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BRIEFING NOTE 87

Our technical director, Mark Speller, takes a first glance at the new LTFM

After over a decade of minor tinkering the LTFM has finally undergone a major revision, virtually a complete rewrite in fact.

As the LTFM is being increasingly used by NHSI to assess mergers, the ability to accommodate numbers of trusts should be a significant improvement on the clunky "transaction version" which invariably needed multiple individual LTFMs to support it.

Structurally the biggest change is that the monthly modelling is now put into a memorandum page, which can be safely ignored if working capital modelling is not needed. This means that the need to start with a mid-year balance sheet has been removed, and with it the largest source of model imbalances. For trusts wishing to concentrate on the long-run position this is a major improvement as it removes the balancing headaches in the outturn year created by lining up figures in the **I-BS Hist** and **I-BS For** tabs.

Where monthly cashflow modelling is important the new working capital page is simpler to manage as it largely works through direct input of figures, rather than percentage calculations.

The downside is it will be significantly more work as many figures which were automatically calculated on the previous LTFM now have to be input directly.

Baseline income and expenditure now sit on one page with the categorisation now more closely aligned with other NHSI planning and monitoring returns and "below the line" items now on the same page. Most notably staff, drugs and clinical supplies no longer move with percentage sliders but are input as cash figures. For trusts aligning an LTFM with another model this makes modelling significantly easier. However the percentages on the old model were

very useful in facilitating quick and easy changes to CIP and activity-related movements and having explicit cost pressure lines.

The simplified I&E input will make it far more important to document the assumed I&E movements as there are no longer explicit lines in the model. Modelling of the outturn year from an existing I&E forecast will be easier but the modelling of those years for which there is no existing forecast will require more care.

CIP now must be analysed across ten major schemes in a similar manner to the planning documentation. The challenge is of course to do that over five years. Whereas the old LTFM allowed you to put in as a percentage against expenditure category this model will expose lack of forward planning by demanding categorisation.

I doubt many trusts have detailed five-year CIP plans. It may well be that trusts need to take more notice of Model Hospital, PLICS benchmarking or other analysis in order that can at least identify those areas in which efficiency opportunities may exist.

The opportunity to have up to ten service developments is a significant improvement, and the ability to model the balance sheet impacts of both service developments and sensitivities corrects a major flaw in the old version. Some functionality has been lost such as the bridging pages which although obscure to interpret, yielded useful data.

Assista Analysis:

The new LTFM has more of the look and feel of an NHSI planning return than a forecast calculation model.

It should certainly make life easier for transactions and multi-trust forecasting. Whether those trusts using it for more straightforward forecasts find it an improvement, depends on whether or not they are using it as a template to input a pre-existing forecast.

Or in other words the model more than ever requires sound input modelling, assumption documentation and output analysis, as cost and activity pressures are no longer so explicit.

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