

Board of Directors (in Public)

Item 4.1

Subject: Trust Review - SOF, Regulatory and Operational Performance Month 7
Date of meeting: Tuesday 26th November 2019
Prepared by: Hayley Kendall, Chief Operating Officer
Martin Curry, Senior Information Analyst - Interim
Presented by: Sue Pemberton, Director of Nursing and Operations
Purpose of Report: To Note

1. Executive Summary

The purpose of this paper is to present an update on the Trust performance for the period ending 31st October 2019. The exceptions to note for this month are:

- The Trust continues to have significant pressures in delivering against the six week diagnostic target with performance at 72.71%, an improved position from the previous month.
- Delivering the surgical activity plan remains a significant challenge with a further underperformance in month, a turnaround plan has been implemented with executive overview and scrutiny and a deep dive at the Divisional Executive Review on the 15th November 2019.
- Patients waiting longer than 18 weeks continues to increase with the significant pressure being in Cardiology. The Division continues to work on capacity to reduce patient delays but there is a risk to the delivery of the Trust aggregate position due to this pressure. The backlog reduction trajectory will be presented to Operational Board at the end of November 2019.
- Sickness remains a significant pressure for the Trust with performance still being far from plan.

The Board is asked to note the content of the paper and associated actions detailed.

2. Introduction

The report is divided into three sections as follows:

- Section 1 - Single Oversight Framework (SOF): This section provides details on the mandated regulatory indicators from NHS Improvement; these inform NHSI's risk assessment (segmentation) which determines the level of autonomy afforded to the Trust.
- Section 2 - Quality of Care Dashboard: internal quality indicators agreed by the Board in April 2019 for routine monitoring on delivery.
- Section 3 - Operational and Financial Performance Dashboard: internal performance, workforce and financial indicators agreed by the Board in April 2019 for routine monitoring on delivery.

Section 1 - Single Oversight Framework (Refer to Appendix 1)

1.1.1 Single Oversight Framework – Exceptions

1.1.2 Indicator: Quantity of Complaints

Accountable Officer: Sue Pemberton

Issue: 8 x Complaints in October against a monthly target of 4

Actions: It is unusual to receive a high number of complaints, in September the Trust had received 5 but previous to this was below 4 since April. The complaints during October show no real trend in operator, area or service and are all quite different in subject matter. There has been a slight rise in medical complaints since September- 3 in October but no trend within them. The Patient and Family Support Manager contacts every complainant as soon as possible following a complaint to discuss to try resolve the issue and negotiate the best plan moving forward with it.

Anticipated Delivery: End of Quarter 3 2019/20

1.1.3 Indicator: Maximum 6 week wait for Diagnostic Tests

Accountable Officer: Hayley Kendall

Issue: Below target for October 2019 at 72.7% against a target of 99%.

Actions: Overall 6 week diagnostic performance is below the 80% trajectory for October 2019 which has previously been agreed with NHSE. The new scanners have been installed and they are due to be fully operational in November 2019. The backlog recovery plan will commence in both CT and MR the first week in November and performance will start to improve.

Anticipated Delivery: Quarter 1 2020/21 for full compliance but improved performance from November 2019.

1.1.4 Indicator: Staff Sickness

Accountable Officer: Sue Hodgkinson

Issue: Staff sickness is 4.34% for October against a target of 3.4% (4.71% YTD).

Actions: An action plan to review attendance management is in development. An audit has been undertaken to review compliance with management of attendance in high reporting areas, individual actions will be addressed throughout the organisation. This will be complemented with the implementation of key health and well being interventions. A further in depth review and action plan will be presented.

Anticipated Delivery: Ongoing monitoring with deep dives being undertaken in the high sickness areas.

2. Section 2 - Quality of Care Dashboard (Refer to Appendix 2)

2.1.1 Quality of Care - Exceptions

2.1.2 Indicator: Mortality screening within 7 days

Accountable Officer: Raph Perry

Issue: Screening of deaths within 7 days is 72% in month (66% YTD) against a target of 95%.

Actions: Work continues to improve the screening times. Complex screens take longer than seven days but then do not necessarily require formal mortality review so improve the overall target. It is difficult to recruit more screeners and efforts are also being made to even out the numbers per consultant.

Anticipated Delivery: Quarter 3 2019/20.

3. Section 3 - Operational and Financial Performance (Refer to Appendix 3)

3.1.1 Operational - Exceptions

3.1.2 Indicator: Improve PET Scanning Turnaround times at 5 days

Accountable Officer: Hayley Kendall

Issue: 37.0% for October and 44.6% YTD (target 75%).

Actions: All LHCH requests for PET scans are managed by another NHS organisation. There is currently a supply issue with the consumables utilised in such scans causing longer than required waiting times. There has been regional progress with improving supplies and performance is expected to improve from January 2020. LHCH escalates to the service provider any areas of concern in delays for patients.

Anticipated Delivery: Spring 2020.

3.1.3 **Indicator: Activity - NHS**

Accountable Officer: Hayley Kendall

Issue: October underperformance against plan of -3.77%.

Actions: Trust wide activity was slightly behind plan in October with the main areas of underperformance in surgery elective activity. Medicine and outpatients performed well in month covering some of the underperformance in surgery. A specific turnaround plan has been instigated within the Surgical Division with executive overview on a weekly basis due to the concern around under performance and the impact this has on the Trust's ability to achieve the financial annual plan. This was presented to IPC in October 2019 with an indepth review and challenge of the actions planned to achieve the revised forecast and the impact that this would have. It should be noted that whilst there are decreases in demand in certain areas of cardiac surgery, in line with the national picture, this is not the reason for the underperformance in month.

Anticipated Delivery: Quarter 4 2019/20.

4.1.8 **Indicator: Radiology - Plain Film – Inpatient**

Accountable Officer: Hayley Kendall

Issue: October performance is 46.8% (YTD 40.6%) against a target of 90%.

Actions: The main reason for underperformance against the plan is consultant capacity. One Radiology Consultant has commenced in post as well as two clinical fellows which increases capacity for reporting. The risk of low compliance against plain film reporting is mitigated as all plain film x rays are primarily reviewed by the lead clinician of the inpatient team

Anticipated Delivery: Quarter 1 2020/21

3.1.4 **Indicator: Radiology - CT - Outpatient**

Accountable Officer: Hayley Kendall

Issue: October performance is 84.5% (YTD 75.7%) against a target of 90%

Actions: Good improvement in performance in month. Compliance has been challenging due to the increase in amount of healthy lung screening CTs. LHCH is significantly over the plan that has been agreed with the commissioners. All requests for scans are screened by the Clinical lead for Radiology. Requests for rapid turnaround for reports are managed cross divisionally on a prioritisation process

Anticipated Delivery: Quarter 4 2019/20

3.1.5 **Indicator: Radiology - MRI - Outpatient**

Accountable Officer: Hayley Kendall

Issue: October performance is 79.3% (YTD 65.7%) against a target of 90%

Actions: Significant improvement in performance in recent months. This is mainly due to the appointment of a locum radiologist who was appointed and thereby increasing reporting capacity. As with CT, all MRI requests are vetted by the Clinical Lead for Radiology to ensure urgent scan requests are expedited. Full compliance against this KPI is expected to be achieved shortly after the new substantive consultant capacity is in place.

Anticipated Delivery: November 2019

3.1.6 **Indicator: Welsh 26 weeks RTT (Admitted, Non Admitted and Incomplete)**

Accountable Officer: Hayley Kendall

Issue: Patients waiting over 26 weeks for treatment. October Performance is:

- Admitted - 85.94% against a 95% target
- Non-Admitted - 93.55% against a 98% target

- Incomplete - 92.73% against a 95% target

Actions: The Trust continues to work with welsh commissioners to improve waiting times for patients and is focused on ensuring any patients that do breach 26 weeks are seen before 36 weeks. The main area driving the under performance is late and incomplete referrals from organisations and extended waiting times for diagnostic tests in Wales. At a recent meeting with the Welsh Commissioners LHCH highlighted the delays being experienced with referring Trust's and requested support in improving the position. This work will continue.

Anticipated Delivery: Ongoing work with welsh commissioners to improve patient pathways.

3.1.7 **Indicator: Turnover Rate between 1-2 yrs service (voluntary (FTC excluded))**

Accountable Officer: Sue Hodgkinson

Issue: 2.52% against a target of 1.40%.

Actions: A Retention Strategy and Action Plan have been developed for 2019-2021, which will review current data captured and develop initiatives to improve turnover. The Trust is also part of NHSI Cohort 4 Retention Improvement Programme supporting Nursing turnover, but any good practice will be shared to include all staff.

Anticipated Delivery: Quarter 4 2020/21

3.1.8 **Indicators: Agency Cost and Proportion of Agency, Bank Cost & Deliver the recurrent CIP**

Accountable Officer: Claire Wilson

Issue, Actions & Anticipated Delivery: Refer to the finance report.

4. **Conclusion**

The Trust is facing some significant challenges including underperformance in a number of indicators in particular the surgical activity position. The continued underperformance against the revised financial forecast poses a risk to the achievement of the Trust's year end financial position. Managers and clinicians are well sighted on the issues and action plans have been produced to improve delivery and these are actively monitored. The Trust continues to work with the external agencies involved in the underperforming service areas to explore all system wide opportunities for improving performance.

5. **Recommendations**

The Board is asked to note Trust performance and associated exception and action reports.

Appendix 1 - Single Oversight Framework

Single Oversight Framework (SOF)											
Indicator		Type	Description	Target YTD	Actual YTD	Trend	Current Month		Previous Month	Frequency	Comments
								Target	Oct-19		
Quality of Care	Quantity of Complaints	Caring	Quantity of complaints	40	27	↓	4	8	5	M	
	Staff Friends and Family - recommend as a place of treatment		Count of those categorised as extremely likely or likely to recommend/count of all responders	94%	95.0%	→	94%	95.0%	95.0%	Q	
	Mixed Sex Accommodation Breaches		Count of number of occasions sexes were mixed on same-sex wards	0	0	→	0	0	0	M	
	Inpatient scores from Friends & Family Test - % positive		Count of those categorised as extremely likely or likely to recommend/count of all responders	95%	99.8%	↑	95%	99.8%	100%	M	
	Community scores from Friends & Family Test - % positive		Count of those categorised as extremely likely or likely to recommend/Count of all responders	95%	99.7%	↑	95%	100%	98.8%	M	
	Occurrence of any Never events	Safe	Count of Never Events	0	1	↑	0	0	1	M	
	VTE Risk Assessment		Number of patients admitted who have a VTE risk assessment/number of patients admitted in most recent month	95%	96.2%	↑	95%	96.4%	95.1%	M	
	Clostridium Difficile		Count of trust assigned C. difficile infections in patients aged two years and over compared to the number of planned C. difficile cases	2.3	5	↑	0.33	0	1	M	
	MRSA Bacteraemias		Count of trust assigned MRSA infections	0	0	→	0	0	0	M	
	MSSA Bacteraemias		Count of trust assigned MSSA infections	4.1	9	↑	0.58	0	1	M	
	Gram Negative Bacteraemias		Count of trust assigned Gram Negative Bacteraemias infections	5.3	8	↑	0.75	0	1	M	
	HSMR for 56 diagnosis groups (supplied from Dr Foster; hospital guide)	Effective	The ratio of observed deaths that occurred following admission in a provider to a modelled expectation of deaths (multiplied by 100) on the basis of the average England death rates for 56 specific clinical groups given a selected set of patient characteristics for those treated there.	100	121.96	↓	100	125.49	99.89	M	Current month: July 2019; YTD: Apr 2019 - July 2019.
Finance	Capital Service Cover	Financial Sustainability		1	1	→	1	1	1	M	Trigger: Poor levels of overall financial performance (average score of 3 or 4) very poor performance (score of 4) in any individual metric Potential value for money concerns
	Liquidity			1	1	→	1	1	1	M	
	I&E Margin	Financial Efficiency		1	1	→	1	1	1	M	
	Performance against plan	Financial Controls		1	1	→	1	1	1	M	
	Agency Spend			1	1	→	1	1	1	M	
	Overall use of resources (UoR) rating	Overall Financial Performance		1	1	→	1	1	1	M	
Operational Performance	Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate - patients on an incomplete pathway	Operational Performance	Count of the number of patients whose clock period is less than 18 weeks during the calendar months of the return/Count of number of patients whose clock has not stopped during the calendar months of the return	92%	92.31%	↓	92%	92.31%	92.47%	M	
	All cancers - maximum 62-day wait for first treatment from (a) their GP who have currently been waiting for less than 62 days for treatment to start from (b) the NHS screening service who have currently been waiting for less than 62 days for treatment to start		Proportion of patients referred for cancer treatment by: a. their GP who have currently been waiting for less than 62 days for treatment to start b. the NHS screening service who have currently been waiting for less than 62 days for treatment to start	85%	93.50%	→	85%	100%	100%	M	
	Maximum 6-week wait for diagnostic procedures		Proportion of patients referred for diagnostic tests who have been waiting for less than six weeks	99%	72.7%	↑	99%	72.7%	67.5%	M	
	Dementia - Find		The number and proportion of patients aged 75 and over admitted as an emergency for more than 72 hours: a. who have a diagnosis of dementia or delirium or to whom case finding is applied; b. who, if identified as potentially having dementia or delirium, are appropriately assessed; and, c. where the outcome was positive or inconclusive, are referred on to specialist services.	90%	96.0%	→	90%	100%	100%	M	
	Dementia - Assess			90%	100%	→	90%	100%	100%	M	
	Dementia - Refer			90%	100%	→	90%	100%	100%	M	
	Review of sustainability and transformation plans and other relevant matters	Strategic Change				-	-	-	-		LHCH is lead for CVD cross-cutting theme
Organisational Health	Staff Sickness	Organisational Health	Level of staff absenteeism through illness in the period Numerator = number of days sickness reporting within the month. Denominator = number of days available within the month	3.4%	4.71%	↓	3.4%	4.34%	4.21%	M	
	Staff Turnover (Voluntary)		Number of Voluntary Staff leavers reported within the period / Average of number of Total Employees at end of the month and Total Employees at end of the month for previous 12 month period. Numerator = number of voluntary leavers within the report period. Denominator = staff in post at the start of the reporting period	10%	11.14%	↓	10%	11.14%	10.80%	M	Turnover based on 'Voluntary' leavers in 12 month period
	NHS Staff Survey - recommend as a place to work		Staff recommendation of the organisation as a place to work or receive treatment	76%	76%	↑	76%	76%	74%	Q	Q3 2018 Staff Survey Data - Previous Period Q3 2017
	Proportion of Agency Staff Costs		Agency staff costs (as defined in measuring performance against the provider's cap) as a proportion of total staff costs. Calculated by dividing total agency spend over total pay bill.	1.90%	2.20%	↓	1.90%	3.08%	2.41%	M	
	Executive Team Turnover	Level of Senior Executive Turnover	Calculation: Leavers in 12 month period / Average Staff in Post in 12 month period x 100	25%	11.10%	↓	25%	11.10%	10.00%	M	
Overall	Segmentation				1	→		1	1	Adhoc	Segment 1: Maximum autonomy; universal support

Appendix 2 – Quality of Care

Regulatory and Operational Performance - Quality of Care

Indicator	Type	Description	Target YTD	Actual YTD	Trend	Current Month		Previous Month	Frequency	Comments
						Target	Oct-19			
% of deaths screened for review within 7 days	Mortality		95%	66%	↑	95%	72%	50%	M	1 month data lag for this measure
% mortality reviews to be completed within 30 days - Doctors			80%	74%	↓	80%	72%	81%	M	1 month data lag for this measure
% mortality reviews to be completed within 30 days - Nurses			80%	97%	↓	80%	94%	100%	M	1 month data lag for this measure
Observed mortality rate		Total number of deaths in month or YTD / Total number of discharges in month or YTD	1.3%	1.5%	↓	1.3%	1.6%	1.4%	M	
HSMR Weekend (supplied from Dr Foster)		HSMR is the ratio of the number of deaths in hospital within a given time period to the number that might be expected if the hospital had the same death rate as some reference population ((Number of observed deaths/ the number of expected deaths) * 100)	100	153.00	↓	100	186.80	91.38	M	Current month: July 2019; YTD: Apr 2019 - July 2019.
HSMR for all diagnosis (supplied from Dr Foster)			100	116.45	↓	100	107.84	102.92	M	Current month: July 2019; YTD: Apr 2019 - July 2019.
Cardiac Surgery observed: expected mortality ratio			1.00	1.11	↓	1.00	1.11	0.87	M	6-month rolling averages; latest Oct-18 to Mar-19
Non-primary PCI observed: expected MACE ratio			1.00	0.16	↓	1.00	0.16	0.08	M	6-month rolling averages; latest Oct-18 to Mar-19
Number of Falls (All Areas)	Incidents	Count of Falls recorded across all areas	42	41	→	6	6	6	M	All falls (avoidable & unavoidable)
Number of LHCH acquired grade 2 pressure ulcers (due to lapses in care)		Count of Pressure Ulcers that were due to lapses in care and reported as grade 2	3.5	5	→	0.50	0	0	M	
Number of LHCH acquired grade 3+ pressure ulcers (due to lapses in care)		Count of Pressure Ulcers that were due to lapses in care and reported as grade 3	0	0	→	0	0	0	M	
Number of Adverse Events (Red Alerts), Serious Incidents and Never Events		Number of events that were reported as a red alert, serious incident or never event	0	6	↑	0	0	1	M	5 x Serious Incidents and 1 Never event YTD
Number of reported patient safety incidents			N/a	925	↓	N/a	135	125	M	6 Month Rolling Average = 135 (810/6)
Follow-up audit of SUI reveals improvement embedded and delivering			No							OL Policy complimenting recent learning from deaths guidance
% Blood Cultures taken within 24 hours preceding first antibiotic given	Sepsis		95%	82.9%	↓	95%	76.5%	83%	M	
% Delivery of at least one sepsis antibiotic within one hour of prescription			70%	74.7%	↓	70%	70.6%	79%	M	
% Delivery of a sepsis antibiotic within three hours of prescription			96%	97.6%	↓	96%	97.1%	100%	M	
% of radiological alerts with a response document			95%	100%	→	95%	100%	100%	M	
Complete a holistic needs assessment for patients diagnosed at LHCH			95%			95%			M	Awaiting Resource to complete assessment
Friends and Family Test Response Rate - Inpatients	Patient Experience	Count of patients responding to the friends and family test in inpatients / count of eligible patients	95%	99.8%	↑	95%	99.8%	100%	M	
Friends and Family Test Response Rate - Outpatient scores % positive		Count of outpatient friends and family test responses that are rated as positive / Count of friends and family tests taken within outpatients	95%	98.4%	↑	95%	98.5%	98%	M	
VTE Prophylaxis		Count of Patients given appropriate prophylaxis / Total patients at risk	95%	97.2%	↓	95%	95.1%	98.4%	M	
All re-inspected KLOE's rated as outstanding			Yes or No							The Trust is waiting for re-inspection to determine whether objective has been achieved

Appendix 3 – Operational & Financial Performance

Regulatory and Operational Performance - Operational Performance

	Indicator	Type	Description	Target YTD	Actual YTD	Trend	Current Month		Previous Month	Frequency	Comments
							Target	Oct-19			
Performance	Number of in-hospital deaths	Mortality	Count of Hospital deaths across the trust for the month/YTD	N/a	116	⬆️	N/a	17	18	M	
	Improve histopathology turnaround times at 7-days	Turnaround Times	Improve histopathology turnaround times at 7-days	70%	60.2%	⬆️	70%	74.9%	61.0%	M	Data reported by Liverpool labs (latest data August-2019)
	Improve PET scanning turnaround times at 5-days		Improve PET scanning turnaround times at 5-days	75%	44.6%	⬆️	75%	37.0%	28.0%	M	Request to scan (does not include reporting time)
	Cancelled Operations	Cancelled Operations	Count of the number of last minute cancellations by the hospital for non clinical reasons	1.5%	2.1%	⬆️	1.50%	1.6%	1.2%	M	Internal Target
	Cancelled Operations <u>NOT</u> seen in 28 days		Count of operations cancelled for non-clinical reasons and not offered a new date within 28 days	0	1	➡️	0	0	0	M	
	Cancelled Urgent Operations cancelled for 2nd+ time		Count of those urgent operations that have already been cancelled on one or more occasions before.	0	0	➡️	0	0	0	M	
	Delayed Transfers of Care	Performance	A delayed transfer of care occurs when a patient is ready to depart from such care and is still occupying a bed.	4.50%	4.11%	⬆️	4.5%	5.47%	3.18%	M	
	Bed Occupancy		Count of beds occupied over all wards/ count of bed available	>=85%	82.7%	⬆️	>=85%	84.6%	82.4%	M	
	Activity NHS	Activity	Count of Total spells - Activity Plan for NHS patients	0.0%	-3.77%	⬆️	0.0%	-3.77%	-2.5%	M	
	Referral to treatment - Incomplete Pathways 52+ weeks	RTT	Count of all patients on an incomplete pathway waiting over 52 weeks (English & Non-English)	0	3	⬆️	0	0	1	M	1 Welsh Patient breach in April, treated 20th May. 1 Breach in August (Cardiology) and 1 Breach in September (Cardiothoracic Surgery).
	Plain Film Inpatient	Radiology Reporting Turnaround Times	Total Plain Film Inpatient Reports within Std	90%	40.6%	⬆️	90.0%	46.8%	47.28%	M	
	Plain Film Outpatient		Total Plain Film Outpatient Reports within Std	90%	89.5%	⬆️	90.0%	96.2%	99.22%	M	
	CT Inpatient		Total CT Inpatient Reports within Std	90%	99.1%	⬆️	90.0%	100%	98%	M	
	CT Outpatient		Total CT Outpatient Reports within Std	90%	75.7%	⬆️	90.0%	84.5%	82.96%	M	
	MRI Inpatient		Total MRI Inpatient Reports within Std	90%	92.8%	⬆️	90.0%	91.7%	89%	M	
	MRI Outpatient		Total MRI Outpatient Reports within Std	90%	65.7%	⬆️	90.0%	79.3%	75.89%	M	
	Ultrasound Inpatient		Total Ultrasound Inpatient Reports within Std	90%	94.7%	⬆️	90.0%	96.0%	100%	M	
	Ultrasound Outpatient		Total Ultrasound Outpatient Reports within Std	90%	95.0%	⬆️	90.0%	92.0%	100%	M	
	14 day wait from referral to date first seen	Cancer	Patients waiting a maximum of two weeks from an urgent GP referral for suspected cancer to date first seen by specialist	93%	100%	➡️	93%	100%	100%	M	
	31 day wait from diagnosis to first treatment		Patients witing a maximum of 31 days from diagnosis to first definitive treatment	96%	100%	➡️	96%	100%	100%	M	
	31 day wait for second or subsequent treatment (surgery)		Patients waiting a maximum of 31 days for all subsequent treatments	94%	100%	➡️	94%	100%	100%	M	
	62 day wait for first treatment from urgent GP referral to treatment - consultant upgrade (Adj)		Patients waiting a maximum of 62 day's from a consultant decision to upgrade the urgency of a patient they suspect to have cancer to first treatment	85%	100%	➡️	85%	100%	100%	M	
	104 Day Cancer		Cancer 62 day pathway patients 104 day RCA 62 target	0	0	➡️	0	0	0	M	
	26 Weeks Referral to Treatment in aggregate - Admitted Pathways	Welsh	Count of the number of Welsh patients whose clock period is less than 26 weeks during the calendar months of the return/Count of number of Welsh patients whose clock has not stopped during the calendar months of the return	95%	87.50%	⬆️	95%	85.94%	84.62%	M	
	26 Weeks Referral to Treatment in aggregate - Non Admitted Pathways			98%	85.92%	⬆️	98%	93.55%	87.27%	M	
	26 Weeks Referral to Treatment in aggregate - Incomplete Pathways			95%	93.97%	⬆️	95%	92.73%	92.71%	M	
	Emergency readmissions following elective admission	Readmissions	Occurs when the next admission to any English NHS hospital is an emergency within 28 days of live discharge.	100	80.51	⬆️	100	80.51	113.61	M	Current month: April 2019; YTD: Apr 2019 - Apr 2019.
	Emergency readmissions following non-elective admission			100	82.86	⬆️	100	82.86	94.36	M	Current month: April 2019; YTD: Apr 2019 - Apr 2019.
Workforce	Mandatory training	Organisational Health		95%	93.9%	⬆️	95%	93.9%	94%	M	
	Appraisals			90%	90.0%	⬆️	90%	90.0%	88%	M	Appraisal window reset May 2019
	Turnover Rate between 1-2 yrs service (voluntary (FTC excluded))			1.40%	2.52%	⬆️	1.40%	2.52%	2.61%	M	
Finance	Net Surplus £000's	Finance		£1,277	£1,446	⬆️	£450	£450	£274	M	
	Normalised Net Surplus £000's			£1,277	£1,281	⬆️	£450	£450	£274	M	
	Cash Balance £000's			£14,656	£27,993	⬆️	£14,656	£27,995	£27,515	M	Cash balances of £27.9m are £13m ahead of the planned position of £14.7m. This is primarily due to phasing of the Original Capital Plan and 18/19 PSF bonus monies
	Capital Expenditure £000's			£8,788	£7,276	⬆️	£732	£3,517	£569	M	Capital is £1.5m behind plan due to a change in the phasing of schemes.
	Total Agency cost £000's			£813	£1,058	⬆️	£116	£215	£164	M	Agency costs are £98k over in month, due to Surgery Jr Drs £54k over in month. YTD Agency is £240k over plan. We are £139k below cap YTD, but if this month's trend continues it will be breached by Year End.
	Total Bank cost £000's			£1,417	£1,464	⬆️	£201	£220	£258	M	Bank Costs are over plan in Month by £19k and YTD £46k, due to SICU £8k Adverse in month £37k YTD and Oak ward £9k adverse in month, £35k YTD.
	Deliver the recurrent cost improvement savings			£2,093	£1,646	⬆️	£314	£256	£242	M	Falling recurring CIP's are partially offset YTD by £112k of non recurring CIP's.