To: The Board

For meeting on: 24 July 2013

Agenda item: 5

Report by: Mark Turner, Regional Director

Report for: Information

TITLE: **2013/14 Annual Plan Review**

Summary:

The attached paper sets out the sector findings of the 2013/14 Annual Plan Review of 145 NHS foundation trusts (FTs) three year plans for the period 2013/14 – 2015/16.

Recommendations:

The Board is requested to note the contents of the attached report.

Public Sector Equality Duty:

Monitor has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. In relation to the issues set out in this paper, consideration has been given to the impact that the recommendations might have on these requirements and on the nine protected groups identified by the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation).

It is anticipated that the recommendations of this paper are not likely to have any particular impact upon the requirements of or the protected groups identified by the Equality Act.

Exempt information:

None of this report is exempt under the Freedom of Information Act 2000.

Annual Plan Review (APR) 2013/14
Board Summary, July 2013

Central Team:
Mark Turner (RD)
Victoria Woodhatch (SRM)
Sebastian Nai (SRM)
Jess Crocker (RM)
Matt Backler (RM)
Belinda Bruce (RM)
Sector Finance and Reporting Team

Contents

Sector highlights

Monitor

Key themes	Key trends
Acute spells are forecast to ↓ -0.9% in Y1 & ↑ +1.2% in Y2 and Y3	FTs are forecasting small overall activity growth but an increase in elective mix.
EBITDA margin is planned to ↓ -0.3% in Y1, ↑ +0.4% in Y2 & ↑ +0.3% in Y3. Consistent with previous years, plans for Y2 and Y3 appear exposed.	EBITDA% is forecast to reduce in year 1 in line with the historic trend, as the sector plans increased WTEs. In Y2 and Y3, planned EBITDA recovery is driven by planned WTE reductions.
WTEs are forecast to ↑ +2% in Y1, ↓ -2% in Y2 & Y3. However, average pay costs are predicted to ↑ +0.5% in Y1, ↑ +1.4% in Y2 & ↑ +1.2% in Y3.	The increase in WTEs in Y1 is driven by additional consultants and junior doctors. In Y2 and Y3 CIPs significantly reduce nurses and admin staff.
Cash is forecast to ↓ -20% in Y1, ↓ -7% in Y2 & ↓ -2% in Y3.	Large capital expenditure plans reduce cash and increase borrowing. However historically the sector has significantly under delivered against its capex plans.
CIPs as a % of operating costs are anticipated to ↑ +0.5% in Y1 (vs 2012/13 delivered), ↑ +0.1% in Y2 & ↓ -0.4% in Y3.	Average CIPs of 3.8% look challenging given under-delivery in 2012/13 and reports that traditional CIPs are nearing exhaustion. There is limited evidence of transformational schemes.

Introduction

Monitor requires each NHS foundation trust board to submit an annual plan and quarterly or monthly reports. These are used to assess risk on a forward-looking basis and to hold boards of foundation trusts to account.

Scope and overview of this report to the Board

- This report is based on analysis of the 2013/14 Annual Plans (written strategies, financial plans and governance returns submitted 1 June 2013), of the 145 NHS Foundation Trusts (FTs) authorised prior to 1 April 2013. Additional information has been made available by the CQC and may have also been gathered from discussions with key stakeholders including CCGs, Area Teams (LATs) and Quality Surveillance Group attendees.

- This report does not include information relating to Kingston Hospitals NHS FT or Western Sussex Hospitals NHS both of which were authorised early 2013/14.

APR Process

- All FTs are subject to a high level review of their annual plans using the information provided in the FT's submissions and their self certification of performance and governance. Monitor is sighted on prospective risk at APR and uses the output to determine a regulatory approach for each trust, assess the risk that an individual trust might breach the terms of its license in the forthcoming period and to form a view of issues across the sector.

1. Executive summary

1.1Context and Overview

Context

The NHS has to deliver high quality healthcare with a budget that is flat in real terms (between 2011/12 and 2014/15), against a background of long term demand growth. This requires a period of prolonged cost control and productivity growth, which is unprecedented in the history of the NHS.

FTs have the freedom to manage their affairs – we do not expect them to break even every year but we do expect them to invest any surplus they make for the benefit of patients over time.

Over the past few years, the majority of FTs have proven to be resilient. However, the number of FTs in financial distress has increased, as have the number of FTs struggling to meet operational demands (e.g. A&E waiting time requirements). Moreover, the findings of the Francis and Keogh reviews suggest that the quality of services across the sector is variable.

Annual Plan Review ("APR") 2013/14

This year's APR, covering 2013/14, 2014/15 and 2015/16, shows FTs planning in very similar ways to previous APR cycles. The profile of a small margin decline in Year 1 followed by modest recovery in Years 2 and 3 mirrors that planned in the past three years. The actual experience (see chart bottom right) has been that margins have continued to erode, with an average annual decline of around 0.3% p.a.

When earlier forecasts of Year 3 are compared to subsequent actual performance, significant forecasting discrepancies are highlighted.

Year 1

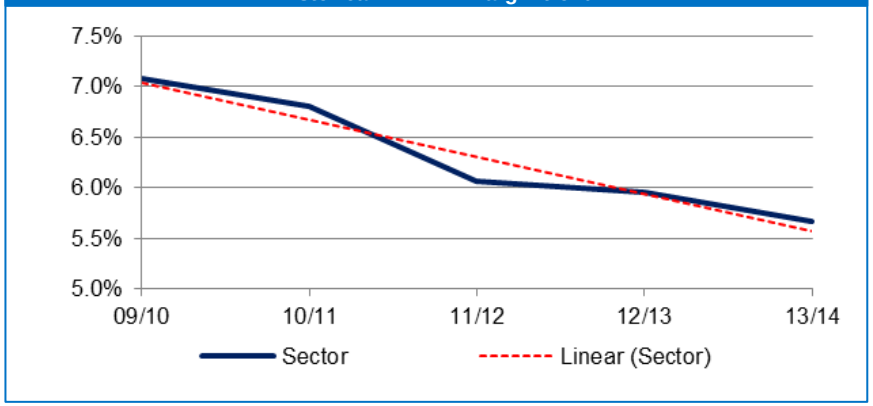
Historically, the sector has a good track record of forecasting its performance in the first year of its plans. FTs are expecting a small decline in margin in Year 1, reflecting their investment in an expanded clinical workforce (and particularly investment in consultant delivered care). This is believed to be connected to the heightened focus on quality across the NHS.

The sector is planning for a combined overall net surplus of £276m in 2013/14. While some Trusts continue to be in financial difficulties overall numbers of those in distress have been relatively stable.

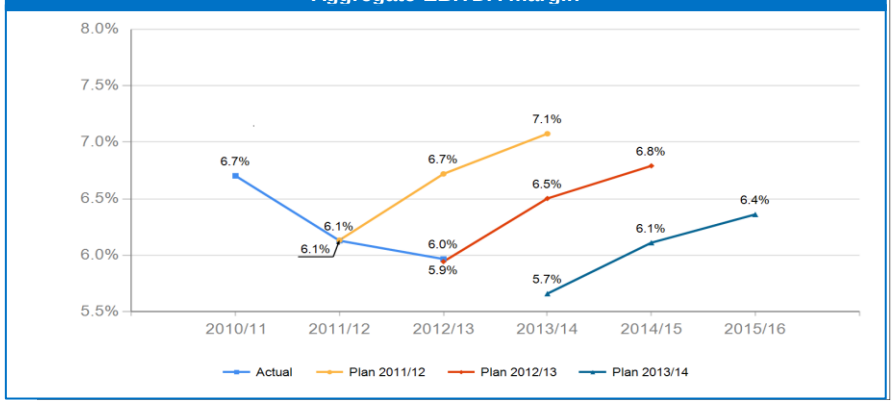
FTs start 2013/14 with a £4.5bn cash balance and, despite projecting cash outflows, may well increase cash balances further in the short-term if capital expenditure slips. Planned capital expenditure (£2.6bn) is 50% greater than actual spend in 2012/13, as the sector continues to build capacity, undertake strategic service developments and invest in improving and modernising the estate.

On the basis of the above, we would expect the sector to be mostly resilient in the near term. However, risk is not evenly distributed across providers and individual trusts may well struggle.

Historical EBITDA margin trend



Aggregate EBITDA margin



1.2 Context and Overview

Longer-term

In Years 2 and 3, FTs are planning for a recovery in profitability (to 6.4% in 2015/16), driven by a reduction in clinical staffing. Historically, this planned recovery has not materialised and margins have continued to decline.

This year's forecast looks similar to last year. Projected savings (cost improvement plans, "CIPs") are below the level of the expected financial pressures, which suggests that, on balance, margins would be expected to decline rather than to increase.

There are, however, a number of reasons to suggest the balance of longer term risks in this year's APR has shifted somewhat to the downside.

First, the outlook on overall funding and commissioner intentions, while similar to last year, is considerably more uncertain. Moreover, the 2013 Spending Review has confirmed that financial pressures will increase beyond 2015/16.

The clearest change from last year is in regard to CIPs. Last year, the view was that the sector had increasingly demonstrated its ability to deliver substantial CIPs (c4%), a level at which profitability might plausibly be maintained.

This year, FTs report that the opportunities for traditional CIPs are increasingly depleted. This is reflected both in the disappointing under-delivery against plan in 2012/13 (21% lower then expected) and in lower levels of planned CIPs over the next 3 years. There is little evidence at this stage to suggest that delivery of CIPs might be expected to improve over the period. This could mean that actual delivered CIPs are at or below 3% in 2015/16.

At the same time, there are clear pressures for increased investment in clinical staff to address both capacity issues (e.g. A&E) and emerging quality issues (in the light of the Francis and Keogh reports). This is reflected in Year 1 of the plan; however clinical headcount is projected to decline in Years 2 and 3. Given the continuing efforts to identify and address poor and mediocre quality (e.g. the new Chief Inspector of Hospitals regime), it is not clear that these pressures will abate.

The sector's cost position has benefited from the pay freeze across the public sector. This is a key factor, given that staff costs typically represent two thirds of the overall cost structure of an FT. However, plans reflect somewhat optimistic assumptions about providers ability to restrain wage growth. These may be hard to realise.

The profile of the profitability of FTs has already shifted, with fewer high margin trusts, more deficit trusts and a flattening (i.e. reduction of profitability) for those in the middle of the curve (representing the majority of FTs). This is represented in the "S Curve" (see slide 2.7). The combination of the challenges over the plan period is likely to erode the "S Curve" further.

Monitor recognises this risk and a key focus of its regulatory approach is in enhanced scrutiny of higher risk areas (including a number of DGHs) to enable early intervention.

Given that traditional cost saving opportunities appear to be increasingly depleted, the only way of addressing financial pressures in the medium term is to deliver more fundamental change. There remain significant, and largely undefined, opportunities to drive productivity and quality improvements through transformation, pathway redesign and innovation. At present, there is only limited evidence of trusts addressing these opportunities in a concerted manner.

It is critical that the sector starts to take steps now to deliver fundamental change. Without such a change there can be no guarantee that the sector will remain largely resilient. Monitor will use the full range of its tools, including the new Risk Assurance Framework, to help promote more strategic thinking and drive better long term strategic planning to enable this critical change.

1.3 Context and Overview

Challenges

- Maintaining the balance between quality, access and cost
- On-going non-elective pressures and stretched capacity
- Uncertain commissioning environment and planned changes to prices
- Anecdotal evidence that CCGs will take a more robust approach to quality
- Identification and delivery of transformational CIPs (and the associated cost of change)
- Effective long term plans and planning process
- Overcoming barriers to transformation and pathway redesign
  - Capability
  - System complexity
  - Regulatory burden
  - Opposition to disruptive change

Downside Risks

- Key areas of uncertainty:
  - pay costs
  - cost of delivering higher quality care
  - changing view of what clinical quality needs to be and the clinical critical mass required to deliver it
  - strength and depth in leadership
  - fragility of the small and medium DGH model

Stabilising factors

- Cash balance
- Opportunity to transform service delivery to improve quality and drive productivity gains

1.4 APR 2013/14 highlights

APR 2013/14 Key Findings

Revenue and Activity

- FTs are forecasting a 1% increase in operating revenue in 2013/14 driven by an increase in revenue generation schemes and “Other NHS Income”. The impact of Tariff reductions are off-set by planned growth in elective mix.
- In Years 2 and 3 revenue is broadly flat. This compares with historical revenue growth of 5% between 2011/12 and 2012/13.
- There is a planned change in revenue mix with a small increase in total clinical income (2%) being offset by a decrease in non-clinical income (8%), probably reflecting commissioning intentions to flex more discretionary budgets such as research and development.
- Forecast activity is relatively flat over the plan period and understated relative to historic trends (2% p.a. increase in total episodes between 2008/09 and 2011/12) and the non-elective pressures providers experienced in 2012/13.
- Non-NHS clinical income is set to significantly grow between 2012/13 and 2015/16 (13.9%) driven, at least in part, by the removal of the PPI cap.
- The largest element of revenue is “Other NHS Clinical revenue” (21%); this has grown rapidly in recent years (accounting for 20% of overall sector revenue growth in 2011/12 and 47% in 2012/13) and is expected to grow further over the plan period. Further analysis is on-going to identify the key drivers here.
- While the sector has historically over-delivered against planned revenue (4% over plan in 2012/13 and 11% over plan in 2011/12), anecdotal signals of changes in commissioning approach (including late signing of contracts) may have an adverse impact. Other factors that may influence delivery are “contract gaps” (providers planning revenue materially in excess of contracted levels) and variance in “Other NHS income” to the extent the latter relies on non-recurrent, non-PbR payments.

Costs

- Staff costs are the main cost element that FTs plan to flex over the plan period (staff costs account for the majority of the cost base, c.65% of revenue on average).
- In 2013/14 there is a planned 2% increase in spending on staff, reflecting a planned net 2% increase (after CIPs) in WTEs. In subsequent years staff costs are forecast to fall by 0.5% p.a driven by planned WTE reductions.
- Average pay is forecast to increase by 1% in Year 1 and 2% thereafter. This contrasts with the historical experience in the pay freeze era which saw annual pay drift of 2.9%.
- Post Francis, the Keogh Reviews and the planned Chief Inspector of Hospital reviews, it is reasonable to expect continuing sector wide pressure to invest further in quality.

Workforce

- The total number of WTE is planned to increase by 2% in Year 1 via net increases in consultants (3%), junior doctors (4%), and nurses and midwives (2%).
- This investment in clinical workforce, and particularly senior leaders, is likely to be driven by the Francis report, addressing shortfalls in A&E capacity and Royal College Guidance on 24/7 working.
- By contrast, across 2014/15-15/16 there is a planned disinvestment, largely through reductions in nursing numbers (4%). This suggests that the previous years investment is seen as a short term fix for operational pressures.

CIPS

- The context for CIP delivery will continue to be challenging (either though continuation of the winter pressures seen in 2012/13 or the increasing scrutiny of quality standards) and is likely to put the delivery of forecast headcount reductions (2% in Year 2 and in Year 3) under strain, despite the significant planned reductions in bank and agency staff (39% in Year 1, 8% in Year 2 and 9% in Year 3).
- There is limited evidence that the sector is attempting multi-year or transformational schemes and anecdotally FTs are saying that there is a dwindling supply of traditional cost saving measures. This has led to them targeting the harder to deliver CIPs related to workforce.
- Given the challenging context, there is likely to be a continuing gap between planned and actual delivery despite lower targets - forecast CIPs for 2013/14 are 3.9% (compared to plan of 4.3% and delivery of 3.4% in 2012/13).
- If the sector continued to under deliver CIPs by 20% across the plan period, by 2015/16 it would deliver CIPs under 3%.

EBITDA margin

- Margins are planned to decline in 2013/14 (0.3%) and then recover strongly in Years 2 and 3.
- The margin decrease in Year 1 is driven by a 2% increase in staff costs with the outer year margin improvement driven by a planned 2% p.a reduction in WTEs and a reduction in expected financial pressures (1%).

1.5 APR 2013/14 highlights

Balance Sheet and Cash

- The sector's current balance sheet is reasonably robust with cash of £4.5bn.
- £2.6bn of planned capital expenditure in 2013/14 results in a decrease in cash and a significant increase in borrowing by the end of the period.
- The 2013/14 capital expenditure plans are higher than in previous plans and 50% greater than actual spend in 2012/13, as the sector continues to build capacity, undertake strategic service developments and invest in improving and modernising estate.
- The sector has historically failed to deliver against its capital plans (with the gap between plan and actual growing) suggesting that capex slippage may exceed the 33% reported in 2012/13 and that the sector is likely to over-deliver against its forecast liquidity of 24.8 days at the end of 2013/14.

Operational Performance

- Operational performance has been maintained, but there are signs of increasing pressure most obviously reflected in the problems with A&E waits in the winter of 2012/13 and there are indicators of a potential knock-on impact on RTT wait times, Cancer and Infection control targets. This is reflected in the increase in forecast target breaches for 2013/14.
- The tri-partite approach to A&E has uncovered the requirement for increasing capacity in a number of areas (beds, consultants, physical capacity) and it is not clear from the APR data that this is reflected in plans.
- While there is no direct evidence that CIPs have impacted quality it is reasonably likely that operational resilience has been reduced as reflected in the A&E performance, reduced bed base and increasing occupancy.

2. Financial analysis

2.1Income & expenditure

Income Statement				
	2012-13 Actual £m	2013-14 Plan £m	2014-15 Plan £m	2015-16 Plan £m
Total Operating revenue	***39,613***	**39,851**	**39,839**	**39,889**
less Donated PPE	***(105)***	**(121)**	**(135)**	**(171)**
Operating Revenue for EBITDA	***39,508***	**39,730**	**39,704**	**39,718**
Pay costs	*(24,715)*	(25,176)	(25,027)	(24,902)
Other operating expenses	*(12,434)*	(12,298)	(12,242)	(12,278)
EBITDA	***2,359***	**2,256**	**2,435**	**2,538**
Depreciation	*(1,129)*	(1,202)	(1,257)	(1,295)
Finance Costs	*(323)*	(333)	(339)	(347)
other expenses	*(365)*	(446)	(447)	(404)
Surplus pre exceptionals	***542***	**276**	**392**	**492**
Gains/(losses) on transfers by absorption	*156*	19	0	0
Impairments	*(617)*	(126)	(107)	(112)
Restructuring Costs	*(48)*	(24)	(11)	(8)
Surplus/ (Deficit)	***33***	**144**	**274**	**371**
Cash & Cash Equivalents	*4,513*	3,604	3,343	3,284
EBITDA %	*5.97%*	5.68%	6.13%	6.39%

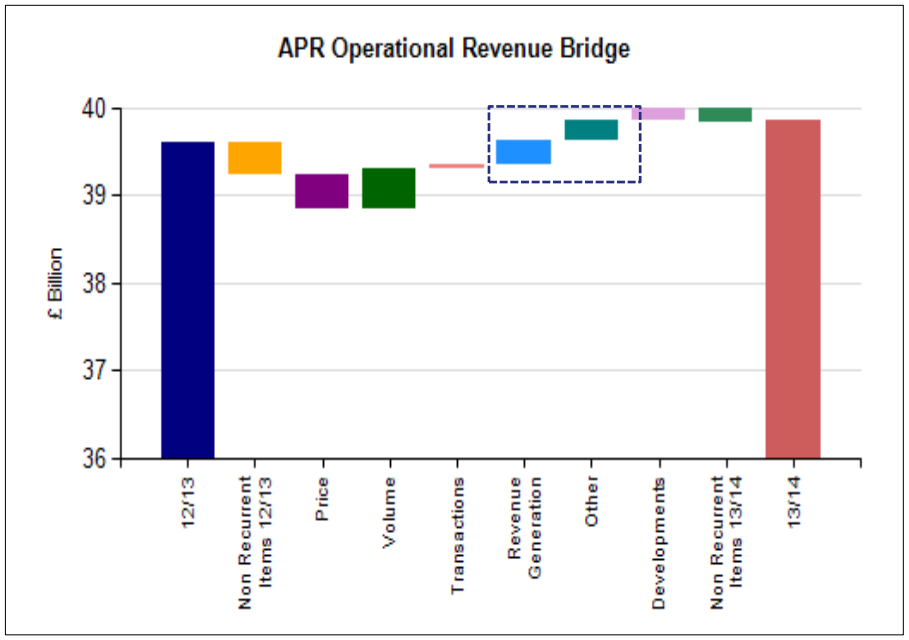
Overview

- EBITDA margin progression (decreasing in Y1 followed by recovery in Y2 and Y3) is driven predominantly by staff cost movements, given revenues are expected to be flat.
- In 2013/14 pay costs are forecast to increase by £0.5bn (2%) due to a 2% planned increase in WTEs. This may be a continuation of the sector's 2012/13 investment in clinical workforce in response to the Francis report, Keogh reviews and A&E non-compliance.
- In the outer years, planned pay cost reductions improve EBITDA margin by 0.7% underpinned by a 4% planned reduction in WTEs (primarily nurses and non-clinical).
- Planned impairments are significantly below the £0.6bn incurred in 2012/13. Impairments are inherently difficult to forecast as they depend on a current review of the balance sheet. It is possible that actual impairments for 2013/14 will be above those planned and this pattern has been observed in prior years.

Planned EBITDA margin progression is driven predominantly by movements in pay costs.
In year one, as the sector increases consultants and junior doctors, the margin falls.
In the outer years, as the sector reduces nurses and non-clinical staff, the margin rises.

2.2 Income and Activity

2012/13 to 2013/14

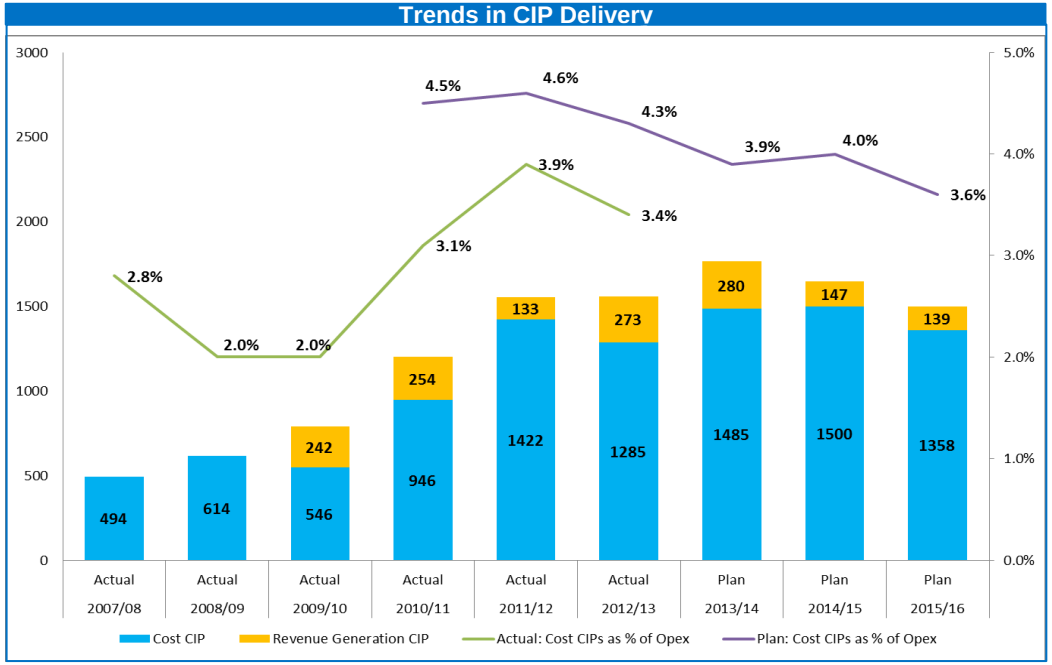


Revenue and activity profile

- Forecast revenue grows by 0.6% in 2013/14 and then remains flat across the outer two years of the plan. Despite a relatively flat overall revenue profile across the three years of the plan, the sector is planning on changes in revenue mix with significant reductions in non-clinical income (-8%) being offset by small increases in clinical income (2%). In addition, the sector is forecasting reduced budgets in "discretionary" non-clinical areas such as research and training.
- The average forecast revenue increase of 0.2% p.a. compares to a historical growth rate of 5% between 2011/12 and 2012/13. This is being driven by a decrease in the expected level of non-recurrent income in 2013/14.
- Previous APR cycles indicate that the sector is weak at forecasting revenue (particularly in the outer years). This may in part reflect prudent planning, but more likely suggests weakness in forecasting activity levels and the impact of demand management schemes.
- "Other NHS income" is the most significant revenue line at c. £8.5bn (21% of the overall planned 2013/14 revenue). Double digit annual growth in this line has accounted for 20% and 47% of overall sector revenue growth in 2011/12 and 2012/13 respectively. This could suggest that the sector may be reporting additional funding above contract and other non-recurrent income in this line which has supported revenue through non-PbR payments in a falling tariff environment.
- If commissioners are unable to manage demand in line with the planned flat activity profile, we may see over performance on revenue as in previous years.

Revenue growth of 0.6% in 2013/14 is driven by revenue generation CIP schemes and "other NHS income". Activity and revenue growth assumptions may be understated as, historically, trusts have been weak at forecasting activity growth and demand.

2.3 Cost Improvement Programmes



Historical CIPS

- Prior to 2012/13, CIPs had been on a strong upwards trend, both in absolute terms and as a % of operating expenses.
- However, in 2012/13, as the context for CIPs became more challenging (pronounced winter pressures and a heightened quality focus arising from the Francis Report and the commencement of the Keogh reviews), CIP delivery disappointed. This resulted in a sharp decrease in delivered CIPs as a % of operating expenses and increasing under-delivery against plan.

Future CIPs

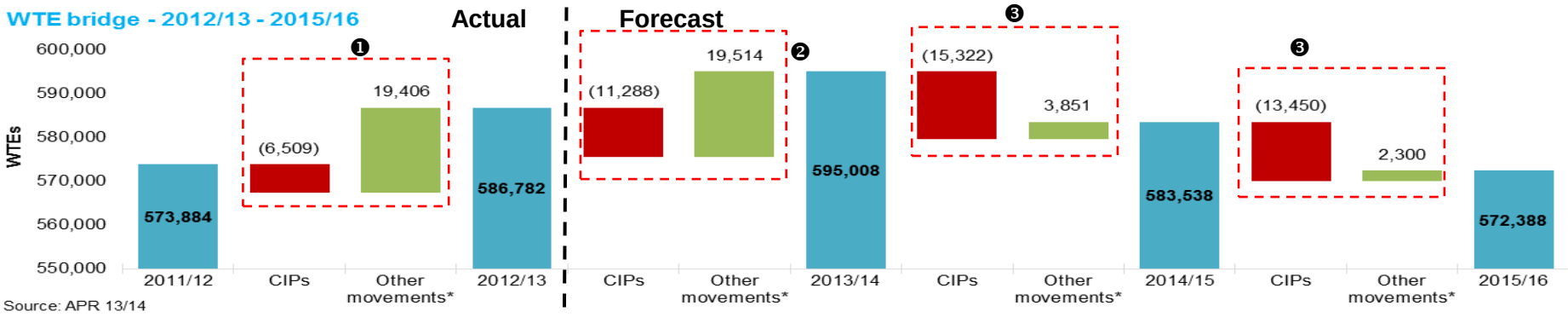
- The sector's planned level of future CIPs could prove challenging for a number of reasons:
  - The sector is planning on reducing levels of CIPs which may be as a consequence of anecdotal reports that traditional CIPs are nearing exhaustion;
  - Given the continuing challenging context for CIP delivery, it may be unwise to expect current CIP under delivery to reduce; and
  - Trusts are increasingly pursuing more challenging staffing related schemes (pay CIPs become an increasingly large proportion of total CIPS - 54% in 2012/13 to 62% in 2015/16).
- Assuming that the sector under delivers forecast CIPs by 20% (as in 2012/13) across the three years of the plan, CIPs would be less than 3% in 2015/16.

Transforming services

- In order to counter the financial pressures facing the sector, trusts must change the way in which they provide services to improve patient care whilst increasing productivity. However, there is limited evidence that this is taking place.

The context for CIPs has become more challenging, leading to significant under delivery in 2012/13, which could be expected to continue.

2.4 Workforce Vs CIPs



Source: APR 13/14

*NB: Other movements include activity growth etc.

❶ There was an overall 2% increase in WTEs in 2012/13, driven by investment in relatively more senior staff (consultants +6% and junior medical +4%), although nurses reduced by 4%. This may be the result of the sector increasing senior decision makers in response to the high profile quality issues which arose during the year.

❷ In 2013/14, FTs are forecasting a net increase in WTEs of 2%, which appears to be a continuation of the recruitment programme which began in 2012/13. The sector is, however, looking to off-set some of the cost associated with these increases by dramatically reducing temporary staffing (-39%).

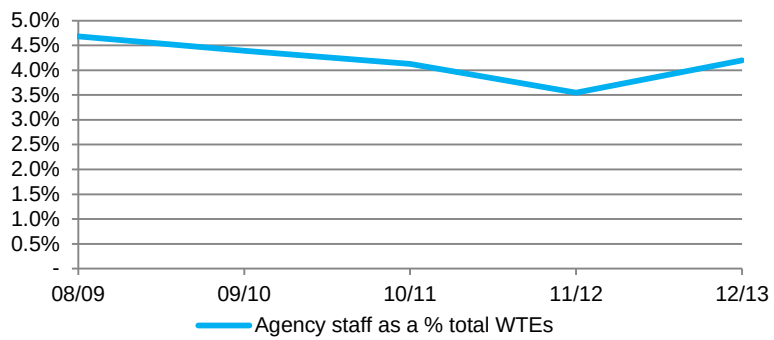
❸ There is a forecast 4% reduction in WTEs in the outer years of the plan, driven almost entirely by CIP plans to reduce WTEs by c30,000.

We expect planned WTE reductions to be challenging: (1) Planned WTEs have continued to rise despite long term plans to reduce WTEs; and (2) Achievability of planned temporary staff reductions may be put at risk from insufficient available staff to fill the vacated positions on a permanent basis.

WTEs are forecast to increase in 2013/14 as the sector invests in senior decision makers in response to Francis and Keogh, and, A&E concerns. Significant forecast WTE reductions in outer years look challenging.

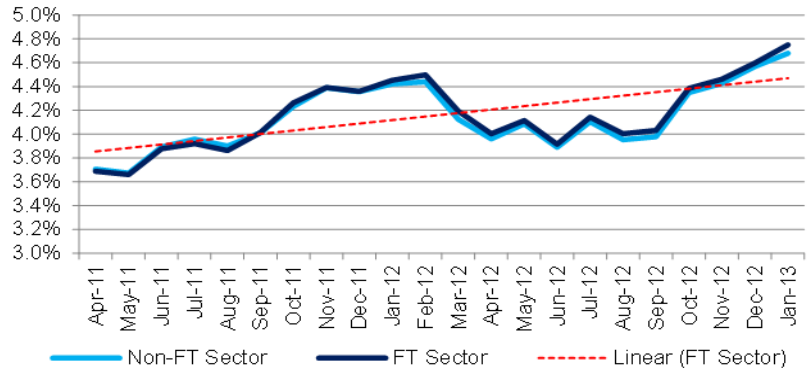
2.5 Workforce pressures

Use of bank and agency



Source: FTC annual submissions

Sickness absence



Use of bank and agency

- A key component of the sector's forecast CIP programme is focussed on reducing the use of bank and agency through appointing substantive staff.

- There is a risk that the sector will be unable to achieve the forecast substantial cost savings via a reduction in the usage of bank and agency staff as:
  - Whilst there has been a downwards trend, trusts have been unable to deliver and maintain large scale reductions in temporary staff in previous years; and
  - There is an observed lack of available staff to fill full time positions.

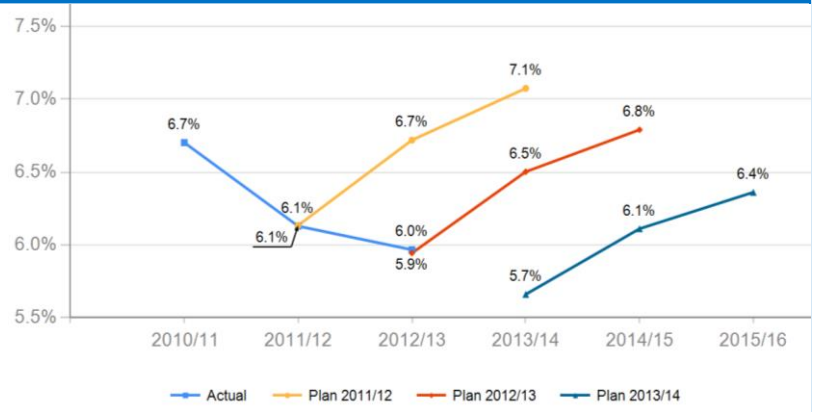
Sickness and absence

- There are financial costs (including the use of bank and agency as above) associated with the upward trend in sickness absence as well as the risk of deterioration in the quality of patient care and experience.

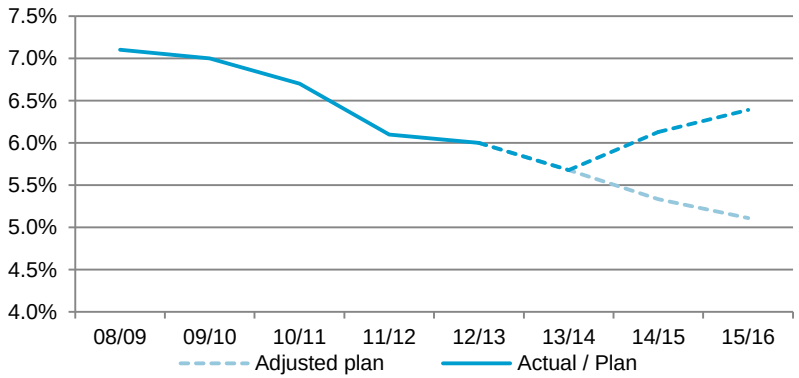
Sickness absence has been trending upwards since April 2011. There is a risk that the sector will be unable to achieve the forecast substantial cost savings within their forecasts via a reduction in the usage of bank and agency staff.

2.6 EBITDA margin

Aggregate EBITDA Margin – Sector planning is overly optimistic



Sector EBITDA Margin (planned vs adjusted)



The adjusted plan reflects the estimated impact of applying the historical under-delivery of actual margin against that forecast in year two and three of the plan as shown above.

EBITDA margin trend

- There has been a long term deterioration in EBITDA margin of 0.3% p.a. Notable exceptions have been 2011/12, where margin declined more severely due to the dilutive effect of TCS and 2012/13, where the decline flattened due to what is believed to be one-off recurrent income.
- Despite the clear long term trend, the sector consistently plans for a deterioration in year one EBITDA margin, followed by recovery in the outer years.

2013/14 margin progression

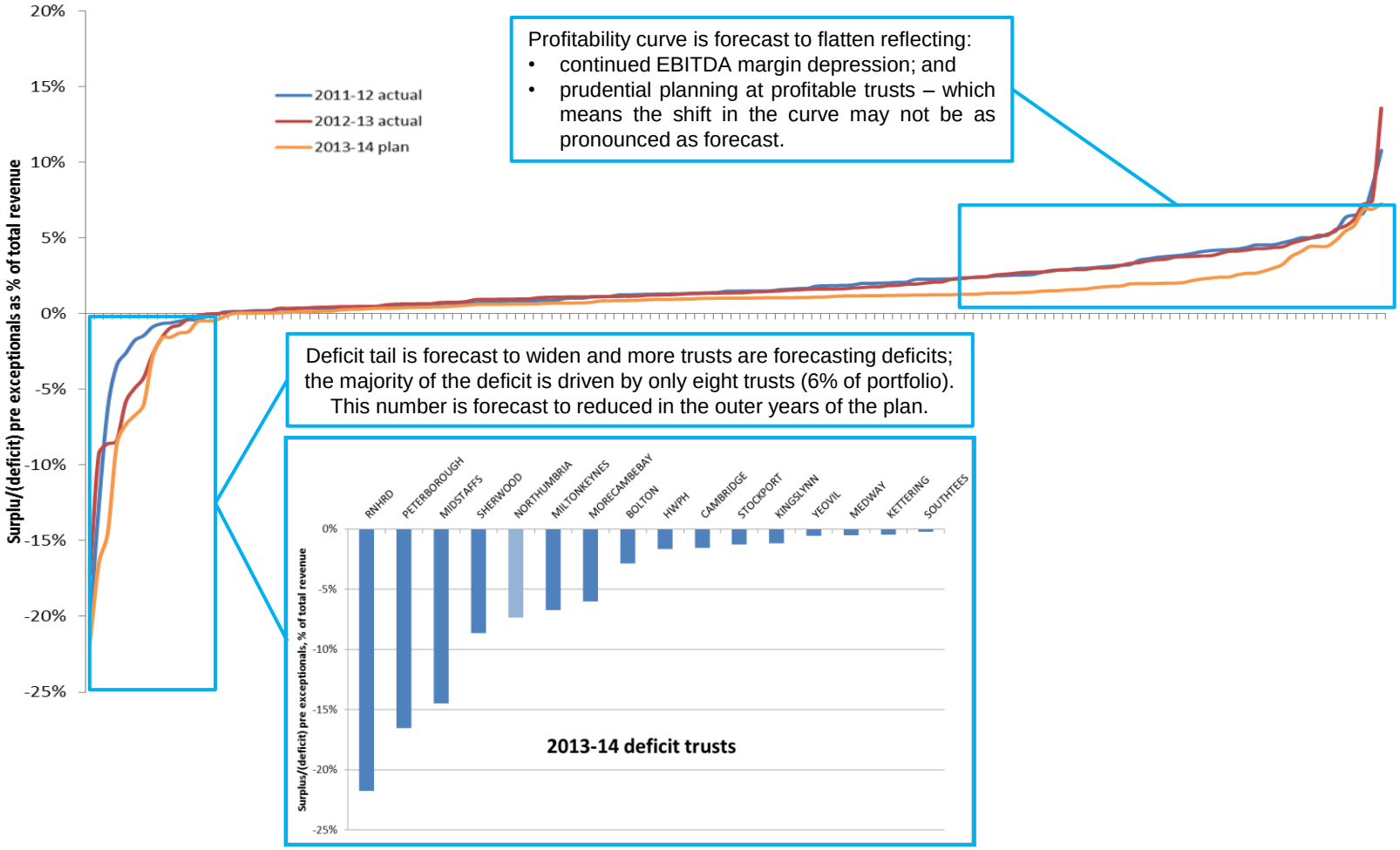
- The sector plans margin decline of 0.3% in 2013/14, due to the impact of additional investment in WTEs.
- Historically, the sector has proven to be accurate in forecasting year one of the plan.
- The decline in margin is consistent with the level of planned CIPs being below the level of financial pressure reflected in Monitor's Assessor Case.

Outer year margin progression

- Planned margin recovery in years two and three, is driven by significant planned reductions in nurses and non-clinical staff.
- The sector has a track record of under-delivering against its year two and three plans (c.10% and c.20% respectively). Applying this level of under delivery to the current plans would suggest a progressive c. 0.3% reduction in margin (left).
- We believe these plans may be optimistic given:
    1. The level of planned CIPs and revenue generation schemes are below Monitor's Assessor Case in both years, suggesting margin *decline* (not recovery). Additionally, planned wage increases appear exposed in light of recent wage increases and the lifting of the wage freeze in April 2013; and
    2. The context for delivering CIPs has become more challenging, and the sector has a weak track record of sustainably reducing WTEs which underpin the planned recovery.

Planned 2013/14 margin decline appears reasonable, but the recovery in outer years looks optimistic

2.7 S curve over time



The S curve is forecast to shift with the number of trusts in deficit increasing, whilst the profitability curve flattens in line with a continuing high level of financial challenge.

2.8 Balance Sheet and cash flow

Summary Balance Sheet 2012/13 – 2015/16				
Financial Position	31 Mar 2013 Actual £m	31 Mar 2014 Plan £m	31 Mar 2015 Plan £m	31 Mar 2016 Plan £m
Total non-current assets	***22,080***	**24,029**	**24,804**	**25,434**
Total current assets	*6,855*	5,843	5,657	5,563
Total current liabilities	*(5,051)*	(4,547)	(4,512)	(4,502)
Net current assets	***1,804***	**1,297**	**1,146**	**1,060**
Total non-current liabilities	***(5,931)***	**(6,342)**	**(6,533)**	**(6,493)**
Total funds employed	***17,953***	**18,984**	**19,417**	**20,002**

Summary Cash Flow 2012/13 – 2015/16				
Cash flow	2012/13 Actual £m	2013/14 Plan £m	2014/15 Plan £m	2015/16 Plan £m
Operating cash flows	*2,421*	2,283	2,521	2,665
Working capital movements	*193*	(461)	(125)	(10)
Net cash inflow/(outflow) from operating activities	***2,614***	**1,822**	**2,396**	**2,655**
Capital Expenditure	*(1,640)*	(2,614)	(2,235)	(2,063)
Other investing activities	*30*	42	140	110
Net cash inflow/(outflow) from investing activities	***(1,610)***	**(2,571)**	**(2,095)**	**(1,953)**
Existing financial commitments	*(706)*	(733)	(883)	(756)
Net increase/(reduction) in borrowing	*168*	574	321	(3)
Net cash inflow/(outflow) from financing	***(538)***	**(159)**	**(562)**	**(759)**
Net increase/(decrease) in cash	***466***	**(909)**	**(261)**	**(57)**
Opening Cash & Equivalents	***4,047***	**4,513**	**3,604**	**3,343**
Closing Cash & Equivalents	***4,513***	**3,604**	**3,343**	**3,286**

Overview

- Forecast surplus is driving an increase in funds employed in each year of the plan (£0.6bn of the increase is attributable to 1 April 2013 asset transfers from PCTs and SHAs).
- The 2013/14 opening cash balance was £1,267m above plan driven by slippage in capital expenditure plans.
- However, cash available for investment of c.£1.1-1.9bn is not sufficient to meet forecast capital expenditure. The shortfall is forecast to be met by:
  - A reduction in cash & cash equivalents and working capital which results in net current assets reducing; and
  - An increase in long term borrowing.
- The implication of this is a likely deterioration in financial resilience through:
  - Reducing liquidity (days are forecast to fall from 31.8 in 2012/13 to 24.8 in 2015/15); and
  - A higher gearing and level of debt servicing requirement.
- However, capex plans have slipped by an average of 27% over the last five years. If this pattern continues, the decline in liquidity and level of borrowing is likely to be less than forecast. In addition, despite the forecast reduction in cash over the plan period, liquidity remains reasonable.

Significant capex plans drive a planned increase in borrowing and a fall in liquidity over the plan years. However, historically trusts have underspent on capex plans by c.27%.

2.9 Summary segmental analysis

Segmental analysis

- The acute segment is the largest, accounting for 71% of total operating revenue. Mental health, specialist and ambulance account for 20%, 7% and 2% respectively.
- EBITDA margin follows the sector profile but varies by segment. Small acutes are unique in forecasting progressive margin recovery.

Large acute trusts

- Tend to have higher margin than other acutes and contribute the most surplus.
- Key pressures arising from:
  - ***High % of R&D and E&T revenue:*** these areas are facing substantial cuts;
  - ***High % of specialist services:*** high level of uncertainty around specialist commissioning; and
- Evidence that a number of high profile trusts are actively addressing the longer term strategic agenda.

Small and medium acute trusts

- Small and medium acute trusts tend to be the most challenged and the APR plans suggest this is likely to continue both in financial and operational areas.
- Key pressures arising from:
  - ***Activity mix:*** tend to be less diversified than their larger peers and are more exposed to increased non-elective pressure (often paid at marginal rate) displacing more profitable services;
  - ***Smaller catchment areas:*** smaller DGH's are likely to have issues with the scale of some services; and
  - ***Revenue exposure:*** pressure on both ends of service spectrum from repatriation of specialist services at the top end and increasing challenge from AQP at the bottom end.

Mental health trusts

- Mental health plans tend to be overly prudent. This suggests that the forecast deterioration in margin in 2013/14 may be over stated.
- Key pressures arising from:
  - ***Declining or flat budgets:*** in the context of rising demand against block contract income; and
  - ***AQP:*** increasing pressures from competition.
- There is some evidence of mental health trusts beginning to address transformational CIPs through TCS.

Specialist Trusts

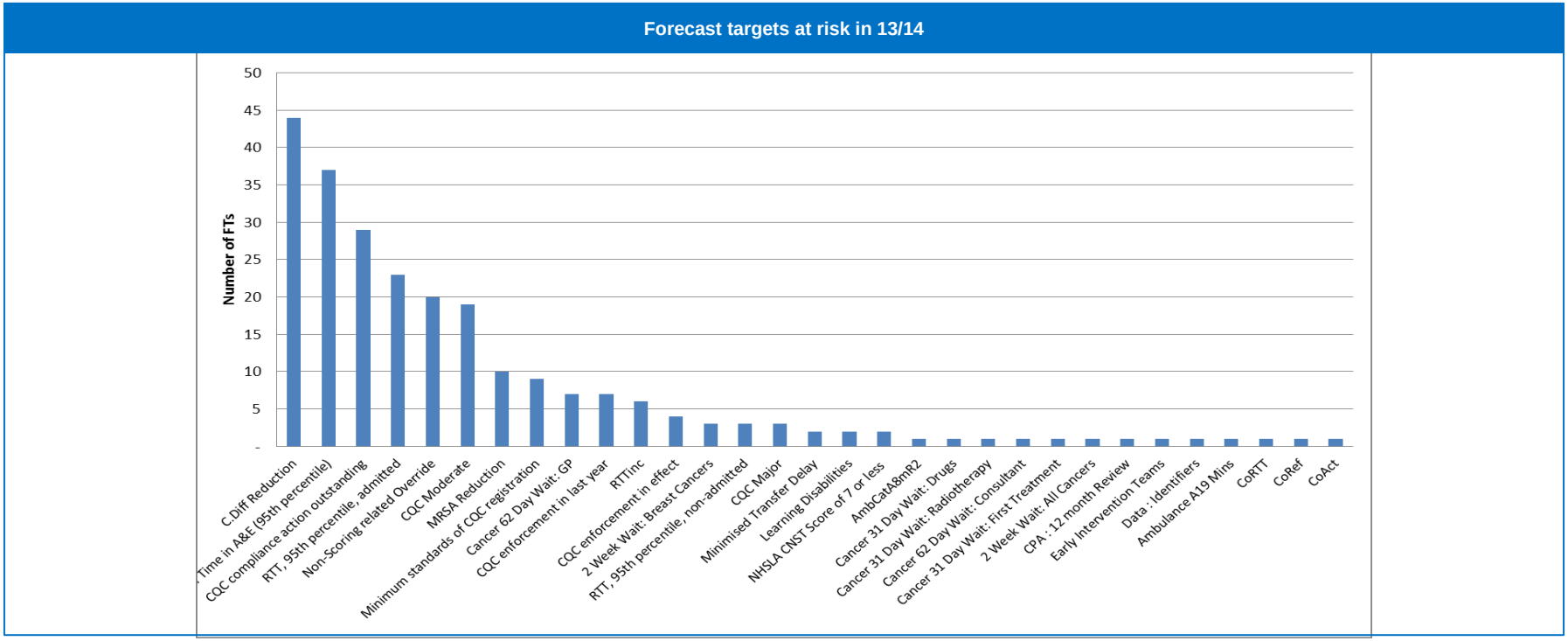
- Continue to be the most profitable sector.
- Key pressures arising from:
  - ***High % of R&D and E&T revenue:*** these areas are facing substantial cuts; and
- Relatively good at planning for the longer term strategic challenges.

Ambulance Trusts

- Sector remains relatively strong although CIPs are becoming more of a challenge.
- Key pressures arising from:
  - ***AQP:*** Non-core 999 services are becoming more competitive; and
  - ***111:*** A number of trusts have taken on 111 services which have had a number of high profile teething problems.

3. Operational performance and quality

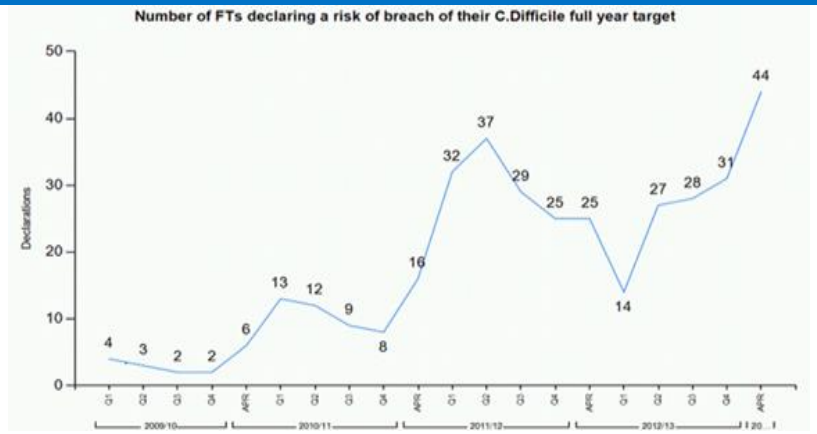
3.1 Forecast target breaches



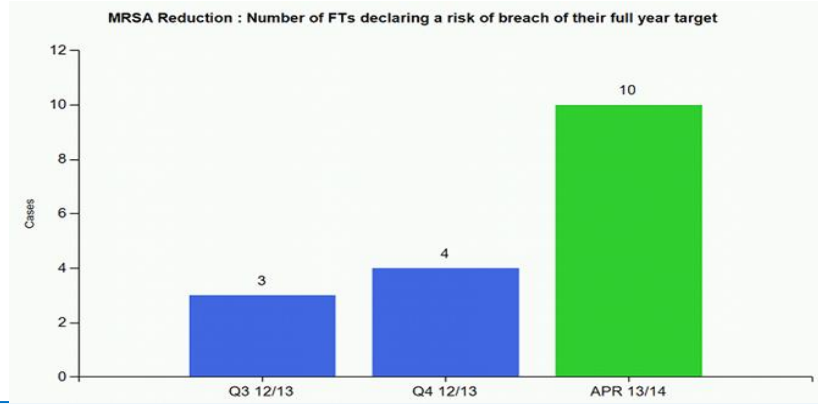
The sector is declaring more potential target breaches than ever before.
The sector is most concerned about remaining compliant with the Cdiff, A&E 4 hour wait and RTT admitted targets.

3.2 Infection control

C-Diffcile



MRSA



C-Difficile

- 44 FTs are declaring a risk against the Cdiff target (the highest number over the last 4 years), however this is in the context of an overall falling trend (c.430 cases per month in May 2011 to around 260 per month in May 2013) and reducing targets.

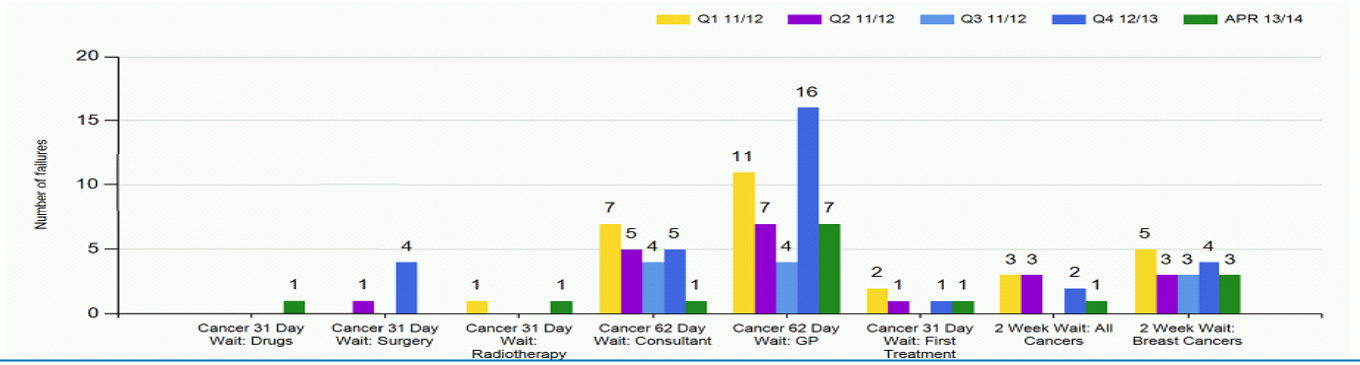
MRSA

- Despite a reduction in the absolute number of reported MRSA cases, the reducing target is becoming more challenging driving the significant increase in the number of planned MRSA breaches.

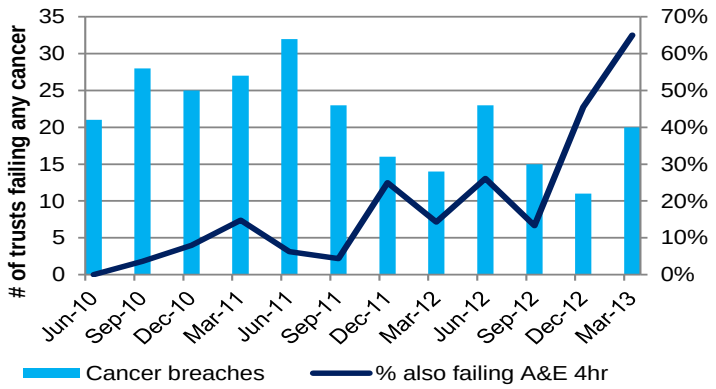
Performance against infection control targets has improved over time.
The forecast increase in non-compliance in 2013/14 appears to reflect more challenging targets rather than deterioration in underlying performance.

3.3 Cancer targets

All Cancer targets



Historical cancer target breaches

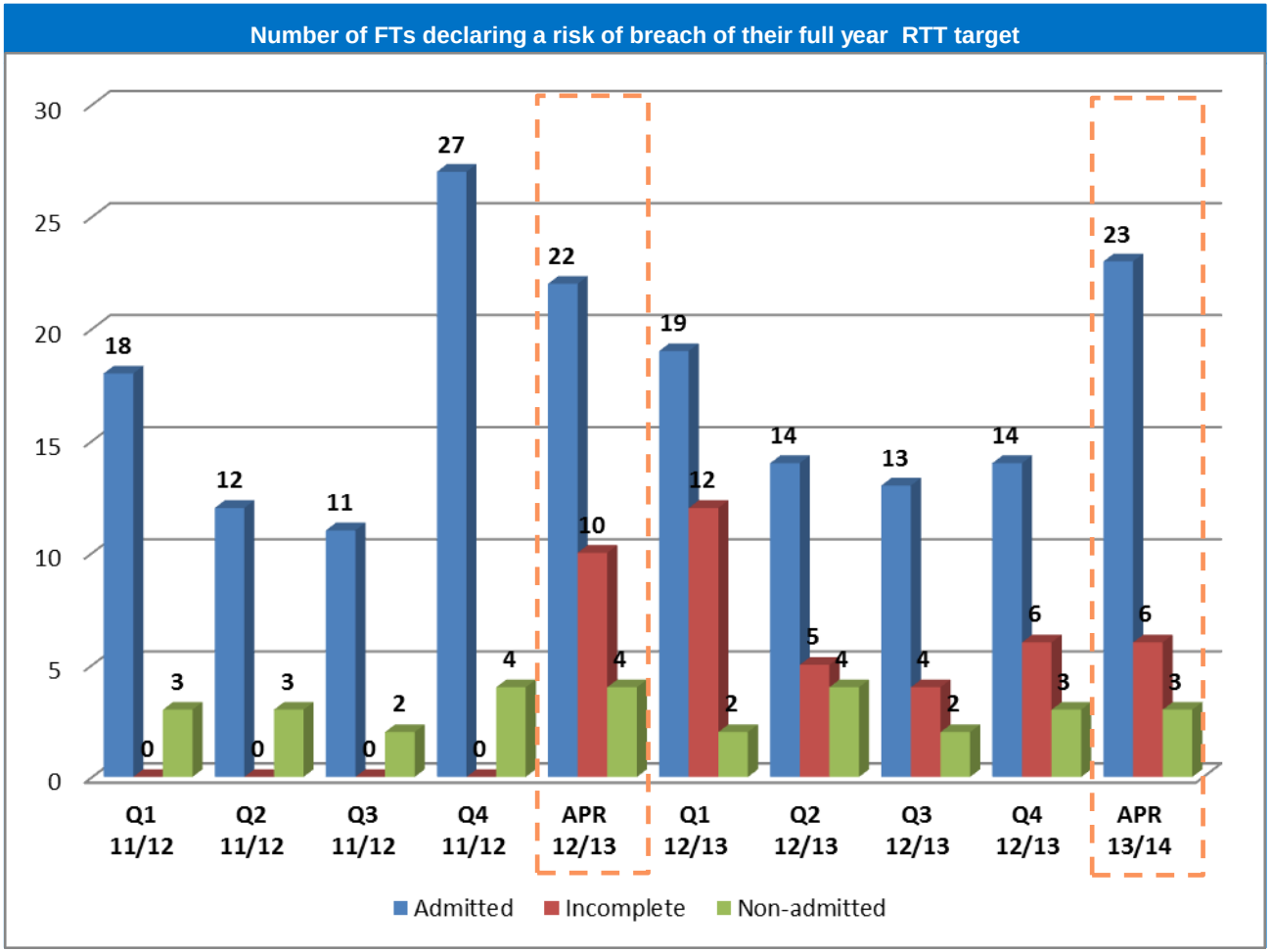


Cancer Targets

- 2013/14 APR declarations forecast improved compliance with cancer targets.
- There is an observed correlation between FTs reporting non-compliance with cancer and A&E, with over 60% of trusts failing a cancer target also failing the A&E target in Q4 2012/13. This suggests that continued A&E pressure could have a knock-on impact on performance against cancer targets.

The sector plans improved compliance against all cancer targets except for the 62 day wait from GP referral target.

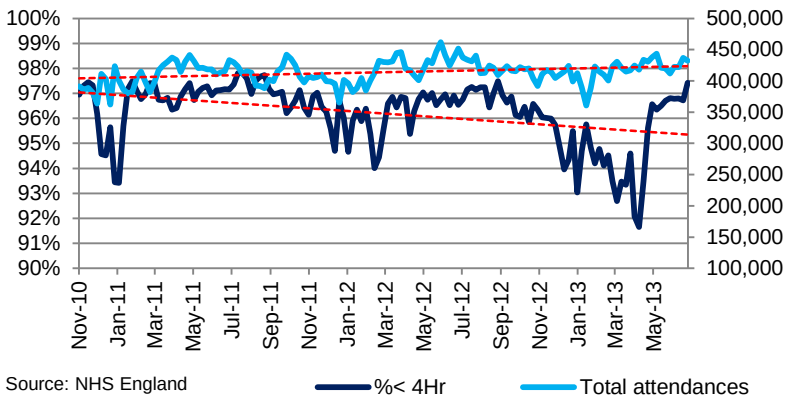
3.4 Referral to treatment (RTT)



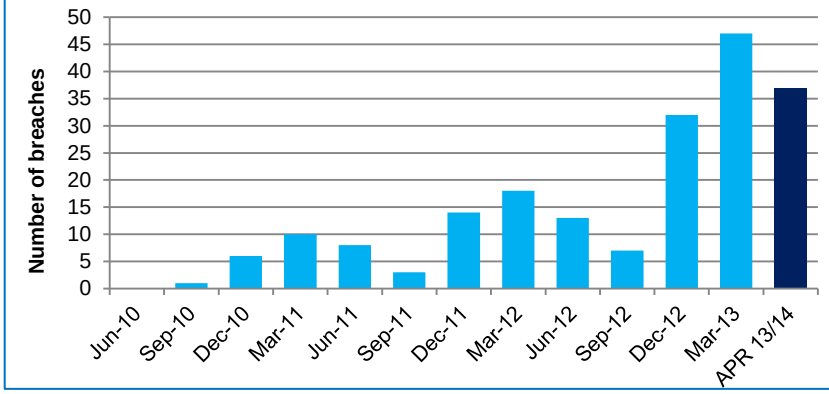
RTT 18 week target for admitted patients is forecast to remain under pressure in 2013/14, particularly if A & E and non-elective pressures continue.

3.5 Accident & Emergency

Average wait



FTs breaching target over time

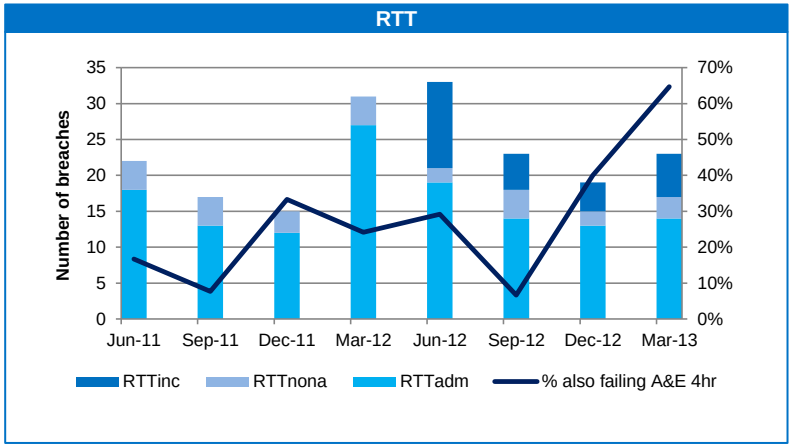


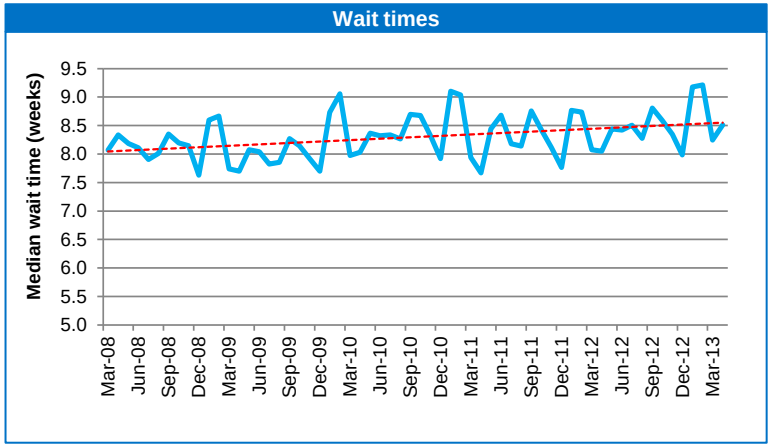
A&E four hour breaches

- In recent years, the sector has experienced increased attendances and flat admissions, but has reported rising non-compliance with the 4hr A&E target.
- This could be a symptom of constraints in capacity, potentially arising from a sustained and substantial CIP challenge over the same period.
- The sector forecasts improved compliance with the A&E target in 2013/14. This may be supported by:
    - The tripartite review process. All non-compliant FTs were subject to tripartite review (Monitor, NHS England and NTDA) of urgent care recovery plans including additional scrutiny over at-risk plans; and
    - The sector as a whole investing in capacity, particularly in consultants and junior doctors.

A&E is forecast to remain a challenging target for the sector, although there are fewer trusts forecasting non-compliance than were observed at Q4 2012/13.

3.6 RTT: Impact of system pressures



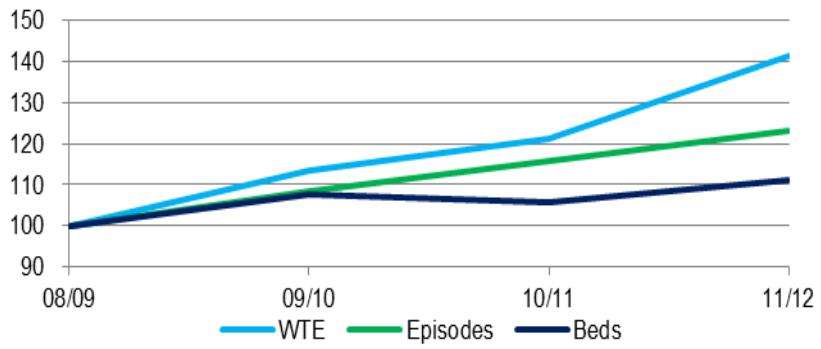


Pressure on resources and cancelled operations driven by non- elective pressures in the second half of 2012/13 may have contributed to the small increase in non-compliance with all three RTT targets seen in Q4 of 2012/13. In addition, median wait times have increased by half a week since Q4 2008/09 and delayed transfers for care for acute patients have increased slightly from Q2 2010/11.

3.7 Wider impact of the efficiency programme

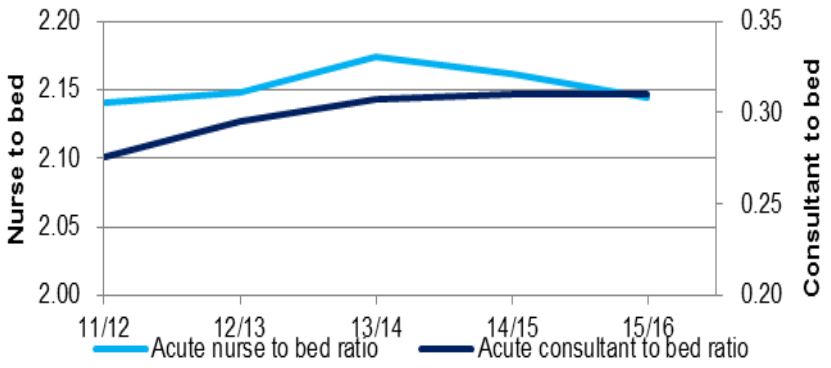
Monitor

Capacity – responding to demand but may be being constrained by CIP



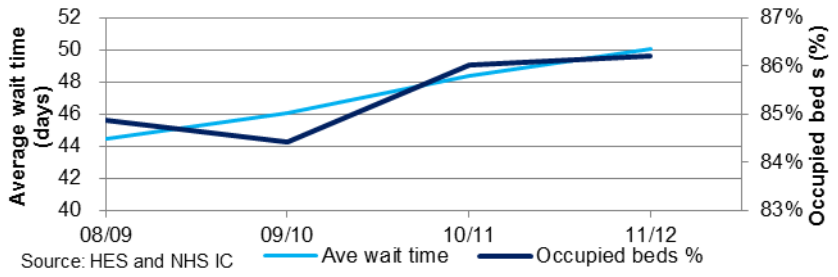
Source: FTC submissions, HES, NHS information centre

Staff to bed ratios



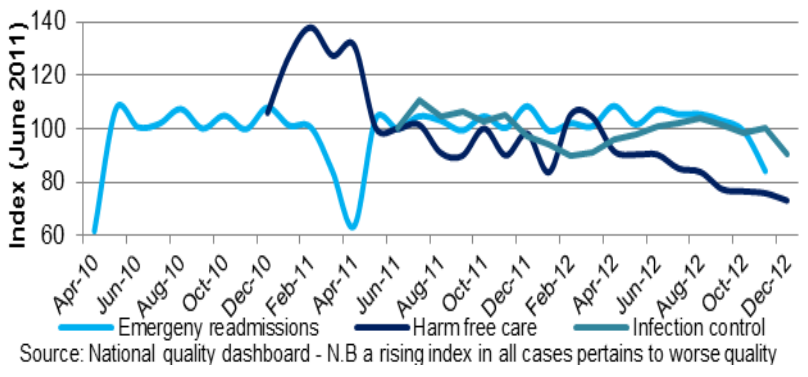
Operational performance – some evidence of reduced resilience

Operational resilience may have declined, evidenced by an increase in average wait time and a reduction in bed headroom (as occupancy increases) This is particularly prevalent in periods of increased NEL activity such as Q4 12/13.



Source: HES and NHS IC

Quality – no clear evidence of detrimental impact of CIP

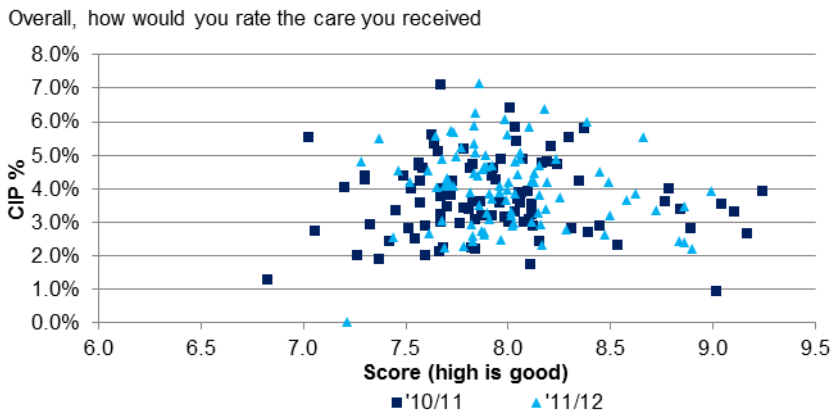


Source: National quality dashboard - N.B a rising index in all cases pertains to worse quality

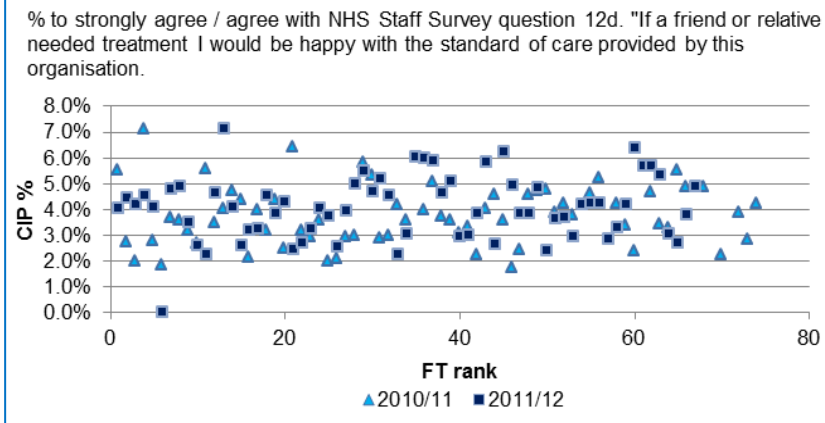
The efficiency/productivity impact of the CIP programme since 2008/09 is mixed, evidence suggests that CIPs have not caused a deterioration in quality or staff to bed ratios, but may have reduced resilience. Relative to activity, beds have reduced, but this is compensated for by WTEs.

3.8 Impact of CIPs

Impact of CIPs – in patient survey



Impact of CIPs – staff survey



We have investigated the correlation between CIPs and the impact on quality through the in patient and staff survey data. No apparent correlation between CIPs and the survey results was observed.

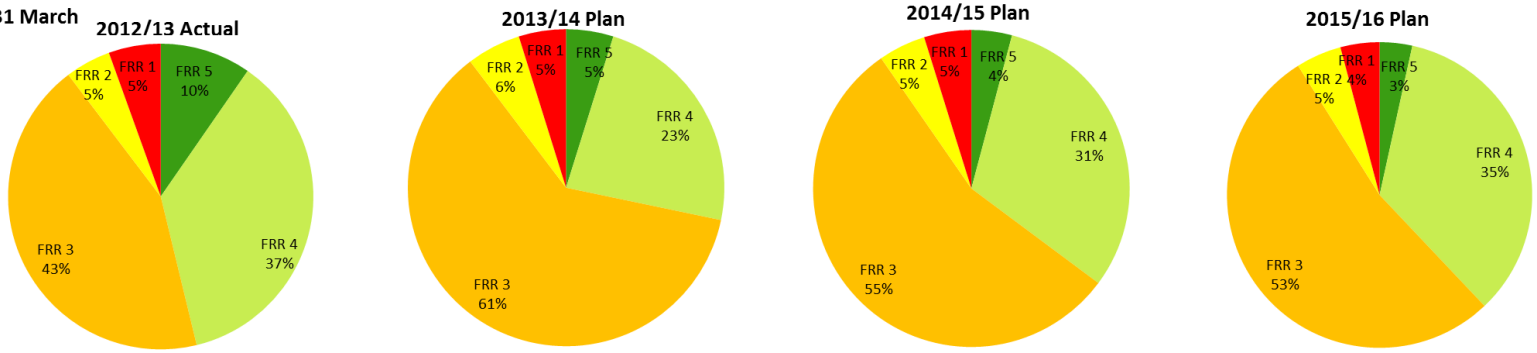
4. Regulatory compliance

4.1Financial Risk Ratings and Continuity of Service Risk Rating

Monitor

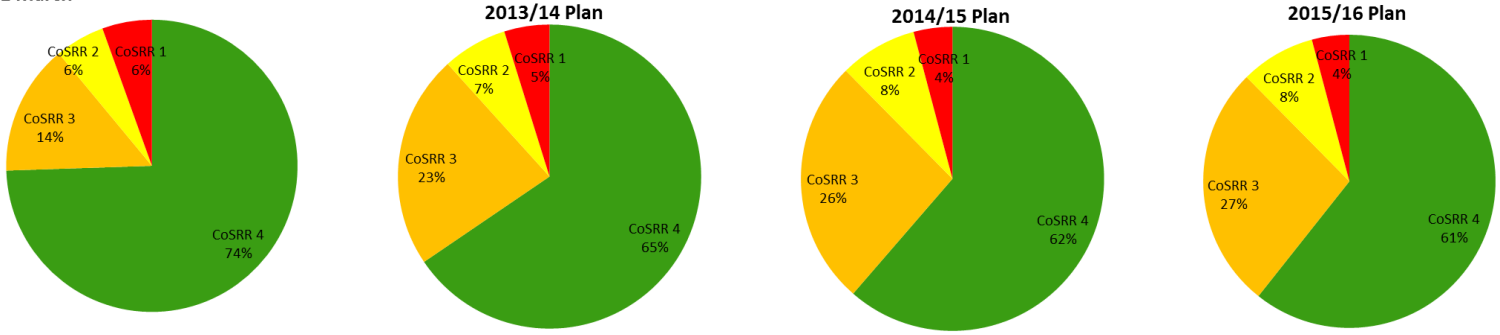
Financial Risk Ratings

As at 31 March



Continuity of Service Risk Ratings

As at 31 March

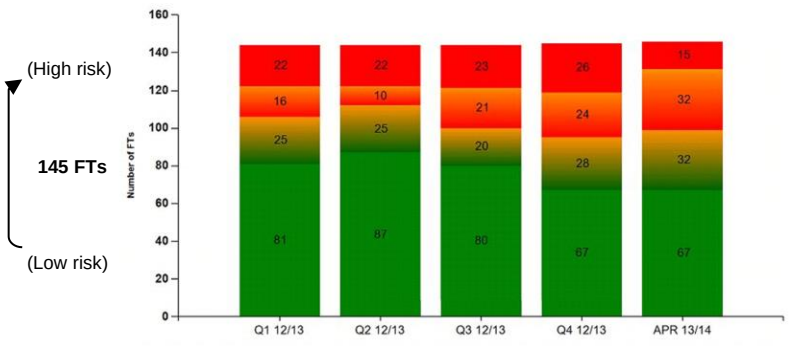


The decrease in the number of trusts forecasting an FRR 4 or 5 in Y1 (from 47% in 2012/13 to 28%) may reflect the forecast EBITDA decline and prudent planning by stronger trusts. The growth in Continuity of Service Risk Rating "3" through the plan period reflects planned falling liquidity and forecast falls in cash, as substantial capital plans are implemented.

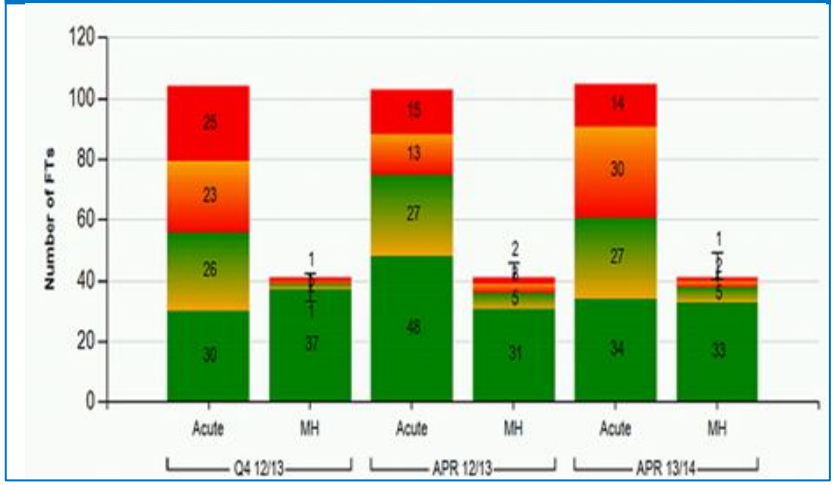
4.2 Governance Risk Ratings

Governance Risk Ratings - All FTs

A planned improvement in 2013/14 for red rated GRRs (vs. Q4 2012/13) contrasts with a worsening trend in planned amber-rated GRRs.



Governance Risk Ratings - Acute FTs



Acute FTs

- Acute FTs have the poorest GRR profile - 15 acute FTs forecast a red GRR at APR last year (with 25 actually red rated by Q4 2012/13) compared to 10 FTs at this year's APR.
- Forecast risk ratings indicate acute GRRs continue to be under pressure with 30 acute FTs planning an amber-red rating for 2013/14 compared to the 23 who returned an amber-red at Q4 2012/13.

There is a small planned improvement in GRR in 2013/14 compared to actual returns at Q4 2012/13: 50 FTs were amber-red or red rated in Q4 with 47 Trusts forecasting this position during 2013/14.

5. Glossary

5.1 Glossary (1 of 2)

A&E target	National threshold that 95% of patients should be seen in A&E within four hours	**CPT**	Contingency Planning Team
Acute trusts	**Large** (over £400m revenue), **medium** (£200m-£400m revenue), **small** (less than £200m revenue)	**CQC**	Care Quality Commission, the regulator of clinical standards in hospitals, care homes and care services
APR	Annual plan review, pertaining to the 2013/14 round submitted on 1 June 2013 unless otherwise stated	**EBITDA**	Earnings before interest, tax, depreciation and amortisation
AQP	Any qualified provider	**EBITDA margin**	EBITDA as a percentage of income
C Difficile/ C.diff target	National objective to reduce cases of infection with the Clostridium Difficile superbug	**FRR**	Finance risk rating - Monitor's measure, updated quarterly, of the robustness of an FT's finances, from 1 (high risk) to 5 (low risk)
Cancer targets	National threshold that 93%of urgent and breast cancer cases should be seen within two weeks, 96% of all cancer patients wait less than 31 days from diagnosis to treatment, and 85% wait no more than 62 days for first treatment	**FT**	Foundation Trust
Capital expenditure / capex	Spending money on acquiring or improving fixed assets (assets that will be in use for more than 1 year)	**GRR**	Governance risk rating - Monitor's measure, updated quarterly, of how well-run is an FT, from red (high risk) to green (low risk)
Cash	Amount held in bank account at end of financial year or reporting period	**I&E**	Statement of income and expenditure which quantifies a trust's profit (or loss) during a given time period
CCG	Clinical Commissioning Group	**Impairment**	Where the market value of an asset falls below its book value (as recorded in the trust's accounts)
CIP	Cost improvement plan - annual programme to make cost savings through increased efficiencies	**KPI**	Key performance indicator
CoSRR	Continuity of Service risk rating	**LAT**	Local Area Team

5.2 Glossary (2 of 2)

Liquidity	Cash, cash equivalents and other assets (liquid assets) net of debt, that can be easily converted into cash	**RTT**	Referral to treatment - National threshold for patients to see a consultant within 18 weeks of being referred (for 90% of admitted patients, 95% of non-admitted patients, and 92% on incomplete pathways)
Liquidity days	Liquidity compared to operating expenses expressed as days	**SHA**	Strategic Health Authority
MRSA target	National objective to reduce cases of infection with the Methicillin-Resistant Staphylococcus Aureus superbug	**Surplus/Deficit**	Unlike NHS trusts, which are expected to break even every year, NHS foundation trusts have more freedom to run their own affairs. Monitor assesses the financial health of foundation trusts on their performance in the medium term and does not require them to break even each year. They are therefore allowed to run a short term deficit, and from a business perspective this can be an acceptable method of managing their finances
PCT	Primary Care Trust	**TSA**	Trust Special Administrator
PDC	Public Dividend Capital	**WTE**	Whole time equivalent
Plan	Annual financial budget and projections, and, operational strategy		