

Public Board Meeting Report

Single Oversight Framework Integrated Monthly Performance Report

Date **6 June 2019**
Authors **Senior Leadership Team**
Lead Directors **Executive Team**

Overall Summary

April was an exceptionally busy start to the year. Nine per cent more patients attended the emergency department at King's Mill Hospital and the Newark Hospital Urgent Care Centre than April 2018. The last four months have been 9%, 10%, 9% and now another 9% busier than the corresponding months a year ago. As detailed below, this is a big concern and we urgently need to understand why this is happening and what we and the health system can do reduce the rate of growth. This needs to be treated as a number one priority for the health system. Whilst the wider NHS remains busy, the growth we have seen recently is a-typical of the national position.

Increasing demand and the impact this has on patient experience, staff welfare and our financial position, is a key risk for us as identified through our Board Assurance Framework. Eleven of the 12 months last year had "better" four hour performance than the year before, but this year the first two months have seen a reduction in timely performance compared to the previous year.

Despite the above, many areas have continued to improve at the beginning of this year. In general, our workforce metrics remain positive, patients are receiving high quality, safe care, our access standards compare well and we have seen a reduction in the number of patients who are waiting exceptionally long times for their care across all pathways, and we are making progress in reducing our deficit and in delivering the financial agreements we have made with NHS Improvement.

Some areas have progressed less well though; sickness absence is higher than expected, avoidable pressure ulcers are higher than we would have wanted, we have missed the diagnostic standard again and our financial improvement plan is for the second year running behind plan.

Organisational Health

At a Glance	Indicator	Plan / Standard	Period	YTD Actuals	Monthly / Quarterly Actuals	Trend	RAG Rating
ORGANISATIONAL HEALTH	WTE lost as a % of contracted WTE due to sickness absence within last 12 months	≤3.5%	May-18 - Apr-19	4.1%	-		R
	Staff Turnover	≤0.9%	Apr-19	0.6%	0.6%		G
	Proportion of Temporary Staff	7.30%	Apr-19	7.4%	7.4%		R

We have not curtailed sickness absence as much as planned at the start of 2019/20. Although it decreased slightly to 4.12%, it has remained higher than expected for April.

The 0.8% stress, anxiety and depression sub-threshold was also breached in April 2019 at 1.01%, but this again was slightly better than March. This is a new KPI and the threshold decrease to 0.8% from 0.9% in April 2019.

The People, OD and Culture Committee received a deep dive report on sickness absence, including that attributable to stress, anxiety and depression at its meeting in May.

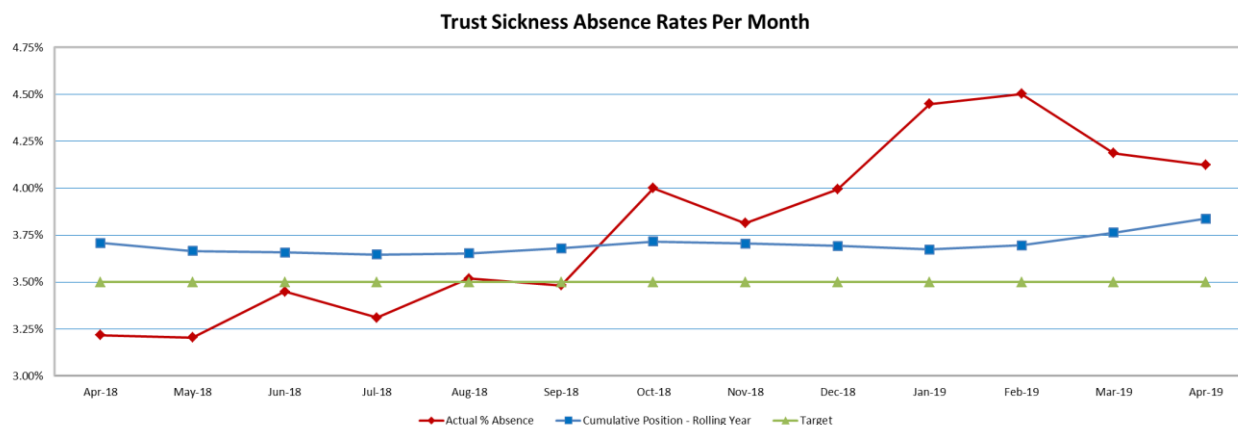
The sickness absence rate, together with vacancies has an impact on the number of shifts requiring bank or agency cover in order to maintaining safe staffing levels. However, the majority of nursing and medical rota gaps are being filled by bank staff as opposed to agency workers. These factors have had an effect on the proportion of temporary staffing used during April being 0.1% higher than the target.

Turnover has remained low at 0.6%, which is well below the threshold of 0.9%.

It is suggested that KPI for vacancies, appraisals and mandatory training are included in the quarterly reports.

Sickness Absence – 3.5% annual / 3.2% April threshold - RED

Sickness absence decreased in April to 4.12% (March, 4.19%). This is 0.92% above the new seasonally adjusted in month threshold of 3.20% for April.



It should be noted that this chart now contains both the actual absence for the month (red line) and the 12 month cumulative absence, which indicates the overall trend. Only

Corporate Division were at or under the seasonally adjusted in month threshold of 3.20% in April 2019, with 2.78% (March, 2.49%). Urgent & Emergency Care, were amber at 3.50% (March, 3.50%), as were Diagnostics & Outpatients at 3.89%. The remaining Divisions were red. These are Surgery, 5.08%; Women & Children's 4.66% and Medicine, 4.35%. Sickness absence for April 2019 is 0.90% higher than April 2018. This may be due to the flu and winter ailments pattern this year, which has appeared to materialise later than usual.

The top three absence reasons in April are:

- Anxiety/stress/depression - 1.01%, 1431.61 FTE Days Lost which is an increase of 81.79 FTE days lost from March 2019. It is above the 0.8% sub-threshold.
- Other Musculoskeletal - 0.50%, 704.01 FTE days lost which is an increase of 71.69 FTE days lost from March 2019
- Gastrointestinal problems – 0.48%, 674.29 FTE days lost which is a decrease of 93.84 FTE days lost from March 2019.

We have wellbeing initiatives in place to support staff, many of which target absence for the top three reasons.

The HR/OD Directorate recently held a managing stress month, where a range of initiatives could be accessed by any member of staff. We have a comprehensive Employee Assistance Scheme that provides a range of offerings, including a telephone counselling service available 24 hours a day. The Occupational Health Department offers a listening service and there is a more formal counselling service available, whereby staff can access a programme of up to six sessions. The latter has a waiting list of 8 weeks and therefore provision is being reviewed. We also have a network of over 30 staff "time to change champions" who are trained in providing support with mental health issues.

Our Occupational Health Department offers an in house physiotherapy service which provides direct support for staff who are experiencing musculoskeletal issues. In some cases, the service has managed to prevent what would otherwise have been a sickness absence period by providing a timely intervention. We also have a moving and handling advisory service, which not only provides mandatory and specialist training, but also conducts workplace assessments. If any ward or department is experiencing a high level of musculoskeletal issues, targeted advice is often provided. In addition, specialist chairs are provided for staff where required.

Gastrointestinal problems are sometimes a symptom of stress and therefore, some of those intervention are also helping to target this area of absence. In line with other NHS organisations, our strict rules concerning staff who are experiencing diarrhoea and vomiting symptoms require them to remain absent from work for 48 hours. This is recorded as sickness absence and it means that there will always be some level of absence for this reason.

All individual sickness absence cases are managed by Divisional management, supported by HR, in line with our sickness absence policy, which has been revised to encourage more discretion.

Training sessions take place to support managers using discretion around sickness absence and bespoke coaching sessions are available to coach managers on their practice.

Confirm and Challenge meetings occur each month and any trends or significant issues impacting sickness levels will be reported at Executive Performance Review meetings.

Turnover – 0.9% Target - GREEN

In April 2019, the overall turnover rate decreased to 0.56% (March, 0.67%). It has now been under the threshold for a year and compares well with other Trusts.

There were 36.65 FTE more starters than leavers in April 2019 (59.88 FTE starters v 23.23 FTE leavers). Registered Nurses had 7.15 FTE leavers, of these 3.35 FTE were Band 5.

Percentage of Temporary Staff - Target 7.3% AMBER




















This was at 7.4% for April. This is mainly affected by sickness absence rates, additional winter staffing requirements and vacancies. The target has just reduced from 7.4% to 7.3%. This figure includes both bank workers and agency staff. Temporary staff have to be used to fill gaps in nursing, medical and AHP rotas, in order for us to ensure safe staffing levels and service continuity.

We continue to focus on recruiting to substantive position in order to reduce the use of temporary staff. Medical vacancies are 9.8%. This figure has only risen since March because additional posts have been added to the medical establishment, which we have not yet had the time to fill.

At the April Registered Nurse Assessment Centre 11 offers were made and 12 nurses have now joined us from overseas. They will have an intensive period of preceptorship to get them to ready to sit the final exams with the plan of gaining their full registration from June.

The next cohort of four nurses are arriving on 23rd May with the final four due to arrive a couple of weeks later, taking the total to 20.

Patient Safety and Quality

At a Glance	Indicator	Plan / Standard	Period	YTD Actuals	Monthly / Quarterly Actuals	Trend	RAG Rating		
QUALITY, SAFETY AND PATIENT EXPERIENCE	Patient Safety	Rolling 12 months HSMR (basket of 56 diagnosis groups)	100	Feb-18 - Jan-19	97.1	-		G	
		SHMI	100	Oct-17 - Sep-18	96.72	-		G	
		Serious Incidents including Never Events (STEIS reportable) by reported date	2	Apr-19	0	0		G	
		Never Events	0	Apr-19	0	0		G	
		NHSE/NHSI Improvement Patient Safety Alerts Compliance (Number open beyond deadline)	0	Apr-19	1	1		R	
	Quality	Safe Staffing Levels - overall fill rate	80.0%	Apr-19	102.2%	102.2%		G	
		Same Sex Accommodation Standards breaches	0	Apr-19	0	0		G	
		Clostridium difficile Hospital acquired cases	4	Apr-19	0	0		G	
		MRSA bacteremia - Hospital acquired cases	0	Apr-19	0	0		G	
		Avoidable Hospital Acquired Grade 2 Pressure Ulcers per 1000 OBDs	0.07	Apr-19	0.11	0.11		R	
		Eligible patients having Venous Thromboembolism (VTE) risk assessment	≥95%	Mar-19	95.2%	95.5%		G	
		Eligible patients asked case finding question, or diagnosis of dementia or delirium	≥90%	Mar-19	97.8%	98.5%		G	
		Eligible patients having Dementia Diagnostic Assessment	≥90%	Mar-19	100.0%	100.0%		G	
		Patients where the dementia outcome was positive or inconclusive, are referred for further diagnostic advice	≥90%	Mar-19	93.2%	98.1%		G	
	QUALITY, SAFETY AND PATIENT EXPERIENCE	Patient Experience	Number of complaints	≤60	Apr-19	20	20		G
			Recommended Rate: Friends and Family Inpatients	97%	Apr-19	98.2%	98.2%		G
			Recommended Rate: Friends and Family Accident and Emergency	87%	Apr-19	93.0%	93.0%		G
			Recommended Rate: Friends and Family Maternity	96%	Apr-19	94.0%	94.0%		R
Recommended Rate: Friends and Family Staff			80%	Qtr4 Yr2018/19	82.7%	83.3%		G	

Overview

Quality – remains on track, with an update on the increase in number of avoidable hospital acquired category 2 Pressure Ulcers per 1000 OBDs

During April 2019 there have been two avoidable Pressure Ulcers (PU) identified and three unavoidable category 2 PUs with four of those being Low Harm and one being No harm. There was one unavoidable category 3 PU with low harm identified. All Pressure Ulcers are reviewed weekly by the Tissue Viability, divisional staff and Chief Nurse or the Deputy Chief Nurse to establish themes and trends.

Access

At a Glance	Indicator	Plan / Standard	Period	YTD Actuals	Monthly / Quarterly Actuals	Trend	RAG Rating	
OPERATIONAL STANDARDS	Emergency access within four hours Total Trust	≥95%	Apr-19	91.0%	91.0%		R	
	Emergency Access	0	Apr-19	0	0		G	
	% of Ambulance handover > 30 minutes	0	Apr-19	10.0%	10.0%		R	
	Referral to Treatment	18 weeks referral to treatment time - incomplete pathways	≥92%	Apr-19	-	90.0%		R
	Number of cases exceeding 52 weeks referral to treatment	0	Apr-19	-	0		G	
OPERATIONAL STANDARDS	Diagnosics	Diagnostic waiters, 6 weeks and over-DM01	≥99%	Apr-19	-	98.0%		R
	Cancer Access	62 days urgent referral to treatment	≥85%	Mar-19	81.4%	88.4%		G
		62 day referral to treatment from screening	≥90%	Mar-19	92.5%	85.7%		R

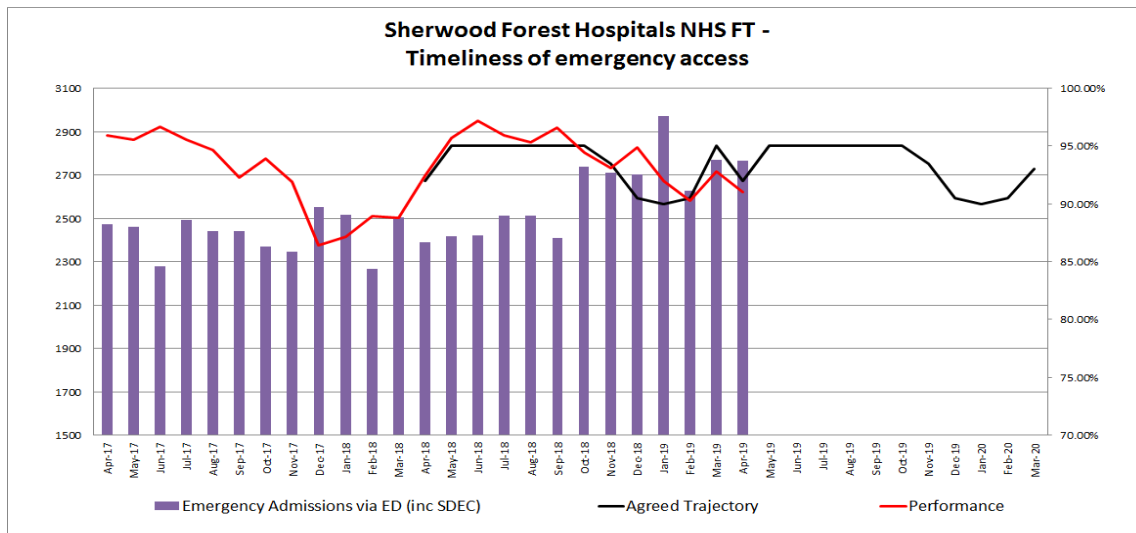
We continue to have a relatively balanced access portfolio despite treating more patients than ever.

Demand for emergency care remains high compounded by the volume of admissions being consistent with the main winter period. Routine elective care performance has been maintained and we continue to report zero 52+ waits. The wait for some routine diagnostic tests has been extended due to cancer and inpatient demand with plans in place to address the deficit by the end of June. We delivered the 62 day cancer standard for the month of March 2019, this remains a key area of focus, notably ensuring capacity is utilised for those who need it the most and reducing the time to diagnosis.

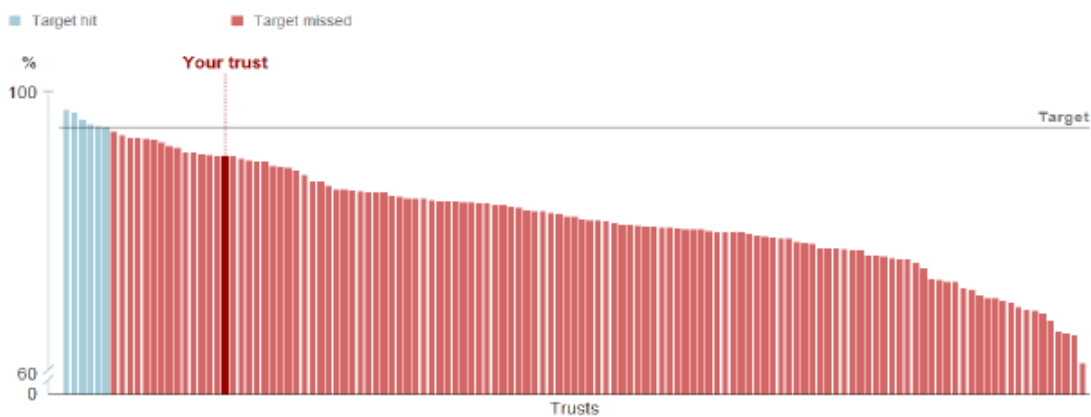
Emergency care

Emergency access performance against the 4 hour wait in April 19' was 91%. This was 1% below the NHS Improvement agreed trajectory. April performance was ranked 22nd of 131 Trusts in the NHS, the same as in March 2019, and in April 2018 we were ranked 28th.

4 Hour Wait	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
19/20 NHSI Trajectory	92.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	93.5%	90.5%	90.0%	90.5%	93.0%
19/20 Actual	91.0%											
19/20 Quarter Trajectory			94.0%			95.0%			93.0%			91.2%
19/20 Quarter actual												
18/19 Actual	92.4%	95.7%	97.2%	95.9%	95.3%	96.6%	94.4%	93.1%	94.9%	92.0%	90.3%	92.8%
Ambulance Handover												
19/20 NHSI Trajectory	9.0%	8.5%	8.0%	7.0%	8.0%	8.0%	5.0%	6.0%	6.0%	6.0%	8.0%	7.5%
19/20 Actual	10.0%											
18/19 Actual	15.9%	9.9%	8.2%	12.7%	13.3%	5.9%	7.3%	8.3%	8.3%	9.2%	8.5%	9.8%



Sherwood Forest Hospitals NHS Trust ranked 22 of 129 trusts



Drivers of performance

The main drivers of 4 hour wait performance are related to the below for Majors and Resuscitation areas of the department:

- Admission and discharge deficit – this is caused by an increase in admissions, a decrease in discharges or a combination of the two and can lead to breaches of the 4 hour wait standard and overcrowding in the emergency department.
- Waiting time to see a Dr – this has numerous root causes. It can be caused by an imbalance between the number of Drs on shift per hour and the arrival number of patients per hour, or it can be caused by overcrowding which is often caused by driver bullet one leading to a lack of physical space for a Dr to see a patient.
- Wait for decision by a Dr – similar causes to bullet 2.

April position

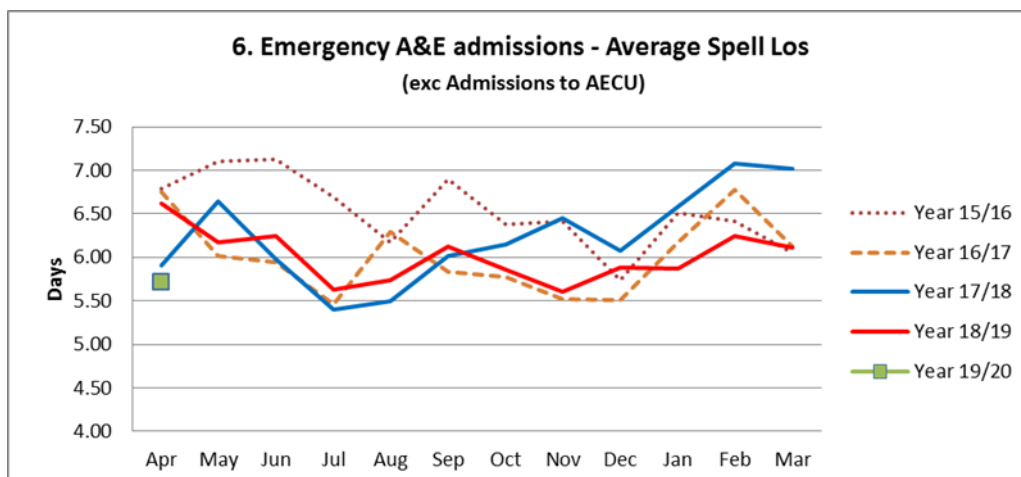
Demand for Emergency care has followed the recent trend following winter, of growth in Majors/Resus attends (161 per day, 19 per day more than Apr 18, 14% growth – 3 per day more than Jan-Mar 19') and admissions to the medicine pathway including same day emergency care (378 more than Apr 18, 15% growth, 289 more than Jan-Mar 19). The

admission growth trend is shown in the chart above with admissions not really falling from the heart winter period. Some of this growth is driven by ambulance demand, some by walk in patients.

Capacity to treat these patients has remained as it was in March 2019, although work has taken place to slowly reduce this capacity as per the agreed winter plan. This capacity will need to start to be reduced in May 19 as it represents winter levels of operating and is eroding the funding reserve required for use in winter 19/20.

- Twenty-four additional medical beds switched from surgery
- Ten extra surgical beds opened
- The opening of 20 additional 'transfer to assess' beds within the community
- Eight additional rehabilitation beds at Newark

Discharges remained high and the use of this capacity showed an improvement in effectiveness with LOS at its lowest ever point in April 2019. Patients with a stay >21 days have reduced in month and continue their reducing trend using 10 less beds than in March 2019.



On a 3 day rolling measure for the month, there were 12 days during April that saw an admission and discharge net deficit and these days led to 59% of the breaches of the 4 hour wait standard over the month. Reducing these deficits remains the majority driver of performance.

Actions being taken to improve back to trajectory levels:

- 'Drivers of demand' work across the ICS to understand why local EDs are seeing increases in attends and admissions and therefore inform actions to be taken. This is being led by Dr Haynes with partners and is due to report at the end of June.
- Additional investment in ED nursing - £700k has been invested in ED nursing to meet growing demand, maintaining the safety of a growing service, and support quicker turnaround of patients. Recruitment is under way and it is likely that this will be in place from September.

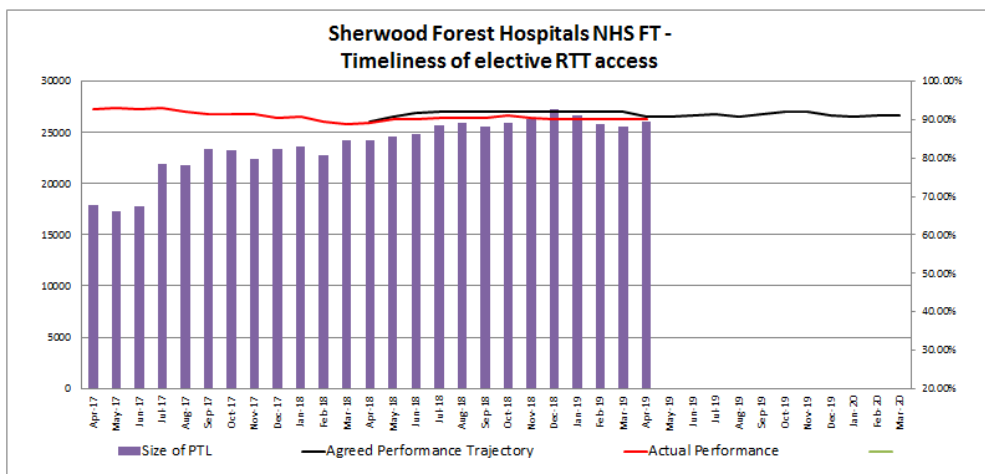
- Variation work within ED – discussions taking place with ED team on reducing unwarranted variation, further workshop to take place on 3rd June. The impact of this is hoped to be an improvement in the consistency of process and admission rates.
- Bed demand and capacity – paper enclosed. This describes the internal actions SFHFT can take to be more efficient and effective on the emergency care pathway. It will go to the A&E Delivery Board for a wider system discussion with partners on 5th June.
- Continued strengthening of weekends – weekend discharges have improved with better planning and the provision of a weekend discharge team and this needs to continue to not only improve weekend performance but to reduce the delays patients experience on a Monday
- >21 days – the new CGG led HFID discharge hub has now started with a focus on getting more complex patients home earlier, this will be measured as to its success at the end of June
- A workshop is taking place, with partners, to redesign and streamline the front door to reduce admissions. This is scheduled to take place on 3rd July. Plans have also been put in place to continue to the excellent progress on ‘Same Day Emergency Care’ with an objective of 15 more majors patients per week being streamed through it thereby reducing admission rate.

Elective care
RTT Incomplete standard

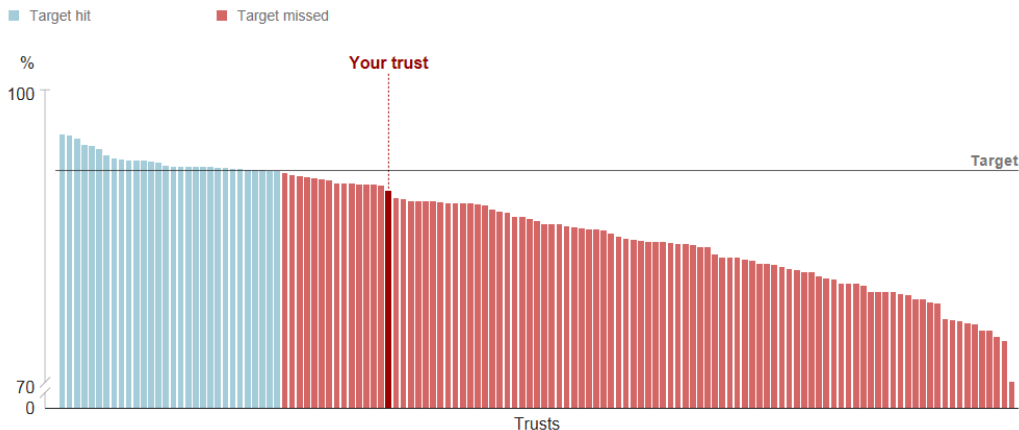
Elective access performance against the 18 week incomplete standard at the end of April 2019 was 90%. This was 0.7% below the 2019/20 trajectory but 0.8% better when compared to April 2018.

April 2019 performance was ranked 45th of 129 Trusts in the NHS a marginal improvement on March’s ranking of 47th. We continue to deliver on trajectory with zero patients waiting longer than 52 weeks.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
19/20 NHSI Trajectory	90.72%	90.90%	91.15%	91.29%	90.87%	91.43%	91.98%	92.00%	90.97%	90.75%	91.17%	91.20%
19/20 Actual	90.0%											
19/20 Quarter Trajectory	90.9%			91.2%			91.7%			91.0%		
19/20 Quarter actual												
18/19 actual	89.2%	90.0%	90.0%	90.6%	90.6%	90.6%	91.0%	90.4%	90.0%	90.03%	90.02%	90.0%



Sherwood Forest Hospitals NHS Trust ranked 45 of 129 trusts



Drivers of performance

The main driver of incomplete performance is an imbalance in demand and capacity for non-admitted activity. From a specialty perspective the biggest risk both in terms of volume and wait for first or follow up is within Ophthalmology. Analysis of referral growth demonstrates an annual increase of 11% and a five year increase of 21%; with the majority related to Macular work.

Demand and capacity modelling undertaken in December 2018 identified a capacity gap in the region of 75 new appointments per week in addition to a backlog of over-due follow ups. A system wide plan has been developed to identify capacity to mitigate the increasing wait for a first or follow up Ophthalmology appointment and surgical intervention; this includes a business case for £1.3m to fund additional staffing and equipment. The short term plan includes ongoing support from Independent sector providers whilst in-house actions progress.

Other actions in place to improve back to trajectory levels are:

- The Outpatient transformation programme focussing on a reduction in face to face follow up activity through the use of virtual clinics, new models of care for long term conditions, risk stratifying pre-op appointments and patient initiated follow ups (PIFU). 25% of the volume of patients >18 weeks are waiting for an overdue follow up.
- The staged implementation of the Medefer Virtual Hospital Model with Cardiology first to go live in June 2019. This will be the first time Medefer has worked with Cardiology and therefore the expected impact is likely to be a 35% reduction in new OP attendances in the first 2 months while the project is closely monitored and results evaluated. The impact is then expected to rise to 70% of patients not requiring a new OP attendance. Dermatology and Gastroenterology will follow with implementation expected in July 2019. Medefer have extensive experience of Gastroenterology and therefore the expected impact (on commencing) is likely to be a 70% reduction in new outpatient attendances.
- Increasing theatre productivity by implementing ways of working more efficiently, reducing the amount of unutilised time on a list and allowing more patients to receive surgery. The key areas of focus in this programme are on the day performance,

improved scheduling and patient optimisation. April's performance is positive with 108 additional cases completed above trajectory.

Diagnostics (DM01)

At the end of April 2019 we failed the DM01 standard for the second consecutive month. Performance of 98.02% is based on 120 breaches from a waiting list of 6,048 procedures. The main driver for underperformance is the volume of breaches in Echocardiography, Respiratory Physiology (Sleep Studies), MRI and Ultrasound.

Drivers of performance

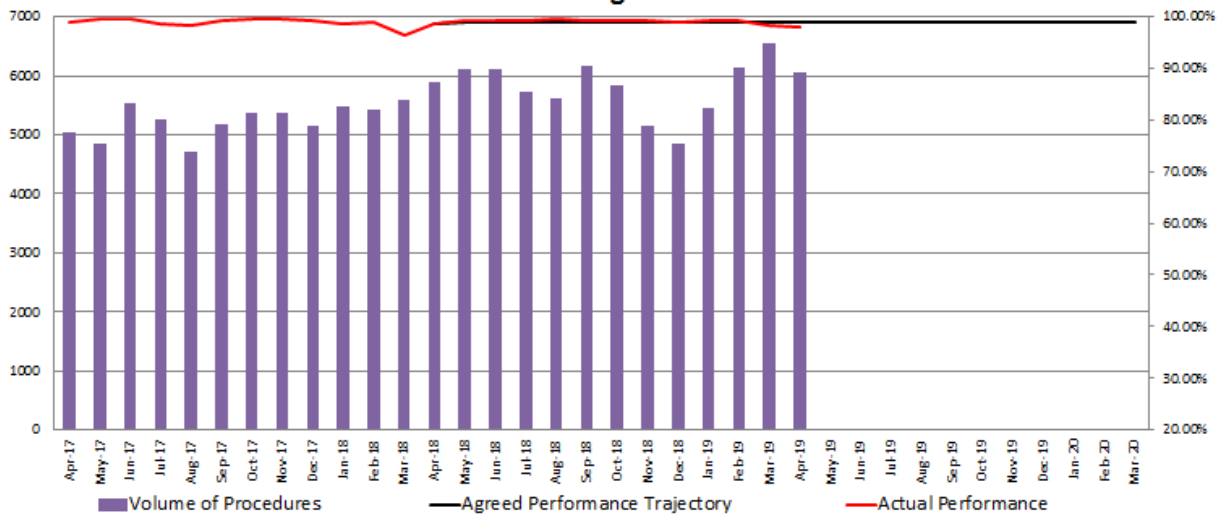
The most significant volume of breaches has been for echocardiology and is a consequence of staff sickness absence within the non-invasive Cardiology Physiologist workforce. Actions to mitigate this reduction in workforce have been securing a locum to run weekend lists alongside substantive workforce to double up weekend activity, formalising a local workforce agreement to enhance weekend working and agreeing a contract with Inhealth Group. The impact of the actions will be evidenced by recovery in June.

As described previously, the MRI the team are prioritising 2WW cancer patients in the current capacity available, this is leading to routine breaches. Additional mobile MRI capacity will be on site in July and will increase flexibility with appointments for both routine and cancer patients. Longer term the business case for a second static MRI has been finalised, however a source of capital funding is yet to be identified.

May continues to be a challenging month for delivery of the 6 week standard, a further risk identified is linked to the tax and pension changes and the ability for clinicians to undertake additional sessions in Endoscopy. All diagnostic teams continue to mitigate where possible and remain confident that the DM01 will recover by the end of June.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
19/20 Trajectory	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%
19/20 Actual	98.02%											
19/20 Quarter Trajectory	99.0%			99.0%			99.0%			99.0%		
19/20 Quarter actual												
18/19 actual	98.59%	99.12%	99.12%	99.13%	99.45%	99.16%	99.37%	99.24%	99.03%	99.13%	99.30%	98.40%

Sherwood Forest Hospitals NHS FT - Timeliness of Dignostic access

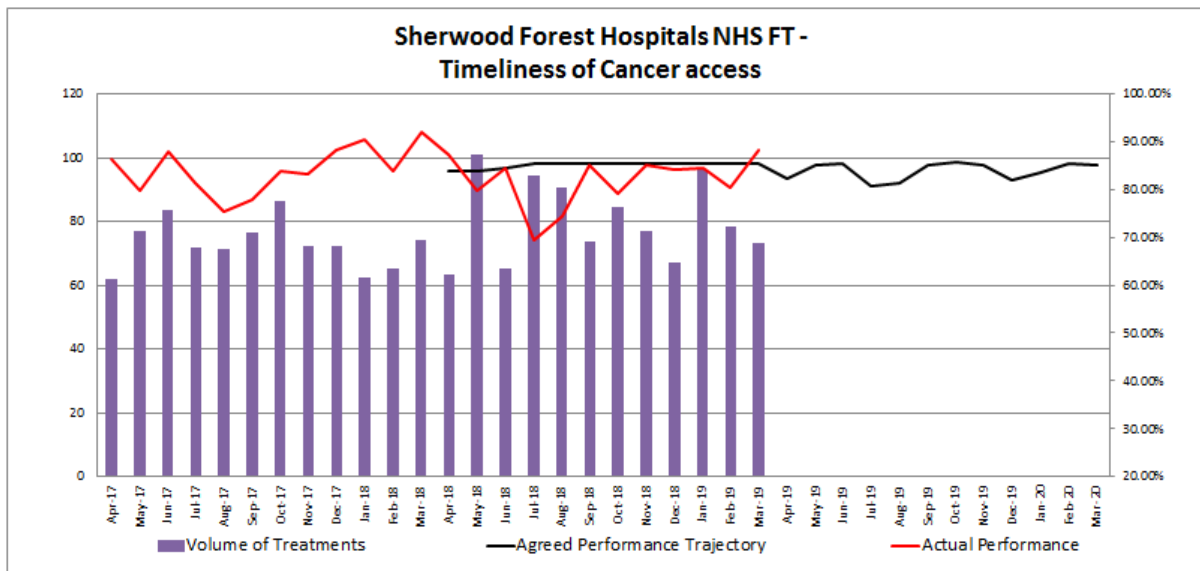


Cancer

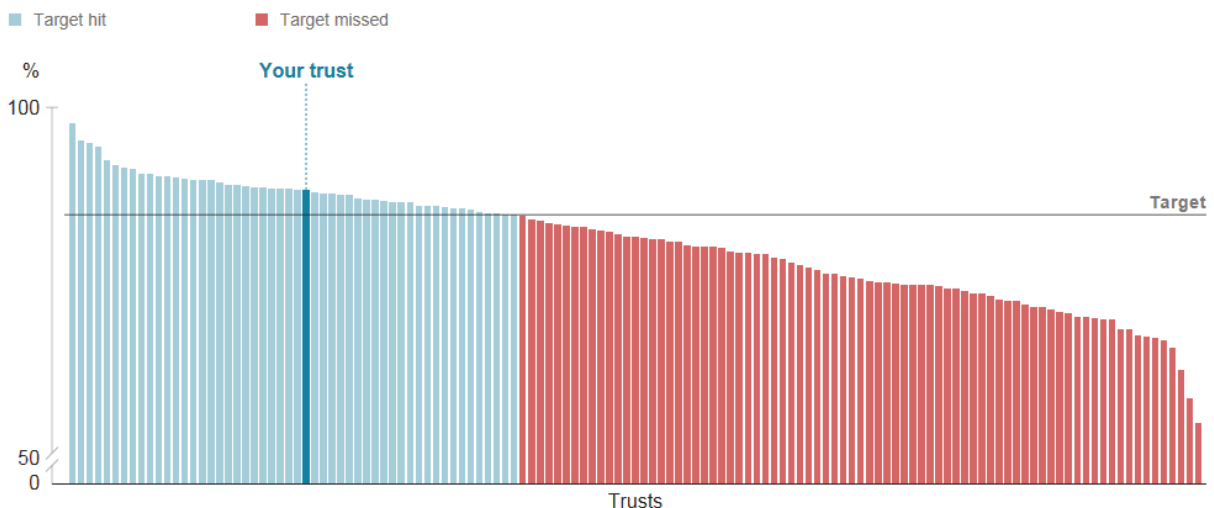
Classic 62 day standard

For the month of March 2019, 88.4% of patients were treated within 62 days of their referral. This exceeded the trajectory and ranks us as 28th of 131Trusts nationally. Quarter 4 performance was 84.4% against a trajectory of 85.4%.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
18/19 NHSI Trajectory	83.80%	83.80%	84.60%	85.40%	85.40%	85.40%	85.40%	85.40%	85.40%	85.40%	85.40%	85.40%
18/19 Actual	87.60%	79.80%	84.60%	69.30%	74.30%	85.10%	79.30%	85.10%	84.30%	84.50%	80.30%	88.4%
18/19 Quarter Trajectory			84.1%			85.4%			85.4%			85.4%
18/19 Quarter actual			84.0%			76.2%			82.9%			84.4%
17/18 actual	86.3%	79.9%	88.0%	81.3%	75.5%	77.8%	83.8%	83.4%	88.3%	90.4%	83.8%	91.9%



Sherwood Forest Hospitals NHS Trust ranked 28 of 131 trusts



Drivers of performance

Underlying sustainability remains an issue; the main reason for this is that the volume of patients that are on the Cancer PTL waiting more than 62 days and who remain undiagnosed or with a treatment date in the future is growing.

There are two main drivers for this; in the first instance a 14% increase in 2WW demand and 14% increase in the volume of treatments causing capacity gaps across most pathways with pressure on outpatient, diagnostic, surgical and oncology capacity both here and at our main tertiary provider. 40% of all breaches in 2018/19 were due to a provider delay to diagnostic test or treatment planning (74/181).

Secondly, the complexity of patients is increasing with multiple co-morbidities requiring additional and often specialist diagnostics both here or at our tertiary provider and discussion at more than 1 MDT meeting. Complex pathways equated to 18% of our breaches in 2018/19

20% of all breaches were due to “other” which can be a myriad of reasons and 11% (19.5/181) were due to patient choice to delay.

Actions being taken to return to trajectory:

- The conversion rate from referral to treatment is approximately 7%. To ensure Outpatient capacity is being utilised for appropriate patients a review of all 2WW forms has been completed with clinical teams and are available for GPs to use. The impact is expected to be a decrease in unnecessary 2WW referrals freeing up capacity for appropriate patients to be seen within 7 days. An audit of LGI referrals has shown that less than 50% were on the correct form and of that 50% had the correct information required (E.G no FIT test). Less than 10% of patients were told there was a suspicion of cancer. The results have been shared with CCG colleagues with a request for a plan to address the variation and quality of referrals by the end of June.
- Demand and Capacity modelling will be refreshed by the end of June to identify any ongoing gaps and the opportunities to bridge the gap.

- Increased use of straight to test in the prostate pathway in June by triaging all referrals negating the need for a 1st outpatient and reducing the time to diagnosis by up to 10 days.
- Recurrent investment of £200k made to continue with the additional MRI capacity that was put in place in summer 2018.
- We have secured £300k of Cancer Alliance funding and is prioritising schemes identified by the tumour sites for transformational improvement; these include an additional Skin cancer nurse and Urology equipment that will improve the accuracy of testing and turnaround of histopathology results. Funding will be released by the Cancer Alliance by the end of Quarter 1.

62 day Screening

At the end of March 2019 we failed the 62 day screening standard at 85.7%. This is based on a total of 7 treatments and 1 breach. 6 treatments were breast screening and were all within target. 1 treatment was for bowel screening and breached due to patient choice.

Finance

At month 1 we are reporting a monthly deficit of £5.46m before non-recurrent income. This is £0.18m ahead of plan.

Non-recurrent income, Provider Sustainability Funding (PSF) of £0.32m, Financial Recovery Fund (FRF) of £0.74m and marginal rate emergency tariff (MRET) of £0.45m have currently been reflected in the position in accordance with the plan. PSF and FRF measures are assessed at quarter end and the amounts are dependent on delivery of control totals across the trust and system. The reported control total deficit is therefore £3.95m, £0.18m ahead of plan.

Key areas of note are: -

- Clinical income is £0.77m above plan in month 1, reflecting non-elective activity performance at 9.3% above plan.
- Pay costs are £0.27m above plan at month 1, due mostly to an increase in the medical pay run rate.
- Agency spend in April increased by £0.35m compared to March. This is £0.35m below the M01 ceiling.
- The Financial Improvement Plan (FIP) has delivered savings of £0.08m in month 1, £0.24m behind planned savings for April.

Other areas to note: -

- The full value of PSF and FRF has been assumed at M1 as both the Trust and the ICS system control totals have been achieved.
- Capital spend at month 1 is £0.14m, £0.03m below plan.
- Closing cash at 30th April was £2.47m, £0.21m below plan.
- A full forecast will be undertaken at the end of the first quarter. A divisional risk assessment has been undertaken and reported to the Finance Committee.

Financial Summary

	April - YTD			Annual Plan £m	Forecast £m	Forecast Variance £m
	Plan	Actual	Variance			
	£m	£m	£m			
Surplus/(Deficit) - Control Total Basis Exc PSF, FRF, MRET and Impairment	(5.64)	(5.46)	0.18	(41.52)	(41.52)	0.00
Surplus/(Deficit) - Control Total Basis Inc PSF, FRF, MRET and Exc Impairment	(4.13)	(3.95)	0.18	(14.87)	(14.87)	0.00
Finance and Use of Resources Metric YTD	3	3		3	3	
Financial Improvement Programme (FIP)	0.32	0.08	(0.24)	12.80	12.80	0.00
Capex (including donated)	(0.18)	(0.14)	0.03	(10.83)	(10.83)	0.00
Closing Cash	2.68	2.47	(0.21)	1.76	1.76	0.00
NHSI Agency Ceiling - Total	(1.40)	(1.05)	0.35	(16.66)	(16.66)	0.00