Trust Board

29 September 2020

Finance Overview Report

Month 5 2020/21 – period ended 31st August 2020

Key points

- We have received most of the retrospective top-up we have requested for M1-4. Should this continue for M5-6, we will be close to break-even for the first half of the year
- Both our NHS and PP activity remain low, though increasing, compared to pre-Covid levels, whereas our cost base is relatively constant. This exposes us to significant financial risk when the funding mechanism changes in M7.
- Plans are being developed to increase both NHS and PP activity further.
- Our cash position remains healthy due to current pre-payment arrangements. When these unwind, and should the risks identified above materialise, we will need to take measures to mitigate our cash position
- Current indications are that we will be funded for high-cost CF drugs; should this not be the case, this will present another material risk

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1. Key Headlines Year-to-Date Month 5 2020/21

Key Headlines

	Plan £000	Actual £000	Variance	Variance %	RAG	Trend
I&E	(761)	(578)	183	24.0%		↔
Control Total	0	(0)	(0)			↔
Control Total exc. Covid 19 Top-Up	(16,040)	(44,545)	(28,506)	-177.7%		↓
Cash	30,284	60,064	29,780	-98.3%		↑
Capex non-Covid 19	18,847	8,396	(10,451)	55.5%		↔
Capex Covid 19	4,557	1,741	(2,816)	61.8%		↔
Agency	(3,275)	(2,562)	713	21.8%		↑
Single Oversight Framework	2	2	0	0.0%		↔

The Trust's financial position for month 5 will depend on the amount of "Retrospective Top-up" provided by NHSE/I. Reflecting NHSE/I guidance our figures above assume approval of the £28.5m Retrospective Top-up YTD in full, (YTD M4 £25.0m), enabling the Trust to achieve break-even on a Control Total basis.

Of the £25.0m claimed YTD month 4 the Trust has received £22.6m, the balancing £2.4 relates purely to the Private Patient increased bad debt provision, and remains unapproved.

Our Month 5 submission is currently being reviewed by NHSE/I and NWL STP to assess whether they accept it as the reasonable financial implications of delivering the capacity required by the system cumulatively to August. It should be noted the Retrospective Top-Up requested by the Trust is one of the 5 highest in the country, as a proportion of turnover, driven by lost PP income and new CF drugs. We are being asked to justify our spend whilst activity remains low, especially on the Brompton site.

The current funding mechanism is summarised in Appendix A and has been extended to the end of September 2020. Final details are yet to be circulated for the new payment mechanism beyond September (and the value of the future funding flows is yet to be circulated); however it is envisaged that

- the Trust will receive a fixed payment, with some adjustment linked to achievement of Covid phase 3 activity targets, with further funding held at system level for distribution by the STP.
- it will no longer be possible for Trusts to receive Retrospective Top-Ups to balance their financial position.
- there will not be full compensation for loss of non-NHS Income, including Private Patients,

The new funding mechanism represents a significant financial risk for the Trust as our PP beds are currently being used for NHS patients. Capacity is currently under review to ascertain whether we can achieve Covid phase 3 operational targets whilst restoring some of our PP daycase and inpatient capacity.

2. Key Financial Risks 2020/21

- New funding mechanism from October 2020:
    - New funding level unknown, but it is anticipated: (i) a component will be directed through the STP, (ii) a component will be reliant on significant increases in activity to delivery Phase 3 targets, and (iii) there may be an expectation of cash releasing efficiency savings
    - Expectation that Orkambi and Kaftrio, will be funded (following NICE recommendations) but it is not certain yet. (Kaftrio is a particular concern, as it has only recently been NICE recommended, and is therefore not been reflected in our Retrospective Top-Up claims to date.)
    - Potential PP contribution losses and other income reductions may not be fully reimbursed, generating a potential pressure of £3m per month, if PP bed capacity remains prioritised for NHS patients.
- £2.6m pressure from increased PP bad debt provision YTD remains unfunded.
- £3.3m of committed Covid capital expenditure is yet to be approved for funding, creating a potential cash and CDEL pressure.
- Funding flows, should the Trust be impacted by further Covid surges are unknown, but it is anticipated we would need to maintain non-Covid activity should this happen.

3. Variance to "Budget"

Summary I&E									Month 5 / 2020/20
	M5			YTD Against Plan			YTD Against Prior Year		
£m	Budget	Actual	Variance	Budget	Actual	Variance	PY	Actual	Variance
Total Nhs Clinical Income	**29.5**	**29.1**	**(0.4)**	**147.7**	**145.9**	**(1.8)**	**140.6**	**145.9**	**5.3**
Total Non Nhs Income	**4.0**	**1.9**	**(2.1)**	**19.9**	**7.9**	**(12.0)**	**18.8**	**7.9**	**(10.9)**
Provider Sustainability Funding	0	0	0	0	0	0	1.9	0	(1.9)
Financial Recovery Funding	0	0	0	0	0	0	4.2	0	(4.2)
MRET Funding	0.0	0	(0.0)	0	0	0	0.2	0	(0.2)
Non Clinical Income	2.1	1.5	(0.5)	10.3	7.1	(3.2)	9.7	7.1	(2.5)
Covid-19 Retrospective Top-Up	0	3.5	3.5	0	28.5	28.5	0	28.5	28.5
Covid-19 ProspectiveTop-Up	3.2	3.2	(0.0)	16.0	16.0	(0.0)	0	16.0	16.0
Total Non Clinical Income	**5.3**	**8.3**	**3.0**	**26.3**	**51.7**	**25.4**	**16.0**	**51.7**	**35.7**
Total Income	**38.8**	**39.3**	**0.5**	**193.9**	**205.5**	**11.6**	**175.4**	**205.5**	**30.1**
Pay Costs	(20.5)	(20.7)	(0.2)	(102.5)	(105.6)	(3.1)	(98.1)	(105.6)	(7.4)
Total Pay	**(20.5)**	**(20.7)**	**(0.2)**	**(102.5)**	**(105.6)**	**(3.1)**	**(98.1)**	**(105.6)**	**(7.4)**
Drugs	(4.9)	(7.1)	(2.2)	(24.6)	(36.2)	(11.6)	(22.1)	(36.2)	(14.1)
Clinical Supplies	(5.8)	(4.4)	1.4	(29.1)	(22.1)	6.9	(27.2)	(22.1)	5.1
Other Costs	(5.2)	(4.7)	0.5	(26.0)	(29.5)	(3.4)	(22.4)	(29.5)	(7.1)
Total Non Pay	**(15.9)**	**(16.2)**	**(0.3)**	**(79.7)**	**(87.8)**	**(8.1)**	**(72.0)**	**(87.8)**	**(15.7)**
Total Expenditure	**(36.4)**	**(36.9)**	**(0.5)**	**(182.1)**	**(193.3)**	**(11.2)**	**(170.1)**	**(193.3)**	**(23.2)**
EBITDA	**2.4**	**2.4**	**(0.0)**	**11.7**	**12.2**	**0.4**	**5.2**	**12.2**	**6.9**
EBITDA Margin %	**6.1%**	**6.0%**		**6.0%**	**5.9%**		**3.0%**	**5.9%**	
Central Costs	(2.5)	(2.4)	0.1	(12.5)	(12.7)	(0.2)	(12.7)	(12.7)	(0.1)
Net Surplus/(Deficit)	**(0.1)**	**(0.0)**	**0.1**	**(0.8)**	**(0.6)**	**0.2**	**(7.4)**	**(0.6)**	**6.9**
Net Margin %	**(0.3%)**	**(0.0%)**		**(0.4%)**	**(0.3%)**		**(4.2%)**	**(0.3%)**	

Please note, due to Covid-19 the planning and contracting processes for 2021 were not completed. The budgets included in the table above reflect the expected income and expenditure used to calculate the £3.2m monthly Prospective Top-Up, and therefore reflect the variances we need to explain to receive Retrospective Top-Up.

The adverse variance reported to the bottom line is solely explained by the financial impact from donated assets, depreciation and income.

It should be noted, YTD the methodology for calculating Prospective Top-Up assumed non-Commissioning contracted income and expenditure would remain at historic levels, with any justifiable variation reclaimed through Retrospective Top-Up.

NHS Clinical Income: in-month adverse variance (£0.4m), YTD adverse variance (£1.8m)

An adverse variance is expected, as the Block Payment only covers income received from commissioning contracts, with the Prospective Top-Up assuming non-contracted activity, provider to provider recharges, and overseas patients with reciprocal agreements would remain at historic levels – all have significantly reduced due to Covid.

Non-NHS Clinical Income: in-month adverse variance (£2.1m), YTD adverse variance (£12.0m)

An adverse variance is expected, with reduced PP ambulatory activity, and inpatient admissions limited to those meeting the same criteria as an NHS admission. Since the end of March all PP wards have been converted to NHS.

Underlying PP income in-month increased by c. £250k compared to July, primarily delivered at Harefield. Wimpole Street activity has recovered to close to pre-Covid levels

Non-Clinical Income without Retrospective Top-Up: in-month adverse variance (£0.5m), YTD adverse variance (£3.2m)

The in-month improvement on trend was driven by increases in Research & Development, rental, and catering income.

Pay: in-month adverse variance (£0.2m), YTD adverse variance (£3.1m):

Our normalised pay variance remained close to budget for August, as it had in July.

Pay expenditure has been analysed at Divisional level, aligning expenditure with income generated under traditional commissioning and activity.

Brompton Heart underlying pay expenditure in-month aligned with 2019/20, with an increase in medical pay , £0.1m, offset by reduction for nursing. A reduction in non-substantive pay of £0.2m is offset by an increase in substantive pay spend. Spells are 32% lower than the comparator period, and combined VV ECMO and Critical Care activity on average lower by 16 beds.

Harefield pay expenditure has increased by £250k compared to last year, £200k nursing, £50k medical, to deliver comparable costed activity. Level 1 bed-days were on average 14 lower than 2019/20

There have been marginal pay reductions in Lung, ACS, and Private Patients.

Note: Activity and cost comparisons in this section are against the mth 8-10 1920 average, consistent with the method used to determine the 'budget', whereas, in section 5, comparison is against the activity and commissioned income plan anticipated pre-Covid

Non-Pay: in-month adverse variance (£0.3m), YTD adverse variance (£8.1m):

Within month drug expenditure and Clinical Supplies expenditure remained on trend, with drugs driven by NICE recommended Orkambi.

Other non-pay costs reduced compared to trend, with PPE expenditure reducing. In-month £0.3m adverse increase in the PP bad debt provision, £2.6m YTD.

YTD, excluding the impact of Orkambi on drug expenditure, we would have a non-pay underspend of £4.7m.

4. Retrospective Top-Up Calculation

The bridge below identifies the financial implications for which the Trust is expecting support through the Retrospective Top-Up.

Covid 19 Income and Expenditure Bridge	Month 5 / 2020/21

Description	In-Month Financial Impact £m	YTD Financial Impact £m
Income		
Reduced NHS Income not included within Block or Initial Top-Up	0.3	1.5
Reduced non-NHS patient income inc. Private Patients	2.2	12.2
Reduced non-patient income	0.4	3.0
Sub-Total Income	2.9	16.8
Pay		
Additional staffing Critical Care and ECMO beds	0.3	1.9
Additional staff absence	0.0	4.8
Additional Bank Holiday enhancements	0.0	0.2
Other Covid increased staffing	0.4	2.2
Staff for Nightingale Hospital	0.0	0.2
Net Saving Staff Expenditure - redeployment	(0.4)	(5.7)
Sub-Total Pay	0.3	3.5
Non-Pay and Central Costs		
Additional Tariff Excluded Drug expenditure	2.6	12.8
Additional non-pay Critical Care and ECMO beds	0.1	2.8
Additional PPE expenditure	0.0	4.4
Increased Bad Debt Provision	0.3	2.6
Other direct Covid 19 non-pay expenditure	0.2	1.8
Net reduction Other non-pay	(3.0)	(16.1)
Sub-Total Non-Pay & Central Costs	0.2	8.3
Deficit exclusive of Retrospective Top-Up funding	**3.5**	**28.5**

The table demonstrates cost savings of c. £21.8m associated with cessation of business as usual activity, netted off against direct costs of delivering care to Covid-19 patients. It should be noted, for staff, this is not reflected as an expenditure reduction, but by an ability to offset some of the Covid-19 pressures by redeployment of staff.

Excluding the loss of PP income and increased expenditure following NICE guidance for Orkambi, in August the Trust would have absorbed pressures from other income sources, whilst remaining £1.3m within the indicative budget set by Prospective Top-Up.

5. M5 Activity and Costed Activity Levels

The table below shows variances for activity and costed activity (ie revenue we would have received under PBR) for our key Points of Delivery (PODs) in-month and year-to-date against our pre-Covid plan. It demonstrates significant under-performance for activity and costed activity for M5 across all PODs, and YTD across all PODs except VV ECMO bed-days. This should be compared with a Phase 3 target for October of 90% inpatients, daycase, and outpatient procedures; and 100% outpatient attendances.

Compared to month 4, the in-month adverse variances in month 5 for Inpatient & Daycase reduced from 55% to 40%, activity, 35% to 23%, costed activity. Total costed activity remained stable compared to July, with an increase at Brompton offset by a reduction at Harefield, but delivered with 3 fewer working days for August

Similarly, compared to July, the adverse variances for Outpatients reduced from 23% to 16%, activity, 32% to 21%, costed activity. Costed outpatient activity reduced in-month by (£75k), 5%, with a 13% reduction in working days.

The adverse in-month variances for Critical Care bed-days and VV ECMO bed-days increased compared to July, this is not impacted materially by the reduction in working days

Under-performance is not unexpected, given restrictions on our ability to delivery activity due to the need to maintain Covid compliant pathways and reduced bed capacity. Performance should be noted against the limited scale of our expenditure reductions and the significant gap to our Phase 3 activity targets, which could create a further financial pressure under the new funding mechanism.

NHS Costed Activity against Business As Usual Plan			Month 5 / 2020/21	
Point of Delivery	**In-Month Variance**		**YTD Variance**	
	Activity	**%**	**Activity**	**%**
Activity				
Inpatient & Daycase Activity	(1,196)	-40%	(10,218)	-63%
Critical Care Bed-Days	(1,099)	-37%	(4,676)	-32%
VV ECMO Bed-Days	(141)	-78%	616	69%
Outpatients	(2,210)	-16%	(20,980)	-28%
Transplant & VADs	(5)	-45%	(26)	-49%
	£m	**%**	**£m**	**%**
Costed Activity				
Inpatient & Daycase Activity	(2.6)	-23%	(26.0)	-48%
Critical Care Bed-Days	(1.7)	-37%	(7.1)	-32%
VV ECMO Bed-Days	(0.7)	-78%	2.7	65%
Outpatients	(0.4)	-21%	(4.1)	-38%
Transplant & VADs	(0.5)	-36%	(2.7)	-45%

The fact our Inpatient & Daycase activity is under-performing by (40%) on pure activity, whilst only (23%) on costed activity, demonstrates an increase in casemix, as we prioritise higher acuity patients. We are yet to receive details of how future funding will be linked to delivery of Phase 3 targets (Appendix F), but it is expected it will be linked to costed activity.

Analysing our NHS Costed Activity by Division, without excluded drugs and devices income, demonstrates that all Divisions are under-performing against their business as usual plan, though it is most significant for Brompton Heart and Lung, where the impact of reduced bed capacity and new pathways is most significant. The adverse in-month variance for Brompton did reduce compared to July, reducing from (£6.4m), 44%, to (£4.4m), 27%.

It should noted performance is measured for NHS activity only, reflecting conversion of a 28 inpatient bed ward at Brompton, and 20 inpatient bed ward at Harefield, from PP to NHS.

NHS Costed Activity against Business As Usual Plan (w/o excluded Drugs & Devices)			Month 5 / 2020/21	
Division	**In-Month Variance**		**YTD Variance**	
	£m	**%**	**£m**	**%**
Brompton Heart Adults	(1.3)	-27%	(9.2)	-35%
Brompton Heart Paeds	(1.2)	-32%	(10.5)	-54%
Brompton Lung	(1.4)	-33%	(10.1)	-44%
Combined Heart & Lung Brompton Site	(4.0)	-27%	(29.8)	-54%
Harefield Heart	(1.7)	-23%	(6.3)	-16%
Harefield Lung	(0.4)	-24%	(3.7)	-39%
Combined Heart & Lung Hareifeld Site	(2.1)	-21%	(10.0)	-26%
Rehab & Therapies	(0.1)	-30%	(0.4)	-35%

6. Cash and Capital

The plan for cash has been set based on the draft plan submitted to NHSE/I in March, and for capital, based upon the updated capital plan submitted to NHSE/I on 29th May, (£50.4m 2020/21 excluding Covid related capital spend). Once financial flows for the remainder of the year have been clarified we will produce a revised plan.

It is assumed that all Covid-19 related capital expenditure will be funded subject to review for reasonableness by NHSE/I. It was anticipated the process for receiving confirmation of additional capital funding would be short, but the quantity of bids and the level of scrutiny at a national level has caused the process to be slower than anticipated, and we still await a definitive response on the majority of our Covid-19 capital submissions.

To the end of May, we had submitted £5.4m of Covid-19 capex cases to NHSE/I for support, (with £3.8m committed at risk), and have received confirmed support for only £0.5m so far. A further update had been expected before the end of July, but is yet to be received.

Cash, at £60.1m, was £29.8m higher than plan, but note within the draft plan it had been assumed the remaining £35.0m of the Imaging Centre bridging loan would be drawn down in May, and this has not needed to happen yet. Taking this into account the Trust has self-generated £64.8m more cash than planned, primarily driven by receipt of both the Block and Initial Top-Up one month in advance, £31.0m, slippage on capital and receipt of £9.1m incentive FRF in May.

Provided the Trust is reimbursed fully for the Retrospective Top-Up, as assumed in the August position, and fully funded for capital expenditure undertaken at risk to support care to Covid-19 patients, we do not anticipate a cash pressure associated with the Covid-19 funding flows under the funding mechanism in place until the end of September.

There is however a significant risk under the new funding mechanism from October the Trust may not be reimbursed in full for lost PP income, which could quite quickly generate a pressure on cash when the current payments in advance are unwound prior to the end of the financial year, as we started the year with a cash balance of only £7.3m.

Capital expenditure to date is £10.1m, of which £1.75m is Covid-19 related . There is slippage on non-Covid-19 capital expenditure, due to a focus on Covid-19. Should Covid-19 capital expenditure not be funded in full, it will not only generate a cash pressure, but it will also generate a pressure against the system CDEL allocation.

The key movement on the Balance Sheet is the accrual for Retrospective Top-Up. It should be noted that though Private Patient debtors has decreased by £2.5m (£1.85m increase embassies, £4.3m decrease insurance companies, £0.05m decrease other

PP), there has been significant ageing of debt generating the increase bad debt provision – debt under 30 days has reduced by £5.2m, debt over 90 days has increased by £6.55m, of which debt over 1 year has increased by £2.05m (Appendix B). Our debt provision matrix starts to generate a provision after 90 days, the level of provision increases with age in stages, including a step change increased provision for debt over 1 year. Embassy debtors remain a particular concern

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15th September 2020	