Paper D

University Hospitals of Leicester NHS
NHS Trust

To:	**Trust Board**
From:	Director of Clinical Quality
Date:	2nd June 2011
CQC regulation:	Outcome 16

Title:	University Hospitals of Leicester's Draft Quality Account for 2010/11
Author/Responsible Director: Director of Clinical Quality / Medical Director	
Purpose of the Report: To provide the GRMC with assurance around the development and content of UHL's second QA.	
The Report is provided to the Board for:	

Decision		Discussion	X
Assurance	X	Endorsement	X

Summary / Key Points:

Quality Accounts (QA) are annual reports to the public from providers of NHS healthcare about the quality of services they deliver. There is a legal requirement under the NHS (QA) Regulations 2010 for all bodies who provide, or arrange to provide (sub-contract) NHS services to produce a QA. This is the second year that we have been required to produce a QA.

Department of Health guidance dictates that a QA has to consist of the following three parts:

- Part 1 - a statement on quality from the Chief Executive of an organisation and a statement from a senior employee outlining that to the best of their knowledge the information is accurate (laid down in regulations)
- Part 2 - Priorities for improvement for 2011/12 and statements relating to the quality of NHS services provided (laid down in regulations)
- Part 3 – review of quality performance of 2010/11, explanation on who we have engaged with to determine the content of the QA and statements from Local Involvement Networks (LINks), Primary Care Trust (PCT) and Joint Health and Overview Scrutiny Committee (JHOSC). The contents of review of quality performance section under part three are for provider determination.

Part 2 of the QA contains mandatory information which is laid down in the NHS (Quality Accounts) Regulations 2010. It includes statements on the review of services, goals agreed with our commissioners, what others say (the Care Quality Commission) about us, participation in clinical audit, participation in clinical

research, data quality (clinical coding error rate and information governance) and our priorities for improvement.

The three priorities for improvement for 2011/12 have been identified as:

- To improve readmission rates
- To improve patients experience in our hospitals
- To improve mortality rates further

The Director of Clinical Quality presented to the Patient Advisors in February 2011, outlining the process and requesting suggestions for inclusion in the report. Patient Advisors provided written feedback to the Director of Clinical Quality on the 17th March. Where possible this feedback was incorporated ahead of circulation to our stakeholders. Where it was not feasible, information was sought from the Director of Nursing and feedback was provided to the Chair of Patient Advisors to answer any queries.

At the GRMC in February and March, members were asked to highlight any areas that should be included in the QA both as a review of 2010/11 and for priorities for 2011/12. These suggestions have duly been included under the 2011/12 priorities section.

There is a statutory requirement that feedback has to be invited from Leicester, Leicestershire and Rutland LINks, the Joint Health and Overview Scrutiny Committee and NHS Leicestershire County and Rutland.

The Director of Clinical Quality presented jointly to Leicestershire and Leicester LINks in February 2011 with an additional presentation to Leicestershire LINks in April. The Director of Clinical Quality presented UHL's draft QA to the Leicestershire and Rutland Joint Health and Overview Scrutiny Committee on 11th April.

The PCT are also required to check the accuracy of the data provided in the QA against any data they have been supplied with as part of their contractual obligations.

Where it has been feasible, the draft QA has addressed the issues raised from our stakeholders. Part 4 provides comments from the LINks, PCT and Joint Health and Overview Scrutiny Committee.

Draft 5 of the QA was presented to GRMC at its meeting on the 26th May and the Medical Director will update the Board in respect of discussions there.

Following feedback from the Trust Board final amendments will be made and the final version of the QA will be submitted to Leicestershire and Rutland PCT, LINks and JHOSC for their information.

Recommendations:
Trust Board are asked to receive and endorse this report and advise the Director of Clinical Quality of any final amendments.

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Previously considered at another corporate UHL Committee ? Yes – Executive Team 17 May 2011 and Governance and Risk Management Committee 26 May 2011	
Strategic Risk Register NA	**Performance KPIs year to date** Q and P Report
Resource Implications (eg Financial, HR) Translated hard copies where requested	
Assurance Implications Reviewed by the PCT	
Patient and Public Involvement (PPI) Implications Information in the public domain. Should be used to determine choice. PPI section in the QA.	
Equality Impact Considered in the QA	
Information exempt from Disclosure No	
Requirement for further review? To be advised	

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

Report to: Trust Board

Report by: Director of Clinical Quality / Medical Director

Date: 2nd June 2011

Subject: University Hospitals of Leicester's Draft Quality Account for 2010/11

1.0 Introduction

1.1 Quality Accounts (QA) are annual reports to the public from providers of NHS healthcare about the quality of services they deliver. There is a legal requirement under the NHS (QA) Regulations 2010 for all bodies who provide, or arrange to provide (sub-contract) NHS services to produce a QA. This is the second year that we have been required to produce a QA.

1.2 These reports are for the public and report on the quality of services looking at the three domains of safety, effectiveness and patient experience.

1.3 The aim of a QA is to enhance accountability to the public and engage the leaders of an organisation in their quality improvement agenda.

2.0 Structure of the QA

2.1 Department of Health guidance dictates that a QA has to consist of the following three parts:

- Part 1 - a statement on quality from the Chief Executive of an organisation and a statement from a senior employee outlining that to the best of their knowledge the information is accurate (laid down in regulations)

- Part 2 - Priorities for improvement for 2011/12 and statements relating to the quality of NHS services provided (laid down in regulations)

- Part 3 – review of quality performance of 2010/11, explanation on who we have engaged with to determine the content of the QA and statements from Local Involvement Networks (LINks), Primary Care Trust (PCT) and Joint Health and Overview Scrutiny Committee (JHOSC). The contents of review of quality performance section under part three are for provider determination.

2.2 Part 2 of the QA contains mandatory information which is laid down in the NHS (Quality Accounts) Regulations 2010. It includes statements on the review of services, goals agreed with our commissioners, what others say (the

CQC) about us, participation in clinical audit, participation in clinical research, data quality (clinical coding error rate and information governance) and our priorities for improvement.

2.3 The three priorities for improvement for 2011/12 have been identified as:

- To improve readmission rates
- To improve patients experience in our hospitals
- To improve mortality rates further

2.4 There is a statutory requirement to feed back on last year's priorities. Last year (2009/10) the following three priorities for improvement for 2010/11 were set:

- To improve patient's experience in our hospitals
- To further reduce healthcare associated Infections
- To reduce venous thromboembolism (VTE)

2.5 Leads with responsibility for those particular areas have provided a summary of progress made during 2010/11.

2.6 Part 3 provides the opportunity for local determination (or local content) and contains information on a cross section of our services (some Trust wide and some at a clinical level).

3.0 The engagement process in producing our 2010/11 QA

3.1 The Director of Clinical Quality presented to the Patient Advisors in February 2011, outlining the process and requesting suggestions for inclusion in the report. Patient Advisors provided written feedback to the Director of Clinical Quality on the 17th March. Where possible this feedback was incorporated ahead of circulation to our stakeholders. Where it was not feasible, information was sought from the Director of Nursing and feedback was provided to the Chair of Patient Advisors to address any queries.

3.2 At the GRMC in February and March, members were asked to highlight any areas that should be included in the QA both as a review of 2010/11 and for priorities for 2011/12. These suggestions have duly been included under the 2011/12 priorities section.

3.3 There is a statutory requirement that feedback has to be invited from Leicester, Leicestershire and Rutland LINks, the Joint Health and Overview Scrutiny Committee and NHS Leicestershire County and Rutland.

3.4 The Director of Clinical Quality presented jointly to Leicestershire and Leicester LINks in February 2011 with an additional presentation to Leicestershire LINks in April. The Director of Clinical Quality presented UHL's draft QA to the Leicestershire and Rutland Joint Health and Overview Scrutiny Committee on 11th April.

3.5 Leicester City LINk, Leicestershire LINk and the Joint Health Overview and Scrutiny Committee all provided feedback and this is included in the QA. Rutland LINk declined to provide a statement for the QA.

3.6 There has been ongoing dialogue with NHS Leicestershire and Rutland PCT throughout the process of developing the QA. Legally, the PCT are required to corroborate our QA by confirming in a statement whether or not they consider the document contains accurate information in relation to the services provided by the provider.

3.7 The PCT are also required to check the accuracy of the data provided in the QA against any data they have been supplied with as part of their contractual obligations.

3.8 Where it has been feasible, the draft QA (at appendix 1) has addressed the issues raised from our stakeholders. Part 4 provides comments from the LINks, PCT and Joint Health and Overview Scrutiny Committee.

3.9 Draft 5 of the QA was presented to GRMC at its meeting on the 26th May and the Medical Director will update the Board in respect of discussions there.

4.0 Next Steps

4.1 Following feedback from the Trust Board final amendments will be made and the final version of the QA will be submitted to Leicestershire and Rutland PCT, LINks and JHOSC for their information.

4.2 A front cover for the QA will be added to match the cover of the Annual Report.

4.3 UHL's QA will be published by the end of June on the NHS Choices (or another website if NHS Choices is not available) and a copy will be sent to the Secretary of State.

4.4 Following the publication of the QA, there is a legal requirement under the Health Act 2009 for a notice to be placed at the premises where patients are receiving their healthcare services, stating where the QA can be obtained. These will be replaced in the main receptions at St Mary's Birth Centre, the Leicester Royal Infirmary, Leicester General Hospital and Glenfield Hospital.

5.0 Recommendations

5.1 Members of the Board are asked to receive and endorse this report and advise the Director of Clinical Quality of any final amendments.

2010/11 DRAFT QUALITY ACCOUNT

Version	Last amended	Main changes
Draft 1	11.3.2011	First draft of account to Executive Team meeting on 15/3/2011
Draft 1.2	17.3.2011	Circulated to Governance and Risk Management Committee members in March Amendments to clinical audit and patient experience priority sections
Draft 2	22.3.2011	Amended to incorporate feedback from the Executive Team meeting
Draft 3	30.3.2011	Amendments to detail of priorities for improvement. Circulated to JHOSC
Draft 3.1	4.4.11	Additional amendments incorporated from Chief Operating Officer and Information Governance Manager. Circulated to LINks, OSC and PCT for commentary
Draft 4	13.5.11	Amendments in light of initial PCT and final OSC and LINks feedback
Draft 5	18.5.2011	Amendments to reflect feedback from Executive Team

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Draft 5 May 2011

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Where possible we have avoided using medical and managerial terminology. Where this has not been possible you will find information in the Glossary at the back of this document which is referenced by a * next to the word.

1.0 Statement from the chief executive

Welcome to the University Hospitals of Leicester's Quality Account for the year 2010/11.

The purpose of this report is twofold.

1. To report back to patients, public and partners our performance against those quality indicators which we said we would improve upon over the last year.
2. To explain which quality indicators we will be concentrating on over the next year.

The report starts with a look back at the last year and an honest appraisal of whether we did what we said we were going to do. And it ends with a look forward to our quality priorities for 2011/12.

What do we mean by 'quality'? One way of looking at it is that
we all accept that people coming into hospital are ill, and in some cases they are severely ill. The good news is that if they come into Leicester's hospitals our mortality rates are better than the majority of hospitals in the UK.

Linked to that is the fact that in Leicester your chance of picking up an infection like MRSA or Clostridium difficile are very small. Our rates have tumbled from a high of 21 cases of MRSA in February 2001 to an average of one per month last year.

The point is that there are many ways to measure the quality of NHS services but some of those ways are so abstract that they become almost meaningless to the public.

Think about it in terms of buying a car or a computer; if like me you are bamboozled by the technical speak about 'torque' or 'available RAM', what do you do? Well, we tend to start to look for other signs of quality which aren't necessarily those in the manual. That means we may judge quality on anything from whether or not the car door makes a satisfying 'clunk' when we close it, to how polite and friendly the salesperson is.

The interesting thing is that usually good service and good products go hand in hand. We all know those places where we can pick up something cheap but if you ask the sales assistant for help they are hardly able to string a sentence together… and we all know those shops where if you ask for help, the person will stop what they are doing and give you their full attention.

Where's this going? Well, we know that sometimes patients judge the quality of our services not just by things like survival and infection rates but also by whether or not we were polite and friendly to them and whether we took the time to find out about their concerns…both approaches are right. And this speaks to the wider point that just because we are on the whole clinically good at something does not mean that we should be allowed to give anything other than excellent patient experience.

Patients and their relatives judge us both on *what we do* and *the way we do it* and as such in this Quality Account you will see, as we did last year, that we are going to concentrate on both improving clinical quality and improving the patient experience.

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Last year we set three quality priorities: improving patient experience; reducing infections, and reducing blood clots or VTEs (venous thrombo embolism), which can be fatal if they end up lodged in the lungs.

We made significant progress on all three but patient experience is still not where we would want it to be. Currently more than 9 out of 10 patients rate their care in Leicester as ‘good’, ‘very good’ or ‘excellent’. We want to be in the top 20% of trusts for excellent patient experience, yet the fact is that we are in the middle 60%...it’s for this reason that we are continuing to make improving patient experience a priority for the second year in succession.

As regards infection control we have reduced our MRSA and Clostridium difficile infections year on year. This means that Leicester’s hospitals are getting safer in terms of these infections.

And in terms of reducing blood clots, this time last year we assessed just 50% of patients on admission and this year we reached 80.6% by the end of March.

Is that good enough? Well it’s your view which really counts but I will share mine. I think Leicester’s hospitals are improving all the time but I want to be able to report to you that the kind of improvements we are seeing in clinical services is being matched by improvements in patient experience.

For next year we will have three quality priorities: **improving patient experience,** which we have already talked about. We will also be seeking to **improve readmission rates** (which mean reducing the number of patients who have to be readmitted to hospital within 30 days of us discharging them). And we want to **improve mortality rates** (Leicester’s mortality rates are really quite good at the moment, meaning that when compared to other hospitals our services have far better than average survival rates) but we think we can go further still.

Before signing off, I wanted to thank those organisations and stakeholder groups which have again helped to guide us in terms of what parts of the quality agenda we should be focusing on and I’d also like to thank the 12,000 hard working members of staff who have contributed to improvements in quality over the last year.

We know what we have to do and I look forward to reporting back progress to you next year.

Malcolm Lowe-Lauri
Chief executive

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1.1 Statement of Responsible Person on behalf of University Hospitals of Leicester

To the best of my knowledge the information included in this Quality Account is accurate.

Signed:
(Malcolm Lowe-Lauri, chief executive)

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1.2 Part two 2011/12 priorities for improvement

1.2.1 We have chosen three priorities for improvement this year (2011/12). The priorities have been developed in conjunction with our Trust board and our commissioners (the local primary care Trusts) and reflect issues high on the national agenda. In addition to these priorities for improvement there are many other quality improvements detailed in our Quality Strategy and CQUIN programme covering safety, experience and effectiveness. The priorities for 2011/12 detailed in this Quality Account are to:

- improve mortality rates further
- improve readmission rates
- improve patients' experience in our hospitals.

1.2.2 These priorities for improvement are not an exhaustive list of all of the quality improvement plans that exist to improve the quality of care provided. Our Quality Strategy also describes priorities for improvement (over the next five years). This is available at (to be inserted)

1.3 Priority 1 – Improve mortality rates further

1.3.1 We want to

- Reduce all in-hospital patient deaths in both elective and non elective care and aim to be have a RAMI* score in the top 25% of Trusts

1.3.2 For 2010/11 our overall risk adjusted mortality index (RAMI) is 'lower than expected' for this financial year. Further details can be found in the Trust Quality and Performance Report , which can be downloaded every month from the About Us section of our website www.uhl-tr.nhs.uk/

1.3.3 We will measure progress by

- Reporting on the number of deaths monthly
- Measuring UHL's Standardised Mortality Rate
- Measuring individual specialty mortality
- Acting on the outcomes of mortality reviews to ensure lessons are learnt
- Monitoring the numbers of deaths in each BME (black and minority ethnic) group on a monthly basis
- Comparing BME mortality rates with other trusts of similar populations
- Comparing standardised mortality rates by BME
- Considering ethnicity factors as part of mortality reviews

1.3.4 We will report progress to

- The Trust board through the quality and performance report
- The Governance and Risk Management Committee
- The Clinical Effectiveness Committee
- Divisional board meetings
- Speciality mortality and morbidity review groups
- Our commissioners as part of our monthly quality meetings

1.4 Priority 2 - Improve readmission rates

1.4.1 We want to

- Reduce avoidable readmissions by 25% in elective and emergency admissions for both adults and children by improving the discharge planning process, improving patient information and therefore improving patient experience.

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1.4.2 Our current year to date performance (as of February 2011) is 5.1% for emergency 30 day readmissions (following elective readmissions). Further details can be found in the Trust Quality and Performance Report, which can be downloaded every month from the About Us section of our website www.uhl-tr.nhs.uk/

1.4.3 We will measure progress by

- Monitoring the number of readmissions monthly
- Monitoring the number of complaints related to admissions

1.4.4 We will report progress to

- The Trust board through the quality and performance report
- Divisional board meetings
- Wards and departments
- Quality and Performance Management Group
- The Finance and Performance Committee
- Our commissioners as part of our monthly quality meetings

1.5 Priority 3 - Improve patients experience in our hospitals

1.5.1 We understand the importance of providing patients with an excellent experience therefore our vision is to continue to build on our Caring at its Best standards, by ensuring that improving the patient experience is everyone's business.

1.5.2 We want to

- Be in the top 20% of trusts for patient experience in relation to privacy and dignity and patients rating their care as excellent

- Reduce the number of complaints related to staff attitudes by 5% each year

1.5.3 This year our performance equated to being in the middle 60% of trusts. In 2010/11 we received 171 formal complaints where the primary subject was 'staff attitude'.

1.5.4 We will measure progress by

- Measuring patient experience through the national patient survey and local polling

- Measuring and analysing complaints related to staff attitudes

1.5.5 We will report progress to

- The Trust board meeting through the Quality and Performance Report and our local performance arrangements
- Our commissioners as part of our monthly quality meetings
- Divisions and clinical business units
- Patients and families
- The Governance and Risk Management Committee with a quarterly patient and family experience report

1.5.6 This will be supported by

- Every nurse and health care assistant will receive 'Caring at it Best' interactive training
- Hourly nursing ward rounds for every patient
- Making clear who the nurse in charge is by a large, red 'nurse in charge' badge
- A matron round and 'meet matron' sessions for every elderly care ward

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- Teaming volunteers up with specific wards and specific duties so that every ward knows in advance what volunteer resource they have to support them
- The launch of the 'Caring at its Best' quarterly awards, linked to UHL values, with endorsement through Age UK
- Holding ward managers / sisters to account for the performance of their wards when the expected standard of care is not provided

1.6 Progress on last year's priorities

1.6.1 Last year (2009/10) we set the following three priorities for improvement for 2010/11:

- to improve patients' experience in our hospitals
- to further reduce healthcare associated Infections*
- to reduce venous thromboembolism (VTE).

1.6.2 Priority 1 – Improving patients' experience in our hospitals

1.6.3 In 2010-11 we aimed to

- Be consistently in the top 20% of trusts nationally for positive patient feedback (via local polling results and the national patient survey). We said we would use two key indicators of patient experience to track experience over time. These two questions encompassed a range of quality questions which gave scores to measure improvements. These were:
    - self reported experience of patients and
    - overall respect and dignity score.
- Ask every patient about their experience of our hospitals through our patient polling. The aim was to feedback this information directly to the wards and clinics to make sure staff were aware of what their patients think about our services. Information was also reported to the Trust board and to our commissioners.
- Make sure that patients' experiences were used to improve the quality of our services. Listening to patients is crucial for us to know what works well and where we need to target improvements.

1.6.4 This year our performance equated to being in the middle 60% of trusts, so moving in to the top 20% will remain a top priority for 2011/12.

1.6.5 We

- Continued to use patients' experiences to improve the quality of our services. During 2010 we introduced a monthly patient experience survey. Every month we are gathering patient experience feedback from approximately 850 patients.
- Have now gathered a great deal of patient intelligence. The monthly patient experience survey allows trends and improvements to be highlighted.

  Data from August 2009 to date shows four key themes emerging, these are:
    - providing information for patients
    - staff behaviours and attitude
    - noise at night
    - pain and comfort management.

  Taken from the national patient survey results and the monthly Patient Experience Surveys each division is working on Caring at its Best projects that focus on these four key areas. Intelligence from the surveys is continually reviewed by each division to monitor progress and improvements in the key

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themes emerging.

1.7 Priority 2 – Further reducing healthcare associated infections

1.7.1 We continue to work hard to maintain our success at reducing healthcare associated infections (HCAI).

1.7.2 In 2010/11 our objective was to have no more than 9 MRSA* bacteraemia cases and no more than 212 patients newly identified with CDT*.

1.7.3 Our final figures for 2010/2011 were 12 MRSA bacteraemia cases and 200 patients newly identified with CDT (compared to 13 MRSA bacteraemias and 236 CDT cases in 2009/10). While not meeting the MRSA objective, we are once again pleased that there has been a continued year-on-year reduction demonstrated as numbers of patients with these infections identified within our hospitals continues to fall. In common with other trusts nationally, as we have become more successful in this fight, the numbers allocated to us by the Department of Health become ever smaller and we all must recognise that a zero rate of infection is not achievable.

1.7.4 For a trust that serves a local population of more than one million people and saw 232,800 come through our doors, we continue in our fight to ensure that our patients do not acquire avoidable healthcare associated infections while in our care.

1.7.5 Last year we indicated we would measure this by:

- staff compliance with hand hygiene. Our results showed that adherence to the hand hygiene policy was consistently over 95% across our hospitals
- completing thorough investigations on any MRSA bacteraemia and where any patient may have CDT identified on their death certificate to ensure all lessons learnt are fed back to ward teams for them to translate into actions
- monitoring antibiotic prescribing against local antibiotic policies. We have two antimicrobial pharmacists who provide expert guidance to our clinicians and we believe we have one of the most robust prescribing policies in England
- monitoring environmental cleanliness against compliance cleaning standards and completing a deep/steam cleaning programme. Minimum cleaning frequencies have been introduced across our hospitals in line with national guidance
- monitoring decontamination of instruments and equipment through an audit programme that links to the national decontamination guidelines. A new decontamination facility has opened at the Meridian Business Park. Leicestershire hospitals will be able to send instruments to a 'state of the art' facility for re-processing, ensuring all our hospitals are able to demonstrate compliance with 'best practise' guidance from the Department of Health
- introducing MRSA screening in both elective and non-elective patients in accordance with the Department of Health guidance
- monitoring compliance with the Department of Health; Saving Lives: reducing infection, delivering clean, safe care frame work and the High Impact Interventions.* Compliance is reported by our nursing teams and also elements of these are included in the Infection Prevention Surveillance Programme
- completion of Aseptic Non-Touch Technique* training to all clinical staff that practice asepsis, across the trust by the end of March 2011.

1.7.6 Success has been celebrated by receiving a Healthcare Associated Technology award from the Department of Health for our success in reducing MRSA and CDT infections. The new electronic patient management system has been

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installed and will provide an invaluable resource to further assist us in our work to keep patients safe in our hospitals.

1.8 Priority 3 – Reducing venous thromboembolism

1.8.1 Hospital patients are at risk of venous thromboembolism (VTE), where blood clots form in leg veins (called deep vein thrombosis or DVT) and may break off and block blood vessels in the lungs (pulmonary embolism or PE). There has been increasing focus on this and mandatory prevention measures have been produced by the Department of Health.

1.8.2 We are one of the 18 VTE Exemplar sites in the UK, with streamlined pathways of care for patients presenting with acute thrombosis, focus on the safe use of anticoagulation therapy and attention to VTE prevention measures.

1.8.3 Last year we said we wanted to increase the number of adult inpatients that had a VTE risk assessment on admission to hospital, increasing the percentage from 50% to 90% by the end of March 2011.

1.8.4 Our achievements

We have consistently increased the number of adult patients who are assessed for their risk of VTE. At the end of March we achieved 80.6%, missing our 90% target.

1.8.5 In addition

- 90% of patients are now receiving heparin (medication to help prevent VTE) when needed.
- All patients receive written information about how they can take steps to prevent blood clots and how they can expect to be treated. This is available at each bedside and can be translated into different languages upon request.
- All hospital-acquired thromboses (HAT) are recorded and the clinical information is analysed to see if the prevention measures could have been improved. This is fed back to the relevant clinical team.

1.8.6 As a result there has been a steady decline in cases of hospital-acquired thrombosis in our hospitals.

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2.0 Part two – Statements relating to the quality of NHS services provided

2.1 For ease of reference you will see this section has been divided into two types of information. Firstly, the information which is in **bold** text is mandatory information; this means that we are legally required to publish this information by the NHS (Quality Accounts) Regulations 2010. Secondly, the information which is in normal text is explanatory information to provide some background detail.

2.1.1 Review of services

2.1.2 During 2010/11 the University Hospitals of Leicester NHS Trust provided and / or sub-contracted 217 NHS services. These include:

- **59 emergency-non elective specialties**
- **59 outpatient specialties**
- **49 day case specialties**
- **50 inpatient specialties.**

2.1.3 The University Hospitals of Leicester NHS Trust has reviewed the data available to them on the quality of care across the four divisions.

2.1.4 The income generated by the NHS services reviewed in 2010/11 represents 100 per cent of the total income generated from the provision of NHS services by the University Hospitals of Leicester NHS Trust for 2010/11.

2.1.5 Examples of how we reviewed our services in 2010/11

The quality of care of patients is reviewed through a number of different ways many of which are trust-wide. Our staff and patients regularly provide feedback on the quality of our services and have been instrumental in developing the Quality Account.

- **Clinical quality performance indicators**

A variety of clinical quality indicators are reported at service level and are reflected in the quality and performance report and reported to our commissioners as part of the quality schedule and CQUIN programmes.

Some of the services have developed a dashboard approach covering a variety of metrics, for example:

- maternity
- care of patients undergoing fractured neck of femur, open fractures and shaft of femurs.

Some clinical areas have 'patient reported outcome measures', for example:

- Hip and knee replacement
- Groin hernia repairs
- Varicose vein procedures.

Some services have 'clinical reported outcome measures', for example:

- stroke
- kidney care
- pneumonia.

- **Comparative Health Knowledge System (CHKS)**

In April 2010 we began to use an information system called CHKS. This looks at our data relating to quality and patient safety (for example mortality, readmissions, complications) and efficiency and service improvements (such as day case, length of stay and outpatient follow-up). The data initially looks at overall Trust level

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information and drills down into each division, clinical business unit and service levels.

At present, data from CHKS is being used to provide benchmarked data for several quality and performance, and the 'Heat-map,' indicators (readmissions, day case rates, mortality etc) and is also being used by divisions to support various effectiveness projects and specifically CQUINs.

Our corporate business analysts are also using CHKS to support the Trust's mortality and morbidity review process both in terms of case mix adjusted mortality and also complications. This enables clinical teams to confirm the accuracy of clinical coding and also to identify areas for improvement in clinical care.

- **Nursing metrics**

The nursing care metrics were initially developed in the north west of England by Suzanne Hinchliffe, chief nurse and have subsequently been adopted by the National Patient Safety Agency as a national care indicator set. We are one of the trusts that teach this initiative and influence its development nationally. The nursing care indicators cover those areas which are our highest concerns:

- pain management
- patient observations
- falls assessment
- pressure area care
- nutritional assessment
- medicine prescribing and administration
- resuscitation equipment
- controlled medicines
- Venous Thromboembolic Disease (VTE)
- patient dignity
- infection prevention and control
- discharge
- continence

These metrics measure our standards of record-keeping for the core activities that we undertake for our patients.

Nursing metrics are collected in all clinical areas and include theatres, maternity and outpatients. They are measured monthly electronically by the senior nursing team (wards do not measure their own).

The results are reported monthly in the quality and performance report which is received by the Trust board, Finance and Performance Committee, executive team, Governance and Risk Management Committee, Quality and Performance Management Group, Divisional Confirm and Challenge meetings and nursing executive.

- **Executive safety walkabouts**

Safety walkabouts are built on the principles of 'visible, felt leadership'. The numbers of walkabouts has increased significantly in 2010 up to 17 per month. Safety walkabouts visit all clinical areas including wards, clinics, operating theatres, laboratories, clinics and outpatient areas, endoscopy rooms and catheter labs. All directors, non executive directors and patient advisers are involved in the walkabout programme.

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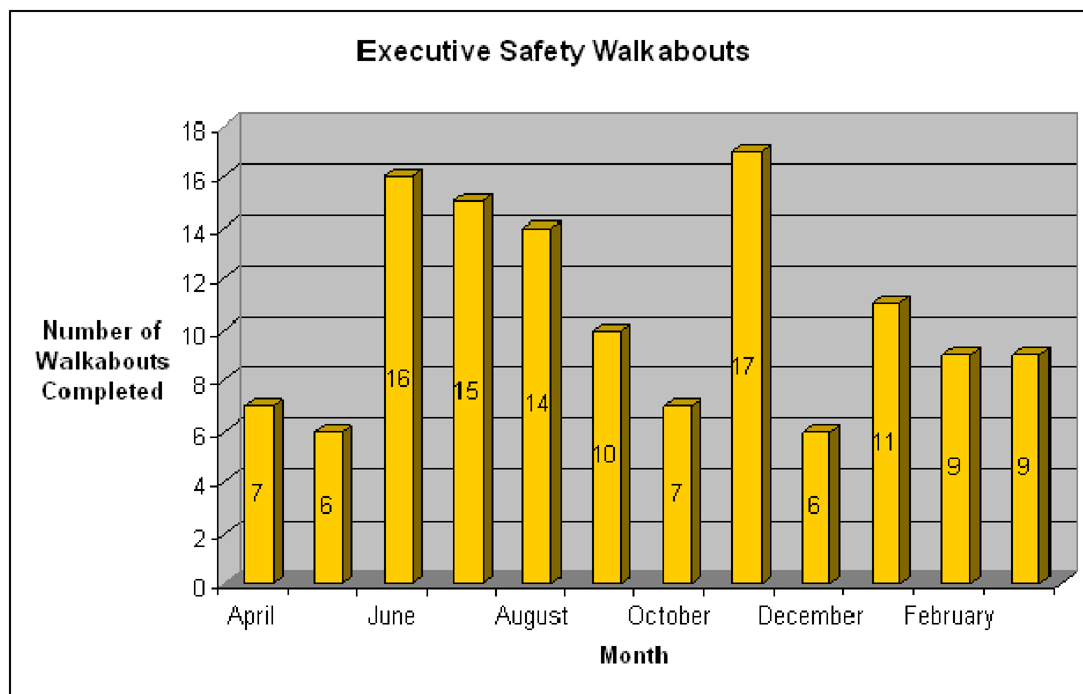
In 2011 the ambition is to expand walkabouts to divisional heads and to further increase the number of walkabouts per month.

The table below illustrates the number of walkabouts that have taken place during 2010/11.



➢ **External visits and accreditations**

There are a number of external agencies that review, inspect, license and accredit our hospitals for example the Care Quality Commission, Human Tissue Authority, Clinical Pathology Accreditation UK Ltd and the Medicine and Healthcare products Regulatory Agency. These reviews may be at a clinical level or in some cases hospital wide. Many of the visits are planned although a number will be unannounced.

The outcome of such visits is usually a report that will make recommendations for further improvement for the service. This information provides assurance to the public, our commissioners and Trust board.

➢ **Care Quality Commission**

The Care Quality Commission (CQC) regulates providers of health and social care. We are required to demonstrate that we comply with 16 essential standards of quality and safety which are laid down in regulations. Monitoring of compliance with these outcomes is carried out on an ongoing basis.

As part of their regulation the CQC have powers to visit us at any time to see how well we are complying with the 16 outcomes. They can do this by carrying out a planned (as part of their scheduled activity) or responsive (in response to information/ intelligence) review of our hospitals.

In 2010/11 the CQC carried out planned reviews at the Leicester Royal Infirmary, Glenfield Hospital and Leicester General Hospital.
The review process involved the following three stage approach:

- submission of information to the CQC
- a site visit

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- publication of a report.

The CQC found that we were compliant with the outcomes at all three sites. Copies of the CQC reports can be obtained from http://www.uhl-tr.nhs.uk/aboutus/performance/care-quality-commission

It is anticipated that a review of St Mary's Birth Centre will commence in the near future.

- ***CQC* Quality and Risk Profile Report**

The Quality and Risk Profile Report (QRP) is an essential tool used by the CQC for gathering together key information about organisations to support how compliance with the essential standards of quality and safety is monitored (and will be used to inform the focus on assessment of compliance). It contains information that the CQC receives about a provider from a variety of sources.

QRPs are not in the public domain but the strategic health authority, Monitor and primary care trusts will have access to these to support continuous monitoring of compliance and to improve how care is provided and commissioned.

Internally the QRP is sent to divisions and is discussed at the Clinical Effectiveness Committee and the Quality and Performance Management Group. The report therefore provides further assurance around quality from a number of different perspectives.

2.2 Participation in clinical audits and confidential enquiries

2.2.1 Participation in clinical audit is a way of monitoring and improving clinical practice and the trust has a very active clinical audit programme.

2.2.2 Part of the programme includes national clinical audits which are largely funded by the Department of Health and commissioned by the Healthcare Quality Improvement Partnership (HQIP) which manages the National Clinical Audit and Patients Outcome Programme (NCAPOP). Most other national audits are funded from subscriptions paid by NHS provider organisations. Priorities for the NCAPOP are set by the Department of Health with advice from the National Clinical Audit Advisory Group (NCAAG).

2.2.3 During 2010/11, 55 national clinical audits and four national confidential enquiries covered NHS services that University Hospitals of Leicester NHS Trust (UHL) provides.

2.2.4 During that period UHL participated in 91% *(50)* national clinical audits and 100% *(4)* national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The table below shows:

- the national clinical audits and national confidential enquiries that UHL was eligible to participate in during 10/11
- the national clinical audits and national confidential enquiries that UHL participated in during 10/11
- the national clinical audits and national confidential enquiries that UHL participated in, and for which data collection was completed during 10/11, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

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2.2.5 National clinical audits

Audit title	Applicable to UHL	Did UHL participate ?	% Cases submitted 10/11 / Further information
Coronary angioplasty (NICOR Adult cardiac interventions audit)	Yes	Yes	100% of applicable cases
CABG and valvular surgery (Adult cardiac surgery audit)	Yes	Yes	100% of applicable cases
Paediatric cardiac surgery (NICOR Congenital Heart Disease Audit)	Yes	Yes	100% of applicable cases
Acute Myocardial Infarction and other ACS (MINAP)	Yes	Yes	100% of applicable cases
Adult critical care (Case Mix Programme)	Yes	Yes	Data collection still ongoing
Paediatric intensive care (PICANet)	Yes	Yes	Data collection still ongoing
Paediatric fever (College of Emergency Medicine)	Yes	Yes	100% n=50
Renal colic (College of Emergency Medicine)	Yes	Yes	100% n=50
Vital signs in majors (College of Emergency Medicine)	Yes	Yes	100% n=50
Severe trauma (Trauma Audit and Research Network)	Yes	Yes	Data collection still ongoing
Stroke care (National Sentinel Stroke Audit)	Yes	Yes	100% of applicable cases
Diabetes (National Adult Diabetes Audit)	Yes	Yes	100% of applicable cases
Falls and non-hip fractures (National Falls and Bone Health Audit)	Yes	Yes	80% of applicable cases
COPD (British Thoracic Society/European Audit)	Yes	No	Service audited in 2009
Patient transport (National Kidney Care Audit)	Yes	Yes	100% of applicable cases
Pleural procedures (British Thoracic Society)	Yes	Yes	Data collection still ongoing
Lung cancer (National Lung Cancer Audit)	Yes	Yes	100% of applicable cases
Emergency use of oxygen (British Thoracic Society)	Yes	Yes	20% of applicable cases
Adult community acquired pneumonia (British Thoracic Society)	Yes	Yes	Data collection still ongoing
Non invasive ventilation (NIV) - adults (British Thoracic Society)	Yes	Yes	Data collection still ongoing
Adult asthma (British Thoracic Society)	Yes	No	UHL did not take part in this audit but does undertake its own internal asthma audit
Bronchiectasis (British Thoracic Society)	Yes	Yes	Data collection still ongoing
Acute stroke (SINAP)	Yes	Yes	Data collection still ongoing

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Potential donor audit (NHS Blood and Transplant)	Yes	Yes	98% of applicable cases
Renal transplantation (NHSBT UK Transplant Registry)	Yes	Yes	100% of applicable cases
Heart failure (Heart Failure Audit)	Yes	No	Not presently involved in this audit but UHL may take part next year.
Renal replacement therapy (Renal Registry)	Yes	Yes	100% of applicable cases
Parkinson's disease (National Parkinson's Audit)	Yes	Yes	Audit not yet started
Ulcerative colitis and Crohn's disease (National IBD Audit)	Yes	Yes	Data collection still ongoing
Ulcerative colitis and Crohn's disease (National IBD Audit)	Yes	Yes	Data collection still ongoing
National Audit of Dementia (TBC)	Yes	Yes	100% of applicable cases
Familial hypercholesterolaemia (National Clinical Audit of Mgt of FH)	Yes	Yes	100% n=50
O neg blood use (National Comparative Audit of Blood Transfusion)	Yes	Yes	100% of applicable cases
Platelet use (National Comparative Audit of Blood Transfusion)	Yes	Yes	100% of applicable cases
Chronic pain (National Pain Audit)	Yes	Yes	Audit not yet started
Peri-operative care study (NCEPOD)	Yes	Yes	100% of applicable cases
Hip fracture (National Hip Fracture Database)	Yes	Yes	Data collection still ongoing
Hip, knee and ankle replacements (National Joint Registry)	Yes	Yes	100% of applicable cases
Bowel cancer (National Bowel Cancer Audit Programme)	Yes	Yes	100% of applicable cases
Head and neck cancer (DAHNO)	Yes	Yes	Submitted minimum requirement 50% of applicable cases
Carotid interventions (Carotid Intervention Audit) 2010-11	Yes	Yes	100% of applicable cases
Abdominal Aortic Aneurysm Quality Improvement Programme	Yes	Yes	Data collection still ongoing
Elective surgery (national PROMs programme) (hips)	Yes	Yes	94% (1st quarter 10-11)
Elective surgery (national PROMs programme) (knees)	Yes	Yes	85% (1st quarter 10-11)
Peripheral vascular surgery (VSGBI Vascular Surgery Database)	Yes	Yes	Data collection still ongoing
Elective surgery (national PROMs programme) (hernia)	Yes	Yes	31% (1st quarter 10-11)
Elective surgery (national PROMs programme) (veins)	Yes	Yes	54% (1st quarter 10-11)

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Heavy menstrual bleeding (RCOG National Audit of HMB)	Yes	Yes	Data collection still ongoing
Neonatal intensive and special care (NNAP)	Yes	Yes	Data collection still ongoing
Diabetes (RCPH National Paediatric Diabetes Audit)	Yes	Yes	Data collection still ongoing
Childhood epilepsy (RCPH National Childhood Epilepsy Audit)	Yes	Yes	Audit not yet started
Decreased conscious level multi-site audit	Yes	Yes	Data collection still ongoing
Paediatric asthma (British Thoracic Society)	Yes	No	Trust not informed of audit until after the audit was closed
Paediatric pneumonia (British Thoracic Society)	Yes	Yes	Data collection still ongoing
Cardiac arrest (National Cardiac Arrest Audit)	Yes	No	UHL does not take part in this subscription audit but does undertake its own internal cardiac arrest audit

Source: clinical audit manager

2.2.6 National confidential enquiries

Title	**Applicable to UHL**	**Did UHL participate ?**	**% Cases submitted 10/11**
Perinatal mortality (CEMACH)	Yes	Yes	All data from Jan – June 2010 submitted
Cardiac arrest (NCEPOD)	Yes	Yes	50%
Peri-operative care study (NCEPOD)	Yes	Yes	100%
Surgery in children (NCEPOD)	Yes	Yes	64%

Source: clinical audit manager

CEMACH* = Confidential Enquiry into Maternal and Child Health
NCEPOD * = National Confidential Enquiry into Patient Outcome and Death

2.2.7 The reports of more than 40 national clinical audits were reviewed by the provider in 10/11 and below are some examples are how the trust has performed and the actions taken to improve patient care:

- Following the national irritable bowel disease (IBD) audit we regularly stress to our junior medical staff the importance of checking stool samples of all patients admitted with ulcerative colitis in order to minimise co-existing infection and we have increased the level of dietetic support provided for our IBD patients.

- The Vascular Society of Great Britain and Ireland Abdominal Aortic Aneurysm Quality Improvement Programme has challenged vascular units to work towards reducing national elective operative mortality rates from 8% to 3.5% by 2013. UHL has already achieved that target with a 0.8% elective mortality rate after 533 procedures over the last five years.

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- This years national lung cancer audit report showed the trust to be performing above national average again this year which reflects the hard work of the Trust's lung cancer team.

- The paediatric intensive care audit network* database is an ongoing audit of all admissions to children's intensive care in the UK and Eire. It provides risk adjusted mortality data, as well as details of occupancy, interventions and patient flows. Where applicable the audit provides data for the paediatric critical care minimum data set. The latest results show that the children's intensive care units are providing high class care to desperately sick children. Our results are equivalent to other children's intensive care units in the country.

2.2.8 The reports of 96 local clinical audits were reviewed by the provider in 10/11 and UHL intends to take the following actions to improve the quality of healthcare provided.

- An audit to assess use and appropriateness of anti-psychotics and sedation in all medical and geriatric wards at the LRI (#4938) has resulted in a new guideline on delirium and dementia being implemented and safe sedation incorporated in junior doctor training programmes.

- Following an audit of immunisation on the two neonatal units (#5001) – 'the immunisation pack and checklist' is being introduced to help clinicians with administrating vaccines.

- An audit of anaesthesia for primary joint replacement surgery (#4977) led to a review pre-assessment staff to ensure appropriate advice concerning fasting is being issued. It has also been agreed to develop a post-operative analgesia and post operative nausea and vomiting management guideline.

- An audit of patients understanding of refractive options after cataract surgery (#4961) has led to the introduction of leaflets discussing refractive possibilities from cataract surgery on an individual basis.

- An audit of the quality of documentation during microbiology ward rounds on the intensive care unit (#4900) has led to new sticker being used for microbiology ward round to improve the quality of documentation.

- An audit of ultrasound assessment of the epidural space (NICE guidance) (#4879) has led to a new training package being developed and used by local school of anaesthesia.

- An audit of the emergency department management of urinary tract infection in children (#4835) has led to the department guideline being updated to help documentation of antibiotic prescribing and the inclusion of paediatric UTI case discussions in junior doctor's induction programme to help raise awareness.

- An audit on therapeutic hypothermia in babies with hypoxic ischaemic encephalopathy (#5263) results have been drafted onto a poster to display and create awareness amongst neonatal unit staff regarding the results and staff involved in nursing babies who are being 'cooled' attend mandatory training sessions.

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- Audit of immunohistochemistry use in the diagnosis of mycosis fungoides (#4945) has led to the department trialling a new ordering form for mycosis fungoides.

- An audit of turn around times on histopathology after the introduction of a digital dictation system (#5251) showed the new system had been successfully implemented and has speeded up reporting for some teams.

- An audit of the stress cardiac MRI service (#5004) showed that the service is safe, well-tolerated and accurate. The audit is reported to be the largest 'real-world' audit of routine practice. Results compared very favourably with previous published research studies involving smaller numbers, and a recent meta-analysis.

- An audit of the timeliness of informing the GP about the diagnosis of cancer (#5163) has led to the GP of each patient diagnosed with cancer in the regional multidisciplinary (MDT) meeting being sent a fax within 24 hours of the MDT decision.

- Following the UHL continence prevalence and assessment audit (#4196) it was agreed to launch a new local adult integrated continence strategy including assessment tools and care pathways.

- Following an audit of end of life care planning in end-stage renal disease (#4312) it was agreed to set up a cause for concern register of patients in whom end of life care needs might be considered.

- An audit to evaluate the hypertension directly observed therapy (DOT) clinic (#3085) led to setting core standards to encourage patient understanding of all aspects of the treatment it offered – this will allow patients to make an informed choice regarding their medication.

- Audit of the emergency department (ED) management of pain in adults (#3939) has resulted in the 'majors' department having a small drugs safe to speed up access to oral analgesia for patients in moderate pain.

- An audit of the NICE guideline on epidemiology of tuberculosis (#4148) has resulted in identifying the need to develop a business case for widespread screening of new immigrants.

- The incidence and severity of hand and foot toxicity with capcitabine chemotherapy in colorectal cancer and breast cancer (#3921) led to agreement that the toxicity assessment on chemocare should be completed at each patient visit.

- An audit of accuracy of community optometrist referrals (#4728) was discussed at the Local Optical Committee for Leicester, Leicestershire and Rutland where it was agreed to use a new referral form to improve the referral system.

2.3 Participation in clinical research

2.3.1 The number of patients receiving NHS services provided by or sub-contracted by University Hospitals of Leicester NHS Trust in 2010/11 that were

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recruited during that period to participate in research approved by a research ethics committee was *15,878.*

2.3.2 University Hospitals of Leicester NHS Trust was involved in conducting 825 clinical research studies.

2.3.3 Of these 368 (45%) were adopted* and 457 (55%) non-adopted. 209 (25%) of the total were commercially-sponsored studies.

2.3.4 University Hospitals of Leicester NHS Trust used national systems to manage the studies in proportion to risk.

2.3.5 36% of the studies given approval were established and managed under national model agreements.

2.3.6 150 Research Passport applications were processed and 10% of eligible research studies involved researchers being issued with either an honorary clinical or research contract or a letter of access.

2.3.7 In 2010/11 the National Institute for Health Research (NIHR) supported 368 (45%) of the total number of research studies through its research networks.

2.3.8 In 2010 there were 583 full papers published in peer reviewed journals.

2.4 Goals agreed with commissioners

2.4.1 The local primary care trusts (PCTs) commission (buy) services on behalf of people in Leicester, Leicestershire and Rutland. As reported in last year's Quality Account we have agreed quality targets and goals with our PCT and these are translated into a quality schedule and a Commissioning for Quality and Innovation programme (CQUIN).* The CQUIN programme and Quality Schedule for 2011/12 has been developed and agreed with Clinical staff across the healthcare community.

2.4.2 A proportion of University Hospitals of Leicester NHS Trust's income in 2010/11 was conditional on achieving quality improvement and innovation goals agreed between University Hospitals of Leicester NHS Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework (CQUIN scheme). This has been the second year of the CQUIN scheme.

2.4.3 Further details of the agreed goals for 2010/11 and for the following 12 month period are available on request from the director of clinical quality by phone (0116 256 3390) or email (sharron.hotson@uhl-tr.nhs.uk).

2.4.4 For 10/11 there were two national and six regional CQUINs.

2.4.5 A further 13 CQUINs were then agreed locally between ourselves and NHS Leicestershire County and Rutland. These were important priorities from across the wider health community including public health. For example:

- increased smoking cessation advice and referral to STOPP
- further development of an infection control surveillance programme
- improving care for patients with pneumonia and reducing mortality

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- improving care for patients with kidney disease
- improving care for patients who have had a stroke
- reducing venous thromboembolism
- improving the experience of patients seen in the emergency department or admitted to medical wards.

2.4.6 This has resulted in the following improved outcomes:

- a reduction in the number of patients suffering from venous thromboembolism
- an improvement in the compliance with pneumonia management guidelines
- further improvement in the number of patients having 'definitive*' access when commencing dialysis treatment
- increased use of theatre utilisation.

2.5 What others say about the provider

2.5.1 Statements from the Care Quality Commission

2.5.2 University Hospitals of Leicester NHS Trust is required to register with the Care Quality Commission and its current registration status is registered without conditions. University Hospitals of Leicester NHS Trust has no conditions on registration.

2.5.3 The Care Quality Commission has not taken enforcement action against University Hospitals of Leicester NHS Trust during 2010/11.

2.5.4 University Hospitals of Leicester NHS Trust has participated in a special review by the Care Quality Commission relating to the following area during 2010/11:

- **Special review of support for families with disabled children. The review looked at support for families with disabled children and aimed to look at delivery and commissioning of specialist health services for families with disabled children, include an assessment of the quality of support in a geographical area linked to PCTs and look at the 'building blocks' of the care pathway which are of particular importance to families.**

2.5.5 Data was submitted to the CQC on the 14 February 2011 and we are awaiting results.

2.5.6 The Care Quality Commission has visited all three hospitals during 2010/11 resulting in an assessment of compliance with the outcomes. The full reports can be accessed via http://www.uhl-tr.nhs.uk/aboutus/performance/care-quality-commission

2.6 Data quality

2.6.1 We require robust and high quality information to support the delivery of patient care and to manage activity and performance. Data that is accurate, timely and relevant supports efficient patient care and reduces clinical risk. Through standardised data collection we can measure our own performance in comparison to other trusts and national trends. Reliable information on all aspects of performance means the planning of future services can be undertaken with confidence.

2.6.2 Data quality is managed via an established set of routine daily checks, management reporting of data quality performance and audit of case note content versus electronic data.

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2.6.3 The University Hospitals of Leicester NHS Trust will continue to take the following actions to improve data quality.

2.6.4 Daily checks include

- **Research of all current inpatients with missing NHS numbers. The Trust typically achieves 99.7% coverage, with most of the outstanding records being overseas visitors**
- **Validation of current GP Practice for current inpatients. Data collected in the Trust is compared with definitive GP registration information for Leicestershire patients and anomalies are updated**
- **New patient registrations are validated to ensure mandatory demographic data is complete to facilitate NHS Number tracing**
- **Updates due to death registrations**

2.6.5 Management reporting occurs as follows:

- **Monthly – use of external (Secondary Uses Service*) and internal reporting to access data quality for the current year. *This is* reported to the Clinical Effectiveness Committee**
- **Quarterly – reporting summary data quality position to the Governance and Risk Management Committee**

2.6.6 Audit

- **Monthly audit of approximately 300+ sets of casenotes, covering inpatients and outpatients**
- **Validity checks on data show high compliance of national NHS code sets being accurately applied within local information systems**

2.6.7 NHS Number, General Medical Practice Code and Ethnicity Code Validity *checks*

2.6.8 The University Hospitals of Leicester NHS Trust submitted records during April to *February 2011* to the Secondary Uses *S*ervice* for inclusion in the Hospital Episode Statistics which are included in the latest published data.

2.6.9 Records with a valid NHS number*

	Trust	National average
Admitted patient care	**99.7%**	98.5%
Outpatient care	**99.5%**	98.8%
Accident and Emergency Care	***98.1%***	91.7%

Source: Secondary Uses Service

2.6.10 Records with a valid General Medical Practice Code

	Trust	National average
Admitted patient care	**100.0%**	99.8%
Outpatient care	**100.0%**	99.8%
Accident and Emergency Care	**100.0%**	99.7%

Source: Secondary Uses Service

2.6.11 Clinical coding error rate

2.6.12 The University Hospitals of Leicester NHS Trust was not subject to the Payment by Results clinical coding audit during 2010/11 by the Audit Commission.

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2.6.13 Information governance toolkit attainment levels

2.6.14 The information governance toolkit is an online system which allows NHS organisations and partners to assess themselves against Department of Health information governance policies and standards.

2.6.15 University Hospitals of Leicester NHS Trust's information governance assessment report score for the period 2010-2011 was 75% and was graded red (not satisfactory).

2.6.16 In order to achieve a satisfactory rating, trusts are required to achieve a satisfactory level in all of the 45 requirements which is a new stipulation this year. A score of 75% was achieved on the assessment which was significantly more robust than last year when the Trust achieved 77% (classed as "satisfactory" under the 2009-10 arrangements).

The four standards where the Trust has not received a satisfactory level (level 2 out of 3) are:

- The training standard, which requires 95% of staff (11,400) having completed the two hour, Connecting for Health provided, e-learning training *or* training which has been approved by Connecting for Health (a later stipulation).

  We were one of the first to use CfH e-learning and approximately 4,000 staff have completed the training and passed the assessment. However, lessons learned in the process suggested that achieving the Department of Health target was going to be problematic.

  Recognising the importance of training, to mitigate the risk of confidentiality and security breaches, we embarked upon a programme to train all staff through viewing a short DVD developed by the strategic health authority with key messages by 31 March. Trust figures indicate that approximately 9,000 (out of 12,000) staff have viewed the DVD. The Trust is currently following up the records of staff who do not appear to have viewed the DVD to ensure that all staff will have received information governance training either by viewing the DVD or used CfHs e-learning module (in the financial year) by the 30 June 2011.

  The Trust expects many other acute providers to have similar difficulties in achieving the DH target.

- The pseudonymisation* standard requires data which is not used for healthcare purposes to be protected through pseudonymisation*. The Department of Health has created this standard so that achievement of a satisfactory score is dependent upon achieving a satisfactory rating in a number of other standards, including the training standard discussed above.

- Corporate record-keeping standards remain at level 1. However, we are reorganising our resource to establish the position of a records governance manager from 1 April to ensure our compliance by developing a performance management framework for all records and standards and supporting Trust record keepers.

- The information asset ownership standard which requires identification of owners for the Trust's information assets. Good progress has been made, but

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the further work is required to embed the responsibilities associated with asset ownership within the Trust. This work is already underway.

3.0 Part Three: Review of our quality performance

3.1 The following section refers to a review of our performance in 2010/11. Quality is reviewed through a variety of mechanisms/vehicles including the Quality and Performance Report, use of CHKS, via the Quality and Governance and Risk Management Committee and through the Quality Schedule and CQUIN programme.

3.1.1 Public and patient engagement

3.1.2 Patient and public involvement (PPI) encompasses a wide range of activity that sees patients and the public engaging in decisions about their health services. Involvement may be at a strategic level, it may be managed through large organised events, through small focus groups or by surveys and questionnaires. Whatever methods are used, we believe that involving our patients and the wider public is the only way to ensure that we are adequately responding to their needs and providing the most appropriate services for our local communities.

3.1.3 Patient and public involvement structure

Good patient and public involvement depends upon the ownership our staff take of this agenda. As such, each clinical business unit has nominated a senior member of staff to lead PPI activity in their area. Supported by the Trust's PPI manager, these leads take responsibility for coordinating and monitoring patient involvement and act as a local PPI resource. Recent activity includes a programme of involvement for families of children with cystic fibrosis run by staff in our Children's Hospital, involvement through user groups led by our lead cancer nurse and a patient experience day organised by nurses in our thoracic surgery team.

3.1.4 We recently combined our regular PPI and patient experience meetings to ensure that activity which aims to improve the patient experience is developed with good patient involvement. We see this as an important step towards building a culture of involvement across the organisation.

3.1.5 Working with Local Involvement Networks

The Trust has developed good working relationships with its Local Involvement Networks (LINks). We welcome the feedback that the Leicester city and Leicestershire LINks have provided and have developed the Quality Account in light of their commentary reproduced in part four. LINk representatives meet regularly with our chief executive and senior managers to discuss any issues and concerns. On request, senior staff attend LINk board meetings and a recently formed Trust LINk sub-group. We are keen to develop our partnership work with LINks and recently joined with both city and county LINk representatives to participate in a national consultation. We also worked closely with both LINk organisations to engage black and minority ethnic (BME) service users in a programme of events which aimed to explore their experience of hospital services (see below).

3.1.6 BME communities' health symposium

We recently analysed our internal patient survey data by ethnicity and found, that in certain areas, BME (black and minority ethnic) patients were less satisfied with our services than the population as a whole. In order to explore this, and to present the survey data to local BME communities, we held a 'Health Symposium'. This well-attended event allowed participants to meet with senior staff in the organisation and identify priorities which would improve their experience of our services.

3.1.7 The symposium was the beginning of a programme of events which aimed to sustain the involvement of local communities in service development. Since this initial event, two further meetings have been held to explore BME community priorities in more detail and agree relevant solutions. This work is continuing with another event planned for spring 2011. A follow-up event in summer of 2011 is planned to provide an update on the programme and reflect on the priorities that were identified during the symposium.

3.1.8 Patient advisors

For the last eight years we have worked with a group of patient advisors who are attached to each of our clinical areas. Patient advisors are lay members of the public who are supported by the Trust to act as 'critical friends'. As such, they champion the patients' perspective and act to challenge the Trust on its performance around patient experience. Patient advisors provide an important user perspective on some of our key decision making forums. For example, patient advisors sit on divisional and clinical business unit (CBU) boards as well as our finance and performance, research and development, governance and risk management and charitable funds committees. In addition to this strategic contribution, patient advisors also support audits, patient surveys and the development of patient information. Any concerns are aired directly to senior staff through regular meetings.

3.1.9 Membership

We are a membership organisation with more than 12,500 public members. In addition to their involvement in our annual public meeting and dedicated events, our members are given opportunities to get more involved in the work of our hospitals. For example, members attended dedicated events during our Foundation Trust consultation exercise, and have recently participated in surveys relating to our discharge processes and the development of our new website. Our monthly 'Medicine for Members' events have also been used to involve members in the development of patient information, and to keep them informed of other Trust initiatives. We will continue to offer our members opportunities to become more involved in our work and ensure that they are kept well informed.

3.1.10 Further information can be obtained from the PPI and membership manager on 0116 258 8685.

3.2 Equality

3.2.1 Our strategic equality objectives (workforce and service delivery) outlined in our Single Equality Scheme that was revised in 2010 are to:

- mainstream equality into all that we do through strengthening our leadership and governance processes
- improve data collection, monitoring and use to better understand where the gaps in services are
- ensure that our workforce increasingly represents the communities we serve
- enhance our engagement strategy with groups/communities that have the potential to be disadvantaged
- improve access to services.

3.2.2 Much progress has been made in all of these areas. We have mainstreamed equality into many of our processes and now have good governance arrangements in place. We have redesigned and re-launched the Equality Board, we produce biannual equality reports to the Governance and Risk Management Committee, an inclusive Equality Impact Assessment process and we delivered an equality seminar to the Trust board.

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3.2.3 In addition we successfully delivered six equality projects as part of the Department of Health national Pacesetter programme. Several of the projects were nationally commended and five of the six projects have continued beyond the life of the programme and are now integrated into the equality work programme.

3.2.4 Pregnancy and you – A guide to understanding your pregnancy

We reported in the last Quality Account that we were producing a translated DVD aimed at Bengali parents. The project was funded through the Department of Health national Pacesetter programme. The DVD details the maternity journey and has been distributed, both locally and nationally.

3.2.5 Midwives have been distributing the DVD when seeing women in clinics, one commented:

> *"From a midwifery perspective it raises the profile again of the difficulties we have engaging women from this group, so as midwives are getting this ready to give out they're thinking, 'hang on, this lady might need a bit of extra help', and that's important for us as midwives to get the reminder that they might be more vulnerable and their outcomes might not be as good as other women"*

3.2.6 There have also been comments from Bangladeshi women who have viewed the DVD, these included:

> *"The DVD is spot on"*
> *"Hats off to them, they've done a great job"*
> *"It's very visual, very practical"*
> *"If I was pregnant, I would watch it"*
> *"That's good [hospital scenes], I didn't have that, it's good to see it as reading about it wasn't as good and I panicked when it happened to me."*

3.2.7 Interpreting and translation service

Many of our patients and their families require a variety of communication support in order for them to receive equitable access to all of our services. In order to improve the current level of provision we have worked in partnership with other trusts across our region to identify a provider that can meet the increasing demands for this resource. With 85 different languages spoken locally it poses a real challenge to health services to provide a responsive, timely, cost effective and appropriate interpreting service.

3.2.8 Other trusts have also experienced similar difficulties and as a result we have been working with NHS re:source Collaborative Procurement Hub and other NHS trusts in the region to procure interpreting and translation services to best meet our local needs whilst ensuring we have a consistent approach across the region.

3.2.9 We now have a new supplier and are confident that this new service will improve the quality of interpretation and translation that we can provide to patients. In the long term it will also prove financially beneficial. Twenty-three trusts have/or will be signed up to the new contract.

3.2.10 Learning disability acute liaison nurses

In 2009 we piloted a service entitled 'Make my stay' which aimed to improve the experience of patients with a learning disability when they access acute care. As a result of the positive outcomes from the project and local commitment from our

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commissioners we secured permanent funding for three acute liaison nurses. The service was launched in October 2010

3.2.11 All three nurses are qualified learning disability nurses and have had experience of working in clinical practice, both within hospital and community settings.

3.2.12 The aim of the team is to improve the link between mainstream general hospital services and primary/community services for people with learning disabilities by providing support and advice. The team have liaised with the community learning disability nurses, health facilitators and social workers in addition to the clinical personnel within the hospitals. They have also established a patient/carer group to participate in service planning and to assist us with evaluating the service.

3.2.13 Since the team came into post they have seen 42 patients which equates to three people a week. Thirty-six (86%) of these patients have been from the white British population and six (14%) from the BME community. The majority have been visits to the patient once admitted to hospital. However, several also included pre-admission or community care liaison to aid planned admissions and treatment.

3.2.14 A patient's story

A patient with profound learning disabilities and associated behavioural difficulties was admitted for day surgery under local anaesthetic within the cardiology unit.

There was some doubt at this stage as to whether the patient would be able to tolerate the procedure. The acute services informed the learning disability acute liaison nurse, who then made contact with all the agencies involved, both within the hospital and externally.

The admission required detailed co-ordination and planning of support needs/risk management/pre admission medication/provision for an overnight stay if required.

The patient's journey on the day was positive, went smoothly and the patient was able to access the required treatment.

3.2.15 The bullying and harassment adviser service…one year on

As the pilot of the bullying and harassment adviser service proved successful, it has now been extended to support staff throughout the Trust. We have six volunteer staff members that provide the confidential signposting and advice service, this is in addition to the formal services available from human resources. To date, 61 people have accessed the service and these have included calls from people from other NHS organisations across Leicestershire. Also in addition we have developed a bullying and harassment e-learning programme for staff which was launched in December 2010.

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3.2.16 Project search

Last year we became a project search site. This is a great initiative which is about providing work trials and potential employment for students aged 18-25 with learning disabilities. As only 7% of people who have a learning disability are in paid employment, this project improves the range of employment opportunities for young people with learning disabilities. Project search was originally developed in America. Due to its success there the model has been adapted by the originators for use in the UK.

3.2.17 The project is managed in partnership with Leicester College, who provide the students and tutors and the supported employment provider Remploy, who provide an on-site job coach to ease the students into their roles.It is a structured framework to ensure that the students have the best chance of success both in terms of their work experience and securing longer term employment. The students are based at the Trust for one year in which time they will complete three different work trials, each lasting up to 12 weeks, in addition to receiving life skills training from our education partner. Early evaluation suggests that the project is proving to be a huge success for both the students and our staff working alongside the students.

3.2.18 Workforce

For any organisation to implement the equality and diversity agenda successfully, it has to be a completely 'embedded' way of thinking about its business and functions in relation to the needs of our diverse communities, who are both patients and/or staff. Every decision made in the organisation should consider the equality and diversity impacts. A workforce report is produced and presented to the Trust board biannually.

3.2.19 The table below details the workforce profile in terms of ethnicity as of April 2010 which indicates that the Trust is broadly representative of our local population. However, the table indicates that BME staff are under-represented in management roles (management roles are included in the administration and clerical staff group).

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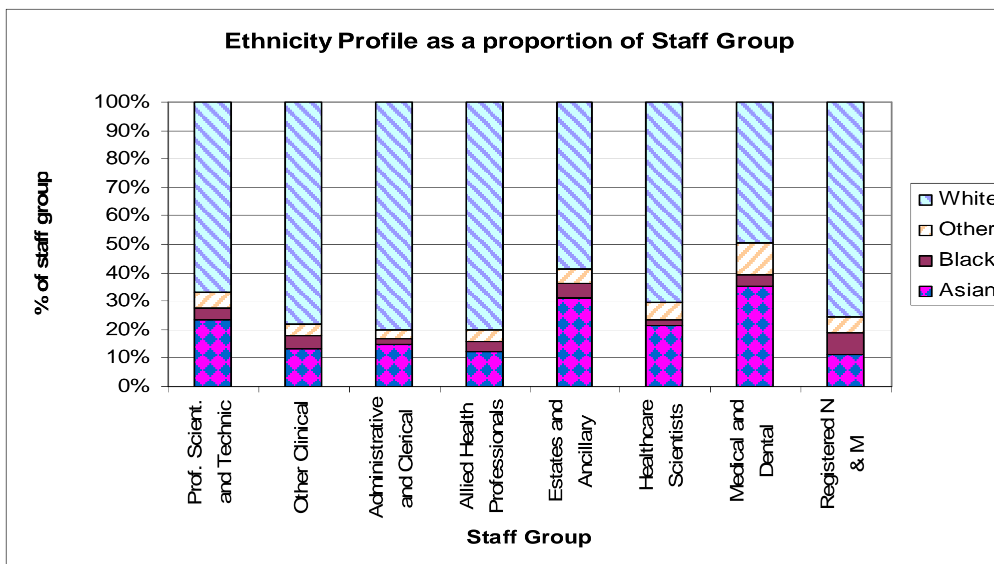

Source: service equality manager

3.2.20 Following submission to the Trust board in 2010 it was agreed that the two issues we need to focus on, are:

1) representation (BME and women) at senior levels
2) the fact that BME candidates did not fare proportionately at short listing, interview and appointment stages.

3.2.21 Representation at senior levels

The make-up of the Trust board has been challenged previously in relation to how representative it is of the local population in terms of BME and disabled people, however the two most recent appointments to the Trust board are non-executive directors; one is from a BME background and the other of Indian origin.

3.2.22 During 2010 there have been only a minimal number of managerial posts recruited to due to our reorganisation from a directorate to a divisional structure. There has therefore only been limited opportunity provided through external recruitment to change the make up of the senior strata of the organisation.

3.2.23 However, in order to provide support to BME and female staff who wish to progress in a management position, we have several initiatives underway:

- Earlier this year, we supported three members of staff on the ‘Towards Strategies for Success‘ initiative which is part of the national ’Breaking Through‘ programme run by the NHS Institute. The ’Towards Strategies for Success‘ programme is a leadership programme specifically aimed at BME individuals in Band 7 or above (or medical equivalent). Three of our staff applied in late 2009 and all three were accepted onto the programme and all have since said it was very valuable.

- Previously a principal pharmacist was also supported via the ’Breaking Through‘ programme on secondment to the primary care trust as head of prescribing and medicines management. She remains seconded to the PCT but has also recently returned to us for half of her working time and is leading on the development of the Trust’s aseptic service and other pharmacy/medicines projects.

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3.2.24 BME candidates through the recruitment process

Data in the Workforce Report shows that BME staff have not fared quite as well as their white counterparts in the recruitment process (table replicated below from the Workforce Report. The data covers April 2009 – March 2010).

Ethnic group	Applications submitted	Applications short listed	Applicants Aappointed
White	46.7%	63.2%	74.2%
Mixed	1.7%	1.4%	1.3%
Asian	41.0%	27.4%	19.0%
Black	7.5%	6.6%	4.1%
Chinese	0.4%	0.4%	0.7%
Other	2.6%	1.0%	0.7%

Source: service equality manager

3.2.25 As a result of the initial analysis we did some more detailed work around some specific areas of recruitment that had been undertaken, for example we analysed the statistics for our band 5 recruitment. A slight bias towards white candidates at short listing stage was demonstrated. It also showed that a proportionate number of people short listed were appointed from both white and BME backgrounds. Further work will be undertaken to look at Band 6 nurses applying for Band 7 ward manager roles as we are aware that the proportion of BME staff in senior posts declines above Band 6.

3.2.26 An exercise was undertaken in the latter half of 2009 to validate information held on staff which reduced the number of staff in the 'unknown' category for a number of equality categories. We saw a significant increase in the numbers of declarations in the disability and sexual orientation categories. We will repeat this exercise biannually.

3.2.27 NHS employers partner status

We were granted NHS Employers Equality and Diversity Partner status for April 2010 to April 2011. This followed a thorough assessment process, evidencing activities being undertaken. Partner sites are considered to be exemplar sites. As a partner, our duties include contributing to the development of good practice and contribute to relevant consultation processes initiated by NHS Employers in response to national equality issues. We have been involved in initiatives to raise our profile in the equality and diversity arena. As part of this we ran a BME Health Equalities Conference in October 2010 (Black History Month), which specifically highlighted that the term 'BME' is very broad, and the different ethnic groups within this often have very diverse health and/or cultural needs.

3.2.28 Community engagement

Our engagement with Black and Minority Ethnic (BME) communities to date has been predominantly via the service equality panel, an advisory group to the director of nursing. This group has membership from a variety of third sector groups representing all equality strands and individual community members from a range of faith groups. The Trust's chairman has undertaken a series of community walkabouts to enhance our profile within our local BME communities. As a follow up to these, communications and external affairs and corporate nursing jointly hosted a BME symposium which took place in November (the results of which can be found in the PPI section of the Quality Account).

3.2.29 The aims of the symposium and follow up events were to:

- develop a representative BME engagement forum for us to steer and monitor service provision

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- explore and identify solutions and actions with the community that can address the differing patient experiences of white and BME communities (earlier work has identified that the overall satisfaction rates are lower amongst BME service users than those from the white community)
- ensure that our future governorship is representative and that the community feels equipped and supported during the recruitment process.

3.2.30 We intend to replicate this model later in the year with local disabled people.

3.3 Safety

3.3.1 Patient safety

We have an excellent incident reporting culture and sit within the top 25% of similar trusts (National Reporting and Learning System Report). All Serious Untoward Incidents (SUIs) are reported in line with national and local requirements; every SUI has a full root cause analysis investigation undertaken. A Corporate Patient Safety Report, detailing information about incidents, complaints and claims is produced quarterly and taken to the Governance and Risk Management Committee and Quality and Performance Management Group. Divisions provide their own quarterly patient safety reports.

3.3.2 In June 2008, the World Health Organization (WHO) launched a second global patient safety challenge, 'Safe Surgery Saves Lives' to reduce the number of surgical deaths across the world. The goal of the initiative is to strengthen the commitment of clinical staff to address safety issues within the surgical setting including improving anaesthetic safety practices, ensuring correct site surgery, avoiding surgical site infections and improving communication within the team. A core set of safety checks has been identified in the form of a WHO Surgical Safety Checklist for use in any operating theatre environment and UHL has adopted this checklist and the concept of team briefings to further enhance the safety of patients undergoing operative procedures. The WHO checklist has been rolled out to all operating theatres within the Trust, and features in the theatre nursing metrics.

3.3.3 There are clear accountabilities for patient safety within the Trust led by the Director of Safety and Risk, reporting through the medical director to Trust board. There is a clear programme for improvement as set out in the Trusts Quality Strategy, the Quality Schedule and CQUIN programme.

3.3.4 We are committed to 'being open' with patients and/or families following SUIs, and share the findings of investigations with them. We actively engage with Patient Safety First* and Safety Express* agendas.

3.3.5 Detailed comprehensive analysis internally and feedback/commentary from our commissioners has influenced our priority safety actions for 2011/12. These actions include:

- improving clinical handovers
- relentless attention to EWS triggers and actions
- develop on-going monitoring arrangements re: CIP schemes
- implement and embed Mortality and Morbidity standards
- improving clinical documentation and notation.

3.3.6 These will be supported and monitored through:

- safety walkabouts
- nursing quality metrics
- Safety Express programme
- Releasing Time to Care modules.

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3.3.7 Never Events

Never Events are serious, largely preventable patient safety incidents. They should not occur if available preventative measures have been implemented.

3.3.8 Since April 2010 we are pleased that no Never Events have been reported and that actions to minimise recurrences are being embedded throughout the Trust.

3.3.9 Central alerting system (CAS) performance

Safety alerts are issued via the Department of Health (DH) Central Alerting System (CAS) and provide safety information regarding medical devices, medicines and clinical practice. It is important safety alerts are managed effectively to ensure all actions to comply with the alerts are completed within the timescales given by the issuing body. Within our hospitals there is an approved policy and process for CAS alerts overseen by our risk and assurance manager via the UHL CAS team. Within our clinical divisions the responsibility for managing the CAS process is delegated to the quality and safety managers.

3.3.10 During 2010 we received 129 alerts, an increase of 26 in comparison with 2009. Of those with a Department of Health deadline within the reporting period 86% were completed within the deadline. This is one percentage point increase above the 2009 figure. We will strive to increase the level of compliance with CAS deadlines year on year. In 2011 the objective will be to achieve a minimum level of 90% of CAS alerts completed within specified timescales.

3.3.11 Divisions or directorates failing to achieve compliance with a deadline provide a report including the reasons for the delay in implementing actions, an action plan identifying responsibilities and an estimated timescale for completion. To monitor performance within the Trust, the risk and assurance manager produces a monthly report showing all alerts that have missed a deadline to a variety of Trust assurance groups.

3.3.12 Complaints

We have a Patient Information and Liaison Service which combines the functions of traditional complaints and PALS. There is a free phone line which allows concerns to be raised and dealt with promptly, and with the agreement of the caller, within 24 working hours as a verbal concern or request for information. The team listen and then direct the issues to the most appropriate individual or service within the Trust for prompt action. Contact can also be made via email and all information is on our website.

3.3.13 All formal complaints are read and assessed by a patient safety manager, who all have a clinical background, as to their seriousness and complexity and to identify the level of investigation required and the time frame for response. When appropriate a telephone call will be made immediately to offer apologies and reassurance that a thorough investigation will be carried out.

3.3.14 Meetings with complainants are encouraged as they support our open approach to providing explanations and achieving resolution. We monitor the number of re-opened complaints and are endeavouring to improve the quality of the initial investigation and handling to reduce the numbers that are not resolved ‘first time’. Complaints training is provided for all staff to ensure they understand the regulations and processes within our hospitals, and their responsibilities to comply with the complaints process.

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3.3.15 Complainant satisfaction surveys are sent out with every complaint response the first week of every month but unfortunately the response rate to this is very poor.

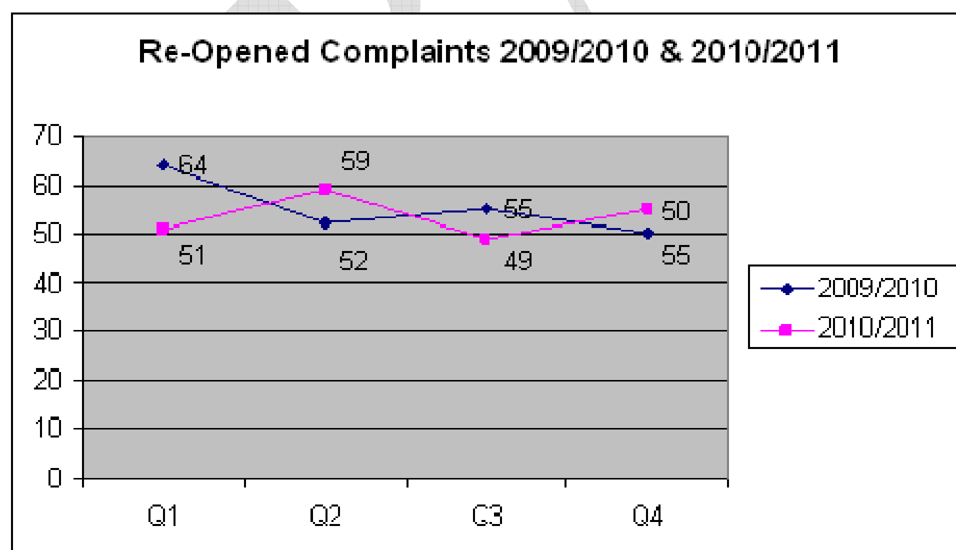
3.3.16 The top 10 primary subject areas across the Trust are shown in the below table.

Formal Complaints Apr - Dec 2010 by Primary Subject and Division - Top 10 Subjects

	ACUTE	CORPORATE	PLANNED	CLINICAL SUPPORT	WOMEN'S & CHILDREN'S	Total
Communication	73	6	107	38	90	**314**
Medical care	83	0	92	9	18	**202**
Waiting times	26	1	82	15	15	**139**
Staff attitude	43	1	38	18	17	**117**
Nursing care	48	1	36	0	7	**92**
Discharge	40	0	18	2	3	**63**
Cancellations	7	0	38	3	4	**52**
Information	9	1	7	1	5	**23**
Car parking	0	18	1	0	0	**19**
Security	9	1	1	0	0	**11**
Totals:	**338**	**29**	**420**	**86**	**159**	**1032**

Source: senior safety manager

3.3.17 The below graph demonstrates the number of re-opened complaints during 2010/11



Source: patient safety manager

3.3.18 Below are just a few examples of actions taken as a result of complaints:

- As a result of complaints in the planned care division about medical staff attitude and complaints about poor outcome we have:

- delivered sessions to consultant staff and registrars on customer care training, communication skills, listening and clear language and the need to offer apologies in some circumstances
- discussed poor outcomes and managing patient's expectations (i.e. full informed consent and the opportunity given to ask questions, written information to be provided) with senior medical staff
- held a session/discussion with trauma physiotherapists about managing patient expectations
- devised a discharge advice booklet for trauma patients
- addressed waiting time in elective OPD at LGH.
  - clinics to be process mapped pertaining to patients being seen, sent for X-ray then being seen again. Dichotomy between Irmer regulations (i.e. patient seen before X-ray requested) and smooth running of clinics to be explored
  - for outpatients we have discussed with clinic staff the need for open verbal communication and signage to indicate delayed clinics.

- In the clinical support division
  - A complaint was received from a patient attending the sleep clinic that staff were chatting about their private lives and appeared to have no urgency in dealing with patients. As a result the service manager reiterated to staff the importance of communication, professional manner and discretion whilst dealing with patients.
  - A complaint was received from a patient regarding the service moving to the Leicester General site from the Leicester Royal Infirmary. Reassurance was given that the same high standard of care will be provided.
  - As a result of complaints from female patients unhappy about the arrangements for ultrasound scans when a male sonographer is the only member of staff present. We are reviewing the signage in the affected areas and changing the wording on the patient information leaflets to explain the availability of female sonographers.
  - Complaints related to outpatient services have been collated and used in learning, and specifically role-play in a day-long staff learning session.

- In the women's and children's division
- A complaint has been related to communication issues between the midwife and the expectant mother when she rang the Maternity Assessment Centre up for advice. The criticism has been that the mothers have not felt that they have received the support and advice that they expected especially about what to do if the membranes have ruptured or when to come in with regards to contractions. We have shared our current telephone assessment proforma with other maternity hospitals via the NPSA maternity network and have now adapted ours to ensure specific questions are asked in order to get a specific set of answers. Based on this the midwife can then advise admission or supportive advice if everything is within a normal range. The aim is that the woman feels that she has received supportive and informative advice.

- Recognising that often poor communication and staff attitude is the root cause of many complaints, customer care training has been added to mandatory training sessions for the planned division and every opportunity taken to:

- provide feedback to individuals involved in complaints
- involve staff in responding to complaints
- invite staff to attend complaints meetings, even in an observational capacity.

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3.3.19 Additionally the quality and safety team has provided training in respect of local resolution of complaints, empowering staff to resolve dissatisfactions locally before a formal complaints process is adopted.

3.3.20 Further information concerning complaints can be obtained from our Annual Report, a copy of which can be obtained from (insert web link)

3.3.21 Safeguarding children and adults

We work hard to provide the highest possible standards of care for all patients in a safe, secure and nurturing environment. Over the past year work has been undertaken to build on our existing child and adult safeguarding practices. The focus has expanded from protection to a much wider remit of developing services to provide early intervention and support to people at risk from abuse. We work closely with partner agencies including NHS partners, social care, police and voluntary organisations to develop initiatives.

3.3.22 During the last year:

- all staff received training in adult and child safeguarding
- we have ensured that all new starters receive safeguarding training during their induction period
- we received positive external reviews from NHS East Midlands and the Care Quality Commission
- we continued full registration with the Care Quality Commission which included evidencing the work undertaken in safeguarding
- our district was recognised as an exemplar for best practice with partners in relation to Deprivation of Liberty Safeguard referrals
- we have a named nurse for safeguarding adults who has raised the profile of adult safeguarding practice by providing access to local expertise on all sites
- we have integrated child and adult safeguarding services through the creation of a head of safeguarding post and the development of infrastructure to support this
- we have strengthened our systems for sharing information between hospital and community services through a review of liaison services in community midwifery and hospital services
- we publicly declared our compliance to provide assurance on our systems, process, policies, training, governance and resource arrangements for child safeguarding practice
- continued participation in a range of multi-agency safeguarding across Leicester, Leicestershire and Rutland
- we have reviewed the reporting mechanisms used within the organisation to record safeguarding incidents and integrated information received from complaints and incidents to ensure that any incidents about safeguarding raised are investigated and lessons learnt where possible.

3.3.23 We recognise the importance of seeking to continually improve the services we provide to safeguard children and adults and plan over the next year to complete a number of initiatives to support this. These include:

- to introduce E Caf, a multi-agency information sharing system aimed at identifying children in need of additional support services at an early stage
- using markers of best practice quality indicators for adult and child safeguarding practice
- to undertake peer review audits with a partner acute hospital trust to share and build upon best practice in safeguarding

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- raising public awareness about safeguarding practice through the introduction of public awareness events.

3.4 Effectiveness

3.4.1 Clinical effectiveness is described as the extent to which specific clinical interventions do what they are intended to do, i.e. maintain and improve the health of patients securing the greatest possible health gain from the available resources.

3.4.2 It involves staff:

- doing the right thing (evidence based practice)
- in the right way (skills and competence)
- at the right time (providing treatment/services when the patient needs them)
- in the right place (location of treatment/services)
- with the right result (clinical effectiveness/maximising health gain). [1]

3.4.3 For the purpose of this report, a number of indicators have been chosen to report against. However, there are many other areas that could have been included. If you would like to see our full Quality and Performance report, it can be downloaded every month from the About Us section of our website www.uhl-tr.nhs.uk/

3.4.4 Emergency department

We have remained challenged throughout the year on our ED performance. The final 2010/11 year to date figure for UHL was 93.8% and the Leicester, Leicestershire and Rutland (LLR) network figure (including minor injuries unit, walk-in centres and urgent care centre) performance was 96.1%. The LLR emergency care system remains fragmented and there is considerable work to be done to improve patient pathways.

In response to this fragmented emergency care system an agreed transformation project across LLR involving health and social care agencies driven by an Emergency Care Network, chaired by the PCT chief executive supported by an operational group and clinicians delivering change group has been agreed. Key focus areas include admission avoidance schemes, available footprint within the emergency system, workforce changes, development of ambulatory care pathways, review of transportation and review of social care and re-ablement opportunities.

3.4.5 Paediatric helpline 07872 419999

A new paediatric children's helpline was launched on 1 August 2010 to help support our GP partners. If they have a general question about paediatric care during office hours, they can now ring a mobile which is carried by a consultant paediatrician. By giving GPs this 'hotline' we can help them do their job better by giving them expert advice, improve the care of their patients and make sure that when they do refer patients to us, they do it right the first time.

3.4.6 Fractured neck of femur

Over the last year we have had an improvement target to get patients to theatre within 36 hours of their admission/diagnosis. This target was 50% in April and increased to 90% in November.

[1] http://www.clinicalgovernance.scot.nhs.uk/section2/definition.asp accessed 28/2/2011

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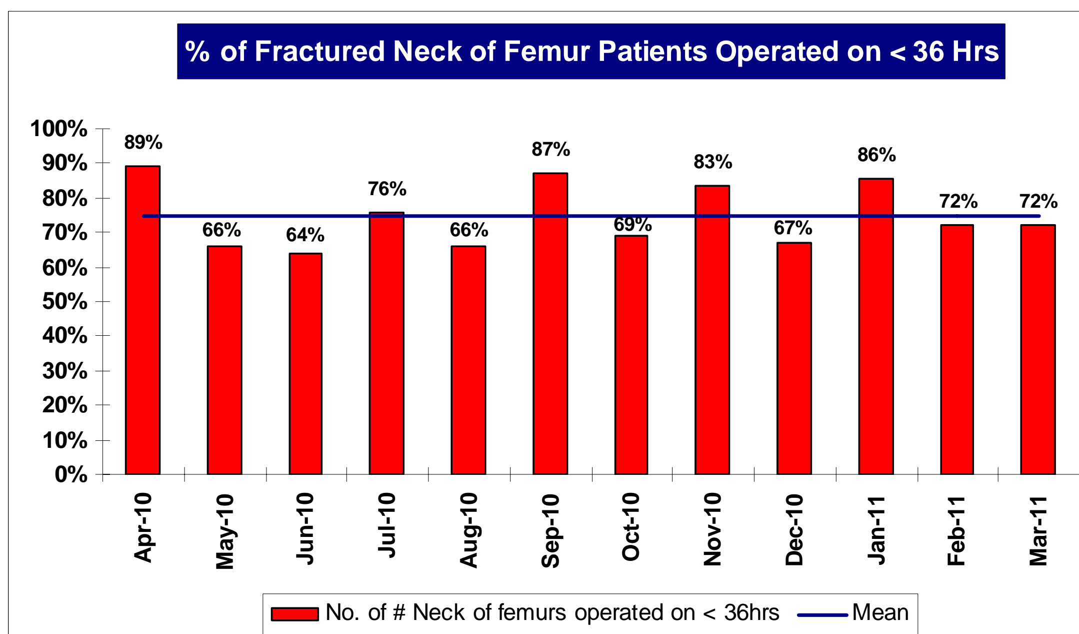
3.4.7 For any patient not getting to theatre for their operation within 36 hours, there is an analysis of why this is the case. Reasons range from lack of theatre capacity to the patients being too unwell for surgery.

3.4.8 Significant progress has been made on this target and the overall year to date average performance is 75%. There is a steering group who will continue to monitor performance and work streams for improvement.



3.4.9 Leicester, Leicestershire and Rutland – End of Life Care strategy 2010 – 2014

We are part of a joint Leicester, Leicestershire and Rutland (LLR) End of Life Care (EOLC) strategy. This strategy was developed by the LLR EOLC Board (LLR EOLC B) in collaboration with Leicester, Leicestershire and Rutland statutory and voluntary sector partners and local stakeholders.

3.4.10 It sets out a vision and pathway for the best quality palliative care across LLR for all adults (18+) approaching the end of life:

- to develop end of life care services that are patient focused and able to meet individual need (including the needs of carers)
- to enable choice in decisions about care and preferred place of death
- to ensure services are equitable, safe and able to meet the needs of a diverse population
- to support care at the end of life with standards and outcome measures – key outcome, 'best possible experience for patients and carers during the last days, weeks and months of life'.

3.4.11 Stroke service

Strokes and transient ischemic attacks or TIA (also known as a minor or mini stroke, where the patient fully recovers within 24 hours) are common, with approximately 3,000 happening every year in Leicestershire.

3.4.12 The TIA clinic is a service which gives GPs and patients the opportunity to seek medical attention following a TIA seven-days-a-week. It is based at the Leicester Royal Infirmary and is run by the stroke consultants seven days a week, 365 days a year with most high risk patients seen within one day of referral. We are investigating improving this even further. Earlier this year the stroke service relocated

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from the Leicester General Hospital to the Leicester Royal Infirmary (where the Emergency Department is situated). The care that stroke patients receive is audited nationally (national sentinel stroke audit) and quarterly as part of the CQUIN programme. The clinic was recently recognised as a leading centre of best practice by the National Audit Office.

3.4.13 Outpatient prescription wait under 30 minutes

Outpatient prescriptions are dispensed at the main dispensaries on each site in addition to the renal satellite dispensary, Leicester General Hospital and Balmoral Outpatient pharmacy Leicester Royal Infirmary. Prescriptions are either tracked using an electronic bar coding system or through a manual system. Only outpatient prescriptions for ambulance patients are generally tracked in Windsor pharmacy. Data has been collated from the systems to produce the following figures. Overall performance of 83.3% dispensed in under 30 minutes across the year from all dispensaries.

3.4.14 Summary data for UHL

Month	Number complete in <30mins	OP prescriptions recorded	% Complete <30mins
Apr-10	4447	5687	78%
May-10	4297	5524	78%
Jun-10	4894	6098	80%
Jul-10	4881	5821	84%
Aug-10	4967	5700	87%
Sep-10	5112	5954	86%
Oct-10	4618	5563	83%
Nov-10	5408	6251	87%
Dec-10	4173	5099	82%
Jan-11	4786	5856	82%
Feb-11	4689	5374	87%
Mar-11	5395	6297	86%
overall	**57667**	**69224**	**83%**

Source: medication safety lead pharmacist

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3.4.15 Breakdown by dispensary

	Glenfield Hospital		Leicester General Hospital		Renal (LGH)		Windsor (LRI)		Balmoral (LRI)	
	total	**% <30mins**	**total**	**% <30mins**	**total**	**% <30mins**	**total**	**% <30mins**	**total**	**% <30mins**
Apr-10	940	73%	1098	80%	115	86%	371	25%	3163	85%
May-10	1028	71%	1096	87%	100	87%	316	22%	2984	82%
Jun-10	1046	73%	1192	89%	106	89%	358	28%	3396	85%
Jul-10	954	77%	1274	84%	117	86%	396	30%	3080	92%
Aug-10	1013	74%	1061	89%	129	90%	316	35%	3181	96%
Sep-10	1073	72%	1197	89%	138	88%	325	44%	3221	94%
Oct-10	995	62%	1069	93%	151	90%	276	28%	3072	91%
Nov-10	1117	68%	1259	90%	174	94%	268	25%	3433	96%
Dec-10	932	67%	1060	85%	125	86%	321	21%	2661	93%
Jan-11	1011	69%	1264	87%	184	95%	269	36%	3128	87%
Feb-11	938	76%	1075	88%	154	71%	272	39%	2935	96%
Mar 11	1142	75%	1324	85%	140	88%	299	41%	3392	94%
overall	**12189**	**71%**	**13969**	**87%**	**1633**	**88%**	**3787**	**31%**	**37646**	**91%**

Source: medication safety lead pharmacist

3.5 Patient experience achievements

3.5.1 The following are a few examples of the initiatives to improve patient experience:

3.5.2 Care and compassion – older people's care in our hospitals

In February 2011 the Parliamentary and Health Service Ombudsman published 'Care and Compassion'. This report highlights ten investigations into complaints made about standards of care for older people in the NHS. The main themes in the report are:

- inadequate privacy and dignity
- poor pain management
- inadequate hydration and nutrition
- poor discharge arrangements
- lack of compassion and care
- lack of family involvement
- poor end of life care.

3.5.3 The Trust Board at its meeting in April 2011 received a detailed report (accessible at www.uhl-tr.nhs.uk/aboutus/our-trust-board/meeting-papers/7-april-2011) and described a ten-point plan to provide an increased focus to improve care of older people:

- roll out of 'Vital' project across older people's care wards
- ensuring the nurse in charge can be easily identified by the wearing of a prominent red badge
- Introduction of hourly rounds on older people's wards and then roll out across the acute division
- increasing the number of volunteers and focus duties to the needs of patients in the older people's wards
- ensuring daily matron/ward sister rounds during visiting times.
- holding ward sisters and staff to account where performance is not at the expected standard

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- ➢ maintaining a regular review of patient acuity and required nurse staffing levels across older people's wards
- ➢ introduction of a dashboard of data to assess each ward's performance in terms of quality and overall patient experience
- ➢ expanding the current staff awards within the Trust
- ➢ Communicating the patient experience approach.

3.5.4 Patient experience survey

The monthly patient experience survey has been in place since July 2010 and is offered to patients, families and carers within inpatient areas. The Patient Experience Team is currently engaged in plans and discussions that will assist all clinical areas to be involved in the monthly patient experience survey during 2011.

3.5.5 Every month we gather feedback from approximately 850 patients. This information is analysed and made available online for all staff to view.

3.5.6 This feedback allows patients to comment on any aspect of their experience that they desire. All patients' comments are collected and fed back directly to the specific clinical areas.

3.5.7 This allows areas to act locally on specific improvements based on their own patient feedback.

3.5.8 Key areas to target from the patient's perspective

Data taken from surveys from August 2009 to November 2010 shows four key themes emerging:

1. Providing information for patients
2. Staff behaviours and attitude
3. Noise at night
4. Pain and comfort management.

3.5.9 Now we have identified the key areas that matter most to patients each division is leading on the key areas to make the improvements over the coming year.

3.5.10 To support these improvements we have developed a monthly patient experience report (dashboard) for each division illustrating trends and analysis of patient feedback. These reports will be key in allowing divisions to act upon feedback from patients, allowing improved patient feedback to be plotted in line with service developments and patient experience projects.

3.5.11 Public website and touch screens

A link is now available on the front page of the public website to allow patients, families and carers to provide us with feedback regarding their experience in our hospitals (www.uhl-tr.nhs.uk/patients/your-experience).

3.5.12 There are also touch screen devices available within our hospitals to allow feedback to be given.

3.5.13 Information is regularly fed back to teams to ensure that changes are made and excellence is celebrated.

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3.5.14 Patient stories

Listening to patient stories are a powerful way to illustrate how it feels to be cared for at our hospitals. These stories can be used to inform staff of the need for change and provide illustrations of how services should be developed in line with patient need.

3.5.15 The Trust board will receive quarterly patient stories with each division having an opportunity to present. Over the next year the divisions will be asked to use patient stories to illustrate key themes identified by patients.

3.5.16 The Patient Experience Team will devise a Trust board template, allowing patient stories to be linked with service improvements and the ongoing review of those services.

3.5.17 Patient diary

A Leicester, Leicestershire and Rutland patient diary has been developed with NHS Leicestershire County and Rutland.

3.5.18 The diary will be given to patients within our hospitals. At the same time sixty patients at a GP surgery will be given a diary when they are referred for a surgical review with us.

3.5.19 The diaries will be returned for joint analysis so all partners can share the results. We are hopeful that the diaries will provide valuable information about patient experience. The results will be used to improve overall care in hospital and community settings.

3.5.20 Carers survey

Nationally and locally there is a clear requirement for trusts to address the issue of recognition and support for carers, particularly around the time of discharge.

3.5.21 We will continue to engage in a number of activities to gather carers' views on the services we provide. This will include listening to carers by attending local carers groups, gathering feedback from the carers surveys completed on our public website and touch screens and from this years CLASP Carers Centre Survey.

3.5.22 Information will be regularly fed back to teams to ensure that changes are made and excellence is celebrated.

3.5.23 Maintaining dignity and respect

We are making sure the privacy and dignity of patients remains a priority for all our staff with a range of initiatives that promote excellent care. These include:

3.5.24 Delivering same-sex accommodation (SSA)

We are pleased to confirm that we are compliant with the Government's requirement to eliminate mixed-sex accommodation, except when it is in the patient's overall best interest, or reflects their personal choice.

3.5.25 We have the necessary facilities, resources and culture to ensure that patients who are admitted to our hospitals will only share the room where they sleep with members of the same sex, and same-sex toilets and bathrooms will be close to their bed area. Sharing with members of the opposite sex will only happen when clinically necessary (for example where patients need specialist care, equipment or facilities such as in intensive care or high dependency units) or when patients actively choose to share (for instance haemodialysis units).

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3.5.26 If our care should fall short of the required standard, we will report it. We also have an audit mechanism to make sure that we do not misclassify any of our reports. We will publish our reports on Unify.

3.5.27 During 2010 all our clinical teams have worked hard to deliver this important patient experience agenda. Patient safety and saving lives will always be our priority, however the provision of same-sex accommodation is now fully available across the Trust.

3.5.28 Privacy and dignity audit

In 2010 A privacy and dignity audit tool was developed reflecting areas that patients and families felt were important to them to improve the privacy and dignity when receiving treatment and care within our hospitals.

3.5.29 The audit was completed in September 2010 across all clinical areas, including outpatients.

3.5.30 The audit results were collated and all clinical areas are busy working on any privacy and dignity improvements the audit has identified.

3.5.31 All areas have worked hard to achieve their individual scores and have been congratulated for their achievements.

3.5.32 The audit will be repeated each year or sooner for some areas depending on their score. This will allow area managers to constantly monitor their privacy and dignity levels for patients.

3.5.33 Red dignity pegs

All of our wards and departments have a supply of red dignity pegs. The pegs clip the curtains together around the bed when privacy is needed. This ensures curtains cannot open and acts as a sign to others not to enter. We have also developed a ‘Care in Progress’ sign for use on paper curtains.

3.5.34 Dignity retreat rooms

Improving access to quality environments for staff, patients, relatives and carers is a priority. There are many patient, family and staff benefits gained from upgrading and developing rooms away from the bedspace. They provide:

- a quality area for families to listen to end of life information
- an area that is free from distraction and extremely private
- an immediate improvement in patient experience and privacy and dignity
- an area that is available for all health care staff to use for their consultations
- a calm and relaxed environment available to break bad news.

3.5.35 A dignity retreat room is in use at the Leicester Royal Infirmary site. A plan is underway for the development of more retreat rooms across the organisation.

3.5.36 Dignity in care training

Dignity in care training is provided through a number of staff induction and development programmes and we also provide a separate dignity workshop which is available to all members of staff.

3.5.37 The training encourages staff to consider the fundamental aspects of dignity that mean so much to each and every one of us, how dignity in practice can be

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improved and what we can do to ensure that people's dignity is maintained at all times. We specifically highlight how we can improve privacy and dignity for older people and how we can improve our practice.

3.5.38 To date approximately 2,000 people have attended the dignity workshop including, staff, volunteers, medical and nursing students. We will continue to deliver this training to ensure that dignity remains at the heart of all that we do.

3.5.39 Older people's champions

An older people's champion is a member of staff who has completed additional training to highlight the specific needs of the older person. We have approximately 1400 older people's champions including both staff and volunteers working across our hospitals to improve the experiences of older people. The staff are clearly identifiable with an older people's champion badge. Information regarding the role of the champions is publicised locally in the bedside information booklet supplied to all patients who are admitted to hospital.

3.5.40 Improving care for patients with dementia

Improving care for people with dementia admitted to the acute hospital is a priority nationally and locally. The newly formed Trust-wide Dementia Care Action Group has a clear vision to improve the quality of care for people with dementia when they are admitted to hospital. The group has identified several priorities for this year following the national audit of dementia care in hospital and will be working together to make those improvements and recommendations.

3.5.41 The Lord Mayor's Forget-Me-Not Appeal funds will be utilised to help support and improve the quality of care for people with dementia, including the development of a sensory garden at the General Hospital. The transformation of patient day rooms into reminiscence/ retreat rooms, enhanced specialist training for staff and volunteers and the introduction of meaningful activities for people with dementia.

3.5.42 Dementia care training

One of the quality standards for dementia is to ensure that people with dementia receive care from staff appropriately trained with the right knowledge and skills to provide the best quality care.

3.5.43 Person-centred dementia care training is provided through a number of staff induction and development programmes and we also provide a separate dementia awareness session which is available to all members of staff. At the end of March 2011 approximately 900 people have attended this training including, staff, volunteers and medical students.

3.5.44 We also chair a Leicester, Leicestershire and Rutland dementia training and competency workforce group with representatives from health and social care. This group has developed a training framework with a pathway approach to three levels of training; basic, enhanced and specialist to develop knowledge, skills and understanding appropriate to staff roles and responsibilities.

3.5.45 Volunteer mealtime assistants

Volunteers are recruited through volunteer services and contribute greatly to a patient's experience. The volunteers are required to undergo all appropriate checks

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before they begin volunteering, including Criminal Records Bureau (CRB) and volunteers' induction.

3.5.46 Volunteers choosing to become mealtime assistants or ward support receive specific mealtime assistant training which covers food hygiene, hand hygiene, a practical session on feeding adults and assisting patients with dementia.

3.5.47 Volunteer mealtime assistants are there to support the mealtime experience for adult patients, this will include the delivery of food, opening packages, cutting up food or sitting with a patient and assisting them to eat and drink.

3.5.48 Volunteers are asked to report to the nurse in charge when they start on each shift, to identify which patients require assistance or if there are any patients with special dietary requirements. If there are any patients with swallowing difficulties a qualified member of staff will assist these patients.

3.5.49 We currently have 160 volunteer mealtime assistants supporting the mealtime experience across our hospitals.

3.5.50 Developing our estates and parking facilities

We have developed a capital investment plan over the next 5-10 year period, which is designed to provide a funding stream which will address the backlog issues which have built up over many years, and in addition will improve the quality of the estate substantially, benefiting patient areas in particular. This capital plan is included in the integrated business plan being developed presently for the Trust.

3.5.51 We have favourable liaisons with the city planning authorities regarding car park capacity at its three sites, and are presently working closely with Leicester Tigers to develop additional capacity on the Leicester Tigers site, which would benefit the LRI. This has potential to offer considerable additional car parking at the Royal Infirmary which would alleviate the current capacity constraints. This is a medium-term project, which will take three-four years to complete.

3.5.52 Celebrating success in patient experience

Service Transformation Award

Hannah Green, a dietetic assistant practitioner at the Royal Infirmary, was commended for excellence in the service transformation award.

3.5.53 Previously, patients attending hospital for chemotherapy or radiotherapy were not able to access the nutrition and dietetics service promptly, which meant they were not always supported to handle the nutrition related side effects to their treatment, such as poor appetite.

3.5.54 The nutrition and dietetic service was successful in securing a grant from MacMillan Cancer Support and set up a nutrition and dietetic service to support the chemotherapy and radiotherapy suites at the Leicester Royal Infirmary, enabling patients to be seen on their day of referral.

3.5.55 Hannah also runs taster sessions to give patients and their carers practical food ideas to try during their weeks of treatment, and provides input to patient support groups.

3.5.56 Customer Services Excellence Award

The facilities teams at Glenfield Hospital and the Leicester General Hospital are providing excellent customer care. They are the first hospital facilities department in

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the East Midlands, and only the second nationally, to receive the Customer Services Excellence award.

3.5.57 The teams had to show evidence of the customer care they provide when delivering services, including catering, cleaning and car parks.

3.5.58 Three of the hospitals' partners, Serco car parks, Medirest Catering and ISS Facilities Services, also received the award, previously known as The Charter Mark, for the customer care they display when delivering their services at the hospitals.

3.5.59 The departments will continue to be assessed over the next five years covering all 57 criteria.

3.6 Our staff

3.6.1 People strategy

Our people strategy (2010 – 2012) is a result of a thorough assessment and prioritisation process that supports our strategic plan in the move towards becoming a Foundation Trust. It outlines how our staff will be enabled to deliver high quality services working together for better patient care.

3.6.2 Learning and development

We also have a learning and development strategy (2010 – 2012). Learning and development are key to ensuring our continued accreditation as a teaching hospital.

3.6.3 We are required to register, and comply with, the Care Quality Commission's (CQC) essential standards of quality and safety. Of particular relevance to learning and development is outcome 14 (supporting workers) which states, 'People are kept safe, and their health and welfare needs are met, because staff are competent to carry out their work and are properly trained, supervised and appraised'. The regulations, therefore, require staff to receive appropriate training, professional development, supervision and appraisals.

3.6.4 To ensure compliance with CQC requirements, an organisational training needs analysis and training plans are in place. We can demonstrate that all areas have a learning and development plan which leads to the development of a programme of activity that meets mandatory, sector body and professional requirements for the designated roles and enables staff to meet their professional registration and development requirements. Processes are now in place to ensure that the learning and development plan for staff is reviewed and adjusted to meet the changing needs of the people who use the service and to ensure that the service is fully able to meet essential quality and safety standards.

3.6.5 We have a bespoke learning management system known as 'EUHL', which includes e-learning and assessments. The EUHL platform was enhanced in December 2010 to bring together all of the various systems which existed for booking and training under a single sign on system and to enable better reporting and monitoring of staff training. As at March 2011, the platform currently has over 12,000 staff users accessing it and deals with more than 2,000 bookings and eLearning courses per month. One of the key enhancements to the new platform is the ability to run training compliance reports. Administrators and managers can interrogate the live database at any time and see details of who has, and just as importantly, who has not within their team completed a training course. This system will be used to produce Trust-wide reports on compliance against statutory and mandatory training requirements.

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3.6.6 Appraisal
Effective appraisal, with review of knowledge and skills framework (KSF) competence where applicable, and personal development planning, is the vehicle for identifying all individual learning and development needs and providing praise and recognition for good work.

3.6.7 We participated in the first AQMAR exercise in 2009 for medical staff and reporting was positive. We are a pathfinder pilot site for medical revalidation and already have a system for strengthened medical appraisal, this is being further developed prior to national revalidation go live in 2012.

3.6.8 Workforce planning
We undertook a workforce planning exercise in divisions and clinical business units (CBUs) to develop a workforce plan for the Trust. This plan was then submitted to the local Workforce Development Team to be incorporated within the Leicestershire, Leicester and Rutland workforce plan which was presented to the strategic health authority. The five workforce development teams within the East Midlands and the SHA considered these plans when setting 2010/11 education and training commissions in September 2010.

3.6.9 A key element of the Trust's foundation application is the development of a robust workforce plan which details the future shape of the workforce and populates the Long Term Financial Model (LTFM). The workforce plans are being developed on an iterative basis by divisions and CBUs and will cover the period April 2011 to March 2016.

3.6.10 We employ practice education facilitators funded by the Leicestershire, Leicester and Rutland Workforce Development Team. The practice education facilitators are the link between the Trust and the education providers, primarily De Montfort University, in ensuring high quality placements, student supervision and student support.

3.6.11 Staff engagement
A staff engagement programme was agreed in 2009 that covered leadership development, appraisal, shared values and strategic vision. Currently the strategy areas are being reviewed and progressed through both the staff engagement steering group, and workforce and organisational development committee.

3.6.12 Particular areas of progress to note are through the revised appraisal process and documentation, and newly configured corporate and local Induction work.

3.6.13 We have begun local quarterly staff polling, to enable us to gather more frequent data on staff engagement. This will enable us to analyse and report the data at many levels, and thus act appropriately with interventions to improve staff morale.

3.6.14 Health and wellbeing
We have a comprehensive health and wellbeing programme which responds to the National Boorman Report of 2009. The programme of work includes actions relating to sickness absence, well being activities, health and safety, stress at work, employee assistance/counselling and occupational health.

3.6.15 The programme is supported by a number of specific steering groups, training and communication all of which have staff side involvement.

3.6.16 Our sickness absence figure is the lowest for acute trusts in the East Midlands.

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3.6.17 Leadership

Our leadership and talent management strategy outlines a framework to enhance leadership capability and capacity across the Trust. It sets out a structured and coherent process of leadership development and support for leaders at all levels and from all groups across the Trust. The strategy sets out the development provision for existing leaders and also outlines the direction of travel in relation to the ways in which we will identify and develop our leaders for the future.

3.6.18 We have a clear leadership excellence programme which 260 of our most senior leaders have been through. The next phase of this programme is to develop our clinical leaders. As apart of the appraisal process, data in relation to our most talented employees is captured to identify potential leaders at all levels of the organisation.

3.6.19 We are part of the East Midlands Leadership Academy where leadership development is accessed for many levels of staff across our diverse workforce.

3.6.20 Empowering staff

We work hard to engage staff and have a Recognition Agreement with more than 10 trade unions. A number of projects are developed in partnership with staff side organisations and there is a regular Joint Staff Consultation and Negotiating Committee, chaired rotationally by the chief executive and Staff Side chair.

4.0 Conclusion

This Quality Account represents a review of the quality of care provided at the Leicester acute hospitals.

4.1 Its content has been influenced and informed by a number of our staff and stakeholders including commissioners, LINks, Overview and Scrutiny Committee and patient advisors.

4.2 A wealth of further information is available and can be discussed through the contacts in this report.

4.3 We want the report to be used as a vehicle for discussion and improvement and welcome your feedback both in terms of the content of this report and also the development of next years Quality Account. Please provide your feedback by email to sharron.hotson@uhl-tr.nhs.uk or by phone 0116 256 3390.

4.4 We look forward to reporting back in June 2012.

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5.0 Part 4: Commentary from our stakeholders

5.1 Statement for UHL Quality Account May 2011 from NHS Leicestershire County and Rutland

The following statement has been prepared by the NHS Leicester City and NHS Leicestershire County and Rutland Trust Boards in relation to the UHL Quality Account.

> "We welcome the opportunity to comment on the annual Quality Account for University Hospitals of Leicester NHS Trust (UHL) regarding the quality of services provided by UHL during 2010/11.
>
> "The Quality Account clearly demonstrates the where achievements have been made in 2010/11 in relation to their priorities and recognises that more work is required, particularly to improve the experience of patients receiving care in the trust.
>
> "In 2010/11 we agreed specific areas of quality improvement with the trust through the quality schedule and the CQUIN scheme. UHL have worked hard to ensure that their Clinical Business Units have seen this as a priority and through the account have demonstrated improvements in key areas. We have been encouraged by the attitude of the Trust staff who have shown an open approach to the quality monitoring visits undertaken by the PCTs. Such visits have given us the opportunity to talk to patients, carers, relatives and staff to hear first hand their experiences of UHL.
>
> "The areas of priority for 2011/12 identified by UHL demonstrate a commitment to improving outcomes for patients, in relation to improving patient experience, reducing admissions and further reducing deaths.
>
> "As commissioners we feel that the Quality Account would benefit from further elaboration on the achievements and challenges faced in the following areas:
>
> - embedding the learning from incidents, investigations and national or local reviews to improve safety of services for patients and ensure a culture of continuous learning across the organisation
>
> - whilst there is a positive approach to patient feedback, consideration should be given to placing greater emphasis on demonstrating patient outcomes rather than data collection.
>
> "We will continue to work in partnership with UHL and seek and obtain assurance of quality improvements through our existing governance arrangements."

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5.2 LEICESTERSHIRE LEICESTER AND RUTLAND HEALTH OVERVIEW AND SCRUTINY COMMITTEE

COMMENTS ON THE UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST QUALITY ACCOUNT FOR 2010-11

11 APRIL 2011

“The Leicestershire, Leicester and Rutland Health Overview and Scrutiny Committee welcomed the opportunity to comment on the Quality Account for the University Hospitals of Leicester NHS Trust (UHL) at its meeting on 11 April 2011. The committee has also maintained an ongoing dialogue with UHL throughout the year and would like to thank officers for their consistently helpful and open attitude when attending Overview and Scrutiny Committee meetings.

“The committee is of the view that UHL has not omitted any major issues from its Quality Account. Work undertaken by UHL during 2010/11 which the committee particularly wishes to commend includes its participation in clinical research and its commitment to equality and diversity. The committee also welcomes the progress made in improving the cleanliness of the hospitals and UHL’s responsible attitude towards information governance and the storage of data.

“The committee welcomes UHL’s response to complaints. However, the committee recommends that information on the number of complaints where action has been taken or the complaint had been reopened is included in the Quality Account to provide context to the statistics.

In general, the committee is satisfied that UHL’s priorities match those of the public. The Committee is particularly pleased with the comments from the chief executive regarding UHL’s priorities. However, the committee is concerned that the key themes arising from the patient experience survey have not been referred to as part of the proposals to improve patients experience in the hospitals. The committee recommends that the improvement plans for the key themes are included in the Quality Account. The committee appreciates that work has been undertaken in the previous year to improve patient experience but feels that there are still issues to be addressed.

“The committee is pleased to note that UHL’s patient advisors and the Local Involvement Networks in Leicestershire, Leicester and Rutland have been involved in shaping the Quality Account for 2010/11.

“The committee feels that the Quality Account would be more accessible to members of the public if the glossary was more extensive and it was made clearer that an asterisk refers to the term being listed in the glossary.

“In conclusion, the committee believes, based on its knowledge of UHL, that the report is a fair reflection of the healthcare services provided and looks forward to the continuation of the strong relationship that has developed between UHL and the Overview and Scrutiny Committee.”

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5.3 Leicester City Local Involvement Network LINk

"The Board of Leicester LINk welcomes the opportunity to respond to the UHL Quality Accounts.

"It has recognised that it has been a difficult year, both financially and in the reorganisation proposals for the delivery of health services and the unsustainable demands made upon its services. The LINk commends the Trust for the work it has done and is continuing to undertake, in its wish to provide the highest quality and standards of health care services.

"The LINk acknowledges the three priorities defined by the UHL management board, and concur that all three have the backing of the LINk.

Mortality rates

Quality of service and care with analysis of detail is felt to be essential in achieving this aim. For persons reading the QA report, greater explanation of this entry is required to avoid misunderstanding.

Improvement to readmission rates

Again this is highly supported. We are of the view however, that there is a substantial need to have evidence of the partnership working between the UHL Trust other trusts and the local authorities. There is a feeling of a lack of proven evidence, which shows understanding of the difficulties experienced by UHL in its working relationships with, for example the provision of care in the community and social care provision. Communication between the local authority and the Trust over transport or road gritting proposals is another example. Many reports indicate discussions and joint working practices are being developed. Other than the Leicester city stroke pathway development, there is a perceived view by the public that the individual working practices and service provision responsibilities remain insular.

Improving patients' experience

Despite extensive work (which is acknowledged has been undertaken in this area), the results of the patient experience outcome remain a cause for concern, requiring further investigation and improvement. Little reference is made to the reasoning or causation of the views, for example of the BME population on this matter. Methodology of obtaining the patient experience feedback, it is suggested, may also benefit by using alternative methods. The LINk were pleased to see recent reports which clearly indicate steps being taken to try to ensure higher standards of patient experience are achieved and maintained.

LINks working relationship with UHL

This is considered to be extremely good with access to key executive post holders when required. Information exchange, is in the main satisfactory, but needs to be built upon further. Closer, meaningful working relationships with the Trust to enhance communication and information exchange will be a key objective sought by the LINk. There have been occasions where the responses required, have not been forthcoming, e.g. as a result of a patient survey undertaken by the LINk,

LINk representatives highlighted some disparity between the PCT and the Trust over the manner in which health care is provided.

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The LINk believe the results of the actions taken in regard to Infection control need greater emphasis, as do those areas where failure to reach required levels has occurred, e.g. in DVT, which we understand will result in financial penalty to the Trust. Whilst recognising the DH requirements for the QA report, plain English should be a keyword."

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5.4 Leicestershire Local Involvement Network (LINK) response to the University Hospitals of Leicester NHS Trust Quality Account for 2010/2011

Leicestershire LINk welcomes the opportunity to comment on the University Hospitals of Leicester NHS Trust Quality Account. The agreed openness and importance of public involvement demonstrated by the Trust, working with the LINk, is appreciated, as was the actions taken by the Trust following our submission to the QA last year.

In principle, the LINk endorses the three quality indicators to be 'improved upon' and those to be 'concentrated upon'.
There was significant concern that the QA covered all three hospitals, which has not been helpful in making a response, as the LINk considers there are considerable differences, compounded by a lack of evidence of consistent good practice. The apparent lack of interchange between directorates was also considered a concern.

The QA does contain jargon and in many cases does not explain the purpose or outcome of the comment. For example there are several references to percentages. Without the number from which the percentage is gained, the figures are meaningless. A comment by CEO that the mortality rates are satisfactory was thought insensitive.

There was overwhelming concern for the need to get back to 'quality nursing care,' common sense and improved communication between staff and patient. Nursing should mean providing care and reassurance, including addressing psychological needs.

It was felt that nursing staff appear to be 'too busy' to deal with patients and often administration at the nurses station, appears to take priority. Fear of voicing concerns or creating a 'fuss' is still very prevalent. Patients should not be fearful and it is important for the Trust to work hard to reassure and improve patient experience. We would therefore wish to see an improvement in patient and carer responses to the patient surveys. Currently it is felt that the questions do not refer to reality and should be reviewed in conjunction with the LINk and other patient groups.
There was huge concern about patients being moved from ward to ward and from bed to bed, almost hourly in some cases. It was unclear whether this was in order to meet government targets or for the benefit of nursing staff. It is very obviously upsetting to patients and work should be undertaken to minimise this situation, which again links to 'improving patient experience.'

The QA makes little reference to the difficulties of improving the quality of services and patient satisfaction, caused it was suggested by lack of evidence of joined-up responsibility and working with other trusts and key stakeholders. There was a feeling of talking but no evidence of positive action, which from the point of view of patients and staff has not translated into reality, for example in the increasing number of people being re-admitted.

Regarding 3.4.12 of the QA, there was concern that 'most high risk patients are seen within one day of referral.' We would expect 'all' high risk patients to be seen the same day, and as speed is crucial, to be seen in hours.

There needs to be greater investment in buildings and estate, with a move towards more single rooms, improved washing/toilet facilities and waiting areas at outpatient clinics.

In a number of places the QA justifies the comments it makes but in doing so gives no explanation or action plan as to what the Trust will be doing to rectify this. An example quoted refers to BME where there was a poor patient satisfaction result.

Training featured highly. We feel there needs to be more training for staff caring for people with learning difficulties, dementia and mental health problems.

We also felt there is insufficient education and awareness between patients and professionals. Self-management can be very effective and financially a viable option.

The Trust is excellent at media communication and PR but it was felt that the direction of communication should be re-examined, with less ‘tell and sell’ and more ‘listen and learn.’

We felt that it is imperative for the Trust to work with the local authorities regarding transport links for county patients, as apparently this does not appear to be under consideration. We were also surprised at the low level of complaints regarding access to and the cost of car parking, especially at the Royal Infirmary, which we are aware is an ongoing problem.

In conclusion it was felt that in view of the exceptionally high level of patients who receive services from the Trust there will always be complaints and things that need to be improved. If a number of the QA aims are followed through to the highest level of improvement then the rewards and quality will be confirmed.

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Glossary of terms

Adopted studies – are those that appear on the NIHR Portfolio. These are studies that are either funded by the NIHR itself or by a recognised research partner such as the medical charities and the research councils, or a commercial partner. Studies are accepted onto the Portfolio via an adoption process or automatically (eg NIHR funded studies).

Aseptic Non Touch Technique - a standardised approach to the practise of asepsis (required when carrying out any procedure that breaches the integrity of the skin or where this has already occurred i.e. during wound care, where there is the potential for micro-organisms to enter the blood stream).

CEMACH (Confidential Enquiry into Maternal and Child Health) -
The Centre for Maternal and Child Enquiries (CMACE) carries out national confidential enquiries into maternal and child health and a range of other related audit and research related activities designed to improve maternal and child health in the UK. National confidential enquiry is a form of national clinical audit and is a method of assessing the quality of care to help identify potentially avoidable factors associated with adverse outcomes.

Clostridium Difficile - is a species of bacteria that causes diarrhea and other intestinal disease when competing bacteria are wiped out by antibiotics.

CQUIN (Commissioning for Quality and Innovation) - the framework makes a proportion of provider income conditional on locally agreed quality and innovation goals. The three domains of quality (safety, effectiveness and patient experience) are covered in the CQUIN.

Definitive - refers to 'a permanent access plan for dialysis therapy'. The aim for the patient is to have a fistula or a graft for haemodialysis but in some cases a dialysis catheter is the only option. Definitive access also includes a peritoneal catheter in the case of peritioneal dialysis.

Healthcare associated infections (HCAI) - infections acquired as a consequence of a person's treatment by a healthcare provider, or by a healthcare worker in the course of their duties. They are often identified in a hospital setting, but can also be associated with clinical care delivered in the community.

High impact interventions - these are designed to promote the reduction of all avoidable HCAI. They relate to those key clinical procedures which can increase the risk of infection if not performed appropriately.

Meticillin-Resistant Staphylococcus Aureus (MRSA) - a common skin bacterium that is resistant to a range of antibiotics. 'Meticillin-resistant' means the bacteria are unaffected by meticillin, a type of antibiotic that used to be able to kill them.

NHS number - the NHS Number is the mandated national unique identifier for patients. It must be used alongside other demographic information to identify and link the correct records to a particular patient.

NCEPOD (The National Confidential Enquiry into Patient Outcome and Death) - is an independent organisation which undertakes clinically led confidential reviews into the quality of care received by medical and surgical patients.

NCEPOD publishes at least two new reports each year, on different topics, which detail recommendations that will improve the quality of care received by patients. Our

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multidisciplinary peer review approach to all data ensures that the findings and recommendations made are clinically robust.

Patient Safety First - a National campaign launched in the UK, to make the safety of patients everyone's highest priority. Patient Safety First focuses on the implementation of 5 initiatives, leadership for safety and four clinical interventions, reducing harm from high risk medicines, Reducing harm in Critical Care, Reducing harm in Perioperative Care and Reducing harm from Deterioration. Their aim is no avoidable death and no avoidable harm.

Paediatric Intensive Care Audit Network (PICANet) - aims to continually support the improvement of paediatric intensive care throughout the UK through clinical audit. The Paediatric Intensive Care Audit Network (PICANet) is a national audit coordinated by the Universities of Leeds and Leicester which collects data on all children admitted to paediatric intensive care units (PICUs) across the UK.

Pseudonymisation – the process of replacing patient identifiable data (such as NHS No) with another reference to ensure that a patient can not be identified from data which is being used for non healthcare purposes (e.g. commissioning services).

RAMI (Risk Adjusted Mortality Index) – CHKS risk adjusted mortality uses a method developed by CHKS to complete the risk of death for hospital patients on the basis of clinical and hospital characteristic data.

Safety Express - a National Patient Safety programme that was launched by the Department of Health , that aims to reduce harm in four areas, pressure ulcers, falls, catheter acquired urinary tract infections and blood clots (venous thromboembolism or VTE)

Secondary Uses Service - is the standard repository for performance data. It is the single source of comprehensive data enabling reporting and analysis for a range of secondary uses including planning, commissioning, management, research, audit and public health. It is designed to be the reimbursement mechanism for acute care.

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If you would like this information in another language or format, please contact the Service Equality Manager on 0116 258 8295

আপনি যদি এই লিফলেটের অনুবাদ - লিখিত বা অডিও টেপ'এ চান, তাহলে অনুগ্রহ করে সার্ভিস্ ইকুয়ালিটি ম্যানেজার ডেভ বেকার'এর সাথে 0116 258 8295 নাম্বারে যোগাযোগ করুন ।

यदि आप को इस लीफ़लिट का लिखती या टेप पर अनुवाद चाहिए तो कृपया डैब बेकर, सर्विस ईक्वालिटी मैनेजर से 0116 258 8295 पर सम्पर्क कीजिए ।

જો તમને આ પત્રિકાનું લેખિત અથવા ટેઇપ ઉપર ભાષાંતર જોઇતું હોય તો મહેરબાની કરી ડેબ બેકર, સર્વિસ ઇક્વાલિટી મેનેજરનો 0116 258 8295 ઉપર સંપર્ક કરો.

Haddaad rabto warqadan oo turjuman oo ku duuban cajalad ama qoraal ah fadlan la xiriir Maamulaha Adeegga Sinaanta 0116 258 8295.

ਜੇਕਰ ਤੁਹਾਨੂੰ ਇਸ ਲੀਫ਼ਲਿਟ ਦਾ ਲਿਖਤੀ ਜਾਂ ਟੇਪ ਕੀਤਾ ਅਨੁਵਾਦ ਚਾਹੀਦਾ ਹੋਵੇ ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਡੈਬ ਬੇਕਰ, ਸਰਵਿਸ ਇਕੁਆਲਿਟੀ ਮੈਨੇਜਰ ਨਾਲ 0116, 258 8295 ਤੇ ਸੰਪਰਕ ਕਰੋ ।

Eĝer bu broşürün (kitapçıĝın) yazılı veya kasetli açıklamasını isterseniz lütfen servis müdürüne 0116 258 8295 telefonundan ulaşabilirsiniz.