To:	The Board
For meeting on:	26 May 2016
Agenda item:	5
Report by:	Bob Alexander, Executive Director of Resources/Deputy Chief Executive Elizabeth O'Mahony, Finance Director
Report on:	Performance of the NHS provider sector: year ended 31 March 2016

Summary

1. Sustained operational and financial challenges continued to affect adversely the performance of the NHS provider sector in 2015/16. Providers faced record high demand and increased cost pressures. Throughout the year, providers worked hard to improve services for patients, reduce costs and maximise resources. Despite these efforts, the sector as a whole continued to underperform against a number of national healthcare standards, and the year-end deficit was almost three times larger than position reported in 2014/15.

2. This report provides a summary of the full-year performance at 31 March 2016 of the 240 licensed providers operating during this period. This comprises 152 NHS licensed foundation trusts and 88 NHS trusts. The financial information contained within the report is subject to a consolidation and full audit process and may change. All performance exemplified in this report is based on the combined performance of NHS trusts and NHSFTs, unless otherwise stated.

3. The financial results of the NHS foundation trust and NHS trust sectors are within the Department of Health Group and these financial results score against the Departmental Expenditure Limit. Other bodies within the Department of Health Group include NHS England, clinical commissioning groups (CCGs), DH (including areas such as European Economic Area Medical Costs and R&D), Public Health England, Health Education England, NHS Property Services, Special health authorities and non-departmental public bodies.

Operational performance

4. There were 20.7 million A&E attendances in 2015/16 which is an increase of 2.9% over the previous year. In March 2016 alone providers saw over 1.88 million patients in A&E, the highest number ever seen in a month, an increase of 7.5% more than in March 2015. Providers worked hard to treat the record number of patients but the unexpected increase in demand impacted on performance and many struggled to meet the four-hour waiting time target. In aggregate, only 91.1% of A&E patients were seen or admitted within four hours in 2015/16, which is below the 95% target. In Q4 2015/16 (January to March 2016), the sector recorded the worst quarterly performance since the standard was introduced, with only 86.6% of patients seen or admitted within four hours.

5. The number of patients who waited longer than four hours on a trolley for a bed in 2015/16 increased by 26.3% to 387,809, compared to 2014/15. This rise is due largely to sustained high levels of emergency admissions and a lack of beds to meet the demand.

6. Ambulance services had difficulty responding to urgent and emergency calls within the target time as demand rose. In Q4 2015/16, ambulance services responded to an additional 8.1% time critical (Category A Red 1) calls and 18.5% 'life threatening' (Category A Red 2) calls than a year ago. Ambulance services in aggregate failed to achieve all key response time targets for Red 1, Red 2 and Category A calls during the period. The rollout of a dispatch-on-disposition pilot, which allows call handlers extra time to triage calls, also affected performance against Red 2 and Category A calls.

7. Demand pressures were not confined to emergency services. The number of patients waiting to start their elective treatment reached a record high of 3.3 million at the end of 2015/16, 15% more than a year ago. The median waiting time of 6.4 weeks was almost a week longer than in 2014/15. Rising demand combined with constrained capacity resulted in providers failing to achieve the 92% referral to treatment target with a performance of 91.2% at the end of 2015/16.

8. Providers failed to meet the 85% national target for the 62-day urgent cancer referral to treatment in each quarter of 2015/16. In Q4 2015/16, providers delivered a performance of 82.1%, which was similar to Q4 last year. However, the number of patients receiving treatment during the quarter rose by 4.5% compared to year ago, to 33,406, suggesting providers were busier than ever.

9. At the end of 2015/16, there were 835,224 patients waiting for a diagnostic test, 3.6% more than a year ago. 1.8% of them had been waiting longer than six weeks, meaning that the 1% target was not met. However, the sector improved its performance against waiting times for endoscopy tests. Work carried out by a national programme team has led to an 8% reduction in the number of patients waiting longer than six weeks for endoscopy procedures.

10. NHS Improvement will continue to support providers to improve their operational performances for the benefits of patients, by driving up standards and delivering consistently safe, high quality care.

Financial performance

11. The NHS provider sector's financial performance declined sharply in 2015/16. The year-end deficit of £2.45 billion was almost three times greater than that reported in 2014/15, and £461 million worse than the revised plan (£340 million worse than initial plan).

12. The run rate forecast earlier in the year suggested the full year deficit could be as high as £2.8bn. The sector's run rate improved during the second half of the financial year as measures introduced by NHS Improvement (including agency and consultancy controls) started to have a positive, albeit limited, impact. Providers were also committed to continually improving their financial sustainability and reducing the sector deficit. Between December 2015 and March 2016, providers realised £724 million of financial improvement opportunities. These included local capital-to-revenue transfers and one-off technical measures.

13. Despite these improvements, providers' year-end financial performance was affected by:

    a) **High usage of contract and agency staff**. The cost of unplanned agency staff contributed £1.4 billion to the full year adverse variance despite agency controls. The overspending was partly offset by savings from underspending on substantive staff.

    b) **Delayed transfers of care**. Providers have estimated that such delays have cost £145 million this year. However, full costs could be much higher.

    c) **Financial sanctions**. Financial pressures were further exacerbated by £498 million of fines and readmission penalties.

    d) **Costs of waiting list initiative (WLI) work**. Providers have spent £143 million on such work this financial year to avoid breaches of waiting time targets.

    e) **A shortfall of £316 million cost savings** against the planned cost improvement programmes.

    f) **A reduction in non-recurrent income** compared to 2014/15 including the loss of one-off deficit support.

14. Whilst the shortfall on cost savings impacted on the year-end financial performance of the sector, providers delivered £2.9 billion of savings this year. Under-delivery of pay related savings schemes accounted for 82% of the gross shortfall with most providers unable to reduce their reliance on agency staffing to the levels planned due to sustained demand, quality pressures and recruitment

difficulties. Over 78% of the shortfall was due to under-delivery by acute providers.

15. Despite financial performance being £461 million worse than planned, the cash position continued to improve month-on-month in 2015/16. Total cash held by providers at the end of the year was £615 million better than planned. Providers achieved this by managing working capital positions and reducing capital expenditure (capex) levels. In 2015/16, total capex of £3.7 billion was 27.8% less than plan. Included within the underspending was one-off capital to revenue transfers totalling £324 million through safe deferral.

Bob Alexander
Executive Director of Resources / Deputy Chief Executive

Elizabeth O'Mahony
Finance Director

Making a difference for patients:

NHS Improvement'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 in Q4 2015/16.

Metrics	*Target*	NHS foundation trusts	NHS trusts	Combined performance
Referral to treatment (RTT)				
18 weeks incomplete (%) – at 31 March 2016	*92%*	91.48%	90.79%	91.22%
52 week waits (number) – at 31 March 2016	-	324	535	859
Accident & emergency				
A&E attendances	-	2.99m	2.29m	5.29m
Performance – All A&E types (%)	*95%*	88.02%	84.71%	86.58%
Performance – Acute trusts only (%)	*95%*	87.14%	83.31%	85.48%
Type 1 performance (%)	*95%*	84.24%	78.36%	81.81%
Cancer				
2 week GP referral to 1st outpatient, cancer (%)	*93%*	94.97%	94.24%	94.68%
2 week referral to 1st outpatient - breast symptoms (%)	*93%*	93.28%	93.98%	93.58%
31 day wait from diagnosis to first treatment (%)	*96%*	97.78%	97.09%	97.52%
62 day urgent GP referral to treatment for all cancers (%)	*85%*	82.91%	80.85%	82.10%
62 day referral from screening services	*90%*	93.13%	89.78%	91.82%
Diagnostic				
Number of diagnostic tests waiting 6 weeks+ (%) – at 31 March 2016	1%	1.87%	1.61%	1.77%
Ambulance				
Red 1 Calls (%)	75%	69.78%	66.66%	68.12%
Red 2 Calls (%)	75%	63.05%	58.71%	60.53%
Category A Call - ambulance arrive within19 mins (%)	95%	91.14%	88.55%	89.64%
Infection control				
C. Difficile (Total cases)	-	709	462	1,171

Financial performance summary

The table below provides a summary of how well foundation trusts and NHS trusts performed financially in 2015/16.

12 months ended 31 Mar 2016	NHS foundation trusts	NHS trusts	Total
No of trusts [1]	152	90	240
Operating revenues (£m)	47,213	28,488	75,701
Pay costs (£m)	(30,206)	(18,565)	(48,771)
Non pay costs (£m)	(15,942)	(9,782)	(25,724)
EBITDA (£m)	1,065	141	1,206
Net surplus/(deficit) (£m) [2]	(1,096)	(1,351)	(2,447)
Net surplus/(deficit) - Plan (£m) [2]	(927)	(1,059)	(1,986)
Variance to Plan	(169)	(292)	(461)
No of trusts in deficit [1]	99	58	157
EBITDA %	2.3%	0.5%	1.6%
Net surplus/(deficit) %	-2.3%	-4.7%	-3.2%
Total agency costs (£m)	2,114	1,521	3,635
Agency costs as % of total pay costs	7.0%	8.2%	7.5%
Cost improvement programmes (£m) [3]	1,762	1,131	2,893
CIPs as a % of expenses [3]	3.5%	3.7%	3.6%

1. NHS trust count includes the double count of 2 trusts which gained foundation trust status in year
   - Bradford Care Trust (authorised on 01/05/2015)
   - Oxford University Hospitals (authorised on 01/10/2015) - Deficit reported in trust sector

2. The "net surplus/(deficit)" is measured slightly differently between NHS foundation trusts and trusts. Monitor measures net surplus/(deficit) before impairments and transfers, whereas 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.

3. Monitor and 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 (ie without PFI costs as these are unavoidable). NHS foundation trusts delivered £383 million revenue generation by year end and, calculated on the NHS trust basis, foundation trusts' CIPS were 3.5% of expenses. Based on Monitor's approach, NHS foundation trusts' CIPs as a % of expense would be 2.9%.

NHS Improvement

Performance of the NHS provider sector year ended 31 March 2016

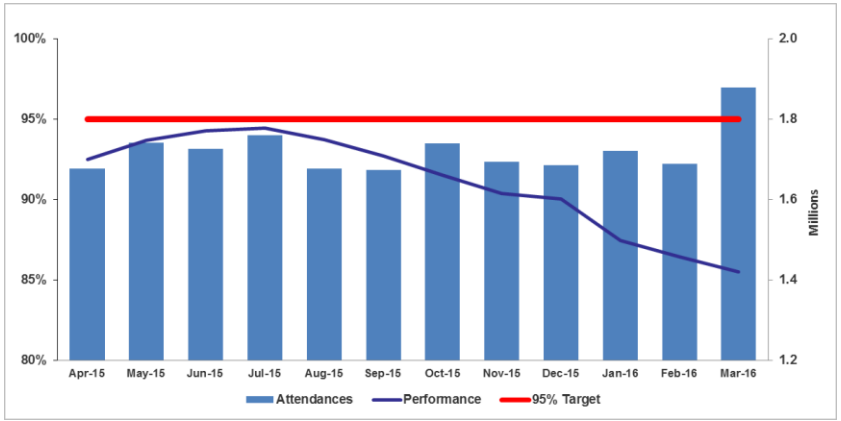


Content

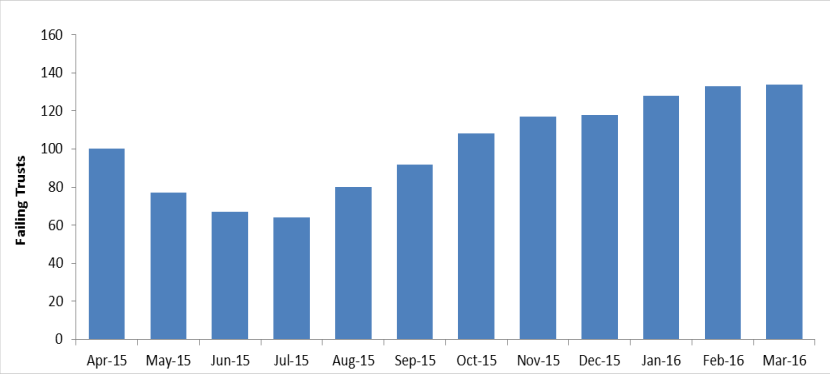
1.0 Operational performance

1.1 Accident & emergency

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



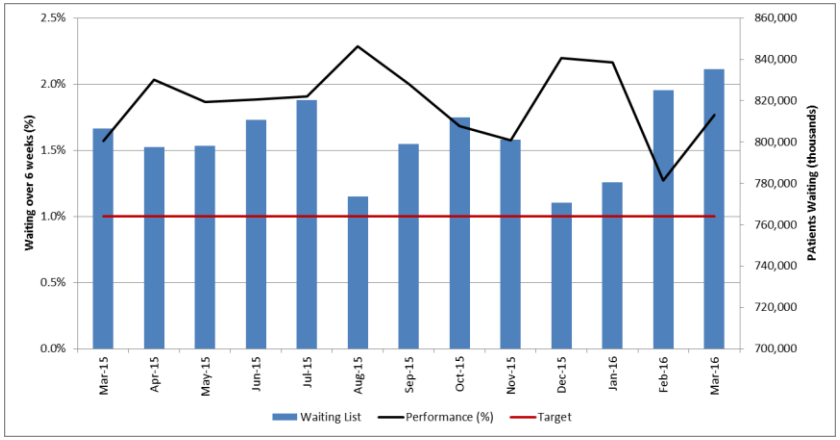
Number of Trusts failing the 4 hour A&E Target by month



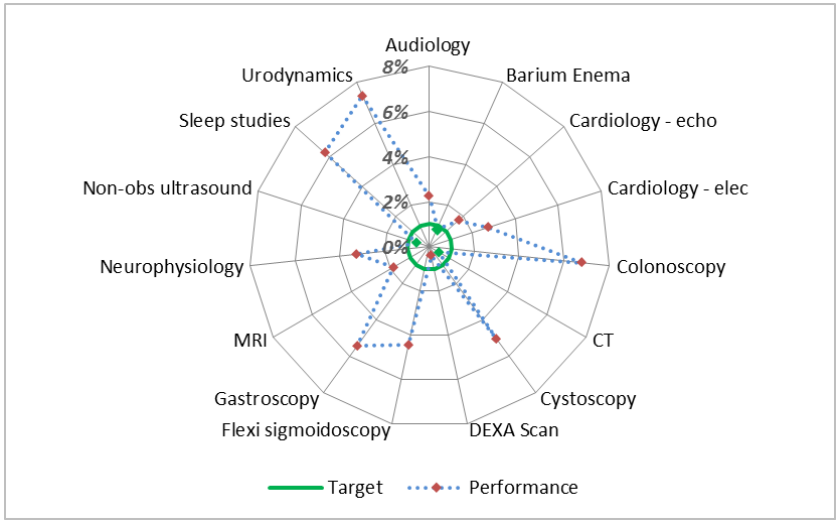
- NHS A&E departments had the busiest year on record in 2015/16. Many providers struggled to meet the national A&E target to treat, admit or discharge 95% of patients within four hours of arriving at an A&E department in 2015/16. In total, providers saw 20.7m A&E patients during the year, a rise of 2.9% from last year. Providers reported a year-on-year rise of 11.3% in attendances in Q4 2015/16 alone. In particular, attendances in March reached a record number of 1.88m.
- As a result, A&E performance against the 4-hour wait standard fell. Performance in Q4 2015/16 at 86.58% was the worst quarterly performance since the standard was introduced and was significantly lower than the performance of 91.02% achieved in Q4 2014/15. March 2016 also saw the worst ever monthly performance against the A&E target (85.90%). Full year performance in 2015/16 dropped to 91.06% from 92.91% in 2014/15.
- An increase in the number of patients requiring emergency admissions added to the operational pressure on A&E departments. This year there were 4.1m emergency admissions from major (type 1) A&E departments, a rise of 2.6% from last year. In Q4 2015/16 there were just over 1.0m emergency admissions from major (type 1) A&E departments, a rise of 6.5% from the same quarter last year.
- Bed capacity constraints due to high occupancy rates and delayed transfers of care resulted in patients waiting longer in A&E departments for emergency admissions. This year 387,809 patients waited longer than four hours on a trolley for a bed, 26.3% more than a year ago. Poor performance in Q4 drove the significant increase in trolley waits in 2015/16. There were 155,253 four hour trolley waits in Q4, a 41.6% increase compared to the same quarter last year.
- The national Emergency Care Improvement Programme (ECIP) is continuing to help providers deliver performance improvements by supporting the 28 worst-preforming sites. ECIP will also be supporting delivery of the NHS England and NHS Improvement plan to recover A&E performance in 2016/17.

1.2 Diagnostic waiting times

Percentage of diagnostic patients waiting over 6 weeks



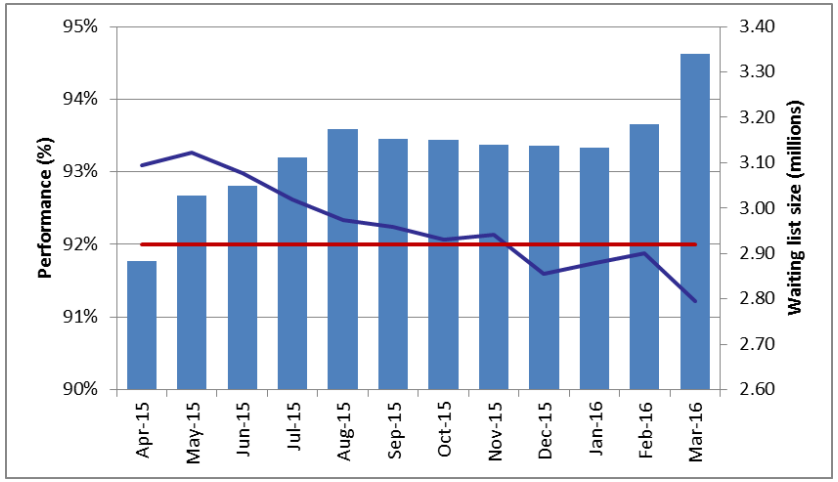
Diagnostic performance by procedures – March 2016



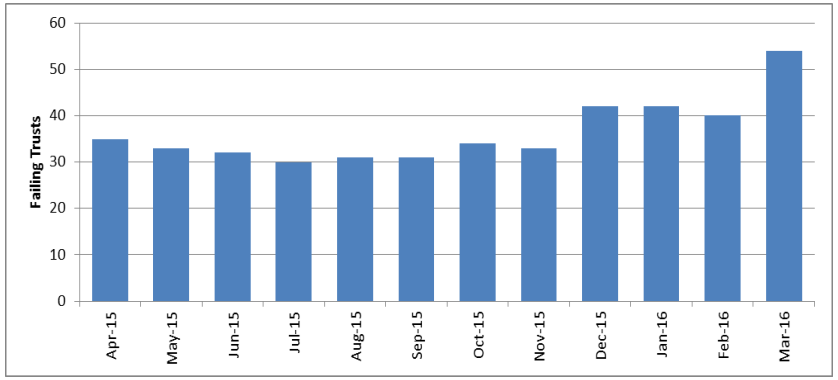
- Diagnostic waiting times are a key part of the delivery of the referral to treatment (RTT) target as the majority of patients will need a diagnostic test. The national waiting time target for diagnostics states that less than 1% of patients should wait six weeks or more for a test.
- At the end of 2015/16, 835,224 patients were waiting for a diagnostic test, an increase of 3.6% compared to the end of last year. In line with increasing demand, patients also waited longer for a test as diagnostic waiting time performance deteriorated slightly to 1.77% from 1.57% last year.
- Providers in aggregate failed to achieve the waiting time standard for 11 of the 15 key diagnostic tests this year compared to eight in the last year.
- Non-obstetric ultrasound had the largest waiting list of all tests (36% of the total diagnostics waiting list), but only 0.61% of patients were waiting over six weeks at the end of the year.
- Waiting times for endoscopy tests, on the other hand, remained a challenge throughout 2015/16. In response, NHS Improvement and NHS England took a coordinated approach to improving performance by working with NHS providers to access additional capacity at other providers including the independent sector. This led to a reduction in the waiting list to 103,377 patients at the end of the year, a drop of over 8% from last year. Performance also improved, only 5.69% of patients waiting more than six weeks for an endoscopy test at the end of 2015/16 compared to 6.12% at the end of last year.
- In 2016/17, there will be continued focus on addressing long-term challenges such as workforce shortages, aging equipment and increases in demand. In the short-term NHS Improvement will be putting in place measures to support poor performing trusts.

1.3 Elective waiting times

RTT 18 week performance and size of waiting list by month



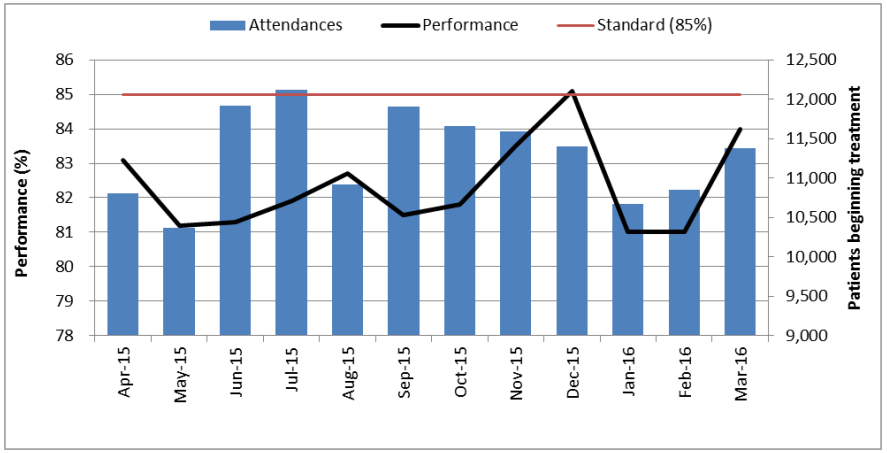
Number of trusts failing RTT 18 week incomplete target by month



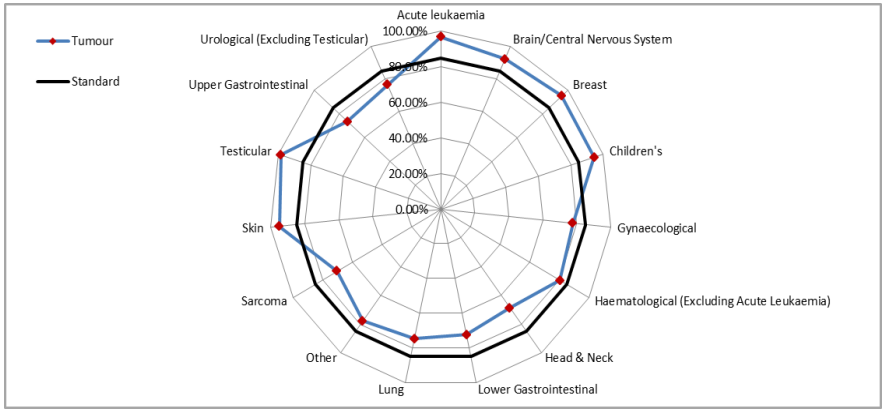
- Following Sir Bruce Keogh's review of waiting time standards in June 2015, the RTT standard for incomplete pathways became the sole measure of elective waiting time performance.
- The number of people waiting for elective care reached 3.34m at the end of 2015/16, a 15% increase compared to a year ago on a like-for-like basis. However, it is not yet clear if the junior doctors' industrial action contributed to the significant jump in the number of people waiting in March.
- Increasing demand and insufficient planned capacity resulted in providers failing to achieve the national RTT incomplete standard target of 92%. At the end of 2015/16, 91.22% of patients were waiting up to 18 weeks to begin treatment compared to 92.96% at the end of last year.
- The median waiting time for patients on an incomplete pathway increased considerably from 5.60 weeks in March 2015 to 6.41 weeks in March 2016.
- The number of patients waiting longer than 52 weeks for treatment increased significantly and stood at 859 at the end of 2015/16, a rise of 82% compared to last year. Much of the increase was driven by King's College Hospital NHS Foundation Trust (23 to 165) and University Hospitals of Leicester NHS Trust (0 to 232). There were seven providers which did not report RTT performance in March 2016 so the actual number of 52 week waiters could be higher.
- In 2016/17, NHS Improvement and NHS England will work collaboratively to deliver programmes which will reduce the waiting list by ensuring capacity keeps up with demand. Specifically, the programmes will focus on reducing 52 week waiters, optimising referral practice and supporting non reporting providers to improve data quality and to re-commence reporting.

1.4 Cancer waiting times

62 day (urgent GP referral) wait for first treatment by month



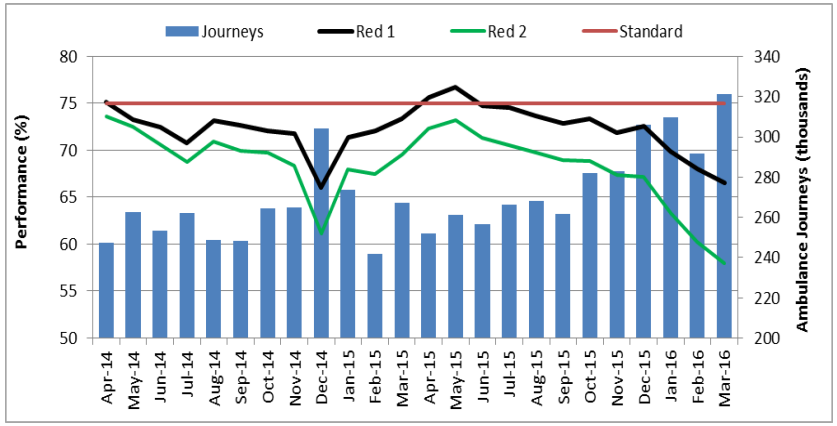
62 day (urgent GP referral) wait for first treatment specialty split – Q4 2015/16



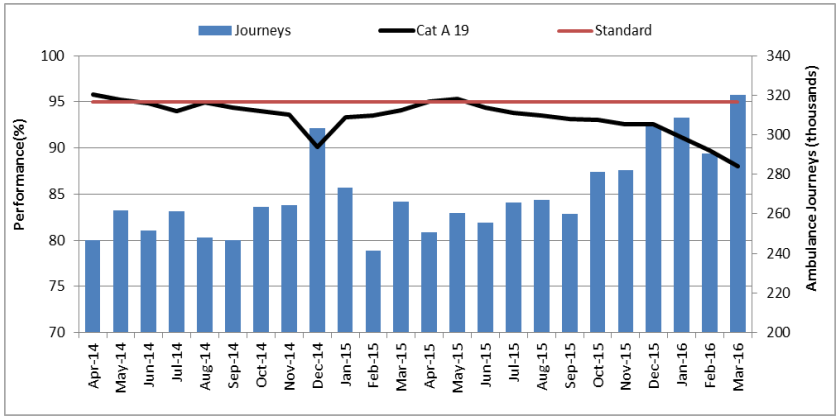
- Providers failed to achieve the 62 day (urgent GP referral) waiting time target for first treatment in every quarter of 2015/16.
- In Q4 2015/16, 33,406 patients began their cancer treatment, an increase of 4.5% from the same quarter last year. Despite the increase in demand, performance against the target at 82.10% was similar to the same quarter last year (82.24%).
- The specialties that contributed most to the underperformance in Q4 2015/16 were Urological (excluding testicular), Upper and Lower Gastrointestinal and Lung. These specialities accounted for only 48.5% of overall activity, but contributed to significantly more than half of the breaches (68.1%) reported.
- Delays in diagnostic tests, especially in endoscopic procedures, have contributed to the pressures in delivering the 62-day target. Nationally, NHS Improvement 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. This has resulted in a significant improvement in waiting time for endoscopy tests. We would expect that, over time, this will have a positive impact on the cancer 62-day target performance.
- Providers continued to achieve all other cancer waiting time standards in Q4 2015/16.

1.5 Ambulance response times

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



Category A19 performance and volume of journeys

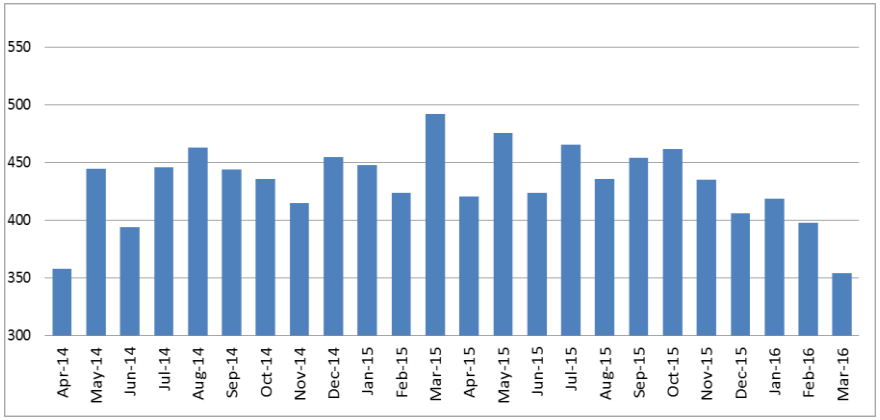


** 11 ambulance services include 10 ambulance trusts as well as Isle of Wight NHS Trust.*

- 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.
- During Q4 2015/16, ambulance services failed Red 1, Red 2 and Category A response time targets with performances of 68.12%, 60.53% and 89.64% respectively.
- During Q4 2015/16, only one of the 11 ambulance services* achieved the Red 1 standard and the Category A19 standard. There were no ambulance services that achieved the Red 2 standard this quarter.
- Ambulance services saw a rise in 'time critical' and 'life threatening' calls during the quarter. 47,554 Red 1 calls were responded to by ambulance services in Q4 2015/16, an increase of 8.13% from Q4 2014/15. The number of Red 2 calls also saw a 18.47% increase compared to the same period last year.
- Due to the introduction of Dispatch-on-Disposition pilots at a number of ambulance services, a direct like-for-like performance comparison between Q4 2015/16 and Q4 2014/15 for the Red 2 and Category A standards cannot 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 NHS Foundation Trust implemented the pilot and in October 2015, the pilot was introduced at four more ambulance trusts.

1.6 Infection control

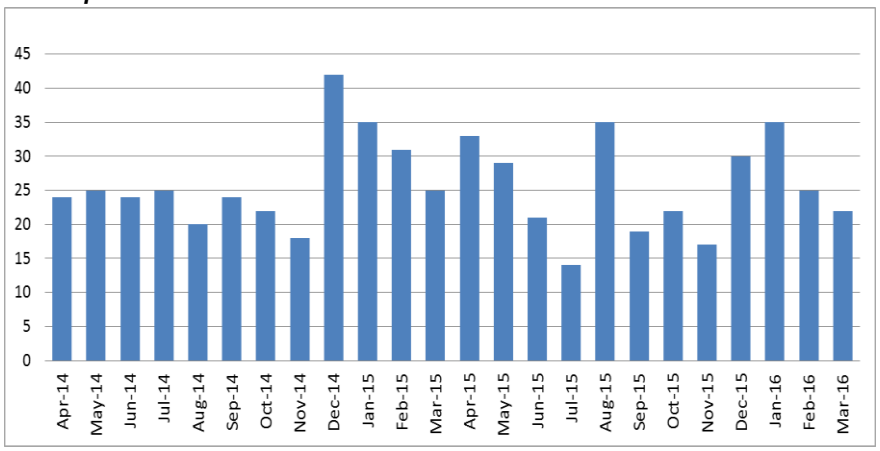
Number of Clostridium Difficile cases



Clostridium Difficile (C. Diff)

- The number of trust apportioned C. Diff cases reported was 1,171 in Q4 2015/16. Of the C. Diff cases reported, 709 were reported by NHS foundation trusts and 462 by NHS Trusts.
- The number of cases reported this quarter decreased by 193 when compared to the same quarter last year.
- Year to date (between April 2015 and March 2016), there have been 5,151 C. Diff cases reported, a reduction of 1.3% i.e. 69 cases lower year-on-year.

Number of Methicillin-resistant Staphylococcus Aureus cases reported



Methicillin-resistant Staphylococcus Aureus (MRSA)

- 82 MRSA cases were reported in Q4 2015/16. Of the MRSA cases reported, 41 were reported by NHS foundation trusts and 41 by NHS trusts.
- There were 9 fewer cases reported in Q4 2015/16 compared to the same quarter last year.
- Year to date (between April 2015 and March 2016), there have been 302 MRSA cases reported, 13 cases more than last year.

2.0 Financial performance

2.1 Income & expenditure

12 months ended 31 March 2016	M12 2015/16 Plan	M12 2015/16 Actual	Variance to Plan		2014/15 Actual
	£m	£m	£m	%	£m
Operating Revenue for EBITDA	**74,183**	**75,701**	**1,518**	**2.0%**	**74,345**
Pay Costs	(47,753)	(48,771)	(1,018)	2.1%	(47,129)
Other operating expenses	(24,538)	(25,724)	(1,186)	4.8%	(24,388)
EBITDA	**1,892**	**1,206**	**(686)**	**(36.3%)**	**2,828**
Depreciation	(2,304)	(2,185)	119	(5.2%)	(2,157)
Finance Costs	(831)	(820)	11	(1.3%)	(787)
PDC Dividend	(938)	(839)	99	(10.6%)	(865)
Other non-operating items	268	286	18	6.7%	209
Restructuring costs	(73)	(95)	(22)	30.1%	(62)
Reported financial position	**(1,986)**	**(2,447)**	**(461)**	**23.2%**	**(834)**
Gains/(losses) on transfers	(12)	(26)	(14)	116.7%	113
(Impairments)/reversals	(317)	(917)	(600)	189.3%	(532)
Other financial performance adjustments	(6)	(14)	(8)	133.3%	(36)
Net Surplus / (Deficit) - I&E	**(2,321)**	**(3,404)**	**(1,083)**	**46.7%**	**(1,289)**
EBITDA %	2.6%	1.6%			3.8%
Reported Financial performance %	(2.7%)	(3.2%)			(1.1%)
Memorandum					
Fines & Readmissions Penalties		498			

12 months ended 31 March 2016 (£m)	Acute	Ambulance	Community	Mental Health	Specialist
	Actual	Actual	Actual	Actual	Actual
Number of Providers	138	10	19	56	17
Operating Revenue for EBITDA	56,104	2,195	2,970	11,278	3,154
Pay Costs	(35,239)	(1,530)	(1,978)	(8,256)	(1,768)
Other operating expenses	(20,558)	(579)	(901)	(2,472)	(1,214)
EBITDA	**307**	**86**	**91**	**550**	**172**
Reported financial position	**(2,583)**	**(12)**	**20**	**54**	**74**
Net Surplus / (Deficit) - I&E	(3,282)	(14)	(44)	(87)	23
EBITDA %	0.5%	3.9%	3.1%	4.9%	5.5%
Reported Financial performance %	(4.6%)	(0.5%)	0.7%	0.5%	2.3%

- The NHS provider sector ended the financial year 2015/16 with a deficit of £2.45bn. This was a £1.6bn deterioration from 2014/15 and £461m worse than that planned. The declining financial performance was a reflection of the sustained financial pressures providers faced in 2015/16.
- Rising demand, especially for urgent and emergency care, and over-reliance on agency staff continued to add significant cost pressures to the sector. Operating expenditure exceeded plan by £2.2bn, offsetting £1.5bn of extra operating revenue generated by delivering additional activity. As a result, EBITDA was reduced by more than £686m or 36.3% compare to that planned.
- However, providers have been working extremely hard to stabilise and improve their financial position. Between December 2015 and March 2016, providers have identified and actioned a total of £724m financial improvement opportunities, including £324m of local capital-to-revenue transfers. As a result, the monthly run rate during the second half of the year improved compared to the first six months.
- In total, 157 licensed providers reported a deficit for the year, including 58 NHS trusts and 99 NHS foundation trusts. Over 75% of these providers were acute, highlighting the significant financial stress in the acute sector.
- 48 deficit trusts reported a deficit of more than £20m, including 11 trusts reporting an individual deficit of more than £50m. Barts Health NHS Trust reported the single largest deficit of £135m in 2015/16.
- In contrast, mental health, community and specialist providers as a group reported a surplus for the year.

2.2 Agency staff costs

12 months ended 31 March 2016	M12 2015/16		Variance to plan	
	Plan	Actual		
	£m	£m	£m	%
Permanent & Bank staff	(45,513)	(45,136)	377	(0.8%)
Agency and Contract staff	(2,240)	(3,635)	(1,395)	62.3%
Pay costs	**(47,753)**	**(48,771)**	**(1,018)**	**2.1%**
Agency costs as a % of total pay costs	*4.7%*	*7.5%*		

- One of the key drivers for this year's decline in financial performance was the continued high usage of agency staff, which contributed to total pay costs exceeding the plan by over £1bn. Providers failed to deliver planned year-on-year reductions in agency costs. Instead, total agency staff costs at £3.64bn were £1.4bn higher than plan, and £545m higher than 2014/15. Nearly two thirds of unplanned agency costs were attributable to NHS foundation trusts.
- The need to maintain safe staffing levels coupled with recruitment difficulties and rising demand have been sustaining the demand for agency staff. In particular, providers in London and the Midlands and East regions faced the biggest recruitment difficulties, reporting agency costs as a proportion of total staff costs at 8.7% and 8.3% respectively for the year.
- A concerted effort has been made this year to curb the overspending. NHS Improvement have introduced a series of control measures on the use of agency staff, they include ceilings on agency nursing staff spend, mandatory use of procurement frameworks and maximum hourly rates.
- These measures have had some positive impact. Providers' weekly submissions to NHS Improvement showed that average price paid for agency staff has seen a significant reduction and there has not been a sharp increase in the number of price cap overrides between the end of November 2015 and the end of March 2016.
- Over time, we would expect a reduced level of reliance on agency staff as agency controls become further embedded, while providers put in place tighter financial controls, supported by more realistic workforce planning and more robust rostering practices.

2.3 Non pay cost pressures

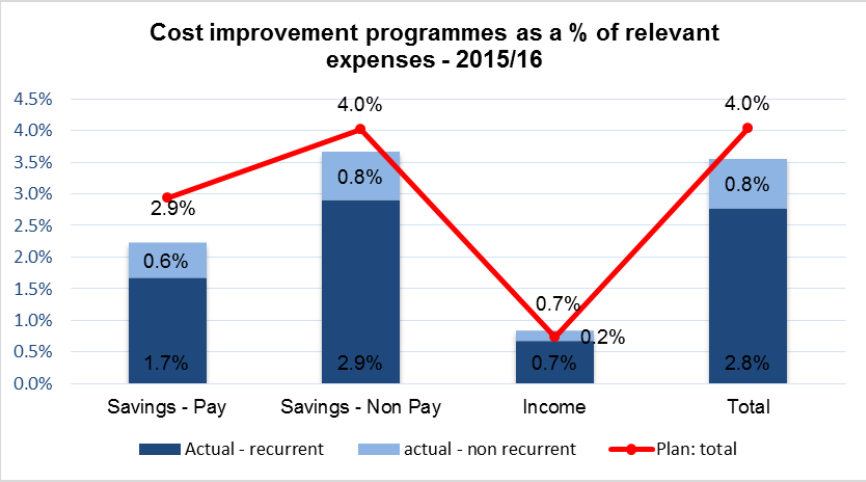
12 months ended 31 Mar 2016	M12 2015/16 Plan	M12 2015/16 Actual	Variance	
	£m	£m	£m	%
Pay costs	**(47,753)**	**(48,771)**	**(1,018)**	**2.1%**
Clinical supplies	(5,944)	(6,197)	(253)	4.3%
Drugs	(4,015)	(4,220)	(205)	5.1%
Non Clinical supplies	(1,715)	(1,799)	(84)	4.9%
Consultancy costs	(246)	(235)	11	(4.5%)
PFI costs	(898)	(898)	0	0.0%
Other operating expenses	(11,720)	(12,375)	(655)	5.6%
Other operating expenses	**(24,538)**	**(25,724)**	**(1,186)**	**4.8%**
Total operating expenses for EBITDA	**(72,291)**	**(74,495)**	**(2,204)**	**3.0%**
Of Which:				
NHS Foundation trusts	(44,790)	(46,149)	(1,359)	3.0%
NHS trusts	(27,501)	(28,346)	(845)	3.1%

12 month ended 31 March 2016	M12 2015/16	Of which: NHS FT	Of which: NHS Trusts
Financial Sanctions (Fines)	502	251	251
Sanctions reinvested	(194)	(53)	(141)
Sub-total: Financial Sanctions	**308**	**198**	**110**
Marginal Rate Emergency Tariff (MRET)	265	124	141
MRET reinvested	(34)	(19)	(15)
Sub-total: MRET	**231**	**105**	**126**
Readmissions	249	123	126
Readmissions reinvested	(59)	(37)	(22)
Sub-total: Readmissions	**190**	**86**	**104**
Delayed transfers of care (DToC) - expenditure incurred on blocked capacity	148	32	116
DToC - reimbursement from Local Authorities	(3)	(1)	(2)
Sub-total: Delayed Transfers of Care	**145**	**31**	**114**
Waiting list initiative work	**143**	**19**	**124**
Outsourcing of work to other providers	**241**	**144**	**97**

- Rising demand in 2015/16 led to non pay expenses exceeding plan by 4.8% and being £1.3bn higher than a year ago. In addition, providers continue to face a number of other cost pressures during 2015/16.
- Among these are the extra costs associated with delayed transfers of care (DToC). In 2015/16, NHS providers reported that over 1.7 million bed days were lost due to DToCs (11% more that in 2014/15). This had cost providers in the region of £145m in direct costs (fully absorbed costs could be much higher). DToCs not only affect trusts' earning and spending, but can also result in operations being cancelled and waiting lists being lengthened. Lord Carter, in his review, regarded DToCs to be a 'major problem' for the NHS and has called for action to be taken to tackle this issue.
- Providers' capacity was further constrained by rising emergency and urgent demand for hospital-based care, which had a detrimental impact on providers' ability to deliver their planned work and meet the elective waiting time target. To avoid breaches of waiting time target, providers have paid £143m for waiting list initiative (WLI) work during the year, adding further cost pressures to the system. In addition, providers also outsourced approximately £241m worth of work to other providers (including the independent sector).
- Failure to deliver national targets had also increased the level of financial sanctions being levied on providers, which affected providers' overall financial position. Gross fines and readmission penalties cost providers a total of £751m. Although £253m has been reinvested by commissioners to improve operational flows, these sanctions nevertheless further exacerbated financial stress.
- In contrast, controls introduced by Monitor and NHS TDA in June 2015 on the consultancy spend had more positive impact, and overall consultancy spend saw a £86m reduction compared to a year ago. Against plan, NHS trusts also spent £29.8m less than that planned.

2.4 Cost improvement programmes[1]

12 months ended 31 March 2016	Month 12 2015/16 YTD				
	Plan	Actual	Variance		YTD as a % of Spend
	£m	£m	£m	%	
Total CIPs	3,209	2,893	(316)	(9.8%)	3.6%
Of which:					
NHS Foundation Trusts	1,881	1,762	(119)	(6.3%)	3.5%
NHS Trusts	1,328	1,131	(197)	(14.8%)	3.7%

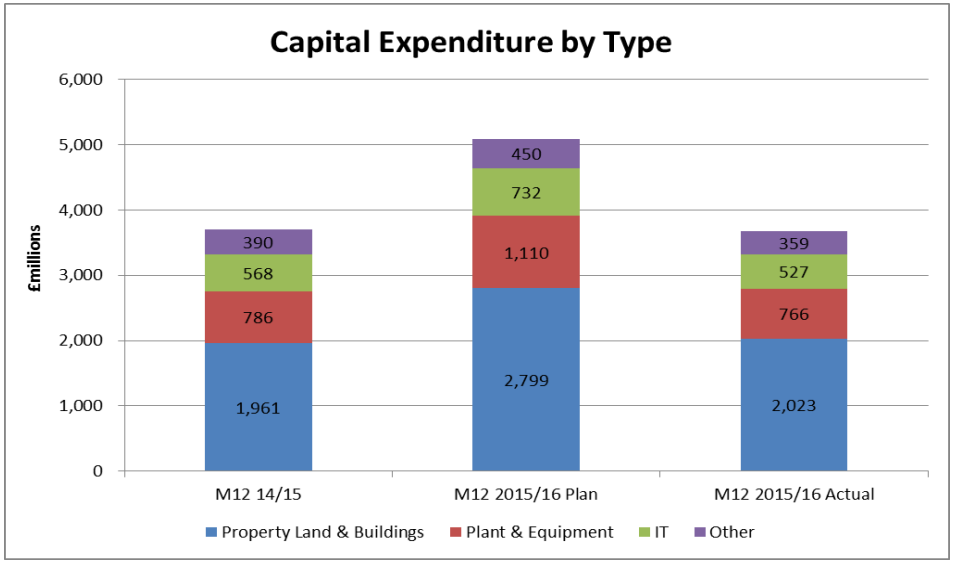


- In 2015/16, providers delivered £2.9bn of savings through cost improvement programmes (CIPs), reducing total year-to-date costs by 3.6%. CIPs achieved were £316m (or 9.8%) short of plan and £6m below providers' forecast at Q3 2015/16. Over 78% (or 247m) of the shortfall was due to under-delivery by acute providers.
- Under-delivery of pay related saving schemes accounted for 82% of the total gross shortfall of £403m. Although most providers had planned to reduce their reliance on agency staff from the start of the year, this has not occurred due to sustained demand and quality pressures and recruitment difficulties. However, as agency controls become further embedded, we would expect providers to improve their delivery over time. In contrast, providers (especially acute trusts) outperformed on the planned income generation schemes by £87m during the year.
- On the whole, 77.7% of CIPs achieved were from recurrent schemes, far below the planned 92.3%. This pattern was consistent across both NHS trusts and NHS foundation trusts.
- The 2016/17 national tariff includes a 2% efficiency deflator, which is based on the provider sector meeting a forecast deficit of £1.8bn at the end of 2015/16, the level of the Sustainability and Transformation Fund. As the 2015/16 deficit exceeds this target, providers will need to deliver higher efficiency levels next year to achieve the control totals set for the sector.

1. *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 NHS TDA's method includes revenue generation and is calculated against total expenditure. For consistency this report adopts the NHS TDA's approach.*

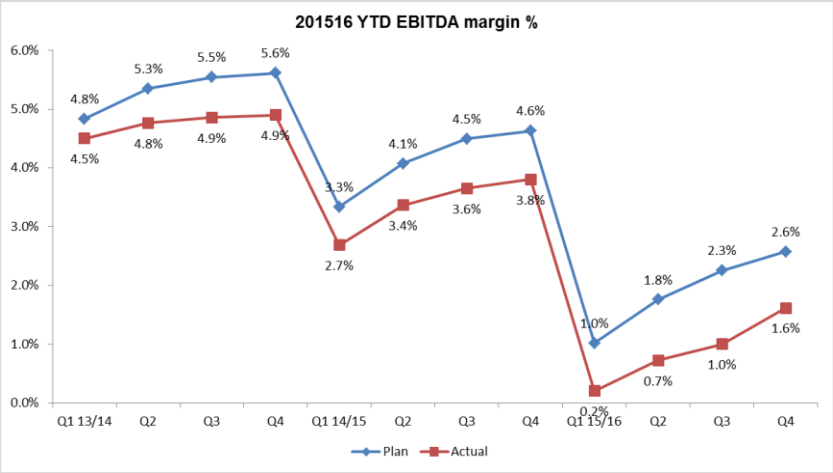
2.5 Cash and capex

Cash balances - 12 months ended 31 March 2016	M12 2015/16 Plan £m	M12 2015/16 Actual £m	Variance to plan £m	Variance to plan %
Opening Cash and Cash Equivalents	4,983	4,983	0	0%
Closing Cash and Cash Equivalents	3,569	4,184	615	17.2%
Movement in Cash and Cash Equivalents	**(1,414)**	**(799)**	**615**	**(43.5%)**



- The aggregate cash position continued to improve month-on-month. The closing cash position of £4.2bn at month 12 2015/16 was £615m (43.5%) better than plan, reflecting providers' continued restraint on capital expenditure (capex) and management of working capital.
- Total capex of £3.7bn for the year was £1.4bn (27.8%) below plan. The level of underspend was similar to the historic level. The level of underspend against plan was greater at NHS trusts (31.2%) than at NHS foundation trusts (25.5%).
- Although, the overall spending on property, land and buildings saw a 3% year-on-year increase. However against plan, providers exercised restraint on their investment in these areas with more than 50% of the underspend from property, land and buildings.
- Included in the year-to-date underspend were £324m of local capital to revenue transfers. During the year, providers identified schemes that could be safely deferred to support financial improvement.
- From 2016/17, the level of capital resource available for the sector will be highly constrained so providers are encouraged to procure their capital assets more efficiently, consider alternative methods of securing assets, maximise disposal proceeds and extend asset lives.

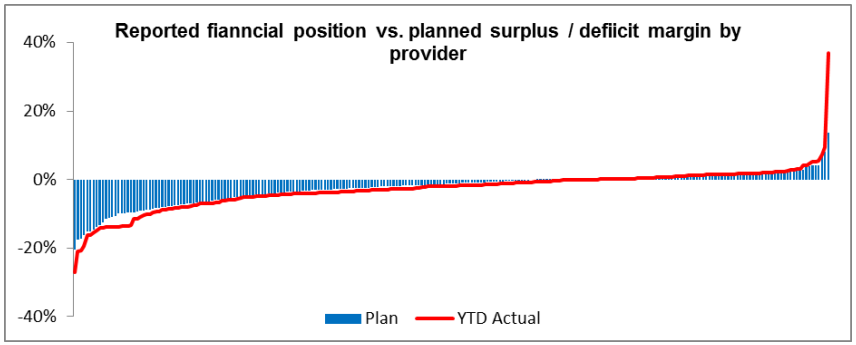
2.6 EBITDA margin

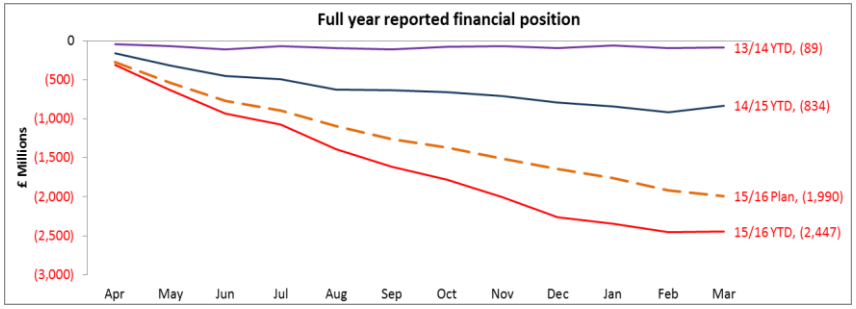


2015/16 M12	Plan	Actual	Variance
	%	%	%
Acute	1.9%	0.5%	(1.3%)
Ambulance	4.5%	3.9%	(0.6%)
Community	3.3%	3.1%	(0.3%)
Mental Health	4.8%	4.9%	0.1%
Specialist	4.5%	5.5%	1.0%
Total	**2.6%**	**1.6%**	**(1.0%)**
Of which:			
NHS Foundation Trusts	2.8%	2.3%	(0.6%)
NHS trusts	2.1%	0.5%	(1.6%)

- Providers have faced unprecedented financial challenges throughout 2015/16, and this has been reflected in the year-to-date EBITDA margin.
- By Q4 2015/16, the provider sector's EBITDA margin had grown to 1.6% from 0.2% at the start of the year. The sector also delivered the biggest improvement in the EBITDA margin during Q4 compared to the historical trend. However, the margin achieved was still below the planned margin of 2.6%.
- Despite a steady improvement in the margin throughout the year, it had trailed behind plan by an average of 1.1% and was far below the margins achieved in previous years. The year-on-year declining margins reflected the increasing financial stress faced by providers.
- In aggregate, NHS foundation trusts delivered an EBITDA margin of 2.3%, whilst NHS trusts reported a 0.5% margin. Both were significantly below their respective planned level of 2.8% and 2.1%.
- Acute trusts continued to face the biggest financial challenge within the NHS provider sector, reporting an EBITDA margin of 0.5%. In contrast, specialist trusts have outperformed their plan and in aggregate achieved the highest EBITDA margin of 5.5%.
- Overall, 53 trusts achieved over 5% EBITDA at year end, 12 fewer than plan, whilst 66 trusts reported a negative EBITDA margin at the year end.

2.7 ‘S’ curve and full year deficit





Month 12 Financial Improvement Analysis	Prior Improvement £m	Improvement Month 9 to 12 £m
Capital to revenue		324
Operational improvement (e.g. Workforce/Agency)	251	51
Other measures	546	349
Total Financial Improvement measures	797	724
Of which:		
NHS Foundation Trusts	464	386
NHS Trusts	333	338

- The NHS provider sector saw a sharp decline in its financial performance in 2015/16. The year end deficit of £2.45bn was almost three times larger than that reported in 2014/15 and slightly worse than the providers’ forecast at Q3 2015/16.
- The ‘S’ curve showed that the level of financial stress was not confined to a small group of providers. Most providers have reported worse-than-planned financial outturn for the year, however, acute providers continued to be more financially challenged than the rest of the sector.
- As highlighted in our previous reports, the deterioration in the sector’s overall performance is driven by: 1) ongoing high level use of contract and agency staff due to recruitment difficulties combined with rising demand and a heightened focus on care quality and safety; 2) demand for care in hospital settings with particular pressures in urgent and emergency care; 3) cost pressures rising from DToCs and fines and penalties; 4) a reduction in non-recurrent income compared to 2014/15; and 5) failure to deliver the planned levels of cost improvement schemes.
- Efforts were made during the year to improve the sector’s overall financial performance. Control measures introduced by NHS Improvement during the year had some positive (albeit limited) impact on the sector's overall performance. Providers were also committed to sustainable improvement actions in response to the financial challenges. In particular, between December 2015 and March 2016, an additional £724m financial improvement opportunities were identified and actioned.
- Notwithstanding these ongoing efforts, the 2015/16 year-end position poses a significant challenge for the sector going into 2016/17. Despite the Sustainability and Transformation Fund (S&T Fund) adding extra funding for the sector in the coming year, providers will need to do more to strengthen their financial grip to improve and sustain their financial performance and meet the sector’s control totals.

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 licensed NHS trusts and NHS foundation trusts operating during the financial year of 2015/16 and one unlicensed shell organisation. Those 240 licensed providers include 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 in the NHS trusts' financial figures where applicable. For consistency purpose with the final accounts preparation, the operating costs of £1.1m of Mid Staffordshire NHS Foundation Trust "shell organisation" was included in the overall I& financial position, but not counted in the number of deficit trusts.
2	Reported Financial Position surplus/(deficit) is measured slightly differently between NHS Foundation Trusts and NHS Trusts. Monitor (NHS foundation trusts) 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 (NHS foundation trusts 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. 184 reported against incomplete pathway targets. The admitted and non-admitted targets were removed in September 2015.
6	131 trusts (NHS foundation trusts and NHS trusts) report performance against the breast cancer: 2 week wait target 151 trusts (NHS foundation trusts and NHS trusts) report performance against the GP referral: 62 day wait target 149 trusts (NHS foundation trusts 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)

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.
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 NHS Foundation Trusts 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.