Monitor
Making the health sector work for patients

To: Board

For meeting on: 25 November 2015

Agenda item: 4

Report by: Jason Dorsett, Finance, Reporting & Risk Director
Yin Shi, Head of Sector Reporting

Report on: Quarterly report on the performance of the NHS foundation trust sector: 6 months ended 30 September 2015

Summary

1. The attached paper reports our findings from a review of the Q2 2015/16 performance of the 151 NHS licensed foundation trusts (NHSFTs) operating during this period.

Overview

2. The drive to improve financial performance and achieve national targets within a far more challenging operating environment has put many NHSFTs under severe pressure. The widespread financial and operational stress within the provider sector was evident in the second quarter's performance, as both operational and financial performance declined further.

3. NHSFTs in aggregate continued to miss key operational targets, including the A&E waiting time target, cancer 62-day target and three key ambulance response time targets. Despite an improvement in the monthly run rate and the year-to-date EBITDA margin, the sector's net deficit (before impairments and gains or losses on transfers) at Q2 2015/16 rose to £729m. Agency staff costs continued to be a major driver for the deficit. Total agency costs of £1.07bn were over 30% higher than the same period last year.

4. Monitor has continued to work collaboratively with the NHS Trust Development Authority (NHS TDA) and other national partners. A series of actions have been undertaken to help NHSFTs strengthen their operational resilience and improve their financial performance.

5. The detailed analysis is in the annex to this paper.

6. All comparisons with prior periods have been prepared on a like-for-like basis, i.e. excluding the impact of new NHSFTs, merger and acquisitions, and non-reporters in some cases, unless specified otherwise.

Operational performance

Emergency care

7. For the seventh consecutive quarter, the NHSFT sector failed the target to see, treat, admit or discharge 95% of accident and emergency (A&E) patients within 4 hours with a performance of 94.5% in Q2 2015/16. Attendances at 2.86m this quarter were 1.4% higher than Q2 last year.

8. NHSFTs have cited high patient acuity as a major cause of the continuing underperformance, as more and more patients attending A&E departments require admission. During Q2 2015/16, almost 565,000 patients (26.4%) attending a major NHSFT A&E (Type 1) unit needed further inpatient treatment which was over 6% higher than previous winter months. This inevitably increased demand on hospital beds. However, for the past two years, most providers have struggled to promptly discharge patients to free up beds due to a lack of social care and community support within the local health economies. Delayed transfers of care (DToCs) during the quarter resulted in over 25,200 trolley waits, almost 15% more than Q2 2014/15. We estimate that DToCs cost NHSFTs £153m year to date based on the daily cost beyond average length of stay for elective inpatients.

9. Q2 2015/16 continued to see a sharp rise in urgent and emergency 999 calls. In total, NHSFT ambulance trusts received 940,000 urgent and emergency calls, 10.7% more than Q2 2014/15. However, ambulances were dispatched only to 450,000 callers, indicating a 1% fall in total journeys compared to Q2 2014/15. In contrast, journeys for Red 1 (most time critical) and Red 2 (serious but less time critical) calls have increased by 39.7% and 1.2% respectively compared to Q2 last year. This has led ambulance foundation trusts in aggregate to breach the targets for responding to 75% of Red 1 and Red 2 call in 8 minutes and 95% Category A calls (life threatening) calls in 19 minutes this quarter, with performances of 74.98%, 72.32% and 94.36% respectively.

10. Although most NHSFTs have local action plans in place to strengthen their operational resilience over the approaching winter months, many have expressed concerns about staff shortage and capacity constraints. Nationally, clinically led Emergency Care Improvement Programme has started a programme of intensive support for 28 urgent and emergency care systems that are under the most pressure, to help them achieve improvement in patient care.

Elective care

11. The sector has consistently achieved the national waiting time target for patients on incomplete pathways, but NHSFTs' performance has steadily declined. The sector's performance at 92.3% in Q2 2015/16 was nearly 1.5% below Q2 last year, but continued to meet the target of treating 92% of patients within 18 weeks.

12. Rising demand has been a major factor affecting elective waiting time performance. At Q2 2015/16 referrals from GPs rose by 3.5%. However, elective activity, compared to the same period last year, grew by only 2% (on a cost weighted basis). At Q2, the size of the waiting list was almost 1.95m, 8.1% bigger than the same period last year. In addition, median waiting times for patients on

incomplete pathways rose from 6.1 weeks at Q1 2015/16 to 6.5 weeks this quarter, despite efforts to reduce the number of patients waiting longer than 52 weeks from 226 at last quarter to 170 this quarter.

13. One important component in meeting the RTT and cancer targets is for patients to receive timely diagnostic tests. The national target expects less than 1% of patients to wait for six weeks or longer. However, the NHSFT sector has been struggling to meet the national waiting time target for diagnostic tests since November 2013. At the end of September 2015, over 470,000 patients were waiting for a test, indicating an underlying growth of 8.3%. Of those patients, 2.4% waited six weeks or longer.

14. A national programme management office has been established jointly by Monitor, NHS TDA and NHS England to help improve access to endoscopy services. The work is now in progress to match demand to spare NHS provider and independent sector capacity to support the delivery of RTT and cancer targets.

Cancer care

15. During Q2 2015/16, 21,123 cancer patients referred by GPs received urgent treatment. This was 10.9% higher than Q2 2014/15 and 6.5% higher than Q1 2015/16. However, performance at 82.56% this quarter was below the target of treating 85% of GP referrals within 62 days. The median waiting time at 45 days remained unchanged from the previous quarter. In addition to the national work to improve timely access to endoscopy services, Monitor has also been working closely with providers to develop improvement plans and specific support has been provided to NHSFTs that are under most pressure.

16. NHSFTs in aggregate have continued to meet all other key cancer performance targets.

Mental health

17. We monitor NHSFTs providing mental health services against a range of standards that aim to improve patient experience and patient access. Although most have performed well against the key targets, the number of trusts breaching the target for DToCs has been on the rise.

C. difficile

18. NHSFTs reported 815 *C. difficile* cases at Q2 2015/16, 19 cases more than the previous quarter; 344 (or 42%) of these cases were confirmed as resulting from lapses in care, highlighting a need to continuously improve patient safety.

Financial performance

Overall performance

19. Monitor has been working closely with NHSFTs to reduce the deficit by tightening spending controls on agency staff and consultancy contracts. However, as expected, these measures are yet to make a significant impact on the year-to-

date performance. During Q2 2015/16, NHSFTs' financial performance continued to decline. Although much of this deterioration was planned, the year-to-date deficit (before impairments and transfers) of £729m at Q2 2015/16 was £169m worse than plan and £284m more than the deficit reported at Q1 2015/16. 110 NHSFTs reported a deficit this quarter, with a total gross deficit of £816m. This was offset by £87m gross surplus at 41 trusts.

20. In line with historical trends, the EBITDA margin improved from 0.9% in Q1 2015/16 to 1.5% as NHSFTs started to build up their in-year efficiencies. However, small and medium acute trusts continued to report aggregate negative year-to-date EBITDA margins of -1.7% and -0.7% respectively.

Performance drivers

21. The worse-than-planned performance for the first half of the year was due to expenditure growing at a faster pace than revenue. At Q2, expenditure was 0.9% above plan, whereas clinical revenue, representing almost 90% of the total revenue, was slightly below plan by 0.2%.

22. Despite the marginal rate emergency tariff being uplifted from 30% to 70% this year under enhanced tariff option, higher than planned growth (3.6%) in non-elective work so far only brought 1% growth in revenue, while elective inpatient and outpatient activity and revenue were significantly behind plan. If this trend continues, this will create further financial pressure on providers.

23. Much of the unplanned expenditure continued to be driven by a high usage of agency staff. Rising demand, a need to maintain safe staffing levels, coupled with recruitment difficulties have led NHSFTs to employ 8,335 more whole time equivalent agency staff in Q2 2015/16. The extra costs outweighed vacancy savings from permanent staff resulting in an in-year adverse pay cost variance. Failure to reduce agency costs has continued to affect NHSFTs' delivery of their cost savings. A £76m under-delivery in pay cost improvement programmes (CIPs) represented 70% of the total year-to-date CIPs shortfall.

24. Monitor and NHS TDA have now developed a package of measures to reduce spending on agency staff. We have introduced the agency staff ceilings for individual NHSFT and mandated the use of framework agreements. We are implementing maximum hourly rate caps with effect from 23 November.

Forecast outturn

25. Worsening performance and concerns about winter months have led NHSFTs in aggregate to revise down their forecast outturn from a deficit of £1.01bn at Q1 to a deficit of £1.08bn. The latest forecast is £148m worse than the plan of £931m for the year.

Cash and capex

26. Although the cash position at Q2 2015/16 deteriorated further to £3.4bn, the decrease was less than planned. NHSFTs continued to achieve this by a combination of managing working capital and reducing planned capital

expenditure (capex). Total cash held at the quarter end was sufficient for 27 days' operation. However, when taking short-term liabilities into consideration, net current assets were £0.8bn, equivalent to 6.8 days' operation, almost seven days shorter than a year ago.

27. Given the current financial difficulties, NHSFTs have started to rein in their capital spend. At Q2 2015/16, total capex of £952m was 33.7% less than planned. However, NHSFTs have increased their reliance on borrowing to fund their capital schemes as cash generated from operations was insufficient to fund the current level of spend. Compared to Q2 last year, schemes funded by loans increased by 120.7%. This evidently is not sustainable. NHSFTs need to review their capital spend to avoid adverse impact on patient care and financial viability. We have been in contact with all NHSFTs to gain a more accurate understanding of their forecast capex outturn, and of the scope for further safe deferral of planned expenditure.

Regulatory actions

28. Both operational and financial pressures have caused more NHSFTs to trigger concerns under our risk assessment framework. In response, we have increased our regulatory effort through both informal actions and some limited formal actions.

29. At the time of reporting, 39 trusts are subject to formal regulatory actions, two more than Q1 2015/16: Taunton and Somerset Hospitals NHSFT (due to financial concerns) and South East Coast Ambulance Foundation Trust (due to governance concerns).

30. Since our last report, we have launched two new investigations in addition to eight ongoing investigations. Both new investigations have been opened due to financial concerns. Investigation at Taunton and Somerset Hospitals NHSFT has since led to regulatory action being taken at the trust. Gloucestershire Hospitals NHSFT has since returned to compliance following an investigation launched in June 2015.

31. We continue to monitor NHSFTs' performance and review our regulatory approach to decide what further actions are needed. In addition, we have now increased our improvement capacity to offer support to NHSFTs. Our new Provider Sustainability Directorate has been engaging with selected NHSFTs at the request of Provider Regulation teams to develop or assure operational improvement plans.

Making a difference for patients:

Monitor's mission is to make the health sector work better for patients. By reviewing foundation trusts' plans we provide insight into the future performance of the foundation trust sector. This informs our regulation of individual foundation trusts by highlighting areas of risk that we follow up in order to identify and resolve problems that may affect patients earlier than would be the case without this insight. Our reports on the sector also inform our other statutory functions and our thought leadership work.

Public Sector Equality Duty:

Monitor has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. In drafting this report consideration has been given to the impact that the issues dealt with might have on these requirements and on the nine protected groups identified by this Act. It is anticipated that the issues dealt with in this this paper are not likely to have any particular impact upon the requirements of or the protected groups identified by the Act because this paper is primarily provided for information rather than for decision.

Exempt information:

None of this report is exempt under the Freedom of Information Act 2000.

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Performance of the foundation trust sector

6 months ended 30 Sept. 2015

GOV.UK/monitor

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1.0 Performance summary

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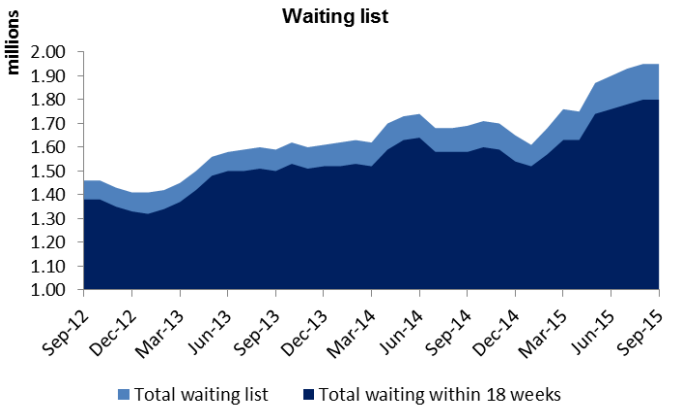
1.1 Operational summary

Description	Activity	Standard	Q2 2015/16 Performance
4 hour A&E waiting time standard	**c. 2.86m** attendances	95%	94.52%
18 week waiting time standard: incomplete pathways	**c. 1.9m** patients waiting	92%	92.32%
6-week waiting time standard for diagnostic tests	**c. 0.47m** patients waiting	1%	2.35%
Cancer standard: 62-day wait for first treatment from GP referral	**c. 21,123** treated	85%	82.56%
Ambulance response times for Red 1 Calls	**c. 18,626** Red 1 calls	75%	74.98%

A&E performance breakdown

Description	Total Attendances	Q2 2015/16 performance
Type 1 - major A&E	c.2.14m	92.83%
Type 2 - single specialty	c.0.08m	99.06%
Type 3 - minor injury unit	c.0.63m	99.63%



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1.2 Financial summary

6 Months ended 30 September 2015

	Number of NHSFT[1]	Operating Revenue[2] YTD £m	Net surplus[2] YTD £m	Number of NHSFT[1] in deficit YTD	EBITDA[2] % YTD	Forecast net surplus[2] for 15/16 £m	GRR red rated trusts[3]	% red rated[3]
Acute	83	16,046	(745)	76	0.4%	(1,107)	34	41%
Mental health	43	4,446	20	20	4.7%	8	4	9%
Specialist	17	1,515	3	9	3.5%	26	-	-
Ambulance	5	467	(7)	4	3.5%	(7)	1	20%
Community	3	278	1	1	2.8%	**1**	**-**	**-**
Total	**151**	**22,751**	**(729)**	**110**	**1.5%**	**(1,079)**	**39**	**26%**

Analysis of Acute sector

	Number of trusts[1]	Operating Revenue[2] YTD £m	Net surplus[2] YTD £m	Number of trusts[1] in deficit YTD	EBITDA[2] %	Forecast net surplus[2] for 15/16 £m	GRR red rated trusts[3]	% red rated[3]
Teaching	20	6,950	(241)	16	4.0%	(188)	6	30%
Large (revenue over £400m p.a.)	6	1,555	(66)	4	5.0%	(508)	3	50%
Medium (revenue £200m-£400m p.a.)	38	5,775	(325)	37	(0.7%)	(79)	19	50%
Small (revenue under £200m p.a.)	19	1,765	(113)	19	(1.7%)	(333)	6	32%
Total	**83**	**16,046**	**(745)**	**76**	**0.4%**	**(1,107)**	**34**	**41%**

1. All information in this report is based on quarter monitoring returns from 151 licensed NHS foundation trusts as at 30 September 2015.
2. All financial information in this report is year-to-date, unaudited, and includes the period after authorisation for the one NHS foundation trust licensed in the year and six NHS foundation trusts licensed in 2014/15 plus the final periods of operation of the three NHS foundation trusts that ceased to be licensed (through merger or dissolution) in 2014/15.
3. Governance risk ratings (GRR) are based on the rating at the time of reporting.

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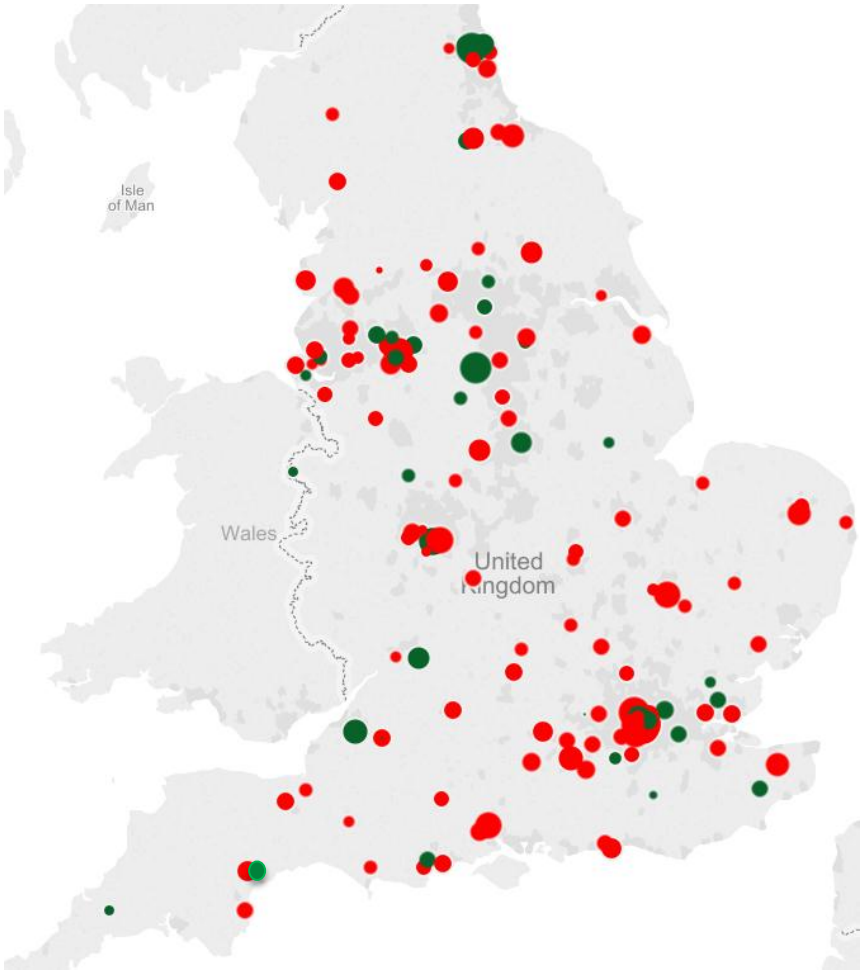
1.3 Regional Summary



The graph is based on Q2 2015/16 information: All NHS foundation trusts are shown located at their headquarters and depicted by a dot, the size of the dot reflecting their revenue (turnover YTD) and the colour their surplus/(deficit) YTD. (*Green: surplus; Red: deficit*).

Regional summary as at Q2 2015/16

Actual	London 20 NHSFTs	Midlands 39 NHSFTs	North 57 NHSFTs	South 35 NHSFTs	Total 151 NHSFTs
Operating Revenue (£m)	**4,607**	**4,972**	**8,180**	**4,993**	**22,751**
EBITDA %	1.7%	0.3%	1.7%	2.2%	1.5%
CIPs as a % of Expenses	2.2%	2.3%	2.6%	2.5%	2.4%
Net (deficit) (£m)	**(145)**	**(227)**	**(224)**	**(133)**	**(729)**
Net (deficit) %	-3.1%	-4.6%	-2.7%	-2.6%	-3.2%
Number of deficit NHSFTs	15	33	43	27	110
% of FTs in deficit	65%	77%	70%	77%	73%
Gross deficit (£m)	**(162)**	**(248)**	**(266)**	**(139)**	**(816)**
Forecast net (deficit) for 15/16 (£m)	**(133)**	**(386)**	**(359)**	**(202)**	**(1,079)**

- The net deficit for the FT sector was £729m for Q2 2015/16, compared to a planned deficit of £560m and a deficit of £445m at Q1.
- Overall, 110 (or 73%) NHSFTs reported a deficit year to date, this varied between 65% (the lowest) in London and 77% (the highest) in the South & Midlands.
- Regionally the NHSFT population is distributed:
  - By number: 38% in the North, 26% in the Midlands region, 23% in the South and 13% in London.
  - By operating revenue: 36% in the North, 22% in the Midlands region, 22% in the South and 20% in London.
  - By gross deficit: 32% in the North, 31% in the Midlands region, 20% in London and 17% in the South.

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2.0 Operational performance

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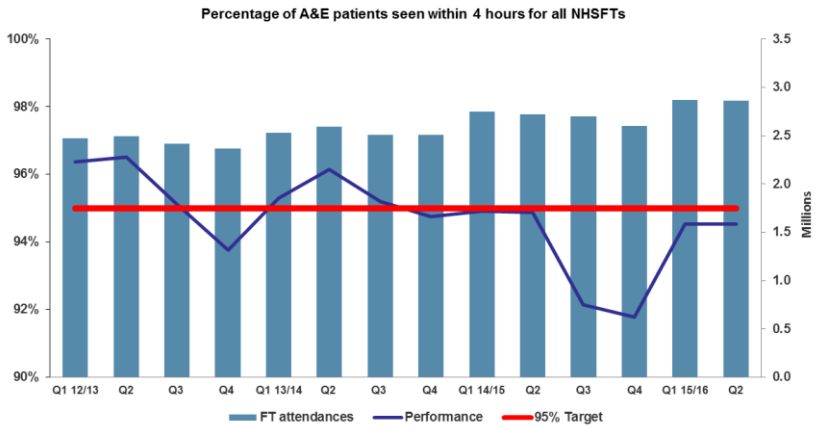
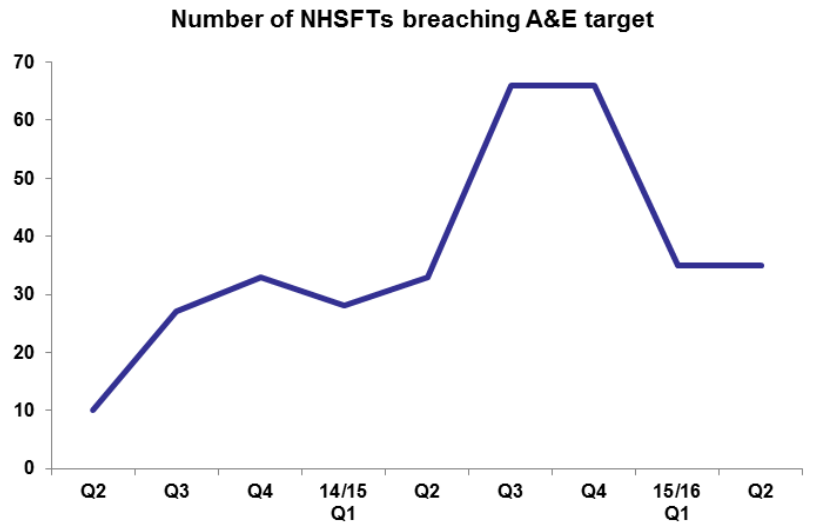
2.1 Accident & Emergency





- The NHSFT sector has failed to meet the A&E 4-hour waiting time target for the seventh consecutive quarter, with a performance of 94.52% in Q2 2015/16. Although performance has remained unchanged from Q1 2015/16, it has declined slightly compared to a year ago (94.88% in Q2 2014/15). The number of NHSFTs failing the target remained at 35 for a second consecutive quarter.
- Total attendances at NHSFTs during the quarter were 2.86m, an increase of 7.23% or 192,789 patients compared to the same period last year. However, 80% of the rise in attendances was due to new NHSFTs and mergers and acquisitions (M&A); excluding these, the like-for-like comparison showed an increase of 1.43% compared to Q2 2014/15.
- As highlighted in our previous report, high levels of emergency admissions continues to put pressure on NHSFT A&Es. The proportion of patients attending a major A&E department (i.e. Type 1) and subsequently being admitted was 26.35% in Q2 2015/16; 0.77% more than the same quarter last year. NHSFTs have cited that A&E departments are dealing with higher acuity patients requiring admissions and that bed shortages due to delayed discharges were impacting patient flow.
- The number of bed days lost due to delayed transfers of care (DToCs) at the quarter end was 81,993 which was 5.88% higher than Q2 2014/15 on a like-for-like basis. The delays are largely driven by a lack of social care and community beds. We estimate that DToCs cost NHSFTs £153m year to date based on the daily cost beyond average length of stay for elective inpatients. The rise in DToCs has also resulted in a rise in four-hour trolley waits from 22,019 in Q2 2014/15 to 25,268 in the current quarter.
- Monitor is currently working with the NHS Trust Development Authority (TDA), NHS England and the Department of Health (DH) to address the performance challenges through a newly established Emergency Care Improvement Programme (ECIP). This programme is designed to offer practical hands-on support this winter to 28 of the most challenged urgent and emergency care systems to help them deliver performance improvements against the 4-hour waiting time target.

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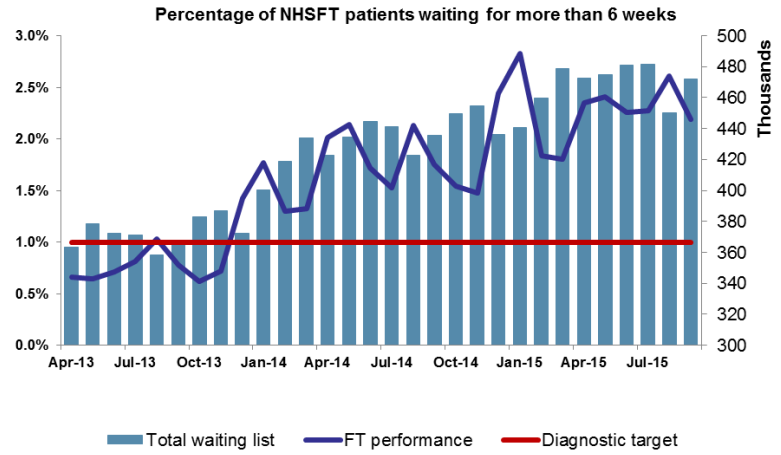
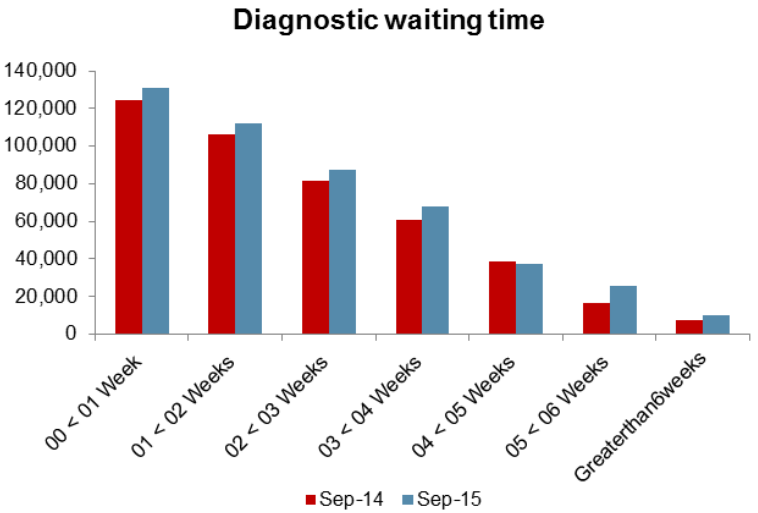
2.2 Diagnostic waiting times





- The diagnostic waiting times standard states that less than 1% of patients should wait six weeks or longer for a diagnostic test, as timely treatments are dependent on timely diagnostic tests. Successful delivery of diagnostic waiting times also forms an important part in the delivery of referral to treatment (RTT) and cancer targets.
- Although only a small number of providers breached the target during the quarter, the NHSFT sector as a whole has been struggling to achieve this target since November 2013. Rising demand for diagnostic services has contributed to the growth in the waiting list which now stands at just over 470,000, an 8.32% increase over the last year (8.63% growth based on a like-for-like comparison excluding the impact of new NHSFTs and M&A).
- Due to planned capacity being insufficient to meet the growing demand, the sector continued to miss the target in Q2 2015/16 with a performance of 2.35%, a decline from 1.80% achieved at Q2 last year.
- However, current median waiting times at 1.9 weeks have not worsened and remained similar to Q2 last year. The longest waits were for endoscopy procedures where just under 9% of patients waited six weeks or more in Q2 2015/16. Endoscopy contributes over 10% of total diagnostics activity, so it continues to significantly impact on overall performance.
- Nationally, work is now progressing to address endoscopy performance with an aim to improving the cancer waiting time target. A national PMO has also been set up to coordinate both NHSFTs and HS trusts' access to independent providers for extra endoscopy capacity.

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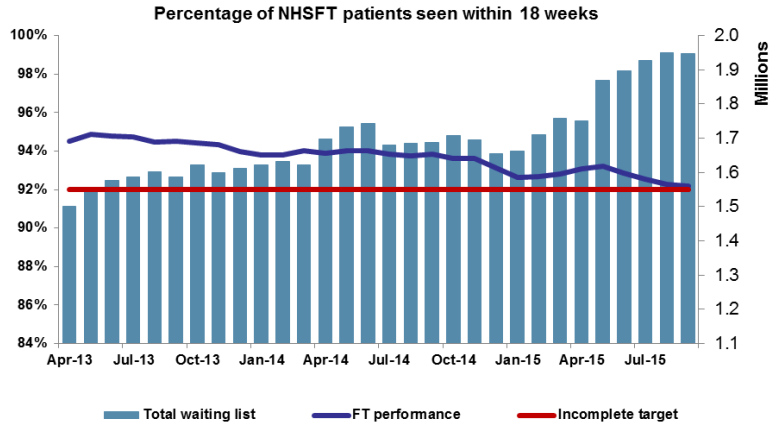
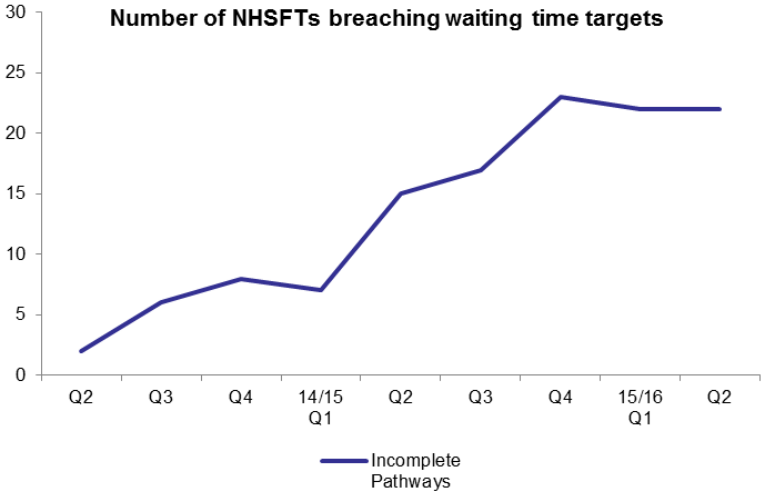
2.3 Elective waiting times





- Since the formal removal of both admitted and non-admitted referral to treatment (RTT) standards in June 2015, the RTT incomplete standard remains the sole measure of waiting time performance.
- Although the NHSFT sector has not failed the 92% target for incomplete pathways, this quarter's performance of 92.32% was a deterioration on the 93.80% achieved in Q2 2014/15. The number of NHSFTs failing the target was 22 in Q2 2015/16 up from 15 in the same period a year ago.
- NHSFTs have cited that staffing issues and capacity constraints are making it increasingly difficult to meet rising demand.
- GP referrals saw a 10.16% (3.52% on a like-for-like basis) rise in Q2 2015/16 compared to the same period last year. The size of the waiting list has been steadily increasing and by the end of Q2 2015/16 was nearly 1.95m, which represented an increase of 12.06% when compared to the end of Q2 2014/15 (8.12% on a like-for-like basis).
- At the end of September 2015, the median waiting time for patients on the incomplete pathway increased to 6.53 weeks from 6.10 weeks in June 2015.
- Despite the increase in median waiting times, the number of patients waiting longer than 52 weeks has reduced to 170 at the end of Q2 2015/16 from 226 at the end of Q1. This was driven by a significant reduction in long waiters at one foundation trust.
- Nationally, NHSFTs are focusing improvement plans on data validation and working with the independent sector programme management office to secure additional capacity.

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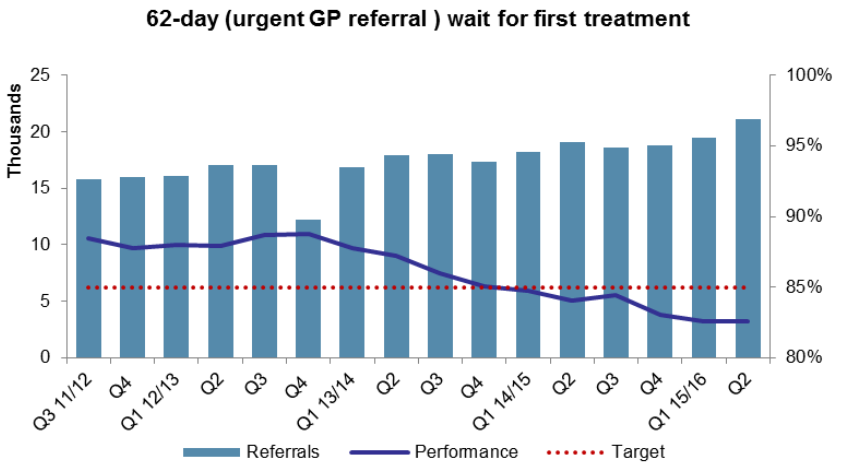
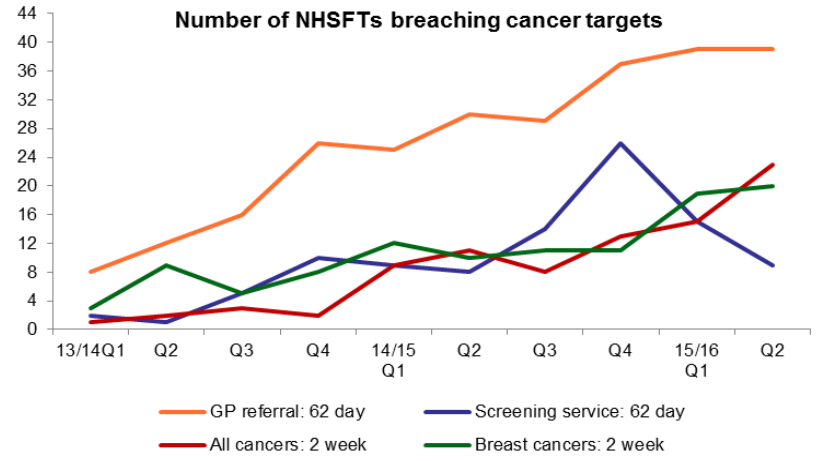
2.4 Cancer waiting time





- The NHSFT sector continued to meet the cancer waiting time standards for 62-day screening services, 31-day first treatment, and 2-week urgent GP referrals. However, performance against the cancer 62-day urgent GP referral target remained below the 85% target for the sixth consecutive quarter in Q2 2015/16 with a performance of 82.56% compared to 84.08% in the same period last year.
- 39 trusts breached the cancer 62-day target in Q2 2015/16 including 24 trusts who also failed at least one of the other cancer targets. This was 9 more than Q2 2014/15 and the same as the last quarter. Increased number of referrals, late referrals from other providers and diagnostic result delays were the top challenges cited by NHSFTs when surveyed.
- In response to rising demand, activity increased further in Q2 2015/16 with 21,123 patients being treated on the 62-day urgent GP referral pathway. This was 10.86% higher than Q2 2014/15 and an 8.77% rise on a like-for-like basis. Average waiting times were, however, similar to the last quarter with the overall median waiting time remaining at 45 days; the median waiting times for lower gastrointestinal and head and neck treatments remained particularly long at around 55 days.
- As highlighted in the previous quarterly report, delays in diagnostic tests, especially in endoscopic procedures have contributed to the pressures in delivering the 62-day target. Nationally, Monitor along with the TDA and NHSE have taken a coordinated approach to improving the endoscopy waiting time.
- Monitor has been working with providers to develop improvement plans and support is being provided to NHSFTs that are most challenged. We are also reviewing the way breaches are shared between providers as many NHSFTs cite this as a significant challenge when trying to deliver the 62 day standard.

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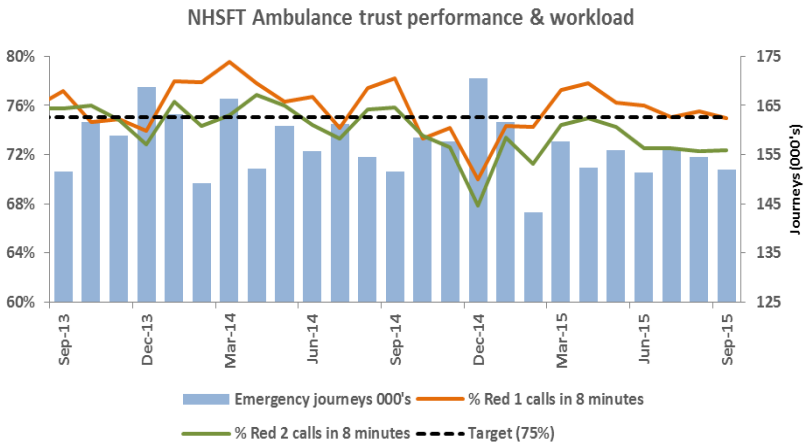
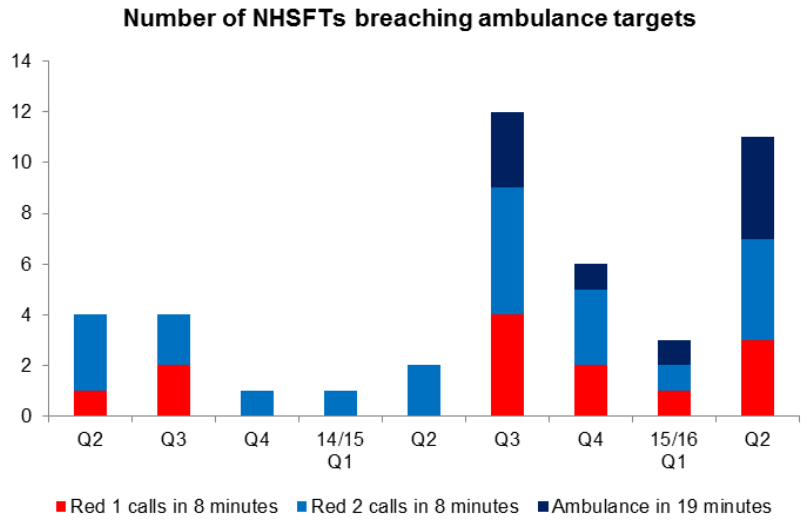
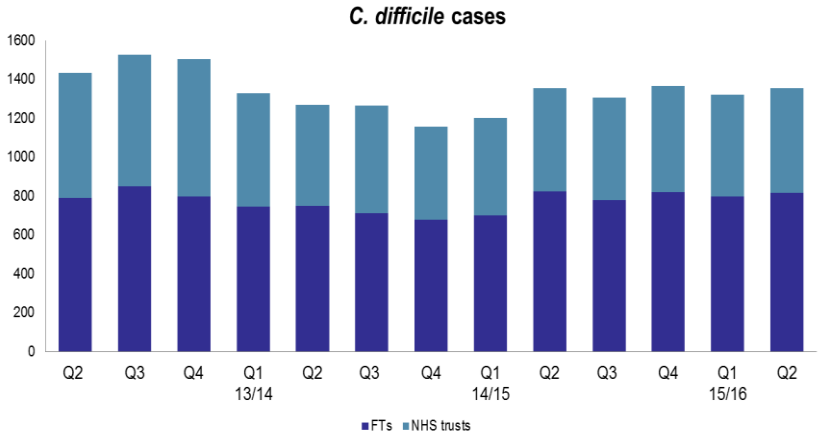
2.5 Ambulance response times

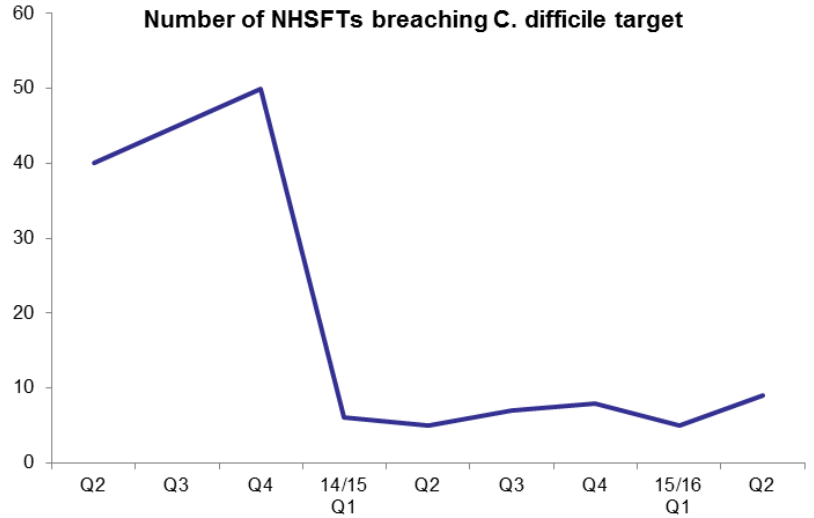




- The national standard sets out that 75% of time critical and life threatening Category A (including both Red 1 and Red 2) calls should receive an emergency response within eight minutes and all Category A calls should receive an emergency response within 19 minutes.
- In Q2 2015/16 NHSFT ambulance services received just under 940,000 emergency and urgent calls including 18,626 Red 1 calls (most time critical) and 320,842 Red 2 calls (serious but less time critical), a 10.68% increase on Q2 2014/15. Although demand has increased, ambulances were dispatched only to 450,000 callers, indicating a 1% fall compared to the same period last year. Despite the fall in total emergency journeys the number of Red 1 and Red 2 journeys have increased by 39.74% and 1.22% respectively from the same period last year. The rise in Red 1 journeys was largely attributable to a re-classification of certain cardiac conditions from Red 2.
- NHSFTs did not meet any of the national standards in Q2 2015/16. The sector marginally failed the Red 1 target by responding to 74.98% of Red 1 calls within eight minutes and failed the Red 2 target for the fifth consecutive quarter with a performance of 72.32% which was lower than the Q2 2014/15 performance of 74.90%. NHSFTs failed the Category A 19 mins target for the first time since Q3 2014/15 with a performance of 94.36%.
- As mentioned in the previous quarterly report, South West Ambulance Service Foundation Trust (SWAST) are running a dispatch on disposition pilot which continues to have an adverse effect on overall performance because it allows call handlers extra time to triage calls. If SWAST data is excluded, the sector's Category A 19 mins performance in Q2 2015/16 would have increased to 95.34%, above the 95% target. However, Red 2 performance at 73.67% would still be below target.

2.6 Infection control





- *C. difficile* infection counts published by Public Health England showed that for Q2 2015/16, 815 out of 1,355 recorded *C. Difficile* cases were attributable to the NHSFT sector, which was seven cases fewer than the same period last year but a rise of 19 cases (2.4%) compared to Q1 2015/16.
- Of those cases attributable to NHSFTs, 344 (or 42%) cases were confirmed to be the result of lapses in care, and a further 305 cases are currently being reviewed by CCGs to determine whether they are due to lapses in care. This was a deterioration from the performance reported for the previous quarter where the sector reported 326 cases caused by lapses in care.
- The current methodology for calculating the *C. difficile* target was introduced in 2014/15 and meant that performance would only be measured based on cases resulting from lapses in care. This has led to a sharp decline in the number of trusts breaching the target.
- In Q2 2015/16, nine NHSFTs failed the *C. difficile* target, including two trusts that have consistently failed for four quarters and two that have failed in three out of the last four quarters. This is the highest number of target breaches since the change to the target calculation methodology at the beginning of 2014/15 and four more than the last quarter.

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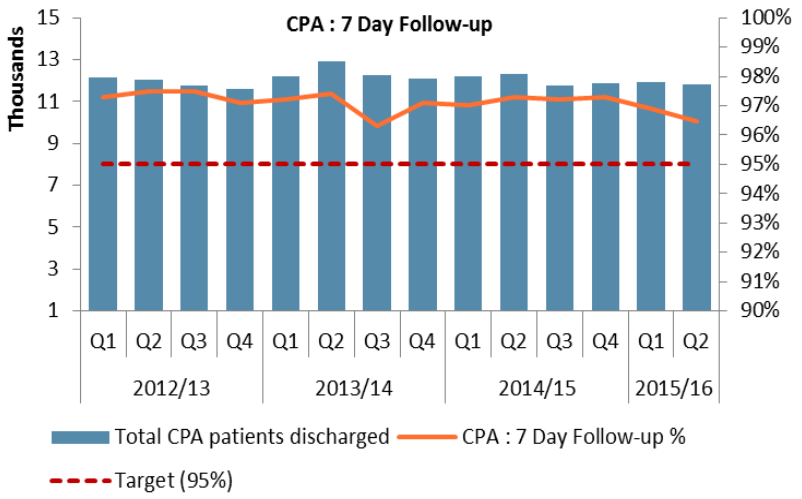
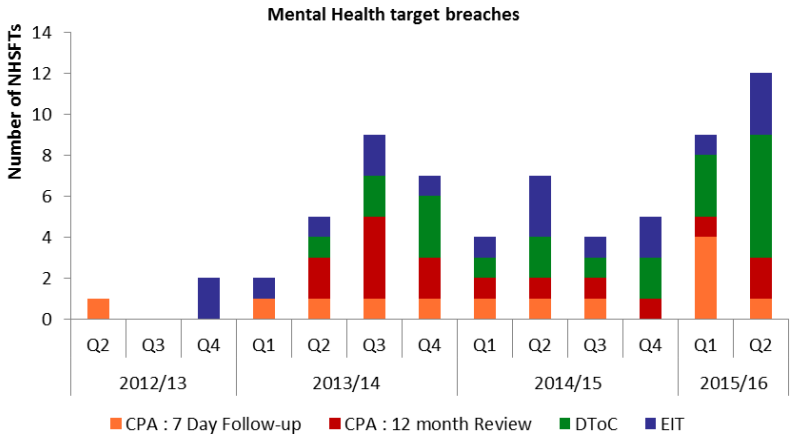
2.7 Mental health





- We currently monitor NHSFTs providing mental health services against a range of standards designed to improve patient experience, and access to support and early intervention,
- In Q2 2015/16, NHSFTs in aggregate saw 96.5% of patients on the Care Programme Approach (CPA) within seven days of being discharged from inpatient care. Although this was 0.4% fewer than the previous quarter and 0.8% fewer than Q2 2014/15, the 95% target continued to be achieved by the sector as a whole. In spite of the drop in overall performance, only one trust breached the target in the current quarter compared to four in the previous quarter.
- Two trusts out of the 43 Mental Health trusts failed to review 95% of patients on the CPA within 12 months, and Early Intervention Teams (EIT) at three trusts failed to see more than 95% of new patients with psychosis.
- Six trusts breached the target for delayed transfers of care (DToCs) with over 7.5% of patients experiencing delays. This was an increase from three trusts in the previous quarter, with two trusts now having missed the target for two consecutive quarters.
- The Department of Health has introduced several new standards designed to further improve access to services, and they have been reflected in our updated Risk Assessment Framework (RAF) published in August 2015. As a result of this change, NHSFTs will be monitored indicatively against the Early Intervention in Psychosis (EIP) standard from Q4 2015/16 and the two Improved Access to Psychological Therapies (IAPT) standards will be monitored from Q3 2015/16.

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3.0 Financial performance

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3.1 Income & expenditure

6 months ended 30 September 2015	Q2 2015/16 Actual £m	Q2 2015/16 Plan £m	Variance to plan £m	Variance to plan %	Q2 14/15 Actual £m
Operating Revenue for EBITDA	**22,751**	**22,716**	**35**	**0.2%**	**21,244**
Pay costs	(14,847)	(14,721)	(126)	0.9%	(13,643)
Other operating expenses	(7,563)	(7,488)	(75)	1.0%	(6,819)
EBITDA	**341**	**508**	**(166)**	**-32.7%**	**791**
Depreciation	(649)	(667)	18	-2.7%	(612)
Finance costs	(192)	(197)	5	-2.5%	(180)
PDC dividend	(282)	(288)	6	-2.0%	(259)
Other non-operating items	68	115	(48)	-41%	24
Restructuring costs	(20)	(32)	12	-37%	(19)
Net surplus/(deficit)	**(729)**	**(560)**	**(169)**	**30.9%**	**(254)**
Gains/(losses) on transfers	74	(5)	78	-1740%	114
(Impairments)/ reversals	(16)	(84)	68	-81%	(81)
Net surplus/(deficit) after impairments & transfers	**(671)**	**(648)**	**(23)**	**3.5%**	**(221)**
EBITDA %	1.5%	2.2%			3.7%
Net Surplus %	-3.2%	-2.4%			-1.2%

6 months ended 30 September 2015	Acute 83 NHS FTs Actual £m	Mental Health 43 NHS FTs Actual £m	Specialist 17 NHS FTs Actual £m	Community 3 NHS FTs Actual £m	Ambulance 5 NHS FTs Actual £m
Operating revenue for EBITDA	16,046	4,446	1,515	278	467
Pay costs	(10,160)	(3,292)	(875)	(193)	(327)
Other operating expenses	(5,830)	(945)	(588)	(77)	(124)
EBITDA	**56**	**208**	**53**	**8**	**16**
Net surplus/(deficit)	**(745)**	**20**	**3**	**1**	**(7)**
Net surplus/(deficit) after impairments & transfers	**(674)**	**16**	**(6)**	**(1)**	**(7)**
EBITDA %	0.4%	4.7%	3.5%	2.8%	3.5%
Net Surplus %	-4.6%	0.4%	0.2%	0.4%	-1.5%

- The NHSFT sector ended the first half of the financial year 2015/16 with a £729m net deficit, a deterioration from a net deficit of £445m at Q1 and £169m worse than plan. However, the run rate during the second quarter showed an improvement.
- The deficit was largely driven by operating revenue being only marginally (0.2% or £35m) better than plan, while excess pay costs (0.9% or £126m) and non-pay costs (1.0% or £75m) were significantly worse than plan. The result was EBITDA being reduced by a third from the planned value.
- The higher than planned pay bill was due to NHSFTs employing 8,300 more agency staff than planned at Q2 to compensate for a significant shortfall in the permanent workforce. The premium costs of agency staff exceed the savings on permanent staff.
- The other major variance which contributed to the overall deficit was in “other non-operating items”. The delays in several planned donations and one property transfer highlighted in our previous report continued to affect the sector’s overall year-to-date performance.
- Although the number of NHS FTs reporting a year-to-date deficit has reduced from 118 at Q1 to 110 trusts at Q2, the sector as a whole still faces unprecedented financial challenges. In particular, acute and specialist trusts continue to be the worst affected, as 92% of the acute providers and 53% of the specialist trusts being in deficit at Q2. Moreover, large single deficits are no longer confined to a small number of providers as seen in previous years. At Q2, 24 NHS FTs reported a year-to-date deficit of more than £10m. Their combined gross deficit at Q2 amounted to £489m.

3.2 Revenue analysis

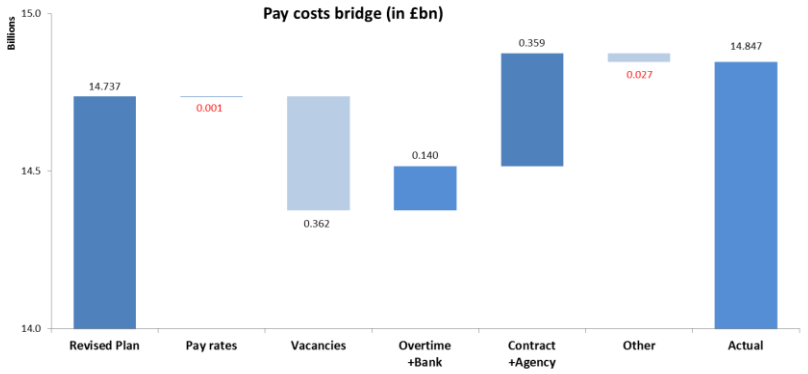
6 months ended 30 September 2015	Q2 2015/16		Variance to plan		Q2 2014/15
	Actual £m	Plan £m	£m	%	Actual £m
Ambulance	445	453	(8)	-2%	430
Community	1,824	1,825	(1)	0%	1,493
Mental health	2,987	2,990	(4)	0%	2,784
Elective in-patients	1,457	1,538	(81)	-5%	1,485
Elective day cases	1,286	1,284	2	0%	1,240
Outpatients	2,376	2,410	(34)	-1%	2,236
Non-elective in-patients	3,392	3,354	39	1%	3,219
A&E	536	531	6	1%	477
Maternity	422	424	(2)	-1%	387
Diagnostic tests & Imaging	193	192	1	0%	203
Critical care: Adult, Neonate, Paediatric	728	734	(6)	-1%	658
High cost drugs revenue from commissioners	236	253	(17)	-7%	929
Other drugs revenue (inc. chemotherapy)	135	147	(12)	-8%	232
Direct access & Op, all services	209	193	16	9%	175
Unbundled chemotherapy delivery	90	91	(2)	-2%	81
Unbundled external beam radiotherapy	94	93	1	1%	95
CQUIN Revenue	228	230	(1)	-1%	251
NHS contract penalties or adjustments	(42)	(29)	(13)	45%	(33)
Non-NHS clinical revenues	486	531	(44)	-8%	392
NHS clinical revenues	19,834	19,825	9	0%	18,506
Total clinical revenue	**20,320**	**20,356**	**(36)**	**-0.2%**	**18,898**
Research and Development	316	322	(5)	-2%	297
Education and Training	787	773	14	2%	750
Other non-clinical revenue	1,396	1,363	33	2%	1,332
Total non-clinical revenue	**2,499**	**2,458**	**41**	**1.7%**	**2,379**
Total operating revenue	**22,820**	**22,814**	**6**	**0.0%**	**21,277**
Less: Donations & Grants of PPE	(68)	(98)	29	-30%	(32)
Total operating revenue for EBITDA	**22,751**	**22,716**	**35**	**0.2%**	**21,244**

- NHSFTs' total operating revenues at Q2 2015/16 were 0.2% above plan and 7.1% (or £1.5bn) higher than the previous year. However, part of the year-on-year growth was the result of new NHSFTs and merger and acquisitions (M&A). Excluding such impact, the underlying revenue growth was only £450m or 2.2%.
- Total clinical revenue, on the other hand, was 0.2% below plan. This was due to clinical activity lagging behind plan for the second quarter in a row. NHS FTs as a whole planned to grow their activity (cost weighted) in the first half of the year by 4.6% on a like-for-like basis (i.e. excluding new FTs and M&A), but this ambitious growth was not fully realised. The sector only managed a 2.5% year-on-year growth.
- In addition, higher than planned emergency activity continued to displace planned elective work. At Q2 2015/16, elective inpatient activity was 8.3% below plan, whereas non-elective activity was 3.6% above plan. Despite the change to the marginal rate emergency tariff from 30% to 70%, the growth in non-elective revenue was not sufficient to compensate for the shortfall in elective inpatient revenue. As a result, year-to-date clinical revenue was off plan. However, compared to Q2 2014/15, clinical revenue still grew by 2.5% on a like-for-like basis.
- Furthermore, contract penalties and adjustments were 45% or £13m higher than plan which had an adverse impact on revenue. NHS FTs told us that delayed discharge and increased emergency admissions were some of the underlying reasons for penalties from CCGs.

3.3 Operating expenses

6 months ended 30 September 2015	Q2 2015/16 Actual £m	Q2 2015/16 Plan £m	Variance to plan £m	Variance to plan %	Q2 2014/15 Actual £m
Pay - employees	13,781	14,096	(315)	-2%	12,826
Pay - contract and agency staff	1,065	624	441	71%	817
Pay expense	**14,847**	**14,721**	**126**	**0.9%**	**13,643**
Ambulance operating costs	37	47	(11)	-22%	34
Clinical supplies	1,783	1,778	5	0.3%	1,830
Drugs *	921	912	9	1.0%	1,762
Non Clinical Supplies *	590	587	3	0.6%	860
Purchase of health care services	418	388	30	7.7%	124
Consultancy costs	69	73	(3)	-4.5%	64
PFI costs	228	229	(0)	-0.1%	207
Other operating expenses *	3,517	3,475	42	1.2%	1,928
Non Pay expense	**7,563**	**7,488**	**75**	**1.0%**	**6,810**
Total operating expenses for EBITDA	**22,410**	**22,209**	**201**	**0.9%**	**20,453**

* A change in the categories used in the 2015-16 Annual Plan means that the values for Q2 2015/16 and Q2 2014/15 In the above table are not directly comparable (for the asterisked rows only).



- Operating expenses at Q2 2015/16 were 0.9% above plan, but £2bn (9.6%) higher than the year before (or 4.7% on a like-for-like basis). Spending on agency staff to compensate for a shortfall in permanent staff continued to be the main reason that pay costs exceeded the plan at Q2 due to premium agency staff costs.
- The total number of agency staff employed by the NHS FT sector rose from 20,130 whole time equivalent (WTE) in Q1 to 21,498 WTE (up at Q2, which was 8,335 WTE more than plan. Registered nurses, clinical support staff and locum doctors represented the large majority of the agency workforce. In WTE terms, acute trusts were by far the largest users of agency staff employing almost 14,700 WTE. In percentage terms, mental health NHSFTs had the highest agency to permanent staff ratio (3.6%).
- Agency costs at Q2 reached almost 7.2% of total staff pay costs, well above the 4.2% planned and higher than 6.9% at Q1 15/16 and 6% at Q2 last year. Regionally, London continued to have the highest spend on agency staff (8.4%) followed by the Midlands and East region (8.0%).
- On average, we estimate that the NHSFT sector paid an agency premium of 131% during the quarter. This level of agency spend is unsustainable. Monitor and NHS TDA have now developed a package of measures to reduce spending on agency staff. We have introduced the agency staff ceilings for individual NHSFT and mandated the use of framework agreements. We are implementing maximum hourly rate caps with effect from 23 November.
- In addition, acute and mental health NHSFTs also sub-contracted more healthcare services to the independent sector this year. During the first six months of the year, mental health trusts spent £121m (50% more than on Q2 last year) and acute trusts spent £254m (compared to £40m at Q2 last year) on additional capacity.
- The only significant area of underspend was savings on fuel costs at ambulance trusts due to lower fuel prices than planned. Some savings, albeit small, were also made on consultancy costs due to controls on consultancy spend introduced by Monitor in June.

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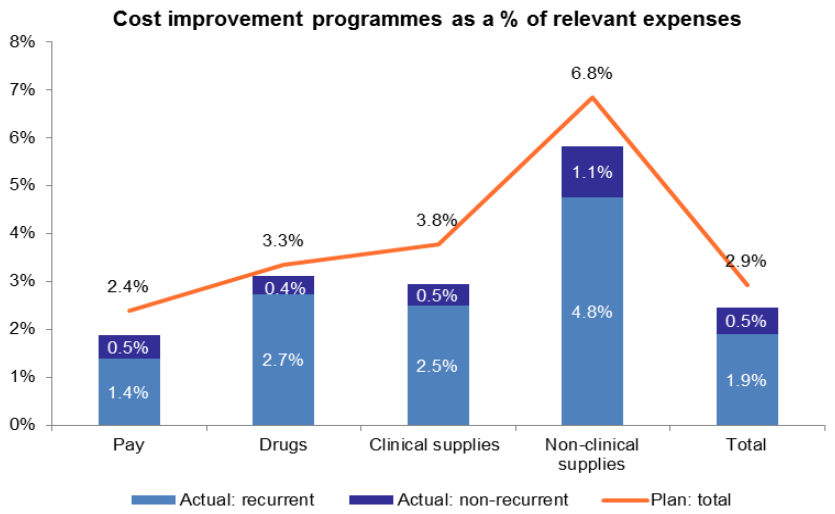
3.4 Cost improvement programmes



Cost improvement programmes as a % of operating expenditure	Sep-15 Q2 2015/16		Sep-14 Q2 2014/15	
	Actual	Variance from plan	Actual	Variance from plan
Teaching acute	2.4%	-0.6%	2.2%	-0.7%
Large acute	2.3%	-1.2%	2.0%	-1.1%
Medium acute	2.5%	-0.4%	2.5%	-0.7%
Small acute	2.1%	-0.5%	2.1%	-0.5%
Total acute	**2.4%**	**-0.6%**	**2.3%**	**-0.7%**
Mental Health	2.6%	-0.1%	2.8%	-0.5%
Specialist	1.8%	-0.5%	1.8%	-0.6%
Ambulance	3.8%	0.0%	3.9%	0.3%
Community	3.2%	-0.8%	-	-
Total	**2.4%**	**-0.5%**	**2.4%**	**-0.6%**

- Cost improvement programmes (CIPs) used to deliver efficiency savings have reduced controllable operating costs by 2.4% (or £554m) at Q2 2015/16. This was in line with the reductions achieved in the same period last year.
- The CIPs shortfall against plan was £109m at Q2. However, the gap between plan and actual has decreased to 16% from 22% at Q1 2015/16.
- NHSFTs delivered 1.9% pay savings at Q2 compared to 1.6% in the previous period, and the shortfall from plan decreased to 21% from 26%. Despite the improvement, NHSFTs were still struggling to deliver pay savings and the result was a £76m under-delivery which represented 70% of the total CIPs shortfall.
- Acute NHSFTs were the main contributor to the CIPs under-delivery. They accounted for £62m (or 25%) shortfall against plan pay CIPs and £97m (or 20%) on overall CIPs.
- NHSFTs have continued to rely on non-recurrent schemes to deliver savings. They had planned to deliver 92% of the savings recurrently at Q2 but only managed 78%. Although this was on par with historically figures, it does raise questions on how robust CIPs were at the planning stage.
- The number of NHSFTs who have under-delivered on their efficiency savings remains the same as Q1 2015/16 at 110. However, NHSFTs with a shortfall greater than 25% has reduced from 61 at Q1 to 49 this quarter.
- The NHS TDA calculates NHS trusts' efficiency savings on a slightly different basis to Monitor, whereby revenue generation is included as part of savings, and percentage is calculated as a reduction of total operating costs rather than total controllable operating costs. NHSFTs achieved £140m of revenue generation at Q2. Therefore, adopting the NHS TDA's approach, CIPs would represent 2.9% of total operating costs on a comparative basis.

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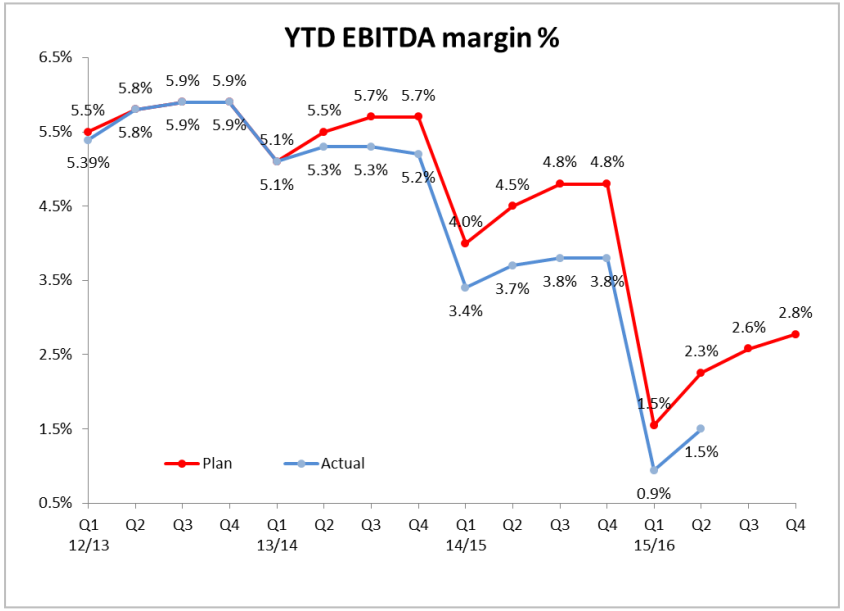
3.5 EBITDA margin



Trust Type	Q2 2015/16		Q2 2014/15	
	EBITDA %	Variance to plan %	EBITDA %	Variance to plan %
Teaching Acute	1.8%	-0.9%	4.4%	-0.9%
Large Acute	0.3%	-2.9%	5.1%	-0.9%
Medium Acute	-0.7%	-1.1%	2.0%	-1.3%
Small Acute	-1.7%	-0.7%	0.0%	-1.3%
Acute	0.4%	-1.1%	3.1%	-1.1%
Mental Health	4.7%	0.6%	5.1%	0.1%
Specialist	3.5%	-0.5%	6.2%	-0.1%
Ambulance	3.5%	-1.1%	5.2%	-0.1%
Community	2.8%	-0.5%	n/a[1]	n/a[1]
Total	**1.5%**	**-0.7%**	**3.7%**	**-0.8%**

[1] Community FTs have only existed since 1 November 2015

- The NHSFT sector projected a sharp fall in the aggregate EBITDA margin this year. Despite the planned year-to-date EBITDA margin of 2.3% at Q2 2015/16 being significantly below all previous years, the sector continued to underperform against plan and achieved an actual year-to-date aggregate EBITDA margin at 1.5%.
- Despite the underperformance, the sector's year-to-date aggregate EBITDA margin improved compared to Q1 as trusts started to build up their in-year efficiency savings. This was in line with the historical trend. Acute NHS FTs in aggregate reported a positive EBITDA margin of 0.4% at Q2, an improvement from the negative margin of -0.3% reported for the previous quarter. However, small and medium acute trusts continued to be under significant financial stress, reporting negative EBITDA margins of -1.7% and -0.7% respectively. Conversely, mental health trusts continued to outperform their plan and in aggregate achieved the highest year-to-date EBITDA margin at 4.7%.
- Across the sector, only 28 trusts (mostly mental health trusts) achieved the 5% threshold which Monitor uses to assess a trust's long term financial sustainability, while 42 trusts (mostly acute providers) reported a negative EBITDA margin at Q2.
- Notwithstanding the quarter on quarter improvement, NHSFTs have expressed concerns over the coming winter months which are likely to see additional financial and operational pressure. Therefore, it will be exceptionally challenging for the sector to achieve their current projection, i.e. an EBITDA margin of 2.3% at the year end. If the last three years' trend was to be repeated, we would expect the EBITDA margin for the next six months to remain relatively flat.

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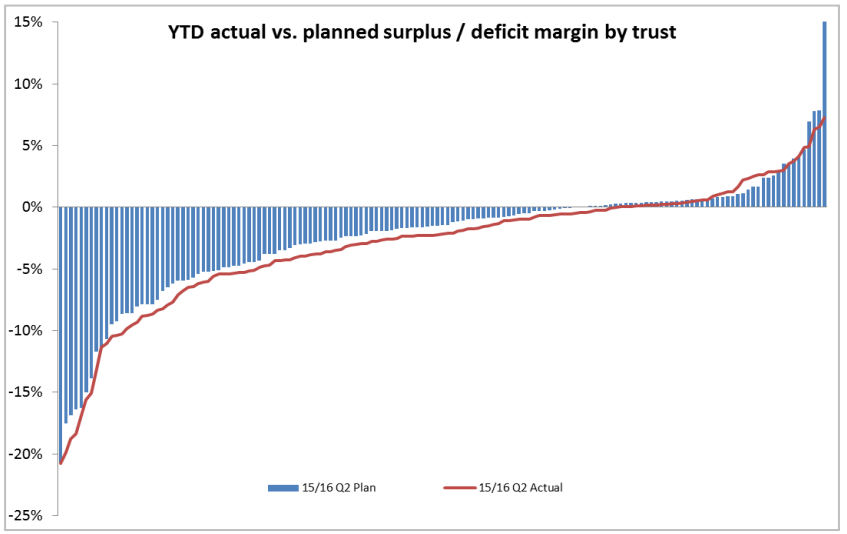
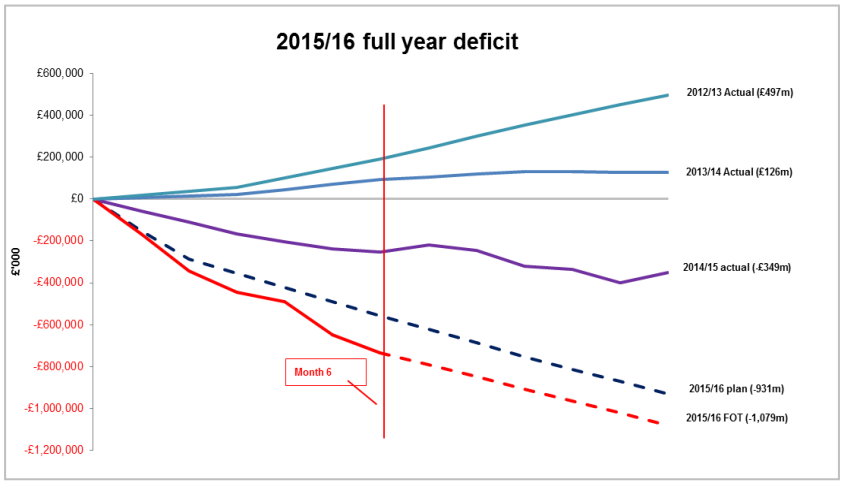
3.6 ‘S’ curve & full year deficit





- As highlighted in our previous quarterly report, NHSFTs face tougher financial challenges this year. The 110 NHSFTs in deficit at Q2 reported a gross deficit of £816m, £148m more than plan. In comparison, the size of the gross surplus at £87m at Q2 was £21m below plan, resulting in a negative year-to-date variance of £169m.
- As highlighted by the right hand end of the ‘S’ curve, NHSFTs with planned large year-to-date surplus margins saw the biggest reduction in margins at Q2 as delays in planned donations and transfers continued to impact on these trusts’ financial performances. In addition, 17 NHSFTs delivered an unplanned deficit, three more than in Q1. Of these trusts, 11 were acute trusts. In contrast, eight trusts reported an unplanned surplus margin at Q2, seven of these were mental health trusts.
- Despite the growing size of in-year deficit and operational concerns over the upcoming winter months, many NHSFTs have told us that they are actively taking actions to strengthen their internal financial controls and improve their operational resilience. As a result, the sector as a whole has not made any significant change to its forecast outturn for the year and the projected sector deficit for the year remained close to £1.1bn which was worse than the original plan of a full-year deficit of £931m.
- However, combining NHSFTs’ current forecast with NHS trusts’ full-year projection, the whole of provider sector would end the year with a total deficit of over £2.2bn. This level of deficit is clearly not affordable. Monitor and TDA have been working closely together to reduce the deficit. Existing measures introduced by both organisations (including controls over consultancy spend and nurse agency spend) will deliver positive benefits to the sector. We are also working to provide further turnaround support to a number of NHSFTs where we believe there are opportunities which will impact positively on the full year outturn.

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3.7 Balance sheet

As at 30 September 2015	30 Sept. 2015		Variance to plan		31 March 2015
	Actual £m	Plan £m	£m	%	Actual £m
Property, etc. (owned and PFI)	22,132	22,310	(177)	-0.8%	21,795
PFI assets	4,136	4,232	(96)	-2.3%	4,039
Other non-current assets	832	872	(40)	-4.6%	808
Total non-current assets	**27,100**	**27,413**	**(313)**	**-1.1%**	**26,642**
Inventories	547	540	7	1.3%	539
Trade & other receivables	1,869	1,856	12	0.7%	2,006
Accrued revenue	713	498	215	43.1%	452
Prepayments	659	428	230	53.7%	433
Cash & Equivalents	3,418	3,331	87	2.6%	3,986
Other current assets	78	65	13	20.8%	105
Total current assets	**7,283**	**6,718**	**565**	**8.4%**	**7,522**
Borrowings	(438)	(432)	(6)	1.3%	(140)
Accruals	(1,995)	(1,735)	(261)	15.0%	(1,768)
Trade & other payables	(2,970)	(2,863)	(107)	3.7%	(3,019)
Deferred income	(716)	(539)	(177)	32.9%	(529)
Provisions	(243)	(221)	(22)	10.0%	(274)
Other current liabilities	(78)	(109)	31	-28.2%	(257)
Total current liabilities	**(6,440)**	**(5,897)**	**(542)**	**9.2%**	**(5,986)**
Net current assets	**844**	**821**	**23**	**2.8%**	**1,536**
Borrowings	(2,675)	(2,761)	86	-3.1%	(2,353)
Deferred income	(149)	(152)	3	-2.1%	(155)
Provisions	(302)	(293)	(9)	3.1%	(306)
PFI leases	(4,208)	(4,296)	88	-2.0%	(4,214)
Other non-current liabilities	(79)	(87)	8	-9.4%	(84)
Total non-current liabilities	**(7,413)**	**(7,589)**	**176**	**-2.3%**	**(7,112)**
Total funds employed	**20,531**	**20,645**	**(114)**	**-0.6%**	**21,065**
Retained earnings	312	390	(78)	-19.9%	992
Public Dividend Capital	14,427	14,503	(76)	-0.5%	14,352
Revaluation reserve	5,681	5,644	37	0.7%	5,620
Other reserves	111	108	3	3.0%	101
Total taxpayers' equity	**20,531**	**20,645**	**(114)**	**-0.6%**	**21,065**

- Total cash held at Q2 was sufficient for 27 days' operations.
- Net current assets at the Q2 was equivalent to 6.8 days' operation.

- NHSFTs' non-current assets have increased by £302m since 31 March 2015 (and £86m since Q1). In Q2 Chelsea NHSFT acquired West Middlesex NHS trust with £116m of assets (including £32m PFI assets).
- The PFI asset variance to plan included a further delay of Alder Hey's £111m PFI scheme, a PFI write down of £46m at Derby, Chelsea's acquisition mentioned above (which was not reflected in their plan), a delay to South Devon's planned acquisition of Torbay NHS trust and a correction of £86m categorisation error made by Manchester.
- The other year-to-date movements in non-current assets came from £950m of capital expenditure/additions, £649m of depreciation, £12m of impairment reversals, £7m of revaluations, £5m of donated assets less £60m of asset disposals at net book value.
- Trade receivables at £1.85bn were slightly above plan, but down by £132m or 6.7% since the start of the year, as NHSFTs collect their revenue faster than before. The "receivable days" showed a reduction from 16.2 at the start of the year to 14.6 at the end of Q2.
- Impairment of gross trade receivables for doubtful debts has not changed since Q1, remaining at 13% (£289m) compared to 10.8% (£239m) at the start of the year. Of the £177m deferred income variance, £89m was related to incomes received from CCGs to support trusts in liquidity difficulties.
- Trade payables at Q2 were £27m higher than planned, but have decreased by £88m (4%) since the start of the year. The "payables days" showed a reduction from 57.2 at the start of the year to 52.1 at the end of Q2. Capital payables were £22m less than planned at Q2, a 25% reduction since the start of the year.
- Cash and equivalents were down by £331m in Q2 and £568m reduced from the start of the year, but this decrease was £87m less than planned.
- So far this year, 17 NHSFTs have received £249.8m worth of DH loans as interim financial support under the distressed provider regime, a rise from Q1 where 11 FTs received £113m worth of distress funding. However, overall, borrowings were £80m less than planned at Q2 2015/16.

3.8 Cash flow

6 months ended 30 September 2015	Q2 2015/16		Variance to plan		Q2 2014/15
	Actual £m	Plan £m	£m	%	Actual £m
Surplus/(Deficit) from operations	**(275)**	**(178)**	**(98)**	**55%**	**113**
non operating & non cash items	655	695	(41)	-6%	656
working capital movements	41	(46)	87	-189%	(98)
Net cash inflow/(outflow) from operating activities	**420**	**472**	**(52)**	**-11%**	**663**
Capital Expenditure	(1,016)	(1,477)	461	-31%	(979)
Other investing activities	58	123	(66)	-53%	43
Net cash inflow/(outflow) from investing activities	**(958)**	**(1,354)**	**396**	**-29%**	**(936)**
PDC capital movements	40	119	(79)	-67%	236
PDC dividend payments	(276)	(289)	14	-5%	(254)
PFI interest & capital payments	(221)	(226)	5	-2%	(213)
Finance lease interest & capital payments	(23)	(22)	(1)	2%	(18)
Loans drawn / (repaid), net	388	467	(79)	-17%	173
Other financing activities	3	146	(143)	-98%	(37)
Net cash inflow/(outflow) from financing	**(89)**	**194**	**(283)**	**-146%**	**(113)**
Net cash inflow/(outflow)	**(627)**	**(688)**	**61**	**-9%**	**(385)**
Opening Cash & Equivalents less overdraft	3,976	3,963	13		4,224
Cash & Equivalents from transfers by absorption	33	40	(7)	-17%	0
Cash & Equivalents from newly authorised FTs	16	16	-	0%	0
Closing Cash & Equivalents less overdraft	**3,398**	**3,331**	**67**	**2.0%**	**3,840**

- NHSFTs closing cash position has deteriorated further at Q2 2015/16 to £3.4bn. The decrease was £67m better than plan, even though the operating deficit was £98m worse than plan. This was achieved by NHSFTs continued management of working capital and reduction in capital expenditure.
- The majority of the working capital movements came from an increase in cash inflow from £271m of accruals and £184m of deferred income against plan, offset by an increase in cash outflow due to £229m prepayments and £218m accrued income. The overall net effect is an increase in working capital of £87m against plan. London NHSFTs do not appear to be tightening their working capital; with a net cash outflow of £79m against a plan net cash inflow of £12m. Two NHSFTs accounted for £55m of this outflow.
- The underspend on capital expenditure (on an accruals basis) was £482m, or 33.7%, against plan, resulting in the cash outflow on capital expenditure being £461m less than plan. The £1.0bn cash paid for capital expenditure outstrips the £420m net cash inflow from operating activities and asset sale proceeds of £61m, forcing both a reduction in cash balances held and requiring DH loans or PDC. In the current climate, this level of capital expenditure cannot continue to be sustainable and Monitor is working closely with NHSFTs to evaluate the available options.
- PDC capital movements are lower than plan and is mainly driven by NHSFTs not receiving anticipated capital funding and DH not issuing PDC as interim support.
- Loans received, net of loans repaid, has increased by 224% at the end Q2 compared to the same quarter last year.
- With NHSFTs facing mounting deficits, there has been an increased need for interim cash support in the form of a revolving working capital facility from DH. By the end of Q2 2015/16, 16 NHSFTs had received a total of £271m, and two NHSFTS had paid back £21m.

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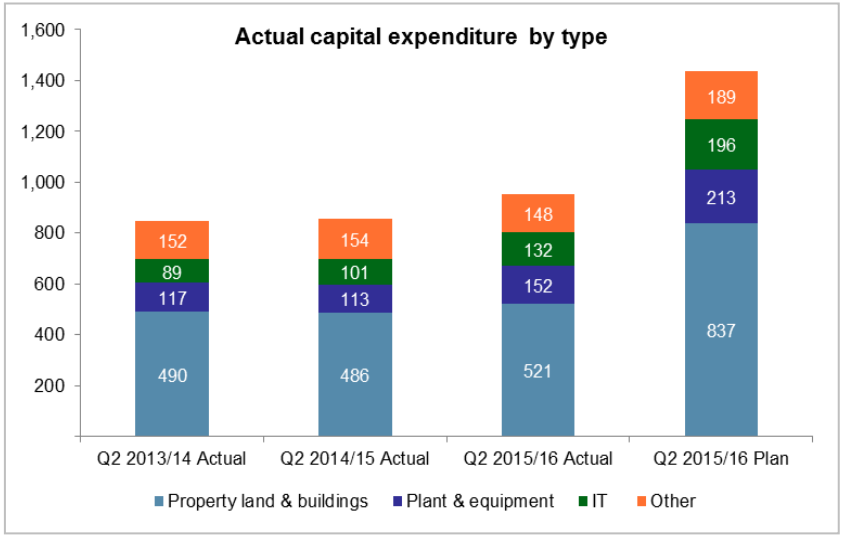
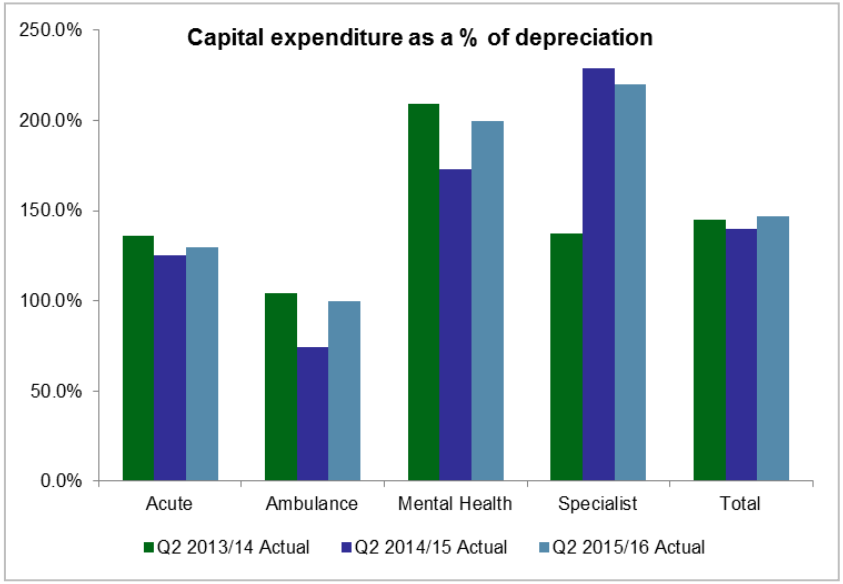
3.9 Capital expenditure





- NHSFTs spent £952m on capital expenditure at Q2 2015/16, 33.7% less than planned. The level of underspend was higher compared to Q2 last year (29.4%).
- Given the current financial pressures, a third of trusts told us that they expected to over/under spend against their capital plans by more than 15%. The majority of trusts indicated that this was due to slippage of capital schemes until the next financial year in order to free up cash for revenue expenditure in 2015/16. The level of underspend by community, mental health and specialist trusts have greatly increased from Q1 2015/16 to Q2 by 33.5%, 13.4%, and 63.0% respectively.
- Although NHSFTs have now started to rein in their capital expenditure, on a cash basis, spending continued to outstrip cash generated from operations and asset sales. At Q2 2015/16, the gap was £534m.
- Typically, public dividend capital (PDC) and loans were used to meet the funding shortfall. In particular, trusts have increased their reliance on loans while draw down on PDC has declined. The total capital schemes funded by loans at Q2 2015/16 reached £388m, a 120.7% increase compared to Q2 last year (on a like-for-like basis).
- Capital expenditure continued to exceed depreciation. Actual capital expenditure was 146.7% of depreciation at Q2 2015/16, which was lower than planned 215.2% but higher than the previous quarter at 141.9%. The rise from last quarter was driven by acute and specialist trusts which comprise 77% of the total capital expenditure for NHSFTs. This shows that trusts continue to invest in their patient care infrastructure.
- Despite the current underspend, most NHSFTs still forecast to be on plan or close to plan in relation to their capital expenditure for the year, and the sector as a whole has projected that its full-year capital expenditure would reach £2.7bn. However, given the current financial stress, reliance on borrowing will not be a sustainable solution to fund future capital schemes. We have been in contact with all NHSFTs to gain a more accurate understanding of their current forecast capex outturn, and of the scope for further safe deferral of planned expenditure.

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4.0 Regulatory performance

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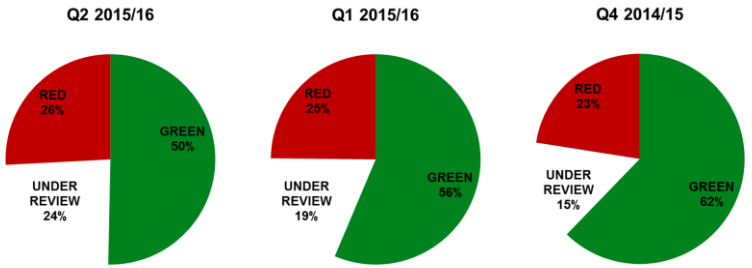
4.1 Risk assessment framework

- The Risk Assessment Framework (RAF) sets out our approach to overseeing each NHSFT's compliance with two aspects of its provider licence: the continuity of services and governance licence conditions.
- To strengthen our regulatory regime and help trusts improve their financial standing, Monitor updated the RAF in August this year following a consultation with the sector. As a result, we have replaced the existing continuity of services risk rating (COSRR) with a new four-level financial sustainability risk rating (FSRR). The new risk rating was created by combining the existing capital service metric and liquidity metric underpinning COSRR with two new measures, an income and expenditure (I&E) margin metric and a variance from plan metric. This new rating has now been applied to all NHSFTs since August 2015.
- Under the updated RAF, each NHSFT receives two risk ratings, a governance risk rating (GRR) and a financial sustainability risk rating (FSRR), to reflect our views of its governance and detect early signs of any financial risks which may jeopardise its financial standing and threaten the on-going availability of key services at the trust.

4.2 Current risks

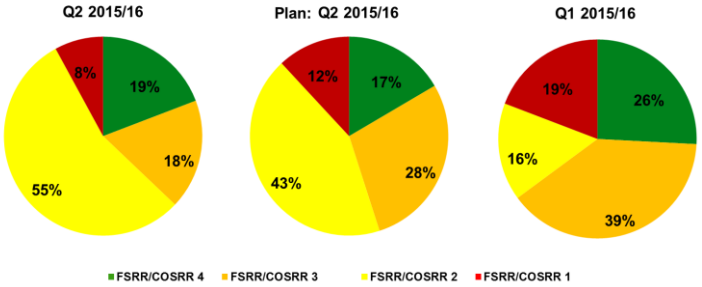
GRR



- Under the RAF, enforcement action may be taken by Monitor if a trust has breached or is breaching one or more of its licence conditions. If we decide to take enforcement action against a trust, the trust will receive a GRR red rating.
- Since our last report, Monitor decided to take enforcement action at two trusts, one acute and one ambulance trust. As a result, the total number of trusts subject to enforcement actions currently stands at 39.
- Among the red-rated trusts, four are mental health trusts, one an ambulance trust and the rest are all acute trusts. This is a reflection of significant operational and financial pressures faced by the acute trust sector, especially the medium and small trusts as they make up over 70% of red-rated trusts.
- Regionally, the South region now has seven red-rated trusts, whereas London still only has two, and Midlands and North regions have 15 each.
- At the time of reporting, the ratings of 37 trusts were in the process of being reviewed and agreed, including eight trusts* which are currently being investigated.

** The figure above excludes both Norfolk and Norwich and Southend, both are already in breach of their provider license.*

FSRR



- FSRR is intended to identify the level of risk a trust faces to the ongoing delivery of its key NHS services. The rating ranges from 1, the most serious risk, to 4, the lowest risk. A trust reporting a deficit may not receive a low FSRR, provided that the trust either has sufficient cash and other reserves to ensure both financial and service sustainability without any detrimental impact on patient care, and/or the variance from plan in relation to its I&E margin is relatively small.
- Given the current financial challenges faced by the sector, 95 trusts received a FSRR 1, 2 or 2* this quarter. Of these trusts, 52 had a COSRR of 1 or 2 in the previous quarter. Almost 75% of the trusts with FSRR 1, 2 or 2* at Q2 were acute trusts, reflecting the significant financial stress they are under. In addition, 20 trust were received a FRSS 1 or 2 which were unplanned this quarter. Of these trusts, eight were acute trusts, five specialist trusts, four mental health trusts, two ambulance trusts and one community trust.
- However, a low risk rating does not necessarily represent a breach of the provider license. Rather, it reflects the degree of financial concerns we have about a trust. Of those trusts receiving an FSRR 1 or 2, 37 are subject to enforcement action, investigations have been opened at six trusts, and further information is currently being gathered from 23 trusts to determine whether formal investigations are necessary .

4.3 Foundation trusts under review

- The *RAF sets out* five triggers for concerns which could lead to a trust being formally investigated or being considered for investigation. These triggers include financial risks, failing access and outcome metrics or governance indicators, reports from the Care Quality Commission (CQC) or other third party.
- Trusts being considered for investigation and being formally investigated are both deemed to be "under review" with respect to their governance risk rating. At the time of reporting, 37 trusts* were under review.

Under investigation

- Since our last report, we have launched two new investigations (see "*trusts under investigation*" table) in addition to eight ongoing investigations*.
- We have concluded our investigations at five trusts. We decided to take enforcement actions at two trusts (Taunton & Somerset NHSFT and South East Coast Ambulance Services NHSFT), but no formal actions at three trusts (Gloucestershire Hospitals NHSFT, Gateshead Heath NHSFT and Oxford Health NHSFT) as their performances improved.
- Financial sustainability concern was either the main reason or a major reason for eight ongoing investigations, reflecting the growing financial challenges faced by the sector.

Requesting further information

- Further evidence is being gathered in relation to 29 trusts to determine whether a formal investigation should be opened into a potential breach of the conditions of their provider licence.

Trusts under investigation

Trust	Main concerns being investigated	Date
Existing investigations		
Norfolk and Norwich**	Financial sustainability concerns at the trust due to deterioration in financial performance	
Southend**	Financial sustainability concerns at the trust due to deterioration in financial performance	Jun 2015
Robert Jones	Governance concerns triggered by breach of RTT targets	Jun 2015
Derbyshire Healthcare	Governance concerns triggered by the findings of a third party report	Jul 2015
Kingston	Governance and financial sustainability concerns, triggered by multiple breaches of the A&E target and financial deterioration	Jul 2015
Mid Cheshire	Financial sustainability concerns at the trust, triggered by a deterioration in the trust's financial position	Aug 2015
Black Country Partnership	Financial concerns triggered by a COSRR of 2 in Q1 2015/16	Sep 2015
Cambridge & Peterborough	Financial sustainability concerns	Apr 2015
New investigations launched since Q1 2015/16 report		
Royal Bournemouth	Governance and financial concerns due to multiple breaches of the A&E and cancer waiting time targets and a deterioration in the trust's financial position	Nov 2015
Doncaster	Concerns due to the scale of deterioration in the trust's financial position	Oct 2015

** The figure above excludes both Norfolk and Norwich and Southend.*
*** Southend and Norfolk and Norwich have a GRR red rating due to breach of targets. Investigations are open for financial sustainability concerns.*

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4.4 Enforcement actions and special measures

- Under the *RAF*, any trust with a GRR red rating is subject to Monitor's enforcement action. At the time of this report, 39 trusts had received a GRR red rating, an increase from 37 at Q1 2015/16. The change was due to our decision to take enforcement action at two trusts following Monitor's investigation:
    - Due to deteriorating financial performance, we decided to apply enforcement action to Taunton and Somerset NHS Foundation Trust in October 2015.
    - We have decided to apply enforcement action at South East Coat Ambulance Service NHS Foundation Trust in October 2015 due to serious concerns raised as a result of a project carried out by the trust. The project to change standard operating procedures for calls made to 111 by setting longer time to re-triage calls breached nationally agreed standards. This is the first ambulance trust that has breached its provider license.
- Seven trusts, subject to enforcement action, continue to be in special measures for failing to provide good and safe care to patients. Burton Hospitals NHSFT has now successfully improved its patient care and is no longer in special measures.

39 trusts are subject to enforcement action
(foundation trusts in special measures)*

Barnsley	Kettering	Sherwood Forest*
Basildon	King's	Southern Health
Burton	King's Lynn	South East Coast Ambulance
Calderdale	Lancashire Teaching	Southend
Calderstones	Medway*	South Tees
Cambridge University*	Milton Keynes	South Manchester
Colchester*	Morecambe Bay*	St George's
Cumbria Partnership	Northern Lincolnshire and Goole	Stockport
Derby	Norfolk and Norwich	Sunderland
Dudley	Norfolk and Suffolk*	Tameside
East Kent*	Peterborough	Taunton & Somerset
Great Western	Rotherham	Warrington
Heart of England	Royal Berkshire	Wirral

4.5 Other regulatory actions

CQC warning notices

- During Q2 2015/16, there were no warning notices issued against any NHSFTs by the CQC.

Contingency planning and other regulatory work

- Following the conclusion of work carried out at the Queen Elizabeth Hospital Kings Lynn NHS Foundation Trust by a Contingency Planning Team (CPT) in August 2015, Monitor continues to work with the local system to deliver the implementation plan and drive forward the CPT recommendations and secure future services for patients at the trust.
- Following the completion of a review of health service provision in Milton Keynes and Bedfordshire has now been completed, voluntary enforcement undertakings have been agreed with Milton Keynes Hospital NHS Foundation Trust to ensure that the trust continues to address short term performance issues and plans for each of the scenarios being considered by commissioners.
- The report by a CPT appointed for Tameside Hospital NHS Foundation Trust in late 2014 was made public in September 2015. The CPT tested the viability of an integrated care model (ICO) for the population of Tameside and developed an implementation plan which will be overseen by a programme board comprising local stakeholders. It is expected the ICO will be established in shadow form in April 2016 with a full go live date of April 2017.
- Monitor, with national partners, continues to work collaboratively to drive progress on the system transformation programme run by Cambridge and Peterborough CCG, which impacts Peterborough and Stamford Hospitals NHS Foundation Trust, Cambridge University Hospitals NHS Foundation Trust and Cambridgeshire and Peterborough NHS Foundation Trust. This work aims to secure sustainable services for patients across the local area.
- Under an ‘enhanced buddying’ arrangement agreed between Medway NHS Foundation Trust and Guy’s and St Thomas’ NHS Foundation Trust, the scope of support provided by Guy’s has been extended to help drive more rapid progress.
- Since January 2015, Monitor has been working closely with King’s College Hospital NHS Foundation Trust, to effect a turnaround of the trust and to find a sustainable solution, to ensure delivery of its two year recovery plan and five year strategic plan.
- Since May 2015, Monitor has been working closely with St George’s Healthcare NHS Trust, to effect a turnaround of the trust and find a sustainable solution. Monitor has also been liaising with the trust to understand the reasons behind its deterioration in performance following FT accreditation.
- In September 2015 Cambridge University Hospitals (CUH) was placed in Special Measures. CUH is also forecasting a deficit of £64m for 2015/16. Monitor is working with local system partners to oversee a quality improvement programme. CUH also agreed further undertakings with Monitor including strengthening leadership at the trust and preparing a financial recovery plan. A new CEO has now started at the trust in November.
- Since October 2015, Monitor has been working closely with Heart of England NHS Foundation Trust, to effect a turnaround of the trust and find a sustainable solution. We continue to monitor progress and expect to see evidence of impact over the next few months. In addition, Monitor appointed a new interim leadership team at the trust in October led by the Chair and the Chief Executive of University Hospitals Birmingham.

New authorisation

- On 1 October 2015, Oxford University Hospital NHS Trust became an NHS Foundation trust.

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5.0 Glossary and end notes

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5.1 End notes

1	All financial information in this report is year-to-date and based on unaudited monitoring returns from 151 licensed NHS foundation trusts as at 30 September 2015. For foundation trusts authorised during the year, we only include financial data from the date of authorisation. There was no new foundation trust authorised during Q2 2015/16.
2	Throughout this report references to surpluses or deficits are before impairments, and gains or losses on transfers by absorption.
3	EBITDA is an approximate measure of available cash flow. It does not take into account the impact of depreciation, amortisation, financing costs or taxation. This means that when taken as a margin on revenue, it can be used to compare performance between organisations that may have very different levels of capital investment and debt financing.
4	"Teaching" acute trusts are those acute trusts who are members of AUKUH (the Association of UK University Hospitals), a list is available on request or at www.aukuh.org.uk
5	109 foundation trusts report performance against the A&E target.
6	Foundation trusts are deemed to have breached a waiting time target if they fail to achieve the performance standard in any month in the quarter. 123 reported against incomplete pathway targets. The admitted and non-admitted targets were removed in September 2015.
7	82 foundation trusts report performance against the breast cancer: 2 week wait target 99 foundation trusts report performance against the GP referral: 62 day wait target 97 foundation trusts report performance against the all cancers: 2 week wait target
8	For consistency with NHS trust reporting, we deduct restructuring costs in calculating net surplus/deficit.
9	Gains/losses relating to the transfer of assets/liabilities from abolished NHS bodies to foundation trusts on 1 April 2013 have been taken directly to reserves, as required under an HMT dispensation to current accounting rules. All other transfers of assets/liabilities from other NHS bodies to foundation trusts are recorded as a gain/ loss on transfer within the current year surplus/deficit.
10	From 1 April 2013 Terms of Authorisation were replaced by the Provider Licence and, from 1 October 2013, the Risk Assessment Framework (RAF) replaced the Compliance Framework.

5.2 Glossary (1/3)

A&E	Accident and Emergency departments offer a 24 hour, 7 day a week service to assess and treat patients with serious injuries or illnesses.
A&E standard	This is the objective that any patient attending an A&E department is seen and transferred, admitted or discharged within 4 hours of arrival. The objective performance against this target is 95% of patients. If a trust falls below this performance level, it is deemed to have breached the target.
Ambulance standard	Red 1 calls - These are the most time critical and cover cardiac arrest patients who are not breathing and do not have a pulse, and other severe conditions such as airway obstruction. Red 2 calls - These are serious but less immediately time-critical and cover conditions such as stroke and fits. Cat A calls - The number of Category A calls (Red 1 and Red 2) resulting in an ambulance arriving at the scene of the incident within 19 minutes.
Admitted patient	A patient who is formally admitted to a hospital for treatment. This includes admission that is not overnight i.e. day cases.
Agency premium	This is estimated based on a comparison between average agency staff cost (per agency WTE) and average permanent staff pay costs (per permanent WTE).
Cancer waiting time targets	This refers to a series of objective waiting times for patients referred for cancer diagnosis and treatment. Each target has a different objective performance. The waiting times for cancer patients are much stricter than the RTT targets, but the RTT targets include cancer patients.
Case mix	This refers to the complexity or combination of illnesses (morbidity) presented by patients. Typically variances in numbers of patients and case mix of patients combine to affect the workload of doctors.
CCG	Clinical Commissioning Group
CIP	Cost Improvement Programme This is usually a 5 year planned cost reduction programme to improve the productivity and streamline operational structures to provide efficient, effective services.
CoSRR	Continuity of Service Risk Rating. This replaced the Financial Risk Rating (FRR) from 1 October 2013. CoSRR primarily focuses on the level of liquidity and capital service capacity. There are four scores, where 1 represents the most serious risk and 4 the least risk. Unlike the FRR, a low Continuity of Service Risk Rating does not necessarily indicate a breach of the provider licence. It rather reflects our degree of concern about a provider's finances and will help determine the frequency with which we monitor the trust.
CPT	Contingency Planning Team is a team appointed by Monitor to develop options for securing sustainable patient services at a financially troubled foundation trust.
CQC	Care Quality Commission (CQC), is the independent regulator of health and adult social care services in England that ensure care provided by hospitals, dentists, ambulances, care homes and home-care agencies meets government standards of quality and safety.
CQUIN	Commissioning for Quality and Innovation is a system introduced in 2009 to make a proportion (2.5% in 12/13) of healthcare providers' income conditional on demonstrating improvements in quality and innovation in specified areas of care. This means that a proportion of each foundation trusts income depends on achieving quality improvement and innovation goals, agreed between the foundation trust and its commissioners.
Day case	A patient who is admitted and treated without staying overnight, e.g. for day surgery.
DH	Department of Health, the government department responsible for the NHS.
DToC	A delayed transfer of care (DToC) occurs when a patient is considered ready to leave their current care (acute or non-acute) for home or another form of care but are still occupying a bed.
EBITDA	Earnings before interest, tax, depreciation and amortisation. This is an approximate measure of available cash flow. It does not take into account the impact of depreciation, amortisation, financing costs or taxation. This means it can be used to compare performance between organisations that may have very different levels of capital investment and debt financing.
Elective patient	Elective surgery or procedure is scheduled in advance because it does not involve a medical emergency.

5.2 Glossary (2/3)

Enforcement actions	The Health & Social Care Act 2012 requires that Monitor issue licences for providers of NHS services and investigate potential breaches of the licence. Monitor can impose a range of enforcement actions ranging from obliging providers to take steps to restore compliance, obliging them to pay a financial penalty, etc. In exceptional circumstances, Monitor will consider revoking a licence.
Exceptional items	Income or costs that are one-off in nature and do not therefore reflect underlying financial performance, i.e. asset impairments and gains/ losses on asset transfers.
Francis	The Francis Inquiry examined the causes of the failings in care at Mid Staffordshire NHS Foundation Trust between 2005-2009 and a final report was published on 6 February 2013 making 290 recommendations including openness, transparency and candour throughout the healthcare system (including a statutory duty of candour), fundamental standards for healthcare providers, improved support for compassionate caring and committed care and stronger healthcare leadership. The government has responded (19 November 2013) to the recommendations of the Francis Inquiry in "Hard Truths: the journey to putting patients first". It includes recommendations for improving patient involvement in their care, increased transparency, changes to regulation and inspection.
FSRR	
GRR	Governance Risk Rating. This is a measure of the risk of governance failure at a foundation trust. The methodology for assessing the GRR of a trust is explained in Monitor's Risk Assessment Framework.
High cost drugs	High cost drugs are typically expensive drugs used for specialist treatments e.g. cancer, that are excluded from the Payment by Results (PbR) tariff as would not be fairly reimbursed if they were funded through the tariff. Commissioners and providers agree appropriate local prices.
HMT	Her Majesty's Treasury, a government department that fulfils the function of a ministry of finance.
Keogh	Following the Francis Inquiry, the medical director of NHS England Sir Bruch Keogh led a review into the quality of care and treatment provided by 14 hospital trusts in England. His subsequent report identified some common challenges facing the wider NHS and set out a number of ambitions for improvement, which seek to tackle some of the underlying causes of poor care. The report signalled the importance of monitoring mortality statistics to highlight any underlying issues around patient care and safety. Using the data to identify trusts who are performing positively will also be helpful in establishing and sharing effective practice across the NHS. The report is available at this link: http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf
Non-admitted patient	A patient on a pathway that does or did not include treatment without admission to a hospital, also known as an outpatient
Non-elective patient	A patient who is admitted for treatment on an unplanned or emergency basis. Such patients are not relevant to referral to treatment (waiting time targets).
Pathways	A Pathway describes the journey of a patient through an outpatient appointment, diagnostic tests, further outpatient appointments to a potential inpatient appointment (e.g., for surgery).
PDC dividends	Public dividend capital represents the Department of Health's equity interest in defined public assets across the NHS including authorised NHS foundation trusts. The department is required to make a return on its net assets, which takes the form of a public dividend capital dividends.
PFI	Private Finance Initiative is a procurement method which uses private sector capacity and public resources in order to deliver public sector infrastructure and/or services according to a specification defined by the public sector. Within the NHS a typical PFI contract involves a private consortium building a hospital and maintaining it to a defined specification for 20+ years for an NHS trust in return for annual payments from the NHS trust which are indexed to inflation.
PPE	Property, plant and equipment, the term used for fixed assets under International Financial Reporting Standards (IFRS)

5.3 Glossary (3/3)

Special administration	In exceptional circumstances, where a health care provider is deemed financially unsustainable, Monitor, as part of its role, appoints a special administrator to take control of the provider's affairs. The special administrator work with the commissioners to ensure that patients continue to have access to the services they need. For statutory guidance for trust special administrators appointed to NHS foundation trusts refer to: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/403437/TSA_guidance_final_for_publication.pdf
Special measures	A hospital trust is said to require 'special measures' on quality grounds when serious and systemic failings in relation to quality of care have been identified, and the persons responsible for leading and managing the trust are unable to resolve the problems without intensive support. An improvement plan will be published and Monitor will provide intense oversight of the trust to ensure that improvement actions are being taken. Monitor is assisted in doing this by allocating an 'Improvement Director' to the trust.
Surplus or deficits	Refers to the net financial position after operational revenue and operating expenses. Throughout this report references to surpluses or deficits are before any impairments and gains or losses on transfers by absorption.
Teaching hospitals	"Teaching" acute trusts are those acute trusts who are members of AUKUH (the Association of UK University Hospitals), a list is available at www.aukuh.org.uk
Waiting times	The time a patient has to wait before treatment, this is termed RTT (referral to treatment) in the NHS
WTE	Whole Time Equivalent is the ratio of the total number of paid hours during a period (part time, full time, contracted) by the number of working hours in the period. one WTE is equivalent to one employee working full-time.
RAF	From 1 October 2013 the Risk Assessment Framework (RAF) replaced the Compliance Framework as our approach to overseeing NHS foundation trusts' compliance with the governance and continuity of services requirement of their provider licence. As a result, there has been changes to how we determine risk ratings. Under the RAF, each FT is assessed and assigned two risk ratings, governance risk rating (GRR) and continuity of services risk rating (COSRR), to reflect our views of its governance and its on-going availability of key services.
GRR	There are three categories of governance rating: A green rating indicates that there is no material governance concerns evident. An "under review" rating is assigned where potential material causes for concerns are identified, the green rating as a result will be replaced with a description of the issue and the steps we are taking to address it. A red rating means regulation actions are taken.
COSRR	Continuity of services risk rating has four categories, where 1 represents the most serious risk and 4 the least risk. However, a low COSRR does not necessarily indicate a breach of the provider licence. It rather reflects our degree of concern about a provider's finances and will help determine the frequency with which we monitor the trust.
FSRR	Financial Sustainability Risk Rating has four categories, where 1 represents the most serious risk and 4 the least risk. FSRR is calculated based on four metrics: capital service metric, liquidity metric, income and expenditure (I&E) margin metric and variance from plan metric. This new rating has now been applied to all NHSFTs since August 2015.

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