Leicestershire County Council

Meeting: **Leicestershire, Leicester and Rutland Health Overview and Scrutiny Committee**

Date/Time: **Friday, 3 July 2020 at 10.00 am**

Location: **Microsoft Teams video link.**

Contact: **Euan Walters (0116 3052583)**

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Membership

Dr. R. K. A. Feltham CC (Chairman)

Cllr. T. Aldred	Mr. J. Morgan CC
Cllr. P. Chamund	Cllr. D. Sangster
Cllr. L. Fonseca	Mrs B. Seaton CC
Mr. T. Gillard CC	Micheal Smith
Mrs. A. J. Hack CC	Janet Underwood
Dr. S. Hill CC	Cllr. P. Westley
Cllr. P. Kitterick	Mrs. M. Wright CC
Cllr. M. March	

Please note: The Leicestershire, Leicester and Rutland Health Overview and Scrutiny Committee meeting on Friday 3 July 2020 at 10:00am will not be open to the public in line with Government advice on public gatherings.

This meeting will be filmed for live or subsequent broadcast via YouTube: https://www.youtube.com/channel/UCWFpwBLs6MnUzG0WjejrQtQ.

AGENDA

Item		Report by	
1.	Minutes of the meeting held on 24 January 2020.		(Pages 5 - 12)
2.	Question time.		
3.	Questions asked by members under Standing Order 7(3) and 7(5).		
4.	Urgent items.		

5.	Declarations of interest.		
6.	Presentation of Petitions.		
7.	Covid-19 - Leicester, Leicestershire and Rutland NHS Response.	Leicester, Leicestershire and Rutland Clinical Commissioning Groups	(Pages 13 - 32)
8.	Prior Year Adjustment to UHL Trust Accounts.	University Hospitals of Leicester NHS Trust	(Pages 33 - 46)
9.	UHL Acute and Maternity Reconfiguration.	University Hospitals of Leicester NHS Trust	

There will be a verbal update from University Hospitals of Leicester NHS Trust.

10. Any other items which the Chairman has decided to take as urgent.

QUESTIONING BY MEMBERS OF OVERVIEW AND SCRUTINY

Members serving on Overview and Scrutiny have a key role in providing constructive yet robust challenge to proposals put forward by the Cabinet and Officers. One of the most important skills is the ability to extract information by means of questions so that it can help inform comments and recommendations from Overview and Scrutiny bodies.

Members clearly cannot be expected to be experts in every topic under scrutiny and nor is there an expectation that they so be. Asking questions of 'experts' can be difficult and intimidating but often posing questions from a lay perspective would allow members to obtain a better perspective and understanding of the issue at hand.

Set out below are some key questions members may consider asking when considering reports on particular issues. The list of questions is not intended as a comprehensive list but as a general guide. Depending on the issue under consideration there may be specific questions members may wish to ask.

Key Questions:

- Why are we doing this?
- Why do we have to offer this service?
- How does this fit in with the Council's priorities?
- Which of our key partners are involved? Do they share the objectives and is the service to be joined up?
- Who is providing this service and why have we chosen this approach? What other options were considered and why were these discarded?
- Who has been consulted and what has the response been? How, if at all, have their views been taken into account in this proposal?

If it is a new service:

- Who are the main beneficiaries of the service? (could be a particular group or an area)
- What difference will providing this service make to them – What will be different and how will we know if we have succeeded?
- How much will it cost and how is it to be funded?
- What are the risks to the successful delivery of the service?

If it is a reduction in an existing service:

- Which groups are affected? Is the impact greater on any particular group and, if so, which group and what plans do you have to help mitigate the impact?
- When are the proposals to be implemented and do you have any transitional arrangements for those who will no longer receive the service?
- What savings do you expect to generate and what was expected in the budget? Are there any redundancies?
- What are the risks of not delivering as intended? If this happens, what contingency measures have you in place?

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Agenda Item 1

Minutes of a meeting of the Leicestershire, Leicester and Rutland Health Overview and Scrutiny Committee held at County Hall, Glenfield on Friday, 24 January 2020.

PRESENT

Dr. R. K. A. Feltham CC (in the Chair)

Mr. D. C. Bill MBE CC	Mr. J. Morgan CC
Mr. J. Dale	Mrs. J. Richards CC
Mr. T. Gillard CC	Micheal Smith
Mrs. A. J. Hack CC	Miss G. Waller
Cllr. P. Kitterick	Mrs. M. Wright CC
Cllr. M. March	

In attendance
Micheal Smith, Manager, Healthwatch Leicester and Leicestershire.
Janet Underwood, Chair, Healthwatch Rutland.
John Adler, Chief Executive, University Hospitals of Leicester NHS Trust (minutes 17 and 18 refer).
Mark Wightman Director of Marketing & Communications, University Hospitals of Leicester NHS Trust (minutes17 and 18 refer).
Andy Williams, Chief Executive, Leicester, Leicestershire and Rutland Clinical Commissioning Groups (minutes 17, 18 and 19 refer).
Richard Morris, Director of Operations and Corporate Affairs, Leicester City Clinical Commissioning Group (minute 17 refers).
Jennifer Fenelon, Chair of Rutland Health & Social Care Policy Consortium (minute 17 refers).
Dr Sally Ruane, Chair of Leicester Mercury Patients' Panel (minute 17 refers).
Sara Prema, Executive Director of Strategy and Planning, Leicester City, West Leicestershire and East Leicestershire CCGs (minute 19 refers).
Ket Chudasama, Director of Performance & Corporate Affairs, West Leicestershire CCG (minute 20 refers).
John Edwards, Associate Director for Transformation, LPT (minute 21 refers).

12. Minutes of the previous meeting.

The minutes of the meeting held on 10 September 2019 were taken as read, confirmed and signed, subject to an amendment recording that Micheal Smith, Manager, Healthwatch Leicester and Leicestershire was present.

13. Declarations of interest.

The Chairman invited members who wished to do so to declare any interest in respect of items on the agenda for the meeting. No declarations were made.

14. Presentation of Petitions.

The Chairman reported that no petitions had been received under Standing Order 35, however a petition had been received in relation to agenda item 6: Acute and maternity reconfiguration therefore it would be considered under that agenda item.

15. Question Time.

The Chairman reported that no questions had been received under Standing Order 34.

16. Urgent Items.

There were no urgent items for consideration.

17. Acute and maternity reconfiguration.

The Committee considered a joint report of the three Clinical Commissioning Groups in Leicester, Leicestershire and Rutland (CCGs), and University Hospitals of Leicester NHS Trust (UHL), regarding the planned 12-week public consultation for proposed investment and changes to the acute and maternity services provided by UHL. A copy of the report marked 'Agenda Item 6', is filed with these minutes as is a supplementary pack containing the appendices to the report.

The Committee was also in receipt of a petition signed by 367 local residents, in the following terms:

> "We the undersigned, are concerned about the ongoing refusal by University Hospitals of Leicester to share detailed information about their plans to reconfigure acute hospital services, which include the closure of the Leicester General Hospital as an acute hospital…We call upon the Leicestershire, Leicester and Rutland Health Overview and Scrutiny Committee to ask for this document to be placed in the public domain now as a condition for future agreement to formal consultation and to consider availing itself of expert advice regarding what the public can reasonably expect and what needs to be in place to ensure there are no grounds for a successful future legal challenge."

The Committee welcomed to the meeting for this item John Adler, Chief Executive, UHL, Mark Wightman Director of Marketing & Communications, UHL, Andy Williams, Chief Executive, CCGs and Richard Morris, Director of Operations and Corporate Affairs, Leicester City CCG.

Arising from discussions the following points were noted:

(i) The responsibility to consult on major service changes fell upon Clinical Commissioning Groups rather than acute providers. The report and documents which members were considering at this point regarded the consultation process which was proposed, not the substance of the proposed changes.

(ii) Concerns were raised by members that the consultation on the acute and maternity reconfiguration was taking place in isolation without the public knowing what the proposals were for other service areas such as Community Services, and it was questioned whether the Community Services Review could become part of the same consultation. In response it was clarified that the Community Services Review

would not be delayed until after the reconfiguration consultation had taken place. The Community Services Review would be taking place at the same time as the consultation on the acute and maternity reconfiguration though the two workstreams were separate and would not be part of the same consultation. The CCGs and UHL were of the view that it was better to progress the acute and maternity reconfiguration rather than delaying until the future of other health services in LLR was more certain. Health services were constantly evolving and their development could not always be perfectly sequenced.

(iii) The CCG clarified that the reason they had brought the consultation document to the Committee at this stage was so that the Committee could help to shape and develop the structure of the consultation. The draft consultation document was currently missing key links, diagrams and financial information and whilst members were in support of the proposed methodology of the consultation, they were reluctant to give assurances regarding the consultation process until the key information was provided. Representatives from UHL and the CCGs were therefore invited to the next meeting of the Leicestershire, Leicester and Rutland Health Overview and Scrutiny Committee to present the completed consultation document.

(iv) The Pre-consultation Business Case (PCBC) had been updated and would be published before the consultation began. In response to requests for the PCBC to be published sooner it was explained that it could not be released until it had been approved by NHS England. It was suggested that the PCBC could have supplementary briefing documents which provided additional information. The CCGs welcomed suggestions from members for the specific topics of those supplementary documents.

(v) In response to concerns about bed capacity at UHL it was explained that whilst the original reconfiguration plans proposed a reduction in the number of beds, it was now proposed to increase the beds by 139. Further details regarding the bed capacity proposals would be available when the consultation commenced. Although the NHS was intending to prioritise investment in primary care, mental health and other community services this did not mean that the acute sector would be smaller.

(vi) In response to concerns that so far there had been insufficient consultation with service users in the maternity department, members were informed that consultation had taken place with the Maternity Voices Partnership but it was acknowledged that more needed to be done not only to engage with mothers of newborn children, but with patients generally across the acute service.

(vii) Reassurance was given that as part of the consultation, engagement would take place with Parish Councils regarding the proposals.

RESOLVED:

(a) That the details of the 12-week public consultation for proposed investment and changes to the acute and maternity services provided by the University of Hospitals of Leicester NHS Trust be noted;

(b) That it be noted that the draft consultation document for the acute and maternity reconfiguration is currently incomplete and missing key information but that the full business case will be published before the public consultation commences.

(c) That it be noted that the Community Services Review will be conducted in parallel with the acute and maternity reconfiguration consultation but that the reconfiguration work will not be dependent on the outcome of the Community Services Review.

(d) That representatives from UHL and the CCGs be invited to a future meeting of the Committee to present a further report regarding the consultation business case when a final version is available.

18. Briefing Paper from the Leicester Mercury Patients' Panel and Rutland Health and Social Care Policy Consortium.

The Committee considered a briefing paper from the Leicester Mercury Patients' Panel and Rutland Health and Social Care Policy Consortium which raised concerns regarding the processes for planning health services for Leicester, Leicestershire and Rutland with particular focus on the NHS Long Term Plan. The Committee also considered a response to the briefing paper from the three Clinical Commissioning Groups in Leicester, Leicestershire and Rutland and University Hospitals of Leicester NHS Trust. Copies of the Briefing paper, marked 'Agenda Item 7', and the response are filed with these minutes.

John Adler, Chief Executive, UHL, Mark Wightman Director of Marketing & Communications, UHL, and Andy Williams, Chief Executive, CCGs remained for this item and the Committee also welcomed Jennifer Fenelon, Chair of Rutland Health & Social Care Policy Consortium, and Dr Sally Ruane, Chair of Leicester Mercury Patients' Panel.

(i) With regard to concerns raised regarding perceived weaknesses in the engagement processes and relevant information being unavailable to the public, it was highlighted that the NHS Long Term Plan was already in the public domain and the local response to the Long Term Plan would be available at the time the consultation started. Members suggested that there could be a briefing document made available to the public which summarised the information already in the public domain regarding confirmed plans for health services in Leicester, Leicestershire and Rutland, and the CCGs agreed to give this consideration.

(ii) Members did not wish to delay the start of the public consultation but wished to ensure the public had sufficient time to read the relevant documents and respond. Therefore it was suggested that the consultation should be extended beyond the proposed 12 week period. In response the CCG stated that extending the consultation would create a delay in the overall programme which was not desirable. Delays could create a cost escalation for the scheme and the values of capital schemes could change and cause operational pressures.

(iii) In response to a suggestion in the briefing paper that Mr Nick Duffin, Fellow of the Consultation Institute could be invited to provide advice to the Committee in person for one hour at no cost, members agreed to give consideration to whether he could be invited to a future meeting.

(iv) The CCGs offered to continue to liaise with Rutland Health & Social Care Policy Consortium, Leicester Mercury Patients' Panel and other interested parties to try and address their concerns.

RESOLVED:

(a) That the contents of the Briefing Paper from the Leicester Mercury Patients' Panel and Rutland Health and Social Care Policy Consortium, and the response from the CCGs and UHL, be noted;

(b) That the LLR Health Overview and Scrutiny Committee will consider the local response to the Long Term Plan in full at a future meeting and will be consulted on the reconfiguration plans as part of the consultation process due to commence at the end of March 2020.

(c) That UHL and the CCGs be requested to consider:

(i) Undertaking further dialogue with Leicester Mercury Patients' Panel and Rutland Health and Social Care Policy Consortium regarding the consultation on the reconfiguration plans;

(ii) Extending the public consultation period to ensure that the public have time to read and understand the proposals before responding to the consultation;

(iii) Creating a briefing document for the public which summarises all the information already in the public domain regarding the proposals which is not subject to change in future so that the public can be informed as much as possible before the business plan is published and the consultation begins.

19. <u>CCG Response to NHS Long Term Plan.</u>

The Committee received a presentation from Better Care Together on the local response to the NHS Long Term Plan. A copy of the presentation slides is filed with these minutes.

The Committee welcomed to the meeting for this item Andy Williams, Chief Executive, and Sara Prema, Executive Director of Strategy and Planning, Leicester City, West Leicestershire and East Leicestershire CCGs.

Arising from discussions the following points were noted;

(i) A full response to the NHS Long Term Plan would be published and considered by the Committee later in the year. The purpose of this agenda item was to highlight key issues to members.

(ii) Conversations had taken place with Local Authority partners regarding the future of health services in Leicester, Leicestershire and Rutland and the feedback had been taken on board. It was noted however that the three upper tier authorities in Leicester, Leicestershire and Rutland had different priorities.

(iii) The outpatient model that was currently in use required updating, and in the future it was intended that follow up appointments would only take place if there was a therapeutic value to them.

(iv) Leicester Royal Infirmary (LRI) was located in an area of poor air quality and the response to the NHS Long Term Plan aimed to move some services away from the

LRI so that there was less congestion in that area of Leicester. A Treatment Centre was being created at the Glenfield Hospital and high volume simple elected procedures would take place there. Two multi-storey car parks would be built on the Glenfield site to deal with the extra demand. However, it was noted that creating additional carparking space only encouraged more people to drive so did not necessarily solve the problems of congestion and air quality.

(v) The CCGs acknowledged that conversations needed to take place with the general public to manage their expectations regarding primary care and improve understanding of what a good service looked like. Patient Care Networks would hopefully enable systems to be standardised across all GP Practices. In future less patients visiting GP Practices would be seen by a doctor and instead greater use would be made of other practitioners like pharmacists.

(vi) Members welcomed the additional appointments which would be available to see a GP in the early mornings, evenings and weekends. However, it was noted that a percentage of appointments at GP Practices were only available to be booked online and not everybody was able to use technology. Reassurance was given that whilst digital technology would be used to improve communication systems in the future, digital was going to be part of the offer not the only offer.

(vii) Members raised concerns regarding patients being triaged at the receptions of GP Practices in front of other patients and it was acknowledged that this was not acceptable.

RESOLVED:

(a) That the CCG response to the NHS Long Term Plan be noted;

(b) That the emphasis on improving access to primary care, and air quality, be welcomed;

(c) That the CCGs be requested to give consideration to how they can make better use of funding provided by developers under Section 106 of the Town and Country Planning Act 1990.

20. <u>Leicester, Leicestershire and Rutland Clinical Commissioning Groups Commissioning Policy for Gamete and Embryo Cryopreservation.</u>

The Committee received a report of Leicester, Leicestershire and Rutland Clinical Commissioning Groups regarding the Policy for Gamete and Embryo Cryopreservation and the four week public consultation which was due to commence. A copy of the report, marked ‘Agenda Item 9’, is filed with these minutes.

The Committee welcomed to the meeting for this item Ket Chudasama, Director of Performance & Corporate Affairs at West Leicestershire CCG.

Arising from discussions the following points were noted:

(i) The Policy proposed that to be eligible for NHS-funded gamete or embryo cryopreservation females could only be up to 42 years old and males up to 55 years old. This was because above those age limits the efficacy of treatment reduced.

(ii) It was queried whether Healthwatch Rutland had been consulted with regarding the Policy and reassurance was given that if they had not yet been consulted they would be immediately.

(iii) A national policy for Gamete and Embryo Cryopreservation could be created in the future but it was thought that the best way of achieving this was to create regional policies first.

RESOLVED:

(a) That the Leicester, Leicestershire and Rutland Clinical Commissioning Group's Commissioning Policy for Gamete and Embryo Cryopreservation be noted;

(b) That the CCGs be requested to ensure that all local Healthwatch organisations are engaged with as part of the four week public consultation which is due to commence.

21. Transforming Mental Health Services.

The Committee considered a report of Leicestershire Partnership NHS Trust (LPT) which provided a high level update on the adult and older people focused mental health programme. A copy of the report, marked 'Agenda Item 10' is filed with these minutes.

The Committee welcomed John Edwards, Associate Director for Transformation, LPT to the meeting for this item.

Arising from discussions the following points were noted:

(i) There was a national target set that by March 2021 there was to be no out of area mental health placements, and LPT were currently within the trajectory to meet that target though it could be difficult to sustain. Some patients required acute care and were placed out of area due to capacity issues within LPT and this could be resolved by improving flow. Other patients were placed out of area because they required specialist placements which were not available in LLR and investment was needed to resolve this issue. It was hoped that with more people receiving treatment in the community in the future there would be less need for specialist placements. In response to concerns raised about whether there would be sufficient capacity to treat patients in the community, reassurance was given that integrating different systems together would increase capacity. Furthermore, there was expected to be national investment in mental health which would be targeted towards community services.

(ii) Whilst members approved of the plans to cease the use of dormitory accommodation at the Bradgate Unit and replace with individual bedrooms, concerns were raised that this would reduce the overall capacity of the unit. In response it was explained that there was a three year plan for the dormitories and in the first year there was not expected to be a loss in capacity because extra space had been found within the unit for beds, however in the following two years there could be a reduction in capacity.

(iii) There was an engagement strategy in place regarding the service changes and each service change would have a specific engagement plan. Healthwatch would be supporting the wider engagement work.

(iv) From July 2020 people would be able to refer themselves to the crisis service and this would be open to everybody not just patients already known to LPT. It was hoped that this new system would reduce the amount of people attending the Emergency Department with mental health issues. If patients did attend the Emergency Department in a mental health crisis standards would be in place which required them to be seen and assessed within one hour. In response to concerns that the self-referral system would be overloaded reassurance was given that it had been modelled on other self-referral systems already in use and the lesson learnt from those other systems was the take up of the service was not as high as expected.

RESOLVED:

That the update on the adult and older people focused mental health transformation programme within Leicestershire Partnership NHS Trust and the changes that are planned in 2020 be noted.

22. Date of next meeting.

The Chairman noted that the next meeting was scheduled to take place on 18 March 2020 at 10:00am however this coincided with a meeting of the A&E Delivery Board which meant that some NHS representatives would be unable to attend both meetings.

RESOLVED:

That officers be requested to circulate an email to all Committee members asking them to provide feedback on proposed options for rearranging the 18 March 2020 meeting.

10.00 am - 1.50 pm
24 January 2020

CHAIRMAN

Agenda Item 7

COVID - 19

Leicester, Leicestershire and Rutland NHS Response

Report to Leicester, Leicestershire and Rutland Joint Health Overview and Scrutiny Committee

1. Introduction

1.1 The initial phase of the NHS response to COVID - 19 commenced on 30th January with the declaration of a Level 4 National Incident. Following the World Health Organisation's declaration of a global pandemic on 12 March, on 17th March, the NHS initiated what has been described by NHS England and Improvement as the fastest and most far reaching repurposing of NHS services, staffing and capacity in its 72-year history.

1.2 This response has been unprecedented and necessary to deal with is one of the biggest international challenges faced in a generation. In Leicester, Leicestershire and Rutland (LLR) the total number of confirmed cases stood at 2,451 as at 24th June. Sadly 772 LLR residents have lost their lives, either in LLR hospitals or elsewhere.

1.3 The need to adapt and respond to the COVID - 19 epidemic has permeated all aspects of NHS services. As this paper highlights, to control the spread of the virus and protect patients, we have had to temporarily redesign how some services are accessed and provided or, in some cases, pause services in the interests of protecting patients and staff, to focus on the anticipated demand to support COVID – 19 cases.

1.4 Overall, the NHS in LLR has coped well under intense pressure as we went through the peak period during April. All patients who needed intensive treatment and support received the care they needed.

1.5 We need to learn lessons, with partners, on from is that the NHS has coped well in response to COVID – 19. In partnership with other agencies in LLR through the joint response arrangements established to manage the incident, the NHS has coped well, notwithstanding the tragic loss of life.

1.6 The hard work and commitment of NHS staff and key workers in other agencies has been instrumental and should also be acknowledged. They have worked through the most challenging of periods with such high levels of dedication, professionalism and commitment to look after the people of Leicester, Leicestershire and Rutland.

1.7 We should also acknowledge the role of the public in the positive response to social distancing guidance which has also helped to protect the NHS.

1.8 This paper describes the NHS response to COVID - 19 in LLR. It provides details of the arrangements for managing the incident, the actions taken and the priorities going forward as we enter the recovery phase.

2. Initial Phase

Planning arrangements

2.1 NHS organisations began preparations for managing COVID - 19 in January 2020, setting up a Health Economy Tactical Coordination group (HETCG) to coordinate the health response in LLR.

2.2 On 24th March, the COVID–19 outbreak was declared a Level 4 national emergency and in response a Major Incident was declared locally. NHS arrangements were integrated within the LLR Local Resilience Forum (LRF) governance and incident management structure under the strategic leadership of Leicestershire Police.

2.3 Within the LLR NHS the Health Economy Strategic Control Group (HESCG) has overall responsibility for the multi-agency management of the incident and to establish the policy and strategic framework within which lower tier command and coordinating groups work. Representatives on the HESCG are senior leaders within the NHS and other organisations including Local Authorities. It is chaired by the Chief Executive of the three LLR CCGs and the CEOs of other NHS organisations are also members.

2.4 The Health Economy Tactical Co-ordination Group (HETCG) is responsible for:

- Coordinating the preparation for, response to, and recovery from any outbreak of COVID - 19;
- Implementing the direction and guidance received from the HESCG, LLR CCGs, NHS England and Improvement Incident Management Centre; and
- Ensuring close partnership working with multi-agency partners through the LRF Tactical Coordination Group and the HESCG.

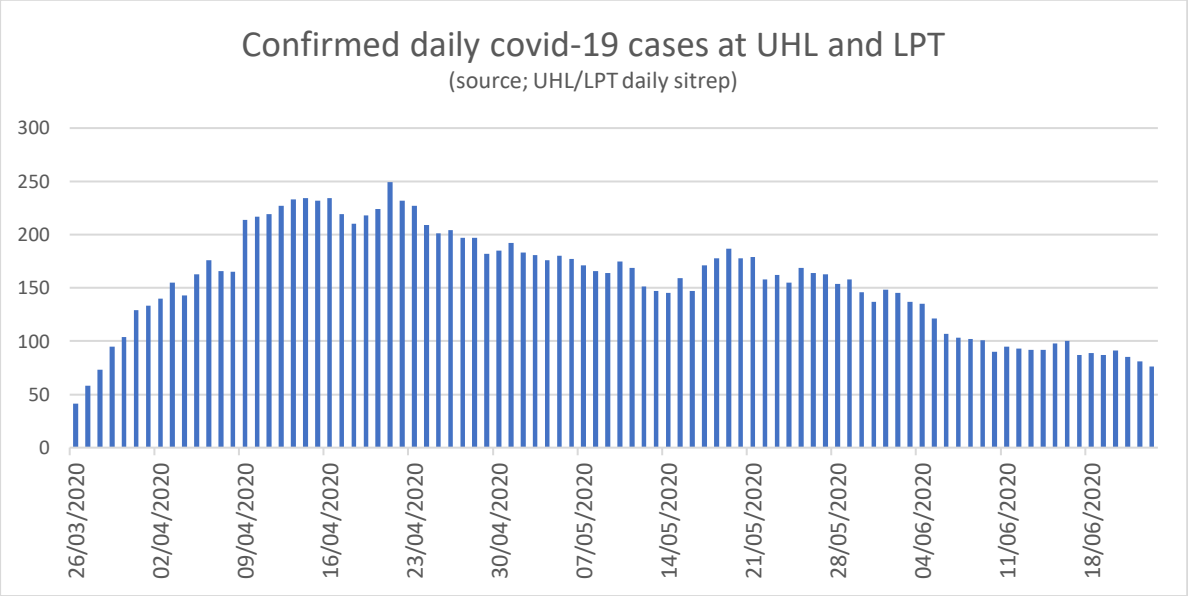
2.5 Supporting the HETCG are 13 tactical cells, each leading the operational response for an organisation or function/activity perspective. The governance structure is at Appendix 1

2.6 Daily situation reports (Sitreps) and tactical cell updates/escalations are discussed at HETCG conference calls. This ensures visibility across the NHS and social care system and ensures any cross - organisational responses can be actioned. The Daily Sitrep covers:

- Capacity at University Hospitals Leicester and Leicestershire Partnership NHS Trust
- ITU/HDU and other bed capacity
- Mortuary capacity
- workforce absences/impact and resilience/wellbeing
- PPE availability/supplies
- Primary care capacity/service levels
- Deaths, suspected and confirmed cases of Covid
- Care home and community resilience and well-being

The latest daily Sitrep up to 24 June is given at **Appendix 2**

2.7 The table below shows the number of confirmed daily cases in UHL and LPT. As can be seen the number of daily cases peaked from 9th April to 26th April when was regularly between 200 and 250 patients.



2.8 The actions we took as a system and the efforts of colleagues directly providing care ensured we maintained capacity and were not overwhelmed.

Actions taken by the local NHS partnership

2.9 Action taken by NHS organisations in the initial phase focussed on increasing capacity to prioritise care for COVID -19 patients and ensure guidance on infection prevention and control was strictly followed. This involved redesigning some services to ensure they could be delivered safely, protecting patients and staff through reductions in face to face contacts and consultations - including stepping up the use of technology, and suspending some elective services.

2.10 It should also be noted that despite these changes the NHS remained open to patients with non-COVID related emergencies or urgent care needs because of the measures being taken to separate COVID and non – COVID patients. For example, using online or telephone consultations (see examples below).

2.11 Specific examples of the actions taken include:

- Increasing critical care capacity in UHL. Critical care beds increased from 50 to 150, with the potential to create around 300 beds.

- Temporary changes to LRI's Adult's and Children's Emergency Departments at UHL. Now split into two separate areas: Blue department - for patients without symptoms of COVID - 19 and The Red Department - for patients with symptoms of COVID – 19.

- All non-urgent elective activity paused at UHL. When clinical necessary and appropriate some non - face to face appointments were held.

- Health and social care working jointly to implement effective arrangements to ensure clinically fit patients can be safely discharged from hospital settings.

- In Leicestershire Partnership NHS Trust action was taken to increase community hospital in-patient capacity by up to 70% for step down patients and end of life care, including the phased introduction of 75 Independent sector beds and up to an extra 72 beds on additional LPT wards. Overall community beds could increase from 222 to around 350. More temporary changes are being undertaken in community inpatient facilities to establish additional capacity to meet any further COVID-19 related surge and create Covid secure wards

- Temporary changes to mental health services including: a new Mental Health Urgent Care Hub to assess urgent mental health patients to reduce demand at the emergency department at LRI; a Mental Health Central Access Point providing a24hour 7 day phone support for the public, including those who have not used mental health services before; and a new community based mental health rehabilitation offer to support people with longer term mental health illness outside of an inpatient setting

- Introduction of remote triage in GP practices (via telephone or online) and option of video or online consultations. This has enabled practices to continue to meet the needs of their patients and provide non-COVID - 19 related care, whilst reducing the risk of infection by minimising face to face contact. Currently all patients are remotely triaged and offered either telephone or video consultations and 65% are offered an online consultation.

- Around 800 patients with heart failure or the lung condition COPD have benefitted from the use of telehealth by Leicestershire Partnership NHS Trust, enabling them to remotely monitor their condition and connect to a team of specialist nurses for a video consultation.

- Video/virtual outpatient appointments at UHL piloting video consultations in areas as broad as haematology, dermatology and general surgery. The Trust also set up a virtual Diabetes clinic experience to enable video consultations and care and support to continue. In May, over 900 online consultations were held.

- Reducing the number of sites providing urgent care to minimise the movement of patients and consolidate clinical staff. All out of hours face to face consultations delivered from Loughborough Urgent Care centre and the creation of ‘hot hubs’ at Loughborough Urgent Care Centre, Oadby and New Parks health centre to see COVID - 19 symptomatic patients: and

- The restriction of visiting arrangements which we fully acknowledge was deeply upsetting for relatives and friends unable to visit their loved ones. Alternative

arrangements were put in place for example the use of iPad to allow video calls to relatives on wards, and messaging/card services.

3. System Recovery

Ongoing incident management

3.1 At the time of writing the UK Government has just declared that the COVID - 19 Alert level has been reduced from level 4 to level 3. NHS England and Improvement has, however, determined that the NHS remains at level 4 for the purpose of ongoing management of the response.

3.2 We are retaining our arrangements for incident management, ensuring the NHS is in a strong position to respond to changes in the prevalence of COVID - 19 and the impact on NHS services. The joint working, particularly between health and social care, has supported more holistic approaches to decision – making, enabling rapid action to be taken to resolve problems, and in many cases creative solutions to long-standing challenges.

3.3 We need to continue to be fully aware of the potential impact of the measures to ease lockdown and will be working closely with local authority colleagues as they develop outbreak plans. Close working with public health colleagues is essential to understand the prevalence of Covid -19 and the potential for 'local hotspots.

3.4. This will include surge exercises to test the system ability to manage different scenarios over the coming months; this will need to consider the likely phased approach to social distancing and any potential peaks in COVID - 19 cases going forward together with normal surge planning events such as winter flu and bad weather.

3.5 Underpinning everything as we go forward will be infection, prevention and control (IPC); NHS England and improvement have made explicit the aim that no patient or staff member should catch COVID - 19 NHS healthcare facilities.

3.6 Like the general population, the NHS will be operating in a world with Covid -19 for the foreseeable future.

3.7 For patients there are now requirements when attending hospital sites to wear face coverings. Visiting restrictions remain in place, but we will review them. NHS Trusts fully acknowledge the difficulties and distress this has caused but we need to continue to protect patients and the public.

3.8 All sites are undertaking risk assessments and audits to ensure they meet the rigorous standards for infection control and social distancing.

3.9 Some of the changes introduced to support our response to Covid – 19 will remain in place where necessary to protect patients and staff.

Infection prevention and control (IPC)

3.10 NHS organisations must ensure the consistent application of Public Health England PHE/NHS IPC guidance. This includes separating/'cohorting' COVID

and non COVID patients. Any services restored will have to be assessed against the new guidance to ensure a safe restart.

3.11 The safety of patients and staff is paramount, and this may lead to some difficult decisions being made about services in the short term. For example, the recent decision to temporarily suspend inpatient facilities at Fielding Palmer Hospital following a review of infection, prevention and control was taken to protect patients and staff.

PPE

3.12 In LLR NHS we faced some challenges with the availability of PPE as was the case nationally. At times stocks of items ran low and it took some time before the supply process worked effectively.

3.13 Mutual aid within the NHS in LLR and with neighbouring Trusts in other areas resolved the situation when necessary but was clearly not sustainable. Once the national supply chain was working effectively, including a central portal for ordering, the situation has largely been resolved but maintaining vigilance on stocks and supplies is essential going forward. We continue to monitor stocks through the daily sitreps.

Care homes

3.14 The joint working arrangements between health and social care has ensured robust support is available to care homes.

3.15 During the earlier stages of the outbreak it should be acknowledge that there were some significant challenges facing care homes: discharge of patients without a negative COVID test, the availability of appropriate isolation facilities for caring for COVID - 19 infected patients, clinical support, shortages of PPE and resilience of staff and impact of staff sickness on capacity all impacted on care homes.

3.16 To support care homes, health and social care have now established processes for the safe discharge of patients to care homes and support arrangements to ensure resilience in homes in response to staff shortages, for example. Training on Infection Prevention and Control and clinical leads to support care homes are also now in place.

3.17 The joint working between health and social care to support care homes will continue as will ongoing monitoring of care home resilience.

Testing and tracing

3.18 The test and tracing service ensures that people who develop symptoms of (COVID-19) can be tested to find out if they have the virus, and also includes targeted asymptomatic testing of NHS and social care staff and care home residents.

3.19 It also helps trace close recent contacts of anyone who tests positive and, if necessary, notifies them that they must self-isolate at home to help stop the spread of the virus.

3.20 Tests are carried out at the testing centre set up at Birstall Park and Ride and through Mobile Testing Units (MTUs), visiting various sites around Leicester, Leicestershire and Rutland. There have been visits to 9 mobile testing sites across LLR and further sites are being identified. UHL staff can also have the test at UHL.

3.21 The Birstall site has carried out 28,946 tests from 30th April to 21st June, whilst the MTUs have carried out 8,775 tests during the same period. From the 27th April to 21st June 1,728 staff have been tested for suspected COVID-19.

3.22 Whether symptomatic or not, all non - elective patients are given the test at the point of admission and elective patients are tested within 72 hours of being admitted.

3.23 We are at the beginning of the antibody testing programme to determine if someone has had COVID-19. The prioritisation and rollout plan for antibody testing is in line with national guidance and is currently available for NHS staff in UHL and LPT and primary care. There is an allocation of 1000 tests per day to cover these groups of staff and almost 12,248 UHL and LPT staff had been tested for antibodies to 21st June. On average 433 tests are carried out

3.24 We are working on extending antibody testing to the wider LRF partnership, including whole care home testing and considering options for home swabbing for surgery patients isolating for 14 days prior to surgery.

3.25 It should be noted that having an antibody test will only inform a person they have had COVID-19 and does not change the advice to self – isolate if they are in close contact with someone who has tested positive for COVID-19. There is currently no guarantee that having contracted COVID-19 a person is immune from future infection with COVID-19.

<u>Service recovery and restoration</u>

3.26 As stated above, our focus in the initial response was the need to deal with COVID - 19 related patients, and the action we took, including the cancellation of non-elective treatments and procedures, reflects this.

3.27 Within the next phase we will be seeking a 'safe re-start' of services stood down or reduced during the initial phase. We have a comprehensive picture and understanding of the impact on services and where waiting lists have a significant backlog.

3.28 Our **aim** is that no patients or staff will catch COVID - 19 in our hospitals and both patients and staff must have confidence in the local NHS. The following are six key areas of action and priorities:

3.29 Meeting patient needs

- Covid treatment capacity: maintaining critical care infrastructure (workforce, estates, supply, medicines) that enables readiness for future covid demand, and managing the separation of COVID and non-COVID patients.

- Re-starting non-covid urgent care, cancer, screening, and immunisations, identifying the highest risk services that have had the most impact in terms of population health. This includes recovering service waiting lists and delayed referrals.

- Services have been prioritised including cancer, maternity, cardiovascular disease, heart attacks and strokes, mental health. **Appendix 3** shows the impact of COVID - 19 at UHL on the level of activity in A&E, outpatient attendances, emergency admissions and referrals by GPs for April to mid - June this year compared with last year. We are working as a system to understand the impact of the fall in activity and addressing the backlog. **Appendix 3e** shows the percentage and number of people waiting at various intervals in weeks. There has clearly been an increase in the number and length of time people are waiting and the system is building a complete picture of the impact of this as an anticipated increase in GP referrals takes place.

- Addressing new priorities: the impact of COVID - 19 on public health including identifying additional needs due to the pandemic and considering health inequalities. This specifically includes responding to the clear evidence to have emerged on the disproportionate impact of COVID - 19 on the BAME community. We also anticipate increased demand for mental health services and support due to the economic consequences of COVID -19 such as increased unemployment for example.

- Staff capacity and wellbeing: including capitalising on new ways of working, considering staffing ratios and moving the current expanded workforce to a sustainable footing.

- Working jointly with LRF partners through the Health and Wellbeing Board (HWB) local resources for staff have been developed. The national resources (wellbeing apps) and support for resilience and counselling.

- We must also ensure we work closely with our BAME colleagues within the NHS workforce to ensure we understand their concerns and respond to them. BAME colleagues must have the reassurance and confidence to feel safe carrying out their work. A programme of risk assessments and listening exercises has been undertaken and through the HWB specific resources have been developed for BAME staff.

3.30 Re-set to a new NHS

- We need to retain acute, primary and community service innovations in future models of care. We are cataloguing the service delivery and clinical pathway changes that have worked to assess these in terms of retaining to share and develop further. This is to support the creation of a ‘new norm’ in the NHS. (Please see below for more on service changes). In response to COVID -19 we have innovated and delivered significant change in a short timescale. Many of these changes, where they demonstrate benefits to patients and are clinically and financially viable should be retained.

- We need consider the impact of services in the light of the long term and strategy for health services in LLR. A clinically led set of service expectations to support and underpin the future development of services have been agreed. We will be engaging on staff, public and other stakeholders to seek views and feedback on these.

4. Review of LLR wide service changes

4.1 As stated above, some service changes have been made in response to COVID -19. We have established a baseline of the service changes and are now reviewing each change to determine whether the service should now be returned to its previous state, continued for a further temporary period, or if steps should now be taken to 'lock in' the benefits of these changes by making them permanent.

4.2 Using an NHSE Impact Assessment Tool (IAT) services are being categorised as 'restore' or 'recover'. The IAT, assesses each change for patient safety, clinical effectiveness, and patient outcomes. Where there are no clearly identifiable benefits the change is not viable, and the service will be restored to its pre-COVID position.

4.3 If the IAT identifies benefits and the service change is viable for consideration as a permanent change a further review is required to ensure it aligns with the long-term plan for health services in LLR.

4.4 The IAT process includes the need to engage with stakeholders, specifically OSCs, Healthwatch and the Care Quality Commission and will follow the NHS *Planning, assuring and delivering service change process.* We will also ensure we engage with local people and consult on service changes where applicable.

5. Public and patient engagement and communication

5.1 We will continue to support public health messaging on social distancing, symptom awareness and hygiene. We are working closely with our partners in the LRF agencies to work jointly on public information. We are also ensuring the public is aware of changes to services and how to access them.

5.2 Public confidence in the safety of services is essential. There is national and local concern that some people did not use NHS services because of concerns about safety as well as not wishing to burden a hard-pressed NHS. To encourage patients, we will publicise and make patients aware of the measures being taken to protect them when they use NHS services as well as ensure they know the NHS is open to meet their needs. Patients will also be made aware of the actions they need to take including the new arrangements for wearing face coverings.

5.3 We will continue to issue a regular stakeholder bulletin to highlight developments related to COVID - 19. We are also working closely with community radio stations to target specific communities including BAME audiences. This includes providing messages in different languages. We will also continue to work through

our network of voluntary and community organisations and our Citizen's Panel to communicate and ask for feedback on people's experiences of services.

5.4 We have carried out, with Healthwatch, an online survey of people's experience of primary care and community services. Over 1400 people responded. We are currently analysing these results and will publish them shortly. The insight gained will help us carrying out the service reviews referred to above.

5.5. We would like to acknowledge the positive response of the public to keeping the NHS safe. Social distancing messages have been adhered to, but we fully understand that for many people, particularly those shielding, this has been incredibly difficult.

5.6 The #ClapforCarers has been fantastic and welcomed by the NHS. The show of support from the public has been motivating and heart-warming.

Conclusion

Covid – 19 has been unprecedented. It has had a profound and distressing impact on many in our community. It has also deeply impacted those providing care and support to people who have been ill with the virus. It is important we acknowledge that.

Notwithstanding this the NHS in LLR coped well, in partnership with social care and other agencies. Whilst incredibly challenging at times, the NHS was not overwhelmed.

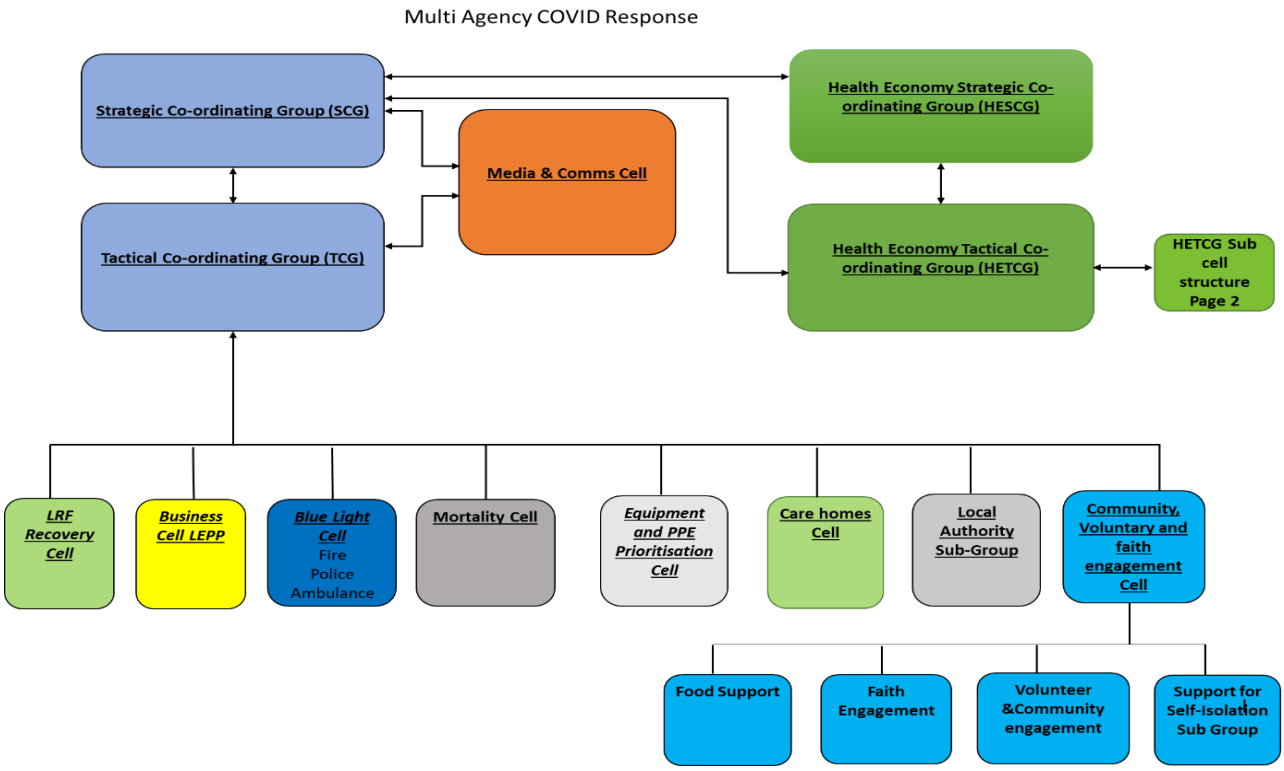
The dedication and commitment of everyone in NHS and our partners should also be acknowledged.

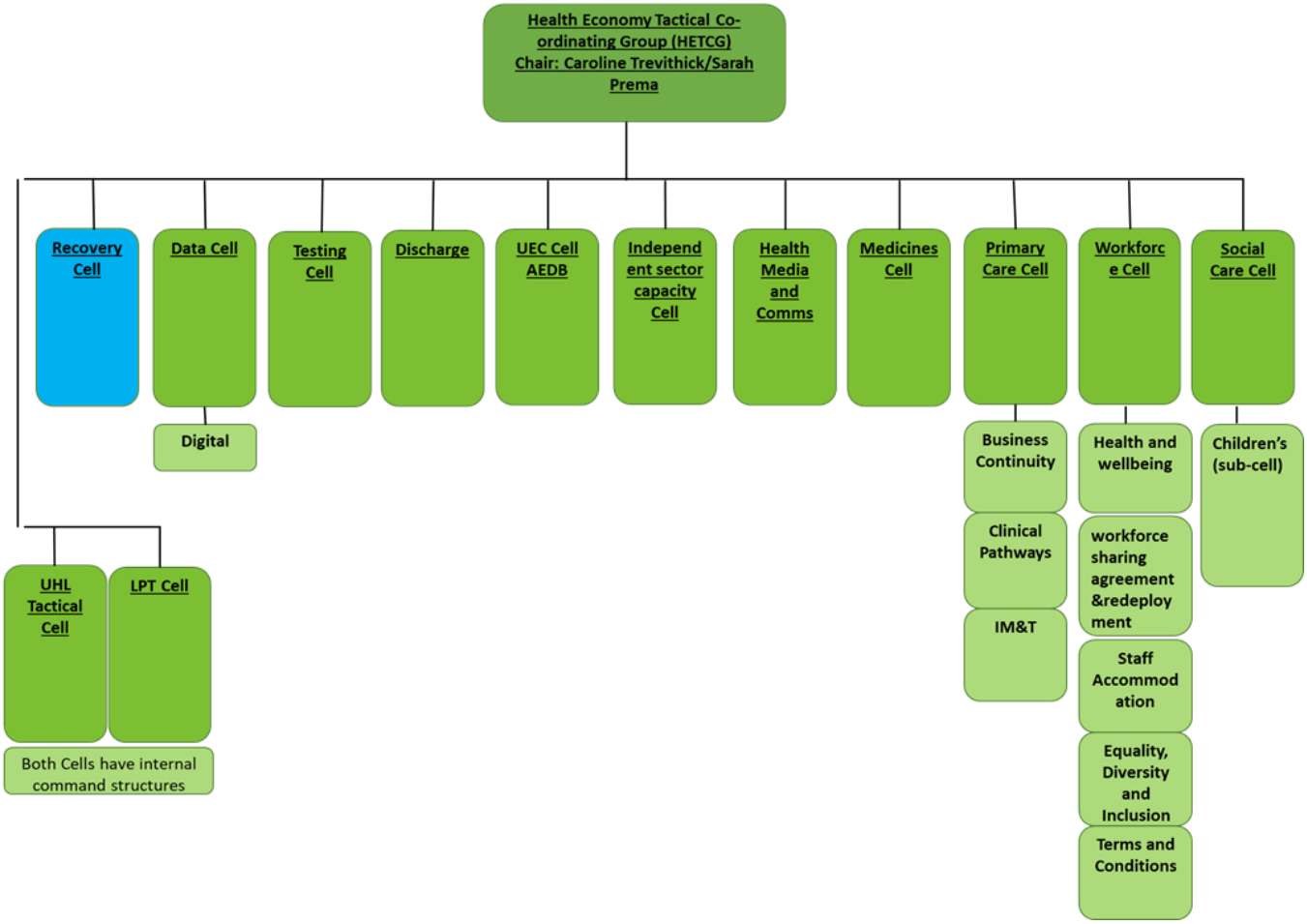
Through effective joint planning and governance, decisions, many of which have led to innovative solutions to longstanding challenges, were taken quickly. It is essential we keep what has worked well where there are demonstrable benefits and improvements to previous service models.

It is also essential that whilst there is currently no vaccine or treatment in place COVID – 19 remains with us so we must continue to be vigilante to the ongoing threat it poses. The response to the outbreak provides us with the infrastructure to do this.

Incident Management Structure

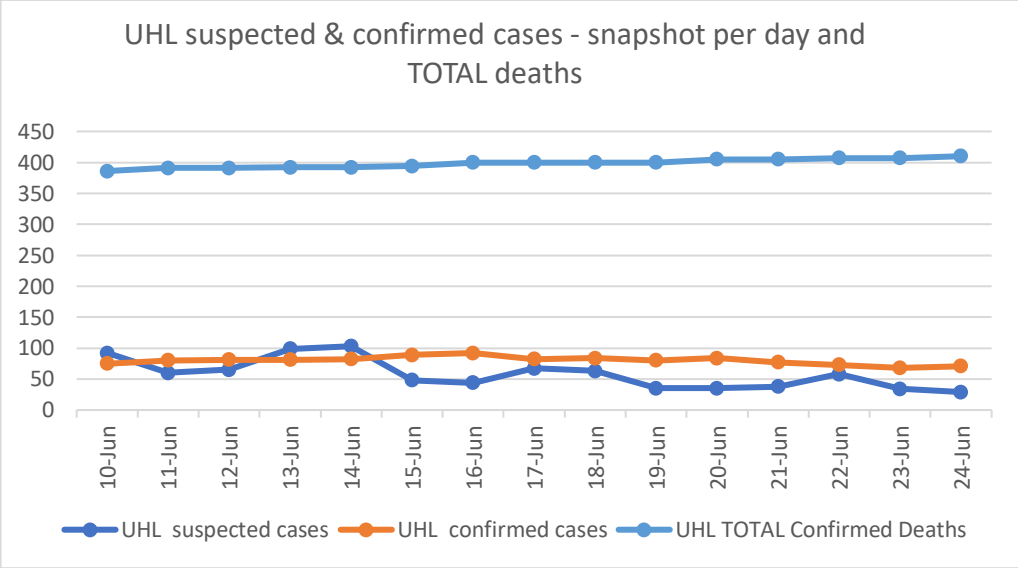
Appendix 1

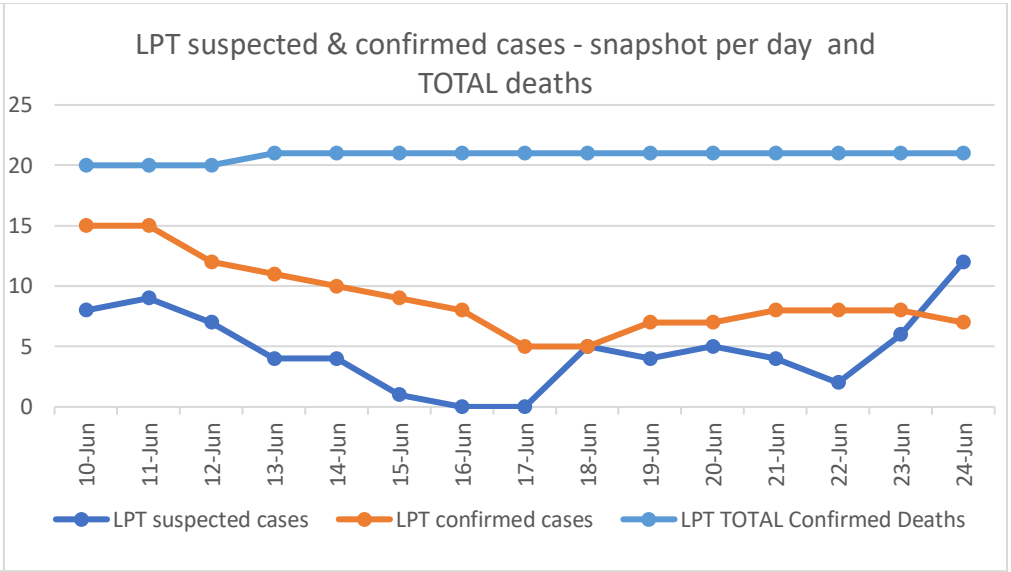


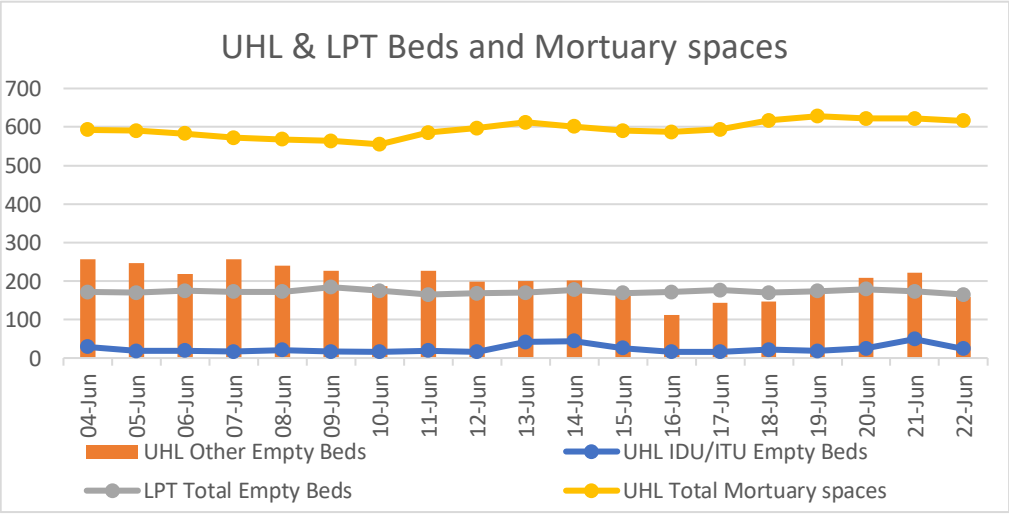

Health Economy Tactical Co-ordinating Group (HETCG) Chair: Caroline Trevithick/Sarah Prema
Recovery Cell
Data Cell
Testing Cell
Discharge
UEC Cell AEDB
Independent sector capacity Cell
Health Media and Comms
Medicines Cell
Primary Care Cell
Workforce Cell
Social Care Cell
Digital
Business Continuity
Clinical Pathways
IM&T
Health and wellbeing
workforce sharing agreement &redeployment
Staff Accommodation
Equality, Diversity and Inclusion
Terms and Conditions
Children's (sub-cell)
UHL Tactical Cell
LPT Cell
Both Cells have internal command structures

Excerpts from Daily Sitrep (up to 22nd June)

Appendix 2a

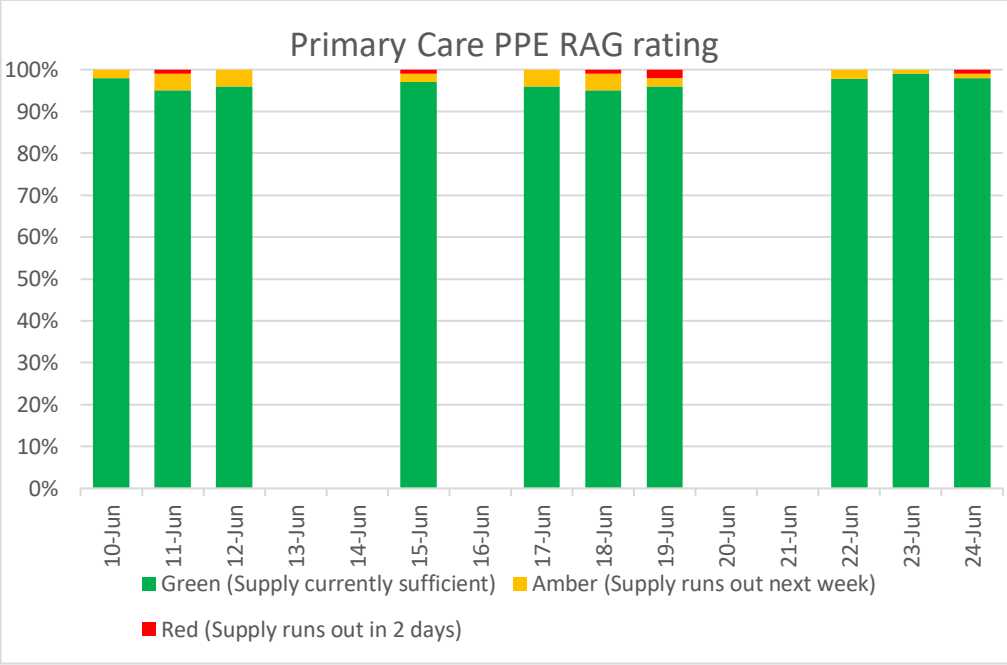


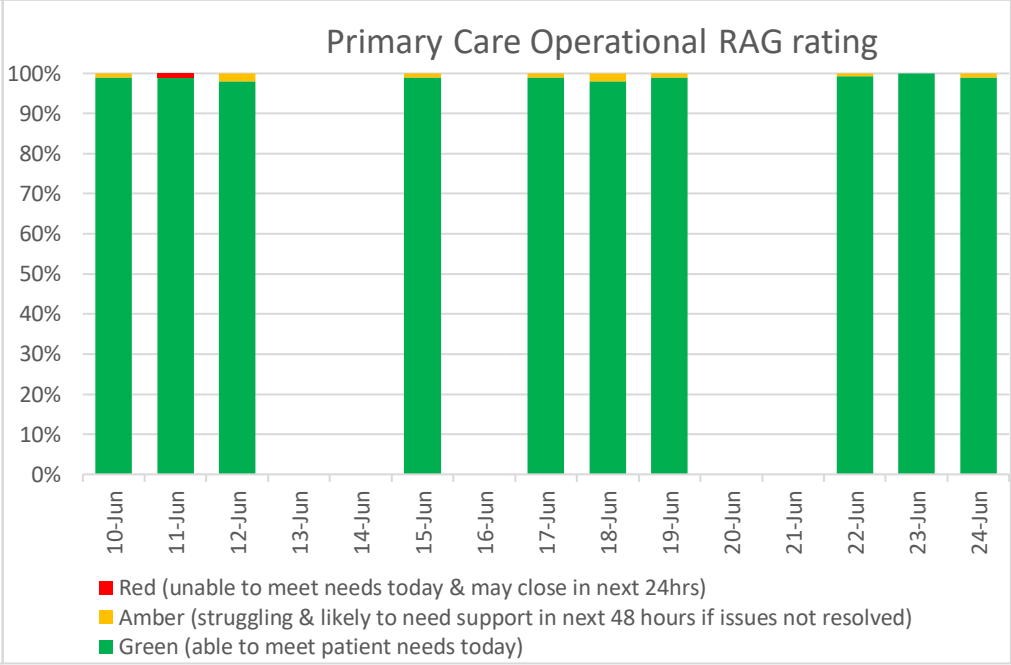




Excerpts from daily Sitrep

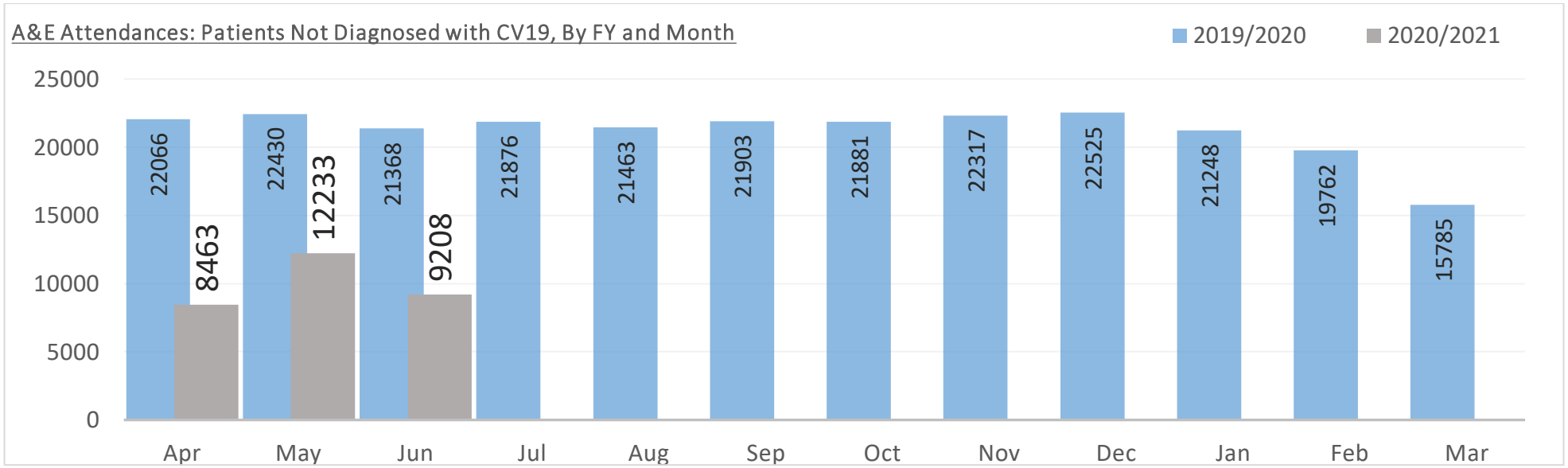
Appendix 2

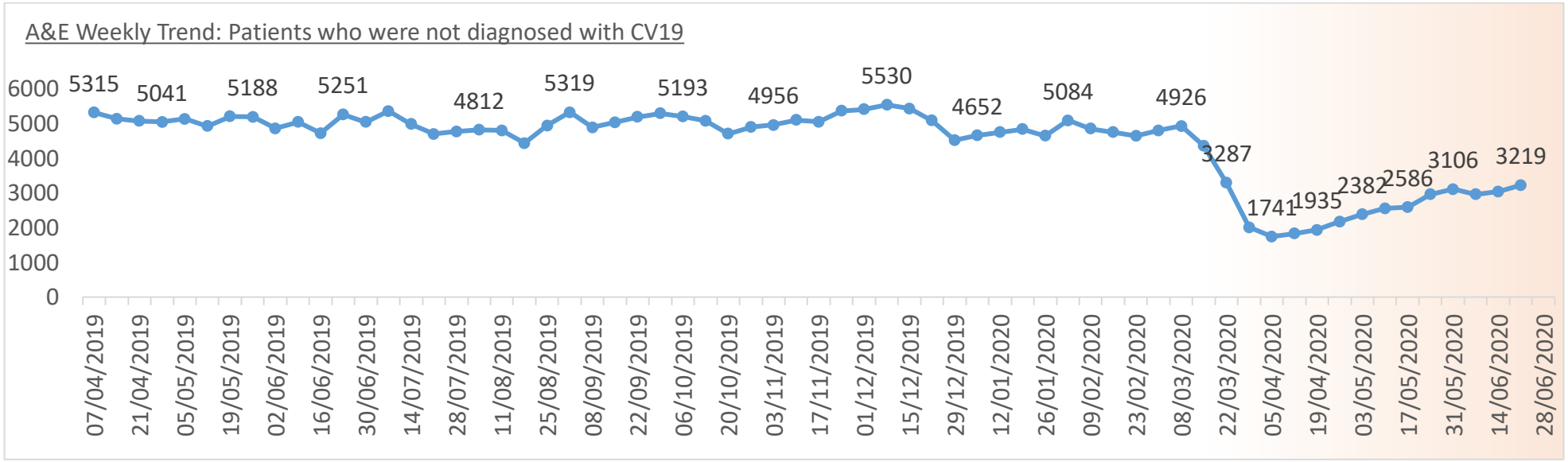




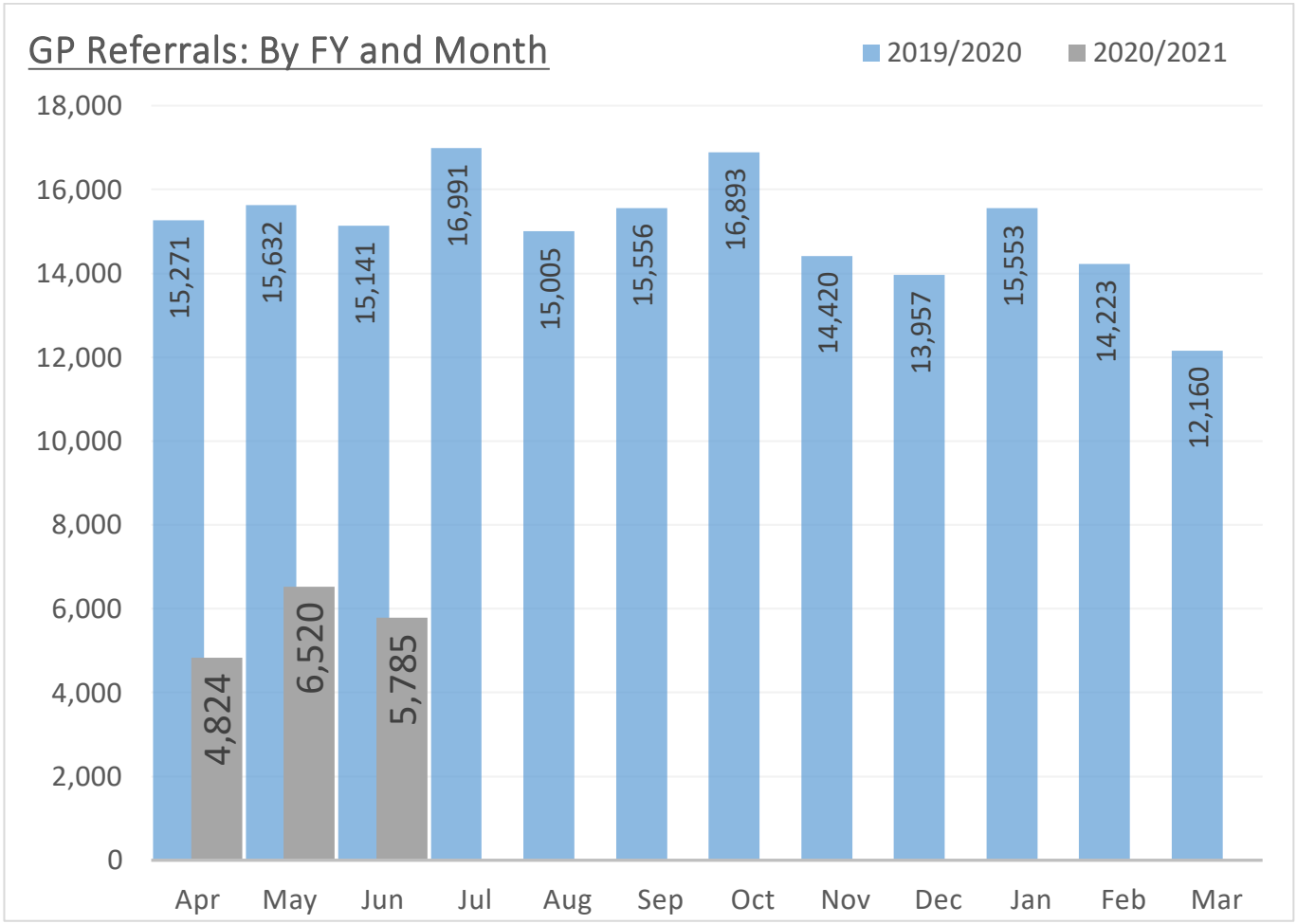
Impact of COVID-19 on UHL activity

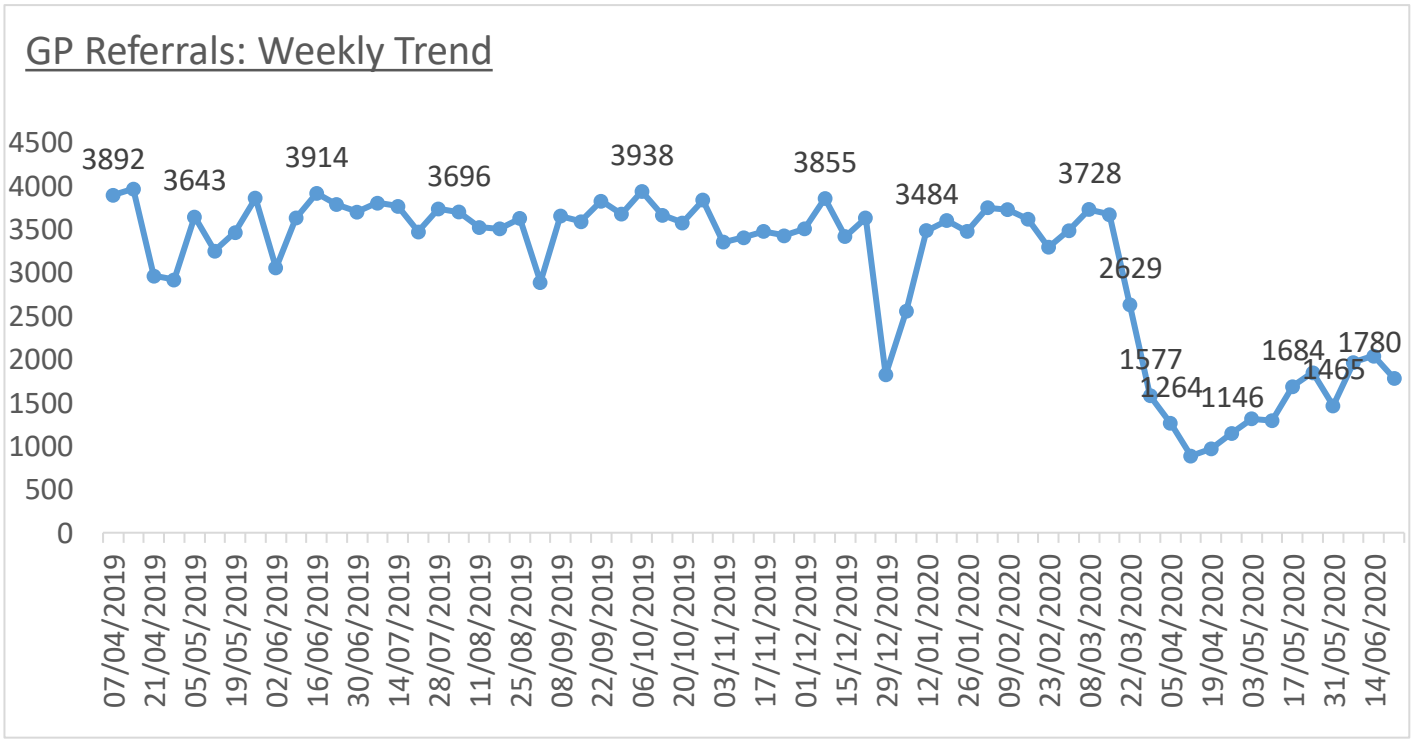
Appendix 3





Appendix 3


GP Referrals: By FY and Month
2019/2020
2020/2021
18,000
16,000
14,000
12,000
10,000
8,000
6,000
4,000
2,000
0
15,271
4,824
15,632
6,520
15,141
5,785
16,991
15,005
15,556
16,893
14,420
13,957
15,553
14,223
12,160
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar


GP Referrals: Weekly Trend
4500
4000
3500
3000
2500
2000
1500
1000
500
0
3892
3643
3914
3696
3938
3855
3484
3728
2629
1577
1264
1146
1684
1465
1780
07/04/2019
21/04/2019
05/05/2019
19/05/2019
02/06/2019
16/06/2019
30/06/2019
14/07/2019
28/07/2019
11/08/2019
25/08/2019
08/09/2019
22/09/2019
06/10/2019
20/10/2019
03/11/2019
17/11/2019
01/12/2019
15/12/2019
29/12/2019
12/01/2020
26/01/2020
09/02/2020
23/02/2020
08/03/2020
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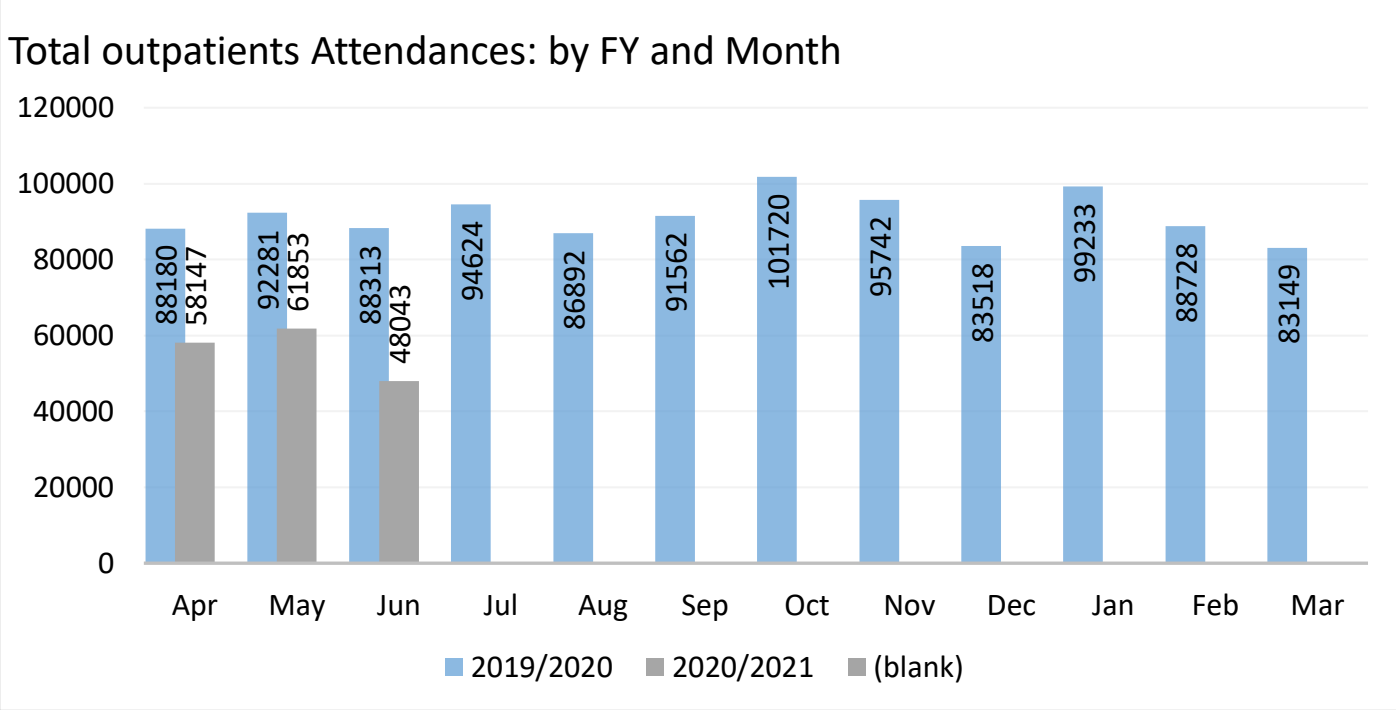
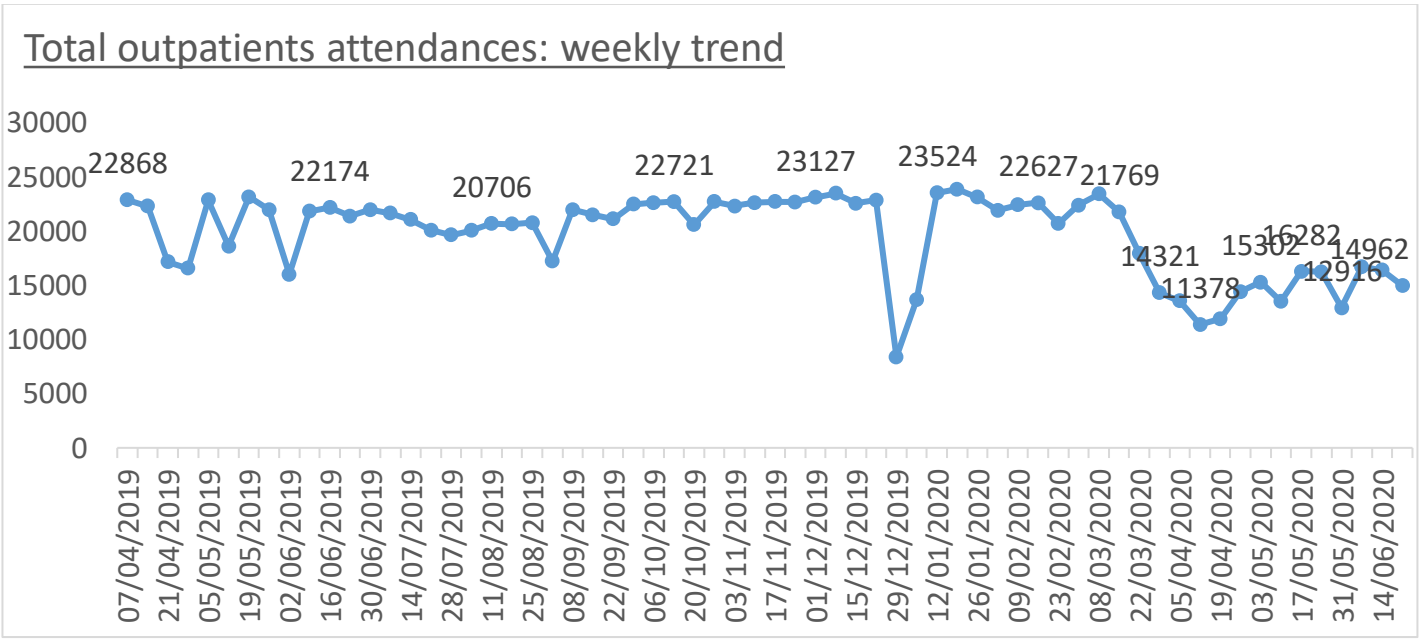
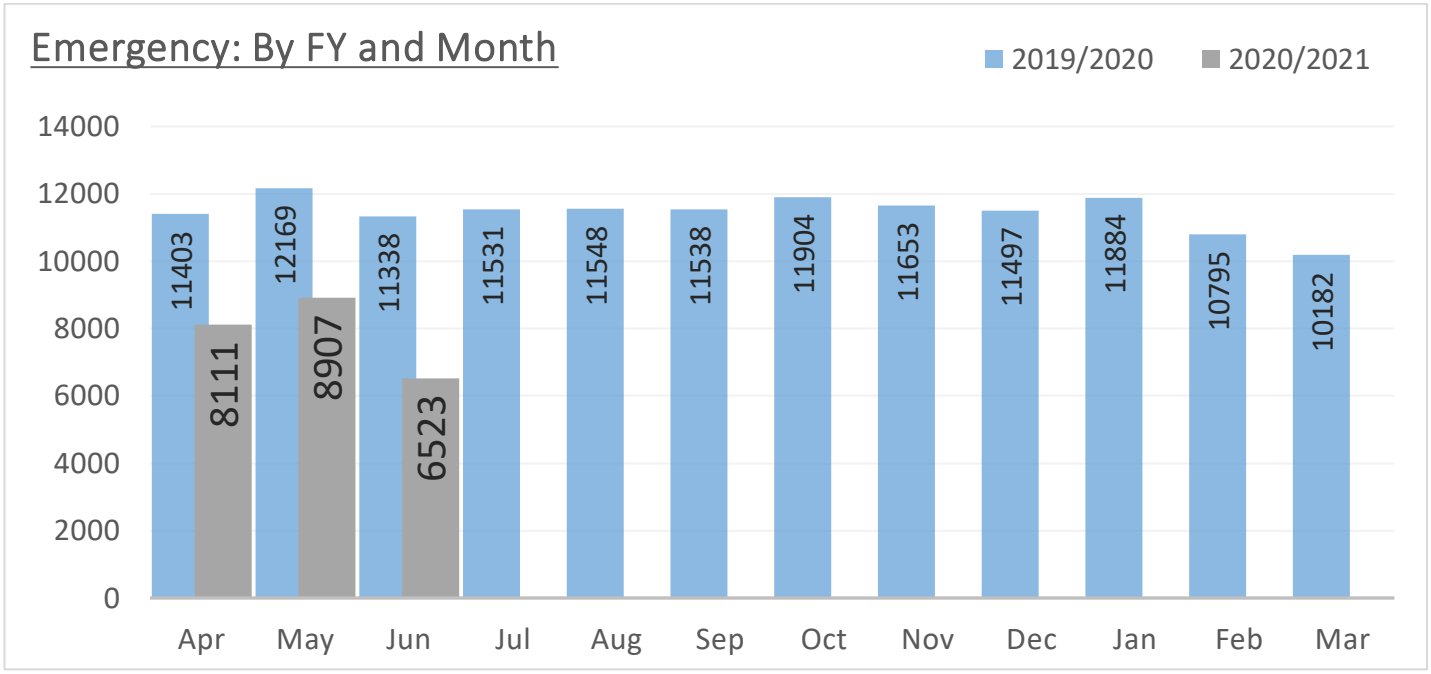
05/04/2020
19/04/2020
03/05/2020
17/05/2020
31/05/2020
14/06/2020

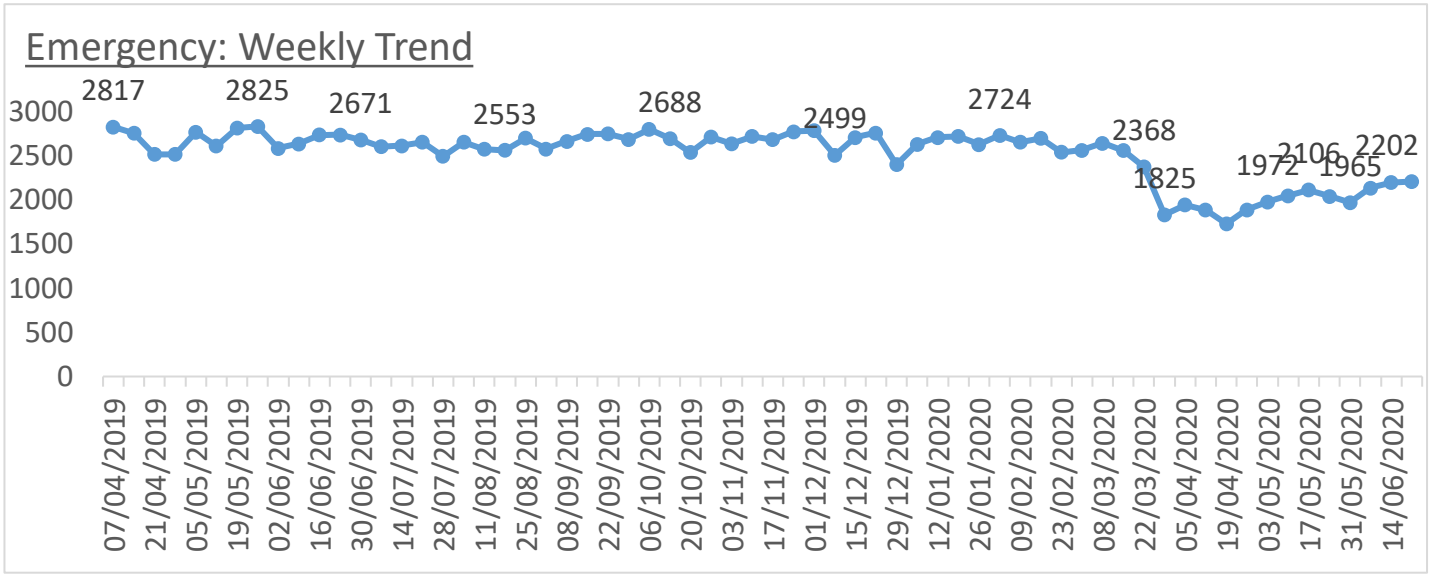
Appendix 3


Total outpatients Attendances: by FY and Month
120000
100000
80000
60000
40000
20000
0
88180
58147
92281
61853
88313
48043
94624
86892
91562
101720
95742
83518
99233
88728
83149
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
2019/2020
2020/2021
(blank)


Total outpatients attendances: weekly trend
30000
25000
20000
15000
10000
5000
0
22868
22174
20706
22721
23127
23524
22627
21769
14321
11378
15302
16282
12916
14962
07/04/2019
21/04/2019
05/05/2019
19/05/2019
02/06/2019
16/06/2019
30/06/2019
14/07/2019
28/07/2019
11/08/2019
25/08/2019
08/09/2019
22/09/2019
06/10/2019
20/10/2019
03/11/2019
17/11/2019
01/12/2019
15/12/2019
29/12/2019
12/01/2020
26/01/2020
09/02/2020
23/02/2020
08/03/2020
22/03/2020
05/04/2020
19/04/2020
03/05/2020
17/05/2020
31/05/2020
14/06/2020

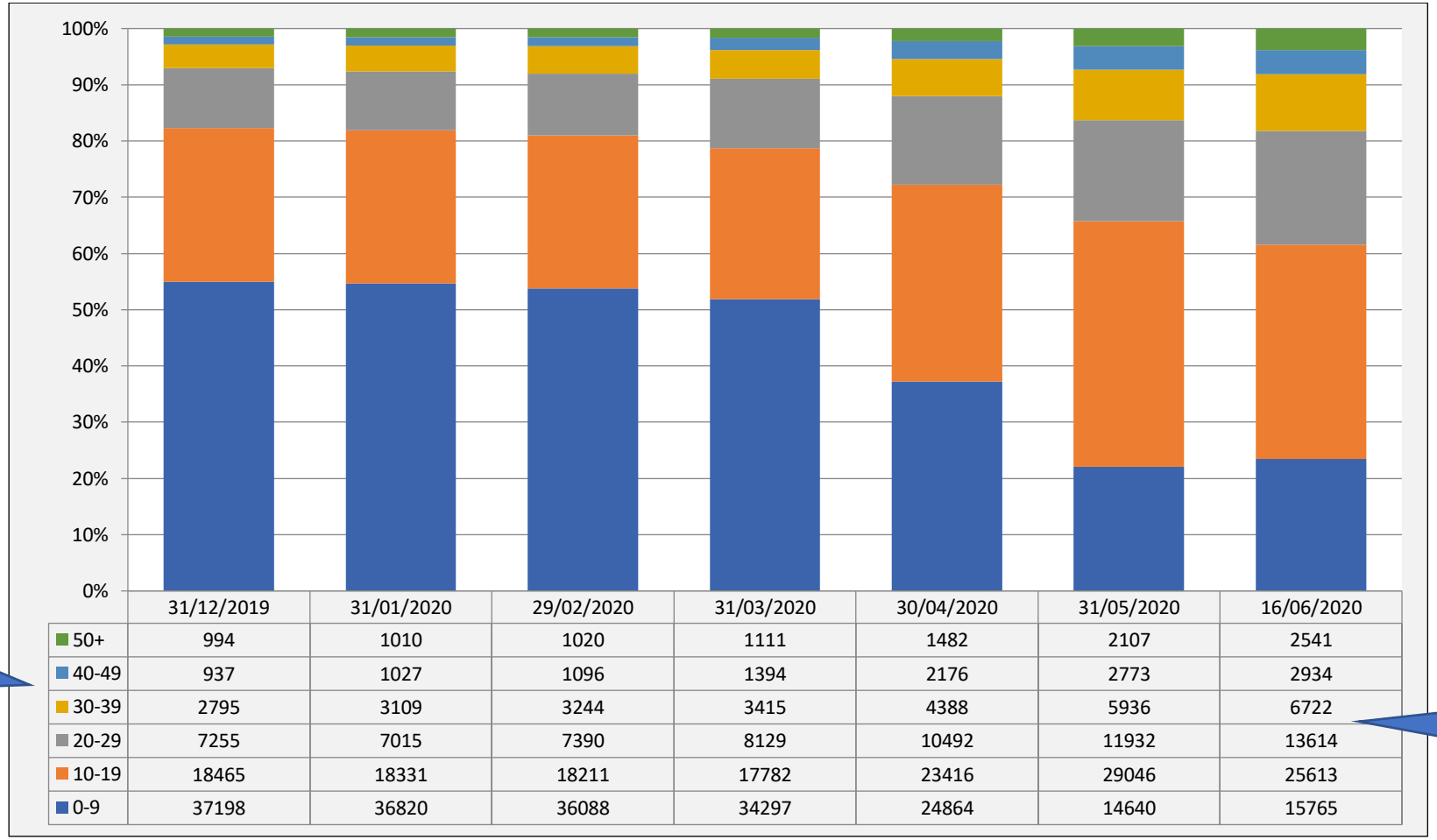
Appendix 3d


Emergency: By FY and Month
2019/2020
2020/2021
14000
12000
10000
8000
6000
4000
2000
0
11403
8111
12169
8907
11338
6523
11531
11548
11538
11904
11653
11497
11884
10795
10182
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar


Emergency: Weekly Trend
3000
2500
2000
1500
1000
500
0
2817
2825
2671
2553
2688
2499
2724
2368
1825
1972
2106
1965
2202
07/04/2019
21/04/2019
05/05/2019
19/05/2019
02/06/2019
16/06/2019
30/06/2019
14/07/2019
28/07/2019
11/08/2019
25/08/2019
08/09/2019
22/09/2019
06/10/2019
20/10/2019
03/11/2019
17/11/2019
01/12/2019
15/12/2019
29/12/2019
12/01/2020
26/01/2020
09/02/2020
23/02/2020
08/03/2020
22/03/2020
05/04/2020
19/04/2020
03/05/2020
17/05/2020
31/05/2020
14/06/2020

COVID – 19: IMPACT ON WAITING

Percentage/number of people waiting at weekly intervals



Waiting time intervals (wks)	31/12/2019	31/01/2020	29/02/2020	31/03/2020	30/04/2020	31/05/2020	16/06/2020
50+	994	1010	1020	1111	1482	2107	2541
40-49	937	1027	1096	1394	2176	2773	2934
30-39	2795	3109	3244	3415	4388	5936	6722
20-29	7255	7015	7390	8129	10492	11932	13614
10-19	18465	18331	18211	17782	23416	29046	25613
0-9	37198	36820	36088	34297	24864	14640	15765

Number of people

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Agenda Item 8

Report to the Leicester, Leicestershire and Rutland Joint Health Overview and Scrutiny Committee

From: University Hospitals of Leicester NHS Trust

Re: The Prior Year Adjustment to Trust Accounts

Date: 3rd July 2020

Author: Rebecca Brown – Acting Chief Executive
Jonathan Shuter – Deputy Chief Financial Officer

Overview:

In January 2020 the newly appointed Interim Chief Financial Officer initiated a review of the Trust's balance sheet in response to concerns identified in the 2018/19 audit.

It thus came to light that the Trust's long standing deficit was significantly misstated in last year's final accounts. This means that the Trust has had to make a 'prior year adjustment' to those accounts amounting to £46m. Despite this, the Trust received an 'unqualified audit opinion' last year. As a consequence of this the regulator, NHSE/ I have asked the accountancy and audit firm, PWC to investigate the Trust's underlying financial position. This has been reported monthly in public during Trust Board meetings.

The financial position deteriorated due in large part to the complex impact of the balance sheet review. This has resulted in the Trust internally reporting a Full Year Outturn (FOT) deficit of £84.1m excluding PSF, FRF and MRET*, funding, (These are NHS central funding allocations to Trusts based on a number of operational and financial performance metrics), and a £66.4m deficit including PSF, FRF and MRET and after adjusting for the expected prior year adjustment of £46.2m.

However, the reported position to NHSE & I in the end of year data return was a £112.6m deficit including PSF, FRF and MRET. This reflects the fact that there will be no prior year adjustment in the national NHS accounts, as the £46.2m is not considered 'material' for national reporting purposes.

The Trust will be in a position to accurately update the forecast once the outcome of the PwC work is available, (at the time of writing this work was ongoing). This work will also help inform the final year end accounts position and external audit.

Clearly, this is a serious issue for the Trust and the team are working very hard to confirm an accurate understanding of the issue and most importantly, to restore the Trust's finances.

The Trust has immediately taken a series of actions to improve and strengthen its financial controls and governance and will act on the findings of PwC's investigation, once finalised, in line with the requirements of NHS E/I.

The measures taken to date and planned include the following:

- Implementation of enhanced financial transaction, journal, balance sheet and cash controls;
- Training commissioned and commenced for the Finance Team;
- Integration of quality improvement and efficiency teams in a revised PMO structure;
- External support secured to underpin leadership and delivery of the savings programme in 2020/21;
- Finance training and development for the Chairman and members of the Trust Board in train;
- Acting Chief Executive now chairs a fortnightly Financial Recovery Board, reporting to the Finance and Investment Committee of the Trust Board;
- COVID-19 expenditure and approvals framework implemented via Budget Holders;
- Commission Finance training and development for clinical leaders and managers, including all key budget holders.

NOTE: It is recognised that NHS finances are notoriously complex. As such the Trust's Deputy Chief Financial Officer will be on hand at Scrutiny to speak to the paper. For completeness the Trust Board Paper dated May 2020 which set out the expected deficit and the £46m Prior Year Adjustment is attached as Appendix 1 with this briefing.

***An explanation of the acronyms:**

'MRET' This is the Marginal Rate for Emergency (admissions) Tariff, which was introduced in the NHS in 2010/11. The rule saw NHS hospitals only paid 30% of the regular Tariff price for emergency admissions above a fixed baseline.

'PSF' And 'FRF' The Provider Sustainability Fund is given to those trusts that agree their control totals with NHSE/I and deliver on operational and financial performance targets. 'FRF' is the Financial Recovery Fund which is superseding PSF but operates on similar principles.

2019/20 Financial Outturn

Author: Chris Williams – Interim Head of Financial Planning & Analysis Sponsor: Simon Lazarus – Interim Chief Financial Officer

Trust Board paper F4

Purpose of Report:

This paper is for:	Description	Select (X)
Decision	To formally receive a report and approve its recommendations OR a particular course of action	
Discussion	To discuss, in depth, a report noting its implications without formally approving a recommendation or action	X
Assurance	To assure the Board that systems and processes are in place, or to advise a gap along with treatment plan	
Noting	For noting without the need for discussion	

Previous Consideration:

Meeting	Date	Please clarify the purpose of the paper to that meeting using the categories above
CMG Board (specify which CMG)		
Executive Board		
Trust Board Committee		
Trust Board		

Executive Summary

Context:

This paper updates the Trust Board on the provisional financial outturn for 2019/20 following previous discussions at Finance & Investment Committee and Trust Board and the completion of the Trust's balance sheet review.

Questions:

1. What is the financial outturn?

The Trust is internally reporting a FOT of £84.1m excluding PSF, FRF and MRET funding and a £66.4m deficit including PSF, FRF and MRET and after adjusting for an expected prior year adjustment of £46.2m. The reported position to NHSE & I in the end of year data return was a £112.6m deficit including PSF, FRF and MRET. This reflects the fact that there will be no prior year adjustment in the national NHS accounts, as the £46.2m is not material for national reporting purposes.

This is a provisional estimated outturn as accruals for annual leave carry forward and working time directive holiday pay are still being completed and the PDC dividend impact of the MEA valuation will not be confirmed until the end of the month. It should also be noted that the Trust's financial position is now being reviewed by External Audit and PwC as part of their external review and the reported position and prior year adjustments may be subject to change as a result.

The provisional outturn is a deterioration of £6.5m from the Month 11 YTD position but is in line with the FOT reported as at Month 11 of a £66.5m deficit against plan (including PSF, FRF and MRET).

2. What risks are associated with the provisional outturn position?

This is a provisional outturn position that includes the estimated impact of final accruals that are being completed and the PDC dividend impact of the MEA valuation. The actual outturn may vary as a result of:

- The actual value of final accruals
- The outcome of the External Audit and PwC external reviews

Input Sought:

The Trust Board is asked to:

- **NOTE** the 2019/20 reported financial forecast and the outcome of the Trust's balance sheet review
- **NOTE** that the position may change once accruals are finalised and external reviews are completed.

For Reference:

This report relates to the following UHL quality and supporting priorities:

1. Quality priorities

Safe, surgery and procedures	**Not applicable**
Safely and timely discharge	**Not applicable**
Improved Cancer pathways	**Not applicable**
Streamlined emergency care	**Not applicable**
Better care pathways	**Not applicable**
Ward accreditation	**Not applicable**

2. Supporting priorities

People strategy implementation	**Not applicable**
Estate investment and reconfiguration	**Not applicable**
e-Hospital	**Not applicable**
More embedded research	**Not applicable**
Better corporate services	**Not applicable**
Quality strategy development	**Not applicable**

3. Equality Impact Assessment and Patient and Public Involvement considerations

- What was the outcome of your Equality Impact Assessment (EIA)? **Not applicable**

- Briefly describe the Patient and Public Involvement (PPI) activities undertaken in relation to this report, or confirm that none were required. **None required**

- How did the outcome of the EIA influence your Patient and Public Involvement? **Not applicable**

- If an EIA was not carried out, what was the rationale for this decision? **Not applicable**

4. Risk and Assurance

Risk Reference:

Does this paper reference a risk event?	Select (X)	Risk Description:
Strategic: Does this link to a ***Principal Risk*** on the BAF?	**X**	Principal Risk 9 - Failure to meet the financial control total
Organisational: Does this link to an ***Operational/Corporate Risk*** on Datix Register		
New Risk identified in paper: What ***type*** and ***description***?		
None		

5. Scheduled date for the **next paper** on this topic: 4th June 2020
6. Executive Summaries should not exceed **5 sides** [My paper ~~does~~/does not comply]

Contents

Executive Summary

Financial performance

Statutory duties

- Delivering the planned deficit: not delivered
- Achieving the External Funding Limit: delivered
- Achieving the Capital Resource Limit: delivered

Financial Performance

- **Deficit of £84.1m excluding Provider Sustainability Funds (PSF), Financial Recovery Fund (FRF), and Marginal Rate Emergency Tariff (MRET):** The Month 12 position is an estimated one as the impact of the MEA valuation on PDC dividend and the final value of the annual leave carried forward accrual will not be confirmed until after circulation of this report. The current position includes the in year impact of the financial review of the balance sheet and operational pressures but is net of an expected £46.2m of prior year adjustments to 18/19 financial statements resulting from the review. This compares to a Month 11 deficit position, after prior year adjustments, of £80.2mA, and is a £6.5mA movement against plan before PSF, FRF and MRET.
- **Including PSF/FRF/MRET: Deficit of £66.4m, £55.7mA to plan**
- **Patient Care Income, £20mF to Plan :** There is £1.7mF movement against plan mainly due to an improvement in the final settlement of outstanding issues with Specialised Services. Although activity reduced significantly in March due to Covid this did not impact on income as a result of the fixed income agreement with CCGs.
- **Other operating income, £6.2mF:** This is £7.5mF in month mainly due to £3.9m Covid income and £1.8m of LDA income that will not be spent until 2020/21
- **Operating Costs, £56.8mA to Plan:** This compares to a Month 11 position excluding prior year balance sheet adjustments of £42.4mA. Pay £4.2mA to Plan in month is due to accruals for clinical excellence and estimated cost of the annual leave carry forward accrual. Non-pay £10.2mA in month. This is £4.6mA to forecast mainly due to Covid costs of £1.2m and movement of £1.2m 7of costs previously allocated against other income.
- **Non operating costs, £4.8mA to plan: improved from £6.5mA**

Cash

Cash Bridge:

- Opening cash balance of £4m, in line with our plan.
- Funded YTD operating deficit (net of PDC) of £112.8m and capital spend by securing £124.0m of external loans; PSF/FRF/MRET funding; internal capital funding and improvement in working capital.
- Cash holding at the year end is £16.0m which includes £2.4m of cash related to Trust Group Holdings, £5m of UHL revenue cash and £8.6m of capital cash to fund 2020/2021's capital program.

Capital

- £49.6m spend to date against a budget of £52.5m

Key
F refers to a Favourable variance to plan, A refers to an Adverse variance to plan

March 2020: Key Facts

Patient Income £20.0mF

Other Income £6.2mF

Substantive Pay £8.7mA

Agency £0.8mA

Non Pay £47.3mA

Non-Op Costs £4.8mA

EBITDA £42.8mA

CIP £1.1mF

Liquidity Indicators

Key

- EBITDA refers to Earnings Before Interest, Taxes, Depreciation and Amortisation
- Colour indicates status of variance on planned position (Green is Favourable/In Line and Red is Adverse)
- Number relates to variance YTD

Financial Performance: YTD Deficit of £66.6m

I & E £'000

	Mar-20				YTD			
	Plan	Actual	Vs Plan		Plan	Actual	F/(A)	
	£'000	£'000	£'000	%	£'000	£'000	£'000	%
Patient Care Income	77,833	79,510	1,677	2%	894,303	914,283	19,980	2%
Non Patient Care Income	519	1,031	512	99%	5,306	5,309	3	0%
Other Operating Income	10,201	17,688	7,487	73%	122,668	128,818	6,150	5%
Total Income	**88,553**	**98,229**	**9,676**	**11%**	**1,022,277**	**1,048,410**	**26,133**	**3%**
Pay Costs	(55,281)	(59,031)	(3,750)	7%	(657,823)	(666,486)	(8,663)	(1%)
Pay Costs: Agency	(1,545)	(1,992)	(447)	29%	(18,860)	(19,629)	(768)	(4%)
Non Pay	(29,789)	(39,998)	(10,209)	34%	(357,737)	(405,077)	(47,340)	(13%)
Total Operating Costs	**(86,615)**	**(101,021)**	**(14,406)**	**17%**	**(1,034,420)**	**(1,091,192)**	**(56,772)**	**(5%)**
EBITDA	**1,938**	**(2,792)**	**(4,730)**	**(244%)**	**(12,143)**	**(42,781)**	**(30,638)**	**252%**
Non Operating Costs	(2,994)	(1,245)	1,750	(58%)	(36,811)	(41,600)	(4,789)	(13%)
Retained deficit	**(1,056)**	**(4,036)**	**(2,980)**	**(282%)**	**(48,954)**	**(84,381)**	**(35,428)**	**(72%)**
Adjustments for Donated Assets	19	125	105	(545%)	232	237	5	(2%)
Net Deficit	**(1,037)**	**(3,912)**	**(2,875)**	**(277%)**	**(48,722)**	**(84,144)**	**(35,422)**	**(73%)**
PSF/FRF/MRET	4,212	572	(3,640)	86%	38,069	17,785	(20,284)	53%
Net Deficit Including PSF/FRF/MRET	**3,175**	**(3,340)**	**(6,515)**	**205%**	**(10,653)**	**(66,359)**	**(55,706)**	**(523%)**

NHS Patient Care Income: £914.3m, £20.0mF including £4.7mF in relation to drugs and devices excluded from tariff with the offset in non-pay and £1.5mF due to Medical Pay Award which is offset in Medical Pay. Underlying over-delivery of £13.8mF. Lower activity in March due to Covid has brought activity back in line with plan for the year, although income remains favourable due to the fixed income agreement with the CCGs and over-performance in Emergency, Outpatients, Direct Access, Diagnostic Imaging and critical care activity earlier in the year.

- **Other Income: £134.1m, £6.2mF to plan.** The Month 12 position includes an expected £1.7m prior year adjustment to 18/19 financial statements resulting from the balance sheet review. The favourable variance is mainly the result of an allocation £3.9m of Covid income in March and £1.8m in LDA monies, which will be spent in 20/21.

- **Total Pay Costs: £686.1m, £9.4mA** including £4.7mF from release of contingency in line with Plan and £1.5mA in relation to the impact of the Medical Pay Award. The overspend of £4m in month is a result of an accrual for Clinical excellence award costs and end year annual leave carry forward.

- **Non-Pay: £405.1m, £47.3mA** including £4.7mA relating to drugs and devices excluded from tariff and £1mF release of central contingency. The Month 12 position is net of an expected £44.4m prior year adjustments to 18/19 financial statements resulting from the balance sheet review. The adverse variance is higher than forecast mainly due to a correction of non pay cost of £1.2m previously allocated against other income and inclusion of £1.2m of Covid costs.
- **EBITDA: deficit of £42.8m, £30.6mA.** This compares to a EBITDA deficit for month 11 of £40m, £25.9mA to plan.
- **Non-Operating Costs: £41.6m, £4.8mA** This compares to non operating costs in month 10 of £40.4m, £6.5mA to plan.
- **PSF, FRF and MRET: £17.8mA to plan** due to loss of PSF and FRF funding in Q3 and Q4 as a consequence of being off plan.

Key
- EBITDA refers to Earnings Before Interest, Taxes, Depreciation and Amortisation
- F refers to a Favourable variance to plan
- A refers to an Adverse variance to plan

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Performance by CMG and Directorates: Year to Date

Performance risks in various CMGS with ITAPS, CHUGGS and MSS in Special Measures. All CMGs and Estates and Facilities have reset control totals and continue to have Corporate Finance oversight outside of the formal monthly PRMs in order to track financial performance and recovery in line with the agreed control totals.

CHUGGS	Plan £'m	YTD £'m	Variance £'m
PCI	168.8	173.5	4.7
Other Income	8.3	8.3	0.1
Total Income	**177.0**	**181.9**	**4.8**
Total Pay	(61.4)	(64.0)	(2.5)
Total Non-Pay	(59.8)	(64.9)	(5.0)
EBITDA	**55.8**	**53.0**	**(2.8)**

CSI	Plan £'m	YTD £'m	Variance £'m
PCI	43.4	46.3	2.9
Other Income	12.6	11.4	(1.3)
Total Income	**56.0**	**57.7**	**1.7**
Total Pay	(91.9)	(92.6)	(0.7)
Total Non-Pay	(2.2)	(11.5)	(9.3)
EBITDA	**(38.1)**	**(46.5)**	**(8.4)**

ESM	Plan £'m	YTD £'m	Variance £'m
PCI	176.0	185.0	9.0
Other Income	9.3	9.7	0.4
Total Income	**185.3**	**194.7**	**9.4**
Total Pay	(108.5)	(115.3)	(6.8)
Total Non-Pay	(50.7)	(51.9)	(1.2)
EBITDA	**26.1**	**27.5**	**1.4**

ITAPS	Plan £'m	YTD £'m	Variance £'m
PCI	38.4	35.8	(2.5)
Other Income	4.0	4.0	(0.1)
Total Income	**42.4**	**39.8**	**(2.6)**
Total Pay	(69.7)	(71.4)	(1.7)
Total Non-Pay	(20.2)	(24.8)	(4.6)
EBITDA	**(47.6)**	**(56.4)**	**(8.8)**

MSS	Plan £'m	YTD £'m	Variance £'m
PCI	109.4	109.7	0.3
Other Income	6.1	4.9	(1.3)
Total Income	**115.6**	**114.6**	**(1.0)**
Total Pay	(57.4)	(57.0)	0.4
Total Non-Pay	(25.7)	(29.2)	(3.5)
EBITDA	**32.5**	**28.4**	**(4.1)**

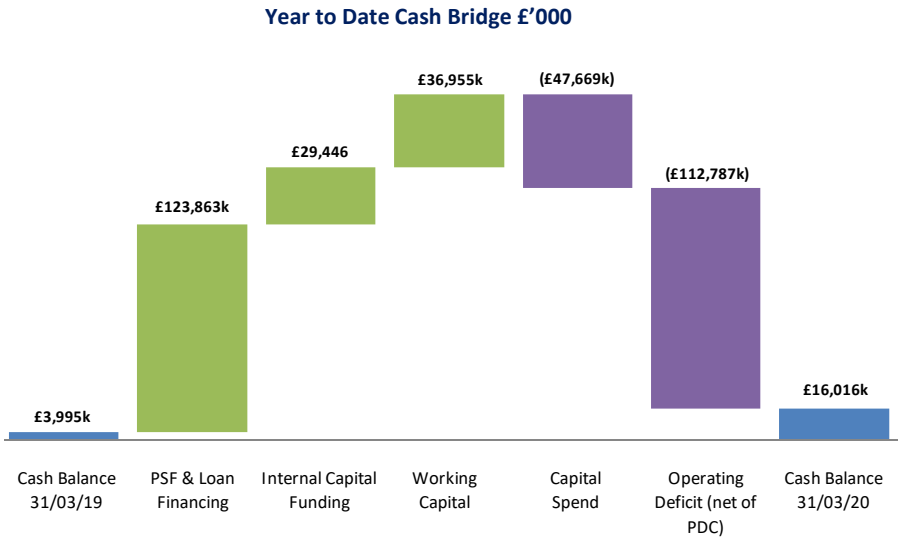
RRCV	Plan £'m	YTD £'m	Variance £'m
PCI	187.1	193.7	6.6
Other Income	8.1	7.5	(0.6)
Total Income	**195.2**	**201.2**	**6.1**
Total Pay	(84.2)	(83.7)	0.5
Total Non-Pay	(59.9)	(65.6)	(5.7)
EBITDA	**51.0**	**51.9**	**0.9**

W&C	Plan £'m	YTD £'m	Variance £'m
PCI	162.0	163.7	1.6
Other Income	9.3	9.2	(0.2)
Total Income	**171.4**	**172.8**	**1.5**
Total Pay	(90.7)	(91.9)	(1.3)
Total Non-Pay	(36.2)	(38.9)	(2.7)
EBITDA	**44.5**	**42.0**	**(2.5)**

ESTATES	Plan £'m	YTD £'m	Variance £'m
PCI	0.0	(0.0)	(0.0)
Other Income	22.2	22.0	(0.2)
Total Income	**22.2**	**22.0**	**(0.2)**
Total Pay	(37.9)	(38.1)	(0.2)
Total Non-Pay	(34.0)	(39.2)	(5.2)
EBITDA	**(49.7)**	**(55.4)**	**(5.7)**

CORPORATE	Plan £'m	YTD £'m	Variance £'m
PCI	0.0	0.3	0.3
Other Income	7.6	8.3	0.7
Total Income	**7.6**	**8.6**	**1.0**
Total Pay	(37.2)	(34.3)	2.9
Total Non-Pay	(40.0)	(42.7)	(2.7)
EBITDA	**(69.5)**	**(68.4)**	**1.2**

March 2020: Cash movement



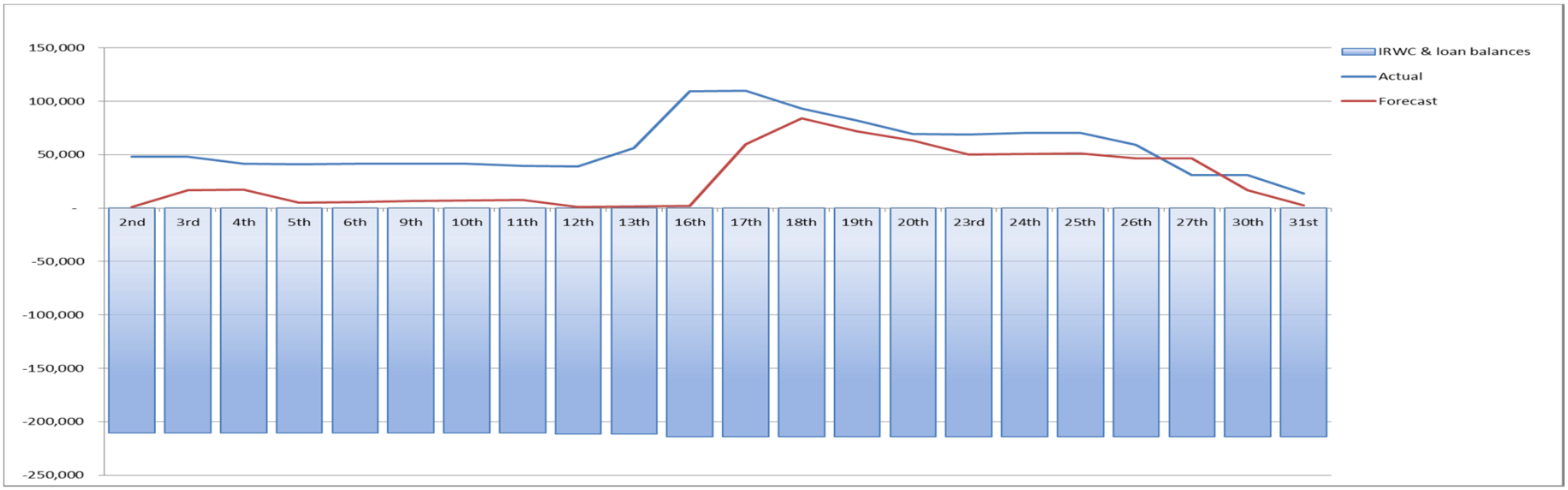
Cash Bridge:

- Opening cash balance of £4m, in line with our plan.
- Funded YTD operating deficit (net of PDC) of £112.8m and capital spend by securing £124.0m of external loans; PSF/FRF/MRET funding; internal capital funding and improvement in working capital.
- Cash holding at the year end is £16.0m which includes £2.4m of cash related to Trust Group Holdings, £5m of UHL revenue cash and £8.6m of capital cash to fund 2020/2021's capital program.

Daily Cash Balance

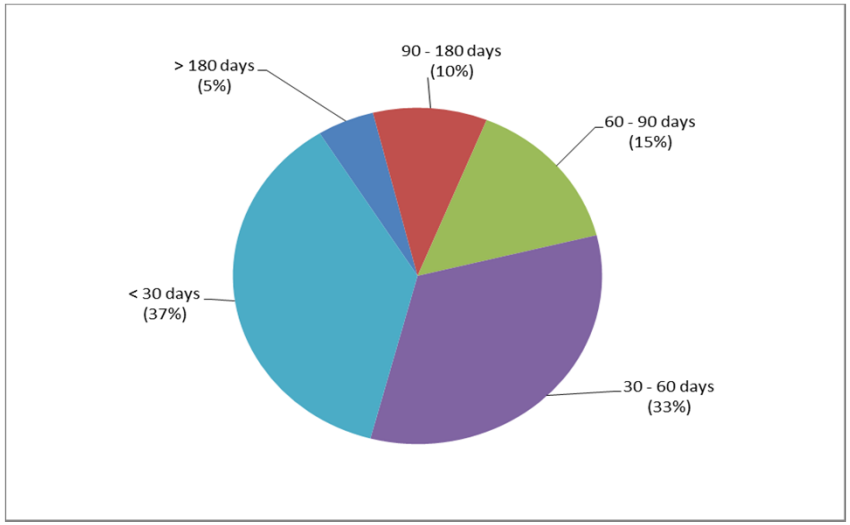
- In line with forecast the mid-month peak is driven by receipt of SLA income and reduction on 27th March due to the monthly payroll run.

Daily Cash Balance – March 2020

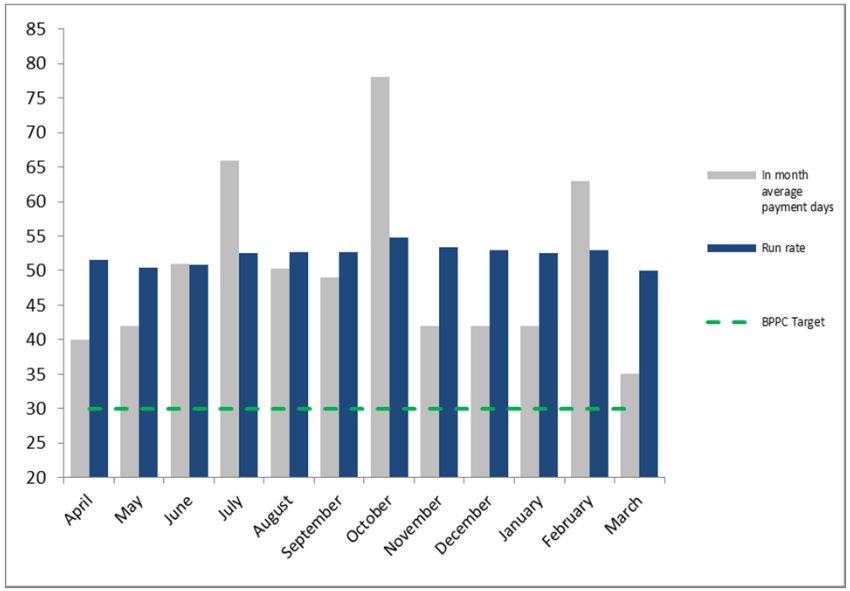


Accounts payable performance

No. days between invoice receipt and payment – Apr 2019 to Mar 2020



Average number of days to pay supplier invoices – Apr 2019 to Mar 2020



BPPC Year to March 2020

Period	% paid within 30 days	
	By volume	By value
Prior month YTD	42%	65%
Current month YTD	47%	67%
Change in performance	**5%**	**2%**
Local SMEs YTD	65%	19%
CRN invoices YTD	96%	97%

Comments

- Performance has improved from the prior month, and this includes the repayment of a large proportion of aged invoices due to increased cash receipts.

- We have a target of no more than two days' of invoices waiting to be entered onto the ledger at any one time. This includes invoices received in the post, via email or through the cloud. At the end of March there were less than two days' of invoices awaiting input onto the ledger.

NIHR Clinical Research Network East Midlands(CRN) invoices

- We host the CRN and the agreement in place requires us to pay their invoices on time each week.

- We paid 94% of these invoices within 30 days by volume and 95% by value in the year to date, and continue to work with the CRN to maintain payment performance and ensure the accuracy of this data.

Rolling 12 months analysis

- This analysis is based on invoices paid (by value) in the last 12 months, excluding direct payments from our bank.

- 37% of all invoices were paid within 30 days of receipt in the year. The run rate for the YTD is 55 days (prior 12 months was 53 days). We prioritise non-NHS suppliers due to the nature of the supplies and the fact that many of these suppliers put our accounts 'on stop' of supply.

Capital: March £49.6m YTD spend

Scheme Name	Annual Budget £'000	Year to Date - March 19 YTD Actual £'000	YTD F / (A) £'000
ICU Pre-commitment	21,567	19,430	(2,137)
Business Cases & Reconfiguration Schemes	3,530	3,221	(309)
Estates & Facilities Schemes	9,046	6,208	(2,838)
IM&T Schemes	4,645	4,858	213
Medical Equipment Schemes	2,724	3,852	1,128
Other pre-commitments	8,429	7,753	(676)
Corporate / Other	2,601	2,747	146
Alliance Asset Transfer	-	1,535	1,535
TOTAL CAPITAL EXPENDITURE	**52,542**	**49,604**	**(2,938)**

The above position on capital spend is subject to a final internal review, and audit.

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