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133-155 Waterloo Road
London SE1 8UG

T: 020 3747 0000
E: nhsi.enquiries@nhs.net
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6 July 2016

[redacted]

By email
[redacted]

Dear [redacted]

Request under the Freedom of Information Act 2000 (the "FOI Act")

I refer to your email of 8 June 2016 in which you requested information under the FOI Act from NHS Improvement. Since 1 April 2016, Monitor and the NHS Trust Development Authority ("NHS TDA") are operating as an integrated organisation known as NHS Improvement. For the purposes of this decision, NHS Improvement means Monitor and NHS TDA.

Your request

You made the following request:

My requests relate to the 'Other measures' referred to on page 17 of the 2015-16 Quarter 4 performance report for NHSi:

1. *Regarding the £546m of 'prior improvement', please list separately all the measures that were taken - including the trust involved, the value of the improvement, and full details of what it relates to and how it was achieved. If you are not able to identify the trusts, please remove the trust names and provide the value and details of each measure taken. For example: Trust A, £5m, details of what the improvement was related to.*

2. *Regarding the £349m of improvements between M9 and M12, please list separately all the measures that were taken - including the trust involved, the value of the improvement, and full details of what it relates to and how it was achieved. If you are not able to identify the trusts, please remove the trust names and provide the value and details of each measure taken. For example: Trust A, £5m, details of what the improvement was related to.*

3. *Please identify the cases where measures were taken subsequent to NHSi receiving trusts' outturn surplus/deficit figure for 2015-16.*

4. *The communications team told me that a letter was sent to trusts about the 'other measures' in January. Please can you provide a copy of the letter they are referring to.*

Decision

NHS Improvement holds some of the information that you have requested.

Questions 1 and 2

In relation to points 1 and 2 of your request, we hold the information relating to the measures taken and the value of the improvement, but do not hold the information requested regarding 'full details of what it relates to and how it was achieved'.

NHS Improvement has decided to withhold the information we hold in relation to these points on the basis of the applicability of the exemption in section 33 of the FOI Act.

Section 33 – public audit functions

Sections 33(1)(b) and 33(2) of the FOI Act provide that information may be exempt from disclosure where disclosure would, or would be likely to, prejudice the exercise of any public authority's functions in relation to the examination, efficiency and effectiveness with which other public authorities use their resources in discharging their functions.

NHS Improvement has functions in relation to the examination of the economy, efficiency and effectiveness with which NHS foundation trusts and NHS trusts use their resources, which we consider would be likely to be prejudiced by the release of the information requested.

The regulation of trusts and NHS Improvement's ability to discharge its functions in examining the economy, efficiency and effectiveness of the trusts it regulates would be prejudiced if sensitive and confidential information were to be disclosed. We consider the information requested in points 1 and 2 to be sensitive and confidential. The relationship between trusts and NHS Improvement, on which the effective performance of our functions depends, would be undermined if providers considered such information would be disclosed, even if the information was disclosed in an anonymised form. Disclosure may result in trusts being less forthcoming in response to requests for information in future. We rely on the full and frank disclosure of information from trusts in order to carry out our functions effectively.

Public interest test

We consider that there is a public interest in relation to transparency of the finances of public authorities and actions taken by trusts as a result of recommendations made by NHS Improvement. However, providers do not expect that such sensitive and confidential information will be placed in the public domain and if they were to consider that the information they provide could be disclosed, they may be less likely to provide this to us or in the detail that we currently receive.

NHS Improvement therefore considers that the public interest in maintaining the exemption outweighs the public interest in disclosure.

NHS Improvement is however able to release a breakdown of the figures requested at a total level:

NHS Improvement - COMBINED Trust & FT Data	Improvement in 15/16 prior to letter and included in the 15/16 outturns (£m)	1516 Financial Improvement Reporting - additional improvement in months 9 to 12 and included in 15/16 outturn (£m)
Reviewing in-year priorities Reviewing other priority areas as set out in guidance. (extra revenue / reduced expenditure = positive number)	218.126	146.793
Balance sheet prudence review Improvement in bottom line in 2015/16. (extra revenue / reduced expenditure = positive number)	217.037	88.355
Bad debt provisions - reviewing basis Improvement in bottom line in 2015/16. (extra revenue / reduced expenditure = positive number)	25.648	8.829
VAT contracted out Reduction in expenditure in 2015/16. (reduced expenditure = positive number)	24.438	5.584
Annual leave carry forwards Reduction in year end accrual / release of prior year accrual (reduced expenditure / accrual release = positive number)	5.769	7.991
Asset valuations PDC dividend saving as a result of moving to alternative site valuation in 2015/16 (reduced expenditure = positive number)	11.802	18.085
Asset valuations Reduced depreciation charge as a result of moving to alternative site valuation in 2015/16 (reduced expenditure = positive number)	10.908	41.612
Asset lives review Reduced depreciation charge as a result of reviewing asset lives (reduced expenditure = positive number)	32.063	32.026
Total Other Measures	545.791	349.275

Question 3

In relation to point 3 of your request the trusts have all taken individual action as part of their accounts process before the outturn figures were submitted to NHS Improvement. No actions have been requested subsequently.

Question 4

NHS Improvement holds this information. The letters sent to the trusts in January 2016 are enclosed with this letter.

Review rights

If you consider that your request for information has not been properly handled or if you are otherwise dissatisfied with the outcome of your request, you can try to resolve this informally with the person who dealt with your request. If you remain dissatisfied, you may seek an internal review within NHS Improvement of the issue or the decision. A senior member of NHS Improvement's staff, who has not previously been involved with your request, will undertake that review.

If you are dissatisfied with the outcome of any internal review, you may complain to the Information Commissioner for a decision on whether your request for information has been dealt with in accordance with the FOI Act.

A request for an internal review should be submitted in writing to FOI Request Reviews, NHS Improvement, Wellington House, 133-155 Waterloo Road, London SE1 8UG or by email to nhsi.foi@nhs.net.

Publication

Please note that this letter and the attached information will shortly be published on our website. This is because information disclosed in accordance with the FOI Act is disclosed to the public at large. We will, of course, remove your personal information (e.g. your name and contact details) from the version of the letter published on our website to protect your personal information from general disclosure.

Yours sincerely,

Steve Hubbard
Head of Financial Reporting

Monitor
Making the health sector work for patients

tda Trust Development Authority
Quality. Delivery. Sustainability.

NHS Improvement
(Monitor and the NHS Trust Development Authority)

Chief Executive
NHS Trust / Foundation Trust
and
Director of Finance <insert> NHS Trusts / Foundation Trust

Wellington House
133-155 Waterloo Road
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SE1 8UG

020 3747 0000

15 January 2016

2015/16 Outturn and 2016/17 Plan including Sustainability and Transformation Fund

As announced in the recent Spending Review, the government has committed to provide an additional £8.4 billion real-terms funding for the NHS by 2020/21. The increase in funding available for 2016/17 totals £3.8 billion in real terms, a £5.4 billion cash increase. It includes a £1.8 billion Sustainability and Transformation Fund (S&T Fund) for the provider sector in 2016/17 which will comprise a 'general' and a 'targeted' element. The general element of the fund will be targeted at providers of acute emergency care.

This is a good settlement for the NHS in times of public spending constraint when the majority of government departments are facing real-terms funding reductions. However, this settlement is dependent on the NHS provider sector delivering a deficit of not more than £1.8 billion in 2015/16 and breaking even in 2016/17 after application of the fund. To realise this settlement, this letter sets out what your board must urgently do during the remainder of the 2015/16 financial year.

2016/17 Financial framework and planning

On 22 December 2015 we published *Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21.* This sets out the steps to help local organisations deliver a sustainable, transformed health service and improve quality of care, wellbeing and NHS finances. The planning guidance includes details of the operational planning approach for the next financial year and sets out a pragmatic approach to tariff setting and business rules, with the aim of supporting system stability and recovery in 2016/17. The key details of this package, which is favourable for most NHS providers, are set out in Appendix 1.

In addition, the planning guidance introduces the £1.8 billion S&T Fund for 2016/17. The fund is to support providers move to a sustainable financial footing. It will be primarily

allocated to providers of acute emergency care that have been under the greatest financial pressure, although it will include an element to support providers achieve overall sustainability by driving maximum efficiencies. The fund will be deployed in a way that creates a balanced aggregate financial position in the NHS trust and NHS foundation trust sector in 2016/17. Payments will be made by commissioners, but approved by NHS Improvement. The fund replaces the need for the current scale of direct Department of Health (DH) cash funding for providers. Details of the fund and of eligibility to access it are attached in Appendix 2.

This additional funding is conditional on the NHS provider sector breaking even in 2016/17. To ensure this happens, every NHS trust and NHS foundation trust will have to deliver an agreed financial control total for 2016/17. This will be a core part of the new financial oversight regime that NHS Improvement will put in place.

An impact assessment model has been developed by NHS Improvement that models a range of known factors at an individual provider level. The outcome of this work will be used to allocate acute emergency care providers with an indicative payment from the S&T Fund and all providers with a control total for 2016/17. The key assumptions and the detail for your trust are attached in Appendix 3.

Please confirm by **8 February 2016** that you accept the control total. It is then our expectation that the operational plans you submit in February and April will be consistent with, or better than, the control total outlined.

The NHS settlement for 2016/17 relies on tight financial management of the capital budget. We will need to work very closely with providers to develop a capital framework which enables them to operate within the resource available. Providers should develop their capital plans for 8 February 2016, distinguishing essential expenditure from strategic investments. This should prepare providers for restrictions to both access to external finance and deployment of existing cash reserves to ensure the NHS does not exceed its capital budget. Providers that have agreed local capital to revenue transfers for 2015/16 will not be disadvantaged by these agreements in 2016/17.

2015/16 Outturn

As you will be aware, the scale of what we need to do in the future depends on how well we end this financial year. Collective urgent action is required now to ensure we contain the aggregate provider deficit position to within a £1.8 billion control total in 2015/16.

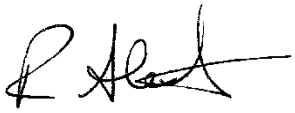
To limit the scale of the financial distress that will be carried forward into 2016/17, we would like your continued commitment to take the actions necessary to improve your current year financial position, while ensuring that safe care is delivered. We also ask you to review your plan for the remainder of 2015/16, focusing particularly on the areas listed in Appendix 4, with the aim of improving your financial position in quarter 4 (Q4;

January to March) 2015/16. These areas include both operational efficiencies and technical or one-off measures that we will need to deploy to deliver the £1.8 billion control total.

In addition, we will be meeting a number of challenged providers this month to agree a set of actions, including headcount reduction, additional to the current plan, with the clear intention of improving the financial position of those individual providers.

We cannot over emphasise that the 2016/17 Spending Review settlement that we have outlined above depends on every NHS organisation delivering the best possible financial outturn for 2015/16.

Many thanks for your continued support.



Bob Alexander
Deputy Chief Executive
NHS TDA

Stephen Hay
Deputy Chief Executive
Monitor

Copy to:

Jim Mackey, Chief Executive, NHS Improvement
Elizabeth O'Mahony, Director of Finance, NHS TDA
Jason Dorsett, Director of Finance, Reporting and Risk, Monitor

Key details of the 2016/17 financial framework for providers

We recognise that the planning documents include a large amount of technical information. Given this, we would like to draw your attention to the key details of the favourable financial framework we have secured for 2016/17 with the aim of delivering maximum stability and financial recovery.

Proposals in relation to the national tariff (soon to be subject to consultation):

- A delay in the introduction of HRG4+ to provide a year of pricing stability combined with no changes to specialised top-ups.
- A cost uplift of 3.1%, reflecting a stepped change in the cost of employers' pension contributions.
- Additional funding to cover the aggregate increased cost of CNST contributions. In addition to the general cost uplift, the majority of the increase in CNST contributions will be targeted at particular HRG chapters.
- An efficiency factor of 2%, which results in a net prices uplift of 1.1%.
- An increase in the marginal rate for emergency admissions to 70% for all providers.
- No application of a specialised services marginal rate in 2016/17. A consultation on the marginal rate will form part of the engagement on the implementation of HRG4+ in 2017/18. We will also move to centralised procurement of devices with set national reference prices.

Other system management changes:

- Commissioners are required to plan to spend 1% of their allocations non-recurrently, consistent with previous years. For provider funds to insulate the health economy from financial risks, the 1% non-recurrent expenditure should be uncommitted at the start of the year.
- The introduction of a commissioner sparsity adjustment for remote areas. The financial impact of this is added to the target allocation of the relevant CCGs. This results in an adjustment for six CCGs in relation to eight hospital sites. The adjustments to target allocations total £31 million.
- The requirement for commissioners and councils to agree a joint plan to deliver the requirements of the Better Care Fund (BTF) in 2016/17. Further, BCF funding should explicitly support reductions in unplanned admissions and hospital delayed transfers of care.

Sustainability and transformation funding

1. The Spending Review settlement confirms a recurrent £5.4 billion cash increase to the NHS England Mandate in 2016/17. This will be deployed as follows:

    - £3.6 billion to flow recurrently into commissioning allocations and related budgets

    - £1.8 billion to be passed through commissioners to fund a Sustainability and Transformation Fund (S&T Fund) which will be provisionally allocated to individual providers this month with the intention of eliminating the NHS provider deficit position in 2016/17 (linked in part to emergency services).

2. The S&T Fund for 2016/17 replaces the need for the current scale of direct Department of Health (DH) cash funding. The fund will be used to support providers move to a sustainable financial footing and will be deployed in a way that creates a balanced aggregate financial position in the NHS trust and foundation trust sector in 2016/17. As such, the 2016/17 S&T Fund will have two elements:

    - a ‘general element’ which will be distributed to all providers of acute emergency care and be linked to the setting of agreed control totals

    - a ‘targeted element’ to support trusts drive efficiencies and go further faster; this will be targeted at leveraging greater than 1:1 benefits from providers.

3. Details on how to access the targeted element of the fund will be made available later in the planning process. This will be particularly relevant for mental health ambulance, and community services providers who are unlikely to be eligible for the general element of the fund.

The remainder of this appendix will consider the general element of the fund.

General element of the S&T Fund

4. To be eligible to access the general element of the fund, providers must provide acute emergency services and formally meet all the conditions in Table 1 below:

Table 1: S&T Fund conditions and measurement

Objective	**Conditions/measurement**
Deliver agreed control total Provider deficit reduction/ surplus increase	Q1: Agreement of milestone-based recovery plan (OR surplus increase) with NHS Improvement AND agreed **control total for 2016/17**. Agreement to capital control total. Plans to include milestones for Carter implementation (including reporting and sharing data in line with the national timetable) and compliance with the NHS Improvement agency controls guidance. Q2 to Q4: Delivery of plan milestones AND **capital and revenue control totals.**
Access standards	Q1: Agreeing with NHS England and NHS Improvement a credible plan for maintaining agreed performance trajectories for delivery of core standards for patients, including the four-hour A&E standard, the 18-week referral to treatment standard and, for appropriate providers, the ambulance access standards. Q2 to Q4: Delivery of agreed performance trajectories.
Transformation	Q1 to Q3: Local Sustainability and Transformation Plans (STPs) – to work with commissioners and develop an integrated five-year plan in line with the national STP timetable. Q4: STP agreed with NHS England and NHS Improvement. Providers will also have the option to volunteer to join an accelerated 2016/17 transformation cohort.

5. As a condition of the overall fund being approved, the NHS has to demonstrate tangible progress towards a credible plan for achieving seven-day services for patients across the country by 2020. Recipients of funding will be expected to continue to make progress towards achieving seven-day services in 2016/17.

6. S&T funding will be made available to providers as income, which will be paid by a lead commissioner and replace the need for the current scale of DH cash support. The S&T Fund allocated to CCG(s) will be ring-fenced as pass-through payments to the relevant provider in addition to normal contractual payments.

7. This funding will be provisionally allocated at the start of the planning process to ensure providers have the maximum amount of time to prepare a credible plan in sufficient detail to meet their control total and achieve the maximum amount of financial benefit in year.

8. Release of funding will be subject to a quarterly review process in arrears. This review process will cover delivery against the S&T Fund only. Arrangements are being agreed for providers who require working capital prior to the release of funds, but are likely to involve interest-bearing working capital facilities provided by DH. Plans should be prepared on this basis until further guidance is provided.

9. Access to funding will be through a formal agreement between NHS Improvement and trust boards in advance of any funds being paid. This agreement will be embedded in a high quality board-approved plan that is fully compliant with the criteria outlined above.

10. In addition, those providers eligible for S&T funding that meet the conditions of the fund will not face a ‘double jeopardy’ scenario whereby they incur contract penalties as well as losing access to funding; a single penalty will be imposed.

11. Providers that are in deficit and that require cash support after receipt of the funding and after local efficiencies will have access to DH interim support loans, as at present via interest bearing loans.

Individual provider detail
2016/17 Sustainability and Transformation Fund

The 2016/17 financial plan for each provider will be contingent upon its 2015/16 year-end financial position. For the purpose of the provider impact assessment, the Month 6, 2015/16 forecast has been used as the baseline adjusted for the assumed effect of agency controls and other recurrent measures in Q4 2015/16. Any further deterioration in this position will require the relevant provider to deliver higher efficiency levels to achieve the 2016/17 control total.

We have also taken into account other national funding flows in setting the control total such as the impact of changes to the tariff, education and training, CQUIN, CNST, etc.

Both the setting of the baselines and the control totals, and the measurement of performance versus control totals, will exclude gains on disposals of assets.

The general element of the fund will be distributed to providers in proportion to the cost of emergency services as reported in the 2014/15 reference costs ('Emergency Services' definition from the 2014/15 Reference Costs).

S&T funding and 2016/17 control total	
General element – S&T Fund Subject to provider eligibility and conditions	
Targeted element – S&T Fund Subject to provider eligibility and conditions	To be confirmed
2016/17 Control total	

This exercise has been undertaken to set control totals for 2016/17 and considers a range of incremental common factors only. Rather than debate the method by which the numbers above have been calculated, provider boards should now consider if, with the proposed tariff/business rule changes and access to the S&T Fund, their control total is achievable in 2016/17.

Details on how to access the targeted element of the fund will follow.

Financial improvement in Q4 2015/16

All providers are requested to consider the following opportunities and to report on them in their Month 9 outturn estimates submitted to either Monitor or the NHS TDA. A simple memorandum schedule detailing how much has been attributed to each of the items below should be submitted.

Description	**Detail**
Local capital to revenue transfers	Delivery of maximum amount of safe deferral or reduction in capital expenditure to be supported by capital-to-revenue transfers as agreed with either the NHS TDA or Monitor and the Department of Health.
Accurate monthly capital forecasting	To assist with the national capital position, ensure accurate capital forecasting including identification of any underspend.
Accurate provision reporting	To assist with the national position, ensure provisions are carefully reviewed at Month 9 and, where possible, accurately estimated for the full year.
Workforce	No non-medical agency cover for short-term sickness (<3 days), implementing acting down/cross-cover arrangements to ensure patient safety.
Agency staffing	Full compliance with the policy, including completing the weekly reporting. Review self-certification in weekly reports to identify opportunities for improvement. Focus on reducing number of shifts above rate caps and remaining within nursing agency ceiling.
Reviewing in-year priorities	Reviewing priorities in all areas: revenue maximisation, cost control, efficiency and investments
Balance sheet review: prudence	Remove prudence from estimates of: • accrual; • deferred income; • injury cost recovery (formerly RTA) debtor • partially completed spells

Description	Detail
Bad debt provisions	Remove prudence in bad debt provisions, including ensuring impairments to receivables are line with IFRS and are based on incurred losses and not general estimates or future expected loss events.
VAT changes	Review latest COS guidance to ensure maximum reclaim of VAT including latest position on IT spend.
Annual leave	To the maximum extent allowed under NHS contracts, manage the carry forward of annual leave. Ensure that this does not lead to the use of additional agency staff to cover leave periods. Ensure data used for calculations from HR systems are robust.
Asset valuations	Revalue operational assets at the modern equivalent asset value using the alternative site method where advantageous.
Asset lives review	Review all equipment and buildings asset lives given that less capital will be available for replacement in future. The resulting adjustment will reduce depreciation charges while creating a one-off impairment. Providers will be held to account by NHS Improvement for their financial performance before accounting for impairments.

Financial improvement in 2015/16 quarter 4: further guidance

Bob Alexander, Deputy Chief Executive of NHS TDA and Stephen Hay, Deputy Chief Executive of Monitor wrote to all NHS trusts and NHS foundation trusts on 15 January providing information on planning for 2016/17 and listing priorities for the remaining months of 2015/16.

As set out in that letter, collective action is required to constrain the aggregate provider deficit position for 2015/16. Appendix 4 of the letter lists areas for review. This document provides additional guidance to accompany some of the items listed in appendix 4 and sets out next steps in this area.

1) Local capital to revenue transfers: NHS foundation trusts

The arrangements for local capital to revenue transactions for the foundation trusts involved were confirmed on 20 January 2016. Please reflect these transactions in year end forecasts from month 9 onwards. If you can offer more capital slippage than previously reported or discussed please include this in the Q3 collection template (details below) and contact your relationship team as soon as possible.

2) Accurate monthly capital forecasting

The Department of Health is set a capital expenditure limit for the year and needs accurate information to know if it is likely to underspend against this before the year end so that it can manage its different budgets set by HM Treasury. It is therefore very important that NHS providers forecast their capital expenditure accurately, including any underspend. Recent experience has revealed many examples of NHS providers underspending against their capital plan but this is sometimes only uncovered late in the financial year.

To assist with the management of national capital position, we rely on all NHS providers trusts to provide accurate and realistic capital forecasts on a monthly basis to reflect to their capital spending commitments.

3) Accurate provision reporting

Provisions are accounted for differently under central government budgeting rules. Provisions created are not charged against the department’s revenue expenditure limit (RDEL) but instead provisions utilised are charged against the budget. Understanding movements in provisions is an important part of the Department being able to assess where it will be against its RDEL. While there are limits to how far it is possible to forecast year end positions at month 9, trusts are asked to forecast year end provisions as at month 9 in their monitoring returns. Please ensure that your month 9 reporting is accurate for provisions at that point as a minimum and the year end position is estimated as accurately as possible.

4) Workforce

NHS providers are encouraged to avoid using agency cover for short term sickness (less than 3 days) in non-medical areas, and to implement acting down or cross cover arrangements as necessary. Any arrangements must always ensure patient safety.

5) Agency staffing

NHS providers should ensure full compliance with the policy[1] in this area. Providers should review their weekly reporting and ensure that:

- reporting is completed
- internal processes are robust, as included in the weekly self-certification
- avoid / minimise overrides of price caps
- avoid / minimise procurement via a non-approved framework or off-framework
- avoid / minimise variance from the nurse agency expenditure ceilings.

6) Reviewing in-year priorities

Many NHS providers have agreed financial priorities with NHS TDA or Monitor. These may include revenue maximisation, cost control, or other areas of efficiency. Finance teams are asked to re-review these in-year priorities (including where not previously discussed with NHS TDA or Monitor) to ensure that all available opportunities have been taken.

7) Balance sheet review: prudence

Analysis of the balance sheets of NHS trusts and NHS foundation trusts reveals wide variation in relative levels of balance sheet items much of which may be caused by differing assumptions or degrees of prudence. In supporting the 2015/16 financial position, providers should remove prudence in estimates of key areas. For example:

- Accruals: are there unnecessary accruals that roll forward between years or unnecessary prudence in estimates?
- Is there deferred income on the balance sheet that could/should be released? Remember that grants relating to capital assets must be recognised in income when there are no outstanding conditions that have not been met.
- Receivable for Injury Cost Recovery (formerly RTA) scheme income – is there any excess prudence beyond the percentage likelihood of non-recovery advised by the Compensation Recovery Unit which could be unwound?
- Partially completed spells: remove any excess prudence in this estimate. However you should continue to agree this accrual with the commissioner as much as possible to facilitate the agreement of balances process.

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[1] https://www.gov.uk/guidance/rules-for-all-agency-staff-working-in-the-nhs

8) Balance sheet review: bad debt provisions

NHS trusts and NHS foundation trusts are reminded that under International Accounting Standard (IAS) 39, financial assets (i.e. receivables in this case) should be impaired based on the 'incurred loss' model. Paragraph 59 of the standard (2011) states:

> *59 A financial asset or a group of financial assets is impaired and impairment losses are incurred if, and only if, there is objective evidence of impairment as a result of one or more events that occurred after the initial recognition of the asset (a 'loss event') and that loss event (or events) has an impact on the estimated future cash flows of the financial asset or group of financial assets that can be reliably estimated. It may not be possible to identify a single, discrete event that caused the impairment. Rather the combined effect of several events may have caused the impairment. Losses expected as a result of future events, no matter how likely, are not recognised.*

If your trust is continuing to apply the 'expected loss' model as applied under UK GAAP this is incorrect. There should not be bad debt provisions based on arbitrary ageing of debt, for example or other broad brush general application of percentages to gross debtor values. Bad debt provisions should only be recorded as a result of an event that occurred after the initial recognition of the debtor and this event has an impact on the estimated future cash flow and can be reliably estimated.

9) VAT claimable on contracted out IT spend

NHS providers should ensure that they take full advantage of the VAT reclaim opportunities on contracted out expenditure. There have been a number of changes to these rules over the past year. Further information is available from CIPFA at http://www.tisonline.net/issues.asp?content_ref=18744 and other sources online. In relation to IT spend these rules allow VAT to be reclaimed on IT systems procured to the specification of the recipient. Given the large number of IT systems procured in the NHS, please ensure you have applied these rules where appropriate.

10) Annual leave

NHS providers are encouraged to implement arrangements that limit the level of annual leave carried forward to the new financial year where possible, which should be reflected in the balance sheet annual leave entitlement accrual. Trusts should also review their methodologies for calculating the accrual as there may be opportunities to reduce the overall accrual whilst operating within the IFRS constraints. Clearly trusts must ensure that any directives given to staff about minimising the level of annual leave carried forward must not compromise the organisational effectiveness of the trust or patient safety. Trusts must also comply with any relevant HR policies that are in place.

11) Asset valuations

As set out in the Department of Health *Manual for Accounts* and Monitor's *NHS foundation trust annual reporting manual*, DH group bodies apply the principles of the HM Treasury *Financial reporting manual* (*FReM*) to asset valuations. This means that the accounting policy for valuation of specialised properties is to use depreciated replacement cost to value the service potential, on a modern equivalent asset basis.

Within this consistent policy, the valuation expert used by NHS bodies will base their work on a number of valuation assumptions as agreed with the NHS body. One of which is whether the MEA valuation is prepared on a 'no-alternative site' or an 'alternative site' basis. The former means that the valuation is based on replacing the asset's service potential on a modern equivalent basis, on approximately the same geographic site as currently. This is commonly the default approach. The latter approach means that the modern equivalent might be constructed on an alternative site. This tends to consider an alternative cheaper site, so usually leads to a lower valuation.

NHS providers should consider whether their site(s) location is geographically constrained. If it is not, it may be appropriate to instruct valuers on the basis of an 'alternative site' valuation, which is likely to lead to a lower asset value, with a corresponding impact on capital charges and depreciation charges.

This valuation basis will not be appropriate for all providers, but all providers should actively consider whether this is appropriate for them.

If an impairment arises from this work, care should be taken to ensure it is categorised correctly in reporting forms. While this will depend on the results of the local valuation, it is likely that an impairment arising from this work would be classified as 'other' in the analysis of impairments. NHS providers are held to account for their financial performance before impairments.

12) Asset lives review

As set out in the letter, there will be less capital funding available in the future and there may be constraints on the Department's capital budget. We therefore need to ensure that the NHS achieves value for money for its spend on capital assets. This includes ensuring that assets are utilised to their full potential and not replaced prematurely, whilst always ensuring that services that depend on assets remain safe.

Given this challenge to ensure that assets are fully utilised, together with potential future constraints on NHS providers' ability to invest in capital, all NHS providers should now review their asset registers and in particular the asset lives ascribed to assets, including plant, machinery and equipment. Some providers have significant numbers of fully depreciated assets on registers which suggests that asset lives for those categories of assets should be extended.

To achieve robust financial accounting it is important that the estimates used for asset lives are accurate and reviewed regularly.

All NHS trust and NHS foundation trust finance teams should therefore take action based on the following:

1. Within existing asset registers, review fully depreciated assets to identify if this indicates whether any types of assets should have their asset life for accounting purposes extended to maintain accurate accounting.
2. Respond to the current challenge to ensure the efficient use of capital by challenging to identify where asset lives could be extended, and reflect this in asset registers.
3. Consider the impact of future constraints in capital budgets to identify if this means assets may be utilised for longer and reflect this in asset registers.

Any extension in asset lives will reduce depreciation charges. In the unlikely event that there is a resulting asset impairment, this would be classified as ‘other’ in the categorisation of impairments.

The Valuation Office Agency (VOA) has a team that can support trusts to provide full valuations of plant and machinery. Their methodology supports the need to review fully depreciated assets on the asset register as a potential indicator that asset lives being adopted may not be realistic. Contact details are available on request.

Next steps: NHS foundation trusts

Monitor will need to collect a small amount of information on the extent to which NHS foundation trusts are able to take advantage of the measures set out above to lead to improvements in their bottom line for 2015/16.

For each of these, NHS foundation trusts will be asked to quantify at month 9 the impact on 2015/16 finances reflected in their full year surplus/deficit forecast, and to identify future opportunities to be reflected in future months where work in the area has not yet completed.

A short collection spreadsheet is being issued on 22 January, to be returned alongside the Month 9 (Quarter 3) monitoring submission on 29 January. This additional ‘financial improvement’ collection template should be returned by noon on 29 January by upload to the Portal with the type ‘Trust Return’ and activity name ‘Other’. Thank you in advance for your help.

Any queries on the areas listed in this document should be addressed to your relationship team in the first instance. Any queries specifically related to the collection template should be addressed to the Compliance mailbox.