NHS Trust Development Authority

Monitor
Making the health sector work for patients

To: The Board

For meeting on: 25 Feburary 2016

Agenda item: 8

Report by: Jason Dorsett, Finance, Reporting & Risk Director (Monitor)
Elizabeth O'Mahony, Finance Director (NHS Trust Development Authority (NHS TDA))

Report on: Quarterly report on the performance of the NHS provider sector: 9 months ended 31 December 2015

Summary

1. NHS providers continue to face sustained operational and financial challenges during the third quarter. Rising demand especially for urgent and emergency care, coupled with high agency costs have adversely impacted the performance of the whole provider sector while efficiencies to date are behind plan. Providers in aggregate continued to underperform against a number of key national healthcare standards, and the deficit projection for the year deteriorated further despite a number of material improvements in individual providers.

2. The year to date deficit was £2.26bn (£622m worse than plan) with the latest forecast outturn being £2.37bn. This is after £452m of improvement measures included in the month 9 forecast, but not affecting the year to date deficit. This level deficit is neither sustainable nor affordable and we will be working relentlessly to target the provider control total of a £1.8bn deficit for the full year.

3. The establishment of NHS Improvement (NHSI) on 1 April 2016 is aimed to support providers in delivering outstanding quality of patient care, constitutional standards and financial balance, eliminating unwarranted variation across all these areas, while also making the transformation that is needed to ensure long-term sustainability. We are developing programmes to support the recovery of providers in 2016/17 including a targeted financial turnaround programme, asking strong performers to support those who are struggling and building on key operational programmes we are already running such as those supporting emergency care improvement and endoscopy.

4. This paper reports the joint findings from a review of the Q3 2015/16 performance of 240 providers including 152 NHS licensed foundation trusts (NHSFTs) and 88 NHS trusts operating during this period. All performance reported in this report is based on the combined performance of NHS trusts and NHSFTs, unless

otherwise specified. Summary data is annexed to this document and detailed analysis is supplied in a separate supporting annex.

Operational performance

5. We are disappointed to report that due to sustained operational pressures, providers continued to miss several national healthcare targets in Q3 2015/16.

6. In Q3 2015/16, almost 5.12 million patients attended an A&E department, nearly 95,000 more than Q3 last year. However, only 90.66% were treated or admitted within four hours, which was significantly below the 95% target and the performance achieved in the same quarter last year (91.45%). Sustained high levels of emergency admissions and a lack of available beds continue to affect overall performance. Almost 1.04 million patients attending a major A&E department (i.e. Type 1) required admissions in Q3. However, delayed transfers of care meant that over 98,568 patients had to wait for longer than 4-hours for a bed, over 2.1% higher than Q3 2014/15.

7. Demand for ambulance services also rose. Time critical (Category A Red 1) and life threatening (Category A Red 2) calls increased by 1.43% and 4.7% respectively. Ambulance services failed to achieve all key response time targets against Red 1, Red 2 and Category A calls. In October and November 2015, the dispatch-on-disposition pilot was rolled out further. The pilot allowed call handlers extra time to triage calls, which has adversely affected performance against Red 2 and Category A calls.

8. Operational pressure is not only confined to urgent and emergency services. As the size of the elective waiting list reached 3.14m, the provider sector has for the first time failed to meet the 92% referral to treatment target with a performance of 91.59% in December 2015/16.

9. Performance against 62-day urgent cancer referral to treatment standard continues to show improvement albeit below the 85% national target. Providers treated 83.5% cancer patients referred by GPs within 62 days of referral in Q3 2015/16. In contrast, sector-wide operational pressures have affected diagnostic waiting time performance in December, following improvement between August and November. The percentage of patients waiting longer than six weeks for a diagnostic test rose to 2.2% in December from 1.6% reported for November.

Financial performance

10. The year-to-date financial performance continues to worsen in Q3 2015/16. The year-to-date deficit at Q3 is £2.26bn, £622m worse than plan. In total, 179 out of 240 providers reported a deficit at Q3 of which, 131 were acute trusts.

11. The financial performance is driven by:

a) Ongoing high-level use of agency staff: the unplanned agency staff usage has contributed £1bn to the year-to-date adverse variance. This is partly offset by savings from underspending on substantive staff.
b) Delayed transfers of care: providers have estimated that delayed transfers of care have cost £104m so far this year albeit other estimates put the true cost at a much higher level.
c) Failure to deliver the level of cost improvement schemes planned at the start of the year: a shortfall of £257m against plan has added further pressure.

12. This financial performance trajectory is neither sustainable nor affordable. We have already introduced measures to reduce agency costs, but these will not be seen in the results until Q4. In addition, in January, Monitor and NHS TDA wrote to all providers calling for urgent action to be taken and suggested a range of improvement actions. Providers have since identified £452m of financial improvement opportunities. Taking this improvement into consideration, the sector is currently forecasting a year-end deficit of £2.37bn. We continue to work with providers to deliver a significant improvement targeting a £1.8bn full year deficit. Achieving this will require both an improvement in the underlying deficit in Q4 and significant further technical measures. We need boards and executive teams to pursue all possible and legitimate savings that can be made from reviewing balance sheets (e.g. specifically reviewing areas such as accruals and bad debt provisions). As we complete the aggregate accounts for the sector we will consider whether any final national adjustments in these areas are justified.

13. Despite financial performance being £622m worse than planned, the cash position at Q3 was £275m better than planned. Providers achieved this by managing working capital positions and reducing capital expenditure levels. Given the current level of financial distress, providers continue to rein in capital spend. At Q3 2015/16, total capex of £2.43bn is 32% less than planned at the start of the year, providing scope for one-off capital to revenue transfers to non-recurrently improve the sector's overall financial position. We expect further slippage in capital spending in Q4.

Jason Dorsett
Finance, Reporting & Risk Director

Elizabeth O'Mahony
Finance Director

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.

Annex

Operational performance summary

The table below provides a summary of how well foundation trusts and NHS trusts performed against key operational targets during Q3 2015/16.

Metrics	*Target*	Foundation trusts	NHS trusts	Combined performance
Referral to treatment (RTT)				
18 weeks incomplete (%) – December 2015	*92%*	92.05%	90.82%	91.59%
52 week waits (number) – at 31 December 2015	-	180	568	748
Accident & emergency				
A&E attendances	-	2,909,726	2,208,824	5,118,550
Performance – All A&E types (%)	*95%*	92.14%	88.69%	90.66%
Performance – Acute trusts only (%)	*95%*	91.64%	87.71%	89.94%
Type 1 performance (%)	*95%*	89.69%	84.14%	87.39%
Cancer				
2 week GP referral to 1st outpatient, cancer (%)	*93%*	95.1%	93.4%	94.8%
2 week referral to 1st outpatient - breast symptoms (%)	*93%*	94.5%	92.0%	93.4%
31 day wait from diagnosis to first treatment (%)	*96%*	98.0%	97.6%	97.9%
62 day urgent GP referral to treatment for all cancers (%)	*85%*	84.0%	82.9%	83.5%
62 day referral from screening services	*90%*	94.1%	92.2%	93.4%
Diagnostic				
Number of diagnostic tests waiting 6 weeks+ (%) – December 2015	1%	2.46%	1.80%	2.20%
Ambulance				
Red 1 Calls (%)	75%	73.58%	71.78%	72.61%
Red 2 Calls (%)	75%	71.05%	65.42%	67.76%
Category A Call - ambulance arrive within19 mins (%)	95%	91.76%	94.03%	92.71%
Infection control				
C. Difficile (Total cases)	-	820	483	1,302

Financial performance summary

The table below provides a summary of how well foundation trusts and NHS trusts performed financially in the first nine months of this financial year.

9 months ended 31st December 2015	NHSFTs	NHS Trust	Total
No of trusts [1]	152	90	240
Operating revenues (£m)	34,753	21,249	56,001
Pay costs (£m)	(22,479)	(13,943)	(36,422)
Non pay costs (£m)	(11,655)	(7,366)	(19,020)
EBITDA (£m)	618	(60)	559
Net surplus/(deficit) (£m) [1]	(1,010)	(1,253)	(2,263)
Net surplus/(deficit) - Plan (£m) [1]	(754)	(887)	(1,641)
Variance to Plan	(256)	(366)	(622)
No of trusts in deficit [1]	111	68	179
EBITDA %	1.8%	(0.3%)	1.0%
Net surplus/(deficit) %	(2.9%)	(5.9%)	(4.0%)
Total agency costs (£m)	1,583	1,145	2,727
Agency costs as % of total pay costs	7.0%	8.2%	7.5%
Cost improvement programmes (£m) [2]	1,208	733	1,941
CIPs as a % of expenses	3.3%	3.2%	3.2%
Forecast outturn for 2015/16 (£m) [1]	(1,141)	(1,228)	(2,369)
No of trusts forecasting a deficit	100	56	156

[1] The "net surplus/(deficit)" is measured slightly differently between NHSFTs and NHT Trusts. Monitor measure net surplus/(deficit) before impairments and transfers, whereas the NHS TDA reports includes adjustment to add back the impact of impairments, IFRIC 12 adjustments, depreciation and amortisation relating to donated or government granted assets, charitable donations and government grants and gains or losses on transfers by absorption.

[2] Monitor and the NHS TDA calculate the "CIPs (cost improvement programmes) as a % of expenses" measure differently. The NHS TDA calculation includes revenue generation as part of their CIPs, and the % is calculated as a reduction of total costs, whereas Monitor's approach does not include income revenue generation as part of the CIPs and the % is calculated as a reduction of total controllable costs (i.e. without PFI costs as these are unavoidable). NHSFTs delivered £216 million revenue generation at month 8 and, calculated on the NHS trust basis, NHSFTs' CIPS were 3.2% of expenses. Based on Monitor's approach, NHSFTs' CIPs as % of expense would be 2.7%.

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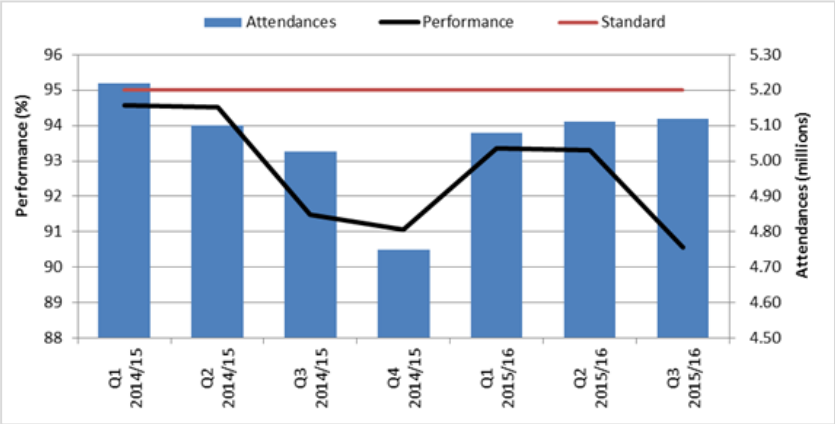
Performance of the NHS provider sector as at 31 December 2015

Content

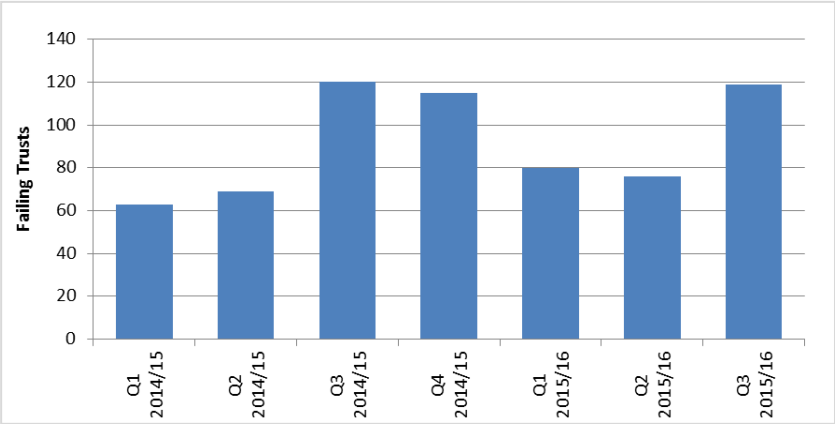
1.0 Operational performance

1.1 Accident & emergency

Percentage of A&E all type patients seen within 4 hours



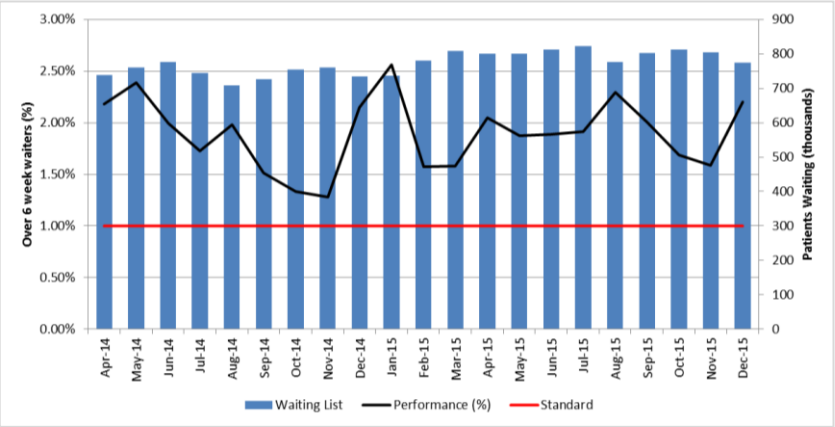
Number of Trusts failing the 4 hour A&E Target by quarter



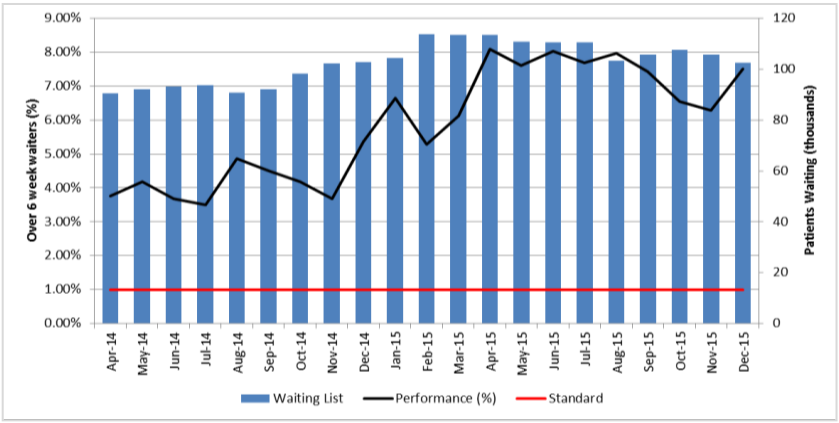
- Delivery against the 95% standard for patients to wait less than 4 hours between arrival, and discharge, treatment or admission continues to be challenging across all sectors of the NHS.
- Despite mild weather between October and December, A&E performance for the quarter fell to 90.66%, failing the 95% standard. Major (type 1) A&E departments struggled the most with a performance of 87.39% for the quarter.
- Only 46 out of 165 trusts achieved the target this quarter as demand rose.
- Almost 5.12 million patients attended an A&E department during the quarter, a 1.84% rise compared to Q3 2014/15. The number of patients waiting more than four hours to be treated, discharged or admitted also rose by 11.33% compared to the same period last year.
- Increased patient acuity among A&E attendees has also led to a rise in emergency admissions. In Q3 2015/16, emergency admissions increased by 1.51% compared to a year ago. However, bed shortages due to delayed transfers of care resulted in 98,568 patients waiting longer than four hours for a bed.
- Nationally, Monitor, the NHS TDA and NHS England are working together to address the performance challenge. The Emergency Care Improvement Programme (ECIP) continues to work closely with the 28 worst performing emergency care systems to ensure that the providers have developed sufficient resilience to meet the challenges of winter months.

1.2 Diagnostic waiting times

Percentage of diagnostic patients waiting over 6 weeks



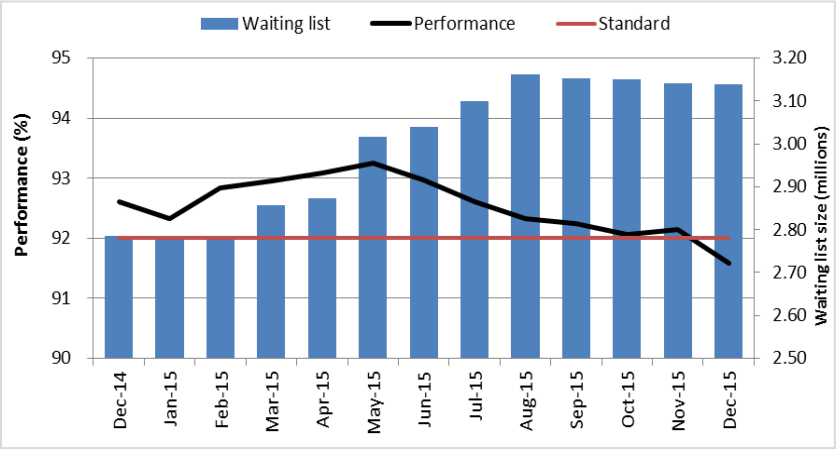
Percentage of endoscopy patients waiting over 6 weeks



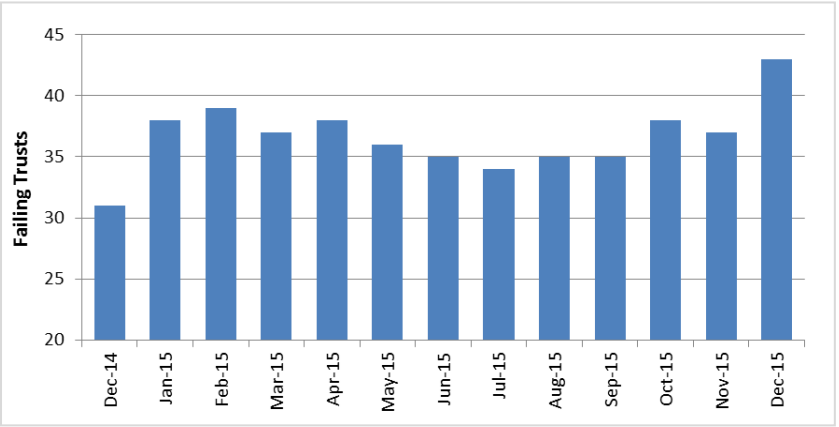
- Diagnostic waiting times are a key part of the delivery of the referral to treatment (RTT) target as the majority of patients will need a diagnostic test. The national waiting time target for diagnostic services states that no more than 1% of total patients waiting should wait in excess of six weeks to be seen.
- Between August and November 2015, the sector delivered month on month improvement against the diagnostic waiting time target, albeit overall performance remained below the national target. However, the performance saw a sharp deterioration in December. At the end of December 2015, there were 770,618 patients waiting for diagnostic tests, a 5.53% rise compared to the same period last year. Of which, 2.2% (or 16,923) had been waiting longer than six weeks.
- Of the 15 diagnostic tests measured, providers failed 12 of them. The longest waits continued to be for endoscopy procedures. In particular, performance at 8.62% against colonoscopy test (a key diagnostic test for patients suspected with bowel cancer) was the worst.
- In contrast, non-obstetric ultrasound had the largest waiting list at December 2015, but a performance of 0.64% meant that the national target was met.
- A national programme team continues to work with providers to address endoscopy performance and capacity issues.

1.3 Elective waiting times

RTT 18 week performance and size of waiting list



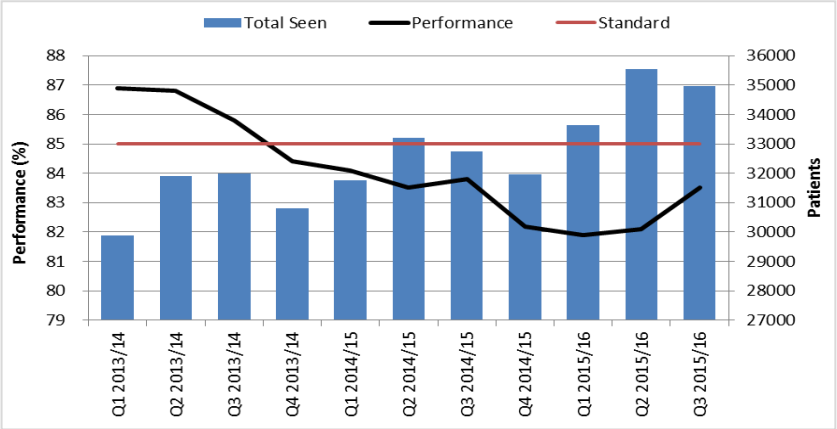
Number of trusts failing RTT 18 week incomplete target by month



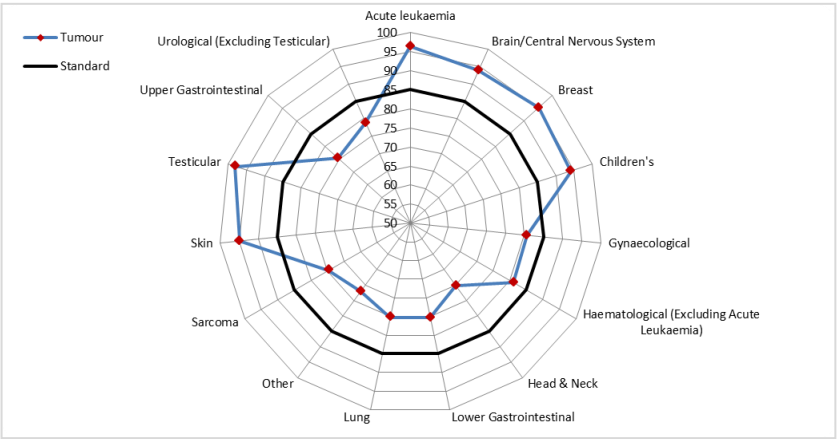
- Following Bruce Keogh's review of waiting time standards, NHS England formally removed both admitted and non-admitted RTT standards in June 2015. The RTT standard for incomplete pathway has now become the sole measure of elective waiting time performance.
- Due to increased operational pressure, the sector's performance against the RTT incomplete standard has been steadily declining since May 2015. In December 2015, the provider sector as a whole missed the standard for the first time with a performance of 91.59%.
- 43 trusts failed the target during the month, and nine trusts did not report against the RTT standards due to system problems.
- The number of patients on incomplete pathways reported in December 2015 was 3,137,789 which was a 12.67% increase on the same month last year.
- In December 2015, 16 providers reported a total of 748 patients waiting longer than 52 weeks. This was a decrease of 70 long waiters from November 2015. Much of the reduction was due to one trust failing to report against the RTT target in December. University Hospitals of Leicester NHS Trust reported 267 and North Bristol NHS Trust reported 167 of these long wait patients.

1.4 Cancer waiting times

62 day (urgent GP referral) wait for first treatment



62 day (urgent GP referral) wait for first treatment specialty split – Quarter 3 2015/16



- In Q3 2015/16, the number of patients beginning their cancer treatments saw a 6.9% rise to almost 35,000. However, only 83.52% of them started their treatment within 62 days after being urgently referred by their GPs. This was below the national target of 85% and worse than the performance of 83.83% achieved in the same quarter last year.
- The specialties that contributed most to the underperformance in Q3 2015/16 were Upper Gastrointestinal, Urological (excluding testicular) and Lung. Together these specialties contributed over 52% of all breaches, although under 39% of patients were treated in these specialties.
- Delays in diagnostic tests, especially in endoscopic procedures have contributed to the pressures in delivering the 62-day target. Nationally, Monitor, the TDA and NHS England have taken a coordinated approach to improving the endoscopy waiting time by working with NHS providers to access additional endoscopy capacity in the independent sector.
- Providers continued to achieve all other cancer standards in Q3 2015/16.

1.5 Ambulance response times

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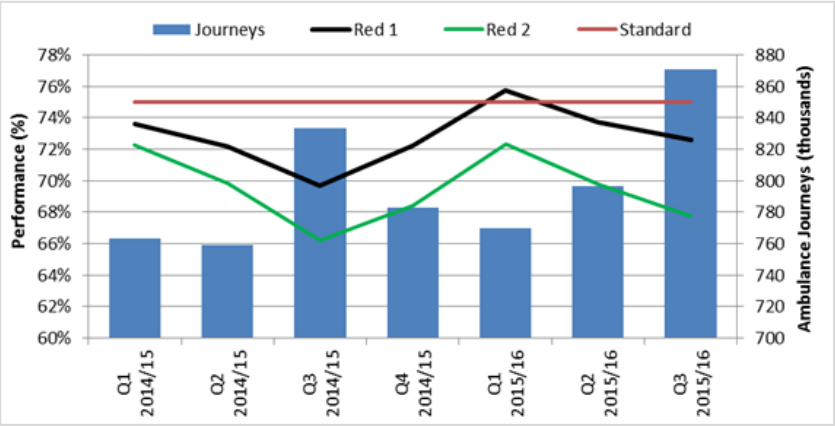
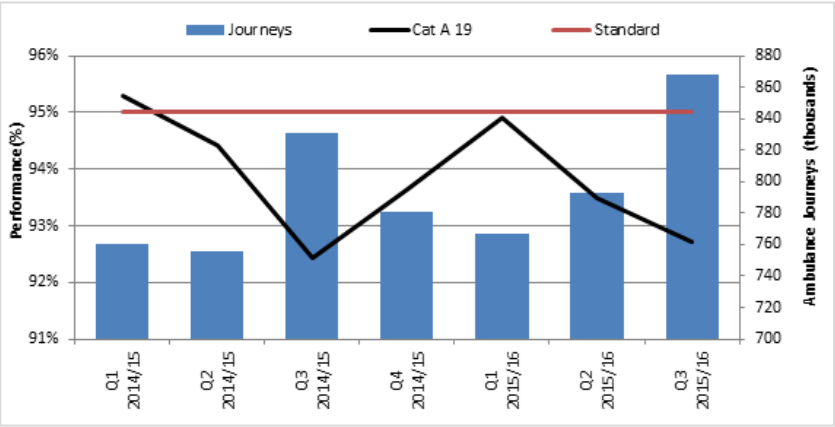
Category A red 1 and red 2 performance and volume of journeys



Category A19 performance and volume of journeys

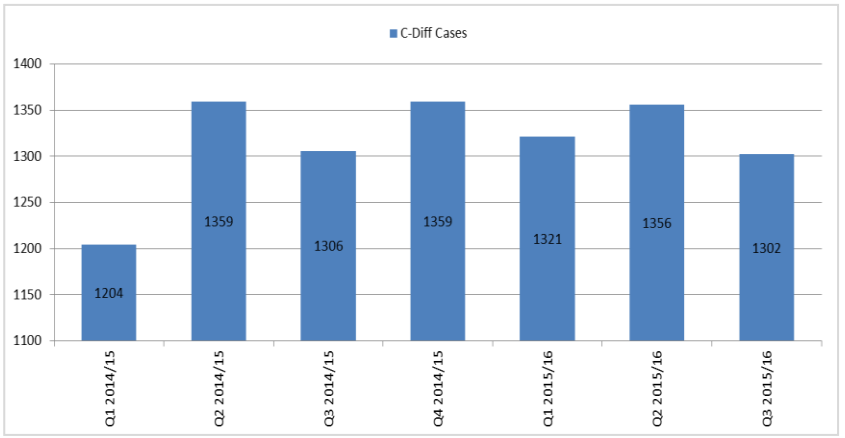


** 11 ambulance services include 10 ambulance trusts as well as Isle of Wight NHS Trust.*

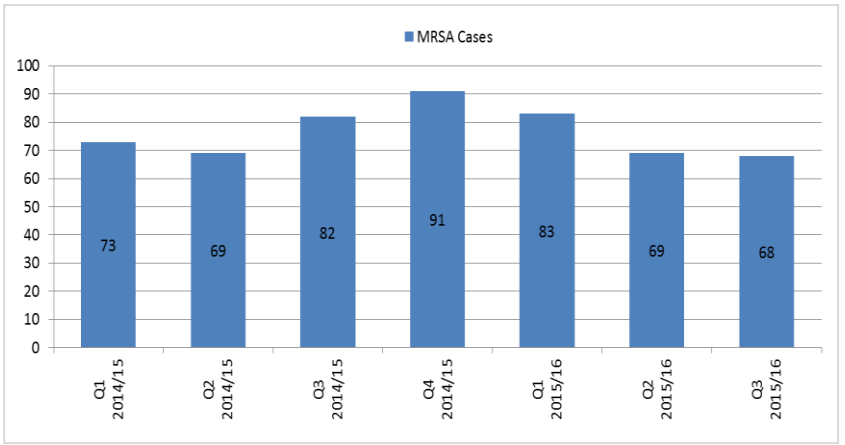
- The national standard sets out that 75% of time critical and life threatening Category A (i.e. Red 1 and Red 2) calls should receive an emergency response within eight minutes, and 95% of all Category A calls should receive an emergency response within 19 minutes.
- For the second consecutive quarter, ambulance services failed Red 1, Red 2 and Category A response time targets with performances of 72.61%, 67.76% and 92.71% respectively. During Q3 2015/16, only two of the 11 ambulance services* achieved the Red 1 and Red 2 standards and three achieved the Category A standard.
- Ambulance services saw a rise in time critical and life threatening calls during the quarter. Circa 45,500 Red 1 calls were responded to by ambulance services, an increase of 1.43% from Q3 2014/15. The number of Red 2 calls also saw a 4.7% increase compared to the same period last year. In total, ambulance services responded to 825,000 Red 2 calls.
- Due to the introduction of Dispatch-on-Disposition pilots at a number of ambulance services, a direct like-for-like performance comparison between Q3 2015/16 and Q3 2014/15 for the Red 2 and Category A standards can not be made. The pilots allow call handlers extra time to triage Red 2 calls and results in different clock start times.
- In February 2015, London Ambulance Service and South Western Ambulance Service Trust (SWAST) implemented the pilot and in October 2015, the pilot was introduced at four more ambulance trusts.

1.6 Infection controls

Number of Clostridium Difficile cases



Number of Meticillin-resistant Staphylococcus Aureus cases reported



Clostridium Difficile (C. Diff)

- The number of C. Diff cases reported was 1,302 in Q3 2015/16. Of the C. Diff cases reported, 820 were reported by NHS foundation trusts and 483 by NHS trusts.
- The number of case reported this quarter remained relatively similar when compared to the same period last year.
- Year to date (between April and December 2015), there have been 3,979 C. Diff cases reported, showing a 2.84% (110 cases) year-on-year increase.

Meticillin-resistant Staphylococcus Aureus (MRSA)

- 68 MRSA cases were reported in Q3 2015/16. Of the MRSA cases reported, 36 were reported by NHS Foundation trusts and 32 by NHS trusts.
- There were 14 fewer cases reported this quarter compared to the same quarter last year.
- Year to date (between April and December 2015), there have been 220 MRSA cases reported, four cases less than a year ago.

2.0 Financial performance

2.1 Income & expenditure

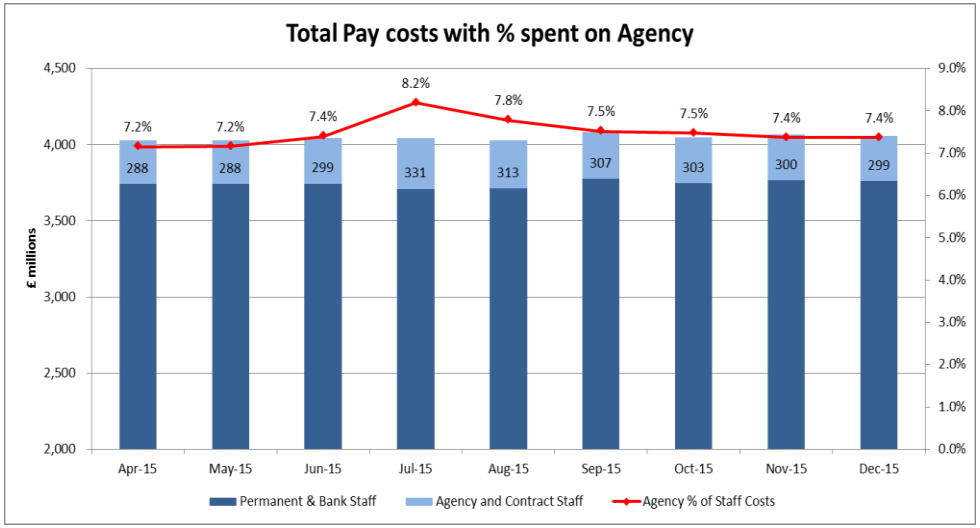
9 months ended 31 Dec 2015	Q3 2015/16 Plan £m	Q3 2015/16 Actual £m	Variance to Plan £m	Variance to Plan %
Operating revenue for EBITDA	**55,578**	**56,001**	**423**	**0.8%**
Pay costs	(35,876)	(36,422)	(546)	1.5%
Other operating expenses	(18,450)	(19,020)	(570)	3.1%
EBITDA	**1,252**	**559**	**(693)**	**(55.4%)**
Depreciation	(1,717)	(1,656)	61	(3.6%)
Finance costs	(621)	(614)	7	(1.1%)
PDC dividend	(704)	(681)	23	(3.3%)
Other non-operating items	200	165	(35)	(17.5%)
Restructuring costs	(51)	(36)	15	(29.4%)
Surplus / (Deficit)	**(1,641)**	**(2,263)**	**(622)**	**37.9%**
Gains/(losses) on transfers	(6)	(35)	(29)	483.3%
(Impairments)/reversals	(171)	(155)	16	(9.4%)
Other financial performance adj.	(10)	(14)	(4)	40.0%
Net Surplus / (Deficit) - I&E	**(1,828)**	**(2,467)**	**(639)**	**35.0%**
EBITDA %	2.3%	1.0%		
Financial performance %	(3.0%)	(4.0%)		
Memorandum				
Fines & Readmissions penalties		*337*		

9 months ended 31 Dec 2015	Acute Actual £m	Ambulance Actual £m	Community Actual £m	Mental Health Actual £m	Specialist Actual £m
Number of Providers	138	10	19	56	17
Operating revenue for EBITDA	41,528	1,612	2,225	8,344	2,292
Pay costs	(26,314)	(1,146)	(1,484)	(6,162)	(1,316)
Other operating expenses	(15,248)	(418)	(684)	(1,775)	(895)
EBITDA	**(34)**	**48**	**57**	**407**	**81**
Surplus / (Deficit)	**(2,267)**	**(26)**	**5**	**21**	**4**
Net Surplus / (Deficit) - I&E	(2,297)	(26)	(51)	(23)	(70)
EBITDA %	(0.1%)	3.0%	2.6%	4.9%	3.5%
Financial performance %	(5.5%)	(1.6%)	0.2%	0.3%	0.2%

- Financial pressures faced by the NHS provider sector continue to rise, and the sector's financial position has declined further during the third quarter despite an improvement in the quarterly run rate. The year-to-date deficit of £2.26bn at Q3 2015/16 is £622m worse than plan. The reported deficit comprises deficit of £1.25bn from NHS trusts and £1.01bn from NHS Foundation trusts.
- 179 (or 75%) providers reported a year-to-date deficit at Q3 2015/16 including 68 NHS trusts and 111 NHS Foundation trusts. The number of providers in deficit at Q3 is three fewer than Q2, but 23 more than plan.
- Despite operating revenue being slightly above plan (0.8%) at Q3, expenditure has continued to grow at a much faster pace than plan, resulting in further performance deterioration. Many providers have cited that their financial performance has been heavily affected by operational pressures arising from increased demand for urgent and emergency care, delays in discharging of medically fit patients and recruitment difficulties to fill vacancies. Fines and penalties have also added £337m of financial pressure to the sector.
- Across the sector, acute providers have been the most challenged financially, reporting a combined year-to-date deficit of £2.27bn at Q3. In contrast, Community, Mental Health and Specialist providers in aggregate have seen an improvement in their financial performance delivering a combined surplus at Q3.

2.2 Expenditure: pay costs

9 months ended 31 Dec 15	Q3 2015/16 Plan	Q3 2015/16 Actual	Variance	
	£m	£m	£m	%
Permanent & Bank staff	(34,160)	(33,695)	465	(1.4%)
Agency and Contract staff	(1,716)	(2,727)	(1,011)	58.9%
Pay costs	**(35,876)**	**(36,422)**	**(546)**	**1.5%**
Other operating expenses	**(18,450)**	**(19,020)**	**(570)**	**3.1%**
Total operating expenses for EBITDA	**(54,326)**	**(55,442)**	**(1,116)**	**2.1%**



- The NHS provider sector's total operating expenses at Q3 2015/16 was 2.1% above plan and almost 6% more than the year before. The negative variance of £1.1bn was driven by overspend on a number of areas. However, the biggest contributor to this variance was higher than planned pay costs, especially unplanned agency staff cost.
- Agency costs at Q3 made up 7.5% of total staff pay costs, well above the 4.8% planned. However, this was an improvement from 7.8% reported for the previous quarter.
- The provider sector planned to reduce its reliance on agency staff at the start of the year. However, recruitment difficulties and a need to maintain safe staffing levels to meet demand rise have led to a year-on-year increase in agency staff costs.
- In order to support providers get the best quality agency staff while reducing overall costs, Monitor and the NHS TDA introduced a series of new rules on use of agency staff. They include ceilings on agency nursing staff spend, mandatory use of procurement framework and maximum hourly rate caps.
- Although the sector is still at an early stage of implementing these measures, the monthly spend on agency staff appears to have stabilised over the last four months, after costs peaked in July and August this year. However, the current level of agency spend is still relatively high, and controls are likely to take some time to embed.
- The sector is forecasting the total spend on agency staff to be in the region of £3.5bn for the year, and the overall agency staff costs as a percentage of total staff costs to fall to 7.2% for the year end. We would expect providers to outperform this forecast as the price caps are more fully implemented.

2.3 Expenditure: non pay costs

9 months ended 31 Dec 15	Q3 2015/16 Plan	Q3 2015/16 Actual	Variance	
	£m	£m	£m	%
Pay costs	**(35,876)**	**(36,422)**	**(546)**	**1.5%**
Clinical supplies	(4,511)	(4,571)	(60)	1.3%
Drugs	(3,048)	(3,163)	(115)	3.8%
Non Clinical supplies	(1,296)	(1,336)	(40)	3.1%
Consultancy costs	(191)	(159)	32	(16.8%)
PFI costs	(674)	(670)	4	(0.6%)
Other operating expenses	(8,730)	(9,121)	(391)	4.5%
Other operating expenses	**(18,450)**	**(19,019)**	**(570)**	**3.1%**
Total operating expenses for EBITDA	**(54,326)**	**(55,442)**	**(1,116)**	**2.1%**
Of Which:				
Foundation trusts	(33,514)	(34,134)	(620)	1.8%
NHS trusts	(20,812)	(21,308)	(496)	2.4%

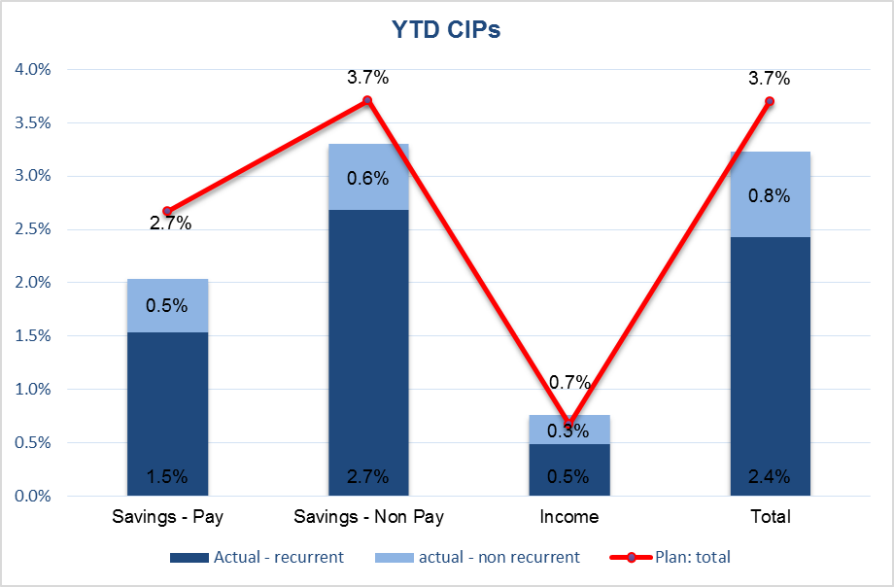
Consultancy spend	Q3 2015/16 YTD Plan	Q3 2015/16 YTD Actual	Q3 2015/16 YTD Variance	2015/16 Full year Plan	2015/16 FOT
	£m	£m	£m	£m	£m
Consultancy costs	190.6	159.4	(31.2)	249.1	214.8
as a % of operating expenses		0.29			0.29
Of Which:					
NHS trusts	83.0	48.5	(34.5)	106.6	68.5
Foundation trusts	107.7	110.9	3.3	142.5	146.3

- Providers have identified that they are facing a number of cost pressures. One particular area of concerns is costs associated with delayed transfers of care (DToCs). In Q3 alone, the NHS providers saw a 10% year-on-year rise in the number of DToCs. Providers have estimated that such delays have cost them in the region of £104m in direct costs so far this year. However, other estimates have put the true costs at a much higher level. DToCs can lead to constrained bed capacity and affect trusts' earning and spending. Lord Carter, in his review, regarded this to be a 'major problem' for the NHS with the fully absorbed costs being even higher than that estimated by providers.
- Of the £391m variance against 'other operating expenses', approximately £100m was related to purchase of healthcare services from other providers including independent sector. Between April and December 2015, NHS Foundation trusts subcontracted £655m worth of services to other providers, which was £468m more than a year ago and £74m (13%) more than planned. Whilst for NHS trusts, their purchases were £25m more than plan.
- In June 2015, Monitor and the NHS TDA introduced control measures to reduce the consultancy spend among NHS providers. Following the implementation of these controls, there has been a reduction in the overall consultancy spend among the providers. However, the current year-to-date underspend of £31m is entirely driven by NHS trusts. Providers plan to spend a total £215m for the year, including £68.5m by NHS trusts and £146.3m by NHS foundation trusts. This forecast appears to be in line with the current monthly run rate.

2.4 Cost improvement programmes

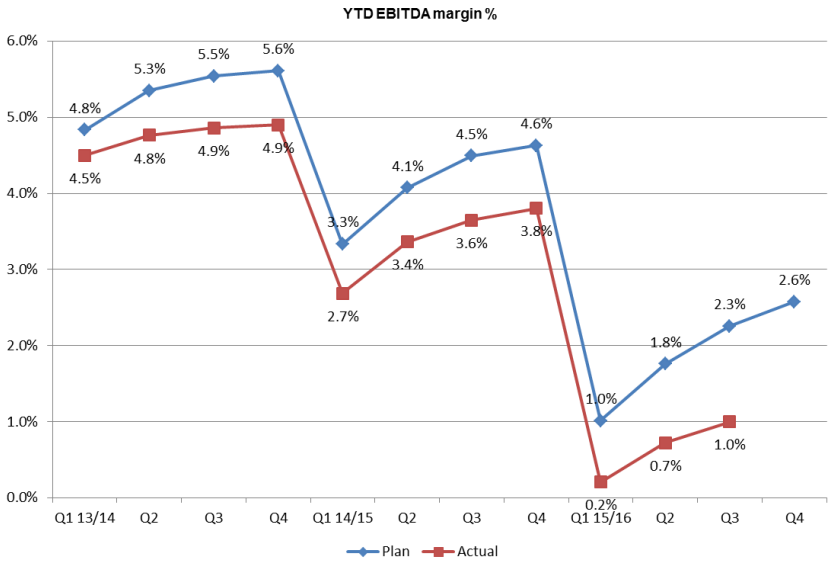
CIPs 9 months ended 31 Dec 2015	Q3 2015/16 YTD				
	Plan	Actual	Variance		YTD as a % of Spend
	£m	£m	£m	%	%
Total CIPs	2,198	1,941	(257)	(11.7%)	3.2%
Of which:					
Foundation trusts	1,308	1,208	(100)	(7.6%)	3.3%
NHS trusts	890	733	(157)	(17.6%)	3.2%

CIPs Forecast	2015/16 FOT				
	Plan	FOT	Variance		% of Spend
Total CIPs	3,226	2,898	(328)	(10.2%)	3.9%
Of which:					
Foundation trusts	1,898	1,748	(150)	(7.9%)	3.5%
NHS trusts	1,328	1,150	(178)	(13.4%)	3.7%



- Monitor and the NHS TDA measure efficiency savings differently. Monitor's approach measures cost savings against total controllable operating costs and excludes revenue generation as part of savings achieved, whereas the TDA's method includes revenue generation and is calculated against total expenditure. For consistency purpose, this report adopts the TDA's approach.
- At Q3 2015/16, providers delivered £1.94bn savings through cost improvement programmes (CIPs) including £426m of revenue generation. This reduced total year-to-date costs by 3.2%.
- The CIPs shortfall against plan was £257m at Q3 2015/16. This equates to a gap of 11.7% between plan and actual. Acute providers were the main contributors to the CIPs under-delivery. They accounted for £215m of the shortfall against plan.
- Pay CIPs accounted for 80% of the shortfall against plan. The above plan spend on agency staff affected providers' ability to achieve anticipated pay cost efficiencies.
- Overall 75% of CIPs achieved were from recurrent schemes (including revenue generation) against a plan of 90%. NHS trusts achieved 80% of CIPs recurrently against a plan of 92%, whilst NHS Foundation trusts only managed 72% against a plan of 88%. Although acute providers are accountable for 80% of the £520m shortfall in recurrent CIPs, they have compensated this shortfall by delivering £211m savings through non-recurrent CIPs.
- The year-to-date shortfall has led providers to project a CIP outturn of £2.9bn at the year end, £328m below the plan. The biggest projected falls are in the specialist and acute sectors at 14% and 11% respectively.

2.5 EBITDA margin

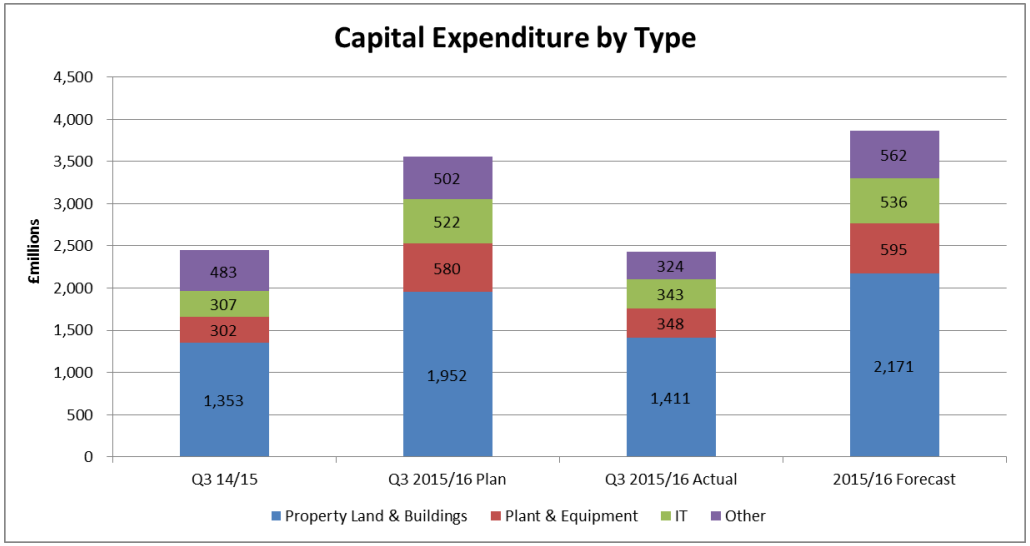


YTD Q3 2015/16	Plan %	Actual %	Variance %
Acute	1.6%	(0.1%)	(1.6%)
Ambulance	4.4%	3.0%	(1.4%)
Community	3.0%	2.6%	(0.4%)
Mental Health	4.6%	4.9%	0.3%
Specialist	4.3%	3.5%	(0.8%)
Total	**2.3%**	**1.0%**	**(1.3%)**
Of which:			
Foundation trusts	2.6%	1.8%	(0.8%)
NHS trusts	1.7%	(0.3%)	(2.0%)

- The EBITDA margin (earnings before interest, tax, depreciation and amortisation as a percentage of income) is an indicator used by Monitor to assess a trust's long term financial sustainability and readiness to be authorised as an NHS foundation trust. An EBITDA margin that is above 5% indicates underlying financial strength.
- As highlighted by the EBITDA margin graph on the right, over the past three years, the combined EBITDA margin for both NHS foundation trusts and NHS trusts has seen a steady fall. The combined year-to-date EBITDA margin at Q3 2015/16 was 1.0%, 1.3% below the plan and significantly worse than the 5% threshold, highlighting a high level of financial stress within the sector.
- In aggregate, NHS Foundation trusts delivered a year-to-date EBITDA margin of 1.8%, whilst NHS trusts reported a negative (0.3%) margin, both are significantly below their respective planned level of 2.6% and 1.7%.
- Acute trusts are facing the biggest financial challenge within the NHS provider sector, reporting negative EBITDA margin of (0.1%). In contrast, Mental Health trusts continue to outperform their plan and in aggregate achieved the highest year-to-date EBITDA margin of 4.9%.
- Overall, 44 trusts achieved the 5% threshold at Q3, 17 fewer than plan. However, 70 trusts reported a negative EBITDA margin at Q3.
- Despite the quarter on quarter improvement of the EBITDA margin, the financial challenge faced by the provider sector is exceptionally tough this year. Many providers have told us that they are committed to ongoing financial improvement.

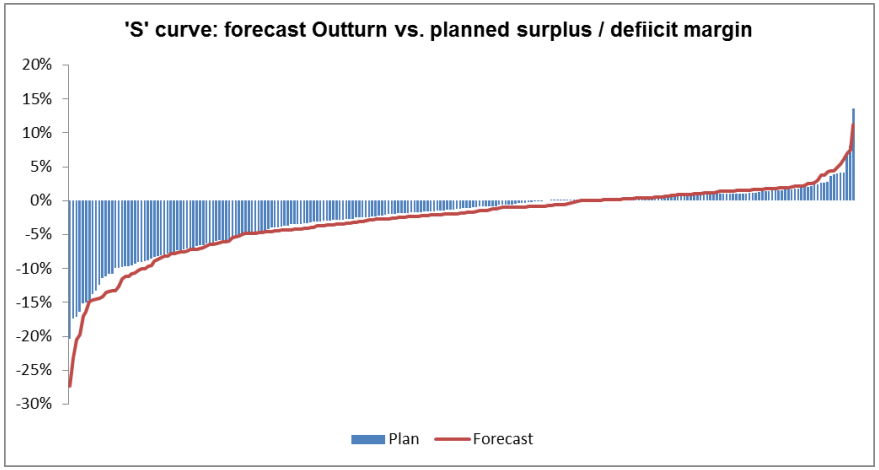
2.6 Cash and capex

Cash Balances for the 9 months ended 31 Dec 15	Q3 2015/16 Plan £m	Q3 2015/16 Actual £m	Variance to Plan £m	Variance to Plan %
Opening Cash and Cash Equivalents	4,963	4,977	14	0%
Closing Cash and Cash Equivalents	3,992	4,281	289	7%
Movement in Cash and Cash Equivalents	**(971)**	**(696)**	**275**	**(0)**



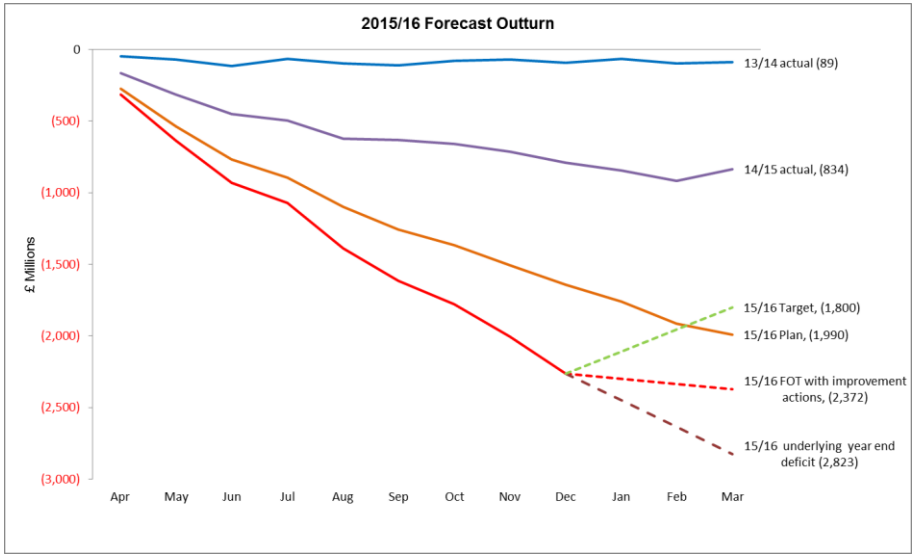
- Despite financial performance being £622m worse than planned, the cash position at Q3 2015/16 was £275m ahead of plan. Providers achieved this by managing working capital and reducing capital expenditure (capex).
- At Q3 2015/16, total capex of £2.43bn was £1.13bn (32%) less than planned. Based on the current underspend, capex for the year is now forecast to be £3.86bn, £1.24bn less than plan.
- The majority of the underspend has been achieved through a reduction in capex on property, land and buildings. The greatest proportional underspend was in plant and equipment at 40%. However the proportion of the underspend which has been deferred into the new financial year instead of permanently cancelled is still to be finalised. To date, providers have identified £320m capex which can be safely deferred to support local capital to revenue transfers as part of financial improvement measures.
- The size of the £1.13bn underspend contributed by NHS foundation trusts and NHS trusts is evenly split. However, this represents a 27% and 40% underspend against plan for each respectively.

2.7 ‘S’ curve



- As highlighted by the ‘S’ curve, the NHS provider sector is under significant financial stress, as most trusts are forecasting to end the year with a deficit. The performance is driven by:
  - ongoing high level use of contract and agency staff due to heightened focus on care quality and safety;
  - demand for care in hospital settings with particular pressures in urgent and emergency care;
  - the significant impact of delayed transfers of care; and
  - failure to deliver the planned levels of cost improvement schemes.
- The pressure is most significant in the Acute sector as 95% of the acute providers are in deficit at Q3 2015/16. 118 (86%) providers forecast to end the year with a deficit. In addition, Ambulance trusts are also under increased pressure with a year-to-date deficit, and are forecasting an aggregate deficit for the year.
- Comparatively, Mental Health, Community and Specialist providers continue to deliver an overall surplus, and forecast to end the year in surplus.
- Responding to the challenging financial position, NHSI has been working closely with providers to support them in improving their financial position. Actions to date include:
  - Agreeing individual stretch targets: a number of trusts have agreed revised plans. Progress has been made against these targets.
  - Introducing expenditure controls especially for consultancy and agency spend to help assist Providers manage and reduce their expenditure in these areas.
- Providers are also committed to sustainable improvement actions. Prior to December 2015, providers have already identified and actioned £781m of financial improvement opportunities, including £336m by NHS trusts and £446m by NHS Foundation trusts.

2.8 Forecast outturn



Financial improvement	Improvement actioned £m	Improvement identified for Month 9 £m	Unconfirmed improvement opportunities £m
Capital to revenue transfer	-	320	24
Operational improvement	247	36	7
Other technical adjustments	534	96	96
Total	**781**	**452**	**127**
Of Which:			
Foundation trusts	446	214	118
NNHS trusts	336	238	10

- Based on the current run rate, the financial performance trajectory indicates that full-year deficit could be over £2.8bn. This is not sustainable and is above the provider sector's control total of £1.8bn. There is an urgent need for sustained collective action to ensure that the provider sector can manage down the deficit and deliver the year-end target.
- In January, Monitor and TDA wrote to all providers calling for collective actions and asked them to consider a list of opportunities. These opportunities include operational efficiencies such as reducing non-medical agency cover and complying fully with agency staffing policies to better manage the workforce requirements, and technical or one-off measures such as local capital to revenue transfers through maximum amount of safe deferrals or reduction in capital expenditure.
- Providers have since identified £452m of financial improvement opportunities in addition to the £781m improvement already actioned, reducing the forecast outturn for the year to £2.37bn. The sector has also identified a further £127m opportunities for the remainder of the year and we believe there is scope for additional opportunities which are yet to be identified.
- The 2015/16 position is essential to ensure the sector goes into 2016/17 in the best position possible. This will allow the sector to receive the maximum benefit from the Sustainability and Transformation Fund (S&T Fund) which was announced as part of the recent Spending Review.
- Although the provider sector will benefit from a real-terms funding increase in 2016/17 as pledged by the government, delivering sustained performance improvement remains as a significant challenge.

3.0 Glossary and end notes

3.1 End notes

1	All financial information in this report is year-to-date and based on unaudited monitoring returns from 240 NHS Trusts and NHS foundation trusts as at 31 December 2015. This consists of 152 NHS Foundation Trusts and 88 NHS Trusts. For foundation trusts authorised during the year, we only include financial data from the date of authorisation in the foundation trusts' performance, whereas pre-authorisation performance of the trusts is included NHS trusts' financial figures where applicable. There was no new foundation trust authorised during Q3 2015/16.
2	Reported Financial Position surplus/(deficit) is measured slightly differently between NHSFTs and NHS Trusts. Monitor (NHSFT's) report the surplus/(deficit) before impairments and transfers, whereas the NHS TDA (NHS Trusts) also include an adjustment to add back the impact of IFRIC 12 and depreciation and amortisation relating to donated or government granted assets, charitable donations and government grants.
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	165 trusts (NHSFT and NHS Trusts) report performance against the A&E target.
5	Trusts are deemed to have breached a waiting time target if they fail to achieve the performance standard in any month in the quarter. 194 reported against incomplete pathway targets. The admitted and non-admitted targets were removed in September 2015.
6	133 trusts (NHSFT and NHS Trusts) report performance against the breast cancer: 2 week wait target 154 trusts (NHSFT and NHS Trusts) report performance against the GP referral: 62 day wait target 152 trusts (NHSFT and NHS Trusts) report performance against the all cancers: 2 week wait target
7	For consistency with NHS trust reporting, we deduct restructuring costs in calculating net surplus/deficit.
8	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.
9	Monitor and the NHS TDA calculate the "CIPs (cost improvement programmes) as a % of expenses" measure differently. The NHS TDA calculation includes revenue generation as part of their CIPs, and is calculated as a reduction of total expenditure, whereas Monitor's approach does not include income revenue generation as part of the CIPs and is calculated as a reduction of total controllable operating costs (i.e. without PFI costs as these are unavoidable). For consistency this report adopts the approach used by NHS TDA.

3.2 Glossary (1/3)

Monitor
Making the health sector work for patients

tda Trust Development Authority
Quality. Delivery. Sustainability.

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.

3.2 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.
HONOS	Health of the Nation Outcome Scales – 12 scales on which service users with sever mental illnesses are rated by clinical staff. Designed to measure the progress in health and social functioning for mentally ill people.
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.

3.2 Glossary (3/3)

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)
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. Please refer to the End Notes as the calculation of this measure differs between the NHSFTs and NHS Trusts.
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.