A lifetime of specialist care

Royal Brompton & Harefield NHS
NHS Foundation Trust

Trust Board

26 January 2021

Finance Overview Report

Month 9 2020/21 – period ended 31st December 2020

Key points

- Under the H2 Financial Regime there is no Retrospective Top-Up, and it is possible for the Trust to generate a surplus or deficit.
- Our In-month deficit was (£0.1m) against a planned deficit of (£2.3m), an in-month favourable variance £2.2m. On a Control Total basis our in-month break-even against a planned deficit of (£2.1m), an in-month favourable variance of £2.1m.
    - The in-month favourable variance is driven by the release of a non-recurrent gain on our H1 drug accrual, £1.9m, and by a further reduction in the PP Bad Debt Provision, £0.3m.
- The YTD deficit is (£3.0m) against a planned deficit of (£7.3m), a favourable variance £4.3m. On a Control Total basis our YTD deficit was (£2.2m) against a planned deficit of (£6.0m), an in-month favourable variance of £3.8m.
    - The YTD favourable variance is also driven by the release of a non-recurrent gain on our H1 drug accrual, £1.9m, and by a reduction in the PP Bad Debt Provision, £2.0m.
- On 15th December we received £6.2m for retrospective top-up relating to Months 5 & 6. We have received £28.8m YTD of retrospective top-up against a claim of £31.7m, with payment not received for the £2.9m increase in PP Bad Debt Provision during H1.
    - However, monitoring of retrospective top-up during phase 3 will continue throughout 20/21 and if on reflection it appears an overclaim, for example by over accrual, NHSE/I reserve the right to recoup.
    - In addition, the audit of our retrospective top-up claim by PWC, as requested by NHSE/I, is on-going.
- It should be noted, our current financial position, following NHSE/I guidance, still assumes retrospective top-up income of £31.7m. There is potential for a reduction in retrospective top-up for both the H1 drug accrual, and reduction in bad-debt provision, which together would eliminate most of our positive YTD variance to plan.
- There is expectation staff may not have used a proportionate share of their leave YTD this financial year, but there is currently a lack of data to make a provision, so this is not included within the YTD position.
    - As staff are now able to carry leave over between financial years, and a process to collate this information (and hence to allow a provision to be calculated) is being undertaken during January, a change in our prevision will be reflected in our M10 reported position and completion accounts. This is expected to generate a cost pressure in M10, which NHSE/I may not have anticipated before M12.

    - At the time of reporting M10 it is not anticipated NHSE/I will have clarified whether providers will be funded for this pressure, whether flexibility will be given against plan targets, or whether providers are expected to absorb. When similar happened at the end of 2019/20, albeit to a smaller scale, no additional funding was provided, instead providers were provided with equivalent flexibility against their Control Total.
- There is no adjustment for the Elective Incentive Scheme (EIS) in the month 9 position as per guidance. We await confirmation of our baseline comparator from 2019/20, and EIS will be calculated on a NWL system, not individual provider, basis, so will depend to some extent on the performance of other trusts in NWL. Based on the expected level of NWL EIS payments, we are not anticipating a material adjustment as a result of EIS.
- Despite increasing pressure on beds as the month progressed, Private Patients generated £1.4m income in-month, against a plan target of £1.5m, an adverse variance of (£0.1m).
    - Due to the growing pressure on beds the Trust has converted all PP beds back to NHS, as during the 1st surge, which will generate a significant pressure during Q4.
    - Q4 planned PP income is £5.7m; should all PP beds remain NHS all quarter this will generate a forecast income shortfall Q4 of c.£5m.
- £1.55m of payments were received from Embassies for PP debt in-month, £1.25m KHO, £0.3m Kuwait Oil. This is the second highest level of payment, (highest November 20) since June 19, and reduced overall Embassy debt in-month by £1.4m. The improvement has been driven by payments from KHO in November and December, whose debt position is now £6.4m compared to £10.5m July 20, and £7.9m December 19.
- 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.
- Following closure of M9 we received payment for M7 high-cost CF drugs
- It has been announced the national planning and contract processes for 21/22, usually undertaken during Q4 20/21, have been deferred at least until to Q1 21/22. Funding for Q1 21/22 will be aligned with H2 20/21 methodology.

Contents:

1. Key Headlines Year-to-Date Month 9 2020/21

Key Headlines						Month 9 / 2020/21
	Plan £000	Actual £000	Variance	Variance %	RAG	Trend
I&E	(7,271)	(3,009)	4,262	58.6%		↑
Control Total	(6,032)	(2,192)	3,840	63.7%		↔
Control Total exc. Covid 19 Top-Up	(56,966)	(53,125)	3,840	6.7%		↔
Control Total exc. Covid 19 Top-Up & Exceptional Gains mths 7-9*	(56,966)	(57,000)	(35)	-0.1%		↔
Cash	59,506	65,778	6,272	-10.5%		↑
Capex non-Covid 19	28,245	20,130	(8,115)	28.7%		↑
Capex Covid 19	2,522	2,260	(262)	10.4%		↑
Agency	(5,010)	(4,207)	804	16.0%		↔
Single Oversight Framework	2	2	0	0.0%		↔
* Exceptional Gains during mths 7-9 includes a reduction in PP Bad Debt Provision (£2.0m) and over-estimated drugs accrual mth 6 (£1.9m)						

The Trust's plan for H2 (agreed with NWL) projected a deficit of (£12.3m), in-month (£2.3m), driven by lost contribution from reduced non-NHS income flows compared to 2019/20, in particular PP. On a Control Total basis, H2 projected a deficit of (£11.5m), in-month (£2.1m)

The Trust's financial position for month 9 will depend on the amount of "Retrospective Top-up" provided by NHSE/I for M1-6. Reflecting NHSE/I guidance our figures above assume approval of the £31.7m Retrospective Top-up YTD in full, enabling the Trust to achieve break-even on a Control Total basis M1-6.

Of the £31.7m claimed YTD, the Trust has received £28.8m. £2.9m not received relates to the Private Patient increased bad debt provision at month 6.

The in-month deficit (£0.1m) is £2.2m better than plan, and the YTD deficit, (£3.0m), is £4.3m better than plan. On a Control Total basis, the Trust is £2.1m better than plan in-month, and £3.8m better than plan YTD. The favourable variances generated by a reduction in our bad debt provision since M6, and a one-off gain from the H1 drug accrual. If these are recovered by NHSE/I through a reduction in Retrospective Top-up, our YTD position is in-line with plan.

For H2 the funding mechanism has changed. Block payments to providers and allocations to systems have been confirmed, and discussions are on-going to finalise our allocation from NWL System reserves.

- Block payments align with those received April to September, though the de-minimus limit has increased from £200k to £500k. The System received resources available for allocation equivalent to Prospective top-up, growth, and Covid pressures (but not Retrospective top-up).
- NWL has not received funding for lost contribution associated with non-NHS income losses, though is in on-going discussions with the Regional and National teams. There will be no Retrospective top-up after September, and there will be adjustments associated with performance against the EIS.

The new funding mechanism represents a significant financial risk for the Trust, the plan assumed the majority of our PP beds would be used for NHS patients following the transfer of lung patients from Fulham Wing, and other non-NHS income flows are forecast to be lower H2 20/21 than 19/20. The lost contribution reflected in the planned (£11.5m) deficit H2 assumed the continued availability of sufficient dedicated PP beds to generate £5.7m PP income Q4. At present all beds are dedicated for NHS patients, with this expected to remain the case for most of Q4, and therefore, without additional financial support, the Trust will generate a significant adverse variance against plan in Q4.

The Cash plan is taken from our H2 Plan submission, whilst the Capital plan is taken from our updated Capital forecast submitted to NWL System, and incorporated within System CDEL.

2. Key Financial Risks 2020/21

YTD M9 the Trust is £3.8m better than plan, on plan on a normalised basis, but the following risks remain within this financial year:

- The H2 plan assumed increased access to beds for PP activity, but since late December there are no dedicated PP beds; again admission is prioritised on purely clinical criteria. There will be a pressure from the lost contribution associated with a shortfall against £5.7m PP income planned for Q4. The income shortfall is likely to be c.£5m, an estimated loss of contribution of c.£4m, as staff, facilities, and consumables will be redeploy for NHS patients..
- Reduced funding for Retrospective Top-Up, H2 plan assumed full receipt. Our latest cash payment for Retrospective Top-Up excluded £2.9m pressure for H1 increased bad debt provision. However, monitoring of retrospective top-up during phase 3 will continue throughout 20/21 and if on reflection it appears an overclaim, for example by over accrual, NHSE/I reserve the right to recoup. NHSE/I have been informed of our £1.9m gain in H2 from the H1 drugs accrual.

In addition, the audit of our retrospective top-up claim by PWC, as requested by NHSE/I, is on-going.

- During Q4 we expect to care for more ECMO and Critical Care Level 3 patients than ever before, even during the first surge, and this will generate cost pressures for our clinical and operational teams. As directed, the H2 plan was submitted on the basis there would no second surge.
- Following National guidance staff are allowed to carry-forward up to 20 days annual leave not taken during this financial year. This will result in a pressure either through additional payments to buyback leave or a significant increase in the annual leave provision. It is a known pressure, but the size of the pressure is currently being estimated, though is anticipated to be in the £4m-£10m range. An exercise is currently being undertaken to ascertain the level of provision required, this will be included in the M10 position.

  As directed by NHSE/I this known pressure is not included at all within our plan, there is no guidance to date on whether additional funding will be provided, whether Trusts and ICSs will be allowed equivalent flexibility against their plans, or will be expected to absorb the pressure. Unless funded with cash this will generate a cash pressure during 21/22 when cover is required whilst staff take the additional leave carried forward.
- We will receive our site revaluation during January, and a reduced valuation of any of our Investment Properties, including CFM, will generate a pressure against our revenue position.
- Financial implications of EIS. YTD and forecast are unknown at present, and not reflected in the position. Under EIS Daycases, Elective Inpatient, and Outpatients Procedure activity are grouped together with a target of 90% for October compared to the same period 2019/20, and all Outpatient Attendances with a target of 100%. (Appendix E)
    - Grouping activity as per EIS, and using activity and costed activity as it would have been charged to commissioners pre-Covid, we achieved 80.9% activity and 99.1% costed activity against the target for procedures. For outpatient attendances we achieved 124.9% activity and 115.8% costed activity.

      It should be noted performance in December 2020 benefited by an additional working day compared to December 2019, but this explains a 5% improvement, and does not explain all our over-performance against targets.
    - Within our overall performance we exceeded the procedure targets for Heart and Paediatrics costed activity, but achieved 61.2% for Lung procedures, but 107.0% for Lung outpatient attendances. It should be noted that Respiratory activity is significantly impacted by Aerosol Generating Procedures (AGPs) and in addition we have converted an estimated 430 Daycase spells per month onto Homecare pathways.

3. Variance to "Budget"

Summary I&E									Month 9/ 2020/21
	M9			YTD Against Plan			YTD Against Prior Year		
£m	Budget	Actual	Variance	Budget	Actual	Variance	PY	Actual	Variance
Total Nhs Clinical Income	**37.3**	**39.7**	**2.5**	**287.0**	**289.0**	**2.0**	**227.3**	**289.0**	**61.7**
Total Non Nhs Income	**1.5**	**1.3**	**(0.2)**	**14.4**	**13.2**	**(1.2)**	**30.3**	**13.2**	**(17.1)**
Non Clinical Income	1.5	2.4	0.8	13.4	14.9	1.6	15.8	14.9	(0.9)
Covid-19 Retrospective Top-Up	0	0.0	0.0	31.7	31.7	(0.0)	0	31.7	31.7
Covid-19 Prospective Top-Up	0	0	0	19.2	19.2	0.0	0	19.2	19.2
Total Non Clinical Income	**1.5**	**2.4**	**0.8**	**64.3**	**65.9**	**1.6**	**27.2**	**59.5**	**32.3**
Total Income	**40.3**	**43.4**	**3.1**	**365.7**	**368.0**	**2.3**	**284.8**	**361.7**	**76.9**
Pay Costs	(20.9)	(21.2)	(0.3)	(188.4)	(188.7)	(0.4)	(158.7)	(188.7)	(30.0)
Total Pay	**(20.9)**	**(21.2)**	**(0.3)**	**(188.4)**	**(188.7)**	**(0.4)**	**(158.7)**	**(188.7)**	**(30.0)**
Drugs	(8.9)	(10.7)	(1.8)	(68.7)	(67.3)	1.4	(36.1)	(67.3)	(31.2)
Clinical Supplies	(5.9)	(5.3)	0.6	(46.2)	(47.3)	(1.1)	(44.8)	(47.3)	(2.5)
Other Costs	(4.4)	(3.9)	0.4	(47.0)	(45.5)	1.5	(34.7)	(45.5)	(10.8)
Total Non Pay	**(19.2)**	**(20.0)**	**(0.8)**	**(161.9)**	**(160.2)**	**1.7**	**(115.6)**	**(160.2)**	**(44.6)**
Total Expenditure	**(40.1)**	**(41.2)**	**(1.0)**	**(350.3)**	**(348.9)**	**1.4**	**(274.3)**	**(348.9)**	**(74.6)**
EBITDA	**0.2**	**2.2**	**2.0**	**15.4**	**19.1**	**3.7**	**10.5**	**12.8**	**2.3**
EBITDA Margin %	**0.5%**	**5.2%**		**4.2%**	**5.2%**		**3.1%**	**5.9%**	
Central Costs	(2.5)	(2.3)	0.2	(22.7)	(22.2)	0.5	(20.2)	(22.2)	(2.0)
Net Surplus/(Deficit)	**(2.3)**	**(0.1)**	**2.2**	**(7.3)**	**(3.0)**	**4.3**	**(9.7)**	**(9.3)**	**0.3**
Net Margin %	**(5.6%)**	**(0.3%)**		**(3.0%)**	**(0.3%)**		**(4.1%)**	**(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 actuals for M1-6, assuming Retrospective Top-Up paid in full, plus our phased H2 Planned deficit (£12.3m).

NHS Clinical Income: in-month favourable variance £2.5m, YTD favourable £2.0m

In-month favourable variance driven by the release of a provision in place M8 prior to full understanding of the drugs accrual gain, linked to excluded drug income and expenditure. The favourable YTD variance primarily driven by higher levels of excluded drug income than planned.

Non-NHS Clinical Income: in-month adverse variance (£0.2m), YTD adverse (£1.2m)

PP income adversely impacted by increasing bed pressures toward the end of December.

Non-Clinical Income: in-month favourable variance £0.8m, YTD favourable £1.6m

Generated in part by increased Donated Income, £0.1m in-month, £0.4m YTD, which does not benefit the Trust position on a Control Total basis. In addition increased rental and R&D income, which does benefit our position on a Control Total basis. Further restrictions on R&D will be re-applied during Q4, generating a further pressure on income.

Pay: in-month adverse variance (£0.3m), YTD adverse (£0.4m)

Pay expenditure, £21.0m in-month, returned to the same level as October, after an increase during November. Given increased ECMO and Level 3 critical care activity during January it is anticipated pay expenditure will increase during Q4 generating a pressure against plan.

Note, a significant pressure is anticipated in M10 when we the annual leave provision is recalculated.

Non-Pay: in-month adverse variance (£0.8m), YTD favourable £1.7m

In-month benefit of £0.3m, YTD £2.0m, from the reduction in PP Bad Debt Provision. In-month adverse variance on drugs due to increased excluded drug expenditure.

4. M8 Activity and Costed Activity Levels

The table below shows activity November 2020 against the same month 2019, with activity grouped as used within the EIS. Activity and Costed Activity have been compiled as we would have charged commissioners pre-Covid, SLAM submission. The Committee should note the EIS calculation is liable to be calculated using our Secondary Uses Services (SUS) submission, and the Trust is currently verifying data used within our 1920 SUS baseline.

Comparison Activity & Costed Activity November 20 against 2019/20								
		Mth 9 2020-2021		Mth 9 2019-2020		Activity as a % of 1920	Costed Activity as a % of 1920	Target Costed Activity as a % of 1920
		Activity	Costed Activity £m	Activity	Costed Activity £m			
Elective, Daycases, and Outpatient Procedures	Harefield & Brompton Heart	2,331	3.9	2,562	3.3	91%	117%	90%
	Harefield & Brompton Lung	1,136	1.4	2,061	2.2	55%	61%	90%
	Paediatrics	840	1.6	701	1.4	120%	117%	90%
Elective, Daycases, and Outpatient Procedures Total		4,307	6.9	5,324	7.0	81%	99%	90%
Outpatient (F2F and NF2F)	Harefield & Brompton Heart	4,766	0.5	3,691	0.4	129%	120%	100%
	Harefield & Brompton Lung	3,770	0.5	3,198	0.5	118%	107%	100%
	Paediatrics	1,159	0.2	873	0.2	133%	131%	100%
Outpatient (F2F and NF2F) Total		9,695	1.2	7,762	1.0	125%	116%	100%

Performance for Heart across sites and Paediatrics are in excess of EIS targets for both procedures and outpatients. The difficulty is for Lung activity, with activity limited for AGP and a conversion of Daycase activity to Homecare.

Bronchoscopy activity can no longer be delivered on Lind ward, instead it is delivered in theatres. Lung Function Tests used to be delivered with a number of patients together in a single room, now it is an individual patient, with a minimum 45 minute break between patients. Despite increasing room capacity for Lung Function Tests, outpatient procedures and attendances have reduced. A number of Asthma, ILD, and Immunotherapy patients have converted from Daycase to a Homecare pathway, reducing Daycase activity by an estimated 430 spells per month.

4. Cash and Capital

The plan for cash has been set based on the H2 plan submitted to NHSE/I in October, and for capital, based upon the updated capital forecast submitted to NWL ICS, also in October.

It is looking increasingly unlikely all Covid 19 related capital expenditure will be centrally funded, with a maximum funding and CDEL risk remaining of £2.15m.

Cash, at £65.8m, was £6.3m higher than plan. The favourable variance driven by higher than expected Embassy debt payments and slippage on capital schemes.

Capital expenditure to date is £22.4m, of which £2.3m is Covid 19 related. There is slippage on non-Covid 19 capital expenditure, but have an updated forecast of £42.3m, £40.0m non-Covid, £2.3m Covid. Previous forecast of £47.5m has reduced to reflect our reduced expectation of PDC funding for Covid, updated cashflow for the Imaging Centre, and slippage as priorities have focused on providing additional capacity for growing ECMO, critical care level 3, and Covid activity. Options to bring capital expenditure forward from 21/22 are being considered, but ability to achive this are limited by other priorities within the Trust and increasing lead times with suppliers.

Private Patient debtors has decreased by £9.1m (£5.7m decrease embassies, £3.8m decrease insurance companies, £0.5m increase other PP), there has been significant ageing of debt generating the increase bad debt provision – debt under 30 days has reduced by £4.85m, debt over 90 days has increased by £0.7m, though debt over 1 year has increased by £2.2m (Appendix A). 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.

Richard Guest	Trevor Mayhew
Chief Financial Officer	Deputy Director of Finance
25th January 2021	

Appendix B

Cashflow Statement

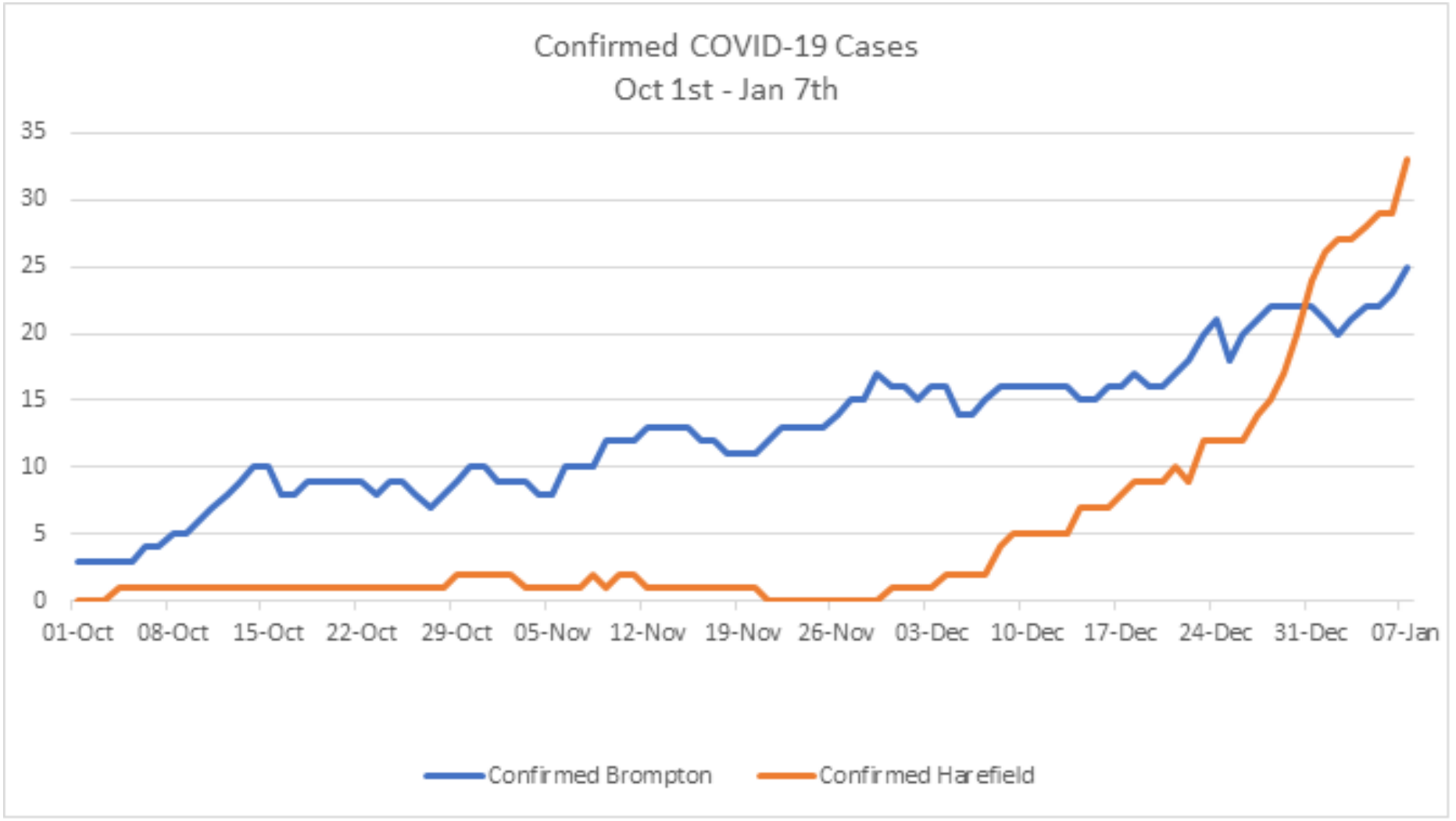
Cash Flow Statement (£m)	YTD to 31-12-20
Cash flows from operating activities	
Operating income	368.2
Operating expenses of continuing operations	(364.2)
Operating surplus/ (deficit)	**4.1**
Non-operating and non-cash items in operating surplus/ (deficit)	
Depreciation & amortisation	15.5
Impairments	0.0
Reversals of impairments	0.0
(Gain)/ loss on disposal	0.0
Other movements in operating cash flows	0.0
	15.5
Operating cash flows before movements in working capital	**19.6**
(Increase)/ decrease in working capital	
(Increase)/ decrease in inventories	(2.7)
(Increase)/ decrease in trade & other receivables	13.1
(Increase)/ decrease in prepayments	(0.4)
(Increase)/ decrease in accrued income	15.1
(Increase)/ decrease in other debtors	6.6
Increase/ (decrease) in trade & other payables	(6.4)
Increase/ (decrease) in pay creditors	0.3
Increase/ (decrease) in deferred income	34.6
Increase/ (decrease) in accruals	11.2
Increase/ (decrease) in other payables	(1.2)
Increase/ (decrease) in provisions	1.4
	71.5
Net cash inflow/ (outflow) from operating activities	**91.1**
Cash flows from investing activities	
Interest received	0.0
Purchase of tangible & intangible assets	(22.5)
Sales of tangible & intangible assets & investment property	0.0
	(22.5)
Net cash inflow/ (outflow) before financing	**68.6**
Cash flows from financing activities	
Public dividend capital received	0.5
Loans received from Dept of Health	0.0
Other loans received	(0.0)
Loans repaid to Dept of Health	(3.9)
Other loans repaid	(1.7)
capital element of finance lease payments	(0.1)
Interest paid (incl interest on finance leases)	(0.8)
PDC dividend paid	(4.2)
Net cash generated from/ (used in) financing activities	**(10.2)**
Increase/ (decrease) in cash and cash equivalents	**58.5**
Cash & cash equivalents - 1 April	**7.3**
Cash & cash equivalents - 31 December	**65.8**

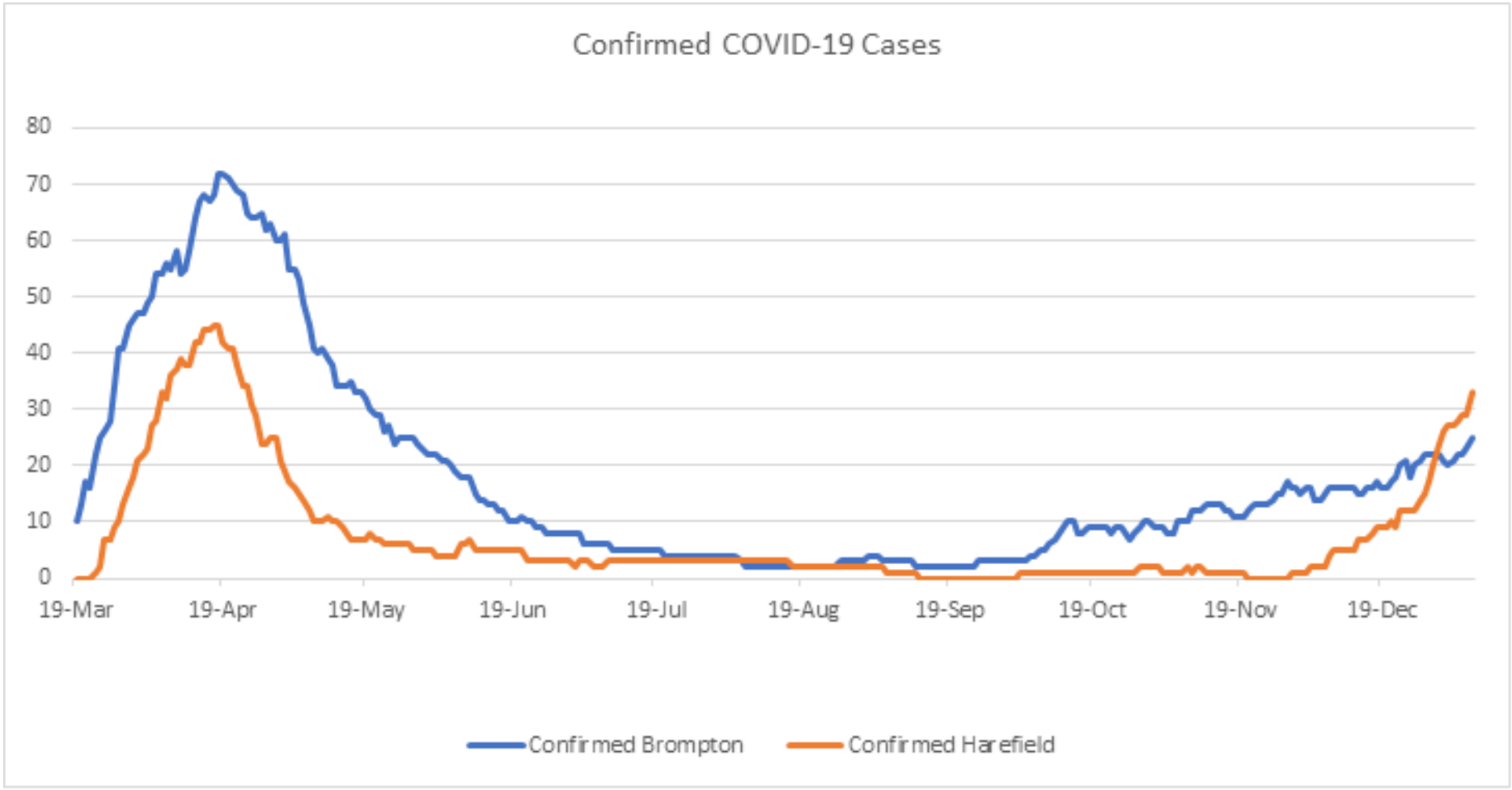
Appendix E

Phase 3 Planned Activity Aims and Targets

Point of Delivery	August * %	September %	October %
Activity			
Elective Inpatients	70%	80%	90%
Outpatient & Daycase Procedures	70%	80%	90%
MRI/CT	very swiftly return to 90% of last year's activity		ambition 100%
Outpatient Attendances & Follow-Ups **	90%	100%	100%
* August is stated as an 'aim'			
** expectation for organisations to maintain the target set from September for the balance of the year			

Appendix F


Confirmed COVID-19 Cases
Oct 1st - Jan 7th
35
30
25
20
15
10
5
0
01-Oct
08-Oct
15-Oct
22-Oct
29-Oct
05-Nov
12-Nov
19-Nov
26-Nov
03-Dec
10-Dec
17-Dec
24-Dec
31-Dec
07-Jan
Confirmed Brompton
Confirmed Harefield


Confirmed COVID-19 Cases
80
70
60
50
40
30
20
10
0
19-Mar
19-Apr
19-May
19-Jun
19-Jul
19-Aug
19-Sep
19-Oct
19-Nov
19-Dec
Confirmed Brompton
Confirmed Harefield