

Board of Directors (in Public)

Item 5.1

Subject: Board Dashboards – Period ended 31st May 2018
Date of meeting: Tuesday 3rd July 2018
Prepared by: Lucinda Tennent - Information and Performance Manager
Presented by: Tony Wilding - Director of Strategic Partnerships & COO
Purpose of Report: To Note

BAF Ref	Impact on BAF
1.1, 1.2, 2.1, 3.2	None

1. Executive Summary

The purpose of this paper is to present an update on Trust performance for the period to the 31st May 2018. The report is divided into the following three sections:

- Section 1 - Single Oversight Framework (SOF): This section provides details on our 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 2018 for routine monitoring on delivery.
- Section 3 – Operational Performance Dashboard: internal performance, workforce and financial indicators agreed by the Board in April 2018 for routine monitoring on delivery.


Section 1 - Single Oversight Framework (SOF)






Refer to appendix 1.

The following indicators, which were under performing against the in-month or year to date target last month, are now achieving target:

- Maximum time of 18 weeks from point of referral to treatment (RTT)
- Staff Turnover

The following indicators are new exceptions this month:

Framework	Rating	Exception
Quality of Care		

Finance and use of resources		
Operational Performance		Maximum 6 week wait for diagnostic procedures (In month and YTD)
Strategic Change		
Leadership and Improvement		
Segmentation		Segment 1: Maximum autonomy; universal support

1.1 Quality - Safe, Effective and Caring

1.1.1 Indicator: Maximum 6-week wait for diagnostic procedures

Accountable executive Officer: Tony Wilding


Issue: Currently below target for May 2018 at 80.09% against a target of 99% with a total of 232 breaches; 3 Sleep Studies, 1 Echocardiography, 131 CT and 97 MRI.

Actions: There are currently business cases being produced for an additional CT and MRI scanners at the Trust to be presented to the Board in May 2018. We are mitigating the pressures by using mobile scanners where available but this is limited and does not meet our needs to achieve the target.

Anticipated Delivery: We will not achieve compliance at year end.

Section 2 – Quality of Care Dashboard

Refer to Appendix 2.

Framework	Rating	Exception
Quality of Care		Mortality screening within 7 days (in month & YTD) Number of falls (YTD)

2. Exceptions

2.1 Indicator: Mortality screening within 7 days

Accountable Executive Officer: Raphael Perry

Issue: Screening of deaths within 7-days is 64% in month and within range, however, and YTD is still below target at 64% against 95%.

Actions: The new mortality review policy has been introduced in September 2017. There is new national guidance on Learning from Deaths which has implications for how organisational learning is identified and implemented. There have been more deaths this year since the target was set. Currently at 30 YTD against a comparison of 215 for the whole of 2017/18.

Anticipated Delivery: Q2 2018/19

2.2 Indicator: Number of Falls

Accountable Executive Officer: Sue Pemberton

Issue: The Trust has reported 8 falls in month against target of 6 however, 10 YTD against a target of 12.

Actions: Falls remain a focus for improvement within the Trust especially within Elm, Oak, Cedar and Birch wards. Preventing patients falling remains a challenge for clinical teams therefore the Trust has invested in a falls prevention alarm system called Rambleguard. These devices are to be installed within Birch and Cedar wards. Ward Managers and Divisional Matrons will be closely monitoring the impact of these devices on reducing patient falls primarily within Cedar and Birch wards.

Anticipated Delivery: Q2 2018/19

3. Section 3: Operational Performance Dashboard

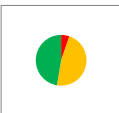
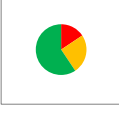

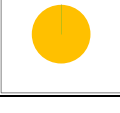
Refer to Appendix 3.

The following indicators, which were under performing against the in-month or year to date target last month, are now achieving target:

- % of radiological alerts with a response document

The following indicators are new exceptions this month:

- 18 weeks referral to treatment incomplete pathways 52 week +
- Delayed Transfers of Care

Framework	Rating	Exception
Quality of Care		Mortality screening within 7 days (in month & YTD)
Operational Performance		Performance: Cancelled operations (In month and YTD) PET Scanning turnaround times at 5-days 18 weeks referral to treatment incomplete pathways 52 week + Delayed Transfers Of Care (In month and YTD) Local Target: Welsh waiting times (in month & YTD)
Financial Sustainability - Value for Money		Deliver the recurrent cost improvement savings (YTD)
Organisational Health		

Exceptions

3.1 Indicator: Cancelled Operations

Accountable Executive Officer: Tony Wilding

Issue: There were a total of 20 cancellations for cardiac surgery in April 2018.

The number of reportable cancellations slightly increased in May 2018 compared to previous month. This was largely due to emergencies taking priority for which the consultant surgeon

had to provide surgical cover for the emergency resulting in cancellation of scheduled patients.

The second leading cause was that of the impact of overnight emergencies. Overnight emergencies resulted in the loss of cover from the following staff groups: Perfusionists, surgical cover resulting in cancellations of scheduled patients.

Elective list overrun and elective bed shortage on POCCU equally emerged as the third leading theme for cancellations in May however cancellations attributed to these reasons was significantly reduced to those resulting from emergencies and impact of overnight emergencies.

All cancellations have been re-scheduled and no 28 day breaches have occurred.

Actions: The Surgical Division has implemented a cancellation action plan with aim of reducing the number of reportable cancellations. Furthermore the date and time of scheduling has been moved to enable clinician presence at the meeting. This will support review of listing complex procedures which is aimed at reducing cancellations for list overrun.

As with previous months the Surgical Division continues to share information relating to cancellations with clinicians at monthly business meetings and in other forums such as Divisional Performance to identify methods to reduce cancellations.

Anticipated Delivery: Ongoing

3.2 Indicator: 18 Weeks Referral to Treatment Incomplete Pathways 52 Week +

Accountable Executive Officer: Tony Wilding

Issue: As part of the month two performance reporting process a 52 week breach patient has been reported. The patient was brought into the Trust as a priority, the consultant explained the issue with the delay and the patient has subsequently had their surgery and is recovering well.

Actions: As part of the learning from this breach additional training is being provided to the patient administration staff.

Anticipated Delivery: 06/06/2018

3.3 Indicator: Delayed Transfers Of Care

Accountable Executive Officer: Tony Wilding

Issue: Delayed transfers of care are above target for YTD and also for May with a performance of 6.51% against a target of 4.5%. The Trust took an active decision to keep patients longer at LHCH rather than transfer to other hospitals in order support the local health economy over the winter period.

Actions: The Trust continues to work with other organisations to ensure patient discharges are managed as efficiently as possible. A flagging system is in place to identify patients with complex discharge needs which are subsequently managed by the care support team

Anticipated Delivery: Ongoing

3.4 Indicator: Improve PET Scanning turnaround times at 5-days

Accountable Executive Officer: Tony Wilding

Issue: May is currently 60% against a 75% target.

Actions: There are ongoing discussions across Cheshire and Merseyside with regards to the current provider of PET scans, a contract that was placed nationally. Current waiting times are higher than required and the trust is working with NHS Specialised Commissioning and CCG to negotiate with the provider for improved access times.

Anticipated Delivery: Ongoing

3.5 Indicator: Welsh 26 weeks

Accountable Executive Officer: Tony Wilding

Issue: All pathways for Welsh RTT patients waiting over 26-weeks for treatment.

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 majority of Welsh pathways are complex and only get referred to the Trust

late in the pathway. The Trust is assisting commissioners in identifying ways of improving the referral process to enable delivery of this target. Additional monitoring of waiting times has also been introduced by Commissioners to identify bottlenecks in the patient pathway; an initiative the Trust is actively participating in.

Anticipated Delivery: Currently under discussion with Welsh Commissioners at the performance meetings.

3.6 Indicator: Appraisals

Accountable Executive Officer: Jo Twist

Issue: Appraisals is currently below the 90% target at 9%, this is due to the appraisal window being reset in May 2018.

Actions: Appraisal window currently open 1st May 2018 – 31 August 2018, trajectories in place for all areas.

Anticipated Delivery: 31 August 2018

3.7 Indicator: Deliver the recurrent cost improvement savings

Accountable Executive Officer: Claire Wilson

Issue: CIP achieved for the month was £399k against a plan of £575k, a shortfall of £176k. This is partly offset by non-recurring CIPs of £24k, leaving a gap of £152k.

Actions: Developing and delivering on the CIP continues to be a priority, the gap for 2018/19 now stands at £583k of which £195k is high risk, however, £180k of non-recurrent measures have been identified in order to support the financial position whilst additional schemes are being identified. The performance for each division was key focus of the recent service review meetings undertaken by the Executive team.

Anticipated Delivery: 31 March 2019

4. Conclusion

The Trust is facing a number of challenges and underperformance in a number of indicators. Managers and clinicians are well sighted on the issues and action plans have been produced to improve delivery and these are actively monitored.

5. Recommendations

The Board of Directors are 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	Trend	Current Month Target	May-18	Previous Month	Frequency	Comments
Quality of Care	Written Complaints - Rate	Caring	Count of written complaints/Count of whole time equivalent staff	16	6	↑	7	0	6	M	Awaiting national technical guidance
	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%	93%	→	94%	93%	93%	Q	Q3 2017 Staff Survey Data
	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%	99.4%	↑	95%	100.00%	98.76%	M	
	Community scores from Friends & Family Test - % positive		Count of those categorised as extremely likely or likely to recommend/count of all responders	95%	100.0%	→	95%	100%	100%	M	
	Occurrence of any Never events	Safe	Count of Never Events in rolling six-month period	0	0	→	0	0	0	M	
	NHS England/NHS Improvement Patient Safety Alerts Outstanding		Number of NHS England or NHS Improvement patient safety alerts outstanding in most recent monthly snapshot	0	0	→	0	0	0	M	
	VTE Risk Assessment		Number of patients admitted who have a VTE risk assessment/number of patients admitted in most recently published quarter	95.0%	97.7%	↓	95.0%	97.6%	97.7%	M	
	Clostridium Difficile		Count of trust apportioned C. difficile infections in patients aged two years and over compared to the number of planned C. difficile cases	1	0	→	0	0	0	M	
	Clostridium Difficile Infection rate (per 1000 beddays)		Rolling 12-month count of trust- apportioned C-difficile infections in patients aged 2 years and over/Rolling 12 Month Average Occupied bed days per 100,000 beds	0.19	0.00	→	0.19	0	0	M	
	MRSA Bacteraemias		Rolling 12-month count of trust assigned MRSA infections/Rolling 12 month average occupied bed days multiplied by 100,000	0	0	→	0	0	0	M	
	MSSA Bacteraemias		Rolling 12-month count of trust- apportioned MSSA infections/rolling 12-month average occupied bed days multiplied by 100,000	N/a	0	→	N/a	0	0	M	
	eColi		Rolling 12-month count of all E. coli infections/rolling 12 month average occupied bed days multiplied by 100,000	-	0	→	-	0	0	M	Current count of eColi
	Potential Under Reporting of patient safety incidents		Count of reported incidents (no harm, low harm, moderate harm, severe harm, death)/estimated total person bed days for rolling six months shown as rate per 1000 bed days	3	2	→	3	2	2	6M	NRLS Report April - September 2017 (3=poor)
	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	123.7	↑	0	98.31	115.60412	M	Current Month is February 2018
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	Financial Sustainability		1	1	↑	1	1	2	M	
	I&E Margin	Financial Efficiency		1	1	→	1	1	1	M	
	Performance against plan	Financial Controls		1	1	↓	1	2	1	M	
	Agency Spend	Financial Controls		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	92.0%	92.92%	↑	92%	92.92%	91.33%	M	Adjusted figure provided
	All cancers - maximum 62-day wait for first treatment from urgent GP referral for suspected cancer		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%	93.90%	↑	85%	94.12%	94%	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%	81.63%	↓	99%	80.09%	83.22%	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	90%	98.7%	↓	90%	97.8%	100%	M	
	Dementia - Assess			90%	100%	→	90%	100%	100%	M	
	Dementia - Refer			90%	100%	→	90%	100%	100%	M	
Leadership	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%	3.32%	↑	3.4%	2.88%	3.32%	M	Turnover based on 'All' Leavers in 12 month period
	Staff Turnover		Number of 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 leavers within the report period. Denominator = staff in post at the start of the reporting period	10%	13.59%	↑	10%	13.48%	13.59%	M	
	NHS Staff Survey - recommend as a place to work		Staff recommendation of the organisation as a place to work or receive treatment	76%	73%	↓	76%	74%	73%	Q	
	Proportion of temporary staff		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.	5%	4.66%	↓	5%	4.68%	4.66%	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%	0.00%	→	25%	0.00%	0.00%	M	*NB excludes Raph Perry who left on Flexi Retirement but returned
Overall	Segmentation									Adhoc	Segment 1: Maximum autonomy; universal support

Appendix 2 – Quality of Care Dashboard

Regulatory and Operational Performance - Quality of Care

Indicator	Type	Description	Target	YTD	Trend	Current Month		Previous Month	Frequency	Comments	Type
						Target	May-18				
% of deaths screened for review within 7 days	Mortality		95%	64%	↓	95%	64%	67%	M	Current month based April 2018	L
% mortality reviews to be completed within 30 days of allocation - Doctors			80%	79%	↑	80%	79%	71%	M	Current month based April 2018	L
% mortality reviews to be completed within 30 days of allocation - Nurses			80%	93%	↓	80%	93%	94%	M	Current month based April 2018	L
Observed mortality rate		Total number of deaths in month or YTD / Total number of discharges in month or YTD	1.3%	1.35%	↓	1.3%	1.40%	1.30%	M		L
HSMR Weekend (DFI)		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	118.99	↓	100	102.4258	0.00	M		L
HSMR for all diagnosis (supplied from Dr Foster)			100	110.91	↑	100	101.8491	107.19173	M	Current Month is February 2018	L
Risk adjusted CABG mortality			1.00	0.95	↑	1.00	0.93	1.00	M	6-month rolling averages; latest due up to September 2017	
Risk adjusted non-primary PCI Mace			1.00	0.46	→	1.00	0.55	0.55	M	6-month rolling averages; latest due up to September 2017	
Number of Falls (Birch, Cedar, Elm and Oak)	Incidents	Count of Falls recorded across all areas	12	10	↓	6	8	2	M		L
Number of avoidable Pressure Ulcers - Grade 2		Count of Pressure Ulcers that were avoidable and reported as grade 2	1	1	↑	0	0	1	M		L
Number of avoidable Pressure Ulcers - Grade 3		Count of Pressure Ulcers that were avoidable and reported as grade 3	0	0	→	0	0	0	M		L
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	0	→	0	0	0	M		
Number of reported patient safety incidents (6 month rolling avg)			N/a	251	↓	N/a	115	138	M		
Follow-up audit of SUI reveals improvement embedded and delivering			No		Comment: OL Policy complimenting recent learning from deaths guidance						
% Blood Cultures taken within 24 hours preceding first antibiotic given	Sepsis		95%	86%	↓	95%	75%	91%	M	May - 9 out of 12 bundles	L
% Delivery of at least one sepsis antibiotic within one hour of prescription			70%	66%	↑	70%	75%	61%	M	May - 9 out of 12 bundles	L
% Delivery of a sepsis antibiotic within three hours of prescription			96%	89%	↓	96%	83%	91%	M	May - 10 out of 12 bundles	N
% of radiological alerts with a response document			95%	87%	↑	95%	91.0%	83.0%	M	YTD is Average	L
Complete a holistic needs assessment for patients diagnosed at LHCH			95%			95%			M	Awaiting Resource to complete assessment	L
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	50%	68%	↑	50%	71%	63.8%	M		
Outpatient scores from Friends & Family Test - % positive		Count of outpatient friends and family test responses that are rated as positive / Count of friends and family tests taken within outpatients	95.0%	97.2%	↓	95.0%	97.19%	97.24%	M		
VTE Prophylaxis		Count of Patients given appropriate prophylaxis / Total patients at risk	95%	97.58%	↓	95%	96.76%	98.62%	M		
All re-inspected KLOE's rated as outstanding			Yes or No		Comment: The Trust is waiting for re-inspection to determine whether objective has been achieved						

Appendix 3 – Operational Performance Dashboard

Regulatory and Operational Performance - Operational Performance												
	Indicator	Type	Description	Target	YTD	Trend	Current Month Target	May-18	Previous Month	Frequency	Comments	
Performance	Number of in-hospital deaths	Mortality	Count of Hospital deaths across the trust for the month/YTD	N/a	30	↓	N/a	16	14	M		
	Improve histopathology turnaround times at 7-days			75%			75%			M	Indicator under development	
	Improve PET scanning turnaround times at 5-days			75%	59.5%	↑	75%	60.0%	59.0%	M		
	Cancelled Operations	Cancelled Operations	Count of the number of last minute cancellations by the hospital for non clinical reasons	1.5%	3.5%	↓	1.50%	3.6%	3.3%	M	Internal Target	
	Cancelled operations seen in 28 days		Count of operations cancelled for non-clinical reasons and not offered a new date within 28 days	100%	100.0%	⇒	100%	100%	100%	M		
	Urgent operations cancelled 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.	4.5%	5.56%	↓	4.5%	6.51%	4.61%	M		
	Bed Occupancy		Count of beds occupied over all wards/ count of bed available	>=85%	83.2%	↓	>=85%	82.8%	83.6%	M		
	Referrals GP	Referrals	Count of referrals received into the trust from GP organisations (Community referrals removed)	3476	3442	↓	1738	1581	1861	M	Community Referrals Removed	
	Referrals DGH (External)		Count of referrals received into the trust from external sources (Community referrals removed)	1684	1768	↓	842	868	900	M	Community Referrals Removed	
	Referrals Other		Count of referrals received internally and all other sources (Community referrals removed)	1848	1726	↓	924	810	916	M	Updated to include Internal Referrals (Community Referrals Removed)	
	Activity NHS	Activity	Count of Total spells - Activity Plan for NHS patients	-			-			M	This indicator is currently under review, however, figures should be available for next month's dashboard.	
	Activity Private		Count of Total spells - Activity Plan for Private Patients	-			-			M		
	18 Weeks Referral to treatment Incomplete Pathways 52 week +	RTT	Count of patients on and incomplete pathway waiting over 52 weeks	0	1	↓	0	1	0	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%	100.0%	100%	M		
	31 day wait from diagnosis to first treatment		Patients waiting a maximum of 31 days from diagnosis to first definitive treatment	96%	99%	↑	96%	100%	98.1%	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%	92%	↑	85%	100%	89%	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%	92.95%	↑	95%	92.96%	87.2%	M		
	26 Weeks Referral to Treatment in aggregate - Non Admitted Pathways			98%	86.07%	↑	98%	86.87%	84.6%	M		
	26 Weeks Referral to Treatment in aggregate - Incomplete Pathways			95%	81.25%	↓	95%	91.25%	94.4%	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	103.34	↑	100	92.01	105.67	M	Current Month is November 2017	
	Emergency readmissions following non-elective admission			100	90.86	↑	100	67.84	102.09	M	Current Month is November 2017	
	Std 2: 7-day Services: First Consultant review - seen/assess <14 hrs (arrival)	7 Day services		90%	100%	⇒	90%			6M	September 2016 Survey	
	Std 2: 7-day Services: First Consultant review - seen/assess <14 hrs (admission)			90%	100%	⇒	90%			6M	September 2016 Survey	
	Std 5: 7-day Services: CT scan within 1 hr for critical care need			70%	100%	⇒	70%			6M	September 2016 Survey	
	Std 5: 7-day Services: Echocardiography within 12 hrs for urgent care need			80%	100%	⇒	80%			6M	September 2016 Survey	
	Std 5: 7-day Services: Microbiology tests within 12 hrs for urgent care need			85%	100%	⇒	85%			6M	September 2016 Survey	
	Std 6: 7-day Services: Access to interventions			80%	96%	⇒	80%			6M	September 2016 Survey	
	Std 8: 7-day Services: Ongoing review twice daily in high dependency area			80%	98%	⇒	80%			6M	September 2016 Survey	
	Std 8: 7-day Services: Ongoing review every 24 hours on general wards			80%	95%	⇒	80%			6M	September 2016 Survey	
	Mandatory training		Organisational Health		95%	94%	⇒	95%	94%	94%	M	
	Appraisals				90%	9%	↑	90%	9%	90%	M	
	Turnover Rate between 1-2 yrs service (voluntary(FTC excluded))			1.4%	1.61%	↑	1.4%	1.61%	1.62%	M		
Finance	Net Surplus £000's	Finance		845	845		501	500	345	M		
	Cash Balance			8736	8973		8736	8973	7988	M	Cashflow is currently 237k ahead of plan, this is due to the net effect of the receipt in May of the Pump Priming funding, delayed payments from Health Education England and lower private patient activity than planned.	
	Capital expenditure £000's			979	1005		479	344	661	M	YTD capital spend is 26k behind plan.	
	Deliver the recurrent cost improvement savings			£ 576	£ 309	↑	£ 288	£ 223	£ 176	M	There are non-recurring schemes of £24k to offset the recurrent CIP underachievement.	

