Agenda

Council of Governors
2.15pm – 4.30pm, Monday 7 September 2020
Via Lifesize Video Conferencing

Part One Agenda – Open Meeting

1	**Chief Executive's Report: 2019/20 Summary and Q1 Report 2020/21** To receive	Enclosure (to follow)	2.15	Patricia Miller, Chief Executive
2	**Welcome and Apologies for Absence:** David Cove, Davina Smith,		2.35	Chair
3	**Declarations of Interest**		2.35	All
4	**Minutes of Council of Governors Part One Meeting 3 February 2020** To approve	Enclosure	2.40	Chair
5	**Matters Arising from those Minutes and Actions List** To receive	Enclosure	2.45	Chair
	Governor Matters: Nil Received		-	
6	**Interim Lead Governor Arrangements** To approve	Enclosure	2.50	Trevor Hughes, Head of Corporate Governance
	Break		2.55	
7	**Finance Report: 2019/20 Summary and Q1 Report 2020/21** To receive	Enclosure	3.05	Paul Goddard, Director of Finance
8	**External Auditor's Statement on the Annual Report and Accounts 2019/20** To receive	Presentation	3.25	KPMG

9	**Feedback from NEDs: Role of the Risk and Audit Committee in the Annual Report and Accounts Process** To receive	Verbal	3.45	Ian Metcalfe
10	**Strategic Estates Masterplan Update** To receive	Presentation	4.00	Ben Print, Programme Manager
11	**Date of Next Meeting (open to the public): Council of Governors, 2pm, Monday 9 November 2020, via Lifesize**			
	Meeting Closes		4.25	

The meeting will be followed by a confidential (part two) meeting of the Council of Governors.

Council of Governors Meeting: Part One

Minutes of the Meeting of Monday 3 February 2020
Children's Centre Seminar Room, Dorset County Hospital

Present:	Mark Addison (Chair)
	Public Governors Margaret Alsop (Weymouth and Portland) Simon Bishop (East Dorset) Sarah Carney (West Dorset) David Cove (West Dorset) (Lead Governor) Wally Gundry (West Dorset) Stephen Mason (Weymouth and Portland) Gavin Maxwell (West Dorset) Christine McGee (North Dorset) Maurice Perks (North Dorset) Dave Stebbing (Weymouth and Portland) David Tett (West Dorset)
	Staff Governors Tracy Glen Tony James
	Appointed Governors Jenny Bubb (Dorset Clinical Commissioning Group) Davina Smith (Weldmar Hospicecare) Peter Wood (Age UK)
In Attendance:	Paul Goddard (Director of Finance and Resources) (item CoG20/007) Nick Johnson (Director of Strategy, Transformation and Partnerships) (item CoG20/005) Inese Robotham (Chief Operating Officer) (item CoG20/005) Stephen Slough (item CoG20/008) Liz Beardsall (Deputy Trust Secretary)
Apologies:	Tony Alford (Dorset Council) Naomi Patterson (West Dorset) Sharon Waight (Weymouth and Portland)
	Four members of the public were present.

CoG20/001 **Welcome and Apologies for Absence**
The Chair welcomed everyone present to the meeting. There were apologies from Tony Alford, Naomi Patterson and Sharon Waight.

CoG20/002 **Declarations of Interest**
The Chair reminded Governors that they were free to raise declarations of interest at any point in the meeting should it be required.

CoG20/003 **Minutes of the Previous Meeting held on 11 November 2019**
The minutes of the previous meeting held on 11 November 2019 were accepted as a true and accurate record.

CoG20/004 **Actions and Matters Arising**
CoG19/059 it was noted that an update on egg-free flu vaccinations had been circulated to all Governors. **Closed.**

CoG19/061 quarterly update on the ASD Service progress against the action plan: the Chair confirmed that reporting would commence in the April Chief Executive's Report, and that the Chief Operating Officer would provide a verbal update at the meeting today. **Closed.**

CoG19/065 a regular update regarding the transformation project to be added to the Council of Governors agenda. The Chief Executive's update regarding this item on the previously circulated actions list was noted. The Chair confirmed that updates regarding the transformation work would be received by Governors via feedback from the Governor Observers at Quality Committee and also through the Strategic Plan Committee. **Closed.**

CoG19/067 it was noted that the slides from the Strategic Plan Committee had been circulated to all Governors. **Closed.**

CoG19/068 it was noted that an update on the Dorset Care Record was on the agenda. **Closed.**

The updates on the action log were noted regarding CoG19/044 (steps taken by the executive regarding the documentation issues highlighted by KPMG during the audit of the 2018/19 Quality Account) and CoG19/046 (the amount of cigarette ends by the main North Wing entrance and the amount of litter around the site generally). **Closed.**

CoG20/005 **Governor Matters – Hospital Performance**
The Chair explained that Governors had raised a number of items relating to demand, capacity and waiting times especially in relation to the emergency department. He said that the Governors' Working Group had requested these matters be addressed together as substantial item on the Council of Governors' agenda. Therefore he had allocated a significant proportion of the agenda to the item and had invited Inese Robotham, Chief Operating Officer and Nick Johnson, Director of Strategy, Transformation and Partnerships, to attend.

The Chief Operating Officer provided Governors with an overview of the hospital's current operational performance. She reported that performance against the emergency department (ED) 4 hour standard was currently below the 95% target, however the hospital was proud of the ED team who were consistently performing above the regional and national averages against the standard. She said that for the third consecutive month there had been a reduction in ambulance handover times at the hospital (59 hours lost October, 8 hours November, 14 hours December and 4.9 hours January) and this was primarily due to the introduction of

the Fast Assessment Bay (FAB) in ED which was a clinician led model. She reported that Bournemouth and Poole hospitals had been to visit the ED to look at the FAB model as it was proving so effective. She said that the Trust was performing well in relation to delayed transfers of care (DTOC) and although the hospital was not achieving the national standard for patients with a length of stay over 21 days (super-stranded patients) the performance was better than the regional and national averages. She said that the greatest concern was elective care and the size of the waiting list. She reported that the Trust was working with Dorset Clinical Commissioning Group (CCG) regarding the Referral to Treatment standard (RTT) especially in relation to ensuring the safety of those patients who were waiting. She explained that the most significant RTT delays were in the orthopaedic, oral surgery/maxillofacial, ophthalmology and colorectal specialties.

Dr Cove asked whether the hospital measured 12 hour waits in ED from the time of arrival (as recommended by the Royal College) or from the point of decision to admit. The Chief Operating Officer underlined that because the hospital was performing so well against the 4 hour standard, there were very few waits over 12 hours, but that these were measured from the time of decision to admit as this was the required measure.

Mrs Carney congratulated the hospital on the excellent reduction in ambulance handover times. She questioned why the hospital could not make greater use of community hospital beds in Bridport and asked for an update on the review of criteria for community bed use which was underway. Chief Operating Officer confirmed that discussions regarding the criteria were still underway. She reported that for the majority of patients with a long length of stay it was not a lack of community beds which was the issue, but often related to court of protection cases or clinical need. She said that the community hospitals did tend to have tight restrictions around the number and timing of admissions, but that staff at the Trust were working closely with the community sector. The Chair asked for the outcome of the review of the criteria relating to community hospital bed access to come back the Governors when this was available.

ACTION: IR

The Director of Strategy provided Governors with an overview of the strategic direction of the Trust in relation to capacity and performance. He reported that the hospital did not have adequate capacity in terms of finances, workforce or infrastructure. Even if there was more money available there might not be the workforce available to staff additional capacity. He reported that there was a shift in NHS thinking away from creating bigger hospitals and towards reducing demand and improving productivity. He said the Trust was endeavouring to do this through a mix of clinical networks with other acute providers, and working with Public Health Dorset, primary and secondary care providers as a community-wide approach to reducing need for acute care. He reiterated that the hospital's ED had been built for 22,000 patients per year but was now seeing c50,000. He said that the CCG's Long Term Plan recognised this continued increase in demand, which previously had not been fully acknowledged in the Clinical Services Review. He explained that there were three phases to the Trust's planning: short term (next 12 month), maximising capacity with the existing footprint, including schemes like the FAB model and the Same Day Emergency Care (SDEC) model; medium term (2-4

years), focusing on the areas of greatest pressure such as ED; and long term (over 5 years), including building work to increase to size of the ED and intensive care unit with an integrated care hub on-site. He said that a number of factors fed into this planning including the developments at Bournemouth and Poole hospitals; theatre, beds and outpatient department capacity; technological advances; and capital and workforce constraints.

Governors raised concerns about staffing and bed shortages. It was noted that these were national problems and that the Trust was taking action to increase the workforce including the recruitment of overseas nurses and the involvement of young volunteers to grow local interest in the hospital as a place to work. The Director of Strategy underlined that whilst there were workforce challenges, the staff at the hospital continued to provide high quality of care and that the hospital maintained safe staffing levels. The Chief Operating Officer reported that new operating guidance had recently been released which contained a directive to keep escalation beds open and indicated a shift towards investment in additional beds in acute and mental health settings.

The Governors discussed: the residential expansion of Poundbury and how this was being taken into account in the modelling work which the hospital was doing to understand future demand; that reports of the hospital missing out on £147 million of funding going to the East were untrue – as the bid for this money was specifically for the reconfiguration of services in the East; that part of the business case for the redevelopment of the ED and intensive care unit would be to consider staffing levels and how these could be met; and that the commitment by the Government to re-introduce partial bursary funding for nursing degrees may increase the number of nurses in training. Mrs Carney noted that the hospital and its staff were doing an excellent job, but wondered if there was something more the Governors could be doing to support the hospital, for example through lobbying on a national level. The Chair suggested that this suggestion needed further discussion, and should come back to another meeting.

ACTION: LB

The Chair asked the Chief Operating Officer to provide a brief verbal update on the Autistic Spectrum Disorder (ASD) Service. She reported a psychiatric had been appointed but that progress had been slower than hoped against the improvement trajectory as the new consultant was not yet signed-off to work independently. This meant it was unlikely that there would be any movement against the trajectory until February or March, which is why the reporting on the ASD Service to the Governors in the Chief Executive's Report was not scheduled to commence until April. She reported that the multi-disciplinary team was still providing a triage service. She said she did not know whether the ASD Service had been raised at with the Integrated Care System (ICS) senior leadership team (action CoG19/054) but she would ask the Chief Executive to provide an update in her next report. She also offered to circulate the most recent figures on the ASD service waiting list.

ACTION: IR

CoG20/006 **Chief Executive's Report**

The Chair drew the Governors' attention to the report from the Chief Executive which had been previously circulated for information and summarised the hospital's performance during the third quarter of 2019/20.

CoG20/007 **Finance Report**

The Director of Finance presented a previously circulated report which summarised the hospital's financial performance for the nine months ending 31 December 2019. He reported that the hospital's financial position remained on track and had delivered an income and expenditure deficit of £3.2 million against a planned deficit of £3.4 million, resulting in a favourable variance of £0.2 million. The cash balance at 31 December 2019 was £12.7 million and capital expenditure was slightly behind plan but the position would be recovered by year end. He highlighted the impact of the operational pressures on the hospital's financial position, especially in relation to increased agency spend due to pressure on staffing numbers and escalation beds. He confirmed that the Cost Improvement Programme (CIP) was on plan, but there would be increasing pressure on this programme by year end.

In response to questions from Governors, the Director of Finance confirmed that the Trust had a limited number of pool cars and that these were kept on site and allocated to staff as required for business mileage only; that the Trust did not cover the accommodation costs of locum doctors but that locums could pay to use hospital accommodation if there was a room available; that the agency cap was set by the regulator based on the organisation's agency spend last year and that the Trust's cap was £3 million but the spend this year was forecast to be £6 million - £7 million; that the underlying deficit position had worsened by c£1 million; that there had been little cost to the Trust so far relating to the multi-storey car park development project and that the scheme would ultimately be paid for through an external financing arrangement.

The Chair thanked the Director of Finance for his report.

CoG20/008 **Dorset Care Record Update**

The Chair welcomed Stephen Slough, Chief Information Officer (CIO) to the meeting. He said the CIO had four roles,; as CIO at the Trust, Dorset Clinical Commissioning Group and Dorset Healthcare, as well as being the lead for digital transformation for Dorset. He explained that the CIO was attending to provide an update on the Dorset Care Record (DCR) as requested by the Governors and confirmed that the presentation slides would be circulated after the meeting.

ACTION: LB

The CIO explained that the DCR was a system to pull together medical, health and social care records so that when seeing a patient, clinicians could view all recent records relating to that person. He reported that the project started a few years ago and that during this time the Trust had been the front-runner in engaging with the project and providing the information required. He said that 4,000 shared records had been viewed in December, which was nearly double that in the previous month. He said that once single-sign on was in place at the hospital, the use of DCR would be heavily promoted throughout the organisation. He said

although the hospital was one of the smaller organisations involved it was consistently demonstrating the highest usage rates. He reported that work was now underway to link with the Hampshire shared record project, so that the DCR could link with Southampton Hospital which provided tertiary services for the Trust. He said that this cross-border project was a national exemplar.

Mr Bishop, who had made the original request for the Governors to receive an update in the DCR, thanked the CIO for his presentation. He noted the good rate of progress and the excellent work in engaging with other organisations.

In response to questions from Governors, the CIO confirmed that patients' primary records would remain with the GP; that there was an ambition to link with hospices, pharmacies and private hospitals, and the CIO would speak with Davina Smith from Weldmar Hospicecare outside the meeting regarding this; that every household in Dorset had been sent a leaflet offering the chance to opt out and that the DCR website also offered further information on consent; that only authorised staff with log-in would be able to access the system and every view or change would be name, time and dated stamped so that audits could be undertaken; that although the presentation referenced the CCG, it was not the commissioning body accessing records but the GP practices themselves and the CCG per se did not have access; that the system would pull in the last two years of paper records in digitised form and that this sat alongside the hospital's own digitisation project, the Digital Patient Record; that the system had a sensitivity flag, which withholds particular sensitive information from certain users where appropriate; that links with other areas, such as Berkshire, formed part of NHS England's ambition that the whole of the country would eventually be covered by linking systems; that the Electronic Discharge Summary system did not currently link directly into the DCR but linked into the other hospital systems; that there were possibilities in the future for using the data in the system to highlight patients who might be suitable to take part in research projects; that in an emergency situation, such as an unconscious patient arriving in ED, clinicians would be able to 'break the glass' and access the patient's record on the system; that the level of financial contribution was based on the size of organisation and therefore other organisations were contributing more than Dorset County Hospital; that the consent model had been based on guidance from the Information Commissioner's Office and that work was continuing to publicise the system and the opt-out.

ACTION: SS

Dr Bubb highlighted that rather than wishing to opt-out, most patients were surprised that organisations did not already share this data and that for most people a coordinated approach to sharing information would be beneficial to their healthcare.

The Chair thanked the CIO for his update.

CoG20/009 **Updates from Governor Committees**

a) Membership Development Committee

Gavin Maxwell, chair of the Membership Development Committee, reported that at the last meeting there had only been three members present and, whilst the meeting was still quorate, it would be nice to see

more Governors engage with the work of the committee. He said that the principle topic of discussion had been local transport services and bus timetables, and that he was discussing this further with the West Dorset Western Area Transport Action Group. Mrs Alsop added that the committee was hoping to revive plans to engage with younger members and to link this with the hospital's young volunteer programme.

The Chair thanked Mr Maxwell for his update, and asked Governors to contact the Deputy Trust Secretary if they wished to fill any of the vacancies on the committee.

CoG20/010 **Date of Next Meeting**

The date of the next meeting open to the public was scheduled for 2pm, Monday 11 May 2020, Children's Centre Seminar Room, DCH.

The Chair thanked everyone for their attendance and closed the meeting.

Council of Governors Meeting – 3 February 2020 Part One

Minute	Action	Owner	Timescale	Outcome
CoG20/005	The outcome of the review of criteria relating to community hospital beds access to come back the Governors when this was available.	IR (AT)	When available	**Closed.** All actions to be closed at this point, as superseded by the pandemic. Governors may request to reopen actions should they come up in the course of future Governor business.
CoG20/005	How Governors could support the hospital on the demand/capacity/funding issue, for example through lobbying on a national level, to be discussed further.	LB		
CoG20/005	The Chief Executive to provide an update in her next report as to whether the ASD Service had been raised at with the Integrated Care System (ICS) Senior Leadership Team (SLT) (action CoG19/054).	IR to PM	May 2020	
CoG20/005	Figures on the ASD service waiting list to be circulated to all Governors.	IR	Feb 2020	
CoG20/008	The CIO to link with Davina Smith regarding the potential use of the DCR at Weldmar Hospicecare.	SS	Feb 2020	
CoG20/008	Dorset Care Record presentation slides to be circulated to all Governors.	LB	Feb 2020	**Complete.** Circulated by email to all Governors 05 02 2020.
CoG20/008	The DCR presentation slides to be amended to clarify it is not the CCG as an organisation that has access to patient records, but the GP members of the CCG.	SS	Feb 2020	**Complete.** Amendment made.

Title of Meeting	**Council of Governors**
Date of Meeting	**Monday 7 September 2020**
Report Title	**Lead Governor Interim Arrangements**
Author	Trevor Hughes, Head of Corporate Governance

Purpose of Report (e.g. for decision, information)
For approval.

Summary

Lead Governors are required by NHS Improvement (NHSI) so that they can have a Governor with whom to communicate - without going through the Chairman or Trust Secretary - if there are problems in a Trust. The functions of Lead Governor, as defined by NHSI, are very narrow. However, in addition to these statutory duties the Lead Governor role at the Trust includes a range of other duties which are listed in the Lead Governor Role Description, as agreed by the Council of Governors in August 2018.

David Cove's current term as Lead Governor runs from 1 October 2019 to 30 September 2020. Following the pause to the Governor elections David's current term as a Public Governor for West Dorset ends on 30 September 2020 and he is currently seeking re-election in the 2020 Governor Election.

Due to the pausing of the Governor Election process, we will need an interim arrangement in 2020 to enable Governors to complete the selection process for a Lead Governor after the 2020 Governor Election process has finished on 1 October 2020.

The Council of Governors is asked to approve the recommendations for the following two scenarios:

Scenario One: if David Cove is re-elected in the 2020 Governor Election to his West Dorset seat, David's term as Lead Governor is extended to 9 November 2020 when the Governors will ratify the outcome of the Lead Governor selection process at the Council of Governors' meeting.

Scenario Two: if David Cove is not re-elected in the 2020 Governor Election to his West Dorset seat, the Governors agree that the Chairman will appoint an interim Lead Governor to cover the period 1 October 2020 to 9 November 2020, when the Governors will ratify the outcome of the Lead Governor selection process at the Council of Governors' meeting.

In either scenario, the process for the selection of a Lead Governor will commence in early October and end with the ratification of the selection at the Council of Governors' meeting on 9 November 2020. The 2020/21 term for the Lead Governor will run from 9 November 2020 to 30 September 2021, to bring the term back in line with the usual arrangement.

Freedom of Information Implications – can the report be published?	Yes

Recommendations	The Council of Governors are asked to approve the recommendations for arrangements for an interim Lead Governor as detailed in the two scenarios above.

Title of Meeting	**Council of Governors**
Date of Meeting	**7 September 2020**
Report Title	**Finance Report**
Author	Rebecca King, Deputy Director of Finance
Responsible Executive	Paul Goddard, Director of Finance and Resources

Purpose of Report (e.g. for decision, information)
For information

Summary
Dorset County Hospital NHS FT (DCHFT) has delivered an income and expenditure surplus of £0.205 million for the 12 months ending 31 March 2020 against a planned break-even position, resulting in a favourable variance of £0.205 million. Within this position is funding of £0.845 million to cover additional costs relating to Covid-19 and £2.5 million of additional CCG funding to support achieving the control total.

The cash balance at 31 March 2020 was £7.335 million.

Capital expenditure was £7.237 million against a plan of £5.430 million for the year.

Paper Previously Reviewed By
Paul Goddard, Director of Finance and Resources

Strategic Impact
The Trust Strategy was to deliver an Income and Expenditure breakeven position for the financial year 2019/20.

Risk Evaluation
The Trust achieved its financial plan target for the 2019/20 year
.

Impact on Care Quality Commission Registration and/or Clinical Quality
As above

Governance Implications (legal, clinical, equality and diversity or other):
As above

Financial Implications
The Trust has performed above plan for the 12 months ended 31 March 2020.

Freedom of Information Implications – can the report be published?	Yes
Recommendations	a) To review and note the financial position at 31 March 2020

COUNCIL OF GOVERNORS FINANCE REPORT FOR 12 MONTHS ENDED 31 MARCH 2020

	Plan YTD £m	Actual YTD £m	Variance £m
Income	194.7	209.3	14.6
Expenditure	(194.7)	(209.1)	(14.4)
Surplus / (Deficit)	**(0)**	**0.2**	**0.2**

1. YEAR TO DATE VARIANCE

1.1 The income and expenditure position at the end of the year is a surplus of £0.205 million against a plan of break even, resulting in a favourable variance of £0.205 million.

1.2 Income levels were £14.6 million higher than plan, with income from patient care activities over achieving by £13.3 million. The most significant parts of this was funding from NHS England to cover the increased employer pension contributions in the year and the £2.5 million system support referred to above. All other income was £1.3 million above plan for the year.

1.3 Pay costs were £10.4 million more than plan for the year. Agency expenditure remained high and exceeded the cap level (set by NHS Improvement) due to vacancies and additional beds open to meet the demands of the ongoing operational pressures. There were also additional costs due to Covid19 and the £5.258 million for the additional pension provision referred to above.

1.4 Operating non-pay costs were £4.4 million ahead of plan for the year, primarily as a result of high drugs costs, outsourced service costs for backlog clearance initiatives, the apprenticeship levy funded training costs (for which there is an offset in income) and additional costs due to Covid19.

1.4 The pay costs and non-pay costs within expenditure were partially offset by a £0.4 million reduction in PDC.

2. CASH

2.1 At the end of March, the Trust held a cash balance of £7.335 million which is £6 million ahead of the planned position, due to improved management of the Trust's working capital position.

3. CAPITAL

3.1 Capital expenditure in the year to 31 March 2020 was £7.237 million, which was £1.807 million above the plan but in line with forecast for the year. The increased expenditure was funded from national funding received for the new

CT scanner of £1.460 million and other schemes linked to Covid19, Endoscopy and IT systems.

4. COST IMPROVEMENT PROGRAMME

4.1 The Trust had set a CIP target for 2019/20 of £7.130 million which equated to 3.7% of annual turnover.

4.2 The Trust delivered £5.711 million of CIP schemes in the year, of which £3.884 million were delivered recurrently.

Title of Meeting	**Council of Governors**
Date of Meeting	**7 September 2020**
Report Title	**Finance Report to 30 June 2020**
Author	Rebecca King, Deputy Director of Finance
Responsible Executive	Paul Goddard, Director of Finance and Resources

Purpose of Report (e.g. for decision, information)
For information

Summary

As a result of the COVID19 pandemic there have been a number of changes to the national finance regime to ensure Trusts have sufficient funding during the initial response period. These changes include trusts being paid fixed income each month at an amount designed to cover expected costs. In addition, trusts can claim for reimbursement of any excess costs that have been incurred (including those relating directly to the COVID19) via Retrospective Top Up funding.

This financial regime is in place for the period April to September 2020, during which trusts are expected to achieve a break even position each month.

This report summarises the Trust's financial performance for the three months ended 30 June 2020, against the planned break even position for the period.

For the three months ended 30 June 2020, Dorset County Hospital NHS Foundation Trust (DCHFT) has delivered a residual deficit of £0.074million against the NHSI plan which relates to donated asset depreciation which is not eligible for 'Retrospective Top Up' funding.

The cash balance at 30 June 2020 was £21.7 million.

Capital expenditure was £1.745 million including £1.144 million of capital expenditure relating to the COVID19 response for which capital funding is being sought from NHS England.

Paper Previously Reviewed By
Paul Goddard, Director of Finance and Resources

Strategic Impact
NHS England is supporting trusts through the period of the COVID19 response to achieve a break even financial position, excluding amounts relating to donated asset income and depreciation.

Risk Evaluation
There is a risk that the additional funding sought by the Trust to achieve a break even

position will not be paid in full by NHS England.	
Impact on Care Quality Commission Registration and/or Clinical Quality As above	
Governance Implications (legal, clinical, equality and diversity or other): As above	
Financial Implications Failure to deliver a balanced financial position could result in the Trust being put into special measures by NHSI.	
Freedom of Information Implications – can the report be published?	Yes
Recommendations	a) To review and note the financial position at 30 June 2020

COUNCIL OF GOVERNORS FINANCE REPORT FOR 3 MONTHS ENDED 30 JUNE 2020

	Plan YTD £m	Actual YTD £m	Variance £m
Income	51.4	53.1	1.7
Expenditure	(51.4)	(53.2)	(1.8)
Surplus / (Deficit)	**(0)**	**(0.1)**	**(0.1)**

1. YEAR TO DATE VARIANCE

1.1 The income and expenditure position at the end of the first quarter is a deficit of £0.074 million against a planned break even position, resulting in an adverse variance of £0.074 million.

1.2 Income levels were £1.759 million higher than plan, predominantly due to the receipt of the additional Top Up funding as mentioned above. Private patient income is behind plan.

1.3 Pay costs were £2.5 million more than plan for the quarter of which 2.2 million related to additional COVID19 expenditure incurred.

1.4 Operating non-pay costs were £1.1 million less than plan for the quarter, primarily as a result of low elective activity and bed occupancy during the first three months.

1.5 Depreciation and PDC Dividend costs were higher than plan by £0.3 million for the quarter.

2. CASH

2.1 At the end of June, the Trust held a cash balance of £21.7 million which is £17.4 million ahead of the planned position, due to the cash regime introduced by NHS England during the COVID19 response period. In April the Trust received two months' worth of "block" contract income monies paid in advance on contracts.

3. CAPITAL

3.1 Capital expenditure in the quarter to 30 June 2020 was £1.745 million. Of this amount £1.144 million relates to capital expenditure as part of the COVID19 response, including infrastructure works to extend ITU capacity, additional clinical equipment and IT costs to support remote working. Capital funding for these costs is being sought from NHS England.