To: The Board

For meeting on: 28 May 2014

Agenda item:

Report by: Jason Dorsett, Director of Finance, Reporting & Risk

Report for: Information

TITLE: Performance of the foundation trust sector: year ended 31 March 2014

Summary:

The attached paper sets out the findings of our review of Q4 2013/14 returns from all 147 NHS foundation trusts (FTs) augmented by externally sourced data about the performance of the FT sector in the period.

Recommendations:

The Board is requested to note the contents of the attached report.

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 relation to the issues set out in this paper, consideration has been given to the impact that the recommendations might have on these requirements and on the nine protected groups identified by the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation).

It is anticipated that the recommendations of this paper are not likely to have any particular impact upon the requirements of or the protected groups identified by the Equality Act.

Exempt information:

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

Monitor

Making the health sector work for patients

Performance of the foundation trust sector

Year ended 31 March 2014

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Contents

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1.1 Executive summary

Operational performance

We track the performance of foundation trusts to help them prevent operational issues becoming ongoing quality problems and adversely affecting patient care. For the year ended 31 March 2014, the sector overall achieved the performance standard for the majority of the targets that we track, but operational pressures increased in the latter half of the year. The A&E 4 hour waiting time target standard of 95% was not achieved in quarter 4 and there has been a deterioration in performance against elective waiting time targets, particularly for cancer patients, over the past two quarters.

Over the year, 95.4% of A&E patients at foundation trusts were seen within 4 hours. However, performance dipped to 94.7% in quarter 4. This was reflected in 34 foundation trusts failing the A&E waiting time target standard in quarter 4, which compares with 28 foundation trusts in the previous quarter, but 47 in the same quarter last year. Weekly figures indicate that performance has improved slightly to 94.9% for quarter 1 up to 11 May. From December 2013 to early April 2014, Monitor tracked individual trust performance on a weekly basis and supported the poorer performers in developing and implementing strategies for improvement. Our data suggests that the greatest pressure is a lack of beds for admission of patients from A&E, which in turn is due to delays in discharge processes and the availability of step down care. Foundation trusts must therefore continue to work with their partners in community health and social care services to address these problems.

For the first three quarters of the year the sector met all elective patient waiting time standards, but in quarter 4 the target to treat 90% of admitted patients within 18 weeks of referral was breached by the sector overall. While reasons given for individual foundation trust breaches vary and the majority of trusts have credible plans for returning to sustainable delivery, these breaches reflect system wide pressures as the waiting list grows and median waiting times lengthen.

The foundation trust sector achieved the performance standards for all cancer waiting time targets for the nine months to 31 December 2014, the latest available data. However, performance against the '62 day wait from GP referral' target has deteriorated to its lowest level in two years over the past two quarters. 26 trusts breached the performance standard this quarter, compared to 16 both last quarter and this time last year. One reason given by trusts for an increased number of breaches both this quarter and last is an increase in referrals due to national awareness campaigns, which is borne out by data available up to 31 December 2013, showing a 3.5% year on year increase in such referrals.

The total number of *C. difficile* cases reported by foundation trusts has continued to fall in 2013/14, with an 11% year on year reduction.

1.2 Executive summary

Financial performance

There was a significant decline in the overall surplus[2] made by foundation trusts from £491m in 2012/13 to £133m (unaudited) in 2013/14.

The majority of foundation trusts are breaking even or are in surplus, but 40 have reported deficits for the year, which is 21 more than planned a deficit and almost double the number of trusts in deficit for the year ended 31 March 2013. The combined value of the individual deficits is £307m against planned individual deficits amounting to £190m. Of the deficit trusts, 20 are subject to regulatory action, through which Monitor is helping them overcome their problems, and a further two are being investigated due to financial concerns, which may lead to regulatory action. These trusts account for 70% of the total deficit value. Two other trusts are reporting a deficit this year due to one off transactions of £62m in total, while the remaining 16 have relatively small deficits of between 0.1% and 2.5% of revenue.

The fall in the value of individual surpluses across all foundation trusts has more significantly eroded the sector's overall financial performance (down by £209m) than the growth in individual deficits (up by £149m). This reflects the decline in the EBITDA[3] margin (earnings before interest, tax, depreciation and amortisation as a proportion of revenue) from 6.0% last year to 5.2% this year, which compares to 5.7% in the plan. This margin decline is due to a failure to deliver planned cost improvements in full, combined with pressures on both pay and non-pay costs that are in excess of activity. This year foundation trusts have delivered cost efficiency improvements of £1.2bn or 3.0% of controllable operating costs, which compares to 3.4% last year and a planned efficiency of 3.9%.

At the same time, staff numbers have increased 4.1% (24,000), compared with 1.4% (8,000) in the plan and 2.4% last year, despite generally lower activity and revenue growth this year. This suggests at least some part of this growth in headcount is attributable to other factors, such as the impact of the findings of Keogh and Francis on clinical staffing levels.

Total cash held by foundation trusts has fallen for the first time this year, to £4.2bn from £4.5bn at the beginning of the year. The primary reason is that the sector spent £0.4bn more on capital projects than it generated in cash from operations. This contrasts with 2012/13 when capital expenditure was £0.9bn lower than cash generated from operations. Borrowings have increased 45% or £0.5bn this year, which is another impact of lower net cash inflows from operations combined with significantly higher capital spend than last year.

1.3 Executive summary

Regulatory performance

At 31 March 2014, 27 of 147 foundation trusts were subject to enforcement action by Monitor. This is 8 more than at 31 March 2013 as a result of *Aintree*, *Calderstones, Colchester, Cumbria Partnership, Dorset Healthcare, Heart of England, North Lincolnshire and Goole* and *The Christie* being found to be in breach of the conditions of their licence during the year. No trusts have had enforcement action lifted during the year.

Since 31 March 2014, we have taken enforcement action at two more trusts, *South Manchester* and *Southern Health*, bringing the total number of foundation trusts currently in breach of their licence to 29. Within this group, 9 trusts are in special measures due to concerns relating to significant quality issues and leadership at the trust. At these, we have appointed an improvement director to monitor progress against the trust's action plan.

Currently, we are formally investigating 5 trusts for potential licence breaches; one due to concerns raised by the Care Quality Commission, two due to repeated failure of the performance standard for one or more operational targets, one due to financial concerns and one due to both operational performance and financial concerns.

Following the Secretary of State's approval of the trust special administrators' report and recommendations on *Mid Staffordshire* in February 2014, we entered into a new contract with the trust special administrator to move into the implementation phase. This has now begun and will involve preparing for the transfer of management and some services from *Stafford Hospital* to *University Hospital North Staffordshire NHS Foundation Trust* and from *Cannock Chase Hospital* to *Royal Wolverhampton NHS Trust,* prior to the dissolution of the trust later this year.

A contingency planning team was appointed at *Peterborough and Stamford Hospitals* in February 2013 to develop options to deliver sustainability and in September 2013 we secured a formal agreement from the trust to implement a recovery plan that will secure vital services for patients and substantially close an annual £40 million financial gap. The plan is being delivered by the trust's existing board and management.

2.0 Summary of the sector

Year ended 31 March 2014

	Number of trusts	Operating Revenue £m	EBITDA %	Average CoSRR	Red rated trusts	% red rated
Acute	83	29,691	4.9%	3.1	23	28%
Mental health	41	8,262	5.3%	3.8	4	10%
Specialist	18	2,907	7.4%	3.9	2	11%
Ambulance	5	901	6.3%	4.0	0	-
Total	147	41,761	5.2%	3.4	29	20%

Analysis of Acute sector

	Number of trusts	Operating Revenue £m	EBITDA %	Average CoSRR	Red rated trusts	% red rated
Teaching [4]	18	12,297	5.8%	3.2	4	22%
Large (revenue over £400m p.a.)	6	3,016	5.8%	3.7	1	17%
Medium (revenue £200m-£400m p.a.)	39	10,824	4.2%	3.1	12	31%
Small (revenue under £200m p.a.)	20	3,554	2.9%	2.9	6	30%
Total	83	29,691	4.9%	3.1	23	28%

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3.0 Operational performance

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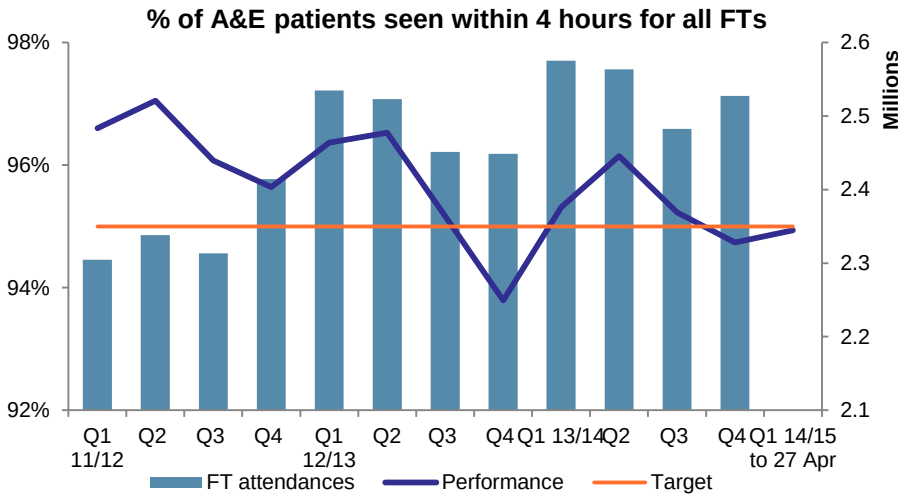
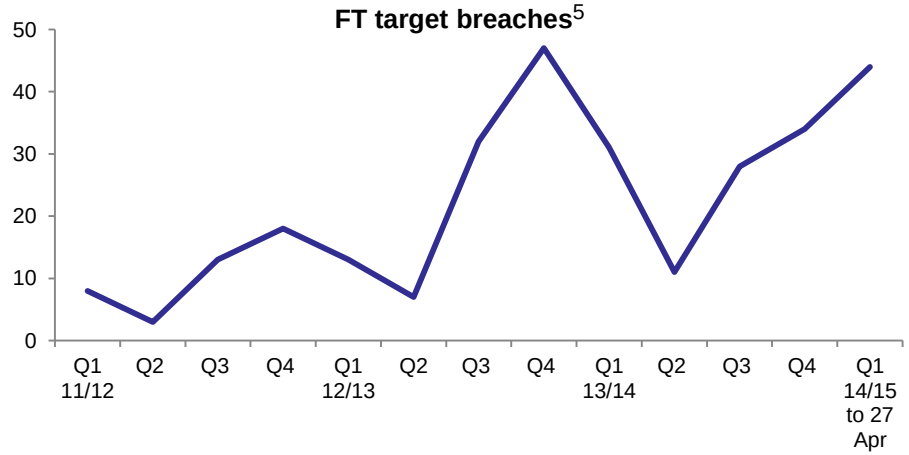
3.1 Accident & emergency





- For the year, foundation trusts as a whole have achieved the A&E four hour waiting time standard, with a performance of 95.4% against a target standard of 95%.
- This quarter, 94.7% of A&E patients at foundation trusts were treated within 4 hours, which is an improvement on 93.8% in Q4 last year, despite 78,771 (3.2%) more attendances this Q4 and 49,451 (3.8%) more emergency admissions.
- From December 2013 to early April 2014, Monitor tracked weekly A&E performance at foundation trusts and assisted poor performers with developing and implementing improvement strategies. Data collected from this process indicated that the greatest pressures in the system arise from temporary mismatches between demand and supply of inpatient beds, primarily caused by surges in the volume and acuity of patients requiring admission (as distinct from the absolute number of attendances), as well as delays in discharging inpatients to free up beds for new admissions from A&E.
- Performance has improved in Q1 14/15 and was at 94.9% up to 27 April, which is to be expected as we move into spring. However, the recovery is less marked than seen in the equivalent period last year.
- 34 (41%) of acute foundation trusts failed the A&E waiting time standard in Q4. This is an improvement on 47 in Q4 12/13 but higher than 18 in Q4 11/12.
- The South and Midlands are the worst performing regions having both failed the 95% performance standard overall in Q4 and with 52% and 48% of their relevant trusts breaching the target, respectively. Meanwhile, London and the North both achieved the 95% performance standard overall with just 13% and 36% of their trusts breaching the target in Q4, respectively.
- Monitor is continuing to collect weekly A&E performance data which is summarised and distributed to foundation trusts as a benchmarking tool. We will consider the need to resume regular support work with trusts as we move into winter 2014/15.

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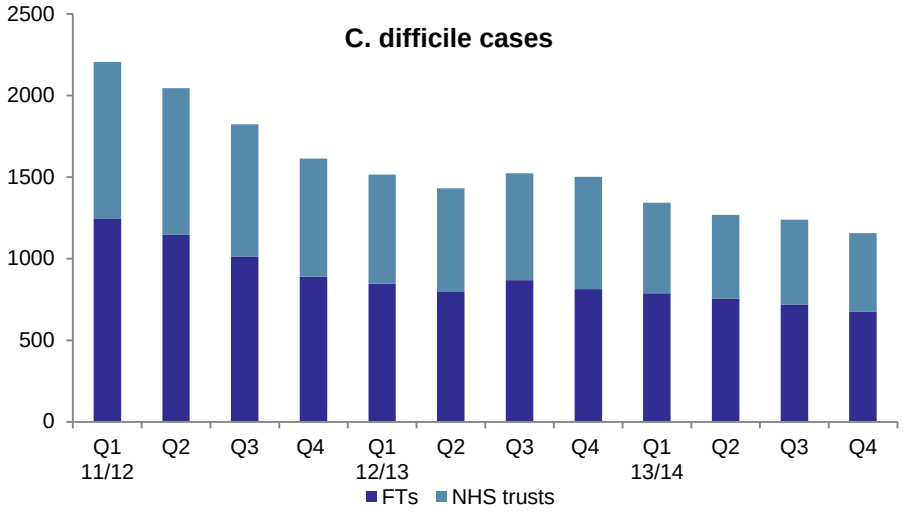
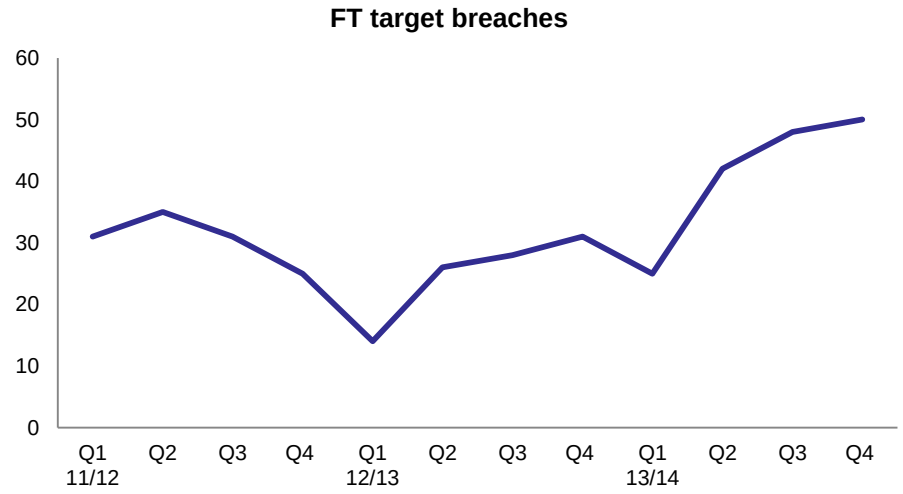
3.2 Infection control





- There is a continuing trend of decline in the absolute number of *C. difficile* cases across the whole of the NHS, as illustrated in the graph opposite.
- Foundation trusts reported a total of 2,953 cases of *C. difficile* in 2013/14 compared with 3,327 in 2012/13, which is an 11% improvement, while Q4 cases have fallen from 813 in 2012/13 to 676 in 2013/14, a 17% improvement.
- However, the number of *C. difficile* target breaches reached an all time high this quarter at 50 trusts. The discrepancy between clear improvements in overall *C. difficile* performance and significant increases in the number of trusts breaching their individual *C. difficile* targets is almost entirely attributable to how those targets are set.
- Each trust's target is based on historical performance with up to a 30% improvement required year on year. For some trusts, their targets have become so low that a very small number of cases can take them into breach and, if they breach in an early quarter, it is unlikely they will be able to recover their trajectory through later good performance.
- NHS England recognises that some trust targets have become too ambitious, resulting in breaches that were not due to particular failings on the part of those trusts. The calculation methodology for the 2014/15 targets has therefore been reviewed, with some trust targets actually increasing in 2014/15. Commissioners will also be given greater discretion about whether they penalise trusts for target breaches.

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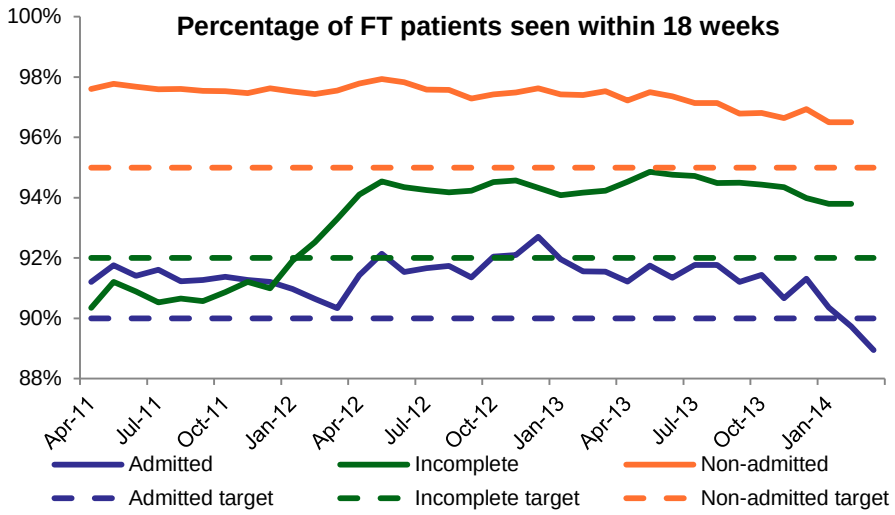
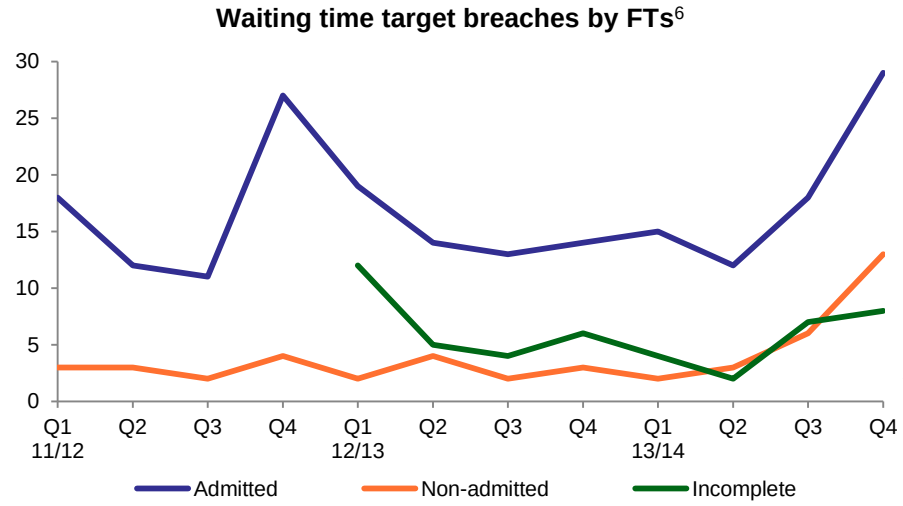
3.3 Waiting time targets





- Throughout 2013/14, foundation trusts as a whole have performed above the 18 week waiting time target standard for non-admitted patients and those still on the waiting list. However, overall performance against the target for admitted patients dipped below the 90% standard in February 2014 to 89.7% and early sight of March data indicates further deterioration.
- The number of trusts breaching each of the three waiting time target standards has increased this quarter in comparison to both last quarter and Q4 2012/13.
- Individual reasons given by trusts for target breaches vary widely and include
  - shortages of consultants in some specialities
  - increased levels of referral due to national awareness campaigns or the availability of new treatments (e.g. the licensing of Lucentis for the treatment of macular degeneration)
  - the impact of clearing backlogs (admitted target)
  - problems with introducing new patient administration systems (PAS) and data validation issues
  - impact of regional service reconfigurations
- The majority of trusts have credible plans to return to sustainable achievement of their waiting time targets within the next couple of quarters. However, there is a risk that the increase in breaches and the overall failure of the admitted standard this quarter reflects challenges across the whole system. This conclusion is supported by the fact that NHS trust performance has also deteriorated this quarter and the median waiting time for admitted, non-admitted and incomplete pathways has increased from 9.2, 3.8 and 5.1 weeks in Feb 2013 to 9.5, 4.7 and 5.4 weeks in Feb 2014, respectively.
- A system wide decline in waiting time performance may be in part due to continuous efficiency drives eroding the headroom on the achievement of these targets, with the result that a single unexpected event, such as a ward closure or staff illness, can tip a trust very rapidly into target failure.

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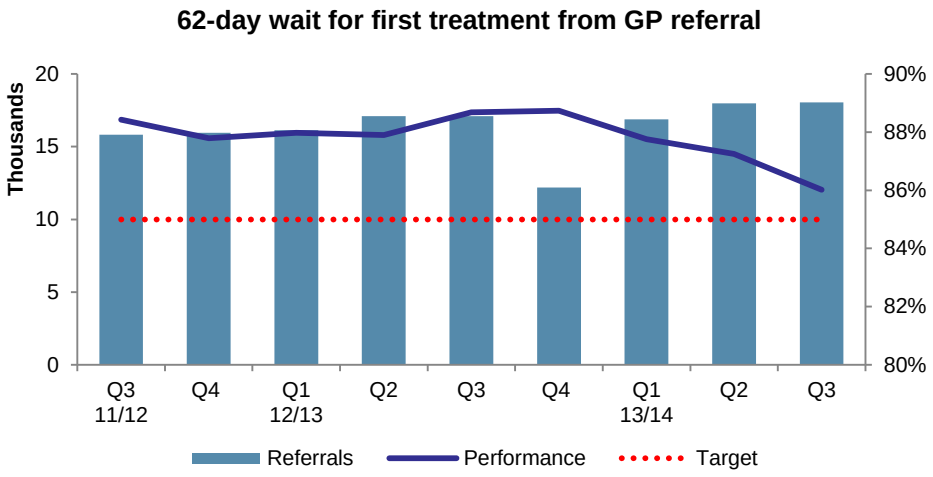
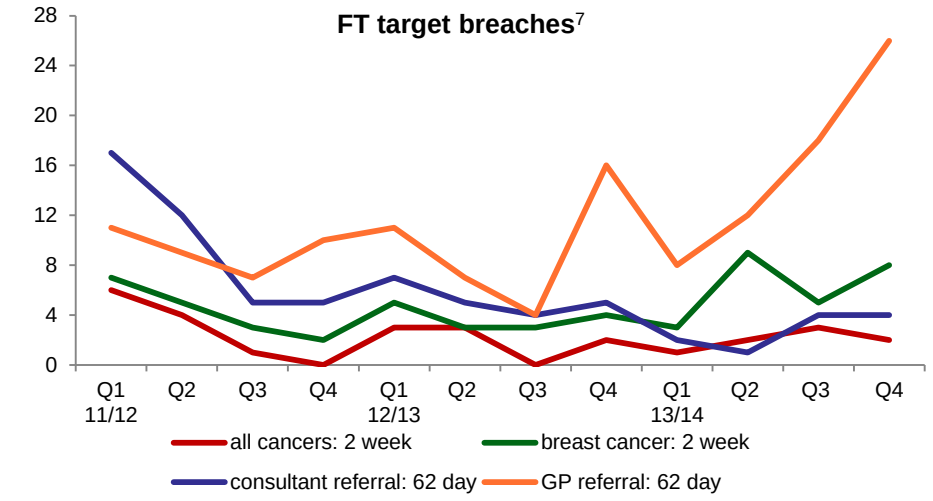
3.4 Cancer waiting time targets





- In the nine months to 31 December 2013, which is the latest available data, the foundation trust sector achieved the performance standard for all cancer waiting time targets.
- However, overall performance against the '62 day wait from GP referral' target has deteriorated each quarter this year with the result that the number of trusts breaching the 85% standard has jumped to 26 this quarter from 16 at Q3. This compares with 16 breaches in Q4 2012/13. Regionally most breaches (10) are in the Midlands and least (4) in London.
- Where trusts have breached this target, several have cited increased referrals as a factor and this can be verified from publicly available data up to December 2013, up to which point there was a 3.5% year on year increase. Complex pathways, late referrals and consultant capacity are also mentioned as reasons for breaches.
- There have also been 11 breaches of the 90% standard for '62 day wait target: consultant referrals' target in Q4, compared with 5 in Q3 and 5 in Q4 2012/13. Regionally the spread of these failures is fairly even.
- Eight trusts have breached the 93% standard for the breast cancer 2 week wait target in Q4, compared with 5 last quarter and 4 in Q4 2012/13. Regionally most breaches (5) are in the Midlands with none in the South. According to data supplied by trusts, out of a total of 454 individual patient breaches, 340 are due to the patients cancelling, declining or being unavailable for an offered appointment, while 97 are due to inadequate outpatient capacity.
- The much higher level of breaches of the 62 day referral to treatment targets than the 2 week referral to first appointment and 31 day diagnosis to treatment targets suggests that problems with meeting cancer targets tends to be in the diagnostic phase of the pathway. However, there has also been an increase in breaches of the 31 days diagnosis to treatment 96% standard, performance against which has historically been very good, to 7 this quarter, from 1 last quarter, and compared with 3 in Q4 last year.

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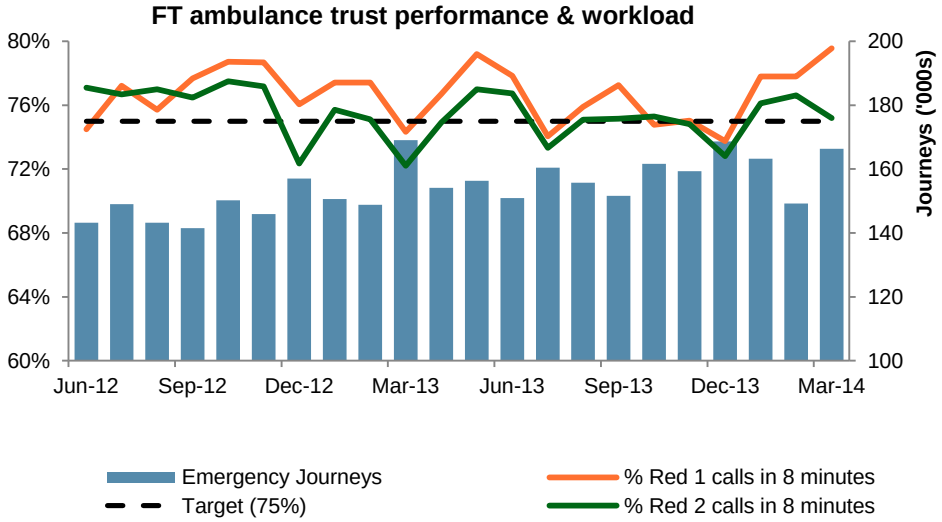
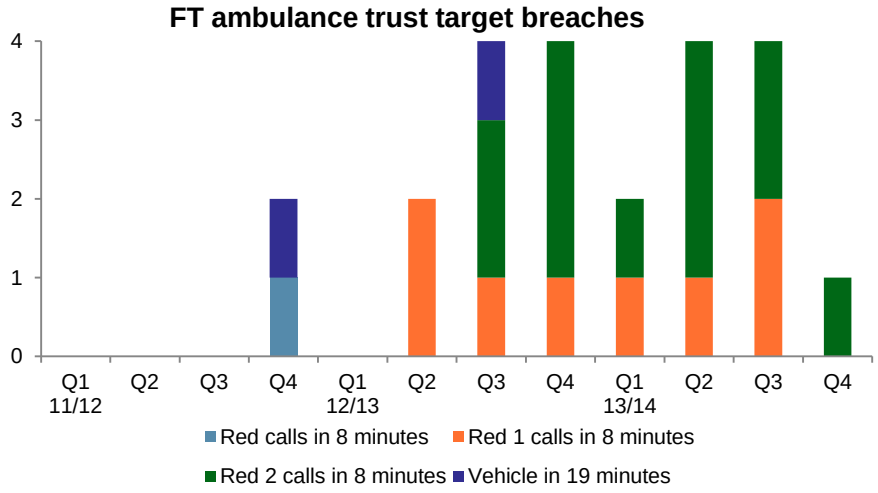
3.5 Ambulance response times





- There are 10 ambulance trusts within the NHS, five of which are foundation trusts. While this represents a small part of the total foundation trust sector in terms of revenue and number of trusts, their performance is of particular interest because of its potential impact on A&E services.
- Throughout 2013/14 foundation trusts as a group have achieved the 'category A call – ambulance within 19 minutes' target standard and it is unusual for this target to be breached by a trust individually.
- In contrast, overall foundation trust performance against the '8 minute response time' red 1 and red 2 targets, has dipped below the 75% standard in several months this year, as illustrated in the chart opposite. What the chart also shows is that there is a correlation between poorer performance and increases in emergency journeys.
- Despite the dips in performance, foundation trusts still met the performance standard for both of these targets for the year as a whole.
- There was only one target failure this quarter, but this was the third consecutive quarter that *West Midlands Ambulance* failed to achieve the performance standard for the 8 minute red 2 response time target, only achieving 73.1% (Q3: 71.9%, Q2: 73.6%).
- Ambulance trusts have cited delays in handing patients over to A&E departments as a factor in recent failures to meet targets, coupled with the challenge of activity levels that do not follow seasonal norms.

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4.0 Financial performance

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4.1 Income & expenditure

Year ended 31 March	2014 Actual £m	2014 Plan £m	Variance to plan £m	Variance to plan %	2013 Actual £m
Operating Revenue for EBITDA	41,761	40,201	1,561	3.9%	39,345
Pay costs	(26,246)	(25,470)	(776)	3.0%	(24,585)
Other operating expenses	(13,354)	(12,437)	(916)	7.4%	(12,414)
EBITDA	**2,162**	**2,293**	**(131)**	**-5.7%**	**2,347**
Depreciation	(1,201)	(1,220)	19	-1.6%	(1,121)
Finance costs	(342)	(340)	(2)	0.5%	(327)
PDC dividend	(461)	(494)	32	-6.6%	(457)
Other non-operating items	26	44	(18)	-40.9%	99
Restructuring costs[8]	(51)	(24)	(27)	110.7%	(48)
Net surplus[2]	**133**	**259**	**(126)**	**-48.6%**	**491**
Gains/(losses) on transfers [9]	91	0	91	0.0%	156
Impairments	(368)	(125)	(243)	194.7%	(615)
Net surplus after impairments & transfers by absorption	(144)	134	(285)	-212.2%	33
EBITDA %	5.2%	5.7%			6.0%
Surplus %	-0.4%	0.3%			0.1%

- Generally foundation trusts are holding up well in tightening economic conditions, given that they are still in an overall net surplus position. However, the number of trusts in deficit has grown from 21 in 2012/13 with a gross deficit of £190m to 40 this year with a gross deficit of £307m (see slide 4.6).
- Although the growing gross deficit has a very significant impact on the bottom line, it is smaller surpluses from the rest of the foundation trusts that has contributed more to the overall decline in the financial performance of the sector.
- Surplus decline is almost entirely driven by the decline in EBITDA both against 2012/13 and plan, though other non-operating items includes two one-off charges amounting to £62m, one of which relates to the buy out of the PFI scheme at *Northumbria*.
- On the face of it, this appears to be due to a disproportionate increase in non-pay costs relative to revenue growth. However, revenue growth is not entirely activity driven and both cost and revenue variances may be distorted by the impact of reimbursed costs. In practice, it is pay cost pressures that cause more concern at trusts, which are exacerbated by the impact of the quality agenda on staff numbers and over reliance on contract and agency.
- The £32m saving in PDC dividends against plan is due to a combination of factors, including unplanned asset impairments and a change in the methodology for calculating the dividend payable.
- While impairments are much higher than planned, they are implicitly unpredictable and at £368m are significantly lower than in 2012/13, which reflects a slowing of falls in market value. £104m of the £243m overspend is at one trust which has virtually halved the value of its assets as a result of a modern equivalent asset valuation.

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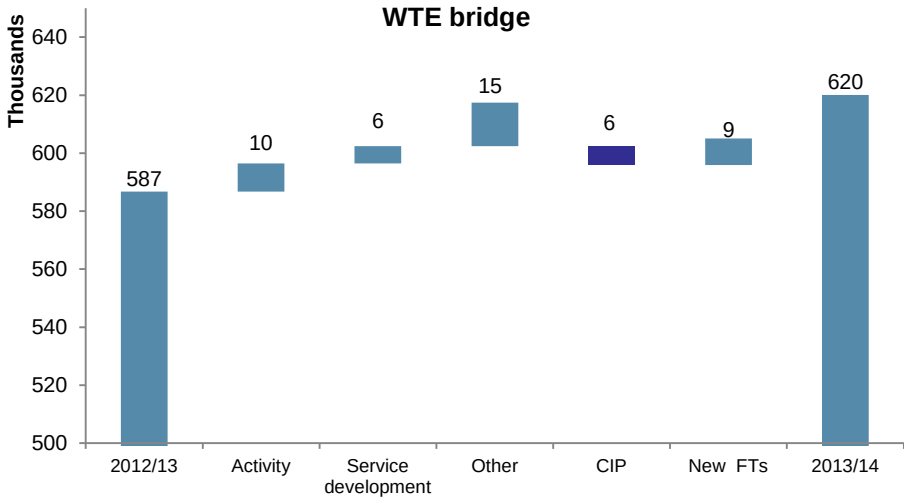
4.2 Revenue analysis

Year ended 31 March	2014		Variance to plan		2013
	Actual £m	Plan £m	£m	%	Actual £m
Ambulance	864	843	21	2%	605
Community	2,993	2,964	29	1%	2,962
Mental health	5,669	5,583	86	2%	5,678
Elective in-patients	2,994	3,093	(100)	-3%	3,099
Elective day cases	2,421	2,329	92	4%	2,088
Outpatients	4,676	4,476	200	4%	4,424
Non-elective in-patients	6,502	6,421	80	1%	6,595
A&E	890	880	11	1%	840
Other NHS clinical	9,195	8,545	650	8%	7,761
Non-NHS clinical	744	702	41	6%	641
Total clinical revenue	**36,949**	**35,837**	**1,112**	**3%**	**34,694**
Research and Development	624	564	60	11%	623
Education and Training	1,538	1,453	85	6%	1,484
Other non-clinical revenue	2,762	2,468	294	12%	2,649
Total non-clinical revenue	**4,924**	**4,485**	**439**	**10%**	**4,756**
Total operating revenue	**41,873**	**40,322**	**1,551**	**4%**	**39,450**
Less: Donations & Grants of PPE	(111)	(121)	10	-8%	(104)
Operating Revenue for EBITDA	**41,761**	**40,201**	**1,561**	**4%**	**39,345**

- Of the £2,416m increase in operating revenue from 2012/13 to 2013/14, approximately £920m is attributable to the impact of new foundation trusts and mergers and acquisitions. After accounting for the 1.3% deflator that was applied to clinical revenues in 2013/14, this implies overall volume driven or other growth of 5.2% for the sector.
- In both absolute and relative terms most of the growth in clinical revenues is within the acute/ specialist trusts.
- The negative variance on elective in-patient revenues, which is outweighed by favourable variances on day cases and outpatients, suggests a deliberate policy to minimise hospital stays, by treating elective cases as outpatients or as day cases where possible. According to the activity data provided by trusts, elective inpatient activity is down 4%, while elective day cases and outpatients are up 2% and 3% respectively.
- The fact that the relevant revenues have not fallen as much/ grown more against the plan than these activity variances may be due to case mix changes.
- In contrast, non-elective revenue growth at 1% is lower than non-elective activity growth of 3%, which reflects the impact of the marginal tariff. It is estimated that if such activity was paid at full tariff, the EBITDA margin for the sector would be between 0.3% and 0.5% higher this year.
- The largest variance continues to be in “Other NHS clinical” revenues, which entirely relates to acute and specialist providers. For the first time this year, we have collected a break down of this figure and found the most significant items are reimbursement of high cost drugs and devices at £1,796m and critical care (outside tariff) at £1,381m. CQUIN payments of £452m are also reported on this line. In the absence of plan data analysed in the same way, it is difficult to interpret what is driving the variance. However, it is of note that by far the largest variance is in the North both in percentage and absolute terms and examination of individual variances, reveals that many of the larger variances are at financially troubled trusts, which suggests a degree of unplanned support funding is flowing from CCGs.
- The variance in “other non-clinical revenue” has more than doubled since Q3. A similar jump in the full year variance was observed in 2012/13, which suggests that trusts hold back on recognising large elements of such revenues until year end.

4.3 Operating expenses

Year ended 31 March	2014 Actual £m	2014 Plan £m	Variance to plan £m	Variance to plan %	2013 Actual £m
Pay - employees	24,874	24,947	(73)	0%	23,507
Pay - contract and agency staff	1,373	523	849	162%	1,078
Pay expense	**26,246**	**25,470**	**776**	**3%**	**24,585**
Ambulance operating costs	72	72	(0)	0%	50
Clinical supplies	3,575	3,353	222	7%	3,341
Drugs	3,247	3,004	243	8%	2,844
Non Clinical Supplies	1,668	1,519	150	10%	1,563
Other operating expenses	4,791	4,489	302	7%	4,616
Non-pay expenses	**13,354**	**12,437**	**916**	**7%**	**12,413**
Total operating expenses for EBITDA	**39,600**	**37,907**	**1,692**	**4%**	**36,998**



- Year end workforce data reveals that the sector wide number of whole time equivalent staff (WTEs) in 2013/14 was 15,889 higher than planned and 24,123 or 4% higher than 2012/13, excluding the impact of new foundation trusts.
- The pay bridge, below opposite, shows that trusts attribute almost as much headcount increase to 'other' as to 'service developments' and 'activity' growth. Half of the increase in headcount classified as 'other' was unplanned, which suggests that up to half of the overall variance against plan is attributable to non-activity driven factors, such as changes in clinical staffing ratios post Keogh and Francis.
- The extra headcount against plan largely accounts for the overspend on pay. However, the average cost of these extra staff is significantly higher than the planned cost per head, which is reflects a greater reliance on contract and agency staff than planned. The impact of this is approximately £100m, which would account for 0.2% of the EBITDA margin deterioration.
- Trusts have consistently cited difficulties recruiting to permanent posts as the reason for the overspend on contract and agency, particularly nurses and middle grade doctors. However, the 2014/15 plan assumes a 40% reduction in contract and agency spend, and the 2013/14 plan assumed a 50% reduction, which suggests that there is an element of unrealistic workforce planning contributing to this.
- Superficially, cost control appears to be a greater problem in non-pay operating costs, with individual variances of between 7% and 10%. However, some of the variances may be significantly distorted by the impact of unplanned 'pass-through' costs, such as reimbursements for high cost drugs and devices. Though, even if 30% of the revenue variance related to such reimbursements, non-pay operating costs are still growing faster than revenues, resulting in an erosion of margins.
- This is a concern, particularly given that trusts are reporting much better cost improvement delivery in clinical and non-clinical supplies than in pay and drugs (see slide 4.4).

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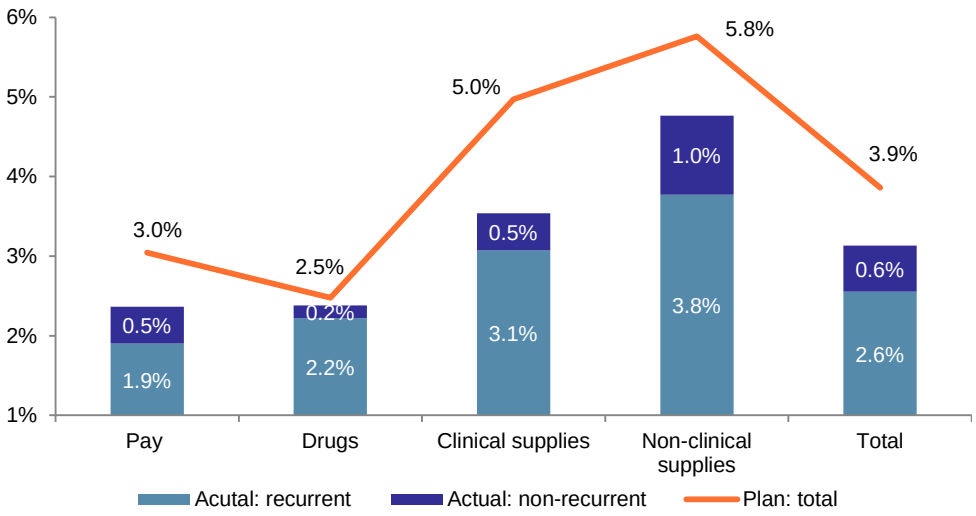
4.4 Cost improvement programmes

Cost improvement programmes as a % of relevant expenses



Cost improvement programmes as a % of operating expenses	2014 Actual	2014 Plan	2014 Variance	2013 Actual
Teaching acute	3.0%	3.7%	-0.7%	3.3%
Large acute	2.9%	4.0%	-1.1%	3.6%
Medium acute	3.2%	4.2%	-1.0%	3.4%
Small acute	2.5%	3.6%	-1.2%	3.4%
Acute	3.0%	3.9%	-0.9%	3.4%
Ambulance	4.1%	4.5%	-0.4%	5.0%
Mental Health	3.4%	4.0%	-0.6%	3.6%
Specialist	2.2%	2.8%	-0.6%	2.6%
Sector total	**3.0%**	**3.9%**	**-0.8%**	**3.4%**

- Overall delivery of efficiency savings through cost improvement programmes has reduced controllable operating costs by £1,228m or 3.0% in 2013/14, compared with a £1,291m or 3.4% in 2012/13. This is £277m or 17% less than planned.
- Had planned cost improvements been fully delivered, the EBITDA margin would be 0.8% higher. However, to some extent, non-delivery will be due to activity being higher than planned. Therefore, it is difficult to quantify the exact impact on margins of cost improvement under delivery.
- It is a concern that trusts are becoming increasingly reliant on non-recurrent schemes to achieve their cost improvements, which will increase the pressure on them in future years. The split between recurrent and non-recurrent has been presented by cost area in the chart below. Overall, 18.6% of total savings was from non-recurrent schemes, compared to 5.8% in the plan and 14.4% in 2012/13.
- The under delivery of cost improvement plans was partly offset by £83m of additional margin from revenue generation schemes, predominately from teaching and medium acutes. The total of £368m from revenue generation schemes in 2013/14 represents 23% of combined cost improvement and revenue generation scheme benefits, up from 17% in 2012/13, placing increasingly reliance upon these schemes.
- Specialist trusts have reported the lowest cost savings, despite continuing to deliver the highest margins.

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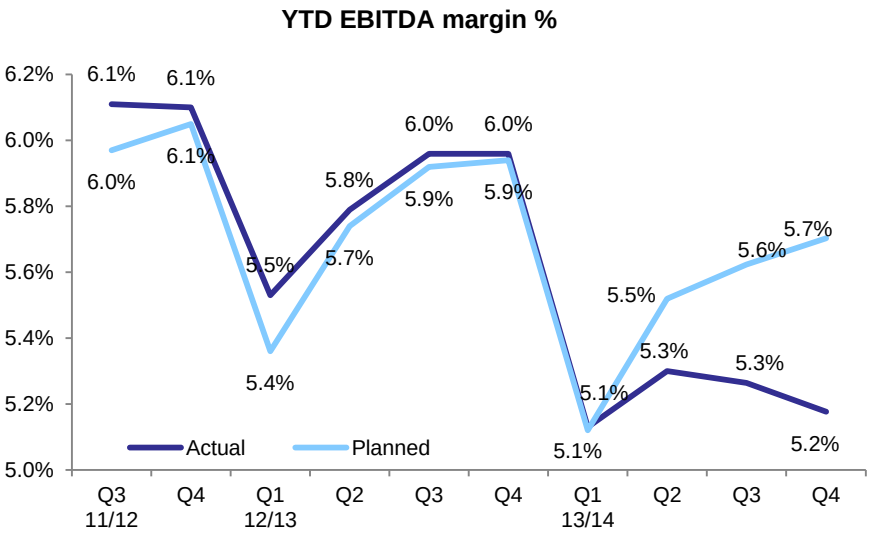
4.5 EBITDA margin



- Historically, the year to date EBITDA has increased as the financial year progresses, which trusts attribute to the build up of efficiency savings and the impact of activity in excess of contract. In the past two financial years, the EBITDA margin peaked in quarter 3.
- For the first time this year, the EBITDA margin declined in quarter 3 and in quarter 4 and, more worryingly, has dropped significantly below plan, as illustrated in the graph opposite.
- This graph also demonstrates the general downward pressure on margins during this period, with the gap between actual and planned performance gradually narrowing to the point of reversing in quarter 2 this year.

	2014		2013	
Trust type	**EBITDA %**	**Variance from plan %**	**EBITDA %**	**Variance from plan %**
Teaching acute	5.8%	-0.3%	6.6%	0.0%
Large acute	5.8%	-0.6%	7.1%	0.1%
Medium acute	4.2%	-1.0%	4.9%	-0.4%
Small acute	2.9%	-1.6%	4.7%	-0.6%
Total Acute	**4.9%**	**-0.8%**	**5.8%**	**-0.2%**
Mental Health	5.3%	0.0%	5.9%	0.7%
Specialist	7.4%	0.5%	7.2%	0.4%
Ambulance	6.3%	-1.0%	7.6%	0.3%
Total	**5.2%**	**-0.5%**	**6.0%**	**0.0%**

- Margins have deteriorated for all types of trust in 2013/14, with small acute trusts suffering the biggest decline against both last year and the plan. However, it remains unclear whether it is the size of the trust that gives rise to the problems. Specialist trusts appear to be under much less financial pressure than general acute and mental health trusts, being the only group of trusts to report a higher EBITDA margin than planned this year.
- Ambulance trusts also perform more strongly than general acute and mental health trusts in EBITDA terms. However this reflects a different operating model, with a higher proportion of their costs being below the EBITDA line, and only small acute trusts have experienced a more significant margin decline against plan in 2013/14.

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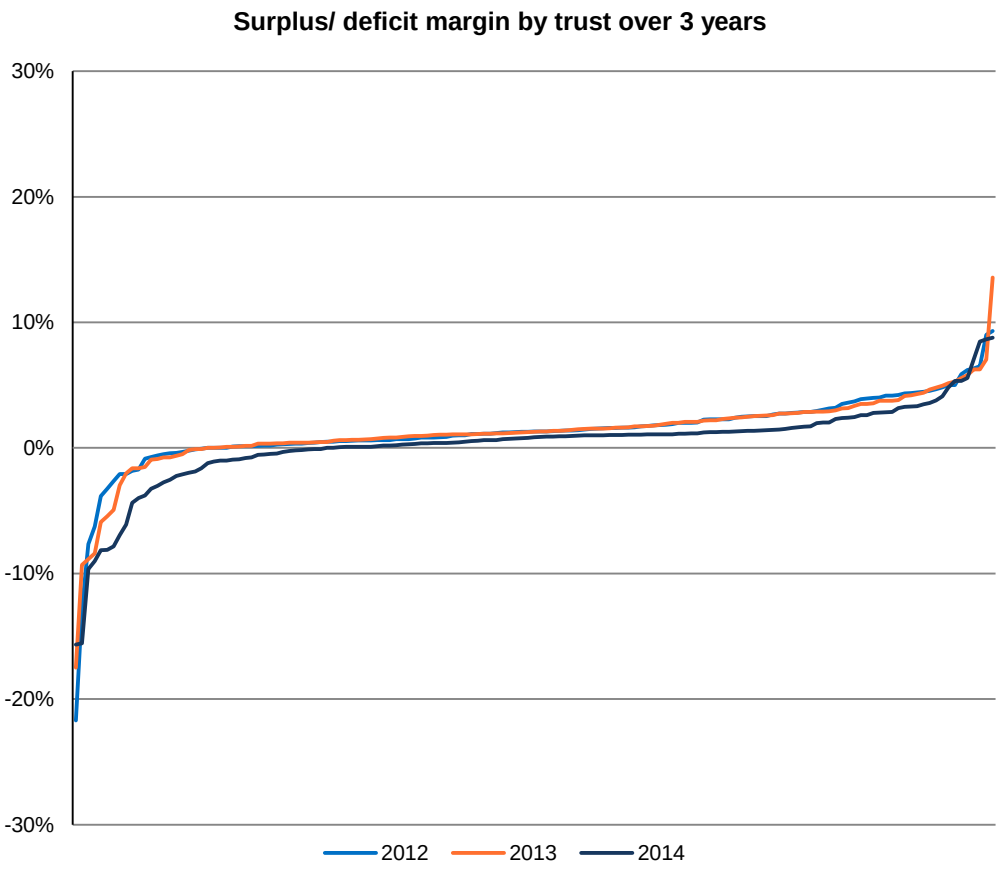
4.6 ‘S’ curve



- Provided we are satisfied that services are sustainable in the medium/long term, trusts may run short-term deficits without regulatory action where we are satisfied that they are addressing any underlying financial or operating issues.
- There were 40 foundation trusts in deficit in 2013/14, against 19 who planned a deficit and 21 who ended 2012/13 in deficit.
- The gross value of these deficits is £307m, compared to £190m in 2012/13 and £180m at Q3. The disproportionate jump in the deficit since last quarter is due to the impact of one off charges at two trusts amounting to £62m.
- The trusts with large deficits continue to be the same challenged group, but there are also 40 trusts with individual deficit margins of under 1% in 2013/14.
- The chart opposite shows that the ‘tail’ of deficit trusts is widening, but more worryingly the S curve has flattened across its whole length. It is this flattening of the curve, due to a general decline in surplus margins, that has the greater impact on the net surplus position for the sector, rather than the increase in the size of the gross deficit.
- 41% (34) of acute trusts, 20% (1) of ambulance trusts, 6% (1) of specialist trusts and 10% (4) of mental health trusts are in deficit.
- 45% (17) of trusts in the Midlands region, 20% (7) in the South, 26% (14) in the North and 11% (2) in London region are in deficit.

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4.7 Balance sheet

Year Ended 31 March	2014		Variance to plan		2013
	Actual £m	Plan £m	£m	%	Actual £m
Property, Plant & equipment	19,843	20,282	(439)	-2%	18,219
PFI assets	3,831	3,351	479	14%	3,354
Other non-current assets	640	779	(139)	-18%	516
Total non-current assets	**24,313**	**24,412**	**(99)**	**0%**	**22,089**
Inventories	489	464	25	5%	461
Trade & other receivables	1,818	1,192	626	53%	1,223
Accrued revenue	340	291	50	17%	261
Prepayments	307	269	38	14%	254
Cash & Equivalents	4,225	3,624	601	17%	4,513
Other current assets	148	58	91	157%	152
Total current assets	**7,328**	**5,897**	**1,431**	**24%**	**6,864**
Borrowings	(117)	(130)	13	-10%	(89)
Trade & other payables	(2,383)	(1,989)	(394)	20%	(2,133)
Accruals	(1,564)	(1,353)	(211)	16%	(1,441)
Deferred income	(486)	(342)	(144)	42%	(504)
Provisions	(376)	(197)	(179)	91%	(339)
Other current liabilities	(653)	(589)	(64)	11%	(569)
Total current liabilities	**(5,580)**	**(4,600)**	**(980)**	**21%**	**(5,075)**
Net current assets	**1,748**	**1,297**	**451**	**35%**	**1,789**
Borrowings	(1,627)	(1,695)	68	-4%	(1,124)
Deferred income	(151)	(154)	4	-2%	(128)
Provisions	(276)	(241)	(35)	15%	(256)
Leases PFI	(4,215)	(4,128)	(87)	2%	(4,194)
Other non-current liabilities	(176)	(181)	5	-3%	(200)
Total non-current liabilities	**(6,444)**	**(6,398)**	**(46)**	**1%**	**(5,902)**
Total funds employed	**19,617**	**19,311**	**306**	**2%**	**17,976**
Retained earnings	1,365	1,521	(156)	-10%	972
Public Dividend Capital	13,413	13,358	55	0%	12,727
Revaluation reserve	4,750	4,332	418	10%	4,187
Other reserves	88	99	(11)	-11%	90
Total taxpayers' equity	**19,617**	**19,311**	**306**	**2%**	**17,976**

- Of the £2,224m increase in the value of non-current assets since 31 March 2013, c. £400m is due to new authorisations, c. £700m is the difference between capital spend, disposals and depreciation and the remainder is largely attributable to the transfer of assets from dissolved NHS bodies (of which c. £100m are PFI assets) into 44 foundation trusts. These transfers also account for most of the increase in the value of retained earnings and the revaluation reserve.
- Trade receivables are £626m higher than planned, and receivable days (the time it takes to collect debts) have increased to 15.9 days against 10.8 days in the overall sector plan and 11.3 days at 31 March 2013. This reflects ongoing problems with slower payment from commissioners than in prior years, particularly NHS England local area teams, due to organisational problems, as well as uncertainty around who is responsible for some elements of commissioning.
- For the first time, cash and cash equivalents for the sector has fallen this year, despite there being two new foundation trusts, which reflects an overall erosion in the financial resilience of the sector. However, cash and cash equivalents have fallen £601m less than planned, primarily due to a £484m cash based underspend on capital projects.
- Foundation trusts appear to have partially funded the shortfall in receivables by stretching the time they take to pay their trade creditors, payable days having increased from 62.7 days at 31 March 2013 to 65.1 days at 31 March 2014, which is significantly higher than the planned 58.4 days.
- Borrowings are 45% higher than this time last year, which may in part be a reflection of the lifting of the prudential borrowing limit.
- Provisions (current and non-current), which are £57m higher than last year end and £214m above plan, saw a big swing between the outturn estimates in the annual plans and the Q4 submissions.

4.8 Cash flow

Year ended 31 March	2014 Actual £m	2014 Plan £m	Variance to plan £m	Variance to plan %	2013 Actual £m
Net Surplus	(144)	134	(278)	-207%	33
non operating & non cash items	2,276	2,182	94	4%	2,445
working capital movements	(423)	(462)	38	-8%	193
Net cash inflow/(outflow) from operating activities	**1,709**	**1,855**	**(146)**	**-8%**	**2,670**
Capital Expenditure	(2,137)	(2,621)	484	-18%	(1,737)
Other investing activities	166	64	102	159%	63
Net cash inflow/(outflow) from investing activities	**(1,971)**	**(2,557)**	**586**	**-23%**	**(1,674)**
PDC capital movements	381	229	152	66%	185
PDC dividend payments	(452)	(480)	27	-6%	(460)
PFI interest & capital payments	(419)	(471)	52	-11%	(417)
Finance lease interest & capital payments	(36)	(34)	(2)	5%	(35)
Loans drawn / (repaid), net	535	580	(44)	-8%	168
Other financing activities	(56)	(32)	(24)	75%	13
Net cash inflow/(outflow) from financing	**(47)**	**(208)**	**162**	**-78%**	**(547)**
Net cash inflow/(outflow)	**(309)**	**(910)**	**602**	**-66%**	**450**
Opening Cash & Equivalents	4,513	4,513	-	0%	3,990
Cash & Equivalents in new FTs at authorisation	21	21	-	-1%	74
Closing Cash & Equivalents	**4,225**	**3,624**	**602**	**17%**	**4,514**

- For the first time in 2013/14 cash has fallen for the sector overall, though not as much as planned.
- The primary reason for this is the under spend against capital plans, though cash spend on capital schemes is £400m (23%) higher than in 2012/13.
- Whereas cash generated from operations was more than sufficient to fund capital expenditure in 2012/13, this year capital expenditure significantly exceeded cash generated from operations, which would account for a much higher drawdown of borrowings at £535m in 2013/14 compared with £168m in 2012/13, though this was slightly less than planned.
- This suggests that the lifting of the prudential borrowing limit, combined with the move from the FRR to the COS risk rating has acted as an incentive for investment
- Of the £381m cash inflow from PDC movements, £188m is funding support for financially troubled trusts *Bolton*, *Heatherwood & Wexham Park*, *King's Lynn*, *Mid Staffordshire*, *Milton Keynes*, *Morecambe Bay, Peterborough* and *Royal National Hospital for Rheumatic Diseases* . A further £26m is in *King's* and relates to its take over of the *Princess Royal University Hospital*. The rest is made up of smaller amounts across 36 trusts and is for centrally funded capital schemes.

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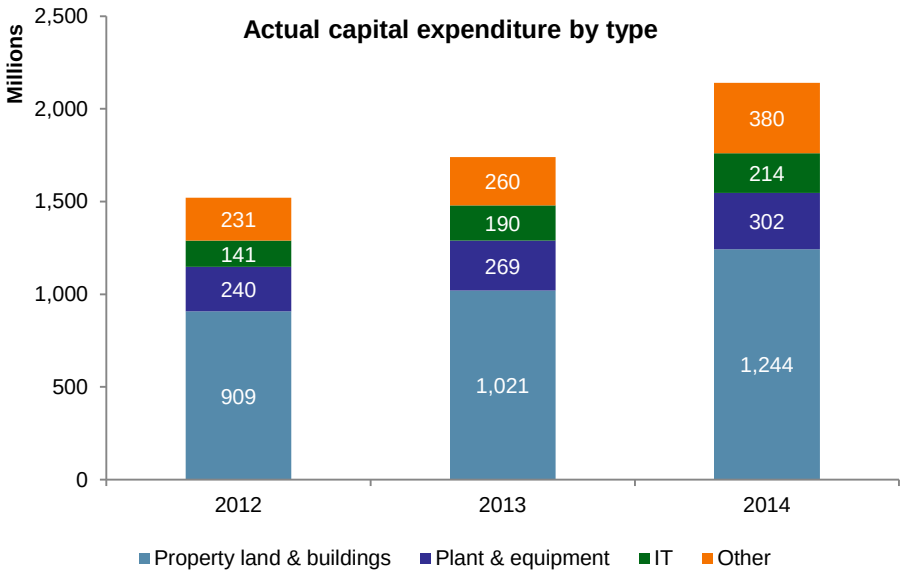
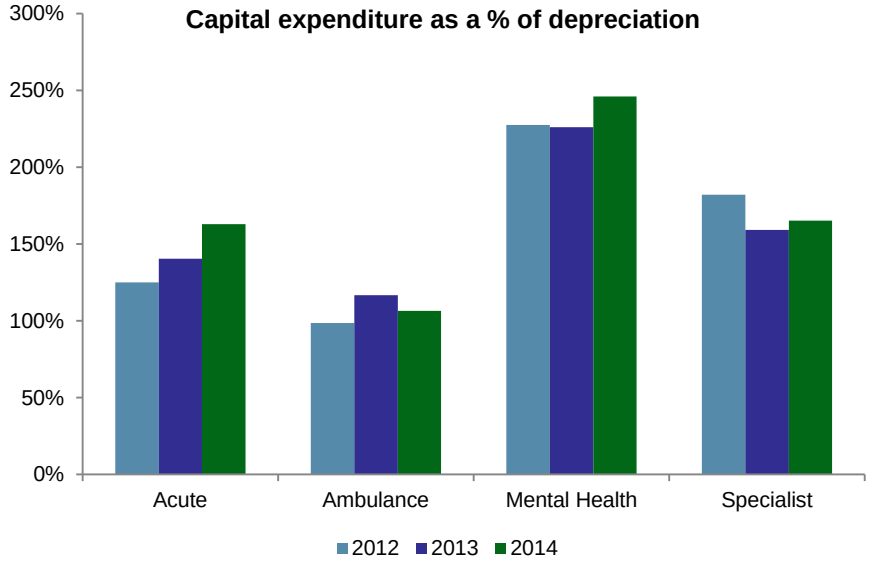
4.9 Capital expenditure





- Capital expenditure in 2014 2013/14 was £2,137m against a plan of £2,579m, on an accruals basis. This means foundation trusts have spent 83% of their plans in 2013/14, compared to only 72% in 2012/13. As the total planned spend was also higher in 2013/14, this has resulted in a significant absolute increase in expenditure, as illustrated in the graph opposite.
- Given the tightening economic conditions, it is encouraging that trusts have increased their levels of investment in 2013/14.
- Actual capital expenditure in 2014 is 170% of depreciation and amortisation charge, suggesting that aggregate investment levels are adequate across the sector. Compared to 150% in 2013 and 140% in 2012. The increase is primarily from acute trusts.
- Specialist trusts are reporting the highest underspend as a sector at 27% of plan, while the Midlands has the largest regional underspend at 23%.

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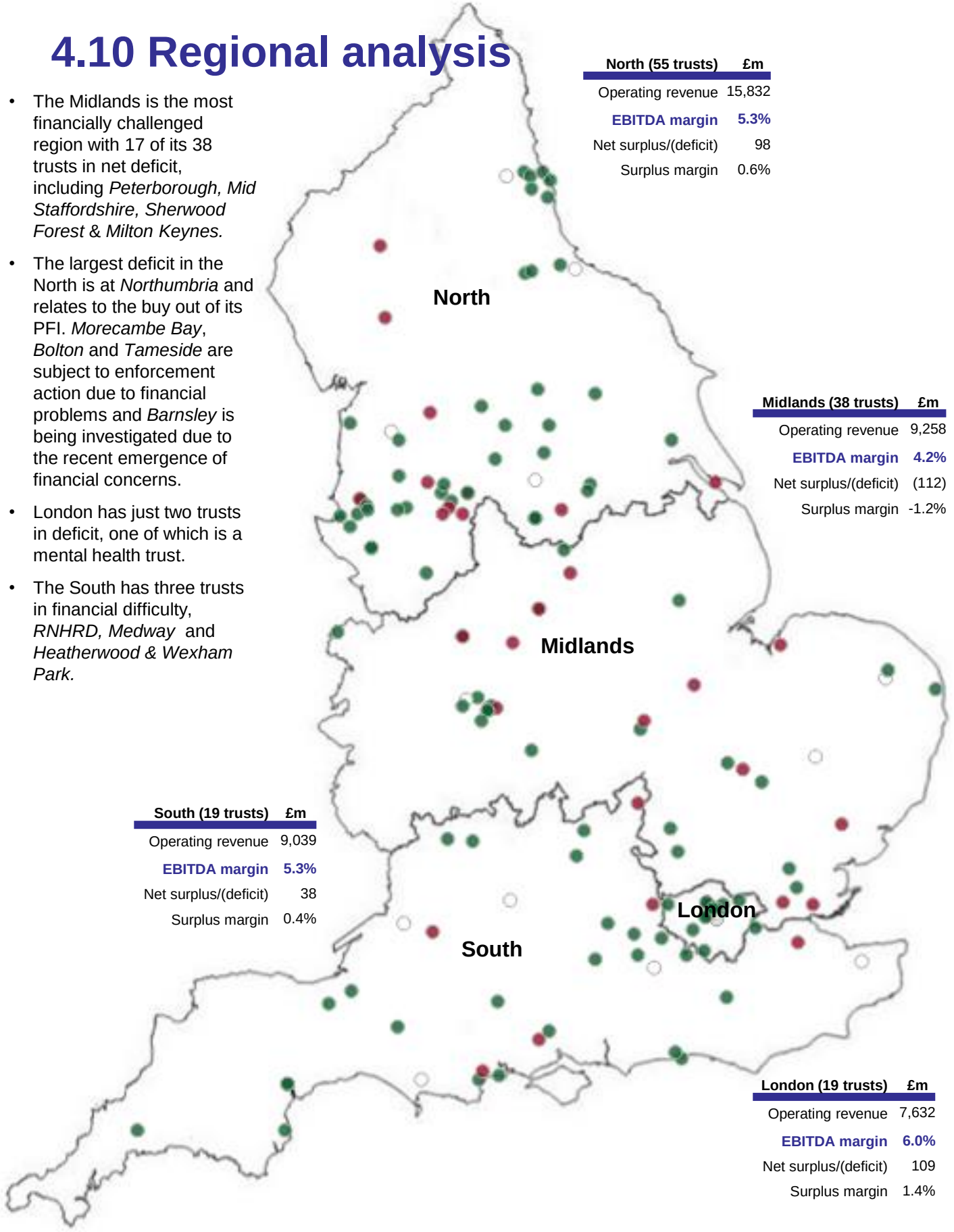
4.10 Regional analysis

- The Midlands is the most financially challenged region with 17 of its 38 trusts in net deficit, including *Peterborough, Mid Staffordshire, Sherwood Forest & Milton Keynes.*
- The largest deficit in the North is at *Northumbria* and relates to the buy out of its PFI. *Morecambe Bay*, *Bolton* and *Tameside* are subject to enforcement action due to financial problems and *Barnsley* is being investigated due to the recent emergence of financial concerns.
- London has just two trusts in deficit, one of which is a mental health trust.
- The South has three trusts in financial difficulty, *RNHRD, Medway* and *Heatherwood & Wexham Park.*



North (55 trusts)	£m
Operating revenue	15,832
EBITDA margin	**5.3%**
Net surplus/(deficit)	98
Surplus margin	0.6%

Midlands (38 trusts)	£m
Operating revenue	9,258
EBITDA margin	**4.2%**
Net surplus/(deficit)	(112)
Surplus margin	-1.2%

South (19 trusts)	£m
Operating revenue	9,039
EBITDA margin	**5.3%**
Net surplus/(deficit)	38
Surplus margin	0.4%

London (19 trusts)	£m
Operating revenue	7,632
EBITDA margin	**6.0%**
Net surplus/(deficit)	109
Surplus margin	1.4%

5.0 Regulatory performance

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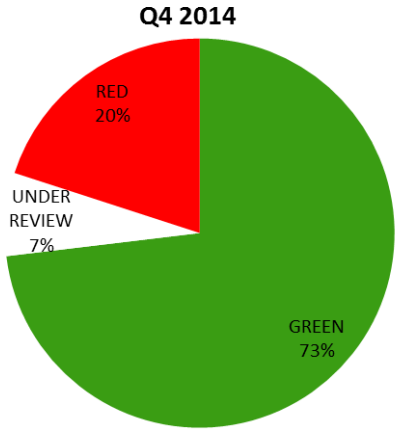
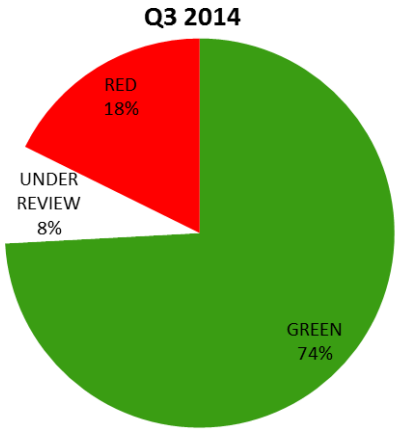
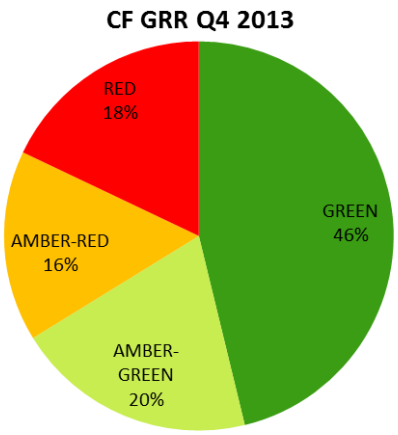
5.1 Governance risk ratings







- From 1 October 2013 the *Risk Assessment Framework (RAF)* replaced the *Compliance Framework* as our approach to overseeing NHS foundation trusts' compliance with the governance and continuity of services requirement of their provider licence. One of the consequences of this has been a change to how we determine governance risk ratings.
- Under the *Compliance Framework (CF),* trusts being formally investigated for potential breaches of their provider licence were rated red, whereas under the *RAF* only trusts that are subject to enforcement action are.
- Under the *RAF*, trusts are assigned a green rating if there are no material governance concerns evident (106 FTs at Q4 13/14). Where we identify potential material causes for concern, we replace the green rating with a description of the issue and the steps we are taking to address it. Trusts falling into this group have been described as "under review" in the above chart (10 FTs at Q4 13/14). Details of this group of trusts can be found on slide 5.5.
- Acute trusts have the poorest governance risk profile with 28% currently being red rated and 4 out of 5 open investigations (80%) being at acute trusts, despite acute trusts representing only 56% of the sector.
- Red rated trusts represents 20% of the total foundation trust sector with Midlands having the highest number of red rated trusts of 13 (45%).

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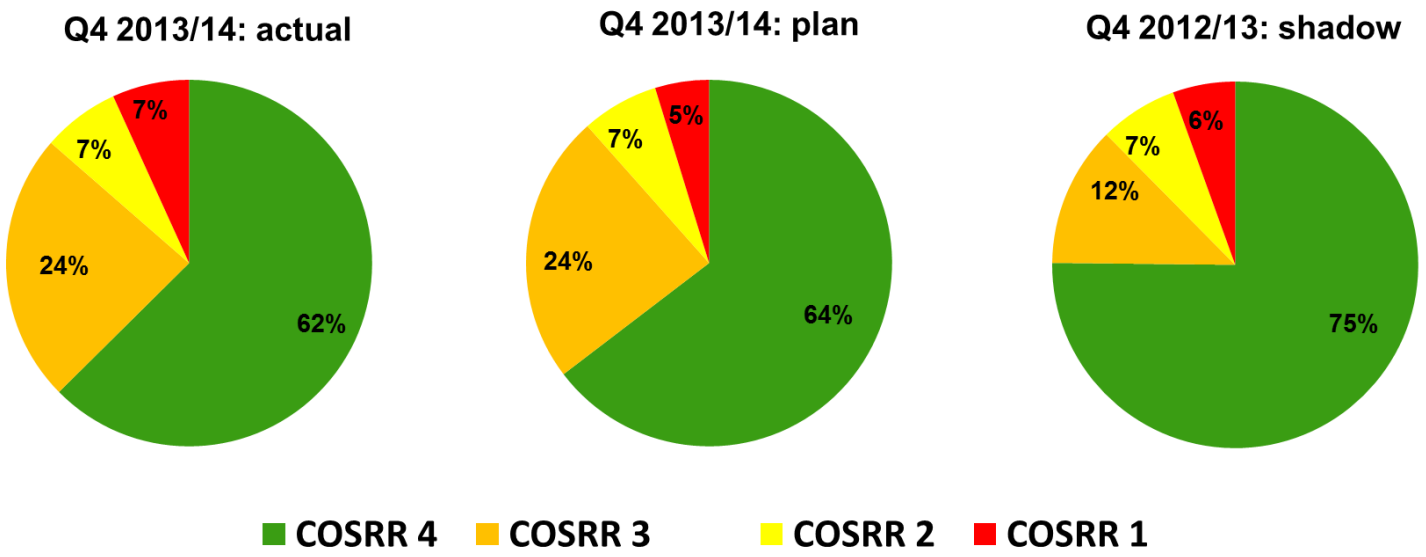
5.2 Continuity of Services risk rating (COSRR)



- Under the *Risk Assessment Framework*, which came into effect on 1 October 2013, the financial risk rating (FRR) has been replaced by the continuity of services risk rating. Therefore, this is the second quarter of it being used as a regulatory tool. Although the continuity of services risk rating was not in effect at Q4 2012/13, Monitor still calculated the trusts' ratings at this date, on a shadow basis.
- While the FRR was intended to identify breaches of a trust's terms of authorisation on financial grounds, the continuity of services risk rating is intended to identify the level of risk to the on-going availability of key services (or 'commissioner requested' services).
- There are four categories of continuity of services risk rating, where 1 represents the most serious risk and 4 the least risk. However, unlike the FRR, a low continuity of services 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.
- At 31 March 2014, 20 trusts had a continuity of services (COS) risk rating of 1 or 2, all of which are acute trusts, with 24% of acute trusts having a COS risk rating of 1 or 2. While 90% of COS 1 trusts are small and medium acutes.
- 100% of Ambulance trusts, 94% of specialist trusts and 80% of mental health trusts have a continuity of services risk rating of 4 at 31 March 2014.

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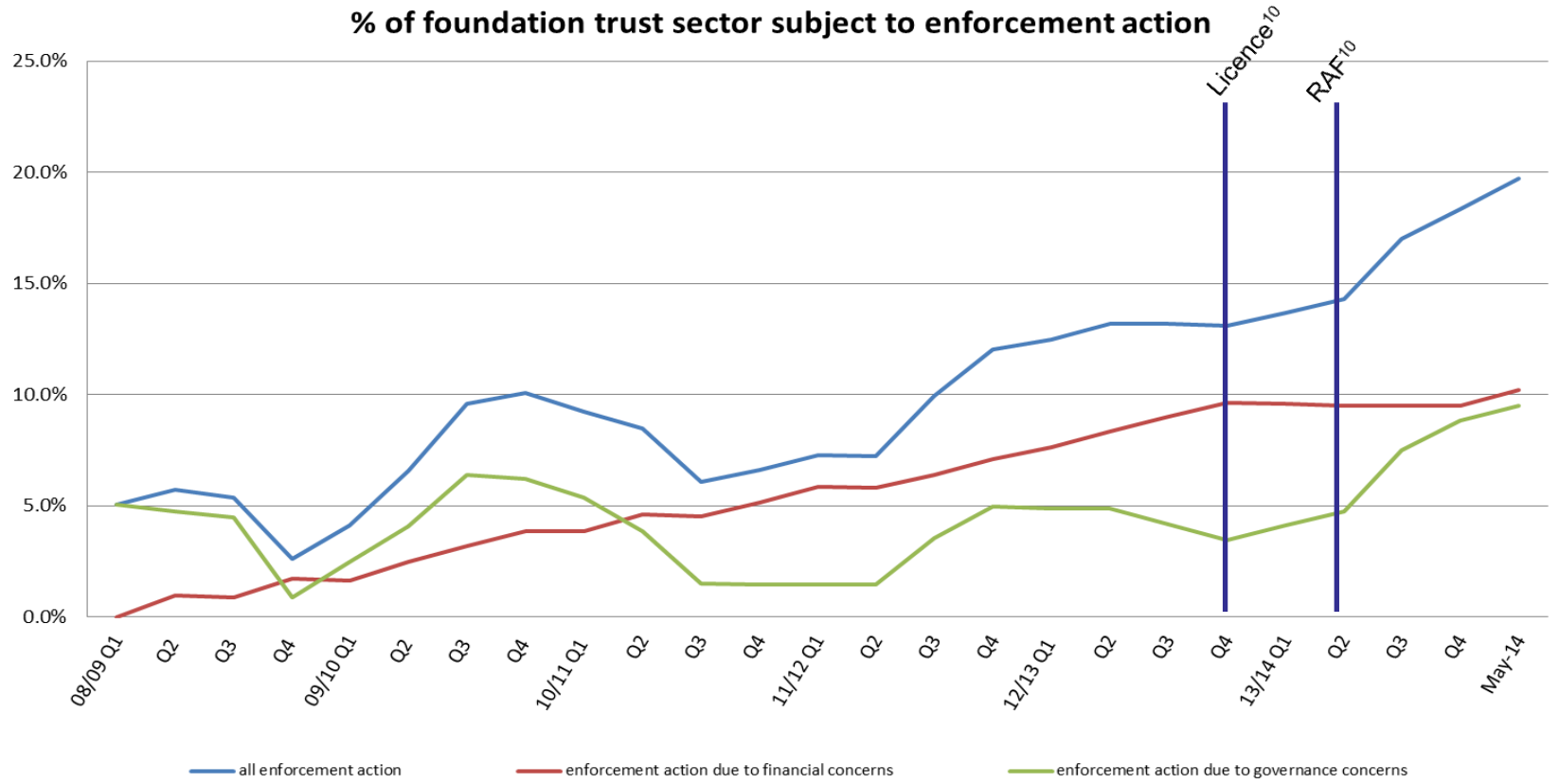
5.3 History of enforcement action



- The number of foundation trusts subject to enforcement action has risen over the last few years due to a gradual increase in trusts found in breach of their terms of authorisation / conditions of the provider licence due to financial issues and increasingly governance concerns since Q2 2013/14.
- Trusts subject to formal enforcement action due to governance issues in 2013/14 are primarily due to quality problems identified by the CQC and trusts' failure to address target performance issues.

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5.4 Current enforcement action

Enforcement action applied in 2013/14	Subject to enforcement action throughout 2013/14		Enforcement action applied in 2014/15
8	19		2
Aintree	Basildon & Thurrock	Milton Keynes	South Manchester
Colchester	Bolton	Morecambe Bay	Southern Health
Calderstones	Burton	Peterborough & Stamford	
Cumbria Partnership	Cambridge University	RNHRD	
Dorset Health	Derby	Rotherham	
Heart of England	Heatherwood & Wexham Park	Sherwood Forest	
North Lincolnshire & Goole	Kettering	Southend	
The Christie	King's Lynn	Stockport	
	Medway	Tameside	
	Mid Staffordshire		

During 2013/14

- 8 trusts had enforcement action applied and none were lifted during 2013/14, bringing the total trusts subject to enforcement action to 27 at 31 March 2014. The date and reason for the enforcement action are listed below
  - April 2013, *Dorset Health* following the issue of a warning notice by the CQC,
  - July 2013, *North Lincolnshire and Goole* following the Keogh review into patient mortality,
  - October 2013, *Aintree* due to governance concerns arising from failure of its annual *C. difficile* target,
  - November 2013, *Colchester* due to serious concerns highlighted during a CQC inspection,
  - December 2013, *Heart of England* due to repeated failure of the A&E target,
  - December 2013, *Calderstones* in relation to a third party report concerning abuse of a patient in the trust's care,
  - January 2014, *Cumbria Partnership* due to the inadequacy of the trust's response to quality issues,
  - March 2014, *The Christie* due to general governance concerns.

Since 31 March 2014

- Since 31 March 2014, two more trusts have been found to be in breach of their licence, bringing the total number of red rated trusts to 29.
  - April 2014, *Southern Health* following the issue of a warning notice by the CQC,
  - May 2014, *South Manchester* due to concerns over the trust's short term financial sustainability.

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5.5 Foundation trusts under review

Risk & Assessment Framework trigger	Considering investigation	Open investigation	Total
CQC information	1	1	2
Access and outcomes metrics	1	2	3
Third party reports	-	-	-
Quality governance indicators	2	-	2
Financial risk	-	1	1
Multiple factors	1	1	2
Total	**5**	**5**	**10**

Background

- On 1 October 2014, Monitor moved from assessing governance risk at foundation trusts under the *Compliance Framework* to the *Risk Assessment Framework*.
- Under the *Risk Assessment Framework*, trusts are given a green rating if there are no evident concerns and a red rating if Monitor has taken enforcement action at the trust.
- If Monitor identifies a potential material cause for concern at a trust, we will gather further information to determine if an investigation should be opened.
- There are five potential triggers of such concerns, as seen in the table below.
- Between a concern being triggered and the decision is made on whether or not to launch a formal investigation, a trust is rated neither green nor red.
- Trusts being considered for investigation and being formally investigated are both deemed to be 'under review' with respect to their governance risk rating.

Investigations

- An investigation was opened at *Central and North West London* following Care Quality Commission warning notices on quality of care at some of the trust's centres.
- Two trusts are being investigated for governance concerns triggered by multiple breaches of operational targets *Lancashire Teaching* for waiting times and *C. difficile* and *South Tees* for waiting times.
- An investigation was opened at *Barnsley* triggered by deterioration in financial performance and multiple breaches of the A&E target.
- An investigation was opened at *West Suffolk* triggered by financial concerns.
- Investigations have recently been closed at 8 trusts: *Bradford, South Warwickshire, Poole, Robert Jones, Royal Berkshire, Tees, Esk & Wear, Southampton* and *Wirral.*

Detailed reasons for all investigations can be found through the NHS foundation trust directory on our website.

Consideration for investigation:

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

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5.6 Other regulatory action

Special measures

- Monitor will consider whether to place a trust in special measures following a recommendation from the CQC, through the Chief Inspector of Hospitals, because the trust is inadequately led, and is inadequate in one or more other areas: safety, care, responsiveness or effectiveness. The normal process is for Monitor to appoint an improvement director and a high performing partner organisation to support improvement at the trust. Monitor will also review the capability of the trust's leadership and will require the trust to publish their progress against an action plan on the NHS Choices website.
    - In July 2013, six foundation trusts (*Basildon, Burton, Medway, North Lincolnshire & Goole, Sherwood* and *Tameside)* and five NHS trusts were placed in special measures as a result of the Keogh review into hospital mortality rates. All six foundation trusts are subject to enforcement action.
    - In October 2013, *The Queen Elizabeth Hospital King's Lynn*, which was already subject to enforcement action under its licence, was also put in Special Measures due to failings in patient care and hospital governance.
    - In November 2013, *Colchester*, which was also identified in the Keogh review, was placed in special measures as a result of serious concerns highlighted during a CQC inspection, regarding the quality of some services for cancer patients at the trust.
    - In May 2014 *Heatherwood and Wexham Park* was put into special measures after the trust failed to deliver an agreed package of measures set with Monitor to improve the standard of care provided and address concerns identified by CQC. The Trust is currently partnered with *Frimley Park* and there is proposed merger of the two trusts which is now cleared by the Competition and Markets Authority.

Special administration

- The trust special administrator was appointed at *Mid Staffordshire* in April 2013 as the trust was found to be clinically and financially unsustainable. Following the Secretary of State's approval of the trust special administrators' report and recommendations on *Mid Staffordshire* in February 2014, we entered into a new contract with the trust special administrator to move into the implementation phase. This has now begun and will involve preparing for the transfer of management and some services from *Stafford Hospital* to *University Hospital North Staffordshire NHS Foundation Trust* and from *Cannock Chase Hospital* to *Royal Wolverhampton NHS Trust,* prior to the dissolution of the trust later this year.

Contingency planning

- Following persistent poor financial performance, we decided that *Peterborough and Stamford Hospitals* was not able to deliver a turnaround plan to return it to standalone financial sustainability. We appointed a contingency planning team in February 2013 to develop options to deliver sustainability. In September 2013 we secured a formal agreement from the trust to implement a recovery plan that will secure vital services for patients and substantially close an annual £40 million financial gap. The plan is being delivered by the trust's existing board and management.

5.7 CQC warning notices

CQC warning notices at 31 March 2014			
Issue date	**Trust**	**Reason**	**Cleared/ outstanding**
Oct-13	King's Lynn	4 warning notices issued. Concerns relating to: insufficient numbers of appropriately qualified staff; inadequate arrangements to protect against abuse; lack of appropriate support of employees to allow them to deliver the appropriate standard of care; and assessment and monitoring of the quality care.	Outstanding
Nov-13, Jan-14 & Mar-14	Southern Health	9 warning notices issued. concerns over the care and welfare of people who use services, cleanliness and infection control, safety and the suitability of premises, safety, availability and suitability of equipment, assessing and monitoring the quality of care.	2 outstanding, 7 cleared
Dec-13	Heart of England	Concerns over the failure to protect patients against inappropriate or unsafe care and treatment as a result of ineffective systems at the trust.	Outstanding
Jan-14	Heatherwood & Wexham Park	7 warning notices issued. Concerns over appropriate patient privacy, dignity and independence, care and welfare of people who use services, cleanliness and infection control, appropriate staffing levels, assessing and monitoring the quality of care and record keeping.	Outstanding
Jan-14	Bradford	Concerns relating to insufficient numbers of appropriately qualified staff.	Outstanding
Feb-14 & Mar-14	Medway	5 warning notices issued in respect of Maternity Services (staffing), supporting workers, assessing and monitoring the quality of service provision, A&E care & welfare and infection control.	Outstanding
Mar-14	Central North West London	5 warning notices issued relating to care and welfare of people who use services, safety and suitability of premises, assessing and monitoring the quality of service provision and safeguarding people who use services from abuse.	Outstanding

- 50 CQC warning notices were issued during 2013/14 against 16 trusts (2012/13: 13 warning notices against 6 trusts). Of these, 22 were issued at 5 mental health trusts, and 28 were issued at 11 acute trusts.
- 2 CQC warning notice have been issued since 31 March 2014
  - Southern Health: in April 2014, due to concerns care and welfare of people who use services.
  - North East Ambulance: in May 2014, due to concerns relating to workers (lack of appropriate qualified staff and background checks).

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6.1 End notes

1	All financial information in this report is year to date and based upon unaudited quarter 4 monitoring returns from the 147 NHS foundation trusts at 31 March 2014. For foundation trusts authorised during the year, we only include financial data from the date of authorisation. New foundation trusts this year are Kingston, authorised on 1st May, and Western Sussex, authorised on 1st July.
2	Throughout this report references to surpluses or deficits are before impairments, and gains or losses on transfers by absorption.
3	EBITDA is an approximate measure of available cash flow. It does not take into account the impact of depreciation, amortisation, financing costs or taxation. This means that when taken as a margin on revenue, it can be used to compare performance between organisations that may have very different levels of capital investment and debt financing.
4	"Teaching" acute trusts are those acute trusts who are members of AUKUH (the Association of UK University Hospitals), a list is available on request or at www.aukuh.org.uk
5	100 foundation trusts report performance against the A&E target.
6	Foundation trusts are deemed to have breached a waiting time target if they fail to achieve the performance standard in any month in the quarter. 122 foundation trusts report performance against the non-admitted and incomplete pathway targets and 106 against the admitted target.
7	80 foundation trusts report performance against the breast cancer: 2 week wait target 88 foundation trusts report performance against the GP referral: 62 day wait target 97 foundation trusts report performance against the all cancers: 2 week wait target and the consultant referral: 62 day wait target
8	For consistency with NHS trust reporting, we deduct restructuring costs in calculating net surplus/deficit.
9	Gains/losses relating to the transfer of assets/liabilities from abolished NHS bodies to foundation trusts on 1 April 2013 have been taken directly to reserves, as required under an HMT dispensation to current accounting rules. All other transfers of assets/liabilities from other NHS bodies to foundation trusts are recorded as a gain/ loss on transfer within the current year surplus/deficit.
10	From 1 April 2013 Terms of Authorisation were replaced by the Provider Licence and, from 1 October 2013, the *Risk Assessment Framework* (RAF) replaced the *Compliance Framework*.

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6.2 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 target	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.
Admitted patient	A patient who is formally admitted to a hospital for treatment. This includes admission that is not overnight, i.e. day cases.
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.
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.
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.
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 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.

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6.2 Glossary (2/3)

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.
FRR	Financial Risk Rating. This was the measure of financial risk used by Monitor as a regulatory tool up until 30 September 2013, at which point it was replaced by the COS risk rating – see 6.2.
GRR	Governance Risk Rating. This is a measure of the risk of governance failure at a foundation trust. The methodology for assessing the GRR of a trust is explained in Monitor's Risk Assessment Framework.
High cost drugs	High cost drugs are typically expensive drugs used for specialist treatments e.g. cancer, that are excluded from the Payment by Results (PbR) tariff as would not be fairly reimbursed if they were funded through the tariff. Commissioners and providers agree appropriate local prices.
HMT	**Her Majesty's Treasury**, a government department that fulfils the function of a ministry of finance.
Keogh	Following the Francis Inquiry, the medical director of NHS England Sir Bruch Keogh led a review into the quality of care and treatment provided by 14 hospital trusts in England. His subsequent report identified some common challenges facing the wider NHS and set out a number of ambitions for improvement, which seek to tackle some of the underlying causes of poor care. The report signalled the importance of monitoring mortality statistics to highlight any underlying issues around patient care and safety. Using the data to identify trusts who are performing positively will also be helpful in establishing and sharing effective practice across the NHS. The report is available at this link: http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf
Non-admitted patient	A patient on a pathway that does or did not include treatment without admission to a hospital, also known as an outpatient
Non-elective patient	A patient who is admitted for treatment on an unplanned or emergency basis. Such patients are not relevant to referral to treatment (waiting time targets).
Pathways	A **Pathway** describes the journey of a patient through an outpatient appointment, diagnostic tests, further outpatient appointments to a potential inpatient appointment (e.g., for surgery).
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)

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6.2 Glossary (3/3)

Special administration	In exceptional circumstances, where a health care provider is deemed financially unsustainable, Monitor, as part of its role, appoints a special administrator to take control of the provider's affairs. The special administrator work with the commissioners to ensure that patients continue to have access to the services they need. For statutory guidance for trust special administrators appointed to NHS foundation trusts refer to: http://www.monitor-nhsft.gov.uk/sites/default/files/publications/ToPublishFinalTSAGuidanceApril2013.pdf
Special measures	A hospital trust is said to require 'special measures' on quality grounds when serious and systemic failings in relation to quality of care have been identified, and the persons responsible for leading and managing the trust are unable to resolve the problems without intensive support. An improvement plan will be published and Monitor will provide intense oversight of the trust to ensure that improvement actions are being taken. Monitor is assisted in doing this by allocating an 'Improvement Director' to the trust.
Surplus or deficits	Refers to the net financial position after operational revenue and expenses. Throughout this report references to surpluses or deficits are before any impairments and gains or losses on transfers by absorption.
Teaching hospitals	"Teaching" acute trusts are those acute trusts who are members of AUKUH (the Association of UK University Hospitals), a list is available at www.aukuh.org.uk
Waiting times	The time a patient has to wait before treatment, this is termed **RTT**(qv) in the NHS
WTE	**Whole Time Equivalent** is the adjustment to translate a number of temporary employees into the equivalent number of full time employees

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