjustments	-1.148	-1.148	0
Total surplus/(deficit) before risks/mitigations	**5.676**	**0.180**	**-5.496**
Risks & mitigations	-1.175	-3.225	-2.050
Contingency	-4.501	0	4.501
Total surplus/(deficit) after risks& mitigations	**0**	**-3.045**	**-3.045**

	2010/11 Annual original plan	2010/11 new plan	2010/11 change
	£m	£m	£m
Surplus as per latest IBP(Base case)	4.500	4.500	0
Adjustments			
HRG4/MFF Mandatory	-7.566	-7.566	0
CNST & IFRS Pressures	-2.819	-2.819	0
HRG4 (Non mandatory issues)	8.265	3.757	-4.508
Other contractual issues	2.000	1.450	-0.550
Performance metrics and new information	0	-1.855	-1.855
Other pressures/adjustments	-1.898	-1.898	0
Total surplus/(deficit) before risks/mitigations	**2.482**	**-4.431**	**-6.913**
Risks & mitigations	-1.425	-2.925	-1.500
Contingency	-1.057	0	1.057
Total surplus/(deficit) after risks& mitigations	**0**	**-7.356**	**-7.356**

6.2 The main changes relate to the revised instructions from NHS London regarding Out-patients and imaging, late data entry penalty and reduction of block SLA items. In addition a lower estimate for DTC activity and a reduced impact of risk mitigations has been reflected.

7.0 Summary Financial Statements

7.1 The following statements show a high level summary of the plan submitted

Income and Expenditure

	Forecast 2008/09 £m	2009/10 £m	2010/11 £m	2011/12 £m
Income				
Elective	21.6	9.2	11.0	11.7
Same day	0	18.6	18.8	19.1
Non-elective	51.2	52.7	51.8	53.3
Out-patients	29.0	29.1	30.2	31.0
A&E	8.3	7.3	6.7	7.0
Other	26.9	27.955	25.744	26.534
Non NHS	1.0	0.7	0.8	0.8
Total Clinical revenue	**138.0**	**145.555**	**144.944**	**149.434**
R&D	0.6	0.1	0.1	0.1
Education & Training	15.5	14.6	14.9	15.1
Other	11.7	8.9	9.1	9.3
Total Non clinical revenue	**27.7**	**23.6**	**24.0**	**24.5**
Total Operating income	**165.7**	**169.155**	**168.944**	**173.934**

Expenditure	Forecast 2008/09 £m	2009/10 £m	2010/11 £m	2011/12 £m
Pay	110.9	113.7	117.6	121.4
Drugs	8.7	8.7	9.0	9.6
Clinical supplies and services	15.2	16.2	16.5	16.7
Other costs	14.1	18.3	18.1	17.9
Contingency	0	0	0	0
PFI	6.3	0.8	0.8	0.8
Total operating expenses	**155.2**	**157.6**	**161.5**	**165.8**
EBITDA	**10.5**	**11.6**	**7.1**	**7.7**
Impairments	0	(0.4)	0	0
Depreciation	(4.9)	(6.6)	(6.9)	(6.9)
Interest receivable	0.3	0.1	0.1	0.3
Interest payable	0	(3.9)	(3.9)	(3.9)
PDC Dividend	(3.8)	(3.7)	(3.7)	(3.9)
Net surplus/(deficit)	**2.0**	**(3.045)**	**(7.356)**	**(6.666)**

Balance Sheet

	As at 31.3.09 £m	As at 31.3.10 £m	As at 31.3.11 £m	As at 31.3.12 £m
Total Non-current assets	120.4	154.4	150.9	148.3
Current assets				
Stock	1.3	1.4	1.4	1.4
NHS Debtors	4.3	4.5	4.6	4.8
Non NHS Debtors	1.1	1.1	1.1	1.1
Cash	3.0	3.1	3.0	3.0
Pre-payments	0.5	0.3	0.3	0.3
Sub total	**10.3**	**10.4**	**10.4**	**10.6**
Current liabilities				
Trade creditors	(4.8)	(5.0)	(5.2)	(5.4)
Other creditors	(4.2)	(4.4)	(4.6)	(4.8)
Capital creditors	(2.2)	(2.2)	(2.2)	(2.2)
Deferred revenue	(0.3)	(0.3)	(0.2)	(0.3)
Accruals	(3.2)	0	0	0
Finance leases PFI	0	(4.5)	(4.6)	(4.7)
Finance leases other	0	(0.9)	(0.4)	(0.3)
Provisions	0	(0.4)	(0.4)	(0.4)
Other liabilities	0	(4.1)	(4.2)	(4.3)
Sub total	**(14.7)**	**(21.8)**	**(21.8)**	**(22.4)**
Total assets less current liabilities	**116.0**	**143.0**	**139.5**	**136.5**
Non current liabilities				
Provisions	(2.5)	(2.1)	(2.1)	(2.1)
Finance leases PFI	0	(37.9)	(38.1)	(38.1)
Finance leases other	0	(3.9)	(3.5)	(3.2)
Working capital loans	0	0	(4.3)	(8.5)
Sub total	**(2.5)**	**(43.9)**	**(48.0)**	**(51.9)**
Total assets employed	**113.5**	**99.1**	**91.5**	**84.6**
Taxpayers equity				
Public Dividend Capital	48.1	48.1	48.1	48.1
Retained earnings	24.0	15.7	8.1	1.4
Revaluation reserve	40.3	34.3	34.3	34.2
Donated asset reserve	1.2	1.0	1.0	0.9
Total taxpayers equity	**113.5**	**99.1**	**91.5**	**84.6**

Cash flow

	As at 31.3.09 £m	As at 31.3.10 £m	As at 31.3.11 £m	As at 31.3.12 £m
EBITDA	10.5	11.6	7.1	7.7
Exclude non-cash I&E items	0	0.9	0.9	0.9
Movements in working capital	0.2	0.1	0.4	0.3
Cash flow from operations	**10.3**	**12.6**	**8.4**	**8.9**
Capital expenditure	(7.0)	(4.8)	(4.9	(5.3)
Interest receivable	0.3	0.1	0.1	0.3
Interest paid on PFI leases	0	(3.7)	(3.7)	(3.7)
Interest paid on other leases	0	(0.3)	(0.3)	(0.3)
Drawdown of working capital loan	0	0	4.3	4.2
PDC Received	0.8	0	0	0
Dividends paid	(3.8)	(3.9)	(4.0)	(4.2)
Net cash inflow/(outflow)	**0.5**	**0.1**	**(0.1)**	**(0.1)**
Opening cash balance	2.5	3.0	3.1	3.0
Net cash movement	0.5	0.1	(0.1)	(0.1)
Closing cash balance	3.0	3.1	3.0	3.0

8.0 Capital Expenditure

8.1 The expenditure programme for the next three is £4.8m, £4.9m and £5.3m respectively. This value is derived from the previously approved control total with an adjustment to remove the PFI residual interest capitalisation value which is no longer possible under IFRS.

8.2 A consequence of adopting IFRS is that additional capital expenditure which has traditionally been incurred via our PFI provider and our managed equipment service provider, now counts towards our capital programme and the Capital Resource Limit (CRL). This in turn requires a larger CRL to be approved by the Department of Health and a request for £1.6m increase has been submitted. Approval will not be known until May and until that point the plan that should be used must be restricted to the values shown in 8.1.

8.3 Any new/replacement leases whether they be Finance leases (counts as capital) or operational leases (counts as revenue) must be subject to the business planning scrutiny and approval process before any additional commitments are entered into. This also applies to requests to our PFI and managed equipment providers and is necessary to closely manage the annual revenue position and ensure that the CRL is not breached.

8.4 The financing source for the capital programme is the Trust's internal depreciation charge which for 2009/10 is £6.6m. This source is in excess of the capital programme and the difference is being used to maintain the cash balance in light of the forecast revenue deficit. Should the Trust return to a recurrently balanced revenue position in

2009/10 and have a plan to deal with 2010/11, there would be scope to increase the capital programme so that the internal resources are fully used each year. The need to conserve cash is particularly important as access to working Capital loans is likely to be limited.

8.5 There is no expectation within the programme for asset disposals or investment loans.

9.0 Cash

9.1 The Trust is on target to achieve the £3m cash balance that it is required to achieve by 31 March 2009. Any variation would result in either a statutory duty breach or a loss of cash. Going forward into 2009/10 a £3.1m year end balance is planned despite a planned deficit of £3m. This is not being achieved through the use of any working capital loans or paying our creditors any less quickly.

9.2 There are three main reasons why the cash balance can be maintained during 2009/10:

- Within the £3m deficit, there is a £2m cost pressure associated with IFRS for which there is a negligible cash impact.
- The capital programme is lower than the depreciation funding source by £1.8m
- The deficit is supported by the potential non-recurrent release of provisions of £0.8m and this is not assumed to be cash backed

9.3 Going forward into 2010/11, the position changes because the deficit increases to £7.4m and whilst there is still a benefit from the first two points above, there would be a need for a loan for £4.3m. This loan would maintain the cash balance at year end at £3m and ensure liquidity during the year. Moving into 2011/12, the deficit remains high at £6.7m and the loan would increase to a total of £8.5m. This level of loan assumes that the cash balance is maintained at £3m and that the two indicated deficits and capital programmes are incurred.

9.4 In order to obtain a loan for working capital purposes, the Trust will need borrow against its Prudential borrowing limit (PBL). This limit is calculated with reference to the size of the balance sheet and the risk rating at the time. Currently the Trust has a PBL of £16m and not consumed any of it by way of either borrowings or Finance leases including PFI.

9.5 From April 2009, IFRS has brought the PFI and some finance leases onto the balance sheet and these will count against the PBL. Clearly the size of these liabilities far exceeds the PBL and the Department of Health is currently reviewing the arrangements for dealing with this consequence. On the basis that the PBL is still available to meet new borrowings or new finance leases, there needs to be confirmation of the available PBL in 2009/10.

9.6 The balance sheet as at March 2011 is worth £91.5m and the projected risk rating for 2010/11 is 2. This means that the Trust could borrow £91.5m x 5% or £4.5m, which is sufficient to cover the estimated requirement of £4.3m. Inevitably, any loan would require a credible plan for repayment and would also consume the entire PBL leaving no room for new leases. The next issue is that moving forward into 2011/12, there is a financing requirement of £8.5m in total and this would breach the PBL and would require special arrangements to be agreed in order to maintain liquidity.

9.7 Consequently, a large sustained revenue deficit will rapidly attract a cash flow problem and the Trust would need to secure concessions from NHS London/Department of Health whilst the revenue deficit is being managed.

10.0 Risk rating

10.1 A rating of 2 is predicted for the next three years using the methodology of NHS London as compared to the expected 3 that is to be achieved in 2008/09. The significance is that borrowing powers are reduced from 15% to 5% of the balance sheet value and that the Trust will receive monthly monitoring.

10.2 Due to the projected deficit, the return on assets, EBITDA margin, surplus margin and liquidity ratio all suffer and consequently, the Trust will experience some intervention by NHS London if a solution cannot be found to balancing its budget and delivering a balanced outturn for the next three years.

11.0 Cost Improvement Plan

11.1 The target for 2009/10 is £8m with following years currently estimated at £4.1m and £4.3m. This target translates into 4.7%, 2.4% and 2.5% respectively of total revenue.

11.2 Within the forecast deficit it has been assumed that £1m will slip recurrently and £1.1m will slip non-recurrently. This is following further reviews of the savings schemes and there is a risk that slippage could still occur.

11.3 The table below highlights the assumptions for the next three years

	2009/10 £m	**2010/11 £m**	**2011/12 £m**
Original 2009/10 programme- recurrent	8.0	8.0	8.0
Less recurrent adj	(1.0)	(1.0)	(1.0)
Less non-recurrent adj	(1.1)	0	0
2010/11 programme – target all recurrent	0	4.1	4.1
2011/12 programme – target all recurrent	0	0	4.3
Total additional CIP (Cumulative)	**5.9**	**11.1**	**15.4**

It can be seen that within the projected deficit of £3m for 2009/10 that £2.1m is due to the changed assumptions around the CIP that is deliverable in 2009/10.

11.4 Going forward expectations of the necessary CIP rise to 4.5% according Monitor in their planning assumptions that were recently issued. This would roughly translate to an extra £4m a year recurrently from 2010/11 on top of the original programme described above of £4.1m to £4.3m

11.5 There is a clear need to return to the original target for 2008/09 on a recurrent basis and plan for higher CIPs in the following years to reflect lower levels of tariff increase and the additional MFF reduction due in 2010/11.

11.6 It not possible to pinpoint the necessary level of CIP at the present time as there are still too many variables that need to be concluded. However, as a minimum it is likely to be necessary to aim for increasing the 2010/11 target from £4.1m to £9.3m whilst at the same time returning to the £8m for 2009/10.This would achieve a break-even position only in 2010/11 under the likely case.

12.0 Budget Setting

12.1 The annual plan was assembled with the involvement of budget holders and reflected expenditure and activity forecasts, approved cost pressures, developments and the CIP. New information has been overlaid such as IFRS,CNST and HRG4/MFF with the annual plan being based upon the likely case forecast for numerous variables.

12.2 A detailed bottom up exercise is in progress to reaffirm the detail of individual budgets with the intention of each budget holder signing off an agreed opening budget for 2009/10. The annual plan took into account any net over and under spending and also re-affirmed the level of CIP, cost pressures and the forecast when it was being assembled.

12.3 Should there be any deviation to this overall approach e.g. building in overspends but not under spends, there will be a further unplanned adverse movement in the bottom line deficit. Consequently, all bottom up budget calculations will be compared to the detailed control total for each division which overall reconciles back to the annual plan. The difference will be analysed and any change in assumptions will require validation and approval before the bottom line deficit is changed.

12.4 In the light of the need to restore financial balance urgently, it is recommended that the control total is maintained unless additional approval is given by the Executive Committee or clear justifiable additional activity can be prudently planned. Consequently, Budget holders would be required to identify compensatory adjustments in order to not breach the overall control target of a £3m deficit.

13.0 SLA Negotiations

13.1 As at 11 March, a revised SLA offer from the PCT commissioning agency had not been received. The deadline for signing is 13 March and a number of differences in position exist. The key differences concern 1) Performance metrics with financial penalties including follow up ratios totalling £3.6m 2) CQUIN 0.5% value £650k 3) Closing the financial gap.

13.2 It is also known that a large gap exists in North Central London between what the Trusts expect and what the Commissioning agency has offered. It is also clear that the agency will not sign an agreement with this Trust if it cannot sign all its agreements with all Trusts. Consequently, it is unlikely that signing of agreements will take place on the 13 March

13.3 The Trust has rejected the use of financial penalties as has all local Trusts and to date there has not yet been a directive from NHS London that they are mandatory. The CQUIN has been requested as a pass through payment this year whilst information systems and data quality is established. The agency does not expect to pass this funding across in this way. The final issue is the size of the financial gap and it is not clear what the present value for this. It is thought that the gaps between agency offers and trust expectations is variable.

14.0 Implications of a deficit plan

14.1 The statutory duty to break-even takes one year with another and allows a three year time frame to ensure a balanced position is achieved. By the end of 2008/09 it is expected the cumulative accrued surpluses less any historical deficits will be £3.9m. This means that the Trust could incur a £3.9m deficit in 2009/10 and still be meeting its break-even duty. Should the Trust then go to incur a deficit of £7.4m in 2010/11, it would have two years to recover that sum plus any new deficits that are generated in the following two years. The three year duty can be extended in exceptional circumstances to five.

14.2 It can be assumed that without a realistic plan to achieve recurrent balance in each year, a breach of the statutory duty will inevitably occur. Implications include 1) Qualified accounts 2)Intervention by the Department of Health and NHS London with a focus on the failure regime 3) ALE score would reduce to 1 4) Whilst the going concern principle may not be challenged by the auditor, it can be assumed that the future of the Trust will be the subject of intense interest by NHS London. 5) Cash flow issues as described within this report 6) Plans would not be consistent with the operating framework as issued by the Department of Health 6) Potential public interest reports from the external auditor.

14.3 A deficit plan is presented at this stage as this represents the likely case assessment of the numerous variables facing the Trust. Following consultation with the external auditor, it is recognised that this position could be viewed as temporary given the uncertainty around the outcome of the SLA negotiation. In addition the CIP, activity levels and the budget setting results need to be reviewed to re-affirm that a realistic position, which is consistent with the level of activity is presented. This review which is already underway needs to be concluded so that the Trust can re-assess its financial position for 2009/10 and beyond. The aim would of course be to balance 2009/10 such that the annual plan can be re-stated and possibly re-submitted to NHS London so that the risks outlined above can be minimised or avoided.

15.0 What would help improve the position ?

15.1 The following would help improve either the likely case or avoid further deterioration:

- IFRS removed from the break-even measurement
- CQUIN received in full
- No loss of historical block funding elements
- Activity data final and correct within one month
- Out-patient procedures and imaging paid at non-mandatory tariff in 2010/11
- No follow up ratios applying
- Budget setting process does not produce additional cost pressures
- That there is no further reduction in activity estimates and that they remain realistic
- Loss of income on ED tender is minimised
- Maternity funding recurrent from 2010/11
- No disputes e.g. N12 Maternity
- Higher levels of activity that is presently un-coded
- No performance penalties e.g. re-admissions
- Tariff increase not as low as Monitor predicts or MFF smoothed
- CIP target achieved in 2008/09 of £8m by identifying replacement schemes

- CIP target set and achieved of £9.3m in 2010/11 subject to other variables changing
- DTC capacity is fully utilised and targets not missed
- PCT demand management land ISTC less effective than PCTs expect
- No loss of stroke services in 2010/11
- Inflation levels lower than assumed

15.2 There are work-streams that are tacking most of the above and it is suggested that all of the information be re-assembled into a revised financial plan that specifically considers each of the above and re-assesses the financial deficit.

16.0 Implications for the FT application

16.1 At this point, the financial position is not sustainable and would deteriorate further once the Monitor assumptions around tariff uplift are applied. Monitor expects CIPs to be detailed for the five year period and amount to an extra 4.5% per annum recurrently. In addition full commissioner support and confirmation of activity levels is essential.

16.2 A Trust cannot be in deficit and must have a risk rating of 3 before it can be considered. In general, the economic outlook and considerable uncertainty on numerous fronts suggests that the Trust is not presently in a position to re-apply to Monitor and should instead concentrate on re-establishing its financial position.

17.0 Conclusions and next steps

- The plan for 2009/10 is a deficit of £3m with deficits of £7.4m and £6.7m in the following two years
- No contingency is included
- Only £0.8m is assumed from potential release of provisions
- CIP in 2009/10 has been reduced from £8m to £5.9m
- DTC income targets have been reduced by £1.5m in 2009/10 recurrently
- Income from Out-patients and imaging consistent with NHS London directive
- Partial inclusion of performance penalties within planned deficit
- Significant risk to position as PCT SLA proposal not agreed or received
- Significant risk re coding of patient data in time
- Budget setting process may produce cost pressures following detailed bottom analysis
- Future years may receive a lower tariff increase and future CIP requirements will need to increase along with a return to the original CIP target for 2008/09.
- PCT affordability is variable and possibly an issue
- Activity projections require further review
- Measures have yet to be agreed for the CQUIN payment and a degree of risk exists
- Loans for working capital will be required in 2010/11 and 2011/12 and these will breach the PBL in 2011/12
- Risk rating of 2 applies across the three years
- There is the risk of a breach of the statutory break-even duty during 2010/11 subject to firming up on the numerous variables
- There are implications for setting an imbalanced plan that is not recovered and rebalanced in the short term.
- The Trust is not currently in a position to re-activate its FT application

Next steps

- Approve the deficit budget of £3m for 2009/10
- The Executive team to prepare proposals to balance the 2009/10 plan by the end of May
- Achieve the best possible outcome on the 2009/10 SLA – March 2009
- Review all activity projections and confirm feasibility – March 2009
- Create replacement proposals to return to a CIP target of £8m on a recurrent basis in 2009/10 – April 2009
- CIPs in 2010/11 should rise to £9.3m from £4.1m – April 2009
- Reconcile and agree to the annual plan control total the outcome of the detailed budget setting process or realistically adjust income or CIP plans – April 2009.
- Ensure that there is an effective action plan in place to code patient data within one month of the month end correctly and fully – March 2009
- Re assemble the long term financial model and identify size of problem – May 2009
- External assurance of financial model to confirm size of problem - June 2009.
- Use financial data as part of the due diligence process for assessing options for future viability – Second quarter onwards