Trust Board Paper R3

To:	Trust Board
From:	Andrew Seddon, Director of Finance & Business Services
Date:	20 December 2013
CQC regulation:	All applicable

Title:	**2013/14 financial forecast**

Author/Responsible Director: Andrew Seddon, Director of Finance & Business Services

Purpose of the Report: To set out the basis for the full year reforecast.

The Report is provided to the Board for:

Decision	X	Discussion	
Assurance		Endorsement	X

Summary / Key Points:

The trust has consistently reported losses through the current financial year. At the end of month 8, year-to-date losses amounted to £20.3 million.

In addition to an underlying deficit at the start of the year of c£15 million, the trust has overspent in-year on the back of increased emergency activity, investment in additional nurses in response to a review of ward staffing levels, and has incurred transformation costs without revenue support.

Discussions have been ongoing with commissioners over several months regarding financial support to the trust, in the shape of strategic transitional support (to fund the underlying deficit) and also transformational funding. Those discussions have now concluded and there is a material funding shortfall.

A full reforecast has been carried out, based on the month 8 results, and has been subject to a limited scope independent review by the trust's internal auditors, PwC. On the basis of that re-forecast the trust's year-end forecast has been revised to a deficit of £39.8 million.

In order to fund the deficit, an application will be made to the Department of Health for PDC funding.

Given the scale of the deficit in 2013/14, and the associated underlying deficit, this will require a medium-term financial recovery plan. This needs to be prepared in conjunction with the Better Care Together programme for service transformation across the LLR health economy. Given the practical constraints over the rate at which clinical change and related cost reduction can be implemented, it is highly likely that 2014/15 will be a deficit plan.

Recommendations:
The board is asked to:

- **note** the contents of the paper,
- **confirm** the year-end forecast deficit of £39.8 million,
- **mandate** the executive team to ensure that the CMG/corporate directorate outturns are no worse than the reforecast
- **note** the proposed measures around working capital and capital expenditure management
- **note** the submission of the revised forecast the NTDA on 16 December
- **mandate** the executive team to further develop the trust's medium-term financial strategy within the context of the Better Care Together programme.

Previously considered at another corporate UHL Committee?
Private Trust Board on 13 December 2013
Executive Team meeting on 17 December 2013

Strategic Risk Register
The Trust will be in danger of breaching its statutory duty to break-even, taking one year with another. (This is generally taken to mean a cumulative breakeven position over 3 years.)

Resource Implications (eg Financial, HR)
Not at this stage, but the trust may decide to seek external support in achieving financial turnaround.

Assurance Implications
The Finance & Performance Committee, on behalf of the board, will continue seek assurance on the robustness of the financial forecast and of the financial recovery actions. The independent limited scope PwC review has given some assurance on the robustness of the basis of preparation of the 2013/14 forecast.

Patient and Public Involvement (PPI) Implications
The size the deficit will understandably lead to public concern regarding the continuity of services at UHL. A comprehensive stakeholder briefing programme earlier this week has sought to proactively address those concerns. PPI involvement is being designed into the Better Care Together work streams.

Equality Impact
-

Information exempt from Disclosure
-

Requirement for further review?
The forecast and recovery plan will be reviewed at each future board meeting.

Andrew Seddon
Director of Finance & Business Services, 20 December 2013

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **Trust Board**

DATE: **20 December 2013**

REPORT FROM: **Andrew Seddon, Director Finance & Business Services**

SUBJECT: **2013/14 Financial Forecast**

1. Introduction and Context

1.1. This paper summarises the full year forecast which is based on the month 8 (November) year to date results, and provides high level analysis of the main factors giving rise to the deficit. The paper also sets the results in the context of the Trust's 2012/13 results and the 2013/14 annual plan. The contents of the paper are as follows:

- 2012/13 results, focusing on this the underlying deficit and non-recurrent support
- 2013/14 Annual Operating Plan – and the key planning assumptions
- 2013/14 results for the year-to-date – focusing on variances against key Plan assumptions
- 2013/14 full year forecast – including key risks and mitigations
- Recommendations.

2. 2012/13 Financial Performance

2.1. Whilst the headlines stated that the Trust delivered its 2012/13 I&E surplus and cash targets, the reported position contained an underlying deficit of at least £12.5m. Within the reported surplus of £90k (0.01% of revenue) were some significant I&E variances. Income was £35.8m (5%) over Plan, after a £5.1m 70% marginal rate deduction in respect of emergency admissions (MRET). Operating costs were £36.1m over Plan, with premium cost staff largely being used to deliver the additional activity.

2.2. Income included £21m related to a year-end agreement with commissioners, agreed during the final quarter of the year. The £21m came from three sources:

- £7.5m via the newly-formed Local Area Team
- £7.0m from the (soon-to-be abolished) PCT cluster
- £6.5m from the PCTs to reflect the re-investment of performance penalties from ED 4-hour and 62-day Cancer target failures.

2.3. Apart from this major year-end settlement, the commissioners also provided £1.3 million of non-recurrent funding for step-down winter capacity during the course of the year, and a further £7.5m to fund agreed transformational schemes. The transformational funding covered projects schemes such as Hospital at Night, outpatients, Transforming Transcription services, enhanced clinical education and emergency flows.

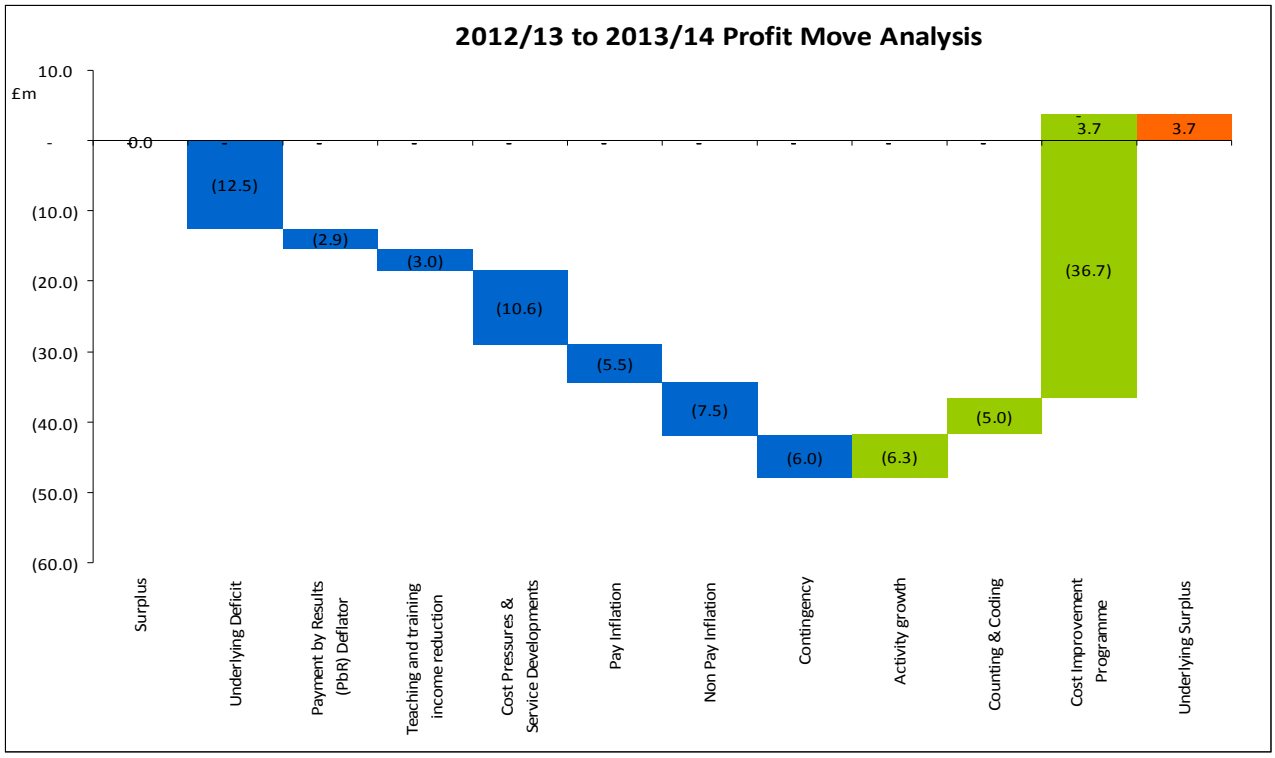
2.4. The non-recurrent nature of the first two funding streams (£14.5m), less £2m of non-recurrent costs, left UHL with an underlying deficit of a minimum of £12.5m. There may be differences of view between UHL and commissioners as to how much of this support could fairly be attributed to headings such as reinvestment of marginal rate (MRET) deductions and readmission fines. What is not contested however is that without a collaborative approach, UHL would have been left with a substantial reported deficit in 2012/13.

(Note: The year-end value of the MRET deduction and re-admission fines was £9.9m – this excludes the financial impact of delivering the increased emergency activity; additional beds, increased staffing costs, particularly premium pay, and cancelled elective activity.)

3. Annual Operating Plan (AOP)

3.1. UHL's 2013/14 AOP was signed off by the Trust Board in March 2013. The AOP was underpinned by an agreed contract with commissioners and with a substantially complete cost improvement (CIP) plan in place.

3.2. The following "waterfall chart" shows the movement from the 2012/13 reported result to the 2013/14Plan surplus of £3.7m.



3.3. The key points to highlight, in addition to the opening underlying deficit are:

- The net **tariff deflator** of £2.9m – this includes a reduction via the national Payment by Results (PbR) mechanism of £9.1m, offset by increases for new tariffs in Imaging and Maternity.
- A reduction in **teaching and training income** of £3m mainly as a consequence of the rebasing of SIFT to a national tariff per student week
- AOP income was stated net of c£8m of marginal rate emergency threshold (**MRET**) deduction and **readmission** penalties. No reinvestment of those monies was assumed within our AOP. This was intended to be a cautious assumption – effectively creating a further contingency within the plan. Planning guidance in these areas for 2013/14 required cooperation and joint decision-making between providers and commissioners regarding the reinvestment of these monies.
- No allowance was made for any performance related **fines or performance penalties** within the AOP.
- The plan assumed **CIP** plans of £40.4m. This represented c5.5% of UHL's cost base. All schemes were reviewed for their quality impact first by UHL's Medical Director and Chief Nurse and then by senior commissioners. Delivery costs of the CIP schemes were assumed to be funded out of the 2% transformation fund that commissioners held for use non-recurrently across the health economy.

  Note: It is clear that this element of the planning process could have been better managed as cost pressures identified subsequent to the end of March – and not funded by commissioners – are a material component of the breakage in the 2013/14 plan. Based on our interpretation of planning guidance, it was reasonable to assume that 2% of the contract value (c£12m) would be available to UHL as a transformation fund. This should have covered implementation costs including project teams, operational inefficiencies, redundancies and

other non-recurrent costs. However, this issue was not sufficiently clarified during the contracting process, resulting in a significant mismatch between the Trust's planning assumptions and the subsequent allocation of the funds.

- **Service development** costs of £10.6m. Key priorities included increases in nurse staffing (acuity and supervisory) and investment in services to support emergency patient flow. A small element of these cost pressures related to transformational schemes, but no matching transformation income was assumed within the Plan. This was intended to be a cautious assumption as application would be made to commissioners to support these transformation costs out of their non-recurrent 2% transformation fund.
- **Inflation** was allowed at just under 2%, totalling £13m across pay and non-pay. This included the national 1% pay increase, AfC incremental drift, drug price increases, and anticipated CNST (the NHS insurance scheme) pressures.
- A **contingency** of £6m (originally intended to be £10 million, but reduced during the final stage of the planning process to offset some of the cost pressures). The reduction in the contingency was phased into Q1 to offset the anticipated deficit from the underlying run rate (see below).

3.4. Against this level of caution and contingency built into the plan, concerns were expressed during the commissioning round by both UHL and commissioners regarding the monthly financial run rate (deficit) exiting 2012/13 and the trust's poor access performance, particularly against the four hour A&E target. In order to address this risk and give a greater degree of certainty around plan delivery, whilst commencing work on the necessary strategic projects designed to resolve the underlying the Trust, the Trust Board determined that strategic transitional support of £15m was needed to assure delivery of the 2013/14 Plan. The finalisation of the 2013/14 plan, including the rollout of budgets to divisions in April 2014, confirmed the need for the additional transitional support to balance the 2013/14 budget.

3.5. Therefore, in response to this concern, the AOP was followed on 8 May 2013 by a request to the Local Area Team of NHS England, the NHS Trust Development Authority and CCGs for transitional funding of £15 million. This was intended:

- To restore the annual plan contingency to the intended level of £10 million
- To provide cover against further slippage in run rate
- To fund the commencement of strategic site reconfiguration projects designed to address the long-term financial and clinical sustainability of the trust's services.

3.6. In making this bid, it was implicitly acknowledged by UHL that the trust is financially and possibly clinically unsustainable in its current (historically-derived) site and service configuration.

3.7. There is a difference of view between the Trust and its commissioners as to whether the 2013/14 contracting agreement was understood to have addressed the Trust's underlying deficit. It is the Trust's contention that this was not the case, hence the need for the bid for transitional support. Nevertheless, it is the case that the bid was only formally quantified after the contracting round had been completed. With hindsight, it would have been better if the quantum of required support been identified in the AOP and contracting round. The position was further confused by initial indications that a national framework was being developed to address such situations. This did not materialise and on 8 September the issue was referred back to the Trust and CCGs for local resolution. It is clear that by this stage the CCGs did not have unallocated resources at this level.

3.8. It should be noted that the Trust's AOP for 2013/14 was developed in the absence of a quantified activity and capacity model emanating from the Better Care Together health economy programme. It should be the case that provider plans are derived directly from such models, so as to ensure complete alignment between commissioner and provider expectations and the continued viability of the economy as a whole.

3.9. The following table summarises the AOP key planning assumptions, especially in respect of income sources, against the likely position, based on most recent discussions with commissioners.

Item	AOP assumption	Current position	Comment
Strategic transitional support	£15 million requested	Nil	The Leicestershire & Lincolnshire Area Team (LAT) was engaged in seeking to broker a solution with LLR CCGs and other parties through to September, at which point the matter was referred back for local discussion. CCGs have indicated that at present there is no basis for the provision of such support and in any event the quantum of funds required is not available.
Transformation funding	2% (£12m) would be available to cover UHL projects.	Comprehensive bid (£12.5m) submitted Q1. c£1.4m funded to date.	Local commissioners have not followed a process which involved discussion with UHL and have not responded to the trust's formal submission (other than in respect of urgent care (see below). We understand that all £20m of LLR transformation funds have now been allocated. Much of this funding has been allocated to schemes which assist with UHL's operations but this does not address the mismatch in financial planning assumptions. Specialised commissioners have not made any transformation funds available (we would have expected c£4 million for UHL schemes).
Readmission penalties	c£4.6m of penalties – no firm assumption regarding reinvestment	Re-admission penalties fully committed to non-UHL schemes.	UHL worked with commissioners to carefully implement 2012/13 readmissions guidance. UHL acknowledge that we did not follow through to agree investment of funds in 2013/14. However, processes around allocation of these funds have been unclear.
MRET	c£3.4m of deductions built into plan	MRET deductions fully committed to non-UHL schemes.	Total MRET deduction increased by £4m in year due to over-performance. The MRET deductions have been invested in their entirety in schemes outside UHL which are aimed at reducing admissions and other schemes in support of the urgent care system.
Winter funding	c£2m built into baseline	£7.8m allocated to UHL (total £9.2m with £1.4m above).	This income is substantially above the AOP assumption but is offset by costs (see below for reconciliation)
Performance fines	No allowance made plan - assumed these would be reinvested in full.	£1.4m of fines / contract deductions recognised in the first seven months	Potential performance failures around: • ED (failure to achieve the recovery plan) and • RTT (as a consequence dealing with backlog) • ambulance turnaround will have a material adverse impact on UHL's position unless reinvested in full.

4. Financial results for the eight months to November 2013

4.1. 2013/14 year to date results have been poor. Continued overheating of emergency demand, and the inability of the hospital to manage this effectively, has led to adverse operational and financial consequences. Delivery of key emergency access targets has been compromised, despite investment of substantial non-recurrent financial resources by the Trust.

4.2. There has been considerable expert external support, changes in clinical management and operational processes and active commissioner support, but A&E performance remains amongst the worst of NHS acute trusts. A successful nursing recruitment campaign – with c500 posts vacant - remains a fundamental challenge for the trust and is now underway in Mediterranean Europe.

4.3. To cope with the additional emergency demand, and to ensure safe staffing levels, the trust has had to resort to substantial use of bank and agency staffing. Nursing ratios were reviewed in the summer and enhanced in the light of the Francis report recommendations and existing local acuity reviews. Partly as a result, the trust has averaged over £3.5 million per month in non-contractual payments, despite an increase in permanent headcount. The enhanced nursing levels add a recurrent £5.8 million to budget baselines (and therefore to the deficit), but in reality the expenditure has been greater as many of those posts have been filled this year at premium rates.

4.4. As a consequence of the poor financial and emergency performance year-to-date, the trust has been graded at Level 4 by the NTDA, which is reserved for those trusts that either submitted a deficit AOP or are reporting material adverse deficits year-to-date.

4.5. Cost controls have been stretched and in part found wanting. Revised procedures have been implemented over the last two months, in particular over the use of agency nursing staff, and we are seeing some improvement in the underlying run rate. Enhanced controls of non-pay have been announced more recently – with a theme being stronger compliance with existing processes.

4.6. The month 8 results and year-to-date performance may be summarised:

	November 2013			April -November 2013		
	Plan £m	Actual £m	Var (Adv) / Fav £m	Plan £m	Actual £m	Var (Adv) / Fav £m
Income						
Patient income	53.8	58.4	4.6	425.6	434.4	8.8
Contigency Release	-	-	-	5.0	5.0	-
Teaching, R&D	5.7	5.6	(0.1)	51.2	50.5	(0.6)
Other operating Income	1.6	1.6	0.0	25.7	25.7	0.1
Total Income	**61.1**	**65.7**	**4.5**	**507.4**	**515.7**	**8.3**
Operating expenditure						
Pay	37.2	39.6	(2.4)	298.8	312.2	(13.4)
Non-pay	23.9	25.4	(1.5)	184.1	194.8	(10.7)
Reserves	(4.1)	-	(4.1)	(7.6)	-	(7.6)
Total Operating Expenditure	**57.0**	**65.0**	**(8.0)**	**475.3**	**507.1**	**(31.7)**
EBITDA	**4.2**	**0.7**	**(3.5)**	**32.1**	**8.6**	**(23.4)**
Net interest	0.0	-	(0.0)	0.0	(0.0)	0.0
Depreciation	(2.7)	(2.7)	(0.0)	(21.7)	(21.5)	0.2
PDC dividend payable	(1.0)	(1.0)	(0.0)	(7.7)	(7.4)	0.3
Net deficit	**0.5**	**(3.0)**	**(3.5)**	**2.7**	**(20.3)**	**(23.0)**
EBITDA %		**1.1%**			**1.7%**	

4.7. The Trust is reporting;

- A cumulative deficit for the 8 months of £20.3m, £23.0m adverse to Plan.
- An in-month deficit of £3.0m, £3.5m adverse to Plan, and £0.5m adverse to the M8 forecast.
- Note that the November result includes £4.1m of the underlying deficit/lack of strategic transitional support.

4.8. **Expenditure**

4.9. The key task for the trust in delivering a controlled full year I&E position is to manage operating expenditure in the remaining months of the year. Operating expenditure is £31.7m above Plan as at the end of November (6.7%).

4.10. **PAY –** as at Month 8, pay costs are £13.4m over budget, £16.7m more than the same period in 2012/13 (5.7%). When viewed by staff group, the most significant increases year on year are seen across agency and medical locums, nursing spend and consultants' costs (see below).

Staff Type	2013/14 £'000s	2012/13 £'000s	Change £'000s	%
A&C / Managers	39,094	39,917	823	2.1
Agency / Medical Locums	15,018	11,268	(3,749)	(33.3)
Allied Health Prof's	12,516	12,509	(7)	(0.1)
Medical - Non Consultant	41,915	40,519	(1,397)	(3.4)
Consultant	59,282	53,796	(5,486)	(10.2)
Nursing & Midwifery	115,797	109,864	(5,933)	(5.4)
Other	28,586	27,593	(992)	(3.6)
TOTAL	**312,207**	**295,466**	**(16,741)**	**(5.7)**

4.11. The year to date £13.4m variance to Plan may be analysed by CMG (the table below excludes Corporate Directorates and Research & Development:

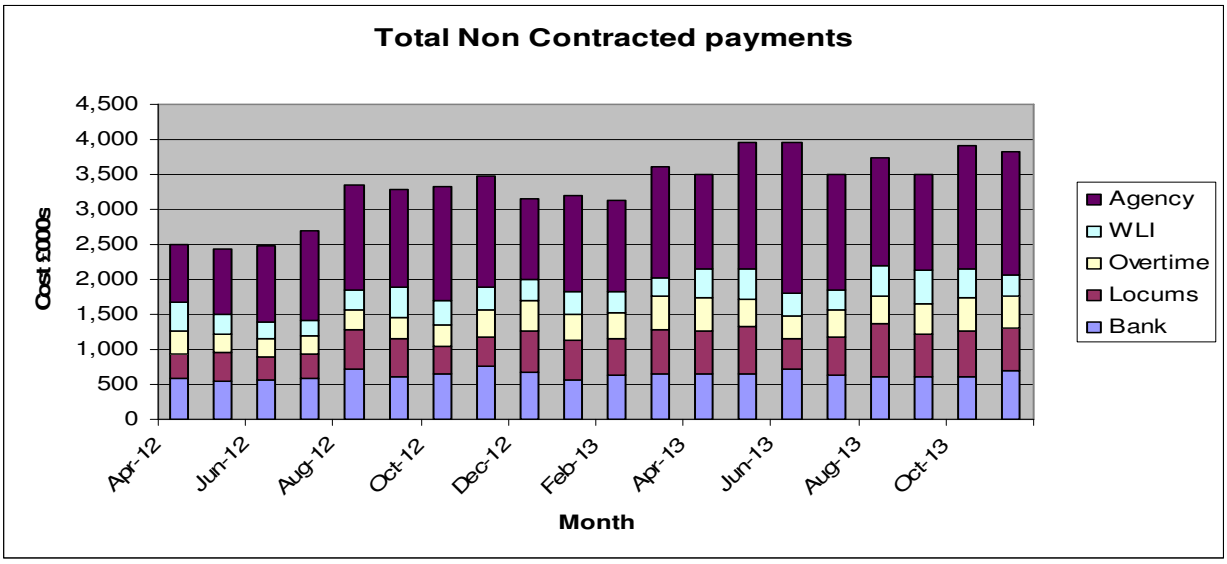
	YTD Budget £000s	YTD Actuals £000s	Variance £000s	M1-8 actuals 2012/13 £000s	Year on year change £000s	Year on year change %
C.H.U.G.S	30,331	30,824	(494)	29,363	(1,461)	(5.0%)
Clinical Support & Imaging	44,867	46,257	(1,390)	44,892	(1,365)	(3.0%)
Divisional Management Codes	2,632	2,533	99	2,512	(21)	(0.8%)
Emergency & Specialist Med	42,307	48,872	(6,565)	41,322	(7,550)	(18.3%)
I.T.A.P.S	33,359	36,320	(2,960)	33,867	(2,453)	(7.2%)
Musculo & Specialist Surgery	29,049	29,992	(943)	29,521	(471)	(1.6%)
Renal, Respiratory & Cardiac	37,409	38,746	(1,336)	37,771	(974)	(2.6%)
Womens & Childrens	49,600	49,564	36	47,083	(2,480)	(5.3%)
Total	**269,554**	**283,106**	**(13,553)**	**266,331**	**(16,776)**	**(6.3%)**

4.12. The main factors are:

- **Activity related - £4.8m** - assuming that marginal pay cost is c50% of patient care income in respect of the increased activity (which assumes non-premium rates)
- **CIP schemes £2.5m** - Declared under-delivery on pay related CIP schemes. Note also that our CIP programme had to be amended to reflect higher than expected emergency activity levels during the summer months.

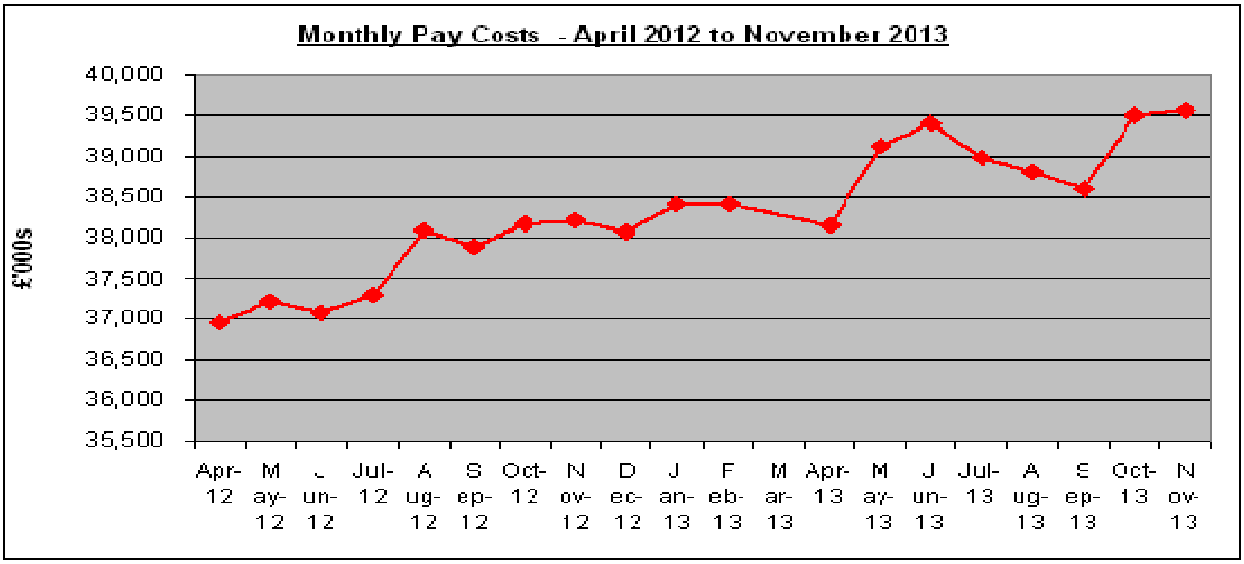
- **Unfunded extra capacity wards** (Fielding Johnson, Ward 1 LRI, Ward 2 LGH, Ward 19 LRI and Odames LRI) to meet the emergency activity levels. Premium spend has covered a significant amount of the staff costs in these areas. Nursing incentives are also being paid to bank and agency to increase the "fill rates", although these are now restricted to the Emergency Care CMG.
- **Increased doctors and nurses in Medicine and ED (£6.6m)** to ensure the flow of patients from ED to support the 4 hour target. The CMG is now £6.6m adverse to the pay plan and spending almost £7.6m (18%) above the same level in 2012/13.
- **A continued reliance on premium payments** as per Chart 1 below. Premium rate spend has continued to rise in 2013/14, averaging between £3.5m-£4m per month. There has been a significant rise in the percentage of pay costs made up by non-contracted spend to almost 10% in Quarter 1 of this financial.

Chart 1: Non-Contracted/Premium Pay Spend



4.13. Total monthly pay costs rose steadily from April 2012 to June 2013, hitting an initial peak of £39.4m in June. The November (£39.6m) position is unsustainable and in excess of our most recent forecast.

4.14. Nursing and related agency costs make up the largest part of the adverse pay variance. Some of the overspend, as described above, is volume related (extra capacity opened) and the impact of agency rates is clear. However a conscious investment in increased nurse:bed ratios following a mid-year acuity review of nursing levels has also pushed up costs. The success of the recruitment drive is essential in reducing this spend whilst enhancing patient safety.



4.15. The continued reliance on premium despite increases in our contracted clinical staff. WTE numbers in medical and nursing professions have increased by 6.0% in the last 20 months, equivalent to an increase of 378 WTE since March 2012. The number of Consultants has increased by 53wte (10%) in that period reflecting different working models, partly due to EWTD and also increased R&D activity.

Staff Type	Movement Nov 13 - March 12		Contracted Staff	
			Nov 13	March 12
	WTE	(%)	WTE	WTE
ADMIN & CLERICAL	(25)	(1.4)	1,762	1,787
ALLIED HEALTH PROFESSIONALS	7	1.5	465	458
CAREER GRADES	10	14.7	80	70
CONSULTANT	53	10.0	586	533
HEALTHCARE ASSISTANTS	26	11.8	243	217
HEALTHCARE SCIENTISTS	(15)	(2.0)	726	741
MAINTENANCE & WORKS	1	10.6	7	6
NURSING QUALIFIED	25	0.8	3,374	3,348
NURSING UNQUALIFIED	227	19.0	1,422	1,195
OTHER MEDICAL & DENTAL STAFF	36	4.0	935	899
OTHER SCIEN, THERAP & TECH	63	23.0	337	274
SENIOR MANAGERS	(36)	(21.0)	135	171
TOTAL	373	3.8	10,072	9,699
MEDICAL & NURSING	378	6.0	6,640	6,262
OTHER STAFF GROUPS	(5)	(0.1)	3,432	3,437
TOTAL	373	3.8	10,072	9,699

4.16. **Non-pay** spend year-to-date is £10.7m (5.8%) adverse to Plan. This is due to three main factors:

- **Activity related marginal costs £2.4m** e.g. keeping Ward 19 open - (assuming that non-pay marginal cost is c25% of patient care income variance)
- **High cost devices - £2.6m** – these costs are fully recovered through patient care income. This includes NICE/HCT costs e.g. haemophilia patients, high cost devices in Renal, Respiratory and Cardiac CMG and Women's & Children's CMG.
- **Other (including CIP under-delivery) £5.7m –** this includes Imaging and laboratory non pay consumables, use of independent sector and contracted clinical services, blood products and a £0.3m increase in security costs in ED and medical wards.

5. Year End Forecast

5.1. The revised year end forecast, taking account of the month 8 results is **£39.8m deficit**. This is summarised in the following table:

	Year End Forecast		
	Plan £m	Forecast £m	Var (Adv) / Fav £m
Income			
Patient income	634.3	655.7	21.4
Contigency Release	-	-	-
Teaching, R&D	78.4	77.1	(1.3)
Other operating Income	33.8	33.9	0.1
Total Income	**746.5**	**766.7**	**20.2**
Operating expenditure			
Pay	447.4	471.5	(24.1)
Non-pay	275.0	291.3	(16.3)
Reserves	(23.7)	-	(23.7)
Total Operating Expenditure	**698.7**	**762.8**	**(64.1)**
EBITDA	**47.8**	**3.9**	**(43.9)**
Net interest			0.0
Depreciation	(32.5)	(32.5)	-
PDC dividend payable	(11.6)	(11.2)	0.4
Net deficit	**3.7**	**(39.8)**	**(43.5)**
EBITDA %		**0.5%**	

5.2. The year end forecast at CMG and Corporate Directorate level is shown in appendix 1, with the performance in November against the forecast shown in appendix 2.

5.3. The principal drivers for the forecast deficit result are:

- Non-receipt of strategic transitional support (£15m) to fund the underlying deficit
- Less than expected non-recurrent funding from commissioners to support the transformation project costs incurred (£5.3m)
- In year operating cost pressures and a conscious investment in nurse staffing to sustain quality of care and patient safety standards (£14.3m)
- Contractual penalties and deductions of £5.2m including a £3.4m increase in MRET deductions (taking the total MRET deduction to £7.1m).

5.4. Within this forecast there are the following potential risks and opportunities;

- Activity, and the associated income, necessary to fully recover and deliver all **RTT targets** is not included in the forecast. There is currently insufficient capacity to undertake this work in-house. Additional (outsourced) capacity may be available to cover part of the gap but presents a major risk to the health economy finances.
- **Activity and income assumptions** have been aligned with our commissioners, both CCGs and NHS England. Current NHS patient care over-performance, excluding additional winter funding, is £13.8m.
- **Winter severity** – the current forecast assumes an average winter in terms of emergency activity, and elective activity assumed to be the same as 2012/13.
- The forecast assumes that **contractual penalties are reinvested**, specifically ED performance fines, ambulance handover and RTT penalties. This has been reconfirmed in discussions with CCGs. MRET deductions, readmission penalties and service line penalties will continue to be transacted and retained by commissioners.
- There is a **contingency of** £1.5m within the forecast, reduced to £0.8m after agreement on the forecast income position and contractual disputes with CCG commissioners.

- Note that **enhanced expenditure controls**, with greater centralisation over discretionary spend, both pay and non-pay, have just been introduced. This will be reinforced through rigorous performance management of the CMG forecasts and operational performance in the remaining months of this year. This will have the effect of creating an additional contingency in the forecast.

5.5. Independent **review of the forecast**

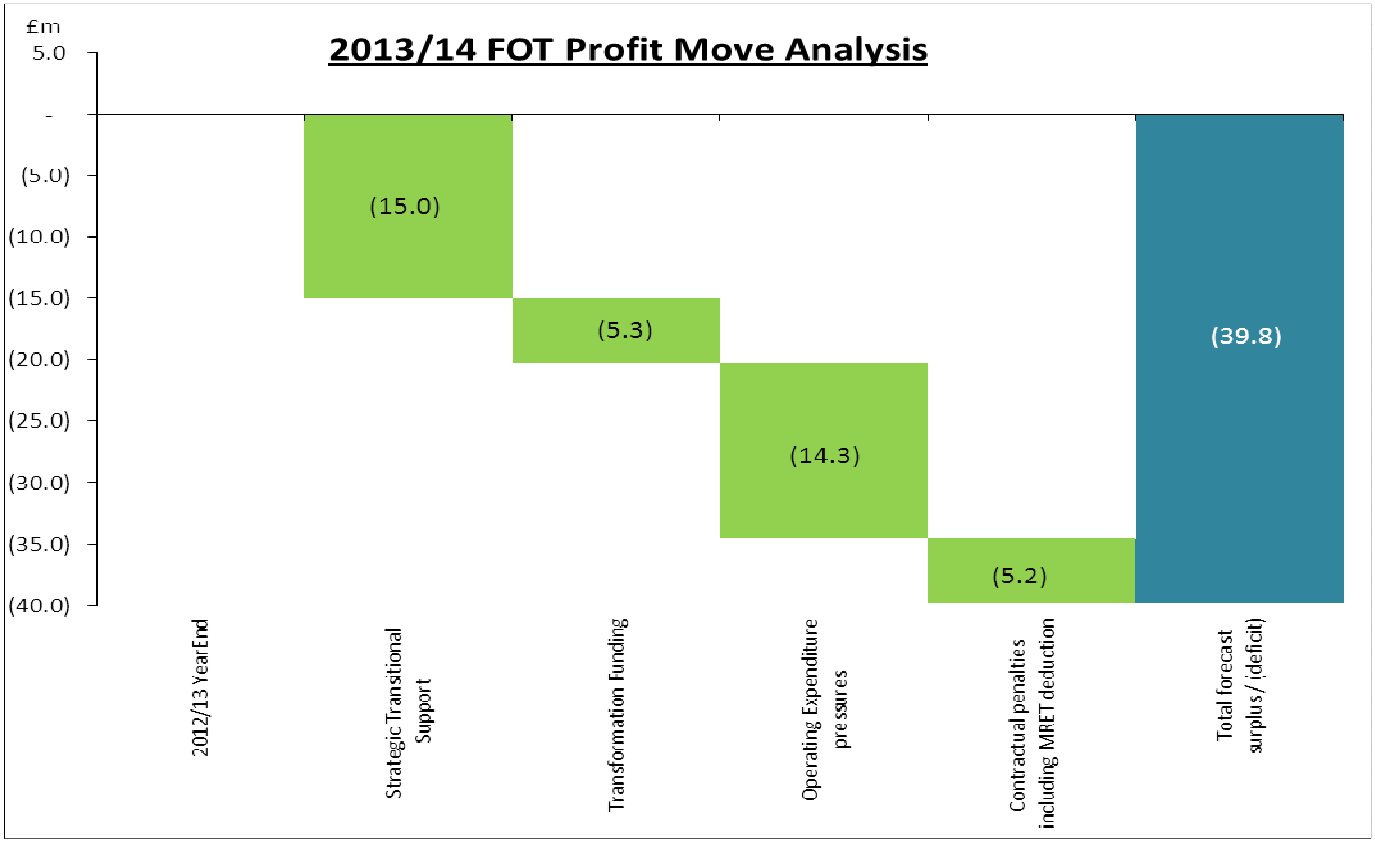
5.6. To give the Trust Board assurance on the robustness of the forecast we commissioned our internal auditors, PwC, to undertake an independent review of the following:

- The methodology used to prepare the forecast,
- The principal assumptions and their vulnerability. This included specific consideration of the workforce assumptions, and specifically,
- the alignment of assumptions in respect of the nurse recruitment programme;
- Undertake a sensitivity analysis of the key risks to the forecast result.

5.7. The draft PwC report indicates that the forecast was prepared using robust methodology, following an inclusive process. PwC's limited scope review did not identify any material errors or omissions within the base case forecast, but highlighted the £0.5m adverse position in M8 to the forecast result. They have prepared an illustrative sensitivity analysis with the risks identified in their review. Key risks relate to:

- controls over temporary staffing
- additional mandatory fines that may be accrued
- delivery of "Amber rated" CIPs
- fluctuations in activity, particularly in emergency inpatient activity.

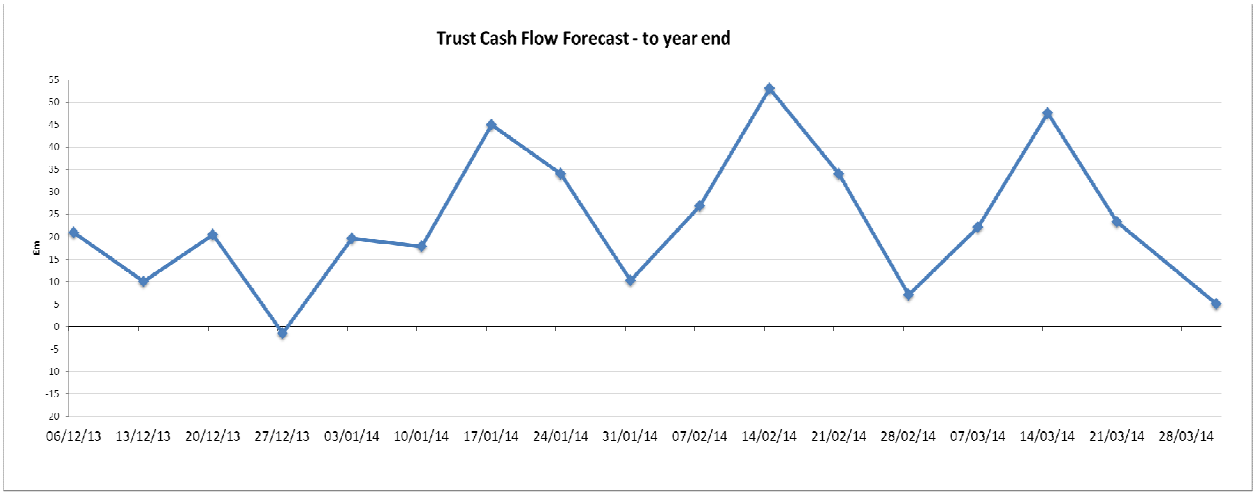
5.8. Following receipt of the draft PwC report, and discussion with the review team, the Board agreed to a forecast deficit of £39.8m.



6. Cash Flow

6.1. The Trust's cashflow forecast has been aligned to the forecast year end deficit of £39.8m. This indicates a year end cash balance of c£4m, as shown on the graph below, against a Plan balance of £19m. The forecast includes the following assumptions:

- capital cash payments will total £34m for the full year;
- the current balance of £15m extended creditor payments will be reduced to £10m by the year end;
- all suppliers remain on 30 day payment terms (apart from specific exceptions); and
- the current level of NHS debtors is reduced by £7.2m.



Capital

6.2. The capital expenditure forecast indicates an outturn of £34m against the capital programme of £39.8m. The forecast includes £15m of cash payments in the last four months of the year.

6.3. To preserve cash it is proposed that the Trust proactively manages capital orders and cash flow around the year-end. If necessary we may slip a proportion of capital expenditure into the next financial year to reduce the cash outflows.

6.4. We have the opportunity to reduce capital cash expenditure by a further £6m by managing capital orders in this way – this is not included in the forecast.

Creditor payments

6.5. We currently have a total of £15m of creditor invoices which are authorised for payment and which are beyond their 30 day payment terms. We are paying invoices in 47 days on average, which is 17 days past their normal due date. We intend to maintain a balance of £10m extended creditor payments through the year-end.

Debtors

6.6. We plan to reduce the current underlying level of NHS debtors by £7.2m from the current balance of £14.6m by the year-end. This is a prudent estimate - the current level of NHS debtors is inflated due to specific issues which have arisen due to the NHS restructure and the change in commissioning responsibilities. These debts include:

- £2.9m legacy debts from the demised PCTs which will now be paid by CCGs; and
- £4.3m overdue debts with NHS England (NHSE) related to Clinical Excellence and SLA performance which will be paid by the year end.

6.7. We continue to work with CCGs and NHS England on a monthly basis and also as part of the NHS agreement of balances exercises in months 6 and 9 to agree all outstanding balances and

ensure they are paid. The receipt of these debts will reduce the NHS debt to approximately £7.4m at the year-end which is a normalised position.

6.8. These receipts are already assumed in the current forecast year end position.

7. 2014/15 cash and medium term loan/PDC application

7.1. We will produce a detailed cashflow model for 2014/15 once the Trust's wider financial budgets and CIP plans have been established. Our forecasts already extend beyond the end of March 2014 and will be refreshed as part of the January 2014 first-cut submission of the 2014/15 annual plan.

7.2. We will work with all relevant stakeholders to understand the likely pressure on cash in early 2014-15. We have commenced work, in conjunction with the NTDA, to prepare an application for either a medium term loan or PDC capital, to be available either prior to the end of 2013/14 or at the very start of the 2014/15 financial year. Discussions with the NTDA during the course of December indicated that the funding is likely to take the form of distress PDC capital, and as such would not be repayable, and would carry an annual interest charge of 3.5%. Assuming illustrative PDC financing of £40 million, this would give an annual PDC dividend (interest) charge of £1.4 million.

8. Communications and Stakeholder briefings

8.1. A deficit of this size, notwithstanding the size of the Trust, is a significant event and has been discussed with the NTDA at a national level. Local stakeholders and Trust staff have been briefed in advance of this paper being released in order to manage the message and address any immediate concerns.

9. Next Steps & Recommendations

9.1. The Trust Board is **RECOMMENDED** to:

- **Note** the contents of this report
- **Confirm** the year-end reforecast of a deficit of £39.8 m.
- **Mandate** the Executive Team to ensure that the CMG and Corporate Directorate outturns are no worse than the reforecast
- **Approve** the proposed measures around capital expenditure and creditor payments to increase year end cash balances
- **Note** the Finance Director's incorporation of the reforecast into the trust's formal M8 submission to the NTDA on 16th December
- **Mandate** the relevant Executive Directors to continue with discussions to further develop the Better Care Together Programme and the Trust's medium term financial strategy within that.

Andrew Seddon

Director of Finance and Business Services

16 December 2013

Appendix 1

FOT Position as at Month 8

		Patient Care Income adj for penalties held centrally			Other Income			Pay			Non Pay			TOTAL			M7 FOT	Change in forecast M7 vs M8
Division	CMG's	Budget £000s	Actual £000s	'Variance £000s	Budget £000s	Actual £000s	'Variance £000s	Budget £000s	Actual £000s	'Variance £000s	Budget £000s	Actual £000s	'Variance £000s	Budget £000s	Actual £000s	'Variance £000s	'Variance £000s	
Clinical CMG's	C.H.U.G.S	117,558	120,133	2,574	2,909	2,885	(24)	45,500	46,497	(998)	35,817	39,431	(3,614)	39,150	37,089	(2,062)	(2,062)	0
	Clinical Support & Imaging	23,831	25,758	1,927	7,253	7,090	(163)	67,000	70,249	(3,249)	2,454	4,587	(2,133)	(38,369)	(41,987)	(3,618)	(3,395)	(223)
	Divisional Management Codes	0	0	0	625	167	(458)	3,941	3,132	809	827	159	669	(4,143)	(3,124)	1,019	967	52
	Emergency & Specialist Med	100,874	113,800	12,927	4,934	4,079	(855)	63,868	74,347	(10,479)	30,011	32,337	(2,327)	11,930	11,195	(735)	(735)	(0)
	I.T.A.P.S	27,005	28,238	1,234	734	706	(28)	49,526	53,860	(4,334)	19,551	19,910	(359)	(41,339)	(44,826)	(3,488)	(3,472)	(16)
	Musculo & Specialist Surgery	93,970	95,750	1,780	1,949	1,510	(439)	43,571	44,898	(1,328)	18,201	18,747	(546)	34,148	33,615	(532)	(533)	0
	Renal, Respiratory & Cardiac	126,547	129,381	2,834	3,250	2,610	(640)	56,033	58,789	(2,756)	41,881	45,560	(3,680)	31,884	27,642	(4,241)	(4,242)	0
	Womens & Childrens	136,989	138,236	1,247	4,052	3,513	(539)	74,589	74,206	383	29,478	30,176	(697)	36,973	37,367	394	117	276
Clinical CMG's Total		**626,774**	**651,296**	**24,523**	**25,707**	**22,560**	**(3,147)**	**404,026**	**425,978**	**(21,952)**	**178,220**	**190,907**	**(12,687)**	**70,234**	**56,971**	**(13,263)**	**(13,354)**	**91**
Corporate	Communications & Ext Relations	0	0	0	33	32	(1)	755	846	(91)	121	151	(30)	(843)	(965)	(122)	(116)	(6)
	Corporate & Legal	0	0	0	0	72	72	971	975	(4)	1,168	1,314	(146)	(2,139)	(2,218)	(79)	(79)	0
	Corporate Medical	0	0	0	1,456	1,577	121	3,800	3,786	14	670	895	(225)	(3,014)	(3,104)	(90)	(94)	4
	Facilities	216	216	0	11,468	11,490	22	1,274	1,230	44	54,874	54,017	857	(44,464)	(43,541)	923	922	0
	Finance & Procurement	0	0	0	50	49	(1)	4,351	4,395	(43)	2,690	2,572	118	(6,991)	(6,917)	74	74	0
	Human Resources	0	0	0	2,858	3,270	411	5,483	5,469	15	1,782	2,150	(369)	(4,407)	(4,350)	57	58	(0)
	Im&T	0	0	0	184	171	(13)	2,490	2,378	112	5,575	5,903	(327)	(7,882)	(8,110)	(228)	(218)	(10)
	Nursing	0	0	0	275	313	38	5,834	5,548	286	13,247	13,647	(399)	(18,806)	(18,882)	(75)	(80)	5
	Operations	276	1,538	1,262	0	72	72	2,934	4,742	(1,808)	214	645	(431)	(2,872)	(3,777)	(905)	(904)	(1)
	Strategic Devt	0	0	0	0	59	59	2,807	3,244	(437)	147	712	(565)	(2,953)	(3,897)	(943)	(927)	(16)
Corporate Total		**492**	**1,753**	**1,262**	**16,324**	**17,103**	**779**	**30,699**	**32,612**	**(1,913)**	**80,489**	**82,005**	**(1,517)**	**(94,372)**	**(95,761)**	**(1,389)**	**(1,365)**	**(24)**
Research & Development Total		**0**	**0**	**0**	**28,019**	**28,436**	**417**	**12,968**	**12,715**	**252**	**15,242**	**15,639**	**(397)**	**(190)**	**82**	**272**	**191**	**81**
Central Division Total		**(521)**	**(3,404)**	**(2,882)**	**49,051**	**49,064**	**13**	**0**	**196**	**(196)**	**20,494**	**46,552**	**(26,058)**	**28,035**	**(1,088)**	**(29,123)**	**(27,963)**	**(1,159)**
Grand Total		**626,744**	**649,646**	**22,902**	**119,101**	**117,163**	**(1,938)**	**447,693**	**471,501**	**(23,808)**	**294,445**	**335,103**	**(40,658)**	**3,707**	**(39,796)**	**(43,502)**	**(42,491)**	**(1,012)**

Appendix 2

November - Actual Results against Forecast

	Variance compared to forecast - November			
	Pay £'000	Non Pay £'000	Income £'000	Total £'000s
C.H.U.G.S	7	(323)	392	76
Clinical Support & Imaging	(64)	(188)	18	(234)
Divisional Management Codes	(1)	(4)	0	(4)
Emergency & Specialist Med	(46)	(227)	410	138
I.T.A.P.S	(207)	(28)	(128)	(363)
Musculo & Specialist Surgery	(153)	(110)	139	(124)
Renal, Respiratory & Cardiac	11	(353)	321	(21)
Womens & Childrens	(86)	(98)	660	476
Total CMGs	**(540)**	**(1,331)**	**1,813**	**(57)**
Communications & Ext Relations	(2)	(6)	(1)	(9)
Corporate & Legal	7	19	0	26
Corporate Medical	(2)	(54)	33	(24)
Facilities	9	25	35	70
Finance & Procurement	14	8	(0)	22
Human Resources	9	(6)	19	22
Im&T	(14)	(34)	1	(47)
Nursing	48	(15)	(1)	33
Operations	(32)	(32)	144	81
Strategic Devt	(3)	(12)	(0)	(15)
Total Corporate Directorates	**35**	**(106)**	**230**	**159**
Total Central	**(65)**	**(210)**	**(332)**	**(607)**
Research & Development	**7**	**(38)**	**42**	**11**
Grand Total	**(563)**	**(1,685)**	**1,753**	**(495)**