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Independent Regulator
of NHS Foundation Trusts

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To: Foundation Trust Applicants
Foundation Trust Unit
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Foundation Trusts

Dear Colleague,

Re: Update to Monitor's financial assumptions

Following the Comprehensive Spending Review, the publication of the Operating Framework for the NHS in England 2011/12, and the latest inflation forecasts from the Office of Budget Responsibility (OBR), we are updating the financial assumptions that we use to assess applicant trusts, and for risk rating investments and transactions undertaken by foundation trusts.

The financial assumptions set out in this letter are exclusively for Monitor's regulatory purposes. They are not intended to provide any basis for commercial decisions made between providers and commissioners within the NHS, including contract negotiations. However, existing NHS foundation trusts may find it useful to consider these assumptions as part of their own annual planning rounds. Careful consideration should be given to individual local health economy circumstances which could mean that either a more optimistic or pessimistic approach should be taken.

As a regulator we use two scenarios as the starting point to assess trusts. These scenarios are the "assessor" case and a more pessimistic "downside" case.

We have decided to adjust both of these cases in light of the new information contained within the CSR, Operating Framework and OBR inflation forecasts. We recognise the scale of the productivity challenge that the revised financial assumptions imply; however it is important that the assumptions reflect the economic outlook and current policy framework. The changes are consistent with maintaining the current "bar" for achieving foundation trust status.

These updated assumptions will come into effect for all foundation trust authorisations and transaction risk rating decisions from 1 May 2011 onwards. Monitor will give additional time to applicants currently with us for assessment should they request it in order to provide the evidence required to meet the revised assessor and downside cases.

Details of the context, methodology and level of the new assumptions are set out below.

Context

Monitor's financial assumptions are used to assess applicant trusts and for risk rating certain investments and transactions undertaken by existing NHS foundation trusts. These assumptions are calculated using an evidence based methodology (described further below) and provide an estimate of the efficiency requirement for trusts over the next five years. As new evidence comes to light and policy develops, it is important for this to be reflected in the assessment assumptions to ensure good decision making both by trusts and by Monitor's Board.

Monitor's Board has therefore decided that the assessment assumptions should be updated to reflect the following high level developments:

- A health settlement that, while generous when compared to other departments, represents a substantial challenge to the NHS given expected demand growth;

- Confirmation of the QIPP challenge to deliver £20bn efficiency savings by 2014/15;
- Significant inflationary pressures as noted in the projections released by the Office for Budget Responsibility in its economic outlook published ahead of the 2011 Budget; and
- The impact of specific tariff rules set out in the Operating Framework and the Payment by Results Guidance for 2011/12 that are expected to have a material effect on trust income.

Methodology

While our assessment assumptions need to be updated to take account of these factors, the approach we are taking has not changed.

As set out above, Monitor uses two scenarios as the starting point for its financial assessments: the assessor and the downside case. The assessor case reflects the expected pressures and risks to providers' costs and incomes and is in line with estimates published by the Department of Health. The downside builds on the assessor case, but reflects a more pessimistic view of the expected pressures and risks.

There are separate sets of assessor and downside assumptions for acute and non-acute providers (i.e. ambulance trusts, mental health trusts, care trusts, and community trusts). To reflect the significant differences in pressures and risks of these two different groups of providers, the overall efficiency requirement for each set of assumptions is built up from two components:

- Sector-wide cost and income pressures that are common to all providers; and
- Specific income pressures - such as those that arise from the application of tariff rules - that are associated with particular contracting mechanisms.

Revised sector-wide cost and income pressures

The revised assumptions reflect a number of updates on both cost and income pressures and risks that will affect all healthcare providers. Cost pressures are composed of pay costs and non-pay costs whereas income pressures arise from reductions to income uplifts.

Our assumptions about cost pressures are based on careful consideration of the likely pay and non-pay pressures in the NHS, including the latest inflation forecasts published by the OBR, historic trends in NHS pay and prices, and stated government policy on public sector pay. Our assumptions about income uplifts are consistent with guidance in the Operating Framework regarding the level of tariff uplift in 2011/12 and beyond.

Based on these updates the sector-wide efficiency requirement facing providers is similar to those underlying our current assumptions, with the exception of 2011/12 when inflationary pressures are expected to be at their highest.

Table 1: Sector-wide efficiency requirements

		2011/12	2012/13	2013/14	2014/15	2015/16
Assessor	*Current efficiency requirement*	*4.0%*	*4.0%*	*4.0%*	*4.0%*	*N/A*
	Revised efficiency requirement	4.0%	4.0%	4.0%	4.0%	4.0%
Downside	*Current efficiency requirement*	*4.5%*	*4.5%*	*4.5%*	*4.5%*	*N/A*
	Revised efficiency requirement	5.3%	4.4%	4.5%	4.6%	4.7%

We anticipate that these levels of recurrent efficiencies will be required from all providers. However, they do not constitute the overall efficiency challenge since we also take into account additional income risks associated specifically with the acute and non-acute sectors.

Additional efficiencies – Acute sector

As well as inflationary pressures and reduction in tariff uplift, to derive the acute assumptions we have taken into account our expectations of the impact of tariff income levers as described in the Operating Framework and Payment by Results Guidance for 2011/12:

- The introduction of tariff rules relating to the non-reimbursement of emergency readmissions within 30 days of discharge.
- The continuation of the 30% 'marginal tariff' for non-elective procedures.
- The introduction of a new tariff flexibility that allows providers and commissioners to agree, in exceptional circumstances, variations from tariff prices below the national published price.

The impact of each lever is based on evidence for the acute sector as a whole and varies in the assessor and downside cases.

Assessor Case

- Readmissions: New readmissions penalties will apply to trusts and these are reflected in the assessor case. The assumption is that providers and commissioners respond to incentives and are able to reduce the current number of emergency readmissions by 60% over the forecast period.
- Non-elective marginal tariff: The marginal tariff will apply to trusts and this is now reflected in the assessor case. The assumption is that providers and commissioners respond to incentives and are able to stabilise non-elective admissions by 2012/13 (i.e. no growth in non-elective admissions from this date).
- Variations from tariff: In the assessor case it is assumed that there is no, or very limited, use of this new flexibility.

Downside Case

- Readmissions: The downside assumption is that providers and commissioners are unable to reduce the current growth in the number of emergency readmissions so that these grow by 4% per year. This is broadly consistent with the average growth in emergency readmissions in the last three years of data on readmissions.
- Non-elective marginal tariff: The downside assumption is that providers and commissioners are unable to reduce the growth in non-elective admissions so that they continue to grow by 2% per year.
- Variations from tariff: The downside assumption is that this flexibility is used for a limited amount of tariff activity in each year in the period.

The impacts of readmissions penalties and the marginal tariff are presented below as non-recurrent efficiencies. Recurrent efficiencies are required year-on-year and so effectively build over time, while non-recurrent efficiencies are only required on a one-off basis and therefore do not.

Table 2: Additional acute efficiency requirements

	2011/12	2012/13	2013/14	2014/15	2015/16
Assessor case					
Readmissions penalties: non-recurrent	0.4%	0.4%	0.3%	0.3%	0.3%
Non-elective cap: non-recurrent	0.3%	0.3%	0.3%	0.3%	0.3%
Variation from tariff : recurrent	0%	0%	0%	0%	0%
Downside case					
Readmissions penalties: non-recurrent	0.6%	0.8%	1.0%	1.1%	1.3%
Non-elective cap: non-recurrent	0.3%	0.5%	0.6%	0.7%	0.8%
Variation from tariff : recurrent	0.3%	0.3%	0.3%	0.3%	0.3%

It is important to note that individual trusts may well be able to provide evidence to mitigate these national figures, for example where providers can show that emergency readmissions and/or non-elective activity growth is lower than the national average, or in the event that providers can demonstrate that there is an integrated and planned approach across a local health economy to address the risks of patient readmissions.

Revised acute assumptions

The overall efficiency requirements in the acute sector are derived by combining the sector-wide efficiency requirements shown in Table 1 and the additional acute efficiency requirements shown in Table 2.

Table 3: Acute Assessor and Downside cases

	2011/12	2012/13	2013/14	2014/15	2015/16
Assessor case					
Sector-wide efficiency requirements	4.0%	4.0%	4.0%	4.0%	4.0%
Additional recurrent efficiency	0%	0%	0%	0%	0%
Total recurrent efficiency	**4.0%**	**4.0%**	**4.0%**	**4.0%**	**4.0%**
Additional non-recurrent efficiency	0.7%	0.7%	0.6%	0.6%	0.6%
Implied in-year efficiency requirement	**4.7%**	**4.7%**	**4.6%**	**4.6%**	**4.6%**
Downside case					
Sector-wide efficiency requirements	5.3%	4.4%	4.5%	4.6%	4.7%
Additional recurrent efficiency	0.3%	0.3%	0.3%	0.3%	0.3%
Total recurrent efficiency	**5.6%**	**4.7%**	**4.8%**	**4.9%**	**5.0%**
Additional non-recurrent efficiency	0.9%	1.3%	1.6%	1.8%	2.1%
Implied in-year efficiency requirement	**6.5%**	**6.0%**	**6.4%**	**6.7%**	**7.1%**

Additional efficiencies – Non-acute sectors

The assumptions have also been revised for the non-acute sectors (i.e. ambulance trusts, mental health trusts, care trusts, and community trusts). As for the acute sector, the revisions reflect the sector-wide updates on both cost and income pressures and risks described in Table 1 above.

The main differences between the acute and the non-acute sectors relate to income pressures and risks, essentially reflecting the difference between tariff and locally agreed contracting arrangements. There is less evidence available on the expected efficiency requirements for the non-acute sectors. Therefore, in line with the intention stated in Department of Health publications (including the Mental Health Strategy) and consistent with guidance in the Operating Framework, the income assumptions for the assessor in the non-acute sectors are based on the acute sector.

The downside case however reflects that historically during periods of financial pressure in the healthcare system, expenditure on activity not covered by tariff such as mental health has fallen more rapidly than expenditure on activity covered by tariff. We reflect this risk in the downside by including an additional 0.7% recurrent efficiency requirement in the non-acute downside case.

Revised non-acute assumptions

Based on these factors, the assumptions have been updated for the non-acute sectors as follows:

Table 4: Non-acute Assessor and Downside cases

	2011/12	2012/13	2013/14	2014/15	2015/16
Assessor case					
Sector-wide efficiency requirements	4.0%	4.0%	4.0%	4.0%	4.0%
Additional recurrent efficiency	0%	0%	0%	0%	0%
Total recurrent efficiency	**4.0%**	**4.0%**	**4.0%**	**4.0%**	**4.0%**
Additional non-recurrent efficiency	0.7%	0.7%	0.6%	0.6%	0.6%
Implied in-year efficiency requirement	**4.7%**	**4.7%**	**4.6%**	**4.6%**	**4.6%**
Downside case					
Sector-wide efficiency requirements	5.3%	4.4%	4.5%	4.6%	4.7%
Additional recurrent efficiency	0.7%	0.7%	0.7%	0.7%	0.7%
Total recurrent efficiency	**6.0%**	**5.1%**	**5.2%**	**5.3%**	**5.4%**
Additional non-recurrent efficiency	0%	0%	0%	0%	0%
Implied in-year efficiency requirement	**6.0%**	**5.1%**	**5.2%**	**5.3%**	**5.4%**

Implications

These assumptions reflect Monitor's current view about the likely impact of the sector-wide changes and the specific risks facing acute and non-acute providers.

Whilst the assumptions are first applied generically to all applicants, it is recognised that individual providers will face their own specific circumstances and will to some extent be able to mitigate the risks (and therefore part of the required efficiency requirements). To the extent that this is possible, and backed up by careful and evidence based planning, these mitigation steps will be considered and the assumptions for individual trusts adjusted as appropriate.

It remains important for trusts to plan effectively and to challenge financial plans and forecasts in light of these updated assumptions. Applicants should continue to develop mitigation plans to address Monitor's downside scenario including developing plans to respond to the impact of the non-elective cap and readmission penalties. In developing such plans applicants will need to pay careful attention to ensure that they can be delivered whilst maintaining quality.

Applicant trusts should contact Richard Guest (Richard.Guest@monitor-nhsft.gov.uk) or Miranda Carter (Miranda.Carter@monitor-nhsft.gov.uk) for further information.

Yours sincerely

Stephen Hay
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CC: SHA Provider development leads