

# **BURTON HOSPITALS NHS TRUST**

Foundation Trust Application

Integrated Business Plan  
April 2008

Submission to Department of Health

## **6.0 Financial Plan**

The financial plan summarises the Trust's historic financial performance as well as outlining the financial strategy and medium term financial plans required to be able to deliver the Trust's service strategy for the next 5 years.

Throughout its history the Trust has demonstrated a good track record in being able to deliver against its financial duties, with the last two years providing a year end surplus of £100,000 and £938,000 respectively. The Trust is in a strong position moving forward into Foundation Trust status and can demonstrate a robust income and expenditure position for the next 5 years

Overall the Trusts' key financial objective remains that of maintaining the Trust's financial viability and improving its financial performance in order to continue to provide the services set out in the Service Delivery Strategy and meet the future ambitions of the Trust.

### **6.1 Historical Performance Analysis**

During 2004-5 the Trust incurred a financial deficit due to the financial consequences of the consultant contract and agenda for change. Although the impact was identified during the year and mitigating action taken this proved insufficient to offset the final cost. Since that year further mitigating action has been taken in the form of service rationalisation and cost improvements in order to deliver a sustainable financial position for the Trust.

The overall deficit in 2004-05 was offset by a RAB adjustment in 2005-06 against which the SHA provided planned support of £2.4m. The withdrawal of the RAB system and the unwinding of the RAB adjustments subsequently corrected the cumulative position by £2.6m.

During the early part of 2006-07 the Treatment Centre on the Trust site opened. The loss of income from the transfer of activity to the Treatment Centre was partially offset by the transfer of staffing and the provision of other services to the Treatment Centre on subcontracts. The retained costs were offset by a one off contribution of £2.3m from the Department of Health in order to assist the Trust into the first year of operation. During that time the Trust rationalised its cost base to ensure that the costs were avoided and/or absorbed.

The outturn of £0.9m in 2006-07 was achieved whilst having also taken the opportunity to pre-pay the repayment of £0.6m of the planned support.

The forecast outturn of break-even in 2007-08 includes a planned £0.4m repayment of planned support plus the opportunity to prepay a further £0.25m. The repayment of the balance of planned support of £1.15m is to be repaid over the next two years as agreed with the local PCT.

The Trust has achieved its statutory break-even duty and remained within its external financing limit, remained within its capital resource limit and achieved the return on its capital employed in all years.

The table below shows the Trust's performance against its break-even duty for the past three years and the forecast outturn for 2007-08.

**Table 6.1: Breakeven Duty Performance 2004/05 – 2007/08**

	2004/05 £000's	2005/06 £000's	2006/07 £000's	2007/08 £000's
Income				
Clinical income	82,200	89,977	91,710	96,485
Other income	16,327	19,537	22,994	27,784
Total income	98,527	109,514	114,704	124,269
Expenditure				
Pay costs	68,916	71,786	75,520	78,476
Non-pay costs	24,429	28,840	29,420	29,925
Total expenditure	93,345	100,626	104,940	108,401
<b>EBITDA</b>	<b>5,182</b>	<b>8,888</b>	<b>9,764</b>	<b>15,868</b>
Losses on disposal of fixed assets	(405)	(78)	(3)	0
Impairments	0	0	0	(6,117)
Depreciation	(4,459)	(5,017)	(5,311)	(5,794)
Interest receivable	190	190	290	199
PDC dividend payable	(3,015)	(3,883)	(3,802)	(4,156)
Reported position Surplus (Deficit)	(2,507)	100	938	0
Cumulative position Surplus (Deficit)	(2,431)	278	1,216	1,216

EBITDA – Earnings Before Interest Taxes Depreciation and Amortisation

### 6.1.1 Normalised earnings

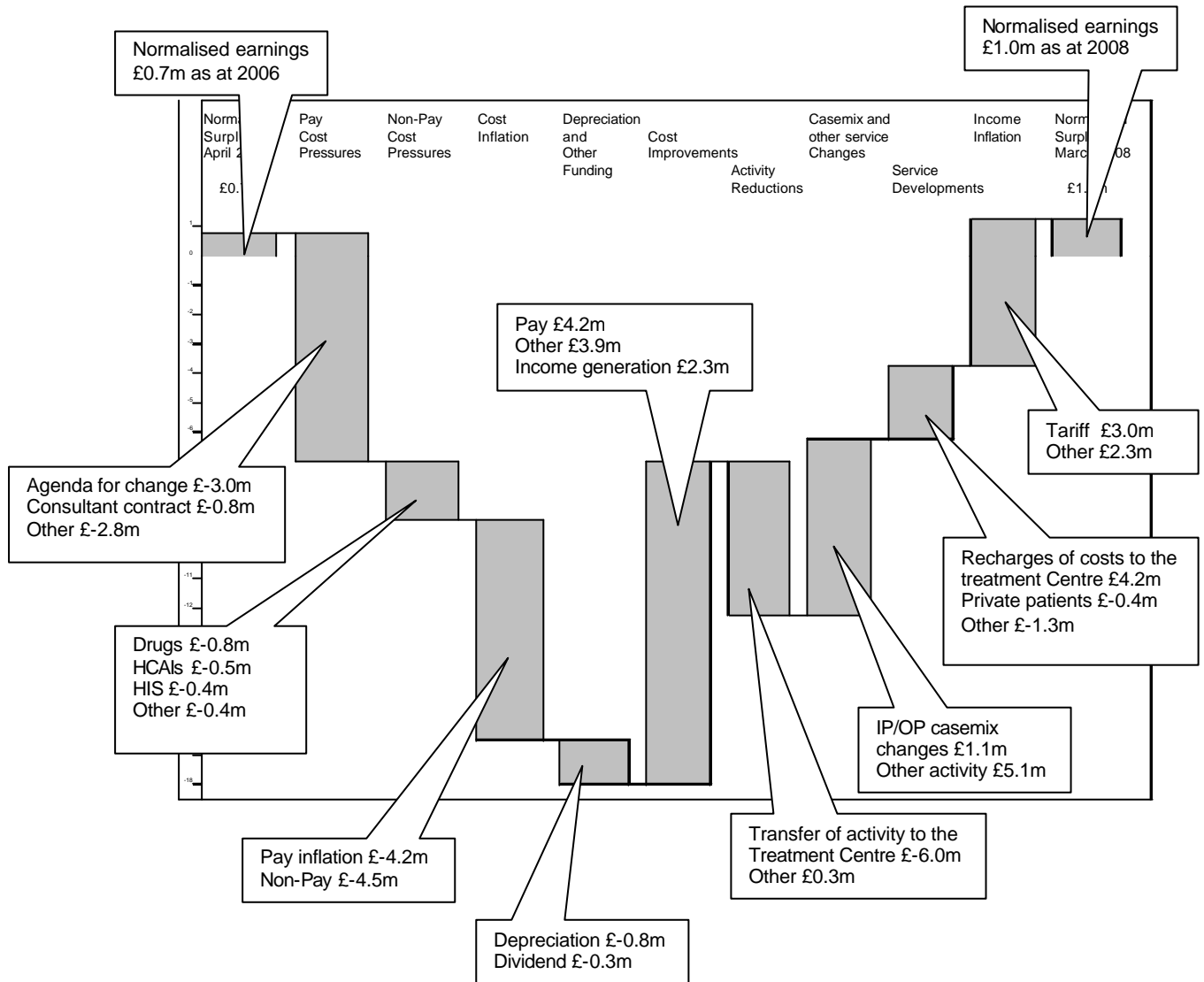
The normalised earnings position for the Trust excludes one-off income and expenditure and therefore reflects the Trust's underlying financial position. Table 6.2 demonstrates therefore, that despite the deficit in 2004-05, the Trust has maintained healthy and consistent surpluses over the subsequent period.

**Table 6.2: Normalised Surplus/Deficit**

	2004/05 £000's	2005/06 £000's	2006/07 £000's	2007/08 £000's
Reported position Surplus (Deficit)	(2,507)	100	938	0
RAB adjustment		2,427	(20)	
Planned support		(2,400)	600	650
TC transitional funding			(2,361)	
Rationalisation costs			243	
Impairment charge				6117
NHS Bank funding				(6,117)
Loss on disposal of assets	405	78	3	
PBR transitional charge		319	675	338
Discount rate on provisions		142		
Normalised Surplus (Deficit)	(2,102)	666	78	988

The bridge analysis between 2005-06 to 2007-08 indicates that the cost pressures, cost inflation and loss of income from the transfer of activity to the Treatment Centre is more than offset by increases in tariff and cost improvements.

**Figure 6.1: Historic Bridge Analysis 2006 - 2008**



### 6.1.2 Reference Cost Index

The Trust's reference cost index (as an indication of cost effectiveness) was 98 in 2006/07. For the last few years the Trust has used the reference cost index at individual service line in order to identify those specialties that exceed 100. This has enabled detailed examination to be undertaken so that cost reductions can be made. The planned intention and ambition of the Trust is for all specialty level reference cost indexes to be 100 or less.

**Table 6.3: RCI**

	2004/05 £000's	2005/06 £000's	2006/07 £000's
Reference Cost Index	104	99	98

### 6.1.3 Cost Improvements

The Trust has a sound track record of meeting its financial obligations by achieving both cost improvements and attracting additional activity at marginal cost.

The financial gap in 2007-08 of £6.1m arose from the efficiency requirement in the national tariff of £2.9m, retained costs following the transfer of activity to the newly opened treatment centre £1.8m, running cost of the picture archiving and communications system (PACS) of £0.6m, increased cost of the orthopaedics business case development £0.3m, repayment of planned support £0.4m and holding a contingency against unforeseen cost pressures £0.1m.

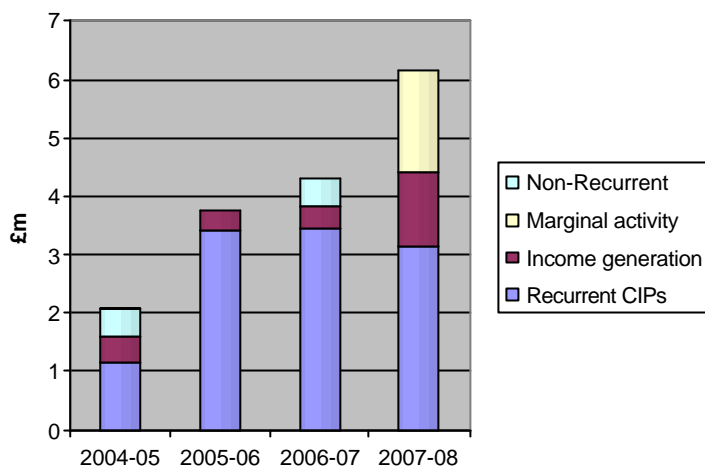
Part of the gap was met by additional activity at marginal cost of £1.7m and other income generation measures. There was therefore a resulting requirement for a cost improvement programme of £3.1m.

In November 2007 the Trust commissioned Grant Thornton to undertake an independent review of its arrangements to manage and deliver planned cost improvements. They examined CIP reports and the budget reconciliations to verify the basis of savings identified and to confirm that material savings had been taken from operational budgets for the year in question. In relation to the historic performance, although the Trust had not always achieved the total planned cost improvements, it had achieved a very high percentage between £3m and £4m in the years 2004-05 to 2006-07 which shows that it can deliver savings. They identified (at the time the report was being prepared) that the potential risk to delivering the 2007-08 planned cost improvements was about 3%. Their conclusion was that the Trust had made considerable progress in developing more robust plans and that this is reflected in reductions in their estimated potential risks. They reported that they had greater confidence in the Trust's CIP arrangements and could foresee no reason why the delivery of CIPs should delay the Trust's FT application.

**Table 6.4: Cost Improvement Delivery**

	2004/05 £000's	2005/06 £000's	2006/07 £000's	2007/08 £000's
Cost Improvements achieved				
Recurrent	1,135	3,421	3,451	3,175
Non-recurrent	485	0	489	0
Income Generation	461	345	388	2,975
Total CIPs	2,081	3,766	4,328	6,150
Percentage of turnover	2.2%	3.7%	4.1%	5.7%

**Figure 6.2: Cost Improvements**



The detailed schemes for each year are listed in the table below showing the expenditure heading where cost improvement has been achieved.

**Table 6.5: Breakdown of CIP**

	2004/05 £000's	2005/06 £000's	2006/07 £000's	2007/08 £000's
Reduction in funded establishment	1,004	1,593	1,330	1,174
Reduction in bank, agency, overtime		922	650	
Prescribing, etc	10		45	75
Procurement		344	423	385
CNST premiums				96
PACS				300
Other non-Pay	230	562	872	925
Capital investment	376		131	220
Rate rebate (NR)			489	
Income generation	461	345	388	2,975
	2,081	3,766	4,328	6,150

NR – non-recurrent one off gain

#### 6.1.4 Balance Sheet

The forecast outturn Balance Sheet for 2007-08 and the actual Balance Sheets for the previous three years is summarised in Table 6.7 below:

**Table 6.6: Balance Sheet 2004/05 – 2007/08**

	2004/05 £000's	2005/06 £000's	2006/07 £000's	2007/08 £000's
Fixed Assets (net book value)	106,048	108,614	118,128	121,264
Current Assets				
Stock	1,843	1,964	2,128	2,128
Trade Debtors	3,290	4,931	8,437	6,785
Impairment Debtor				6,117
Cash	2	2	329	1,500
	5,135	6,897	10,894	16,530
Current Liabilities				
Trade Creditors	(6,128)	(5,430)	(5,835)	(4,151)
Capital Creditors	(962)	(838)	(498)	(1,800)
	(7,090)	(6,268)	(6,333)	(5,951)
Long Term Liabilities	(1,614)	(1,209)	(1,315)	(1,275)
	102,479	108,034	121,374	130,568
Funding				
Public Dividend Capital	50,011	53,630	58,484	59,327
I&E reserve	3,845	5,199	6,137	6,137
Revaluation reserve	45,490	46,246	53,824	62,283
Donated asset reserve	3,122	2,949	2,918	2,810
Other Reserves	11	10	11	11
	102,479	108,034	121,374	130,568

Capital investment over the past three years has amounted to £19.2m of which £9.3m has been funded from public dividend capital. The most significant items are £2.9m on ISTC enabling works, £0.7m on decontamination, £1.6m on the pharmacy manufacturing unit, £2.3m on the picture archiving and communications system (PACS), £4.2m on scanners and other equipment. The remainder is on maintenance of the Trust's infrastructure.

Assets have been increased in value in accordance with Department of Health guidelines. Indexation is applied annually and the last quinquennial revaluation (by the District Valuer) was in 2005. Assets which have no further potential use have been written down (impaired). In 2007-08 the following asset values were written down –

**Table 6.7: Assets Written Down 2007/08**

	2007/08 Asset Value £000's	2007/08 Impairment £000's
Clock Tower wing***	3,005	1,932
Child Assessment Unit	485	485
HSSU	1,121	1,121
Outwoods boiler house	850	850
Outwoods House	1,205	1,205
Outwoods workshops	456	456
Houses	68	68
		6,117

\*\*\* note that only 2/3rds of the Clock Tower Wing has been taken out of use in 2007-08

Cash balances have been held within the 0.3% maximum limit required by the Department of Health until 2007-08 when this restriction has been removed.

A significant amount of cash has been tied up in the balance sheet as increased debtors for over-performance and reduced creditors as payments are made towards the year-end to reduce the amount of cash held by the Trust. This has been released as local commissioners have now paid for the accrued over-performance.

## **6.2 Income and Expenditure Five Year Projections**

The Trust has submitted its long term financial model (LTFM) constructed from a baseline that incorporates Commissioner agreed activity trends adjusted for demographic factors, the implications of waiting times, the effect of the transfer of activity to the treatment centre and fully funded service developments from the local PCT's service strategy, the impact of competition, planned changes to the service portfolio included in the Trust's service strategy, the effect of the marketing strategy.

The future financial plan (beyond 2007/08) is based on a number of key assumptions:

- (a) **Achieving financial balance or better:**  
The plan is to make a sufficient recurrent surplus in each year to provide financial headroom against unforeseen cost pressures (or income reductions) and provide reserves for the improvement and development of services. This will be used to repay the balance of the planned support in the early years.
- (b) **Income from activity and the cost of delivering it :**  
Income and costs are based on an assessment of activity to be contracted and the staffing and other resources needed to deliver it.
- (c) **Cost efficiencies to be achieved recurrently:**  
Cost efficiencies are essential to both preserve competitiveness and productivity as well as to achieve a surplus.
- (d) **Capital investment to remain affordable:**  
The baseline capital programme has been set at the level of the annual depreciation to ensure that the estate is maintained at its current levels. The estate strategy creates savings through the removal of the older/surplus buildings and disposal of part of the Outwoods site. This provides funds for some of the cost of the re-provision onto the main site of modern/effective services, the balance coming from internally generated cash surpluses.
- (e) **Financial support to be repaid:**  
The repayment of the balance of the planned support is assumed to be phased within the next two years as agreed with the local PCT.
- (f) **Balance Sheet to be improved:**  
A more rigorous approach to treasury management will reduce the level of unpaid debtors and make payments of creditors based on when they are due for payment and not based on when they are received. The Trust will work with local commissioners to ensure that activity undertaken is paid for as soon as possible.
- (g) **Cash balances to be increased:**  
On the basis of the above, the Trust is able to maintain a healthy cash balance over the period of the LTFM and provide sufficient funds for re-investment.
- (h) **Key Capacity Assumptions:**  
The key capacity assumptions that are detailed in section 5 and built into the 5 year income and expenditure projections are as follows:-

- (i) A small reduction in the bed base brought about through increased efficiency, in order to facilitate an increase in the provision of single rooms;
- (j) Service improvements through;
  - i. Improving Length of stay
  - ii. Improved Theatre Utilisation
  - iii. Redesign of pathways through improved discharge processes

## 6.2.1 Revenue

**Table 6.8: Projected Revenue**

	2008/09 £000's	2009/10 £000's	2010/11 £000's	2011/12 £000's	2012/13 £000's
Income					
Clinical income	99,306	101,920	103,393	104,818	106,613
Other income	22,175	22,960	23,615	24,208	24,816
	121,481	124,880	127,008	129,026	131,428
Expenditure					
Pay	(80,063)	(80,876)	(81,582)	(82,617)	(83,356)
Non-Pay	(30,248)	(31,177)	(31,542)	(32,430)	(33,845)
	(110,311)	(112,053)	(113,124)	(115,047)	(117,201)
EBITDA	11,170	12,827	13,884	13,979	14,227
Loss on asset disposals					
Depreciation	(6,378)	(6,321)	(6,461)	(6,863)	(7,152)
Impairment		(9,708)			
Interest received	265	377	335	392	555
Dividend	(4,306)	(4,329)	(4,508)	(4,682)	(4,865)
Revenue Surplus (Deficit)	750	(7,154)	3,250	2,826	2,765

EBITDA – Earnings Before Interest Taxes Depreciation and Amortisation

## 6.2.2 Normalised Earnings

The normalised earnings position is the above revenue surplus/deficit with certain non-recurrent items taken out.

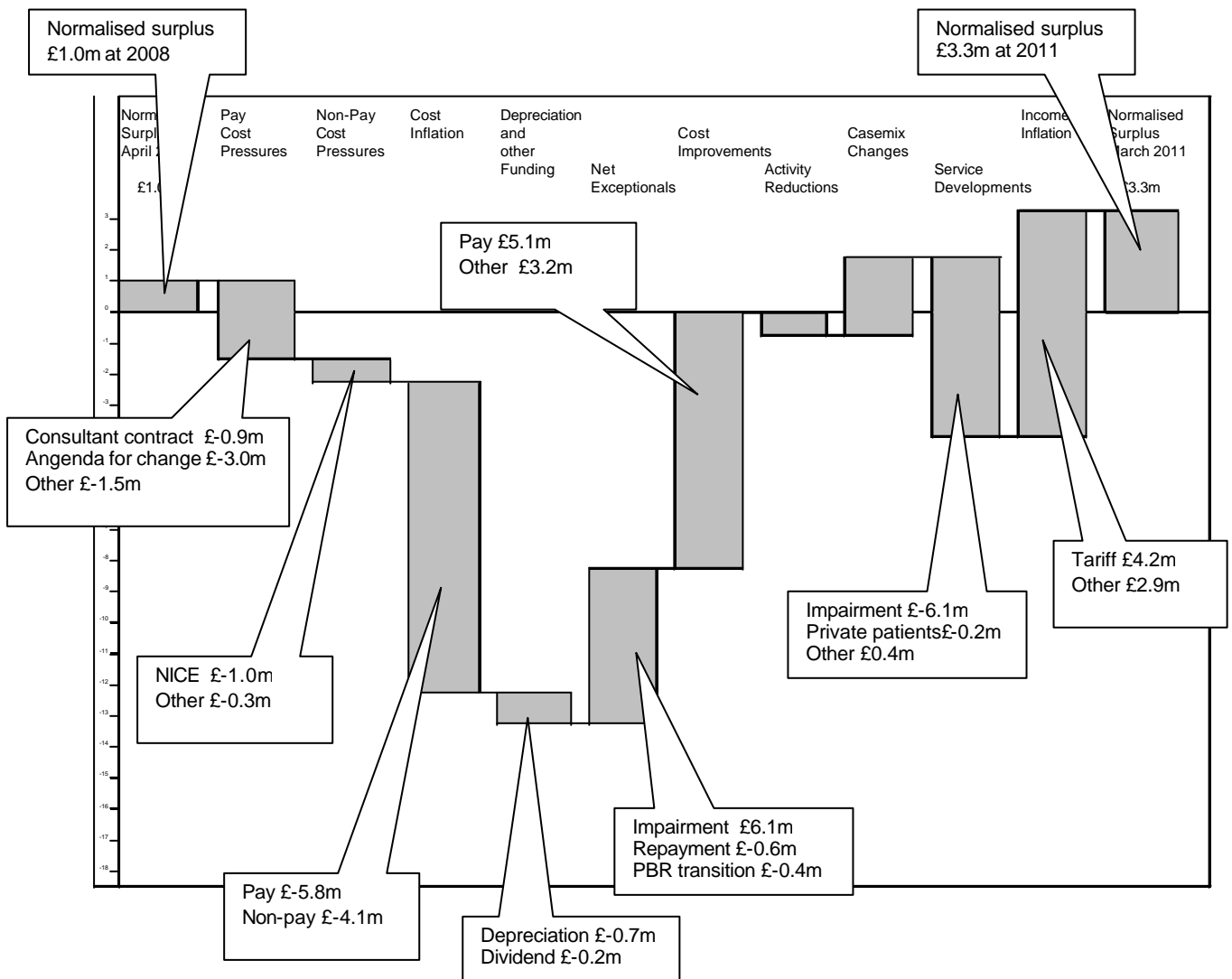
- Repayment of historic planned support to the local PCT
- Impairments of fixed assets
- PBR transition

Based on these adjustments the normalised surplus as shown in Table 6.10 below:

**Table 6.9: Normalised Surplus**

	2008/09 £000's	2009/10 £000's	2010/11 £000's	2011/12 £000's	2012/13 £000's
Revenue					
Surplus (Deficit)	750	(7,154)	3,250	2,826	2,765
Less NR items					
Loss on asset disposal					
Impairment funding (100%)					
Planned support repayment	450	700			
PBR transitional charge					
Fixed asset impairment		9,708			
Normalised Surplus (Deficit)	1,200	3,254	3,250	2,826	2,765

**Figure 6.3: Three Year Bridge Analysis 2008 - 2011**



### 6.2.3 Cost Improvement Plan

A process of business improvement that commenced during 2005 has been strengthened across the Trust in order to fulfil the recording and performance management of CIP delivery going forward and to support the organisation to continue to transform its culture into one which is more commercially minded.

Cost improvement targets have been set for each directorate for the next 5 years. The approach to delivering CIP is maturing from the list of numerous schemes identified to deliver savings to a more strategic approach which supports the delivery of Trusts strategic direction, and continuous drive to improve services.

Benchmark data is routinely used by clinical and non-clinical teams to improve productivity and efficiency with a view to delivering at median and top quartile performance levels.

The CIP plan for the next 5 years has used benchmark data from a number of sources (see BIP strategy, Annex 5) to identify areas where performance can be improved and savings generated. These can be summarised as:-

- Improved procurement for non pay services and items
- Reduce Length of Stay and improvements to patient pathways
- Estates Rationalisation following reconfiguration of services
- Review and rationalisation of clinical support services

To improve performance many of services and departments will need to change methods of service delivery and clinical pathways; achieving this kind of change is challenging and the Trust has established a Programme Board, chaired by the Chief Executive, to oversee the clinical re-design of services. The Programme Board has a number of separate projects as detailed in Section 5.

Each of the projects has a detailed project plan including a timetable for changes to clinical services. There is a high level of clinical engagement in all projects. The impact of these changes will be to increase efficiency and productivity within the Trust e.g. by reduced length of stay, increased throughput in theatre sessions, etc

Each project has identified lead Director Sponsorship with project managers being assigned where appropriate. The project plan clearly details scope, timescales for delivery, risks and issues and an estimate of the potential benefits that will be achieved; cost efficiencies/savings, operational benefits or qualitative benefits over a profiled period.

Rigorous performance management arrangements have been agreed with monthly reports being presented:

- By the Directorates at the Trust performance meeting, highlighting progress to date and identifying remedial action plans where necessary;
- At the Executive Management Team (EMT) to ensure new schemes are highlighted and any dependencies or risks are considered across the organisation;
- To the Finance and Contracting Committee, where both Executive and Non Executive Directors review performance.

The CIP plan focuses on 3 key areas where actual costs can be released:

## Workforce and Reduced Pay Costs

As approximately 70% of the Trust's expenditure relates to pay costs control of workforce numbers is key to delivering the annual efficiency savings. In order to facilitate improvement the Trust has undertaken a detailed workforce review for each service, looking at:-

- Activity profile and case mix changes
- Known changes in clinical care or service redesign (see above)
- Opportunity for skill mix review
- Reference cost information

Using this information and workforce information including the age profile of the workforce, each service has produced a workforce plan identifying changes over the next 5 years. Plans are being rigorously reviewed and will be performance managed to ensure the required level of saving will be released. Planning ahead in this way allows the necessary HR processes to be put in place so that it is very unlikely that any redundancy costs will be incurred.

This review demonstrates how the savings identified from service re-design and reconfiguration identified within the programme boards will be delivered. For example it demonstrates the impact of increased efficiency by reducing outliers, reduced length of stay which enable beds to be closed and staff reductions to take place

The savings on the pay bill will also be delivered as a result of effective job planning, ensuring the efficient use of medical resource across the organisation. This has resulted in an immediate reduction in the overall number of programmed activities initially by limiting the Supporting Professional Activities (SPAs). Over a two year period it is anticipated the majority of consultants will be asked to deliver a maximum eleven Programmed Activity (PA) job plan, with the ability to flex up to twelve PAs if demand in activity increases.

## Estates Rationalisation

The Estate Strategy aims to consolidate all services onto the main site and dispose of most of the Outwoods site (excluding the educational buildings and mental health services). As buildings become surplus to requirements their book value will be reduced to zero (impairments) and demolished. Once the site is vacated it can be sold off. The proceeds will be used to re-provide services on the main site.

The reduction in capital charges (dividend and depreciation) relating to the current book value of the buildings identified for demolition/disposal would be phased as follows. The phasing reflects the part year effect of the dividend being the average of the opening and closing assets values. Depreciation charges are saved the quarter following impairment.

**Table 6.10(a) : Impairments**

	2007-08 £000's	2008-09 £000's	2009-10 £000's	2010-11 £000's	2011-12 £000's	2012-13 £000's
Clock Tower Wing	33	94	19	52		
Child Assessment Unit	9	25				
Outwoods boiler house	15	56				
Outwoods workshops	8	19		5		
Houses	1	3				
CSSD	20	91				
Outwoods House	21	66				
Geoffrey Hodges Wing			123	364		
Laundry			9	20		
Robert Bewick House			18	46		
	107	354	169	487		

### Table 6.10(b) : Disposals

The savings from the disposal of surplus assets and vacated land is set out below. The savings from the land disposal reflects only the dividend as there is no depreciation on the land.

	2007-08 £000's	2008-09 £000's	2009-10 £000's	2010-11 £000's	2011-12 £000's	2012-13 £000's
Disposal of houses			10	25		
Disposal of Outwoods site					113	113
			10	25	113	113

### Maximising Non Pay Savings

The Trust will deliver 3% efficiency savings on its non pay costs each year. A procurement work-stream has been established to work with the regional procurement hub (Healthcare Purchasing Consortium) to deliver cost efficiencies through increased buying power. A programme Board chaired by the Director of Finance oversees a variety of clinical and non-clinical schemes with each Directorate having an operational procurement group as well to ensure effective implementation of schemes.

Other non pay savings have been identified including achieving higher CNST ratings, prescribing efficiencies, etc

Service Line management is being implemented across the Trust. This is being enthusiastically received by the clinical staff. It is expected that as the process is rolled out and embedded within the Trust that there will be increased standardisation of practice in most clinical processes e.g. use of diagnostic tests which will result in non pay savings.

### Summary

The CIP programme within the Trust is driven by the efficiencies arising from the redesign of clinical processes project and increased efficiencies within non pay expenditure. The development of the CI programme has involved clinicians as well as managers to ensure that it supports the Trust in achieving its strategic ambitions.

A summary of the CIP programme for the 5 year period is shown below.

**Table 6.11: Five Year CIP**

	2008-09 £000's	2009-10 £000's	2010-11 £000's	2011-12 £000's	2012-13 £000's
Establishment review	877	2,743	2,808	2,171	2,448
Junior Doctors review	250				
Job planning and awards	166				
Procurement	322	446	452	574	587
Prescribing	24	55	56	57	59
CNST and risk management	811				
CNST premiums	180	73		277	
Histopathology	62				
Endoscopy	26				
Ophthalmology	37				
Low visual aids	21				
Service Line Management	0	112	169		
IT benefit schemes	161				
Electronic Staff Records	52				
Stationery	10				
Boiler house replacement	146	167			
Estate rationalisation	363	141	507	173	227
Income Generation	437	218	110		
<b>Total</b>	<b>3,945</b>	<b>3,955</b>	<b>4,102</b>	<b>3,252</b>	<b>3321</b>

#### 6.2.4 Service Line Reporting

The Trust is keen to enhance its current system of contribution accounting with the implementation of comprehensive Service Line Reporting and Management. By increasing the Trust's understanding of cost behaviour, individual Clinicians will be able to improve the decision making process through the understanding of profitability, and provide incentives for increased efficiency and cost savings.

#### Methodology

In order to achieve maximum managerial and clinical engagement and ownership of the process, and its results, the Trust has decided to define its service lines at specialty level and to recharge support services and overhead costs based on each specialty's usage of services and facilities.

The annual budgeted cost divided by an annual activity plan will produce a standard cost for support services i.e. a cost per theatre minute, whilst annual budgeted overhead costs will be divided by a measure of the overhead used i.e. a cost per square meter occupied.

Recharging costs at a budgeted rate will avoid passing on any department's inefficiencies and will reflect a specialty's actual usage of services and overheads based on measurable and transparent currencies.

Department inefficiencies will remain within the department's budget unless it can be accredited to specialties as a result of inefficient ordering, wastage, cancellations etc.

## Timetable

The report included a timetable showing the proposed implementation of Service Line Reporting (SLR) at Burton Hospitals with each department progressing through the following three phases:

- Information Development – this involves working with department managers in verifying department's annual budget, establishing a measurable unit of currency and restating the annual plan if necessary, and calculating a standard cost.
- Shadow Reporting – this involves counting & collecting verifiable units of usage, applying standard costs, and reasonableness checking the resultant effect of the recharges on the support/overhead department and the recipient specialties.
- Board Reporting/Management – presentation of the resultant effect of recharging costs, ultimately matching the full hospital cost of activity to income received, by specialty. With guidance on interpretation, use for short and long term decision making, and department/specialty incentives for increased efficiency and cost savings.

## Challenges and Benefits

The above implementation process provides the Trust with a number of challenges including a thorough understanding of budgets, activity plans and cost drivers, problems with data collection and verification, and acceptance of the cost implications of clinical practice and support service / overhead usage.

Prior to recharging its service out to specialties each department will have to review its costs, activity, data collection, wastage and inefficiencies in order to understand and negate any resultant adverse variances.

### 6.2.5 Income

Assumptions for 2008/09 and beyond are based on 2007/08 forecast outturn and 2008/09 start budget baselines. Beyond this, prudent assumptions have been made as follows:

- Inpatients reflect the local demographic changes and stated purchaser intentions
- Outpatients reduced for phased improvement in new/follow-up ratios

**Table 6.12: Inpatient/Daycase Activity**

	2007/08 Spells	2008/09 Spells	2009/10 Spells	2010/11 Spells	2011/12 Spells	2012/13 Spells
Elective Inpatients	5,562	5,588	5,695	5,760	5,817	5,874
Elective Day Cases	10,433	10,150	10,337	10,437	10,528	10,620
Non-elective Inpatients	24,034	23,480	23,596	23,657	23,714	23,776
Total	40,029	39,218	39,628	39,854	40,059	40,270

**Table 6.13: Outpatient Activity**

	2007/08 Contacts	2008/09 Contacts	2009/10 Contacts	2010/11 Contacts	2011/12 Contacts	2012/13 Contacts
New Outpatients	48,006	51,561	52,373	52,860	53,317	53,558
Follow-up Outpatients	93,099	94,603	89,598	87,205	84,689	85,068
Total	141,105	146,164	141,971	140,065	138,006	138,626

Tariff prices have been uplifted in line with guidance received including 3% annual reduction for the efficiency gains required in all future years.

Non-tariff price increases have been weighted to reflect income from recharges that are recharged at cost. All other non-tariff prices are assumed to be the same as tariff increases.

**Table 6.14: Income Inflation**

	2008/09 %	2009/10 %	2010/11 %	2011/12 %	2012/13 %
Clinical income	2.3%	1.5%	1.5%	1.3%	1.3%
Other income	2.3%	3.2%	3.2%	3.0%	3.0%

Other income average uplift reflects the weighted average of recharges at cost (recharges to the Treatment Centre, drugs, etc) for which there is no efficiency requirement. All other income has been increased in line with NHS inflation (ie tariff) with an assumed efficiency requirement of 3% each year.

There is no detailed information about the future impact of the introduction of HRGv4.0. The potential impact is considered in the risk analysis section. Consequently, the total income planned is as follows:

**Table 6.15: Total Income**

	2008/09 £'000	2009/10 £'000	2010/11 £'000	2011/12 £'000	2012/13 £'000
Elective	17,024	17,590	18,042	18,448	18,862
Non-elective	39,385	41,047	41,511	42,084	42,784
Outpatients	17,130	17,097	17,230	17,306	17,611
A&E	4,578	4,671	4,766	4,852	4,940
Other	21,190	21,514	21,843	22,127	22,415
NHS Clinical income	99,306	101,920	103,393	104,818	106,613
Non-NHS clinical income	2,578	2,617	2,657	2,692	2,727
Other income	19,597	20,343	20,958	21,516	22,089
Total Income	121,481	124,880	127,008	129,026	131,428

### 6.2.6 Expenditure

The following inflation assumptions have been used:

The pay costs inflation uplift includes prospective pay awards plus the further costs of agenda for change, consultant contract, etc

The drugs inflation uplift includes for the impact of NICE

The non-pay inflation uplift reflects the underlying cost increases plus the impact of CNST premiums in 2008-09

**Table 6.16: Inflation Assumptions**

	2007/08 %	2008/09 %	2009/10 %	2010/11 %	2011/12 %	2012/13 %
Pay Costs	3.7%	4.0%	4.4%	4.4%	4.0%	4.0%
Drugs	16.5%	11.5%	12.5%	12.5%	12.5%	12.5%
Other non-pay	5.0%	5.6%	2.8%	2.8%	2.8%	2.8%
Capex	6.6%	4.0%	4.0%	4.0%	4.0%	4.0%

Workforce numbers are based on paid hours, i.e. pay costs include the cost of staff employed by the Trust including overtime, etc plus the cost of bank staff contracted as and when required. Workforce numbers are planned to reduce over the period by about 220 in contracted numbers as well as skill mix changes.

**Table 6.17: Planned Workforce Numbers**

	2007-08 WTEs	2008-09 WTEs	2009-10 WTEs	2010-11 WTEs	2011-12 WTEs	2012-13 WTEs
Direct clinical staff	1,264	1,266	1,238	1,207	1,190	1,167
Other clinical staff	449	450	415	392	378	366
Non-clinical staff	476	477	464	450	447	438
Total staff	2,190	2,194	2,117	2,048	2,015	1,971

WTE – Whole Time Equivalent

Non-pay costs have been included based on the start budgets for 2008/09 adjusted for the marginal cost/saving of changes in activity. Marginal costs are predominantly drugs and other clinical costs. Any semi-fixed change to the workforce and buildings costs will be dealt with through the business improvement plans.

In summary, the planned cost base is as follows:

**Table 6.18: Planned Cost Base**

	2008/09 £'000	2009/10 £'000	2010/11 £'000	2011/12 £'000	2012/13 £'000
Pay	(80,063)	(80,876)	(81,582)	(82,617)	(83,356)
Drugs	(8,006)	(8,928)	(9,956)	(11,101)	(12,387)
Clinical	(7,444)	(7,577)	(7,785)	(7,731)	(8,072)
Other	(14,799)	(14,673)	(13,801)	(13,597)	(13,386)
Total Expenditure	(110,311)	(112,053)	(113,124)	(115,047)	(117,201)

## 6.2.7 Cost Improvements

The Cost Improvements targets over the period of the financial model amount to £18m cumulatively. This is equivalent to about 17% of the Trust's cost base:

**Table 6.19: CIP Targets**

	2008/09 £000's	2009/10 £000's	2010/11 £000's	2011/12 £000's	2012/13 £000's
Annual cost improvements	3,945	3,955	4,102	3,252	3,321
Percentage of cost base	3.2%	3.3%	3.5%	2.8%	2.8%

### 6.3 Cash Flow

The cash position is healthy with the balance forecast to grow to nearly £16m over the next five years.

Most of the cash improvement has come from the surplus revenue position in each year. In addition there is some improvement in the balance sheet referred to in the section above.

The cash plan includes the assumption that the £11m cost of re-provision of facilities from the Outwoods site would be partly funded from the disposal of the site and the balance would be funded from internally generated cash.

The £10m improvement in the balance sheet includes £3m as creditors return to normal levels as there is no requirement to reduce cash to 0.3% and the settlement of the £6.1m outstanding impairment debtor with the local PCT raised in 2007-08. This £6.1m is offset by a reduction in PDC thereby making it cash neutral.

The PDC raised over the two years totalling £2.1m relates to the boiler house scheme funded from the Department of Health.

The sale of assets of £0.5m relates to the disposal of surplus houses and the £6.5m is the expected proceeds from the disposal of the Outwoods site once the site has been vacated and cleared. The proceeds will be used to meet part of the £11m cost of re-provision onto the main site.

The working capital facility to cover 30 days would be around £8.5m. There is no requirement in any year of the plan to draw the working capital facility. The Trust's bankers have been made aware of the requirement and they have indicated that there should be no problem in securing the facility when it is needed.

**Table 6.20: Projected Cash Balances**

	2008/09 £000's	2009/10 £000's	2010/11 £000's	2011/12 £000's	2012/13 £000's
Net cash from trading operations (EBITDA)	11,170	12,827	13,884	13,979	14,227
Less non-cash items	(289)	(257)	(178)	(173)	(167)
Balance Sheet movements	9,996	905	512	250	130
Capital pmts for fixed assets	(8,201)	(5,817)	(12,047)	(11,284)	(6,531)
Sales of fixed assets		545		6,472	
Public Dividend Capital raised	1,264				
Public Dividend Capital repaid	(6,117)				
Dividend paid	(4,306)	(4,329)	(4,508)	(4,682)	(4,865)
Interest received	265	377	335	392	555
Cash movements in-year	3,781	4,252	(2,002)	4,953	3,350
Year-end cash balances	5,281	9,533	7,531	12,484	15,834

### 6.3.1 Capital

The capital programme is set at a level that can be funded from internally generated resources (mainly depreciation), whilst at the same time meeting the capital priorities for the next 5 years. Five year annual maintenance and replacement programmes have been agreed for replacement of medical and IT equipment and the maintenance of the estate. Other development schemes are included subject to the approval of a detailed business case – for example, new medical assessment unit, improved outpatients department, additional maternity delivery rooms. The capital programme has been adopted by the Trust Board as follows –

**Table 6.21: Projected Capital**

	2008/09 £000's	2009/10 £000's	2010/11 £000's	2011/12 £000's	2012/13 £000's
Medical equipment	290	1,308	1,337	1,170	1,217
Decontamination	104	108	112	117	122
Student accommodation (SIFT)	343	324	457		
Pharmacy Manufacturing Unit					
Information Management	390	681	1,462	1,755	1,460
Site rationalisation	242	541	567	584	608
Boiler house	2,495				
CPU/HSSU	1,500	520			
Clinical services developments	323	886	1,012	1,521	1,947
Re-provision onto Main Site			6,000	5,000	
Maintenance CapEx	1,254	1,494	1,150	1,192	1,237
<b>Total capital programme</b>	<b>6,941</b>	<b>5,862</b>	<b>12,097</b>	<b>11,339</b>	<b>6,591</b>

The backlog maintenance is relatively small at around £3.5m as most of the site was developed in the early '90s. The requirement is also reducing as the older Victorian buildings are being taken out of use and demolished. An annual £1m per year is set aside in the capital programme to ensure that the Trust can maintain its estate.

A five year replacement schedule for medical equipment has been agreed through a medical equipment group. This forms the basis for the annual capital investment required for routine replacement (and upgrade where necessary) of medical equipment as it reaches the end of its expected life.

An annual replacement schedule is used to similarly plan for the replacement of IT equipment.

Additional funding of £2.1m has been received from the Department of Health to partly fund the boiler house scheme that is part of the national initiative to reduce emissions and increase efficiency. The balance of the cost of the scheme is being funded from internally generated resources.

The £11m re-provision onto the main site from the Outwoods site can potentially be funded from the sale proceeds and from the accumulated cash balance. If the cash balance were insufficient for this purpose, the Trust would consider taking an external loan based on a robust business case that demonstrates that the repayments would be affordable from within the resources available.

The Trust's prudential borrowing limit is in excess of £33m based on the Monitor risk assessment score of 4 (see section 6.5).

## 6.4 Balance Sheet

Set out in the following section is the Balance sheet for the next 5 year period.

It has been assumed that with regard to the originating debt the public dividend capital, income and expenditure reserve and revaluation reserve at 1st October 2008 will form the originating debt of the Foundation Trust.

NHS debtors are now subject to the new NHS standard form of contract that requires the base contract to be paid regularly on the 15th of each month and variations paid within 30 days of the invoice. Trade debtors are reduced by taking robust action to secure non-NHS debts as soon as possible. This reflects a reduction from an average period for outstanding debtors from 12 days down to 9 days.

Trade creditor periods are increased from around a 19 day average to 27 days as payments are made when they are due and not when they are received. The average remains within the 30 day better payment policy.

Trade creditors are expected to revert to the normal level once the 0.3% restriction on year-end cash balances has been removed. The early payment of the March tax and national insurance during March amounts to about £2.6m alone.

Capital creditors are higher than normal in 2007-08 due to the additional capital commitments made late in the financial year to ensure that the capital allocation is spent to avoid/reduce any cash claw-back by the Department of Health. The future level of capital creditors is consistent with the normal level expected over the year-end.

Apart from the reduction of £6.1m impairment cash and the £1.3m balance of the boiler house funding there are no other changes to PDC in the future.

**Table 6.22: Projected Balance Sheet**

	2008/09 £000's	2009/10 £000's	2010/11 £000's	2011/12 £000's	2012/13 £000's
Fixed Assets (net book value)	<b>127,336</b>	<b>121,714</b>	<b>132,217</b>	<b>135,523</b>	<b>140,391</b>
Current Assets					
Stock	2,128	2,128	2,128	2,128	2,128
Trade Debtors	6,169	5,534	5,391	5,204	5,083
Cash	5,281	9,533	7,531	12,484	15,834
	<b>13,578</b>	<b>17,195</b>	<b>15,050</b>	<b>19,816</b>	<b>23,044</b>
Current Liabilities					
Trade Creditors	(7,453)	(7,765)	(8,176)	(8,281)	(8,334)
Capital Creditors	(540)	(585)	(635)	(690)	(750)
	<b>(7,993)</b>	<b>(8,350)</b>	<b>(8,811)</b>	<b>(8,972)</b>	<b>(9,084)</b>
Long Term Liabilities	(1,235)	(1,194)	(1,152)	(1,109)	(1,065)
	<b>131,686</b>	<b>129,365</b>	<b>137,304</b>	<b>145,259</b>	<b>153,286</b>
Funding					
Public Dividend Capital	54,474	54,474	54,474	54,474	54,474
I&E reserve	6,888	(266)	2,984	5,810	8,575
Revaluation reserve	67,009	71,967	76,705	81,879	87,181
Donated asset reserve	3,304	3,179	3,130	3,085	3,045
Other Reserves	11	11	11	11	11
	<b>131,686</b>	<b>129,365</b>	<b>137,304</b>	<b>145,259</b>	<b>153,286</b>

## 6.5 Monitor Risk Assessment

The following shows the Trust's planned compliance with the Monitor risk assessment criteria (for the base case scenario). This shows that the Trust scores 4 in all years –

**Table 6.23(a): Monitor Risk Assessment**

	2008-09	2009-10	2010-11	2011-12	2012-13
<b>Metric</b>					
EBITDA Margin	9%	10%	11%	11%	11%
EBITDA achieved	100%	100%	100%	100%	100%
Return on Assets	4%	5%	6%	5%	5%
I&E surplus ratio	1%	2%	3%	2%	2%
Liquidity ratio (days)	62	41	51	42	56
<b>Financial Criteria</b>					
Underlying performance	4	4	4	4	4
Achievement of plan	5	5	5	5	5
Financial efficiency	3	4	4	4	4
Liquidity	5	5	5	5	5
Overall rating	4	4	4	4	4
<b>Final rating ***</b>	<b>4</b>	<b>4</b>	<b>4</b>	<b>4</b>	<b>4</b>

\*\*\* the final rating takes into account over-riding limitations – eg that a FT of less than 1 year cannot score more than 4

### 6.5.1 Prudential Borrowing Limit

Based on this rating of 4 the Trust has a prudential borrowing limit of 25% of its asset base in all years amounting to around £33m in 2008-09.

The Trust is planning no external loans over the period provided that sufficient cash can be generated to support the capital investment in the re-provision of the services currently on the Outwoods site.

**Table 6.23(b): Prudential Borrowing Limit**

	2008-09	2009-10	2010-11	2011-12	2012-13
PBC Ratios					
Maximum Debt/ Assets Ratio	0%	0%	0%	0%	0%
Minimum Dividend Cover	2.7x	3.1x	3.2x	3.1x	3.1x
Minimum Interest Cover	-	-	-	-	-
Minimum Debt Service Cover	-	-	-	-	-
Maximum Debt Service to Revenue	0.0%	0.0%	0.0%	0.0%	0.0%
Test					
Maximum Debt/ Assets Ratio (limit)	25.0%	25.0%	25.0%	25.0%	25.0%
Maximum Debt/ Assets Ratio	YES	YES	YES	YES	YES
Minimum Dividend Cover	YES	YES	YES	YES	YES
Minimum Interest Cover	YES	YES	YES	YES	YES
Minimum Debt Service Cover	YES	YES	YES	YES	YES
Maximum Debt Service to Revenue	YES	YES	YES	YES	YES
PBC ratio test passed	YES	YES	YES	YES	YES

### 6.6 Conclusion

The Trust's five year financial projections demonstrate that it will continue to deliver sound financial management, whilst at the same time generating surpluses in each year. The cash flow can be managed without resorting to the financing facility. The strong Balance Sheet places the Trust's in an excellent position to deliver its commitments and pursue its ambitions.