CONFIDENTIAL - COMMERCIAL

AGENDA ITEM NO:

UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST
COUNCIL OF GOVERNORS
THURSDAY 19 JULY 2012

Title:	**FINANCIAL PLAN 2012/13**
Responsible Director:	Mike Sexton, Director of Finance
Contact:	Julian Miller, Deputy Director of Finance, ext. 53074

Purpose:	To present the 2012/13 Financial Plan to the Council of Governors
Confidentiality Level & Reason:	Confidential – Commercial
Medium Term Plan Ref:	Aim 2: Maintain our reputation and position at the leading edge of performance and quality Aim 3: Enhance our reputation for excellent financial management
Key Issues Summary:	A surplus of £0.6m is planned for 2012/13, increasing to £1.5m in 2013/14 and £2.4m in 2014/15. The Trust should retain a Financial Risk Rating of 3 from Monitor throughout this period
Recommendations:	The Council of Governors is asked to: • Note the detailed Financial Plan for 2012/13 and longer term projections for 2013/14 and 2014/15

Signed: M Sexton	**Date:** 11 July 2012

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FINANCIAL PLAN 2012/13

PRESENTED BY THE DIRECTOR OF FINANCE

1. Introduction

This paper sets out the Trust's detailed Financial Plan for 2012/13, longer term financial projections for 2013/14 and 2014/15 and the key financial risks faced by the Trust. It is based on the final Financial Plan approved by the Board of Directors in April 2012 but also incorporates some of the supporting information provided in the Financial Planning Outlook paper presented to the Board in February 2012 and is consistent with the 3 year Monitor Annual Plan submitted in May 2012.

The 2012/13 Financial Plan provides for a surplus of £0.6m in 2012/13 and this is expected to increase to £1.5m in 2013/14 and £2.4m in 2014/15. Over this period the Trust is required to reduce it's reliance on the non-recurrent PFI transition support funding and will also have to manage challenges including further downward pressure on the national tariff and planned reductions to education funding. Therefore it will be important to maintain financial discipline, deliver planned cost improvements and achieve the planned levels of activity growth. The Trust is expected to maintain a Financial Risk Rating of 3 from Monitor over the next three years.

2. Background / Planning Context

2.1 Economic Context

The coalition government's main economic focus remains the reduction of the UK's annual borrowing (the Public Sector Borrowing Requirement) with the intention of significantly reducing the deficit by the end of the current parliament. The debt reduction strategy has two key strands:

1. The implementation of a package of austerity measures including tax rises and public sector spending reductions.
2. The encouragement of economic growth, led by the private sector, to expand national output as measured by Gross Domestic Product (GDP). This is intended to create jobs, reduce social security spending and increase tax revenues as well as reducing accumulated debt as a proportion of GDP.

Annual borrowing has started to reduce, although progress remains slow. The latest forecast produced by the independent Office for Budgetary Responsibility (OBR) in January 12 projects that the Public Sector

Borrowing Requirement will be £127.1bn (8.4% of GDP) for 2011/12 down from £136.1bn in 2010/11. This is forecast to continue reducing year on year but is still expected to be around £53bn (2.9% of forecast GDP) by 2015/16.

Other economic indicators remain extremely pessimistic. Annual economic growth (as measured by Gross Domestic Product) stood at just 0.9% for 2011 and the economy actually contracted by (0.2%) in Q4. This has raised fears that the economy may actually slip back into recession, defined as two or more successive quarters of negative growth. The latest OBR estimate for 2012 is growth of just 0.7%, down from previous forecasts of 2.5%. Levels of unemployment have risen slowly over the last 12 months from 2.48 million to the current 2.67 million, with public sector job losses accounting for much of this increase. Critics of the government's approach argue that public sector cuts have gone too far too fast and that the austerity measures are preventing economic growth which is counter productive to the deficit reduction strategy. However, the coalition has maintained that the measures are necessary to retain the confidence of the international ratings agencies in order to maintain the UK's top credit rating and keep borrowing costs down. The government position is that the weakening economic growth is more to do with the sovereign debt crisis and prospects of recession in the euro-zone.

The annual increase in inflation (as measured by Consumer Price Index (CPI) was 4.2% in December 2011. Although this remains well above the government target of 2.0% the consensus view is that it will fall back during 2012. The alternative inflation measure, the Retail Price Index (RPI) was 4.8% for the year to December 2011. This has a direct impact on the Trust as the annual payments for the new hospital are indexed by RPI inflation. The Bank of England has continued to maintain base interest rates at the record low level of 0.5% since March 2009.

Despite the public sector spending cuts total NHS funding is due to increase by £10.6bn to £114.4bn between 2011/12 and 2014/15. This represents an average annual cash increase of around 2.5%. Based on the inflation projections included in the Comprehensive Spending Review this equates to a real terms increase of 0.1% per annum. Whilst this is relatively generous compared to most other government departments, a broadly flat real terms settlement will be extremely challenging to manage compared to the 6% average increases experienced in the past decade and 4% historic average annual growth.

Accumulated government borrowing (Public Sector Net Debt) is around 64% of GDP and is forecast to rise to 78% of GDP by 2014/15. Interest payments will continue to account for an increasing share of government expenditure, suggesting that significant pressure will remain on public sector spending over the longer term, even once the annual deficit is eliminated.

2.2 2012/13 Operating Framework / QIPP

The Operating Framework for 2012/13 was published on 24 November 2011, setting out the national priorities, business rules and accountability arrangements for the NHS in the year ahead. This includes the transitional arrangements to the new NHS Structure as set out in the Health and Social Care Bill which is currently progressing through Parliament. The Operating Framework highlights the need to maintain tight financial controls during the transition and to deliver the Quality, Innovation, Productivity and Prevention (QIPP) savings required by the NHS. This refers to the estimated £15bn to £20bn of savings needed to bridge the gap between proposed NHS funding and the likely costs rises facing the service as a result of demand increases, the ageing population and technological advances.

A more detailed summary of the 2012/13 Operating Framework and its likely impact on the Trust is included as Appendix 1.

3. Summarised Income and Expenditure 2012/13

The table below summarises the planned 2012/13 Income Statement. Details of operating revenue and operating expenditure follow in sections 4 and 5 respectively.

Table 1 – UHB Summary Income Statement 2012/13

£ million	**11/12 plan**	**11/12 outturn**	**12/13 plan**
Operating Revenue	552.9	584.3	597.2
Operating Expenses	-516.0	-545.4	-559.4
EBITDA	**36.9**	**38.9**	**37.8**
Donations received as Assets	0.8	2.4	3.2
Interest Revenue	0.6	0.8	0.8
Interest Expense - PFI assets	-17.5	-17.5	-18.4
Depreciation and Amortisation	-18.2	-20.1	-19.3
PDC Dividend Expense	0.0	0.0	0.0
Non operating PFI costs (contingent rental)	-2.1	-2.0	-3.5
Profit (Loss) before restructuring costs	**0.5**	**2.4**	**0.6**
Impairment Losses (Reversals) net	-49.1	-31.7	-
Restructuring Costs	-3.5	-4.3	-
Profit (Loss)	**-52.0**	**-33.6**	**0.6**

4. Income Plan 2012/13

4.1 Income Estimate 2012/13

The 2012/13 estimated income is set out below:

Table 2 – UHB Summary Income Estimate 2012/13

Income Type	2011/12 Outturn	2012/13 Plan	Increase	Increase
	£m	**£m**	**£m**	**%**
Clinical				
NHS	454.7	471.3	16.6	3.7
Non-NHS	14.3	12.8	-1.4	-10.1
	469.0	484.2	15.2	3.2
Non-Clinical				
Education	32.7	32.7	0.0	0.0
R&D	25.9	22.5	-3.5	-13.3
PFI Specific	13.0	12.9	-0.1	-0.8
Trading / Other Misc.	43.7	45.0	1.3	2.9
	115.3	113.0	-2.3	-2.0
Total Operating Income	**584.3**	**597.2**	**12.9**	**2.2**
Non-Operating Income	3.1	4.0	0.8	27.0
Total Trust Income	**587.4**	**601.2**	**13.7**	**2.3**

The income estimate set out above shows total income increasing by £13.7m (2.3%) from £587.4m in 2011/12 to £601.2m in 2012/13. The key assumptions are summarised below:

4.2 NHS Clinical Income

PCT Allocations 2012/13

Primary Care Trusts remain the statutory bodies to which allocations will be made for 2012/13. There will be no further moves towards the weighted capitation formula targets in 2012/13 and therefore all PCT's will receive a standard uplift of 2.8% to their recurrent allocations. This excludes an additional £150m which has been released nationally for re-ablement. Taking account of this, PCT allocations will increase by 3.0% in 2012/13. Commissioner's overall purchasing power for 2012/13 will increase by more than this because of the tariff reduction and new business rules (see below).

National Tariff

The Operating Framework for 2012/13 set out a 1.5% net reduction in the average price for acute hospital activity for both tariff and non tariff work. In addition there is a further 0.3% efficiency embedded within the structure of the 12/13 tariff. The resultant losses will be partially offset by an increase in the value of CQUIN payments from 1.5% to 2.5%, subject

to achieving the quality goals. There are also several other changes to the structure of the tariff and the accompanying business rules that will impact on the Trust's income for 2012/13. Further detail is provided in Appendix 1.

Contracted Income

The total value of contracted NHS healthcare activity for 2012/13 is £460.3m. This is approximately £6.9m higher than the outturn figure for 2011/12 but includes growth of £13.0m in respect of Major Trauma and cost per case drugs and devices, as well as the 1% increase in Commissioning for Quality and Innovation (CQUIN) payments from 1.5% to 2.5%. The contract values also include specific disinvestment of £2.5m relating to new Quality Innovation Productivity and Prevention (QIPP) schemes, including advice and guidance, end of life care and outpatient referral management. There is no change in the expected value of non-payment for emergency readmissions which remains in the contract at £2.0m.

NHS Clinical Income - Contracted	2012/13
£000	Plan
NHS Baseline inc. CQUIN	449779
MTC Growth	5639
CPC Growth	7327
QIPP	-2478
	460267

After taking account of the growth and QIPP there is a year on year reduction of circa £3.6m against baseline activity. This is broadly in line with the expected 0.8% loss against tariff and local prices (1.8% gross reduction offset by 1% additional CQUIN payments). Any differences are likely to be attributable to timing differences with the contract based on actual activity for the 12 months from December 2010 to November 2011 rather than 2011/12 projected outturn.

Risk Income

The 2012/13 plan includes £14.1m of risk income over and above contracted activity levels. Of this £11.6m is due to planned activity growth. With the exception of Major Trauma and some cost per case activity (see above) commissioners have opted not to purchase growth within the contract and therefore the majority of new business cases approvals will represent risk income in 2012/13.

Should the QIPP schemes not deliver, agreed contract terms provide for the Trust to be paid for it as over-performance, subject to complying with the agreed protocols and clinical pathways.

Total risk income equates to 3.1% of contracted activity for 2012/13 i.e. the Trust needs to over-perform its commissioner targets by this amount in order to achieve the income included in the financial plan. This value is higher than in recent years and therefore delivery of this growth represents a key income risk for 2012/13.

Payment Contingency

As outlined above the income plan includes £14.1m of risk income and there are further specific payment risks including CQUIN delivery, counting and coding challenges, and failure to achieve the performance targets included within the contract. To provide some mitigation against these risks a payment contingency of £3.0m has been included in the plan. This is an offset to the contracted and risk income figures above and therefore the net value of planned NHS healthcare income for 2012/13 is £471.3m as summarised in the table below. Further details of the main income risks are provided in section 8.

NHS Clinical Income - Summary **£000**	2012/13 Plan
Contracted	460267
Risk	14081
Payment Contingency	-3000
	471348

4.3 Non NHS Clinical income

The 2012/13 Non NHS Clinical income targets total £12.8m and have been set as follows:

- Private Patients – set at 2011/12 outturn plus planned increases.
- Injury Cost Recovery Scheme (formerly RTA Income) – set at 2011/12 outturn plus a £0.6m uplift to account for additional income associated with the Major Trauma Centre business case.
- Ministry of Defence (MoD) Treatment Contract – set at the baseline contract value i.e. excludes non-recurring over performance.

4.4 Education income

As reported previously the planned changes to education funding have been deferred until 2013/14 and therefore the Trust's income in 2012/13 will remain based on the existing MPET (Multi Professional Education and Training) allocations, comprising SIFT (Service Increment for Teaching), MADEL (Medical and Dental Education Levy) and NMET (Non Medical Education and Training) levies. The value of these allocations for 2012/13 has not yet been confirmed and therefore the income estimate has been based on 2011/12 outturn values adjusted for any known changes.

4.5 Research and Development income

R&D income targets for 2012/13 are based on 2011/12 outturn adjusted for known or expected changes. Total income is forecast to be around £22.5m which is around £3.3m lower than the 2011/12 outturn value.

This reduction reflects the release of non-recurrent deferred income during 2011/12 and the 10% cut in the funding allocated to the Birmingham and Black Country Comprehensive Local Research Network (BBCCLRN) which is hosted by the Trust. Allocations from the CLRN to member organisations have not yet been announced and therefore the plan assumes that the element retained by UHB reduces on a proportional basis.

4.6 PFI Specific income

The Trust receives recurrent PFI income through the agreed contributions to the Unitary Payment from the University of Birmingham and the Ministry of Defence. These charges total around £2.0m in 2012/13 and have been increased to reflect changes in RPI and the latest payment schedules agreed with the two organisations.

The 2012/13 plan also includes a further £10.9m of non recurrent PFI income reflecting the second year of using the transition support funding. It is intended that the transition funding is phased out at an average rate of around £1.9m per annum to be replaced by a contribution from activity growth and the delivery of efficiency savings over and above the value of cost pressures.

4.7 Other income

This includes income from a range of sources such as recharges to other NHS bodies (e.g. payroll, laboratory services, telecommunications, etc.), trading income (e.g. catering receipts, accommodation, etc.) and other miscellaneous revenues. The 2012/13 targets are based on 2011/12 outturn values adjusted for known changes including income generation CIP's.

5. Expenditure Plan 2012/13

Incremental expenditure increases are planned for 2012/13 based on an assessment of Trust-wide cost pressures and the outcome of Financial Planning meetings with Divisions and Corporate Departments. These are classified under different categories as detailed below:

5.1 <u>Trust-wide costs</u>

Trust-wide costs totalling £4.3m are included set out in the table below. The largest element is the £2.0m incremental drift pressure across nursing. This has not featured in the plan in recent years as an equilibrium position had been reached, with new annual increases offset by turnover. Due to changes in the workforce, including the growth in substantive nursing numbers, new hospital skill mix changes and variations in the staff turnover rate, this is no longer the case and the average costs within each band have increased above the previously funded levels. A further £0.6m is included to cover pay

awards for staff earning under £21,000 who will again receive a flat increase of £250.

The other significant pressure is a £1.5m increase in clinical negligence premiums for 2012/13. This represents a circa 35% increase and reflects a combination of national clinical claims growth, rebasing of some speciality weightings, e.g. Maternity has decreased but Orthopaedics (inc. Trauma) has increased, and increases in the Trust's medical staff WTE numbers, due to new posts associated with service developments and a reduction in medical vacancies compared to previous years. The WTE data has now been validated and a small number of discrepancies have been identified. These have been notified to the NHS Litigation Authority which may result in a small reduction in the final pressure.

Trust-wide Costs	**£000**
Pay Inflation	627
Pay Incremental Drift	1990
CEA Premiums	205
CNST Premiums	1499
	4321

5.2 Non-Pay Inflation

As in previous years the plan includes funding for specific contractual inflation increases. This is set out in the table below.

Non-Pay Inflation	**£000**
PACs	46
Waste	31
Non Emergency Patient Transport	118
B Braun Decontamination	86
NHSBT	104
Lab Contracts	134
Other Equipment Maintenance	46
Other Contracts	79
	644

5.3 Investment Decisions

The 2012/13 financial plan includes the impact (£15.8m) of new business cases that have been approved by the Board of Directors or under delegated limits. Most of the cases are 'income backed' with the additional costs covered by the resultant activity and income growth. This is included in the income plan as either additional contract income or risk income depending upon whether the case has received explicit commissioner support. Income is typically 21% higher than the expenditure provision to account for a contribution to Trust overheads in line with the business case for the New Hospital.

The lower section of this table lists non-income backed investment decisions i.e. business cases with no direct income stream.

5.4 Healthcare Activity Related

An assessment has been made of the investment necessary to bring divisional expenditure baselines back in line with the activity plans on which the income estimate is based. This is set-out in the table below and includes recognition of marginal costs within clinical support services such as laboratories, imaging and theatres. It should be noted that some activity related costs are also included within the section 4.3 in respect of the Major Trauma Centre and Liver Surgery expansion cases which both include a mix of existing activity and growth.

Healthcare Activity Related	**£000**
Division A	1248
Division B	1125
Division C	2040
Division D	1505
12/13 Cost per Case Growth	7327
	13245

5.5 New Hospital Specific

As in recent years, the 2012/13 plan includes cost pressures specifically associated with the New Hospital. The service charge element of the Unitary Payment increases by £1.2m due to the full year effect of the phases handed over in 2011/12 and the annual inflation based on the Retail Price Index. Other cost pressures linked to the New Hospital include energy and utilities volume increases, with usage in the new building greater than previously modelled, and a further stepped increase in rates due to the full opening of the facility.

NHP Specific	**£000**
Unitary Payment Service Charge	1172
Other contractual payments	22
ICT Service Payment	-62
Other Interim Services	-324
Energy volume increases	668
Carbon Tax	114
Utilities	200
Rates increase	486
	2276

5.6 Other Expenditure Reserves

Reserves have been created to cover other new and existing cost pressures flagged through the planning process. Some of these items

have already received the appropriate approval although costs need to be finalised, whilst others have yet to be authorised in line with the Trust's Scheme of Delegation.

Other Expenditure Reserves	**£000**
SLA Changes	374
HCLV Income Risk	783
New maintenance contracts	277
Residential Accommodation - loss of income	112
Barclays Overdraft Fee	30
NICE / CQC / other standards	334
Legal Costs	90
Software costs / licences / PC's	98
IT / Wolfson costs	71
Patient Travel	23
Postage	83
Infection Control	96
Falls & Fracture	57
Dignity in Care project	70
Aseptic unit relocation	74
Ward Catering	116
Other	980
	3669

5.7 2011/12 Non-Recurring Expenditure

During 2011/12 the Trust has incurred expenditure in a number of areas where non recurrent income has been received, including the MoD Treatment Contract and Research and Development. Adjustments have been made in respect of these amounts to ensure that the expenditure plan remains consistent with the income estimates.

5.8 Efficiency Savings

The 2012/13 Financial Plan includes total planned efficiency savings of £18.3m. This includes £1.9m in respect of the final single site savings resulting from the move to the New Hospital. Within the cost improvement programme £1.5m is attributable to additional non-clinical income generation and this is included within the estimate for other income rather than as an expenditure reduction.

Cost Improvements	**£000**
Divisions	-14033
Corporate Departments	-2361
Single Site	-1886
	-18280
less income generation schemes	1516
	-16764

5.9 Summary of Operating Expenditure

The changes in operating expenditure detailed above are summarised in Table 3 below. These figures exclude non-operating costs (depreciation, interest payable, etc.) which are described in section 6 below.

Table 3 – Summary Operating Expenditure Plan 2012/13

	£m	**£m**
2011/12 Outturn		545.4
Incremental Changes		
Trust-wide costs	4.3	
Specific non-pay inflation	0.6	
Investment Decisions	15.9	
Healthcare Activity Related	13.2	
New Hospital Specific	2.3	
Other Expenditure Reserves	3.7	
2011/12 Non-recurring	-9.3	
Cost Improvements	-16.8	
		14.0
2012/13 Budget		**559.4**

6. Non-Operating Expenditure

The 2012/13 financial plan includes a £1.6m net increase in non-operating expenditure. This is due to a £0.9m increase in Interest Payable against the PFI finance lease, reflecting the full year effect of the phased opening, and a £1.5m increase in Contingent Rental (the inflation element of the Unitary Payment), due to the increase in RPI. These pressures are offset by a small reduction in planned depreciation charges and PDC dividend payments should again be zero in 2012/13 as the Trust's balance sheet continues to show net liabilities.

Table 4 – Summary Non-Operating Expenditure Plan 2012/13

	2011/12 Outturn £m	2012/13 Plan £m	Increase £m
UP Interest Payable	17.5	18.4	0.9
UP Contingent Rental	2.0	3.5	1.5
Depreciation	20.1	19.3	-0.8
PDC Dividends	0.0	0.0	0.0
Total	**39.6**	**41.2**	**1.6**

7. Restructuring Costs / Impairments

During the past two financial years, the Trust has incurred significant non-recurrent expenditure related to the new hospital, comprising the impairment of the building and the costs of the transition (restructuring costs). The impairment of the building was completed in 2011/12 however it had previously been thought that some residual transition costs may be incurred in 2012/13. This has been reassessed following the transfer of Laboratory Services and it has been determined that there is no longer a requirement to include restructuring costs in the plan for 2012/13.

8. Medium Term Financial Plan

Foundation Trust's are required to submit a rolling three year financial plan to Monitor by the end of May each year. Table 5 below summarises the planned income and expenditure for the next three year period. The key assumptions for years 2 (2013/14) and 3 (2014/15) are set out below the table.

Table 5 – UHB Summary Income Statement: 3 Year Forecast

£ million	**12/13 plan**	**13/14 plan**	**14/15 plan**
Operating Revenue	597.2	606.5	619.6
Operating Expenses	-559.4	-563.8	-574.6
EBITDA	**37.8**	**42.7**	**45.0**
Donations received as Assets	3.2	0.4	0.4
Interest Revenue	0.8	0.8	0.8
Interest Expense - PFI assets	-18.4	-18.0	-17.6
Depreciation and Amortisation	-19.3	-20.3	-21.3
PDC Dividend Expense	0.0	0.0	0.0
Non operating PFI costs (contingent rental)	-3.5	-4.1	-4.9
Profit (Loss)	**0.6**	**1.5**	**2.4**

The medium term financial plan set out above is based on the following assumptions for years 2 and 3:

1. The net change in the National Tariff is -1.0% in 2013/14 and 0.0% in 2014/15.
2. NHS cost inflation (excluding PFI costs) is +3.0% in 2013/14 and +3.5% in 2014/15.
3. Activity growth is 3.0% per annum in both 2013/14 and 2014/15. This is under half of the average real terms growth in healthcare income over the last five years which has been around 6.3% per annum.
4. Activity growth is delivered at an average marginal cost of 60% in 2013/14 and 65% in 2014/15.
5. Education funding is planned to reduce by £1.5m in 2013/14 and a further £1.5m in 2014/15 as a consequence of the MPET rebasing exercise.
6. Efficiency savings of 4.0% (of operating costs) are required in 2013/14 and 3.5% in 2014/15 in line with tariff requirements.
7. PFI transition support funding of up to £9.0m is utilised in 2013/14 and £7.0m in 2014/15.
8. RPI inflation, on which the unitary payment is indexed, is +2.5% per annum during 2013/14 and 2014/15.
9. No account has been taken of either the potential proceeds of the SOH land sale during this period or the potential costs of redeveloping the QEH site.

9. Financial Risks 2012/13

At a national level the financial risk facing the NHS remains significant in 2012/13 with a continued push to deliver £20bn of efficiency savings whilst simultaneously managing the structural changes set out in the Health and Social Care bill including the transition to GP commissioning. This is mirrored at a local level where the Trust faces a significant challenge to manage the various cost pressures it is facing in conjunction with a further reduction to the national tariff. Therefore there are a number of key operational risks that need to be managed in 2012/13 to ensure delivery of the planned financial position.

On the income side the main risks include:

- Activity growth – the 2012/13 plan includes £11.6m of risk income linked to business case growth activity. In addition to this there are a number of further business cases due to be considered over the next few months. The Trust must now ensure full delivery of this activity in order to achieve the financial plan. This activity represents over-performance against commissioner contracts and therefore there are also payment risks as well as delivery risks.
- CQUIN – With the increase in the value of CQUIN payments from 1.5% to 2.5% of planned NHS healthcare income in 2012/13 a greater proportion of income (circa £10.1m) is now predicated on full achievement of CQUIN goals. This clearly carries a significant payment risk although the general contingency included in the plan provides some mitigation against this.
- Contract Penalties – the standard NHS contract includes a wider range of financial penalties for failure to achieve performance targets and quality standards. Key risks include maintaining 18 weeks, achieving further reductions in Healthcare Acquired Infections, avoiding single sex accommodation breaches and the continued provision of the agreed contract data set within the prescribed timelines. The Trust has a good record of meeting contract targets and not incurred significant financial penalties in recent years.
- Demand Management – The Trust is working with commissioners on initiatives to reduce admissions and referrals, the 2012/13 income estimate includes £2.5m of risk income due to QIPP initiatives. This is mitigated by payment contingencies within the income plan and the risk lies with commissioners should the schemes not deliver.
- Education funding – the Trust has yet to receive notification of the Multi Professional Education and Training (MPET) funding values for 2012/13.
- R&D income – there remains some uncertainty over total R&D income with the Trust yet to receive notification of its 2012/13 funding from the Birmingham and Black Country Comprehensive Local Research Network (BBC CLRN). The plan assumes that this will reduce by around 10% in line with the network's overall allocation.

On the expenditure side the key risks include:

- Cost Improvement Programmes - the main expenditure risk for 2012/13 is again the delivery of planned efficiency savings. The Trust's target of £18.3m is broadly comparable with the amount achieved in 2011/12 however the single site savings are lower and the challenge for Divisions and Corporate Departments is slightly higher. Opportunities for to deliver further savings via activity growth will generally be more limited and consequently there is a need for a greater level of pay savings which are typically more difficult to achieve. In overall terms the Trust has a good track record of achieving cost improvements and delivery will continue to be tightly managed.
- Operational Cost Control – during 2011/12 there has been a significant over spend across operational divisions. Although this has been largely offset by clinical income growth it is important that the non activity related overspends are addressed. Over the last 12 months good progress has been made in reducing the level of the medical staffing overspend but there remains a sizeable overspend on nursing pay including significant usage of external agency. Additional resources have been allocated through the planning process to address incremental drift and capacity issues however it is increasingly important that wards and departments manage sickness, leave and other workforce pressures effectively in order to keep within agreed budgets.
- Avoidance of new costs – it remains important that all business cases which introduce new expenditure are subject to robust scrutiny and challenge. Cases with no corresponding income stream should be avoided where possible.
- Energy & Utilities - energy and utilities (water) usage in the New Hospital continues to run significantly above the levels previously expected. Work to review this continues and measures taken to improve energy efficiency across the Trust should be considered in 2012/13.
- Retained Estate & Selly Oak – The Trust's long term financial plans include limited funding for keeping these areas open and operational. There will be a need to review and renegotiate interim service requirements during 2012/13 when existing agreements expire and this could present a further cost pressure. To inform this process it will be important to firm up the timelines for the relocation the remaining staff from Selly Oak and the disposal of the site.

Although the overall level of financial risk remains high in 2012/13, the challenges facing the Trust are not unusual in their nature. The Trust has a strong track record of negotiating with commissioners, delivering activity targets, managing cost pressures and achieving efficiency savings year on year. These risks are largely within the organisation's own gift to manage and performance will continue to be monitored closely during 2012/13 to ensure that remedial actions can be taken at an early stage should the need arise. The Trust has a further option to mitigate any unplanned in year losses via greater utilisation of the non-recurrent PFI transition support. This would create the headroom to develop and implement a recovery plan but would also increase reduce the funding available in later years and therefore should be seen as a measure of last resort.

More detailed analysis of the key financial risks and mitigating options are included in the Trust's Long Term Financial Plan. This will be refreshed following the submission of a new 3 year plan to Monitor at the end of May and presented to Audit Committee in November 2012.

10. Financial Risk Rating

Self assessment indicates that the Trust will achieve an overall FRR of 3 for 2012/13, 2013/14 and 2014/15 based on the plans set out above.

11. Conclusion

The 2012/13 financial plan provides for a surplus of £0.6m. The external environment facing the Trust remains extremely challenging with factors such as the 4% tariff efficiency, non payment for emergency readmissions, incremental pay cost pressures and high non pay inflation putting further pressure on the Trust's finances during 2012/13. Although a small surplus is planned this is not without risk and relies on full delivery of £18.3m of cost improvements. The 2012/13 Financial Plan is also underpinned by £10.9m of non-recurrent PFI transitional support. Although this is in line with the planned trajectory the Trust remains in recurrent deficit in 2012/13.

Despite this the Trust remains well placed to meet the financial challenges ahead, in comparison to most of the NHS, with strong demand for services continuing to drive activity growth. In order to deliver this activity on the most cost effective basis it is important that planned productivity and efficiency gains are fully realised and that there is a continued focus on cost control. The extent to which these things are achieved will determine the size of the financial challenge ahead and the level of cost improvements required over the coming years.

11. Recommendations

The Council of Governors is asked to:

- Note the detailed Financial Plan for 2012/13 and longer term projections for 2013/14 and 2014/15.

Mike Sexton
Director of Finance
11 July 2012

APPENDIX 1

2012/13 NHS Operating Framework

Overview

The 2012/13 Operating Framework was published by the Department of Health on 24 November 2011. The operating framework sets out the business and planning arrangements for the NHS including the national priorities and system changes required to deliver continuing quality improvements and financial stability.

The operating framework sets out four inter related challenges which the NHS needs deliver:

1. Maintain the strong financial performance and service quality.
2. Address the service provision changes required to meet the QIPP (Quality, Innovation, Productivity and Prevention) challenge.
3. Complete the transition to the NHS delivery system set out in *Liberating the NHS.*
4. Ensure elderly and vulnerable patients receive dignified care in every part of the NHS.

The main issues in each theme are set out below;

Performance

- Continue to deliver low waiting times (including treatment within 18 weeks)
- Continue the improvements within infection control
- Maintain financial controls.
- Maintain a stable system with financial risks balanced between commissioners and providers.

Meeting the QIPP Challenge

- Bold, long term solutions will be required to secure the sustainable savings required.
- Centralised networks of clinical care will be created with further integration where appropriate.
- The pace of QIPP delivery needs to be increased with more savings released from clinical service redesign
- Faster adoption of best practice across all organisations.

NHS Delivery System

- SHA's and PCT's remain accountable for the NHS operational delivery and accountability throughout in 2012/13.
- The emerging clinical commissioning groups (CCG's) will be supported and developed during the year with authorisation guidance expected in the year. Budgets will increasingly be delegated to these CCG's.
- New Health & Wellbeing Boards will operate in shadow from April 2012 and become fully operational form April 2013.

- CCG's will be accountable to the new NHS Commissioning Board from 2013/14 for their performance and statutory duties.
- The NHS Commissioning Board will take on full statutory duties from April 2013 be responsible to the Secretary of State
- The provider landscape will change as more Trusts gain Foundation Trust status either on their own or as part of an existing NHS FT by April 2014.
- The Any Qualified Provider option for patients should be rolled out giving patients choices or providers. Patient Choice will also be provided by offering choice around;
    - Named consultant teams
    - Diagnostic Test providers
    - Care for long term conditions and
    - Choice about maternity care.

Dignified and Compassionate Care

- Shortcomings in dignity and care need to be addressed urgently, increased leadership and focus needs to be provided on the quality of care for elderly and vulnerable patients including nutrition, continence and communication.
- The Operating Framework sets out further requirements additional clinical audits of basic care.
- The use of the NHS Safety Thermometer will be promoted to keep patients safe from harm.
- Providers must comply with NICE quality standards

Business Rules

- Renewed emphasis and focus on both the 18 week waiting time and the 95% A&E four hour target.
- PCT recurrent allocations will increase by 2.5% on average.
- PCTs are again required to set aside at least 2.0% of funding for non recurrent costs.
- All PCT legacy debts must be resolved in 2012/13 rather than passed onto the new organisations.
- The 2012/13 efficiency requirement will be 4.0%. The overall national tariff price decrease of at least 1.5% (see below).
- The scope of CQUIN is expanded and will represent a further 1.0% (2.5% in total) of providers' contract value in 2012/13 based on meeting a number of quality standards.
- The 30% marginal rate payment for emergency admissions over the 2008/09 baseline threshold continues, the Trust therefore needs to undertake further work to minimise emergency admissions where possible.
- The non payment for readmissions policy will continue.
- 2012/13 healthcare income contracts will be for one year only.
- Staff earning less than £21,000 will receive a £250 increase in 2012/13. Pay grades for other NHS staff will continue to be frozen.

National Tariff 2012/13

The draft ("road test") version of the 2012/13 national tariff was released on the 15 December 2011. This followed a process of "sense checking" undertaken by a number of NHS providers and commissioners including this Trust. The final 2012/13 national tariff is not scheduled to be released for released until mid February 2012.

Tariff Uplift

As outlined above, the 2012/13 national tariff includes an efficiency requirement of 4.0%. The gross uplift for pay and price inflation has been set at 2.2% which results in a net tariff reduction of -1.8%. Of this 0.3% will be delivered through efficiencies embedded within the tariff structure in relation to the pricing for some of the best practice tariffs. Therefore actual tariff prices will reduce by 1.5%. This is also applicable to services outside the scope of tariff i.e. local prices will reduce by 1.5%.

Pay and price inflation	2.2%
Efficiency requirement	-4.0%
Net price adjustment	**-1.8%**
Embedded efficiency: Best practice tariff extension	+0.3%
Tariff Reduction	**-1.5%**

Other Changes

The other main changes to the scope and structure of the tariff for 2012/13 and the accompanying business rules are set out below:

Specialised Top Ups

There children's top up has been reduced from 60% to 50% in 2012/13. Other top up payments are as previously:

- Spinal Surgery – 32% (restricted eligibility)
- Neurosciences – 28% (restricted eligibility)
- Orthopaedic – 24% (no restriction)

Best Practice Tariffs (BPT)

Best Practice Tariffs (rather than average cost) have been revised or expanded into the following areas:

- Fragility hip fracture and stroke – increased differential between BPT and standard tariffs
- Interventional radiology – extended coverage of BPT's
- Same day emergency care – new BPT's to promote management of certain conditions on a same day basis in ambulatory emergency care
- Day case settings – extending the BPT approach to additional conditions
- Outpatients – new BPT's for three further procedures
- Home Haemodialysis – use of BPT's to promote greater choice for patients of home therapies for dialysis

- Major Trauma – additional payments to reward providers who meet criteria on a per patient basis to support the Major Trauma Centre model.

Extending the scope of PbR

- New post discharge tariffs for:
  - Cardiac rehabilitation
  - Pulmonary rehabilitation
  - Hip replacement rehabilitation
  - Knee replacement rehabilitation
- Mandatory tariffs for:
  - Adult renal dialysis
  - Direct access diagnostics including imaging, simple respiratory tests and flexible sigmoidoscopy
- Mandatory currencies for:
  - Adult mental health (to be used with local prices)
  - Chemotherapy and radiotherapy (with non-mandatory prices also published)
  - Ambulance services (to be used with local prices)
- Phased introduction of a new 'year of care tariff' for cystic fibrosis
- New non-mandatory currencies for a range of community services

Business Rules

- The 30% marginal rate for emergencies above the 2008/09 baseline will continue to apply
- Reinforcement of the policy of non-payment for emergency readmissions with final guidance due to be published in late February.