



London Ambulance Service **NHS**
NHS Trust

Financial Planning Policy

DOCUMENT PROFILE and CONTROL.

Purpose of the document: The document is intended to set out the Trust’s approach to the main aspects of Financial Planning.

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1. Introduction

The Trust is required by the NTDA (NHS Trust Development Authority and DH (Departmental of Health) to produce an Annual Budget & Plan covering one year in detail and a further 4 years in outline. It is recognised that this key activity requires a sound governing policy approved by the Finance & Investment Committee (FIC).

2. Scope

The document covers the high level budgeting and planning requirements relating to Income, Expenditure, Cost Improvement Plans, Operational Performance, Balance Sheet, Capital Expenditure, Staffing Levels, Risk and Cash Flow.

3. Objectives

The document is intended to set out the Trust's approach to the main aspects of Financial Planning.

4. Responsibilities

The responsibility for the accuracy and completeness of the budget for each directorate rests with budget holders. Finance will assist budget holders with the completion of the budget detail in the required format and will summarise budgets for reporting purposes. The preparation of all balance sheet and cash flow elements of the Plan will be undertaken by Finance. Completion of the Long Term Financial Model (LTFM) will undertaken by Finance. Financial commentaries on the budgeted results will be completed by Finance. Population of the NTDA returns and reporting to the Trust Board, EMT and FIC is the responsibility of Finance.

5. High Level Financial Planning Timetable

The Trust will have in place and maintain a high level Financial Planning timetable which will be reviewed and specified on an annual basis. In broad terms the timetable will conform to the key activities and tasks identified below and will require action from the Trust Board, EMT and FIC:

Key Item	Description	Deadline
Budget Setting Guidance	Operating framework and commissioning intentions received. High level Business Planning guidance issued to all key stakeholders	Expected Q3
High Level Business Planning	High Level Income & Expenditure, Capital and Cash Plans agreed with key stakeholders (e.g. Divisional Directors, Capital Working Group)	November / December
Initial Planning Sign Off and Submission	Board / EMT Review and approve high level plans that are submitted in draft to the NTDA	January

Detail Level Business Planning	Details of Income & Expenditure, Capital and Cash Plans discussed and agreed with key stakeholders (e.g. Divisional Directors, Capital Working Group).	January / February
Final Draft Detailed Planning Sign Off and Submission	Board / EMT Review and approve detailed plans for submission to the NTDA.	February
Finalise Detailed Budget Position	Final reviews to close any remaining budget gaps, mitigate risks and finalise CIP plans.	March
Final Draft Detailed Planning Sign Off and Submission	Board / EMT Review and approve final detailed plans for submission to the NTDA. All individual budgets are signed off by their respective leads.	March
Budget Upload	The Budget will be uploaded to the Ledger following the year end close down of the ledger in late April.	May

The dates indicated in this paper may be subject to change in light of emerging guidance from the NTDA, NHSE, Monitor and Commissioners. As specific timelines for action are published, these will be communicated to the Trust Board, EMT and FIC.

6. Key Policy Areas and Associated Procedures

The Trust will routinely address the following key areas of financial planning in an appropriate, integrated, robust and timely fashion. The Finance Director will maintain relevant procedures to achieve this.

The Trust is required to produce an Integrated Financial Plan each year. As a minimum this plan should provide a detailed plan of all aspects of financial performance for the following 5 years, and may be required to cover the following 10 years if so directed by the NTDA. For each year of the financial plan it must include, but not be limited to:

- An income plan including contract and non-contract income.
- An activity plan detailing the activity by type and source of referral. This should be consistent with both the income and expenditure plans.
- An expenditure plan.
- A workforce plan detailing staff numbers and type aligned with the expenditure plan

- A Cost Improvement Programme (CIP).
- A capital expenditure plan, including Capital Resource Limit (CRL)
- A Cashflow plan.
- A balance sheet.
- A clear articulation of any external financing requirements (EFL), whether through loans or additional Public Dividend Capital.
- A Continuity of Service Risk Rating (CSRR) assessment
- A clear articulation of financial risks

These financial plans should be supported by an integrated financial model which should ensure that the assumptions made across the range of financial statements are consistent. The model must have the ability to provide the monthly phasing of plans across the initial 2 years of the planning period.

- A clear statement of assumptions. These should take account of national guidance from the NTDA, Monitor and NHSE, all statutory and legal requirements, CCG commissioning intentions as well as any internal development requests.

The integrated financial plan should seek to deliver the stated financial aims of the Trust across the planning period defined. It must be recognised that the financial aims of the Trust will both determine and be determined by the clinical, operational and strategic aims of the organisation as a consequence of emerging development needs and pressures. As such it is likely that there will need to be several iterations of the financial plan to help test and identify acceptable and achievable outcomes. As an NHS Trust, London Ambulance Service is bound to seek to ensure that it meets its statutory duties; these are;

- To achieve the minimum breakeven requirements. Current NTDA guidance would indicate a Trust should seek to secure a minimum surplus of 1.0% of turnover.
- Meet its External Financing Limit (EFL)
- Meet the statutory return on investment of 3.5%.

The Trust should also plan to;

- Meet its Capital Resourcing Limit (CRL)
- Achieve targeted levels of performance against the Better Payment Practice Code (BPPC), as stated at the time.

Good practice would indicate that the Trust should work to ensure the financial plan is produced and agreed in advance of the start of the new financial year. As a minimum the Trust Board should work to ensure the financial plan is approved before the end of March each year, if not earlier. It is the responsibility of the Director of Finance to ensure that steps are taken to achieve this timetable.

A. Annual Financial Planning Guidance

Each year (October/November) the Trust will issue Financial Planning guidance to all key stakeholders including but not limited to:

- Directors
- Divisional Leads
- Budget Holders

The guidance will address the following and procedure notes will be provided as required:

- i. **Planning Timetable** - this will include key dates, actions and requirements for sign off
- ii. **Budget Holder Guidance** – this will be issued on an annual basis tailored for the particular budget requirements of the period and the needs of key stakeholders. It will cover the following issues:
 - Budget setting principles
 - Budget Holder Responsibility
 - The role of finance in Budget setting and monitoring
 - Expectations for managing a budget
 - Budget Meetings
 - Budget Templates

B. Income & Activity

As income is the means by which the LAS funds its resource, it is critical to have comprehensive plans in place to understand the financial envelope within which the Trust will be operating.

i. Contract Income

The main source of Trust income derives from the contract with the Clinical Care Groups (CCGs) in London. Contract negotiations are led by the Contracts Team and Finance will support and attend relevant meetings with commissioners to establish a viable and reasonable financial settlement for the Trust. A copy of the detailed financial settlement and heads of agreement will be used to inform the income budget and stored for reference.

It is critical for the income to align with the Trust's activity planning assumptions as these will inform resource requirements. Activity plans will be produced by the Contracts department supported by Operations, Performance and Management Information. Where contract income cannot be accurately identified, the Trust will take a prudent approach to estimating the income and provide details on any risks.

Within the main contract a number of other factors will need to be considered and factored into the business plan (as a minimum as a risk factor):

- a) **Tariff Deflators** – these are changes in individual prices paid expressed as a % reduction in overall income for the LAS (who do not currently

operate PbR). The Tariff deflator will be set out in the national business planning guidance.

- b) **Penalties & Risks** – the contract will contain a number of penalty clauses based on operational performance. If the Trust fails to meet the required performance standards, the CCGs may levy material financial penalties against the value of the contract. The Trust will also be set Quality related targets called CQUINs that have financial incentives associated with them. It is important to note that the Trust cannot plan to incur penalties and must always plan to achieve performance. However, the risk of penalties must always be stated.
- c) **CQUINs** - The Trust will be set quality related targets called CQUINs that have financial incentives associated with them. These will be negotiated and agreed in advance of contract sign off.
- d) **Other Elements** – there are a number of additional income items within the main contract that need to be assessed. These include but are not limited to: HART (Hazardous Area Response Team), Merit (Employment of Doctors), EBS (Emergency Bed Service). Commissioners may also factor in additional elements to the contract as formal variations (e.g. Research Programmes and Service Developments). The Director of Finance will maintain a full list of all additional items for consideration and inclusion.

ii. Other Income

- a) **Commercial Income** – Other contractual income that is separate from the main contract. This would include but not be limited to Patient Transport Services (PTS), The Heathrow Contract and Stadia. The Trust needs to ensure that all income identified in the plan is real and achievable; where commercial contract income cannot be accurately identified, the Trust will take a prudent approach to estimating the income and provide details on any risks.
- b) **Non Contract Income** – The Trust also earns miscellaneous income which will need to be estimated in a meaningful way to be included in the position. The types of income would include but not be limited to: Road Traffic Accident (RTA) Income, Non elective BETS etc. Methods used to project income will include previous period's activity, activity plans, known price changes, expert advice etc. The Trust needs to ensure that all income identified in the plan is real and achievable; where non contract income cannot be accurately identified, the Trust will take a prudent approach to estimating the income and provide details on any risks.

C. Expenditure

The expenditure budget will cover all aspects of operating expenditure expected to be incurred by the Trust.

i. General Principles

There will be a number of budget factors that need to be considered for all areas of expenditure (and indeed income):

- a) **Base Budget assumptions** – will the budget be rolled forward or zero based?
- b) **Recurrent / Non Recurrent Split** – what is the true underlying position of the Trust?
- c) **Service Developments and Cost Pressures** – What new elements will be considered in the business plan? Items where there is a contractual, statutory or clinical requirement (e.g. national NHS requirements) will be included as cost pressures. Any other new items will be collated as service developments and the Board will prioritise these based on Trust strategic objectives
- d) **Phasing (incl. Workforce Planning)** – will the budgets be evenly phased, based on activity, based on workforce plan etc.?
- e) **High Level vs Detailed Budgeting** – initial business planning will be conducted at a high level and consider overarching principles to establish a financial envelope at divisional level for pay, non-pay and financial charges. Following this initial stage, the budget will be developed with individual budget holders at detailed transactional level to ensure the financial envelope is realistic. Any gap between the higher level and detailed level plans will have to be assessed and managed down.

ii. Pay

- a) **Frontline Staffing (Rota based)** – frontline staffing will be informed by the workforce plan and the operational rota patterns within the trust
- b) **Non Frontline Staffing (Structure Based)** – the budgets for all other staff will be based around existing budgets and agreed divisional staffing structures presented in the initial budget setting round.
- c) **Incremental Progression and Pay Inflation** – these elements will be factored in based on national guidance and the NHS operating framework
- d) **Vacancies / Establishment (incl. Workforce Planning)** - Overall establishment will be a function of resourcing requirement to meet performance and financial limits. Vacancies will be costed using an agreed methodology defined in the annual budget setting guidance.

iii. Non Pay

- a) **Contractual** – The Trust has a number of external contracts (Notably in Fleet & Logistics, IM&T and Estates). Finance will work with the Trust lead on these contracts to ensure any changes in terms, price and volume are captured and integrated into the plan.
- b) **Inflation** – General inflation will be assessed and held as a general reserve, only inflation that can be evidenced on an individual basis (e.g. as part of a contractual obligation) will be allocated to specific budgets
- c) **Expenditure trends** – the spending patterns for non-pay (e.g. seasonality) will be considered by finance and included in the business planning process.

iv. Capital Charges

- a) **Depreciation** – this will be based on the Trust's projected capital asset base (including the Capital plan) throughout the planning period
- b) **Interest** – based on current borrowing arrangements and interest yielding deposits
- c) **PDC Dividend** – this represents 3.5% of average relevant net assets

D. Workforce Planning

As far as possible the guidance will include the methodology for deriving a detailed workforce plan which would be informed by Operations, Training and Recruitment. This area would primarily focus on operational staff. The intention would be that the operational workforce plan and the financial plan for pay must be precisely aligned in terms of cost, staff numbers (wte), skill mix and phasing.

E. Capital Planning

Capital expenditure is defined generally as expenditure on an asset held for use in delivering services or for administrative purposes where it is probable that future economic benefits or service potential will flow to the Trust; the asset must have a purchase value in excess of £5k and a useful life of greater than 1 year. The main areas of spend within the LAS are Fleet (vehicles and equipment), Estates, IM&T and Other Medical Equipment.

i. Capital Resourcing Limit (CRL)

- a) The CRL controls the amount of capital expenditure a Trust may incur in a year and covers all capital expenditure. A Trust must not incur expenditure in excess of this limit.
- b) Each NHS Trust will be allocated an initial CRL based on planned capital expenditure. This will change during the year if additional capital resources are allocated. Additionally NHS Trusts credit the carrying value

of asset disposals to CRL which allows them to use the proceeds of such disposals to incur capital expenditure.

- c) CRL can be allocated to NHS Trusts in two ways. As part of initial limits where a Trust's initial CRL is based on agreed plans. This will include all expenditure financed from internally generated sources excluding disposals, capital grants and donations. CRL can also be allocated in-year for additional expenditure as agreed with the NTDA e.g. via loans or PDC or through the allocation of central programme budgets.
- d) NHS Trusts must not overspend against CRL. This is a regulatory and departmental duty. In addition significant under spending would be considered as an indicator of poor financial planning. Therefore accurate capital planning is essential.

ii. Capital Working Group

Capital Planning will be led by the Capital Working Group which will be formed of a subset of key senior stakeholders including but not limited to:

- A Senior Finance Manager (e.g. Deputy DoF) – Chair
 - Head of Estates
 - Head of IM&T
 - Head of Fleet
 - Head of Logistics
 - Senior Operational/Clinical Representatives
- a) Initially the Capital Working Group will collate a long list of potential Capital programmes establishing a minimum dataset of financial and operational information to allow each programme to be assessed and prioritised.
 - b) Long term Capital programmes will need to be considered by the Capital Working Group.
 - c) Finance will calculate the likely Capital funding based on established Capital Planning guidance.
 - d) The Trust Board will agree which Capital Programmes will proceed to the value identified in the initial financial plan.
 - e) Once prioritised, all relevant programmes will be developed into formal proposals to be assessed by EMT/the Board (via a Gating Template or Business Case)
 - f) Following planning sign off, the Capital Working Group is tasked with monitoring the delivery of the capital plan ensuring all key milestones are achieved and plans deliver within budget.

F. Cash and Balance Sheet Planning

i. Cash Planning

- a) The Trust must make a detailed assessment of its key operational and investment receipts and payments (inflows and outflows). The key categories to be considered would be:
 - i. Operating income and expenditure
 - ii. Increase/decrease in current assets
 - iii. Increase/decrease in current liabilities
 - iv. Increase/decrease in provisions
 - v. Capital expenditure
 - vi. Dividend payments
 - vii. Financing obtained (PDC and Loans taken)
 - viii. Financing paid (PDC and Loans repaid)
- b) The planning must align with the detailed income, capital and expenditure plans
- c) Accurate planning will ensure that the Trust can meet its key liquidity requirements e.g. the Continuity of Service Risk Rating (CSRR) and meet its obligation to creditors when they fall due.

ii. External Financing Limit (EFL)

- a) EFL is a control on net cash flows of NHS Trusts. It sets a limit on the level of cash that a NHS Trust may either:
 - 1. draw from either external sources or its own cash reserves – positive EFL;
 - 2. Repay to external sources or increase cash reserves - negative EFL.
- b) External Financing Requirement (EFR)
 - 1. In essence, the External Financing Requirement (EFR) is the difference between the cash a NHS Trust plans to spend in a year and what it can generate through its operations. EFR can be positive or negative. A positive EFR indicates a net requirement for cash and a negative EFR indicates that a NHS Trust plans to spend less cash overall than it will generate.
- c) EFL performance
 - 1. EFL performance is measured by comparing EFL against EFR for the full year.
 - 2. If the EFR exceeds the EFL, this is an EFL overshoot. NHS Trusts must not overshoot their EFL. This is a regulatory and departmental duty.
 - 3. Undershooting the EFL (i.e. the EFR is lower than the EFL) should be avoided but is considered less serious, however significant

undershoots may be considered as an indication of weak financial planning.

- d) EFL at plan
 - 1. At plan stage, the EFL is set to equal the EFR.
 - 2. EFL may be positive or negative. A negative EFL does not indicate that a NHS Trust must make a PDC repayment; rather it indicates that the NHS Trust is generating a net inflow of cash from operating/investing activities.
 - 3. Equally a positive EFL does not indicate that a NHS Trust is eligible for PDC; simply that it has a net cash requirement which may be met through its own reserves, loans or PDC.
- e) Initial limits
 - 1. Initial EFL is based on the EFR from the agreed plan, but excluding spend on capital which requires external financing in the form of capital investment loans or PDC. EFL is allocated alongside CRL when these elements of financing are agreed.

iii. Balance Sheet Considerations

- a) The Trust will be required to plan the expected movements in assets and liabilities (current and non-current). As a minimum this should cover:

1. Non-Current Assets

- i. Property, Plant & Equipment
- ii. Intangible Assets (e.g. software systems)

2. Current Assets

- i. Trade & Other Receivables
- ii. Cash & Cash equivalents
- iii. Inventories
- iv. Assets held for sale

3. Current Liabilities

- i. Trade & Other Payables
- ii. Provisions
- iii. Short Term Borrowings

4. Non-Current Liabilities

- i. Provisions
- ii. Long Term Borrowings

iv. Disposals

- a) It is essential that the Trust includes any planned asset disposals (e.g. sale of property) into its plan as this is likely to have an impact in terms of cash, I&E and Capital plans.

v. Borrowings

- a) If the Trust plans to borrow capital, it is probable that there will be a material impact in terms of cash, I&E and Capital plans.
- b) Borrowing would be included in the plan for two principle reasons:
 1. Investment in Capital
 2. Supporting the liquidity of the business
- c) If borrowing is included in the financial plan, it will need to include a number of aspects as regards any loans:
 1. Total value of the loan
 2. Repayment period
 3. Interest rate
 4. Explanation on how the debt will be serviced (is it affordable?)
 5. Reason for loan

G. Cost Improvement Programmes (CIPs)

NHS Trusts are required to plan for CIPs for 2 reasons:

- Nationally required efficiencies issued as part of the annual NHS operating framework to support NHS efficiencies.
- Local investment and development requirements

The Cost Improvement Programme will be scoped based on the national operating framework that is received during quarter 3 and any local requirements. Finance will then calculate an initial indicative figure to be used to guide the level of savings required. Financial values will be monitored to ensure they remain adequate; any changes will be reported back to the relevant stakeholders. CIPs will be developed between Divisional Leads, Finance and the CIP Programme Manager initially at a high level developing into a signed off CIP plan including project owners, detailed financial delivery plans and key milestones. CIPs will be monitored in year by the CIP Programme Board which is attended by the Chief Executive and Director of Finance

H. Long Term Financial Planning

- i. Finance will maintain a Long Term Financial Model (LTFM) covering 5 year projections in line with its existing 1 year planning process and Monitor/NTDA requirements
- ii. It is critical that the LTFM aligns with the Integrated Business Plan (IBP) which is owned by the Director of Strategy

I. Periodic Monitoring

i. Reporting against the Financial Plan

- a) The Trust will produce reports for relevant stakeholders (e.g. Trust Board, FIC, NTDA, and Budget Holders) to agreed timescales highlighting key issues and variances from the Financial Plan and identifying corrective action.
- b) Finance will ensure (under the guidance of FIC) that Financial Reports remain fit for purpose and are regularly reviewed.

ii. Monitoring the Financial Plan

- a) Performance against the financial plan will be reported to a number of forums including:
 - 1. The Trust Board
 - 2. EMT
 - 3. SMT
 - 4. FIC
 - 5. NTDA
- b) Finance will conduct monthly financial reviews with key budget holders to ensure plans are delivered and, where variances occur, to support and challenge appropriately to ensure the position can be recovered.

iii. Forecasting

- a) In addition to year to date monitoring the Trust will produce a detailed financial forecast informed by all divisional leads to ensure that the full year financial plan is on track or, where there are variations, appropriate actions are identified.
- b) Full detailed forecasts will be produced formally on a quarterly basis.

IMPLEMENTATION PLAN				
Intended Audience	The document applies to Finance staff and designated Budget Holders.			
Dissemination	The document will be made available on The Pulse and the LAS Website.			
Communications	Staff will be informed via the RIB.			
Training	Training is not required. Guidance will always be given to new Budget Holders.			
Monitoring:				
Aspect to be monitored	Frequency of monitoring AND Tool used	Individual/ team responsible for carrying out monitoring AND Committee/ group where results are reported	Committee/ group responsible for monitoring outcomes/ recommendations	How learning will take place
Income, Expenditure, Cost Improvement Plans, Operational Performance, Balance Sheet, Capital Expenditure, Staffing Levels, Cash Flow.	The Budget & Plan will be prepared annually and compared monthly against the actual financial results of the Trust.	The Annual Budget & Plan and all iterations thereof will be presented by the Director of Finance and the Director of Transformation and Strategy to the Executive Management Team, Finance & Investment Committee and Trust Board.	Executive Management Team, Finance & Investment Committee and Trust Board.	Budget Holder meetings with Finance.