Agenda Item 12

University Hospitals of Leicester NHS
NHS Trust
Caring at its best

HEALTH OVERVIEW AND SCRUTINY COMMITTEE : 12TH MARCH 2014

REPORT OF UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

UPDATE ON CURRENT ISSUES

PURPOSE OF REPORT

1. The purpose of this report is to update the Health Overview and Scrutiny Committee on the following issues:-

   - 'Never events' 2009 – 2014;
   - UHL hospital-acquired pressure ulcers;
   - nursing and medical staff – agency usage;
   - cancelled operations;
   - Emergency Department performance;
   - UHL financial position;
   - CQC inspection

2. The following Trust postholders will be in attendance at the Committee meeting to present this report:-

   - Mr P Hollinshead – Interim Director of Financial Strategy
   - Mr R Mitchell – Chief Operating Officer
   - Ms R Overfield – Chief Nurse

NEVER EVENTS 2009-2014

3. Never Events are incidents that have the potential to cause severe harm or death and are largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. Never Events are governed by the 'Never Events Policy Framework' document produced by NHS England.

4. The Trust Board takes Never Events very seriously and accepts the National Patient Safety Agency's (NPSA) view that these events are 'inexcusable'. Failure to learn the lessons from Never Events could be perceived as organisational failure on the grounds of patient safety. There does not have to have been actual severe harm or death for an incident to be classed as a Never Event. The Never Events criteria require that the type of incident has the potential to cause severe harm or death.

5. A thorough Root Cause Analysis investigation is undertaken with robust action plans developed for each Never Event reported and the Trust follows the requirement for all Never Events to be reported in public at Trust Board meetings. The Trust has undertaken an internal thematic review of all Never Events and assurance is given that actions are tracked and monitored to prevent re-occurrence. In March 2013 UHL's Never Events were subject to an external independent review by MD Consulting which concluded that '*in all cases the investigation process was attended to with an appropriate degree of gravity.'*

6. The following table shows a description of all **14** Never Events which have occurred at UHL since 2009 together with the primary root cause and key recommendations to prevent reoccurrence.

Never Event 2009/2010	Description	Key Findings following recurrence	Key Actions to Prevent Recurrence
1. Retained blade post operation November 2009	Retained foreign object post operation	No. 23 blade missing during routine total hip replacement, failure to follow "The Management of Surgical Swabs, Instruments, Needles and other Accountable Items within the Operating Theatre" policy.	➢ The Consultant Orthopaedic Surgeon has emphasised to the investigation team that in future, were the same situation to arise, he would ensure that the patient was x-rayed prior to leaving theatre. ➢ Anaesthetists to carefully consider their role, as a senior member of the theatre team, in ensuring that where radio-opaque equipment is unaccounted for at the end of surgery the patient should not normally be woken up until an x-ray has been performed to exclude the missing item from being in the patient. Even though not proven to be a contributory factor in this case, it is beneficial to reiterate the importance of ensuring the integrity of instrumentation when preparing for theatre cases.
2. Wrong site knee surgery February 2010	Wrong site surgery	Person who took consent and person doing operation not the same. Site marking not	➢ To improve compliance in relation to using the UHL Safer Surgery Checklist without

		prominent. WHO safety checklist not used.	prompting ➢ Rotating the theatre table in preparation for the next case must only be undertaken after first checking the operating list, consent form and site. ➢ The operating surgeon must physically review the patient prior to the surgery. ➢ Operation sites should be marked in accordance with the Correct Site Surgery Policy? ➢ Staff who are to have any involvement with a patient in theatre must be fully briefed in respect of type of operation, site, side, etc
3. Retained surgical swab March 2010	The patient had an Oesophagogastrectomy and anastomosis of oesophagus to stomach. A large abdominal swab was retained.	Failure to follow "The Management of Surgical Swabs, Instruments, Needles and other Accountable Items within the Operating Theatre" policy. Highly complex surgery with two teams in theatre, increasing difficulties in tracking swabs. No verbal acknowledgement of swab going in to the cavity.	➢ To-re-enforce aspects of the '*Management of Surgical Swabs, Instruments, Needles and other Accountable Items within the Operating Theatre Policy and Procedures*' which is to be updated. ➢ Consistent use of the UHL Safer Surgery Checklist 'sign-out' to ensure that there has been confirmation of swab count. ➢ Simultaneous counts to be undertaken.
4. Wrong Route Chemotherapy April 2011	Chemotherapy agent administered intra-muscularly instead of intravenously as prescribed.	Lapse in checking of the route of administration on the prescription chart by both nurses.	➢ Review whether all nurses have been competency reassessed. ➢ Nurses to have their accountability

			reinforced ➢ Revision of the Competency Assessment Framework for Chemotherapy administration, to ensure this refers to and reinforces the use of 5Rs in drug administration.
5. Retained Vaginal swab June 2011	Vaginal swab retained following an instrumental delivery	No root causes have been identified. This is in part due to the fact that the investigation team were unable to clarify what the retained swab was and therefore from what procedure it possibly could have been retained.	➢ Spot checks to be carried out by the Delivery Suite Managers with regards to appropriate documentation of checks relating to swabs and instruments used during deliveries. ➢ In cases of retained swabs a full description of the swab including sizes must be recorded to allow correct identification
6. Wrong implant/ Prosthesis April 2012	Wrong lens implant	There was a failure in the checking process immediately prior to implantation to ensure the correct lens had been selected	➢ Development of an intra-ocular lens protocol which includes the responsibility of the surgeon to select the appropriate lens ➢ Report and outcomes shared with clinical staff
7. Wrong site surgery April 2012	Surgery commenced on the wrong finger	The marking on the finger nail of the correct digit became washed off or obscured by the skin prep. A definitive “STOP” to check and verbalise the correct operation and site did not occur	➢ Review of marking policy and implementation of a verbal “STOP” before incision. ➢ Report and outcomes shared with clinical staff
8. Wrong dental extraction May 2012	The wrong tooth was extracted	The procedure was undertaken by 2 doctors who did not utilise a definitive	➢ Implementation of the “STOP” moment prior to extraction.

		"STOP" moment to assure they were removing the correct tooth	➢ Report and outcomes shared with clinical staff
9. Inappropriate administration of daily oral Methotrexate August 2012	Once a week medication of Methotrexate was administered on 2 consecutive day	Use of patient's own medication and failure to prescribe medication correctly on day chart	➢ Introduction of electronic prescribing ➢ Report and outcomes shared with clinical staff
10. Retained vaginal pack November 2012	Retention of vaginal swab following management of massive obstetric haemorrhage	Failure to follow Trust polices and procedures	➢ Vaginal swabs to be included in the swab count & audit compliance ➢ Memo to all staff reminding of the need to include removal of pack in the management plan ➢ Review of the obstetric emergency guideline with reference to guidance about vaginal packing when a Bakri balloon is used for the management of post partum haemorrhage. Including documentation ➢ Formulate a post-operative sticker ➢ Report and outcomes shared with clinical staff
11. Retained foreign object post operation October 2012	During closure of the wound the needle snapped and was retained in the patient	Failure to follow agreed procedure not to move patient out of theatre before x-ray of patient	➢ Re-enforced safer surgery policy ➢ Report and outcomes shared with clinical staff
12. Wrong Knee Implant April 2013	A prosthesis for a right sided procedure rather than for a left sided procedure was inadvertently implanted into a patient's knee.	-Selection of the incorrect prosthesis from the Store Room -Failure of the checking process to ensure that the correct prosthesis had been selected (there was one	➢ To review the signage within the Store Room to indicate shelf placement of Left and Right prostheses ➢ To amend the Management of Surgical Swabs,

		incomplete check and then no further checks prior to the prosthesis being implanted) -Staff being pre-occupied, interrupted or distracted by other tasks	Instruments, Needles and other Accountable Items within the Operating Theatre Policy and Procedures (2013) in respect of the prosthesis checking section to clarify that: (i) there must be a second, separate check; (ii) LEFT or RIGHT must be stated where applicable and; (iii) the details of the implant must be read out loud by the Scrub Practitioner and Surgeon whilst the rest of the team stop and listen ➢ To re-enforce to staff what is meant by the prompt in ORMIS: *'Insertion of implant, prosthesis, plate or screw – pause and double check by surgeon and scrub'* ➢ To implement an education / change of practice campaign to encourage pausing and double checking of a prosthesis prior to cementing into a patient, by the following: ➢ Placing a laminated poster in a high visibility area in Orthopaedic Theatres: "Check before you cement"! & sending an electronic version of the poster to all surgeons and theatre staff

			➢ Re-launch of the 'Caring at its Best Theatres Etiquette' package for all staff to complete, to re-enforce the key messages from this incident. ➢ Listening into Action project: 'Team Work is Safe Work' to be rolled out in Orthopaedic Theatres.
13. Wrong Lens Sept. 2013	An intraocular lens with a power of +24.5 dioptres instead of +21.0 dioptres was inadvertently implanted into the patient's eye.	*Inefficiency of the pre-operative systems leading to an increased workload.* *Human error led to the incorrect lens being selected by the Consultant Ophthalmologist after misreading her handwritten additions to the Theatre List on the wall in Theatre.* Weakness of the checking process at the lens selection stage to ensure that the correct prosthesis was taken into Theatre.	➢ To continue to implement the actions contained within the Ophthalmology Action Plan and to progress in line with the recommendations outlined by the Clinical Problem Solving Group (CCG/UHL). ➢ To formally notify surgeons that the practice of handwriting the power of lens on the Theatre list must cease. ➢ To use the electronic UHL Cataract Waiting List Form to ensure that all information is captured pre-operatively so negating the need to make handwritten additions to the list. ➢ For the surgeon to check the biometry results in the anaesthetic room with another member of the theatre team, following which the

			lens details must be immediately transcribed on to the Theatre white board by the surgeon and the appropriate lens selected from the lens store by the surgeon. ➢ During the 'Time Out' phase of the Safer Surgery Checklist, there must be a further confirmation of the patient's biometry results by referring to the medical records ➢ To amend and re-circulate the 'Intra Ocular Lens Protocol' to all staff working in Ophthalmic Theatres to include the two additional checks outlined in recommendations 2 & 3. ➢ Placing the revised laminated poster in a high visibility area in Eye Theatres ➢ Sending an electronic version of the poster to all surgeons and theatre staff ➢
14. Retained Swab February 2014	Vaginal swab retained following an instrumental delivery	Investigation on-going	➢ A formal memo has been sent out to all Medical & Midwifery staff reminding them to have all swabs and needles checked and to document this count on the white boards and patient's medical records

The Committee is invited to note the Never Events that have taken place at UHL, the root causes and the organisational actions which have been implemented.

HOSPITAL ACQUIRED PRESSURE ULCERS (HAPU) IN UHL

7. This paper describes the national context of pressure ulcer prevention and measurement of the prevalence of this harm by the 'NHS Safety Thermometer' (ST). Comparative ST data from peer organisations across England provides assurance that UHL is not an outlier with HAPU incidence when compared to other Trusts.

8. The report outlines the processes that support the prevention, management and reduction of hospital acquired pressure ulcers (HAPUs) across the University Hospitals of Leicester (UHL) and confirms the key themes in HAPU development.

9. Evidence to support UHL's zero tolerance approach to avoidable HAPUs is provided within the paper which is further supported by the gradual reduction in the number of avoidable HAPUs reported for 2013/14.

10. Finally, the paper describes the actions taken to date to reduce HAPUs and the significant investment that has been made to support pressure ulcer prevention strategies in relation to increasing the nursing workforce and pressure relieving equipment.

National context - why focus on pressure ulcers?

11. Treating and caring for people in a safe environment and protecting them from avoidable harm remains a key objective in the NHS Outcomes Framework for 2014/15. Pressure ulcers represent a major burden of sickness and reduced quality of life for patients and create significant difficulties for patients, their carers and families as well as being clinically challenging for patients, their carers and NHS staff.

12. Pressure ulcers can occur in any patient but are more likely in high risk groups such as the elderly, obese, malnourished and those with certain underlying conditions. The presence of pressure ulcers has been associated with an increased risk of secondary infection and a two to four fold increase of risk of death in older people in intensive care units. Pressure ulcers are a recognisable proxy measure for the quality and safety of care patients receive and therefore, can be used to measure standards of nursing care.

Classification of pressure ulcers

13. Pressure ulcers are categorised into four stages:

Grade 1 - discolouration of the skin
Grade 2 - superficial skin damage
Grade 3 - skin loss
Grade 4 - extensive skin destruction

14. Grade 3 and 4 pressure ulcers are reported as Serious Untoward Incidences (SUI) and require a 'root cause analysis' investigation into their cause. In addition, The Trust has to determine whether they were avoidable or unavoidable as per the Department of Health (DH) definitions.

15. **Avoidable** ulcers are those that could have been prevented with the use of pressure relieving equipment, changing patient's position. All pressure ulcer interventions and nursing care have to be clearly documented

16. **Unavoidable** pressure ulcers are those where the tissue damage developed regardless of interventions or where the patient was not compliant with pressure ulcer prevention regimes that were prescribed in the care plan.

17. The process of reporting in-patient pressure ulcers begins at ward level. New pressure ulcers are reported by ward staff onto DATIX (a clinical incident reporting system) and an initial investigation into their cause will begin. At the end of the month, Heads of Nursing for each Clinical Management Group (CMG) will review every pressure ulcer with the ward manager (or deputy) tissue viability nurse specialist, the Assistant Director of Nursing or the Head of Quality for the Clinical Commissioning Group (CCG). A decision as to whether the ulcer was avoidable or unavoidable is then made by the head of Nursing and actions or lessons learnt are identified, agreed and documented with the ward team. The data is then sent to the CCGs and presented at the monthly Clinical Quality Review Group comprising of commissioners, GPs and the UHL senior nursing, medical and quality team.

The NHS safety thermometer

18. The NHS Safety Thermometer (ST) was developed by the NHS for the NHS and is a tool that allows healthcare professionals to measure a snapshot (or prevalence) of harm and the proportion of patients that are 'harm free' in relation to:-

    - Pressure ulcers,
    - Venous thrombo-embolism (VTE),
    - Catheter associated urinary tract infections (CAUTI)
    - Falls.

19. The ST was fully implemented in UHL in March 2012. In UHL, harm data is now collected for every patient on the second Wednesday every month with the exceptions of patients in Theatres, Day Case areas, Emergency Department, and Outpatients (as per national guidelines). The audit is a paper based ST survey and is completed by the Ward Managers (or nominated deputy. Data for every ward and patient is checked before the information is sent electronically to the Health and Social care Information Centre. The data is published on a public website www.safetythermometer.nhs.uk

20. The ST data records the prevalence of **'old'** pressure ulcers that were present when the patient was admitted to hospital (or developed within 72 hours of coming into hospital) and **'new'** pressure ulcers defined as those that developed 72 hours or more after the patient was admitted to hospital i.e. hospital acquired. The ST does not take account of avoidable or unavoidable pressure ulcers and so care must be taken when comparing ST pressure ulcer prevalence data to monthly avoidable pressure ulcer incidence data.

Safety thermometer prevalence data for all grades of new pressure ulcers (UHL and other trusts patients of all ages)

21. Charts one and two on page three illustrate a gradual reduction in the prevalence of pressure ulcers in UHL for patients of all ages and patients over 70 years of age. Although there has been a slight increase in prevalence for January 2014, overall, UHL does not appear to be an outlier when compared to other acute Trusts of similar size and complexity.

Chart one – Prevalence of New Pressure Ulcers (all Patients) from Nov 2012 to Jan 2014

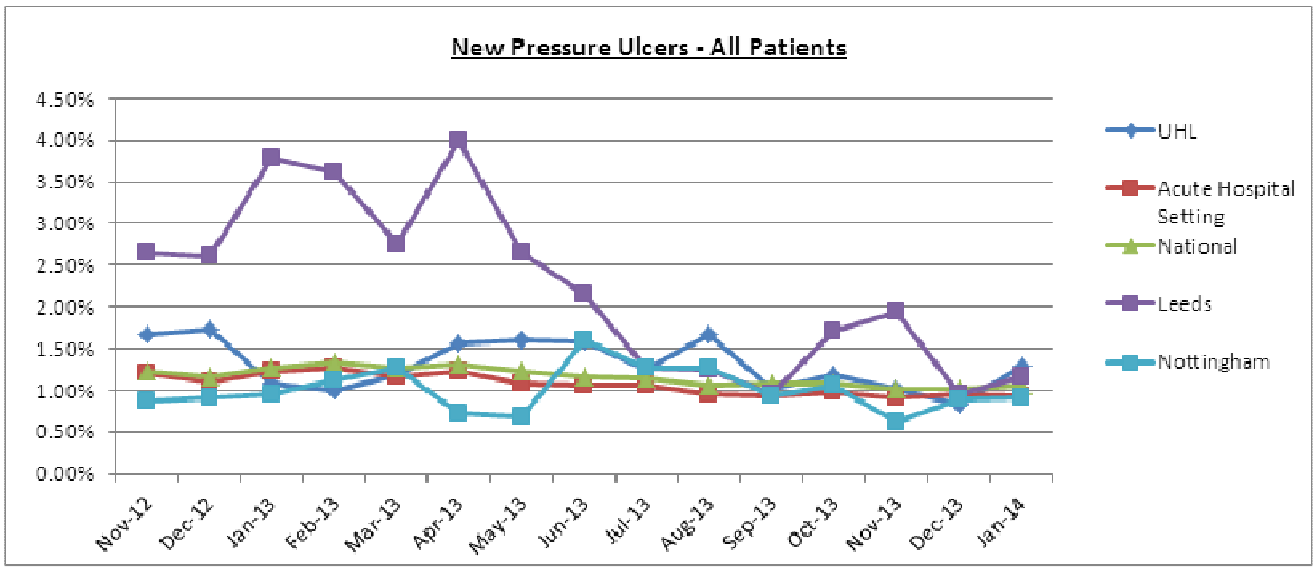
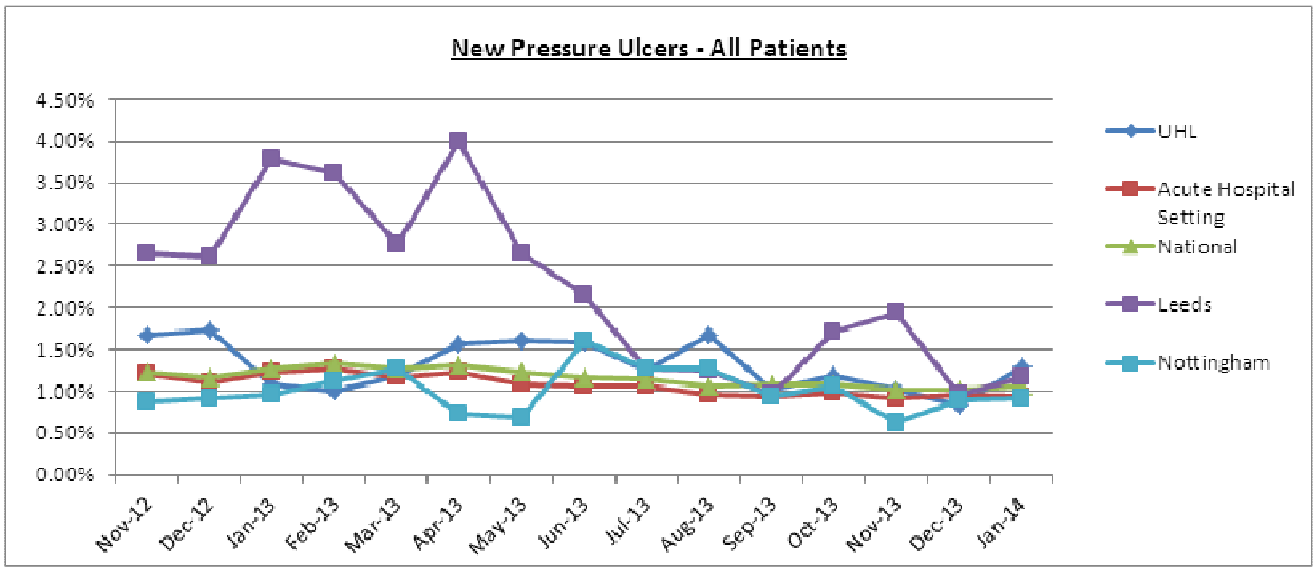


Chart Two – New Pressure Ulcers (Patients over 70 years) from Nov 2012 to January 2014



UHL pressure ulcer incidence data from April 2013 – January 2014

22. UHL reports the number or incidence of pressure ulcers on a monthly basis to the commissioners and Trust incidence data can be found on page four. Reduction thresholds for the number of avoidable pressure ulcers in UHL were agreed with the commissioners in April 2013. From November 2013, the Trusts maximum threshold for grade 2 ulcers is nine and for grade 3 ulcers it is seven. The Trust has a financial penalty of £50,000 for every month that the threshold has been breached.

23. A threshold of zero grade 4 ulcers (the most severe tissue damage) has been agreed with commissioners and the Trust has achieved this with the exception of one grade 4 ulcer in October 2013. The Trust has a financial penalty of £100,000 for every month that the threshold has been breached

24. Tables one and two on page four demonstrate that over the last twelve months UHL has seen a reduction in the incidence of all categories of pressure ulcers.

25. Unfortunately, obtaining comparative incidence data from other Trusts is very difficult, but commissioners have advised that UHL is not an outlier when compared to other hospitals of a similar size and complexity.

Table one – Avoidable Grade 2 Pressure Ulcers April 2013 to January 2014

Trajectory for Grade 2 Avoidable Pressure Ulcers 2013/14													
Month	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**YTD**
Trajectory	0	0	0	**11**	**8**	**4**	**0**	**9**	**9**	**9**	**9**	**9**	**68**
Incidence	11	11	19	21	10	4	8	8	5	**10**			**99**
+ / -	**-11**	**-11**	**-19**	**-10**	**-2**	**0**	**-8**	**+1**	**+4**	**+1**			

Table two – Avoidable Grade 3 & 4 Pressure Ulcers April 2013 to January 2014

Trajectory for Grade 3 & 4 Avoidable Pressure Ulcers 2013/14													
Month	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**YTD**
Trajectory	0	0	0	**5**	**4**	**3**	**0**	**7**	**7**	**7**	**7**	**7**	**47**
Incidence G3	11	3	8	7	8	5	4	4	5	**7**			**62**
Incidence G4	0	0	0	0	0	0	1	0	0	0			**1**
+ / -	**-11**	**-3**	**-8**	**-2**	**-4**	**-2**	**-5**	**+3**	**+2**	**7**			

Key themes contributing to pressure ulcers and actions taken

26. Following detailed analysis of every grade of avoidable pressure ulcer, key themes that led to tissue damage have been identified across the Trust and include the following;

- Additional bed capacity with reliance on bank and agency staff who maybe unfamiliar with local policies and procedures.
    - **ACTION**: All new temporary staff to the Trust received pressure ulcer prevention information which has also been sent directly to the nursing agencies. There are also regular teaching sessions and updates available for UHL bank nurses.
- Reduced staffing levels
    - **ACTION**: Review of staffing in 2013 and investment in additional registered nurses. 100 additional nurses from Spain, Portugal and Ireland have commenced in the Trust in January / February 2014. A further 100 nurses to commence in next few months.
- Increase in 'trolley waits' in the Emergency Department
    - **ACTION**: Patient assessment and pressure ulcer prevention strategies have increased in this area over the last six months. The area has benefited from new, innovative pressure relieving mattresses for use on patient trolleys.

- Delays in obtaining pressure relieving beds and mattresses

    - **ACTION**: Additional £80,000 investment in beds and mattresses across the Trust in November 2013. Significant reduction in delays experienced at ward level

- Poor Nursing Documentation in relation to staff not documenting patient assessments on admission and pressure ulcer prevention strategies.

    - **ACTION**: Review of nursing documentation across the Trust to streamline and reduce paperwork. Standard of documentation is audited monthly and reported to Quality and Nursing Boards. Performance management of ward teams and accountability meetings with the Chief Nurse where there is no improvement in documentation.

27. The Overview and Scrutiny Committee are asked to receive and note the report and the actions being taken by the UHL in the prevention and management of avoidable pressure ulcers.

NURSING AND MEDICAL STAFF AGENCY USAGE

28. Temporary staffing utilisation is reported on a weekly basis across the organisation, this is for both nursing and medical staff. The reporting is always retrospective, with the current system, however once the Electronic Rostering system has been completely rolled out across the organisation, then reporting will be in real time, as senior managers/clinicians will have their temporary staffing utilisation at their fingertips.

29. The key themes from the utilisation are detailed below.

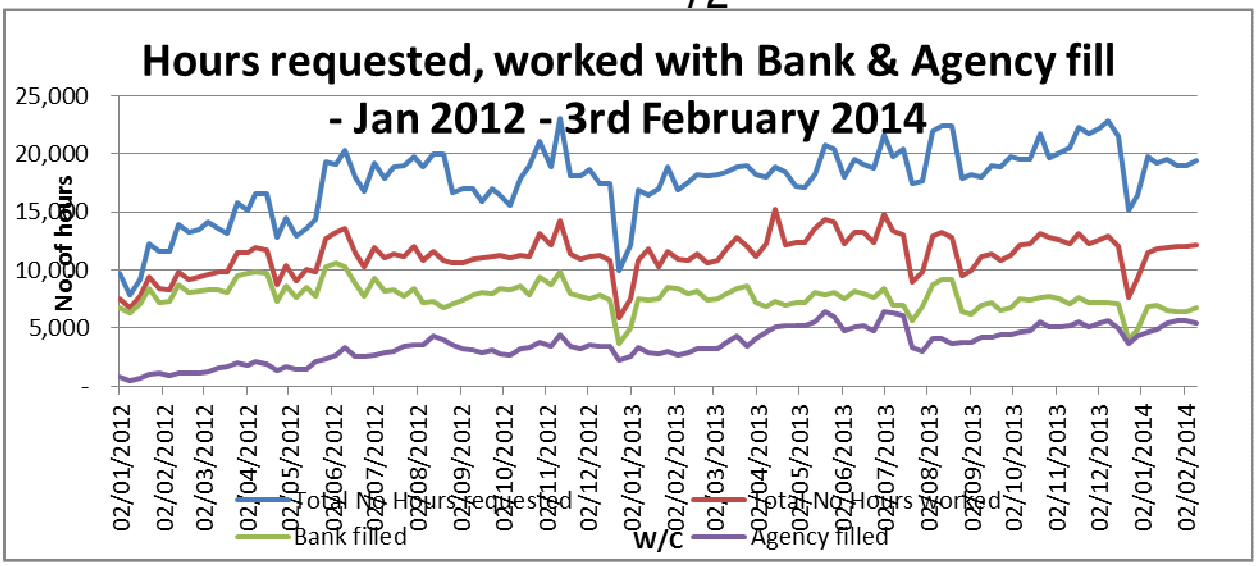
Nursing bank & agency usage within UHL

30. There is a steady increase in the amount of hours requested month on month for temporary nursing staff.

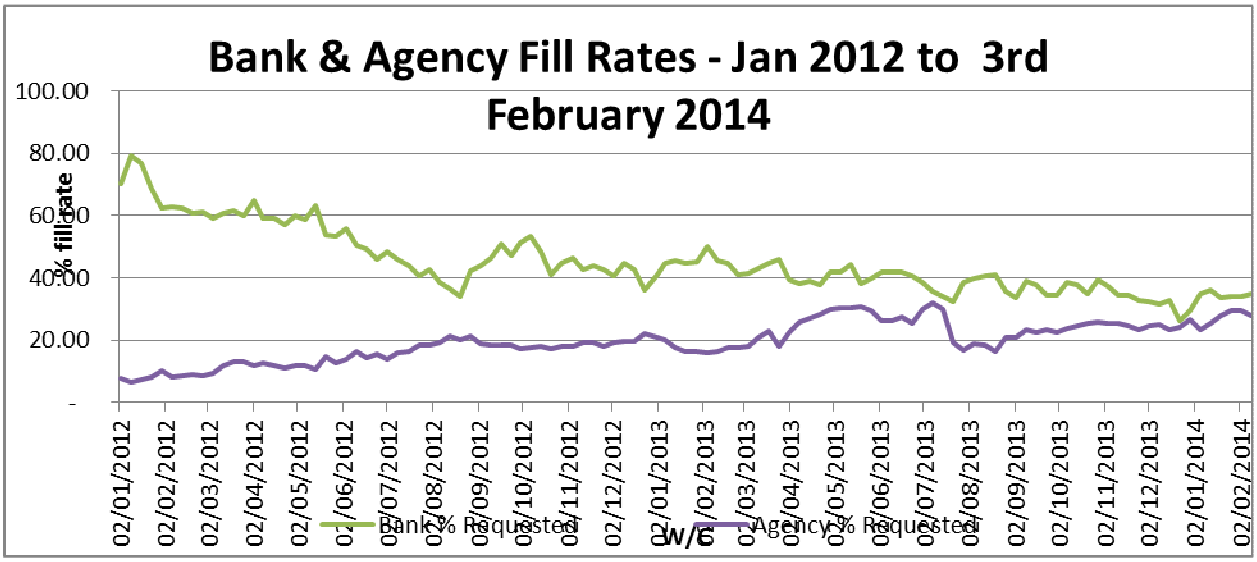
    - There is an increase in nursing requests of approximately 18% since January 2013
    - The percentage of bank fill versus agency has decreased, since January 2013
    - The percentage of agency fill has increased
    - It is clear we are not filling the gap and this poses potential risks.
    - We are consistently using non framework agencies and are escalating to Thornbury
    - The average **weekly cost** for agency nurses is **£150k** in January and **£100k** for bank

31. For the month of January 2014, the average figures are

Requests	19400 hours-this equals 517wte, which supports the felt vacancy figures
Fill rate	61%
Bank filled	6710 hours
Agency filled	5144 hours



32. There has been the predicted dip in requests over the Christmas 2 week period



33. Bank and Agency fill rates have been almost equal over the 2 week Christmas period

Nursing recruitment

34. The current recruitment plan incorporates a recruitment schedule which is supported by campaigns to attract new applicants to UHL.

35. Detailed below update of Nursing and HCA recruitment for January 2014

	CHUGS		EM & SM		MSK & SS		CSI		R,R & C		ITAPS		W&C			TOTAL		
	Band 5's	HCA's	Band 5's	HCA's	Band 5's	HCA's	Band 5's	HCA's	Band 5's	HCA's	Band 5's	HCA's	Band 5's	Midwife's	H/MCA's	Band 5's	Midwife's	HCA's
Pre-employment checking stage	3	2	15	3	3	3	2	0	10	1	14	1	4	4	8	51	4	18
Confirmed start date February 2014	0	0	1	0	0	0	0	0	0	0	0	0	2	1	0	3	1	0
Confirmed start date March 2014	8	0	9	0	2	0	0	0	10	0	4	0	2	2	0	35	2	0

International recruitment

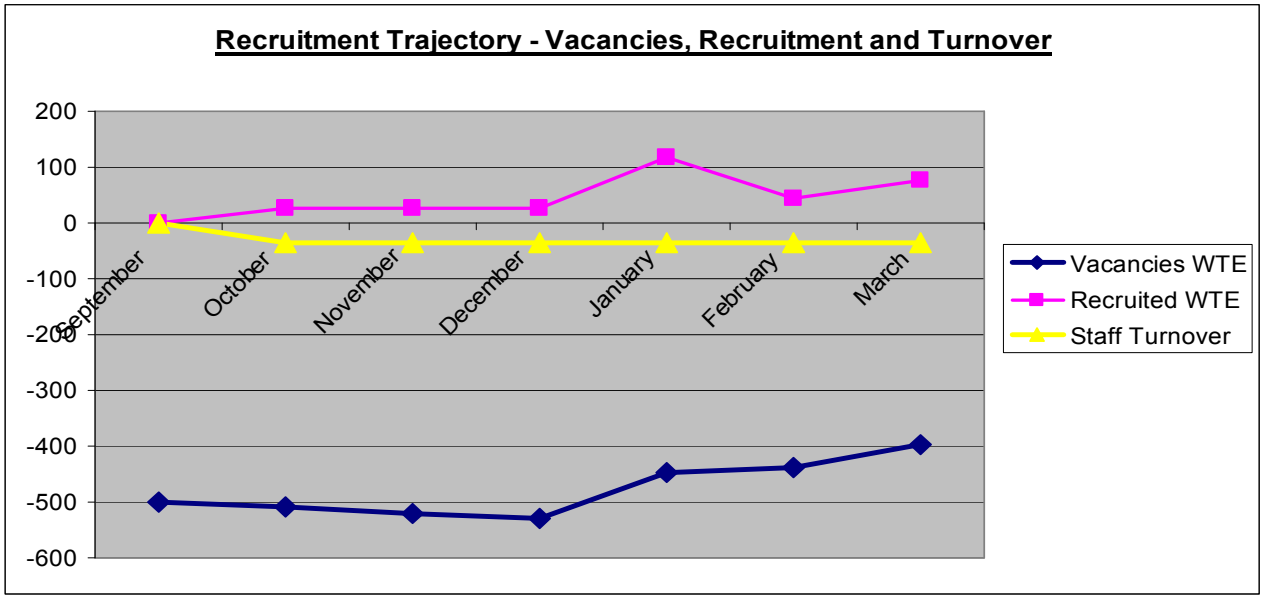
36. Robust plans have been put in place to support relocation for successful applicants including access to Trust accommodation, a mentorship/buddying arrangement and orientation to support the settling in process. This will be supported by a dedicated HR resource.

The Executive Team has supported an increase in the number of international recruits to 200, 102 new nurses have arrived to UHL, 49 completing their induction this week, with 53 starting their induction this week, so very busy time for our EPD teams.

37. It must be noted the cost of supporting these nurses in supernumerary status for a month is approximately £100k for 40 nurses per month. Therefore for a 3 month period, for both cohorts the costs is circa **£750k**

Trajectory

38. The graph demonstrates that despite active recruitment plans and assuming that turnover stays at the current rate of 35 nursing staff per month, we will only see an overall increased fill of 100wte. We therefore need to take every opportunity to over recruit based on turnover predictions.



Medical Bank & Agency usage within UHL

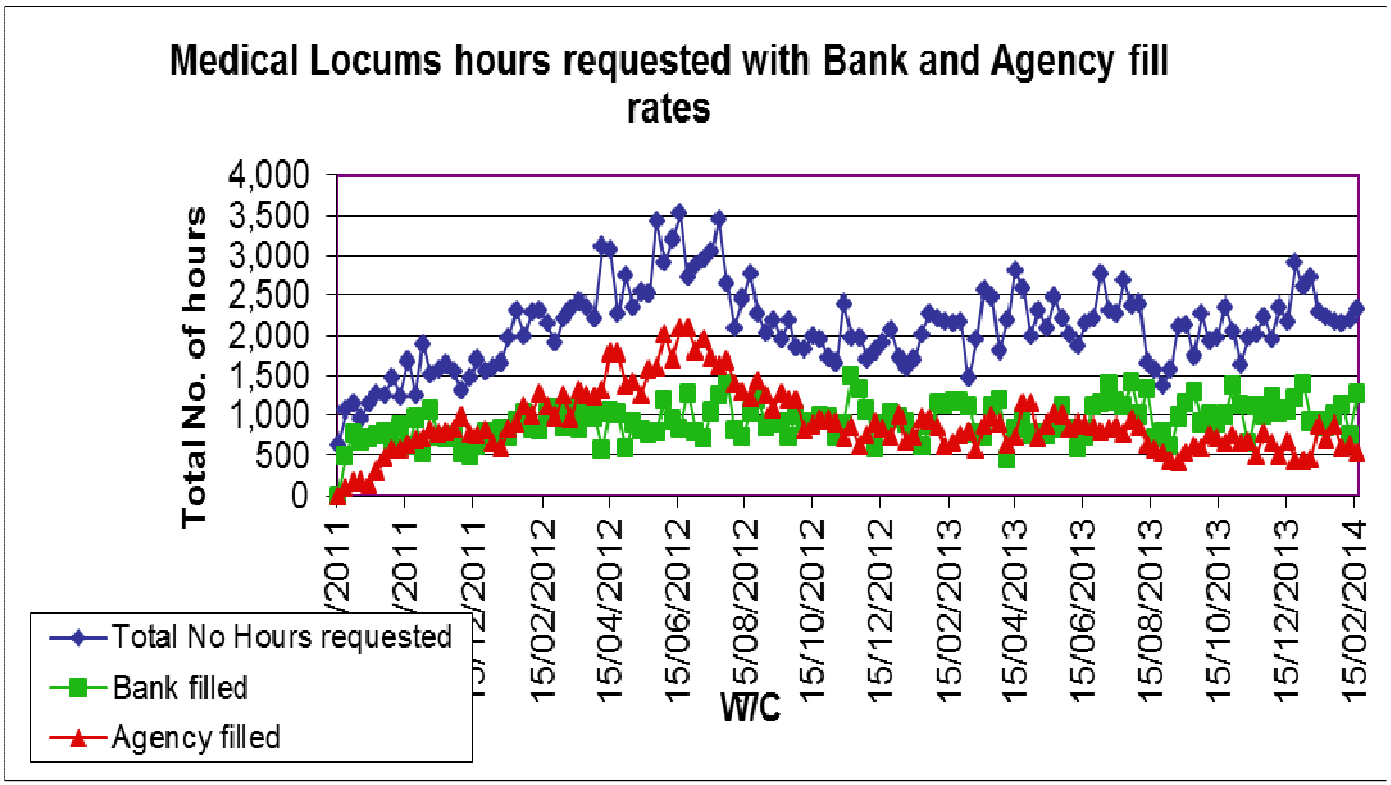
39. There is a steady increase in the amount of hours requested month on month for temporary medical staff.

- There is an increase in medical requests of approximately 10% since January 2013
- The percentage of bank fill versus agency has increased by 15%, since January 2013
- The percentage of agency fill has decreased by 16%
- It is clear we are not filling the gap and this poses potential risks.
- The average fill rate % for Jan 14 is 75%, and in Jan 13 this was at 85%, however there has been a 10% increase in the amount of requests in the last 12 months.
- The average **monthly cost** for agency doctors is **£675k** in January and **£601k** for internal locums/bank medical staff

40. For the month of January 2014, the average figures are

Requests	2710 hours-this equals 72wte
Fill rate	75%
Bank filled	9706 hours

Agency filled 701 hours



41. There is robust monitoring in place within UHL in relation to the use of agency staff with clear recruitment plans in place to reduce this spends, over the next 6 months. The Committee are asked to note the content of this report.

CANCELLED OPERATIONS

42. The cancelled operations target comprises three components:

    1. The % of cancelled operations for non clinical reasons on the day of Admission

    2. The % of patients cancelled who are offered another date within 28 days of the cancellation

    3. The number of urgent operations cancelled for a second time

43. Trust performance in January:-

    1. *The percentage of operations cancelled on/after the day* for non-clinical reasons during January was 1.5% against a target of 0.8%. The year to date performance is 1.6%.

    2. *The % of patients cancelled who are offered another date within 28 days of the cancellation.* The number of patients breaching this standard in January was 8 with 94.3% offered a date within 28 days of the cancellation.

    3. *The number of urgent operations cancelled for a second time* , Zero. A remedial action plan against the two standards that the Trust is failing has been submitted to commissioners in response to a contract query notice and this is awaiting final sign off by commissioners.

44. The recovery trajectory submitted to commissioners anticipates that standard 1) will be recovered by August 2014 and that standard 2) will be recovered by May 2014.

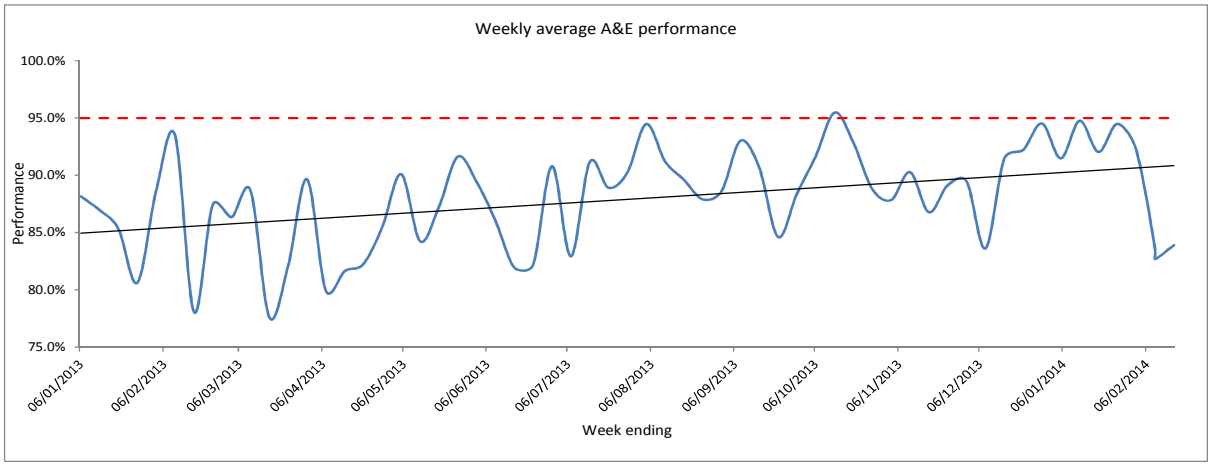
EMERGENCY DEPARTMENT PERFORMANCE

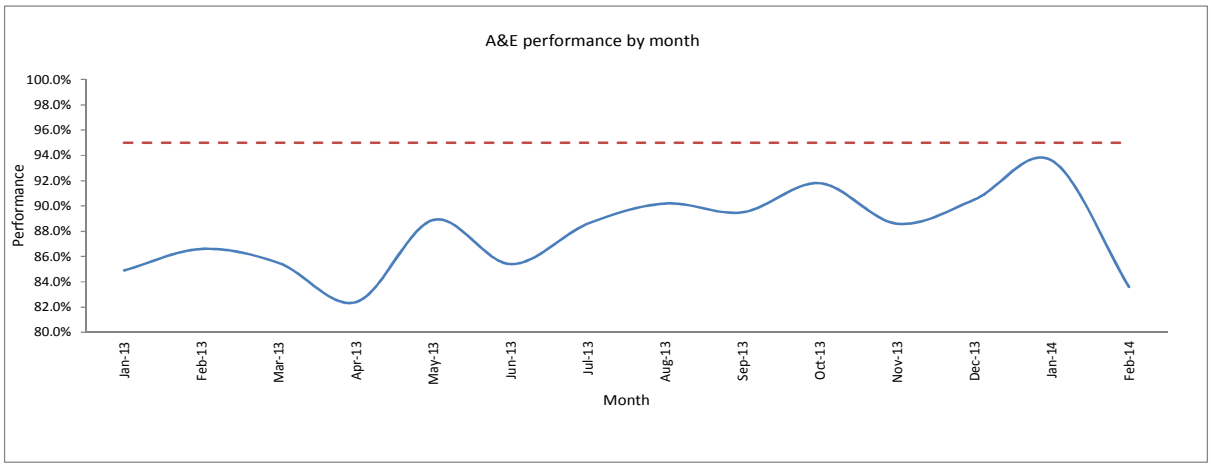
45. Performance in January 2014 against the 4 hour target was 93.6% which was the best performing month for the last 15 months. This was because of the actions taken over the last six months including; twice daily discharge meetings, command and control leadership through the site meetings, the focus on non-admitted breaches and 'super weekends'. Performance has deteriorated since the end of February primarily because of a significant increase in emergency admissions and Leicester, Leicestershire and Rutland's (LLR's) inability to increase the UHL discharge rate.

Performance overview

46. Performance in January was good, when compared to previous months at UHL and neighbouring acute trusts. 93.6% of patients were treated, admitted or discharges within four hours (graph one). There were 12 days of performance above 95%, two weeks above 94% including one week at 94.8% and by the end of January there had been eight consecutive weeks above 90%. Performance at this level was particularly pleasing because the month of January is often the most challenged month of the year.

47. However, performance in February has dramatically deteriorated, with no days above 95% and only one day above 90%. Year to date performance is 88.46%.

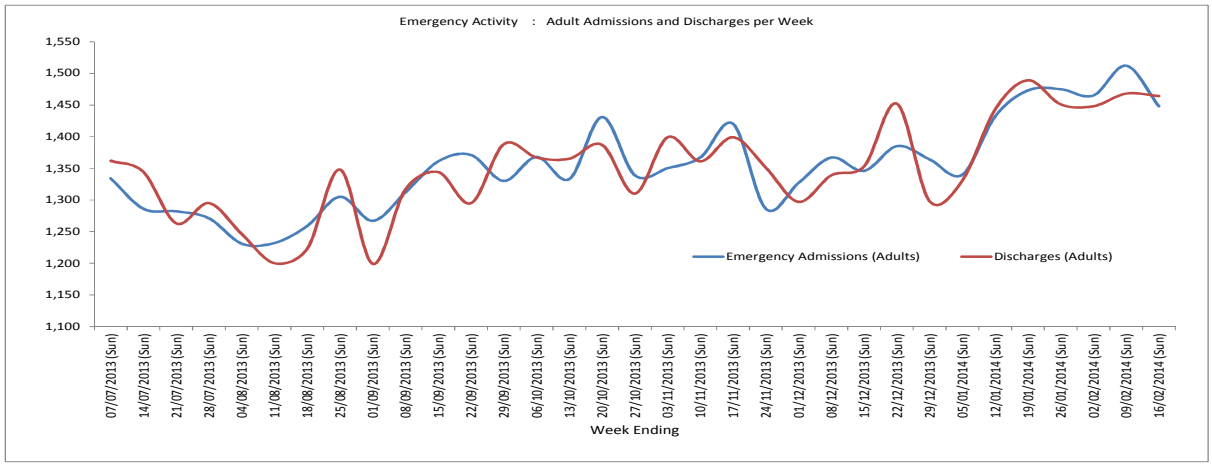




Reasons for deterioration in performance

48. **Increasing admissions** - Admissions have recently been very high. UHL's bed shortage is clearly documented and when we have increased levels of admissions,

we quickly become unable to cope. Over the first six weeks of 2014 compared to 2013, we have 26.7 more beds full of patients per day with a length of stay of between two and 15 days. When short stay attendances (LOS less than two days) are included, this increase widens to 35.5 days. The increase in short stay admissions may well be because we opened up 16 more short stay beds and are caring for patients more effectively in them, when in the past they would have gone to a base ward.



49. **High DTOCs** (Delayed Transfers of Care) - The number of patients with a delayed transfer of care has increased over the last couple of months. In early January, 3.5% of UHL bed's had DTOC patients in them. This has increased to 4.7% (66 patients) last week, an increase of nearly a ward's worth of patients. One of the problems is that community capacity has now got a higher number of patients who should be cared for in another location. Community capacity last Wednesday (19 Feb) had 15 patients who were solely awaiting a package of care, 15 patients who were awaiting placement either self-funded or social funded and 10 patients who were waiting for a continuing healthcare placement. Super weekend work and the focus on weekend discharge has continued throughout February although the level of ED performance has deteriorated. Last weekend (15-16 Feb), 291 patients were discharged from UHL with 312 discharged the weekend before. The second super weekend, when we had exceptional performance, discharged 304 patients. Weekend discharge rates have not changed.

50. **Community capacity** - CCGs have taken the decision to reduce community capacity which reduces our ability to discharge patients, hindering flow. For most of last week, UHL had 24 unfunded beds open and we cancelled the majority of elective and daycase work.

51. **Internal process** - Internal processes are not as good as they were previously. Since the morning of Friday 31 January, we have not had a day when we had continuous flow out of ED. Occupancy in ED has been very high with up to 17 ambulances waiting outside and in the evenings over 100 patients waiting in ED. With this level of sustained pressure, it is inevitable that process will suffer.

52. **Actions** - We continue to work closely with CCGs and external providers to deliver compliant performance. The level of performance over the last three weeks has been very disappointing and many difficult decisions to open additional capacity within UHL have been taken. The UHL process is not broken and we proved for a prolonged period of time that we can deliver many days of strong performance and weekly performance touching 95%. Many staff at UHL have been working most weekends in January and February to keep the super weekend effect going and discharges over the weekends remain high. There are a number of factors outside of UHL that we need LLR support to resolve. Within UHL, we must continue to ensure that when possible we keep flow going and maintain a positive, focussed effort to providing a better level of emergency care for our patients.

FINANCIAL POSITION 2013/14

57. This purpose of this report is to provide the Committee with an update on performance against the Trust's key financial duties as follows:

- Delivery against the planned surplus
- Achieving the External Financing Limit (EFL)
- Achieving the Capital Resource Limit (CRL)

58. The paper also provides further commentary on the year-end forecast based on the Month 10 results, key risks and the main financial statements.

Key Financial Duties

59. The following table summarises the year to date position and full year forecast against the financial duties of the Trust:

Financial Duty	YTD Plan £'Ms	YTD Actual £'Ms	Forecast Plan £'Ms	Forecast Actual £'Ms	RAG
Delivering the Planned Surplus	4.1	(31.0)	3.7	(39.8)	R
Achieving the EFL *	n/a	n/a	(1.4)	(1.4)	R
Achieving the Capital Resource Limit	25.9	18.9	41.8	33.0	G

Key Issues

- The Trust will not deliver its planned surplus and is forecasting a deficit position of £39.8m, and as such will not meet its breakeven duty
- The Trust has formally written to the NHS Trust Development Development Authority (NTDA) to amend the EFL to enable the deficit to be cash managed
- The Capital Resource Limit will be achieved but further focus on the management of the programme is required

Year to Date Financial Position and Month 10 Results

60. The Month 10 results and year-to-date performance may be summarised:

	January 2014			April - January 2014		
	Plan £m	Actual £m	Var (Adv) / Fav £m	Plan £m	Actual £m	Var (Adv) / Fav £m
Income						
Patient income	49.5	56.0	6.4	530.1	547.3	17.2
Teaching, R&D	6.1	4.4	(1.8)	62.6	60.3	(2.3)
Other operating Income	3.2	3.5	0.3	31.9	32.9	1.0
Total Income	**58.9**	**63.9**	**5.0**	**624.5**	**640.4**	**15.9**
Operating expenditure						
Pay	37.2	39.8	(2.6)	373.3	392.7	(19.4)
Non-pay	23.2	22.8	0.4	230.3	242.3	(12.0)
Reserves	(6.3)	-	(6.3)	(19.9)	-	(19.9)
Total Operating Expenditure	**54.1**	**62.6**	**(8.5)**	**583.8**	**635.0**	**(51.3)**
EBITDA	**4.8**	**1.3**	**(3.5)**	**40.8**	**5.4**	**(35.4)**
Net interest	0.0	0.0	(0.0)	0.0	0.0	0.0
Depreciation	(2.7)	(2.8)	0.1	(27.1)	(27.1)	(0.0)
PDC dividend payable	(1.0)	(0.9)	(0.0)	(9.6)	(9.3)	0.3
Net deficit	**1.1**	**(2.5)**	**(3.4)**	**4.1**	**(31.0)**	**(35.1)**
EBITDA %		**2.0%**			**0.8%**	

61. The Trust is reporting:

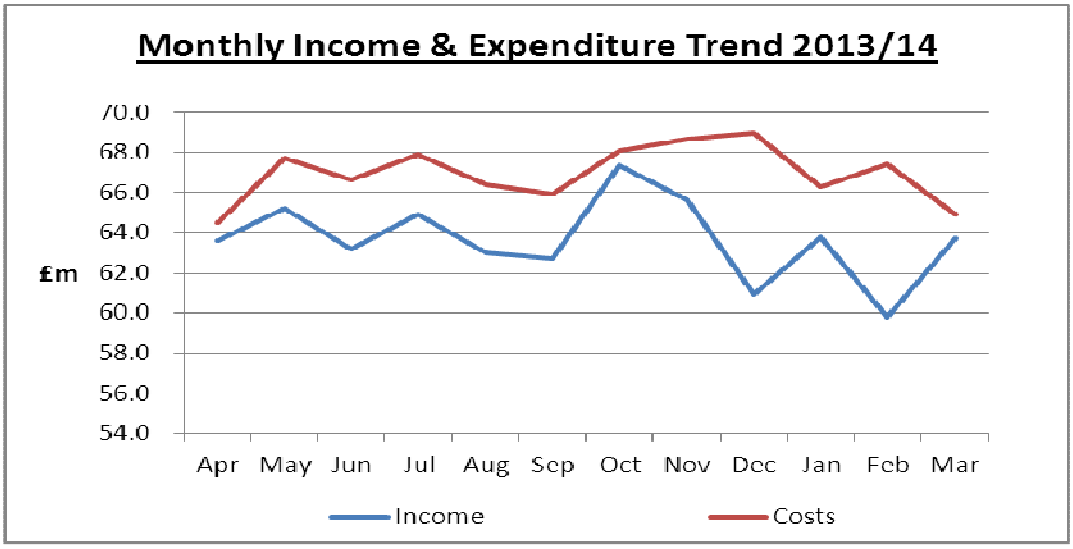
- A deficit at the end of January 2014 of £31.0m, which is £35.1m adverse to the planned surplus of £4.1m
- In month position is a £2.5m deficit, £3.4m adverse to the Plan
- The forecast for January was a deficit of £2.3m; therefore the January actuals reflect a £0.2m adverse position to forecast

Year End Forecast

62. The revised base-case forecast, taking account of the Month 10 results, is consistent with the agreed year end control total at £39.8m deficit. This is summarised in the following table:

	Year End Forecast		
	Plan £m	Forecast £m	Var (Adv) / Fav £m
Income			
Patient income	634.0	654.1	20.1
Teaching, R&D	75.0	70.8	(4.2)
Other operating Income	38.2	39.0	0.8
Total Income	**747.1**	**763.9**	**16.8**
Operating expenditure			
Pay	447.6	473.1	(25.5)
Non-pay	275.7	287.5	(11.8)
Reserves	(24.0)	-	(24.0)
Total Operating Expenditure	**699.4**	**760.6**	**(61.2)**
EBITDA	**47.8**	**3.3**	**(44.5)**
Net interest	0.0	-	0.0
Depreciation	(32.5)	(32.3)	0.2
PDC dividend payable	(11.6)	(10.8)	0.8
Net deficit	**3.7**	**(39.8)**	**(43.5)**
EBITDA %		**0.4%**	

64. The following chart highlights, graphically, the monthly trends of both income and expenditure to the year end:



65. The risks and opportunities within the year end forecast are shown in the following table to provide a risk range:

	Risk	Downside £000	Likely Year End £000	Upside £000
Month Gross 10 Re-forecast (I&E deficit)		**(44,731)**	**(44,731)**	**(44,731)**
Risks & Opportunities				
Additional Education & Training income	G	300	300	300
Theatre Tray Stock Count	A	0	1,500	2,500
Reduction in Contingency	A	0	800	1,200
PDC Dividend revised Calculation	G	0	400	600
Depreciation	A	0	300	300
Corporate Forecast Improvement	A	0	500	700
CMG Forecast Improvement	A	0	500	700
Winter	G	0	600	750
Sum of upside / downside issues		**300**	**4,900**	**7,050**
Revised Year End Forecast (I&E deficit)		**(44,431)**	**(39,831)**	**(37,681)**

66. The key financial risks are as follows:

- Winter pressures beyond the levels planned resulting in premium costs and the loss of elective income

  Mitigation: The Trust is closely monitoring the impact providing additional resource as required. The position will be escalated with CCGs through the contract management process

- CCG income assumptions

  Whilst activity and income assumptions are aligned between the Trust and Commissioners, there is a 'subject to affordability' clause within the CCGs' position

  Mitigation: Contract settlement sought with Specialised Commissioning and local CCGs

- Unforeseen events

  The Trust has very little flexibility and a minimal contingency to manage unforeseen financial pressures and as such these risks will impact on the bottom line position

- Liquidity

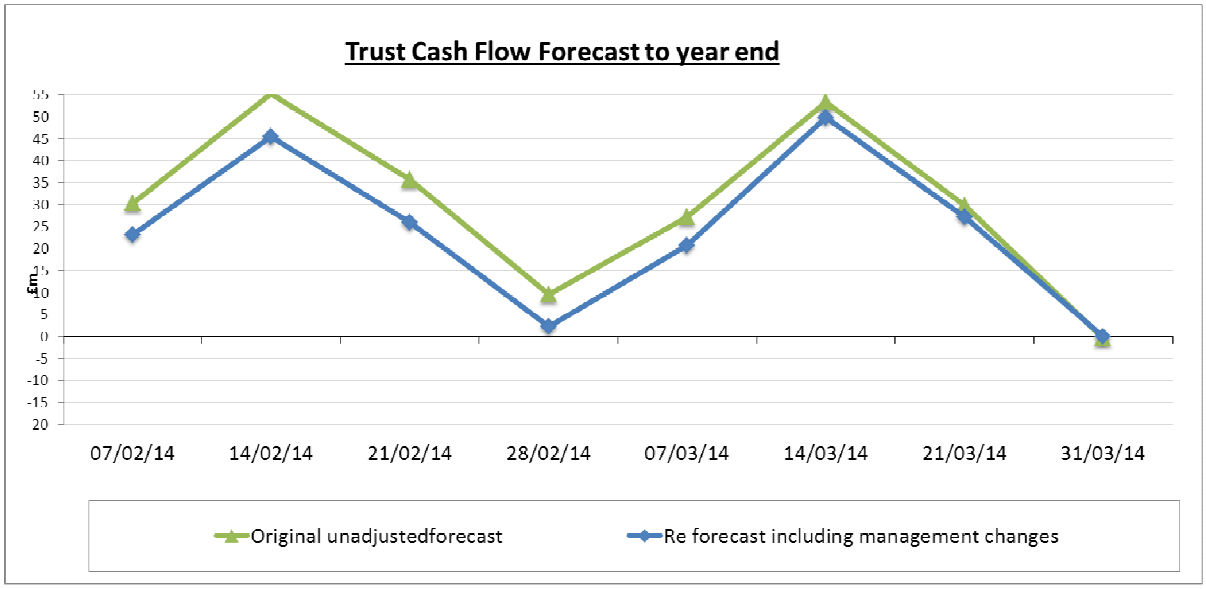
  The projected £39.8m deficit creates liquidity issues for which an EFL adjustment has been requested

  Mitigation: Contingency plan will be considered by the Finance and Performance Committee.

Cash Flow Forecast

67. The Trust's current cashflow forecast is aligned to the forecast year end deficit of £39.8m. This indicates a deliberate year end cash balance of zero against a Plan balance of £19m. The forecast is shown on the graph overleaf and includes the following assumptions:

- Capital cash payments will total £31m for the full year
- The current balance of £13m extended creditor payments will be reduced to less than £5m by the year end
- All suppliers will remain on 30 day payment terms (apart from specific exceptions)
- The current level of NHS debt will reduce by £7.0m



68. The Trust set an initial plan for 2013/14 to achieve a year end cash balance of £17.3m (2012/13 - £19.98m) based on a retained Income & Expenditure (I&E) surplus of £3.7m. This level of planned cash equates to an External Financing Limit of (£1.4m), which is a statutory financial duty that the Trust must achieve. Failure to achieve the planned level of cash means that we will not achieve our EFL.

Year End Cash Forecast

69. To achieve the planned level of cash without external support, the Trust will need to maintain a backlog of unpaid and overdue creditor invoices totalling at least £26.90m, which approximates to one month of creditor payments over and above the Trust's standard 30 day payment terms. There are considerable operational risks to the Trust of

maintaining such a high level of unpaid invoices, such as key suppliers putting the account on stop and not maintaining a continuity of supplies essential to patient care.

70. The Trust is not in a position to apply for a longer term loan given the current timescales and lack of certainty concerning its granting. Equally, temporary borrowing repayable by 31 March 2014 would not solve the in-year liquidity problem.

71. The Trust has therefore formally requested from the NTDA that our EFL is reset from (£1.4m) to £19m. This will enable us to reduce our year end cash balance to zero and minimise the level of backlog invoices whilst still achieving the EFL. We are currently awaiting approval for this adjustment.

72. The Trust will apply for temporary borrowing to be received on 1 April 2014 which will ensure an adequate level of cash in the first quarter of 2014/15 until a longer term financing solution is secured.

Capital

73. The capital position at end of January 2014 is £19.2m against the annual plan of £40.1m.

74. The year end forecast is now £33.5m. Key deliverables to meet this forecast are CHP Units (£2.1m), Facilities Backlog (£3.7m), Medical Equipment (£1.1m), IM&T (£1.4m) and ED Floor (£1.1m).

75. External funding bids of £2m, £0.75m and £0.16m have been awarded this month around successful IM&T, maternity and safer ward bids. The majority of this funding is required to be spent by the end of the year and is within the cash position.

Recommendation

76. The Committee is recommended to note this report:

CQC INSPECTION

77. The CQC conducted an inspection of the Trust in January 2014.

78. The Trust has yet to receive the draft inspection report. This is due w/c 3 March 2014.

79. The Trust understands that the final report will be published by the CQC in April 2014.

CONCLUSION

80. The Committee is invited to receive and comment upon this report. Representatives of the Trust will be in attendance at the Committee meeting (as identified in paragraph 1.2 above) to respond to the comments and questions of Members.

OFFICER TO CONTACT

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