To:	**TRUST BOARD**
From:	**Medical Director**
Date:	**28 June 2012**
CQC regulation:	**16**

Trust Board Paper J

Title:	Final Draft Quality Account

Author/Responsible Director:
Director of Clinical Quality

Purpose of the Report:
The purpose of this report is to present the final draft of the Quality Account to the Trust Board on 28th June 2012.

The Report is provided to the Board for:

Decision		Discussion	
Assurance	X	Endorsement	X

Summary / Key Points:
The final draft of the 2011/12 Quality Account has gone through several iterations following feedback from the Executive Team, GRMC and external Stakeholders. External assurance will be provided at the meeting.

Recommendations:
The Trust Board to endorse Quality Account.

Previously considered at another corporate UHL Committee?
GRMC 25th June 2012.

Strategic Risk Register N/A	**Performance KPIs year to date** Q&P Report

Resource Implications (eg Financial, HR)
Printing costs.

Assurance Implications
External auditors view to be provided at the Trust Board meeting on 28th June 2012.

Patient and Public Involvement (PPI) Implications
LINks feedback, consultation with Trust members, our "potential Governors", recent BME symposium programme attendees and City, County and Rutland LINK for 2012/13 priorities.
Presentation of the QA to OSC and LINks.

Equality Impact
Service Equality Section.

Information exempt from Disclosure
No.

Requirement for further review ?

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

REPORT FROM: **MEDICAL DIRECTOR**

DATE: **28TH JUNE 2012**

SUBJECT: **DRAFT QUALITY ACCOUNT 2011/2012**

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1. BACKGROUND

1.1 The draft Quality Account (attached at Appendix 1) has gone through several iterations following feedback from the Executive Team, GRMC and external stakeholders.

1.2 The purpose of this report is to share the final draft of the QA with the Trust Board.

2. ASSURANCE FOR THE 2011/2012 QUALITY ACCOUNT

2.1 The Department of Health has asked that external assurance of Quality Accounts be undertaken on the 2011/12 accounts and has provided guidance to external auditors in this respect.

2.2 Our external auditors, KPMG have received the final draft Quality Account together with Stakeholders' commentary and have been asked to provide their opinion. This will be provided at the Board meeting on 28th June 2012. They will be seeking to issue an unqualified limited assurance opinion.

2.3 KPMG continues their review of the Quality Account and testing of specified indicators. Feedback to date has suggested there is nothing of significance to impact upon the limited assurance opinion.

2.4 Trusts are also required to complete the Statement of Directors' Responsibilities. This was presented and discussed at Governance and Risk Management Committee and Audit Committee in May.

2.5 The statement takes the form of bullet points followed by a signature from the Chairman and Chief Executive.

2.6 The following information is provided in support of the steps taken:

- **The Quality Accounts presents a balanced picture of the Trust's performance over the period covered**

  The 2011/12 Quality Account reports back on performance in relation to the 2010/11 Quality Account – the priorities for improvement and follows the same format of the previous year's report to allow comparisons. Recognising that it is difficult to report exhaustively on performance the Quality Account provides a number of web links to detailed performance reports for example the Quality and Performance Report and the CQC reports.

- **The performance information reported in the Quality Account is reliable and accurate**

  Collection of performance information for the Quality Account has been subject to a number of checks and balances including:

  - Triangulation with other data sources/reports, for example those submitted to the Clinical Quality Review Group and Contract Performance Meeting
  - Review by the Assistant Director of Information
  - Amendments following review by the OSC, LINks and Commissioners
  - Confirm and Challenge by the Director of Clinical Quality where data conflicting. A clear audit trail of these queries is available and resultant actions.

- **There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice**

  The internal controls over collection and reporting of measures of performance in the Quality Account has been subject to review by KPMG in May 2012. Development of the Quality Account has been discussed at QPMG, the Executive Team and GRMC in 2011/12.

- **The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Account has been prepared in accordance with Department of Health guidance**

  There are close working arrangements with the Information Department. Performance data is considered, confirmed and challenged at various groups including: Confirm and Challenge meetings, QPMG, F&PC, GRMC and TB in addition to 'specialist' committees such as the Clinical Audit and the Research and Development Committees.

2.7 The Department of Health toolkit (accessible via http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_122540.pdf) has been reviewed and all mandatory statements included are explicit through their inclusion in bold text.

2.8 Department of Health guidance has been provided to GRMC members, LINks, PCT and the OSC through various reports and presentations.

3. GENERAL ASSURANCE OF DATA QUALITY

3.1 In addition there are a number of internal controls and standards in relation to data quality including:

- **NHS Healthcare Income Audit –** East Midlands SHA Internal audit Feb 2011. The audit opinion demonstrated significant assurance.

- **Information Quality Policy** – DMS Doc 20243 – last approved January 2011. The policy gives the Trust's standards on maintaining high information quality.

- **Clinical Coding Audit** - external audit by D&A Clinical Coding for General Surgery March 2012, to Connecting for Health Standards. Audit results not yet finalised.

- **Payment by Results Follow-up Audit** – external audit by KPMG to follow-up all previous local work delivered by the PbR assurance framework. Of the nineteen actions twelve were completed on time and seven were satisfactory progress has been made and it is reasonable to expect it to be still in progress

- **Case note Audit** There are 300 patient activity records e.g. Inpatient record / Outpatient record audited internally each month to compare the case note content against the electronic record. Detailed reports to Divisions, summaries to CEC and GRMC – good results.

- **Monthly reporting to the Clinical Effectiveness Committee** on current data quality standards for the year

- **Quarterly reporting to the Governance and Risk management Committee** on current data quality standards for the year. We are among the highest performing Trusts.

- **Documentation of routine data quality processes is available** e.g. daily monitoring of duplicate records created, and checks against current demographic information.

- **Operational and Management reporting.** There are a whole suite of daily and weekly data quality reports available to support local management of data and identification/correction of errors in a timely manner.

3.2 Following KPMG's review of the Quality Account in 2010/11 external dry run exercise 9 actions were identified for improvement, three relating to the data quality kite mark. The Quality and Performance Report is currently being refreshed to reflect the operating framework and provider management regime requirements. The review will include content, format and use of the quality diamond and further work improvement will continue in 2012/13.

4. STAKEHOLDERS COMMENTARY

4.1 Draft 7 of the Quality Account was submitted to GRMC at the March meeting and shared with stakeholders in April. Commentary has been received from Leicestershire LINks, County OSC and the Commissioners and this has been included in the QA. Changes to QA have been made as a result of these commentaries.

5. RECOMMENDATIONS TO TRUST BOARD

5.1 The Trust Board are asked to receive and endorse the final draft of the QA, Stakeholders commentary and Statement of Directors' Responsibilities. Note that the draft QA has been extensively discussed at GRMC and with external stakeholders resulting in amendments ahead of the final draft.

5.2 To note the findings regarding external assurance from KPMG.

5.3 To advise on any final changes ahead of the publication and uploading on the NHS Choices website.

Sharron Hotson, Director of Clinical Quality

University Hospitals of Leicester NHS
NHS Trust

Caring at its best

Quality account

2011/2012

Contents Page

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 next word

Part one Statement from the chief executive

Hello and welcome to this, the third University Hospitals of Leicester, Quality Account.

Not that long ago the story which dominated the headlines when the media discussed the NHS was, 'hospital acquired infections'. Patients and the public worried about whether they would be kept safe from infection whilst in hospital. Nasty organisms, with difficult names like MRSA and clostridium difficile were part of the national conversation.

Today the fear of infection has receded. The public led the way in terms of demanding a different approach from the NHS and the NHS has responded. Wherever there are sick people there will be organisms which have evolved to take advantage of weakened immune systems and poor overall physiology but the risks to patients has diminished to the point where infection prevention and control is no longer the concern it was for patients or those of us who work in the service.

Now, we have a different challenge. Or perhaps it would be more accurate to say that we have a challenge which has existed for some time but has only recently started to dominate the national conversation.

It's not as you may be thinking, money, though clearly that is important. It's care and compassion, and especially the way we care for older people in, and out of hospital.

There are two strands to this. First, there is the 'structural' element. We have an ageing population who are living longer and living with illness for longer. For example, in UHL we now have a new category of patient… these are the '105 years and older'.

The second strand is 'cultural'. As a society it sometimes feels that older people or the ageing population are described as an 'issue' and that begs the question, when did we start seeing older people as an 'issue' rather than as valuable and contributing members or our society?

I don't have all the answers but I do know that with regard to the NHS and with particular reference to the local NHS in Leicester, Leicestershire and Rutland, this is our biggest challenge.

The challenge is often referred to as 'patient experience' and given that the overwhelming majority of our patients are over 70 their experience in hospital is really THE experience of hospital.

For the last two years a key element of our Quality Account has been to improve patient experience and though we have fallen short of the high standards we set for ourselves we have shown improvements (see page 11).

This year we are going to carry on with the drive to improve patient experience in hospital. Our approach will tackle the structural issues. We will work with our GP partners in primary care and social services to create more and better services for older people which reduce the need for them to be in hospital in the first place.

And we will also tackle the cultural issues; we know for example that whilst the numbers of nurses on our wards meets the national standards, there are times when demand for services are so high that we struggle to provide the kind of care we aspire to. Hence, we will invest in more nurses on certain of our wards so that their desire to deliver care with compassion is not hindered through lack of time.

I have spent most of this introduction talking about our response to the public's justifiable demand for better care for our older people. I make no apologies for that, to

borrow and adapt a saying from Gandhi, “the NHS’s greatness is measured by how we treat our frailest patients.”

Elsewhere in this Quality Account you will see that in response to the views of stakeholders and our members we will be seeking to drive down rates of readmission to hospital and improving our overall mortality rates (see page 7).

Finally, I would like to say thank you to our staff, who through their daily diligence and innate compassion continue to deliver a quality service to our patients…even when the demand for our services threatens to overwhelm us. I would also like to thank our partners and stakeholders, there are too many to mention by name but their support, constructive challenge and passion for Leicester’s hospitals is greatly appreciated.

Yours sincerely,

Malcolm Lowe-Lauri, Chief Executive

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)

Part two
Priorities for improvement 2012/13

We have chosen to continue to focus on last year's priorities for improvement this year (2012/13). This decision has been made following discussion with board members, divisions and our commissioners (our local primary care trusts).

In choosing our priorities for improvement we also sought feedback from the public, canvassing the views of more than 8000 people.

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 discussed on page 27. In addition the CQUIN* programme includes stretching targets each year.

Priority one: improving patient experience

We want to:

Increase the opportunity for patients, carers and the public to provide feedback on services and care offered through a range of mediums such as questionnaires, interviews, focus groups, patient stories and diaries. Feedback from all patients will be acted upon with specific focus being given to listening and responding to the views from:

- Older People
- People with dementia
- Carers
- Patients in relation to dignity in care
- Establish the Net Promoter Score across all clinical areas for 10% of inpatient discharges for any given week at or within 48 hours of discharge. The first month of reporting will be April 2012 following which a trajectory for improvement will be agreed to ensure either a 10 point improvement in the Net Promoter score* or maintenance of top quartile performance throughout 2012/13.

We will measure progress by:

- Monitoring of the Net Promoter Scores by ward and speciality.
- Demonstrating an increase in the number and diversity of feedback mechanisms across the trust.
- Evaluate and establish the use of email surveys offered to patients who attend Maternity Services, Emergency Department and Outpatient's facilities.
- External events engaging with the public who have had experience of care in the trust – minimum of two large scale events a year.
- The results of our patient surveys presented in a 'dashboard' (a visual representation and series of graphs and tables that report a large number of quality/outcome measures including patient experience feedback, nursing measures, complaints, compliments, staff experiences and many other quality indicators) a useful tool to benchmark progress

We will report to:

- The Trust Board meeting
- Our commissioners as part of our monthly quality meetings
- Divisions and Clinical Business Units

- The Governance and Risk Management Committee
- Annual Patient Feedback Event

Priority two: improving readmission rates

We want to:

- Work with our partners to reduce readmissions by 5% in elective and emergency admissions for both adults and children by improving the discharge planning process, working with partners to improve discharge support and improving patient information, therefore improving patient experience.

Our current year to date performance (as of January 2012) is 7.4% for 30 day readmissions.

We will measure progress by:

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

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

Priority three: reducing mortality (SHMI*)

We want to:

- Achieve an in year reduction in our SHMI and be better than the majority of other Trusts in the UK.

Our SHMI value for 2010/11 was 106.

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

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

Other priorities

In addition to these three main priorities for improvement we have also identified other specific areas for improvement as detailed below.

- Improving the use of the WHO checklist and team briefings in all our operating theatres by achieving 97% compliance with WHO checklist usage in patients having operations in our theatres
- Reducing cancellations on the day of elective surgery by 50% by ensuring that elective surgical patients receive their procedure on the intended date and working collaboratively across the organisation to maximise theatre use
- Improving standards of end of life care by ensuring patients and carers receive the highest possible standards of end of life care through advance care planning and training of staff in end of life care
- Improving awareness and diagnosis of dementia through improved awareness and diagnosis of dementia using risk assessment.

Finally in 2012/13, we are embarking upon a transformational safety programme called "5 Critical Safety Actions". The 5 Critical Safety Actions programme seeks to embed safety processes across all our clinical business units to ensure systematic, consistent and high quality care.

The 5 Critical Safety Actions are:-

1: Improving clinical handover
2: Relentless attention to EWS triggers and action
3: Implement and embed Mortality and Morbidity standards
4: Acting upon results
5: Senior Clinical review, ward rounds and notation

These Critical Safety Actions are supported by our commissioners and are subject to routine monitoring via agreed key performance indicators.

Progress on last year's priorities

Last year (2010/11) we set the following three priorities for improvement for 2011/12:

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

Priority one: improve mortality rates further

We aimed to reduce all in-hospital patient deaths in both elective and non elective care and to have a Risk Adjusted Mortality Index (RAMI)* score in the top 25% of trusts nationally.

Although we have not met our target to be in the top 25% of trusts we are in the middle in terms of our performance.

Our crude mortality rate* for 2011/12 is 1.3%, this is an improvement on 2010/11. The crude mortality rate looks at the number of deaths that occur in a hospital in any given year and compares that against the amount of people admitted for care in that hospital

for the same time period. The crude mortality rate can then be set as the number of deaths for every 100 patients admitted.

Our RAMI for 2011/12, as calculated by Comparative Health Knowledge System (CHKS)*, has remained below the threshold of 85 which was agreed by the Clinical Effectiveness Committee in July 2011.

Both the crude and risk adjusted mortality rates are reported and reviewed at the monthly Clinical Effectiveness Committee and the trust board through the quality and performance scorecard, as well as our commissioners through the Clinical Quality Review Group.

Mortality rates are presented for elective (planned) and emergency admissions as well as the overall inpatient population. Both the crude and risk adjusted rates are reviewed for all three groups.

Each specialty has reviewed its processes for holding mortality and morbidity meetings following the implementation of our mortality and morbidity* review. Part of that review was to agree criteria for which patients should be reviewed, both in respect of mortality and morbidity, and to confirm the process for ensuring any learning points are acted upon.

We experienced an increase in our elective mortality rate during May, the findings from speciality mortality and morbidity reviews were reported to the Clinical Effectiveness Committee in October. One of the key findings of the review was that some patients had been recorded as being an elective admission, which means their admission was planned in advance, but they were in fact urgent admissions of deteriorating patients arranged at very short notice. This meant they were coded as elective admissions. The mortality and morbidity reviews also confirmed that the deaths were primarily due to their complex case mix.

At the end of October 2011, the new Summary Hospital Mortality Index (SHMI) for 2010/11 was published for all trusts. This national indicator is different to both the Dr Foster HSMR (Hospital Standardised Mortality Rate) and the CHKS RAMI.

SHMI uses a different risk adjustment model to both of the above, for example no adjustments are made for patients identified as at the end of their life, known as palliative care. The SHMI also includes deaths which occur up to 30 days after a patient was discharge from hospital; this means it reflects the performance of the health community as a whole rather than focusing on the acute hospital. Due to the fact that 'out of hospital deaths' are included, the SHMI is always 6 months behind RAMI and HSMR.

Our SHMI value for 2010/11 was 106 and falls within an expected range when using the 95% control limits but is classed as higher than expected when using the more sensitive 99.8% control limits. Our 'in-hospital mortality' for the same time period is 'within expected' for both CHKS (RAMI = 86) and Dr Foster (HSMR = 102)

Pneumonia was the main diagnosis of patients who died either in hospital or out of hospital. One of this year's CQUINs for UHL has been to improve assessment of the severity of illness with patients admitted with suspected pneumonia in order that early treatment is started in line with the severity. The mortality rate for patients with severe pneumonia is over 25%.

Further to publication of our SHMI for 2010/11 a case note review has been undertaken of patients with three other diagnostic groups and this has identified that documentation of the patients' diagnosis on admission and other existing illnesses (co-morbidities) was not always clear.

Following this review we have agreed a consistent approach to documentation of diagnosis and co-morbidities for all specialities across the trust. Clearer documentation will enable our clinical coders to identify and code the confirmed admission and discharge diagnoses plus all relevant co-morbidities. The expectation is that both of these will then be more accurately reflected in the SHMI risk adjustment model. Guidance is being shared with all clinical teams, individual consultants and, where appropriate, admission documents will be revised to incorporate this guidance.

Although we are able to monitor the number of deaths and crude in-hospital mortality for BME groups, we are not currently able to benchmark our BME mortality rate against other trusts as CHKS does not include ethnicity as part of its risk adjustment model.

Our overall mortality rate for 2011 was 1.4%. The mortality rate, during the same time period, for patients in BME groups was 0.9% whilst the rate for patients from White British group was 1.5%.

In order to better understand how the in-hospital mortality rates compares with overall mortality rates by BME group and how this relates to the local health community, further analysis and review of data is to be carried out in collaboration with public health colleagues.

Priority two: improve readmission rates

We aimed to reduce avoidable readmissions by 25% in elective and emergency admissions for both adults and children. We planned to do this by improving the discharge planning process and improving patient information therefore improving patient experience.

Although we have missed the 25% target, the annual readmission rate was 7.4% (compared to 7.7% for 2010/11). However, this was still above our internal trajectory of 25%. We also remain below the Emergency Care Network plan of a 10% reduction although our performance continues to be better than other university teaching hospitals.

A readmission within 30 days of discharge is seen as a quality marker for an organisation. However, not all readmissions are avoidable. There are many readmissions that are necessary for continuing to deliver quality care and save lives. Avoiding readmissions is a key priority for the whole health economy, meaning that hospital teams, GPs, and community teams need to work together to support patients better within the community and reduce readmissions where they are avoidable.

When looking at readmissions it is essential that we examine both the high level readmission rate of the hospital and the number of readmissions, but also an underlying rate of avoidable readmissions and their number too. Reducing readmissions isn't just about the rate it is about impacting on patients' lives by keeping them out of hospital where possible. The readmissions rate from April 2011 to March 2012 was 7.4%, 0.3% down on the same period in the previous financial year. The actual number of readmissions was lower.

A programme is in place to support the continued reduction of readmissions. This is supported by partners from health and social care and supports the Leicester, Leicestershire and Rutland (LLR) Emergency Care Network goal of reducing readmissions by 10%. Work to improve patient pathways has been carried out. The emergency frailty unit has reduced the number of readmissions of older people through assessment by a geriatrician within the ED and redirection to community frail and older people's services.

There has also been significant work to ensure our data quality is correct to ensure targeting of the right groups of patients. This is essential in terms of ensuring that all readmissions are actual readmissions enabling a focus on the patients who most require different services to reduce the number of admissions they have.

Within the community a number of new schemes have been introduced in December, they include Practical Help at Home scheme, an Extended Integrated Community Team, and the integration of the Rapid Intervention team.

The readmissions project will continue next year with the aim of reducing readmissions by 10% across Leicester, Leicestershire and Rutland.

Priority three: improve patient experience in our hospitals

We wanted to be consistently in the top 20% of trusts nationally for positive patient feedback, according to local patient experience survey results and the national patient survey.

We said we would use two key indicators of patient experience to track experience over time. These two indicators encompassed a range of quality questions which gave scores to measure improvements. These were:

- Self reported experience of patients
- To be in the top 20% of trusts for patient experience in relation to privacy and dignity and patients rating their care as excellent.

Based on the 2011 survey although we have not achieved the 20% target we are in the middle 60% of trusts for patient experience in relation to privacy and dignity and patients rating their care as excellent.

Encouragingly our local patient experience surveys tell us:

- 94% of our patients said they were always treated with respect and dignity
- On average, three quarters of our patients rate their overall care as excellent or very good, with the vast majority rating it as excellent.

Of course our aim is to provide Caring at its Best for all patients and we continue to use the experiences and views of patients, relatives and carers to guide developments in our services.

We have continued to develop the ways we collect feedback from patients by expanding our inpatient satisfaction survey across all of our wards including day case units. We gathered patient experience feedback from on average 1,272 patients every month from completed patient experience surveys and a further 200-300 email surveys a month from patients who attend the emergency department, outpatients and maternity services

We have also introduced a message to matron system which is now used across all divisions and gathers data from 145 clinical areas and 40 matrons. The messages have been 76% compliments and 24% suggestions. The top three themes of compliments and suggestions are:

Top three compliment themes	Top three suggestion themes
1. Staff attitudes and behaviours	1. Reduce waiting times
2. Quality of care	2. Staff attitudes and behaviours
3. Communication / providing information	3. Communication / providing information

As a result of feedback we have made many changes to continue to improve the patient experience, including:

- Nurses and health care assistants receive Caring at it Best interactive training
- In appropriate areas patients receive hourly nursing ward rounds
- The nurse in charge is easily identifiable by their large, red badge
- Older people's wards have a ward round by matron and meet matron sessions
- Wards know what volunteer resource they will have to support them by allocating volunteers to specific wards and duties
- Ward managers or sisters are held to account for the performance of their wards when the expected standard of care is not provided
- Dashboards
- Rewards/Awards - the quarterly "Caring at its Best Awards" were launched on 21st September and reflect six categories, one for each of our values and one public nominated award.

Specific projects

Following feedback four specific projects were established:

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

Our surveys show that all four of these areas have improved since their introduction in March 2011, with notable improvements in the noise at night and providing information projects. The action plans and projects will be reviewed in April 2012.

Part two

Statements relating to the quality of NHS services provided

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.

Review of services

During 2011/12 University Hospitals of Leicester NHS Trust provided and / or sub-contracted 314 NHS services. These include:

- **Inpatient = 58 specialties**
- **Outpatient = 78 specialties**
- **Day case = 56 specialties**
- **Emergency = 71 specialties**
- **Non-elective = 50 specialties**
- **Direct access* to 5 specialties**
- **4 national screening programmes[1]**

[1] The screening schemes are retinal screening (diabetes), breast screening (cancer) bowel screening (cancer) and abdominal Aortic Aneurism AAA (vascular)

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

The income generated by the NHS services reviewed in 2011/12 represents 100 per cent of the total income generated from the provision of NHS services by the University Hospitals of Leicester NHS Trust for 2011/12.

Examples of how we reviewed our services in 2011/12

The quality of care of patients is reviewed through a number of ways.

- **Review of Cost Improvement Programme for Quality Impact Assessment**

The Governance and Risk Management Committee has agreed a process for CIP schemes to be quality assured ensuring that any significant risks to patient safety and/ or quality of care are regularly monitored and mitigated to acceptable levels.

As part of this process clinical divisions and corporate directorates were asked to identify any schemes where the value was above £65k and / or there was a risk score of 12 or above in relation to patient /safety /quality of care issues.

Schemes in the above categories have been risk assessed at divisional and directorate level and key performance indicators (KPIs) identified that can be monitored to ensure that the scheme is not having an adverse impact upon patient safety/ quality of care.

To provide assurance to GRMC of effective management of those schemes where a risk to patient safety/ quality of care has been identified a monthly exception report will be provided outlining those schemes where a deteriorating position in relation to patient safety / quality of care has been identified.

- **Clinical quality performance indicators**

A variety of clinical quality indicators are reported at service level and are reflected in the quality and performance report which is 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
- Children's services
- Care of patients undergoing fractured neck of femur, open fractures and shaft of femurs
- Emergency department.

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)**

We use an information system called CHKS. This looks at our data relating to quality and patient safety such as mortality, readmissions and complications, as well as efficiency and service improvements such as day case, length of stay and outpatient follow-up. The data initially looks at overall trust wide information and then goes down to clinical business unit and service level.

Data from CHKS is used to provide benchmarked data for several quality and performance indicators as well as the heat map indicators, such as venous thromboembolism*, falls and pressure ulcers* and is also being used by divisions to support effectiveness projects and CQUINs.

Our corporate business analysts continue to use CHKS to support our 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**

Nursing metrics are collected in all clinical areas including theatres, maternity and outpatients. They are measured monthly by the senior nursing team and have demonstrated positive and sustainable improvements.

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

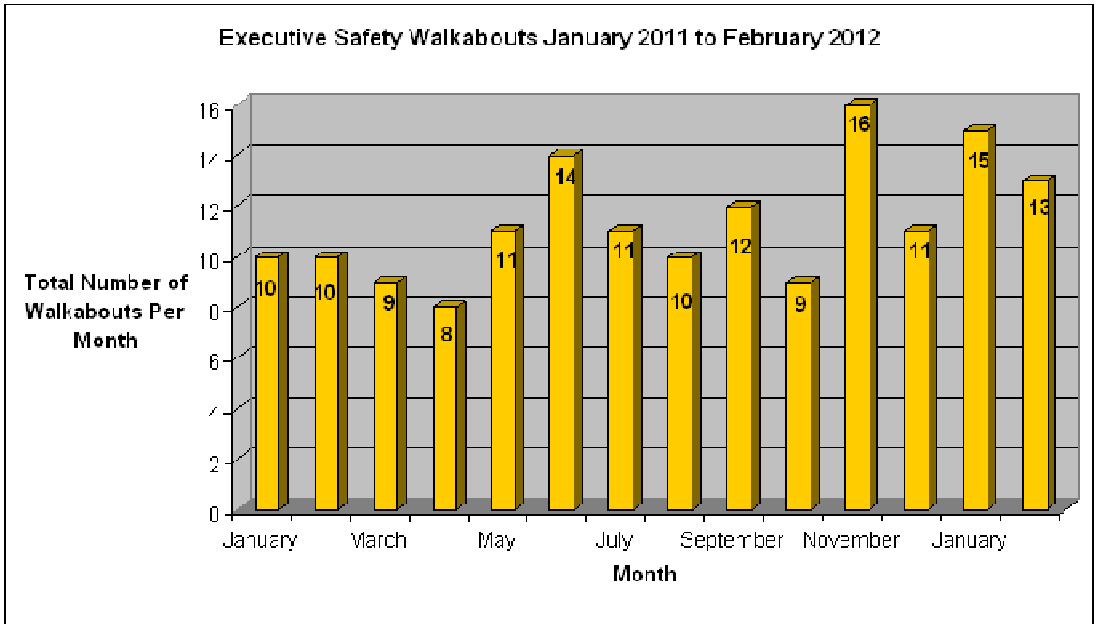
- Pain management
- Patient observations
- Falls assessment
- Pressure area care
- Nutritional assessment
- Medicine prescribing and administration
- Resuscitation equipment
- Controlled medicines
- Venous Thromboembolic Disease (VTE)
- Patient dignity
- Infection prevention and control
- Discharge
- Continence.

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 walkabout programme**

In addition to our structures, processes and policies relating to patient safety, the safety work is supplemented by a comprehensive executive safety walkabout programme which visits all types of clinical areas throughout the organisation. These walkabouts are led by directors with non executive directors, patient advisers and other external visitors contributing to the programme. Issues and themes from the walkabouts are reported at committees and actions are followed up by relevant staff. The table below

details walkabout visits from January 2011 to February 2012.



Source: Director of Safety and Risk

In addition to these timetabled visits members of the Executive Team and senior staff visit clinical areas on a daily basis.

- **External visits and accreditations**

There are a number of external agencies that review, inspect, license and accredit our hospitals, including, 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 all are captured on a schedule.

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

- **NHS Litigation Authority**

The National Health Service Litigation Authority (NHSLA) handles negligence claims made against NHS organisations and works to improve risk management practices within the NHS. It manages the following schemes:

- Clinical Negligence Scheme for Trusts (CNST)
- Liabilities to Third Parties (TPS)
- Property Expenses Scheme

All NHS organisations in England can apply to be members of these schemes. Members pay an annual contribution to the relevant schemes, which are similar to insurance.

As a member of these schemes we must undergo regular assessment of compliance against the NHSLA Acute Risk Management Standards (ARMS) and CNST (Maternity Standards). Compliance is assessed at three levels with the attainment of each level securing a 10% discount on contributions up to a maximum of 30%. Our hospitals are currently compliant at level one of both the NHSLA ARMS and CNST standards demonstrating that we have policies in place describing the processes for managing risks. It is our ambition to move to level two in the early part of 2013/14.

- **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 review, as part of their scheduled activity, or a responsive review, in response to information or intelligence.

In 2010/11 the CQC carried out a planned review at the Royal Infirmary, Glenfield and the General followed by St. Mary's Birth Centre in early 2011/12.

The CQC found that we were compliant with the outcomes at all our sites at that time. Copies of the CQC reports can be obtained from our public website www.leicestershospitals.nhs.uk under 'performance' in the 'about us' section. http://www.leicestershospitals.nhs.uk/aboutus/performance/publications-and-reports/compliance-reviews/?locale=en

In March 2012 the CQC undertook an unannounced inspection on the acute medical unit at the Royal Infirmary and found in their judgement that there were major concerns in relation to the care and welfare of people who use the service. These concerns relate to information to patients who may wait on a trolley, the appropriateness of some of the patients transferred to a chair or trolley, the monitoring of length of time whilst on a chair or trolley and the privacy and dignity of patients during this time.

There were also comments by the CQC in terms of medication supplies, the suitability of the clinic room and also mechanisms for staff to receive feedback when concerns were raised.

The CQC carried out a follow-up inspection on the Acute Medical Unit on the 4th May and found that we are now compliant with the warning notice and were satisfied that patients experience care, treatment and support that meet their needs and protect their rights. A copy of the report is available via http://www.leicestershospitals.nhs.uk/

- **CQC quality and risk profile report**

The quality and risk profile report (QRP) is an essential tool used by the CQC for gathering 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, primary care trusts and Monitor have access to these to support continuous monitoring of compliance and to improve how care is provided and commissioned.

The QRP is analysed by expert leads within our hospitals to see how we can improve our services. The report is discussed at the Clinical Effectiveness Committee and Quality and Performance Management Group thereby providing further assurance around quality from a number of perspectives**.**

- **Commissioner quality visits**

Our commissioners (the local primary care trusts) conduct quality visits on a quarterly basis at all three of our hospitals. There is immediate feedback followed by a report

highlighting good practice and areas for improvement which is discussed at a quality contract meeting with our commissioners. We get 24 hours notice of a visit and we are informed of the areas which will be visited when the commissioners arrive.

Participation in clinical audits and confidential enquiries

Participation in clinical audit is an effective way of monitoring and improving patient care and the trust has a very active clinical audit programme.

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 Advisory Group on Clinical Audit and Enquiries (NAGCAE) (formerly known as National Clinical Audit Advisory Group (NCAAG)).

During 2011/12, 54 national clinical audits and 4 national confidential enquiries covered NHS services that University Hospitals of Leicester NHS Trust provides.

During that period University Hospitals of Leicester NHS Trust participated in 92 % (n=44/48) 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, Patient Reported Outcomes (PROMS) and national confidential enquiries that UHL was eligible to participate in during 11/12
- The national clinical audits and national confidential enquiries that UHL participated in during 11/12
- the national clinical audits and national confidential enquiries that UHL participated in, and for which data collection was completed during 11/12, 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 (where known or the data collection period is complete).

National clinical audits / Patient Reported Outcome Measures

Audit Title	Applicable to UHL?	Did UHL participate?	% Cases submitted 11/12 / 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 & 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
Severe trauma (Trauma Audit & Research Network)	Yes	Yes	Data collection still ongoing
Diabetes (National Adult Diabetes Audit)	Yes	Yes	100% of applicable cases
Pleural procedures (British Thoracic Society)	Yes	Yes	100% of applicable cases
Lung cancer (National Lung Cancer Audit)	Yes	Yes	100% of applicable cases

Emergency use of oxygen (British Thoracic Society)	Yes	Yes	100% of applicable cases
Adult community acquired pneumonia (British Thoracic Society)	Yes	Yes	Data collection
Non invasive ventilation (NIV) - adults (British Thoracic Society)	Yes	Yes	To start
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	100% of applicable cases
Acute stroke (SINAP)	Yes	Yes	Data collection still ongoing
Potential donor audit (NHS Blood & Transplant)	Yes	Yes	100% 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	100% of applicable cases
Cardiac arrest (National Cardiac Arrest Audit)	Yes	No	UHL does not take part - undertakes own audit
Pain Management (Paeds) (College of Emergency Medicine)	Yes	Yes	100% of applicable cases
Severe Sepsis & Septic Shock (College of Emergency Medicine)	Yes	Yes	100% of applicable cases
National Audit of Seizure Management	Yes	No	Trust not informed of this audit so unable to take part
Cardiac arrhythmia (Cardiac Rhythm Management Audit)	Yes	Yes	100% of applicable cases
Liver Transplantation (NHSBT UK Transplant Registry)	No	N/A	N/A
Prescribing in Mental Health Services (POMH)	No	N/A	N/A
Schizophrenia (National Schizophrenia Audit)	No	N/A	N/A
Ulcerative colitis & Crohn's disease (National IBD Audit)	Yes	Yes	ADULT: -100% (20 UC and 20 Crohn's patients) PAEDS:- 100% of applicable cases
Hip fracture (National Hip Fracture Database)	Yes	Yes	100% of 836 applicable cases
Hip, knee and ankle replacements (National Joint Registry)	Yes	Yes	94% of applicable cases
Bowel cancer (National Bowel Cancer Audit Programme)	Yes	Yes	100% of 460 applicable cases
Head & neck cancer (DAHNO)	Yes	Yes	Submitted minimum requirements: 31% (60) of 191 applicable cases
Carotid interventions (Carotid Intervention Audit) 2010-11	Yes	Yes	100% of 124 applicable cases

Peripheral vascular surgery (VSGBI Vascular Surgery Database)	Yes	Yes	100% (32 Peripheral Vascular cases 63 Lower limb amputations)
Oesophago-gastric cancer (National O-G Cancer Audit)	Yes	Yes	100% of applicable cases
Platelet use (National Comparative Audit of Blood Transfusion)	Yes	Yes	100% of applicable cases (40/40)
O neg blood use (National Comparative Audit of Blood Transfusion)	Yes	Yes	100% of applicable cases (70/70)
Care of the Dying in Hospital (NCDAH)	Yes	Yes	100% of 120 applicable cases
Chronic pain (National Pain Audit)	Yes	Yes	Data collection still ongoing
Risk Factors (National Health Promotion in Hospitals Audit)	Yes	No	Trust not informed of this audit so unable to take part
Intra-thoracic Transplantation (NHSBT UK Transplant registry)	No	N/A	UHL have not been invited to take part in this study
Heavy menstrual bleeding (RCOG National Audit of HMB)	Yes	Yes	100% of applicable cases
Neonatal intensive and special care (NNAP)	Yes	Yes	100% of applicable cases
Diabetes (RCPH National Paediatric Diabetes Audit)	Yes	Yes	100% of applicable cases
Childhood epilepsy (RCPH National Childhood Epilepsy Audit)	Yes	Yes	100% of applicable cases
Paediatric pneumonia (British Thoracic Society)	Yes	Yes	100% of applicable cases
Perinatal Mortality (MBRRACE- UK)	Yes	Yes	100% of applicable cases
Elective surgery (National PROMs Programme) (hips)	Yes	Yes	85.3% (1st & 2nd quarters 11/12)
Elective surgery (National PROMs Programme) (knees)	Yes	Yes	74.9% (1st & 2nd quarters 11/12)
Elective surgery (National PROMs Programme) (hernia)	Yes	Yes	32% (1st & 2nd quarters 11/12)
Elective surgery (National PROMs Programme) (Veins)	Yes	Yes	32% (1st & 2nd quarters 11/12)

National confidential enquiries

Title	Applicable to UHL	Did UHL participate?	% Cases submitted 11/12
Bariatric Surgery (NCEPOD)*	Yes	Yes	8/8 (100%) submitted
Cardiac Arrest Procedures (NCEPOD)	Yes	Yes	6/6 (100%) submitted
Peri-operative care (NCEPOD)	Yes	Yes	15/15 (100%) submitted
Surgery in children (NCEPOD)	Yes	Yes	12/12 (100%) submitted

NCEPOD *= National Confidential Enquiry into Patient Outcome and Death

The reports of more than 60 national clinical audits were reviewed by the provider in 11/12 and below are some examples are how the trust has performed and the actions taken to improve patient care:

Title of Audit (Ref number)	Key findings	Area for improvement / agreed action
Feverish Children (#5052)	100% compliance with the provision of safety net in children (with no diagnosis is found and with amber features) & also in not prescribing antibiotics to children with amber features and without an apparent source of infection.	Development of an Standard Operating Procedure covering high risk fever patients/sepsis including guidelines for juniors to emphasis what is a high risk presentation
National Stroke Audit (#4265)	Overall performance has improved when compared to previous audit with the move to the LRI mainly as a result of direct admissions of stroke patients from ED (via CT scan) to the unit.	A stroke nurse now reviews all stroke patients in Emergency Department and ensures urgent contact with the stroke registrar or consultant.
Audit of the ED management of moderate and severe asthma in adults (#4635)	Compliance with the national standards variable.	Implementation of Emergency Department audit / management proforma for adult patients with asthma (integrated guidance / documentation tool). Improved medical staff education - asthma management integrated into induction program and rotating daily teaching topics. Improved nurse education about what to at initial & repeat assessment, and about the need for rapid initiation of treatment.
National Oesophago-Gastric Cancer Audit (#4336)	Both the network and UHL results are within the national rate control limits.	With regards to the 7 Recommendations from National Report – the LNR network / UHL have implemented 6 of them and it has been agreed that brachytherapy would be not be cost effective to set up for a tiny number of patients given the good range of alternative treatments. Minimally invasive oesophagectomy is starting soon within UHL with NIPAG* approval.
National Bowel Cancer Audit (#4337)	National comparisons within the group have not revealed any outliers in terms of outcomes but there are procedures in place to examine further any such instance. All participants find the process reassuring, educational and ultimately of benefit to their patients.	None required
Myocardial Ischemia National Audit Project (MINAP) (#4579)	Good compliance with national standards and comparable with national results.	The monthly MINAP meetings review all reperfused patients who present with STEMI*. If there are any identifiable delays or deviations from hospital pathways these are discussed and action plans made
Peritoneal Dialysis (PD) compliance with Renal Association Standards	Slight improvement in the mean haemoglobin reported.	More frequent monitoring of haemoglobin was agreed
National Comparative Audit of Blood Collection (#4552)	The audit showed that at the time a unit of red cells is collected from a hospital's main blood fridge, the person collecting the unit had adequate written patient details and completed the procedure for collection.	Further education set up on the process of transfusion and the checking that is required has taken place and will continue indefinitely.

The reports of over 200 local clinical audits were reviewed by the provider in 2011 and below are some key findings and the actions taken to improve patient care:

Title of Audit (Ref number)	Key findings	Area for improvement / agreed action
Audit of NICE guidelines in managing patients with chronic heart failure on ward 24 in Glenfield hospital (#5636)	The majority of our patients audited were discharged with the recommended combination of B blocker, ACE I or ARB and diuretics	All patients with moderate to severe left sided heart failure should be referred to community specialist nurse.
Outcomes of radiological interventions on AV fistula (#4892)	Intervention is effective and success rate and complications in line with published results	None required.
Appropriate use of platelets in Paediatric Intensive Care Unit at Leicester Royal Infirmary (#4553r)	All patients had pre and post transfusion testing. Majority of patients given transfusions at appropriate level of platelets.	Documentation of indications for transfusion.
Emergency admissions seen by consultant in 12 hours audit (NCEPOD) (#4751)	Virtually all eligible patients receive a consultant review within 24 hours of admission to the AMU	Standard Operating Policy written to confirm that a consultant review is needed within 24 hours.
Anti-retroviral drug therapy to suppress the HIV Viraemia (#5282)	There are a higher proportion of patients (93.8%) on antiretroviral treatment than generally quoted figures from other units (60-70%) which reflects our local practice of late presenting patients	None required.
Audit of use of Intravenous Immunoglobulin use and adverse events in patients with peripheral neuropathy (#5113)	The use of IVIG in neuropathy patients was in accordance with DoH guidance.	Patient risk factors to be assessed prior to initiation of IVIG therapy, and monitored regularly.
Re-audit of TB contact screening by Interferon gamma release assay in contacts of TB index cases (#4153)	Screening was offered to all the household contacts of any person with active TB, irrespective of the site of infection.	IGRA testing will be performed earlier in highest risk groups.
Audit of Routine nebuliser use post thoracic surgery (#5281)	To reduce the amount of time that patients are receiving un-necessary nebuliser therapy	Agreed that patients undergoing major surgical procedures, or those with any predisposing factors, should receive 48 hours of nebulised Saline and Salbutamol.
Reaudit of Administration and Effectiveness of Analgesia Post Lower Segment Caesarean Section (#5373)	Better adherence to prescribing according to protocol	Self administration of medication implemented on ward - which will release midwifery time to complete documentation of observations required following neuraxial opioid administration.
Discharge planning re-audit (#5291)	Overall there has been a general improvement across UHL with the availability of the discharge planning template and documentation relating to the discharge planning for patients with ongoing care needs.	Patient information board have been introduced to address issues with easily accessible patient information for MDT regarding discharge planning referrals and where the patient is in the discharge planning process and identification when patient requires TTO.
Evaluation Of The Quality Of Oral Nutritional Provision Delivered To Fractured Neck Of Femur Inpatients On Ward 18 LRI (#4771)	Highlighted that areas of nutritional care could have been improved on the ward as some patients were not consuming enough calories and protein.	Nutrition Care Pathway developed for #NOF Patients. Additional measures put in place for this patient group. Many work streams to make it a comprehensive package – including fridges to chill supplements, special cutlery. Education provided for nurses, patients and families. Training to all staff to drive improvements in core patient care.
An audit assessing antenatal screening for Haemoglobinopathies (#5592)	The majority of couples consented to father testing. However, parents living at different addresses were a common factor in couples not consenting to father testing. Gestation at booking predictably had significant influence on the	Presented results of audit at national meeting (British Society of Haematology Obstetric Meeting) to increase awareness of issues raised in audit, including need to consider a national campaign to encourage early booking.

	timing of counselling/father testing. Mothers/couples were being counselled by appropriately trained professionals.	
Audit of Dabigatran in elective orthopaedic (hip and knee replacement) patients (#5378)	The incidence of leaking wounds in total hip replacement [THR] patients on Dabigatran was a lot higher (32%) than that in total knee replacement [TKR] patients (12%).	Cease use of Dabigatran for elective orthopaedic. Report incidence of leaky wounds to drug 'watchdog' - Medicines and Healthcare products Regulatory Agency (MRHA)
Surgical Pre- operative assessment with or without the use of proforma (#5239)	Documentation improved with the use of a proforma.	Pre assessment form implemented to assess patient's pre operatively and improve documentation consistency.
Audit of adherence to UHL Guidelines on Vitamin D Deficiency (#5585)	All children had their pre-treatment Vitamin D levels measured and received Vit D dose as stated in guidelines according to age group.	It was agreed that < 6 months age group need treatment for 6 weeks only rather than 8 weeks. Follow up levels are required to ensure levels are in 'ideal 'range until further audit.
Antenatal Booking Documentation Re-Audit (#5513)	There has been consistent improvement in compliance with the NICE guidelines since the introduction of audit in this area.	Midwives to ensure Chlamydia screening is offered to mothers.
Audit Of Early Pregnancy Bleeding Referrals To Gynaecology Ward At The Leicester General Hospital. (#5402)	Only 75% of patients had a referral letter from the GP and minimal information was included	Agreed to implement flow-chart for management of Per Vaginal bleeding in early pregnancy for GPs to follow, which will act as a referral letter.
OSTRICH (Oxygen Saturation To Really Improve Child Health) Initiative (#5579)	Following implementation of the OSTRICH Initiative the compliance to guideline for oxygen saturation limits increased from 22% to 91%.	Continue with the initiative to encourage further MDT team work.
Smoking Cessation in Pregnancy (#5002)	% of Women who smoked that were either referred or declined referral to smoking cessation service has risen from 91% (1st audit) to 100% (re-audit)	None required

Participation in clinical research

The number of patients receiving NHS services provided by or subcontracted by University Hospitals of Leicester NHS Trust in 2011/12 that were recruited during that period to participate in research approved by a research ethics committee was 13,610.

We were involved in conducting 842 clinical research studies.

Of these 460 (55%) were adopted* and 382 (45%) non-adopted. A total of 208 (25%) were commercially sponsored studies.

We used national systems to manage the studies in proportion to risk.

Forty two percent of the studies given approval were established and managed under national model agreements.

Seventy nine percent of the 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.

In 2011/12 the National Institute for Health Research (NIHR) supported 460 (55%) of the total number of research studies through its research networks.

In 2011 there were 369 full papers published in peer reviewed journals.

Awards for our research

We were awarded a combined £15.5 million for three Biomedical Research Units (BRU) in the summer of 2011. These prestigious awards were made by the National Institute for Health Research on the basis of research of international quality. We are the only NHS Trust outside Oxford, Cambridge and London to hold three BRUs.

Two of the awards, with the University of Leicester, are to look at cardiovascular disease and respiratory disease. The third, in conjunction with Loughborough University as well as University of Leicester, will look at nutrition, diet and lifestyle.

The nutrition, diet and lifestyle research will focus on new areas of physical activity research including the potential benefits of short periods of exercise, particularly in patients with type II diabetes* and chronic kidney disease.

The cardiovascular research is set to include studies and trials into better predicting those at risk of heart attack as well as trials to see if drugs can be developed to limit damage to the heart after a heart attack.

The respiratory research aims to focus on the development of new and effective treatments for severe asthma and chronic obstructive pulmonary disease (COPD)*.

Goals agreed with commissioners

The local primary care trusts (PCTs) and the East Midlands Specialised Commissioning Group (EMSCG) buy, or commission, services on behalf of people in Leicester, Leicestershire and Rutland[2] (LLR). As part of our contract with the PCTs and EMSCG, we have agreed quality targets and goals 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 was developed and agreed with clinical staff across the healthcare community.

A proportion of University Hospitals of Leicester NHS Trust's income in 2011/12 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 third year of the CQUIN scheme.

Further details of the agreed goals for 2011/12 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).

For 2011/12 there were two national and 12 regional CQUINs. The two national CQUINs were

- Assessment of patients on admission for risk of developing a venous thromboembolism (blood clot)
- Improving responsiveness to patients' needs as assessed by the national patient survey

The 12 regional CQUINs had several indicators within each of the schemes and included:

- Improvements in stroke care, including time to brain scan, assessment by all members of the multi disciplinary team
- Giving smoking cessation advice and referral to the STOP smoking cessation service

[2] EMSCG also commission specialised services for patients living outside of LLR eg Cardiac Surgery

- Discharge planning
- Preventing and reducing hospital acquired pressure ulcers, in-hospital falls and urinary catheter related infections
- Increasing home therapy for patients with cancer, HIV and Hepatitis C
- Increasing home dialysis for renal patients
- Improving screening of neonates.

A further five 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:

- Improving communication with primary care (to include quality and timing of outpatient, inpatient discharge and emergency department letters)
- Further development of an infection control surveillance programme
- Further improvements in care for patients with pneumonia and reducing mortality.

The CQUIN schemes have led to:

- Fewer patients acquiring a pressure ulcer or having a fall whilst in hospital
- More patients being able to have their treatment at home
- Less infections for patients having bowel surgery, cardiac surgery, hip and knee replacements, a caesarean section or urinary catheter inserted
- More patients being given advice about their medication and who to contact if worried after discharge
- Improved compliance with treatment and better outcomes for patients with HIV and Hepatitis C
- Increased feedback from patients.

What others say about us

Statements from the Care Quality Commission

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.

The Care Quality Commission have taken enforcement action against University Hospitals of Leicester NHS Trust during 2011/12.

The CQC issued University Hospitals of Leicester NHS trust with a warning notice on 10th April following major concerns of compliance with outcome 4 (care and welfare of patients who use the service). We had until the 30th April to comply.

The CQC carried out a follow-up inspection on the Acute Medical Unit on the 4th May and found that we are now compliant with the warning notice and were satisfied that patients experience care, treatment and support that meet their needs and protect their rights. A copy of the report is available via http://www.leicestershospitals.nhs.uk/

Data Quality

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 carried out with confidence.

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. A Data Quality Improvement Plan is in place in our hospitals. This focuses on obtaining correct and timely admission data for patients and ensuring that the patients' registered General Practice is recorded correctly.

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

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 and other patients with no current number**
- **Validation of current GP Practice for all patients. Data collected in the Trust is compared with definitive GP registration information for Leicestershire patients and anomalies updated**
- **New patient registrations are validated to ensure mandatory demographic data is complete to facilitate NHS Number tracing**
- **Updates due to death registrations and notifications.**

Management reporting occurs as follows

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

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.**

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

The University Hospitals of Leicester NHS Trust submitted records for April to October 2011 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics. The percentage of records in the latest published data:

Records with a valid NHS Number

	Trust	National Average
Admitted patient care	**99.7%**	98.7%
Outpatient care	**99.8% (an improvement of 0.3% on previous year)**	99.0%
Accident and Emergency care	**98.2% (an improvement of 0.1% on previous year)**	92.7%

Source: secondary uses service

Records with a valid General Medical Practice Code

	Trust	National Average
Admitted patient care	**100%**	99.8%
Outpatient care	**100%**	99.7%

Accident and Emergency care	**100%**	99.4%

Source: secondary uses service

Clinical coding error rate

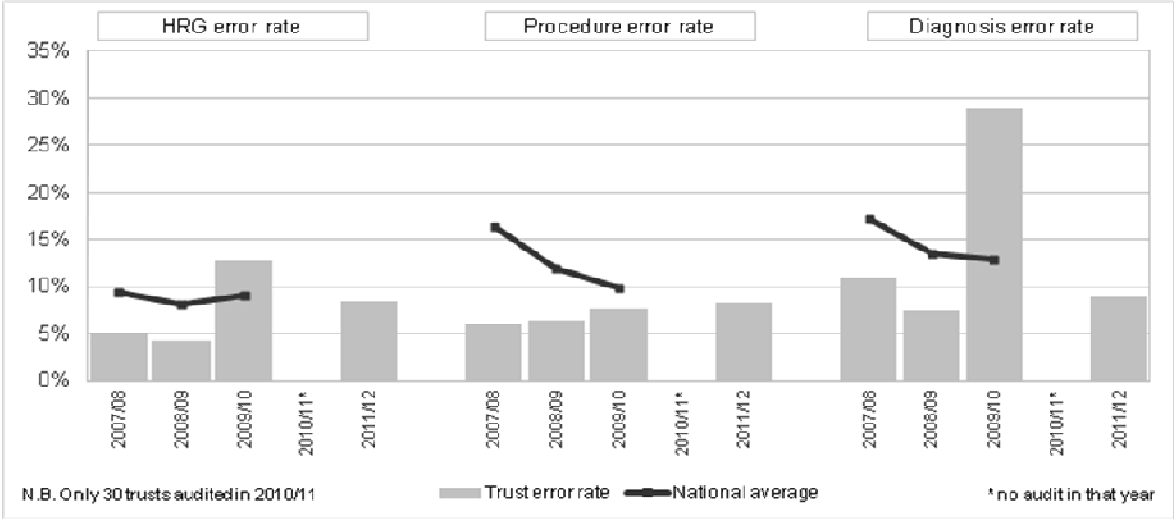
Clinical coding translates the medical terminology written by clinicians to describe a patient's diagnosis and treatment into standard, recognised codes. The accuracy of this coding is a fundamental indicator of the accuracy of the patient records. Information about the Payment by Results Data Assurance Framework clinical coding audit is available from the audit commission website.
www.auditcommission.gov.uk/health/paymentbyresults/assuranceframework/Pages/Default.aspx.

The clinical coding results should not be extrapolated further than the actual sample size audited. The auditors randomly selected 100 episodes from trauma and orthopaedics specialty and 100 episodes from across the whole range of activity provided.

University Hospitals of Leicester NHS Trust was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were:-

- **Primary Diagnoses Incorrect 8.5%**
- **Secondary Diagnoses Incorrect 9.3%**
- **Primary Procedures Incorrect 9.6%**
- **Secondary Procedures Incorrect 7.1%**

We have started an extensive coding transformation plan, designed to improve the quality of coding, which has already begun to improve accuracy in clinical coding with an overall 4 percentage point improvement in the Health Resource Group (HRG) accuracy in this year's audit findings. An HRG is essentially a case mix grouping. Different patient treatments within a cluster of both diagnosis and procedure which are deemed to have consumed the same level of resources are assigned to an HRG. The performance of the Trust compared to the performance of all trusts over the past four years is shown.



Source: Audit Commission PbR audit

Information governance toolkit attainment levels

The information governance toolkit is an assessment tool which allows NHS

organisations and partners to assess themselves against Department of Health information governance policies and standards to determine compliance and performance levels on an annual basis.

University Hospitals of Leicester NHS Trust's information governance assessment report score for the period 2011/2012 is 84% and will be graded green (satisfactory). Following a score of 75% for 2010/11 this is a significant improvement as a result of improvements in the total number of staff trained in information governance, improving policy standards and our new project team dedicated to managing information risks across our systems.

The specific standards where the Trust has received an improved level of compliance include the training standard, which requires 95% of staff (11,400) having completed the Connecting for Health (CfH) provided, e-learning training *or* training which has been approved by Connecting for Health. We continue to promote CfH e-learning and approximately 4,000 staff have completed the refresher training and passed the assessment following the promotional campaign that was put into place during the preceding year.

Compliance with the required information asset ownership standard which requires identification of owners for our information assets has improved performance in this vital area. New modular training and the creation of new compliance standards for staff charged with managing information assets means that improvement can continue during the forthcoming year. Corporate record-keeping standards have also improved through the establishment of the position of a records governance manager from 1 April 2011. A dedicated project has seen compliance raised against a number of standards with the ongoing commitment to developing a performance management framework for all records and standards and supporting Trust record keepers.

There remains a range of Information Governance standards to improve including in relation to ongoing training for staff and audit spot-checks to help identify and manage information risks across our hospitals. However, with the establishment of the new Information Governance Programme Board for 2012/13 the continuous improvement sought in this area can be driven across all parts of the organisation.

Part three
Review of our quality performance

The following section is a review of our performance in 2011/12. Quality is reviewed through a variety of mechanisms including the quality and performance report, use of CHKS, through the Governance and Risk Management Committee and through the Quality Schedule and CQUIN programme.

Quality Strategy

Although the quality account identifies three areas for improvement, the quality strategy (2011 -14) underpins this and comprises a small number of ambitious hospital wide quality goals covering safety, clinical outcomes and patient experience and aims to drive year on year improvements.

These goals reflect local, as well as national, priorities that are relevant to our patients and staff and have been selected to have the highest possible impact across our hospitals. These hospital wide quality goals are relevant to divisions and clinical business units and may be tailored to specific services. For each of the goals there are clear action plans with designated leads and timeframes, however these are at varying degrees of development.

The quality strategy was approved in June 2011 and was developed over a number of months following discussions with the executive team with input from board development sessions and a variety of staff meetings.

Our objectives

We treat people how we would like to be treated

- We will be in the top 20% of Trusts for patient experience in relation to privacy and dignity and patients rating their care as excellent
- We will reduce the number of complaints related to staff attitudes by 5% each year

We are passionate and creative in our work

- We will pursue innovation in service design and delivery that will improve outcomes, increase patient satisfaction and deliver greater efficiency
- We will reduce by 25% the spells associated with readmission in 11/12 and show an improvement year on year

We will do what we say we're going to do

We are one team and we are best when we work together

- Our staff will feel more engaged, empowered and motivated than in other hospitals

We focus on what matters most

- We will consistently have a RAMI score in the top 25% of Trusts across all our specialties
- We will have lowest infection rates across acute hospitals reducing our MRSA and CDT figures year on year
- We will risk assess all patients for VTE (minimum target 90% 2011/12)
- We will eliminate preventable hospital acquired pressure ulcers demonstrating a 5% reduction each year**.** For those areas of high incidence there will be a 20% reduction target
- We will have a 5% year on year reduction in incidents of patient falls
- We will ensure all patients undergoing surgery have the WHO checklist completed prior to surgery (theatre checks)

Progress against the quality strategy objectives is reported monthly in the quality and performance report and in this QA.

Patient experience achievements

The following are a few examples of the initiatives we use to improve patient experience.

Patient experience survey
During 2011 we developed a comprehensive range of patient and family feedback mechanisms. Feedback from patients, relatives and visitors is encouraged in a number of ways. We have already talked about some of the ways we collect feedback and measure progress in the previous section on our first priority, improving the patient experience.

The patient experience survey is the main method used for gaining patient feedback. The return rates have been increasing throughout the year with an average of 1,272 surveys returned per month, an increase from last year.

The results from the patient surveys are available for staff to see exactly what their patients are experiencing and feedback from the survey is continually used to improve services and the quality of care for our patients.

Share your experience
We have launched a project called share your experience in some services aimed at patients who are only in hospital for a very short amount of time, such as in the emergency department, outpatients and maternity services. The project, which is being trialled for one year, provides fast and convenient methods of collecting feedback, such as email, and can show live results and deliver automated systems to analyse the potentially large volumes of data collected.

Over the last year a total of 3,409 patients have been invited to complete a survey and 1,329 patients have responded.

Postcard from Leicester
In our three outpatient departments we are also using a postcard from Leicester. The postcard allows patients to comment on “what did we do well?” and “what can we improve upon?” The matron ensures the responses are themed, displayed and acted upon. Of the 2,724 completed postcards received between March and August 78% of the comments were compliments and 22% suggestions.

Public website and touch screens
A link is now available on the homepage of our website to allow patients, families and carers to provide us with feedback of their experience in our hospitals (www.leicesterhospitals.nhs.uk/feedback/). There are also touch screen devices within our three hospitals to allow feedback to be given.

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

Patient stories

Listening to patient stories is 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.

Over the last year our trust board has heard a number of patient stories from relatives and carers. This has allowed the board to draw on a range of experiences directly from patients and families. This greater understanding and transparency has informed decisions and priorities that have supported changes based on patient feedback.

Our Trust board continue to receive quarterly patient stories with each division presenting.

Patient diary

A patient diary was developed across the healthcare community and given to patients within our hospitals. At the same time 60 patients at a GP surgery were given a diary when they were referred for a surgical review with us.

The diaries were returned and jointly analysed and provided valuable information about patient experience. The results were used to improve overall care in hospital and community settings.

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.

We continue to engage in a number of activities to gather carers' views on the services we provide. We have attended local carers' groups, gathered feedback from the carers' surveys completed on our public website and touch screens as well as a survey with the Carers of Leicestershire Advocacy and Support Project (CLASP).

Feedback from carers has illustrated that carers have lower levels of satisfaction of care. To identify the priority areas for improvement with carers we held an engagement event. This was facilitated by the patient experience team in conjunction with CLASP and Support for Carers Leicestershire, a service funded through Leicestershire County Council. More than 50 people came to the event including voluntary agencies such as; Alzheimer's Society, ANSAAR (a Leicester based community project set up for people with learning disabilities), age UK, Barnardos and Chimex care.

The actions prioritised on the day will be discussed and implemented with the wider organisation and progress fed back to participants.

Engaging with black and minority ethnic (BME) groups

Analysis of our monthly patient experience survey highlighted that feedback from BME groups was not representative of the local population. In consultation with these particular groups it was identified that the survey would not be the preferred way of giving feedback for many of these ethnic groups. It was agreed that more focus group work outside of the hospital would be well received.

The patient experience team and patient and public involvement manager have arranged to meet BME groups across the city and county to gather opinions and experiences of care within our hospitals. So far there have been two events with the most recent being with the Jagruti Group and more are planned.

Key issues identified to date include providing more information of a higher quality or relevance, appropriate food menus, hospital noise, addressing poor staff attitudes and inadequate pain management.

Once all of the issues have been collated, a summary will be fed back to the divisional and CBU teams through the Patient Experience Group for information and to be incorporated in the divisional patient experience project action plans. Comments around food will be given directly to the UHL Food Forum.

Older people's champions

An older people's champion is a member of staff or volunteer who has completed additional training to highlight the specific needs of the older person. We have approximately 1,600 older people's champions working across our hospitals to

improve the experiences of older people. Champions are identified by their older people's champion badge or lanyard.

We hold quarterly forums for champions to feed back on how they have made a difference for older people in hospital, share some of the issues older people are facing and discuss how we can improve our services.

Each year we hold a celebration event to note and share best practice achievements by our network of older people's champions. Colleagues from other health and social care organisations as well as the voluntary sector and older people's focus groups also attend the event.

Improving care for patients with dementia

Improving care for people with dementia admitted to the acute hospital is a priority nationally and locally. It has been identified as a national CQUIN and it is one of our areas for improvement for the coming year. Our Dementia Care Action Group has a clear vision to improve the quality of care for people with dementia when they are admitted to hospital. Priorities for this year have been identified through the Joint Dementia Commissioning Strategy and the 17 key objectives of the National Dementia Strategy (NDS). The priorities in the commissioning strategy have been grouped into four themes. These reflect the overarching national NDS objectives and stakeholder workshop recommendations. These are:

1. Early diagnosis and access to care and support services
2. Improved experience of hospital care
3. Improved quality of care in residential/care homes
4. Personalisation of care and living well with dementia in the community

We will work with our local primary care partners to lead on the work stream to improve the experience of hospital care.

The charitable funds raised through the Forget-Me-Not appeal have been used to support and improve the quality of care for people with dementia in hospital. This has included the transformation of two patient day rooms into retreat and activity rooms, enhanced specialist training for staff and volunteers and the introduction of a meaningful activities co-ordinator to work with people with dementia with the support of volunteers to keep people with dementia meaningfully occupied in hospital.

Dementia care training

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. Over 1,000 people have attended this training including, staff, volunteers and medical students.

We have also launched a basic awareness dementia e-learning module which was developed in conjunction with the Alzheimer's society, members of staff across Leicester, Leicestershire and Rutland's health and social care organisations and De Montfort University. People living with dementia and their carers were also consulted to ensure that their views were incorporated into the training programme.

As part of the Forget-me-not appeal enhanced dementia training was completed by staff. The course gave an overview of what dementia is and the impact on the brain, signs and symptoms, the enriched model of dementia care, understanding psychological needs, psychosocial interventions, restraint, ethics and case scenarios. Staff attended from different professional backgrounds, including nurses and allied health professionals and education and practice development team members.

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

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.

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.

In February 2012 we had 203 volunteer mealtime assistants supporting the mealtime experience across our hospitals.

We have secured charitable funding for a one year pilot project coordinator post to support and develop the mealtime support volunteers in the wards, and to work with staff to fully and appropriately utilise the potential that volunteer support can offer.

Maintaining dignity and respect

We strive to ensure the privacy and dignity of patients remains a priority for all our staff with a range of initiatives that promote privacy, dignity and respect. Some of these are detailed below.

Same sex accommodation

We continue to care for patients in same sex areas, except when it is in the patient's overall best interest, or reflects their personal choice, to be cared for in a mixed area.

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).

To ensure we are compliant with same sex accommodation we carry out quarterly inspections of wards and departments with our estates department.

If our care should fall short of the required standard, we will report it both locally as per agreement using the same sex accommodation decision matrix for our hospitals and nationally we publish our reports.

To help continue to raise awareness of same sex accommodation amongst staff in our hospitals, a guided flow chart has been devised to help staff follow the correct procedures and highlight persons responsible for addressing issues that may arise with same sex accommodation.

Red dignity pegs

All of our wards and departments have access to red dignity pegs to help maintain patient's privacy. They ensure curtains cannot open and act as a sign to others not to enter. A sign saying Care in Progress is also available for use on paper curtains and side rooms.

Dignity retreat rooms
During 2011 an additional three dignity rooms have been built. Having these rooms away from the bed space means relatives, patients and staff have a private area to have potentially difficult conversations such as about end of life care or for families to hear bad news.

Dignity training
Dignity training is provided through a number of staff induction and development programmes across the trust. The training encourages staff to consider the fundamental aspects of dignity that mean so much to each and every one of us and how dignity in practice can be improved and maintained at all times.

Patient experience across our divisions

Some services have specific needs when it comes to improving the patient experience and we have small projects all over our hospitals to address these needs, some are detailed below.

Outpatient departments
A number of changes in the outpatient departments have led to big improvements in their quality metrics and patient satisfaction scores, particularly in respect of nutrition. Patients in the departments at the General and Glenfield hospitals now have vending machines and water fountains as well as access to a WRVS shop. At the Royal Infirmary a WRVS trolley service and hot drinks machine have improved access to nutrition and hydration making outpatient visits a more pleasant experience.

Clear signage boards have been introduced on consulting rooms to make it easier for patients to find where they need to go. Literature racks have also been added giving easier access to patient information leaflets and to donated magazines.

Seating has been rearranged to improve dignity and comfort within the plaster rooms and storage systems in consulting rooms have been improved to improve cleanliness and reduce waste at the General.

At the Royal Infirmary toys, crayons and colouring paper are keeping children amused in the department.

Children's Hospital
Within our children's hospital there had been a number of concerns raised regarding perceptions of staff attitude and the level of communication. A review of complaints confirmed that communication issues were cited in 90% of them. When investigating the complaints it became apparent that there was a considerably difference in the information clinicians thought they had provided to families and what families thought they had been given.

To reduce the incidence of this happening in the future communication sessions have been included in mandatory training, the induction of nursing staff and the induction for junior doctors. These sessions review the different ways of communicating as well as highlighting how staff can and are perceived. The sessions included the review of actual complaints by the staff with set questions to identify what the issues identified and how these would be reviewed.

This has resulted in a reduction in the number of complaints where communication is the main theme identified.

Women's services
In women's services we have also introduced these communication sessions, as well as customer care training after discovering that 75% of all complaints identified staff attitude and communication as issues.

The communications session includes how body language and comments can be perceived in a different way from which they were intended. And all new staff receive information about how to handle a complaint as part of their induction.

Cancer services
Treatment at home
We are offering all suitable patients with early or advanced breast cancer, being treated with Herceptin®, the option to receive their treatment at home.

We are working in partnership with Healthcare at Home Ltd to offer this service which will improve patient experience by reducing the stress and expense of travel, they can receive treatment in the comfort of their own home, they will not need as much time off work and carer's will not need to accompany patients to hospital.

The advantage to us and to our other patients is that it reduces the number of patients within the Chemotherapy Suite. The first patient was treated during January 2012 and other patients are being referred to the service.

New Macmillan cancer information centre
In early January work began on a new Cancer Information and Support Centre at the Royal Infirmary.

The new build will see an expansion of the front of the Osborne Building incorporating an information drop-in area, a multi-purpose room, a quiet room, a refreshments area and an office for the information team. Our Hair Loss Service will also be based in the new centre, along with a benefits clinic, complementary therapy sessions and support groups. We will be working with other health professionals to increase the range of services offered in the future

The current Information Centre opened in July 2002 and has steadily risen in popularity. We saw and helped around 1,622 people in the first year, and that's now risen to over 6,000 in the last year.

Work is due to finish in June 2012 and the new centre will be run two Macmillan information staff, helped by a team of volunteers.

Information leaflet for haemodialysis patients
We have developed a newsletter for patients on the haemodialysis unit. Recent feedback from patients and relatives had indicated that they were lacking information about issues in the unit.

The first newsletter explained about appointment times, named nurse, self care, transport and exercise. The newsletter has been welcomed by patients in the unit and has been positively evaluated.

Noise at night in hospital
As discussed on page 12, this is one of the four projects led by the clinical divisions following patient feedback. There are two specific questions in the national patient survey that relate to noise at night; "Were you ever bothered by noise at night from other patients?" and "Were you ever bothered about noise at night from hospital staff?"

Ear plugs were distributed throughout our hospital and a number of noise monitors were strategically placed by nurse's stations on wards to encourage staff to talk quietly. Standards of care have been written and implemented guiding staff on the specific care issues relating to night, such as lighting.

The monthly inpatient surveys have shown an improvement since March 2011 and scores indicate that patients are having a more positive experience at night.

Pain and Comfort Management

This project, one of the four discussed on page 12, has been led by the clinical divisions following patient feedback. The inpatient experience survey asks the specific question "Do you think the hospital staff did everything they could to help control your pain?"

- The Pain Nurse Specialist Team have produced booklets to improve knowledge of pain management for nursing staff
- A multi disciplinary team are reviewing all current policies and guidelines relating to bowel management to bring this work together in an overarching policy
- Medical leads are reviewing analgesic pathways for specific patient pathways.

Acute wards

Patient stories

The daughter of a patient who was cared for in one of our older people's ward provided us with her insight and feedback on her mother's experience.

From the story she told of how we did not communicate effectively we introduced a number of initiatives, which have since been rolled out across our hospitals. Red nurse in charge name badges are now common place in all our wards. The matron undertakes regular ward rounds and meets relatives at visiting times. Message to matron boards are displayed and post cards distributed for patients and relatives to complete and the matron to receive and act upon appropriately.

Communication

A number of strategies have been implemented in the acute division to improve communication including, laminated posters at each bed explaining how relatives can make an appointment to see the patient's consultant.

Relatives are routinely phoned to inform them that the patient is being transferred from an assessment unit to a ward. The ward clerk explains which ward they are moving to and provides directions.

Patients are also given a discharge card which explains how they can contact the ward to seek advice for 72 hours following discharge.

Information needs

The daughter of a patient who was discharged from a ward told us that her father did not know who to contact if he had any concerns when he left the hospital. He was dependant on social services for support and expected a visit from the district nurse.

Since then the medicine clinical business unit has introduced follow up phone calls, where the ward sisters or deputy phones the patient, relative or carer 24 to 48 hours after discharge.

Hourly rounds

A patient's perception of the quality of nursing care largely depends on the nurse's ability to meet the patient's needs. Research has indicated that hourly rounds cut the use of patient call bells significantly, decrease inpatient falls and reduce pressure ulcers.

Further work to embed hourly rounds will take place in 2012/13, with specific outcome measures, including increased patient experience scores, reduced complaints relating to nursing care and improved staff satisfaction.

Post oesophagectomy* support group
We have established a group for post operative oesophagectomy patients after these patients told us we needed more face to face support on discharge. This is a multi disciplinary team between the consultant, specialist nurse and dietician.

About 90 patients and carers attended the first meeting which focused on sharing experiences and developing coping strategies. The group plans to meet quarterly.

Safety

Central alerting system (CAS) performance
Safety alerts are regularly issued via the Department of Health Central Alerting System (CAS) from external agencies including:

- Medicines and healthcare products regulatory agency (MHRA)
- National patient safety agency (NPSA)
- Department of Health estates and facilities division.

Safety alerts provide important safety information regarding medical devices, medicines and clinical practice with the aim to reduce the level of risk of untoward incidents to patients or staff. It is important that safety alerts are managed effectively to ensure all actions to comply are completed within the timescales given by the issuing body.

During 2011 we received a total of 126 alerts of those 91% were completed within the deadline specified by the Department of Health, which is a five percent increase above the previous year's figure. In 2012 the objective will be to achieve a minimum level of 95% of alerts completed within specified timescales, this will be measured quarterly.

Staff concerns reporting line
We operate a staff concerns reporting line whereby any member of staff can raise safety concerns without fear of recrimination by calling extension 3636. Issues reported in this way are reviewed by a director and reported on at the executive team meeting.

Never events
Never events are very serious, largely preventable patient safety incidents that should not occur if the relevant preventative measures have been put in place.

During the year the incidents on the never event list have expanded. There are now 25 Never Events, 23 of which relate to our organisation's services. The full document can be accessed via the Department of Health website.

The Department of Health acknowledge that "never" is an aspiration. These errors should not happen and all efforts must be made to prevent these mistakes being repeated. This means that the overriding concern for the NHS in implementing the "never event policy" is to report, discuss and investigate these events when they occur and to learn from the mistakes that were made.

We have reported two never events for 2011/12. One related to the "wrong route administration of chemotherapy", the second to "retained foreign object post-operation". Both were reported promptly, investigated fully using root cause analysis and reports with action plans provided. These SUIs are subject to internal scrutiny through the Learning from Experience Group and the Quality and Performance Management Group.

Chemotherapy incident

- Review and revision of competency assessment framework for chemotherapy administration
- Prescription charts to be pre-printed or accessed through electronic prescribing
- Presentation at key groups for divisional and organisational learning.

Retained foreign object incident

- Detailed description to be included within patients notes of any swabs left in situ
- On discovery of retained object – item to be retained for examination/identification.

These were shared internally with Trust board, externally with our commissioners, and with the patient/relatives in line with our "being open" policy.

Neither patient involved suffered long term harm from the never event.

Serious untoward incidents (SUI)

A SUI can be classified as a serious untoward incident where some, or all, of the following apply:

- A patient suffers severe unexpected impairment of health or injury, death or disability during the course of their care within the trust
- The event is likely to result in litigation against the trust
- The event is likely to attract significant media/external interest
- The event is likely to jeopardise the reputation of the trust
- The sequence or series of similar events is likely to be repeated in future i.e. a possible serial event.

We continue to have a strong reporting culture with a total number of incidents reported during quarters one to three in 2011 of 15,303. Of these incidents 176 were graded as SUI's. Of this number 44 related to patient safety, two to information governance, 28 to infection control and 102 to grade three and four pressure ulcers. All of these are subject to a full root cause analysis investigation and action plans.

Some examples of changes and actions taken include:

- The development and implementation of internal professional standards for the review and assessment of patients on admission
- Development of a protocol for patients who, following orthopaedic surgery fail to progress as expected, to be subject to review by a multi-disciplinary team
- Revision of induction for junior emergency department doctors and nursing staff in relation to the recognition and management of penetrating injuries
- Development of the "five rights for administration of medication" within the children's hospital to reduce the number of medication errors.

Critical safety actions

The principal patient safety work for the coming year is the 5 Critical Safety Actions programme. These critical safety actions were selected following a detailed review of our incidents, SUIs, complaints, claims and inquests. Implementation of actions for improvement monitored through agreed key performance indicators will lead to a reduction in avoidable mortality and morbidity.

The 5 Critical Safety Actions are:-

- Improving clinical handover
- Relentless attention to Early Warning Score (EWS) triggers and action
- Implement and embed mortality and morbidity standards
- Acting upon results
- Senior clinical review, ward rounds and notation

Work is underway to identify key performance indicators around these work streams.

Complaints

Complaints continue to be managed corporately by the Patient Information and Liaison Service (PILS), with investigations conducted by the divisional quality and safety teams.

The top ten primary subject areas across our hospitals are shown in the table below:

Formal Complaints April 2011-December 2011	Acute Care	Corporate	Planned Care	Clinical Support	Women's & Children's	Total
Medical Care	164	N/A	181	16	66	427
Communication	134	7	164	29	82	416
Waiting Times	71	3	147	25	43	289
Nursing Care	107	N/A	79	1	49	236
Staff Attitude	99	4	83	26	60	372
Discharge	67	2	33	8	11	121
Cancellations	17	NA	72	3	0	92
Information	18	5	22	1	11	57
Dignity/Privacy	16	N/A	21	2	6	45
Car Parking		17	2		1	20

Source: senior safety manager (clinical risk and complaints)

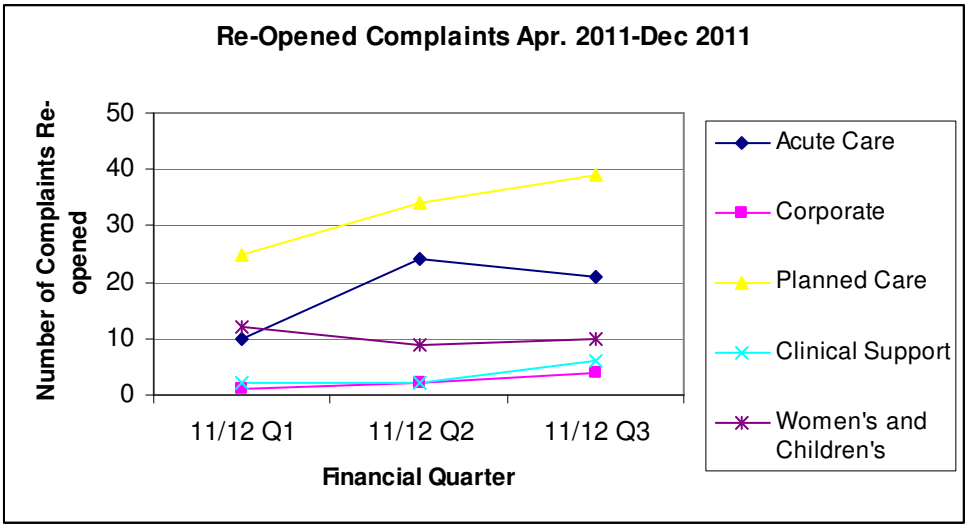
We set a target to reduce the number of complaints related to staff attitudes by 5% each year. Unfortunately this has not been achieved and the numbers have in fact increased. Work is being carried out, especially in planned care and acute care to reduce this type of complaint. Matrons are now trying to address all concerns raised immediately to try and seek a prompt resolution. The heads of nursing are also working with nursing staff to confirm their expectations in relation to professionalism and attitude. All complaints relating to other disciplines are referred to the appropriate divisional manager or clinical supervisor for action. For doctors this includes copying to the Medical Director for attention.

The corporate safety team are also undertaking work with other acute organisations to agree a common set of codes for complaints, and agree a definition for “attitude” so that it will be easier to benchmark our performance.

There is evidence however of a reduction in the amount of complaints related to staff attitude and behaviour in the women’s and children’s division (see page 33).

If complaints are not resolved by the Trust’s initial response they are re-opened and a further written response or meeting is made. Meetings are strongly encouraged as it is usually far more helpful to discuss concerns face to face.

The table below shows the numbers of re-opened complaints for each division.



Source: Senior Safety Manager (clinical risk and complaints)

Infection prevention
We continue to achieve a year on year reduction in our numbers of methicillin resistant staphylococcus aureus MRSA* bacteraemia and clostridium difficile* infection.

Hospitals are given a target figure beyond which they are not expected to exceed. For MRSA bacteraemia this was nine cases and for CDI this was 165 cases for 2011/12. For 2011/12 we had eight MRSA bacteraemias and 113 CDI.

We know there must be sustained effort to ensure these reductions continue and we aim to prevent all avoidable infections in our patients. Successful strategies are already in place to promote the reduction of healthcare associated infections (HCAI)* and throughout the coming year, we will continue to ensure these are not only maintained but we will seek to develop new and innovative ways of supporting our clinical teams in the prevention of infection.

Reducing patient falls
Preventing patients from falling is a particular challenge in hospital. Hospital patients are at greater risk of falling than people in the community. Patients over 85 are at the highest risk of falling and those that have fallen once are at risk of falling again. In our hospitals the incidence of falls is highest in the medical and respiratory specialities; this is because of the age and fragility of these patients.

A falls prevention strategy was developed after we found there had been an increase in falls from quarter one 2010 to quarter one 2011. The strategy included standardised falls risk assessments and multi disciplinary care plans for all at risk patients, robust and transparent monitoring and reporting arrangements to commissioners as well as dedicated nurse education and training falls prevention programmes. Our fall rates in 2010 were in line, if not slightly lower, than the 2009 national average. Next steps include embedding hourly rounds, monitoring ward data and focusing on supervision of patients and education.

VTE risk assessments
Many hospital patients are at risk from Venous Thromboembolism (VTE), where blood clots form in the leg veins, (called deep vein thrombosis or DVT) and can break off and block blood vessels in the lungs (pulmonary embolism) which can be fatal.

We now risk assess 90% of our adult patients for their risk of VTE. We are one of 22 VTE exemplar sites* in the UK and are committed to preventing VTE in patients admitted to our hospitals. We have streamlined pathways of care for patients who come

to us with acute thrombosis, focussing on the safe use of anticoagulation therapy and attention to VTE prevention measures.

Monthly data is reported to the Department of Health through the UNIFY* system.

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.

Ongoing education programmes help to maintain staff awareness of VTE.

The ambition is for all VTEs to be recorded and then investigated to determine whether they were associated with hospital admission or surgery (hospital-acquired thromboses HAT). Clinical information is analysed to see if VTE prevention measures could have been improved. This is fed back to the relevant clinical team on a monthly basis for further review and assessment of necessary actions.

Up until February 2012, 152 potential HATS required investigation. 122 (86%) had a root cause analysis undertaken by Clinical Nurse Specialist.

Our aim was to have a HAT rate at no more than 0.16. There was seasonal variation resulting in an increase for Q3 from 0.18 to 0.22.

Avoiding preventable hospital acquired pressure ulcers*
We aimed to eliminate preventable hospital acquired pressure ulcers by demonstrating a 5% reduction each year. There has been a gradual reduction in the number of HAPU's across the Trust that began in July 2011 and continued throughout the year achieving an approximate 36% reduction in ulcers when comparing data from 2010/11, therefore exceeding our 5% improvement target.

This was achieved with targeted training in the areas with the most pressure ulcers from the Tissue Viability (TV) teams (nurses who specialise in the prevention and management of wounds and pressure ulcers). The TV team have also worked with physiotherapists, other therapy teams and theatre staff to improve their knowledge and raise awareness of their impact on maintaining good pressure area care of patients in their care.

Our aim is to maintain a zero tolerance to avoidable pressure ulcers and we will continue to reduce the number of hospital acquired ulcers over the next twelve months.

Theatre checklist
The WHO checklist provides a consistent and organised approach to the management of surgical operating lists to reduce risks and improve patient safety.
The theatres, anaesthesia, pain and sleep team aim to improve our patients experience and the quality of service provided through effective utilisation of the WHO checklist to ensure patient safety.

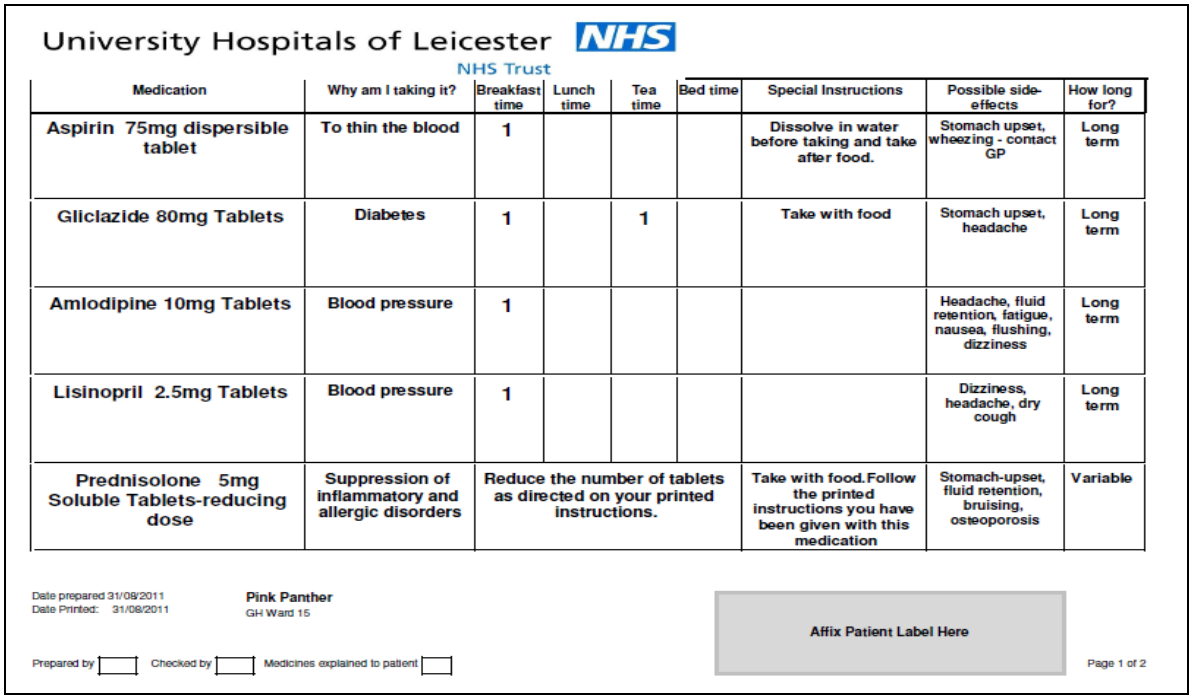
Since its introduction in 2010 there has been a consistent increase in the use of the WHO checklist, we monitor its use monthly through the operating room management information system and have included this as an ongoing priority for next year.

Patient safety across our divisions
Some services have specific needs when it comes to patient safety and we have small projects all over our hospitals to address these needs, some are detailed below.

Medicines reminder and information card

Results from our patient polling told us that our patients do not receive all the information they would like about their medicines. A group was set up specifically to review the provision of medicines information to patients.

We produced a simple medicines reminder and information card which included the medicine name, reason for being prescribed the medication, dosing instruction, basic side effects and length of course.



University Hospitals of Leicester NHS
NHS Trust

Medication	Why am I taking it?	Breakfast time	Lunch time	Tea time	Bed time	Special Instructions	Possible side-effects	How long for?
Aspirin 75mg dispersible tablet	To thin the blood	1				Dissolve in water before taking and take after food.	Stomach upset, wheezing - contact GP	Long term
Gliclazide 80mg Tablets	Diabetes	1		1		Take with food	Stomach upset, headache	Long term
Amlodipine 10mg Tablets	Blood pressure	1					Headache, fluid retention, fatigue, nausea, flushing, dizziness	Long term
Lisinopril 2.5mg Tablets	Blood pressure	1					Dizziness, headache, dry cough	Long term
Prednisolone 5mg Soluble Tablets-reducing dose	Suppression of inflammatory and allergic disorders	Reduce the number of tablets as directed on your printed instructions.				Take with food. Follow the printed instructions you have been given with this medication	Stomach-upset, fluid retention, bruising, osteoporosis	Variable

Date prepared 31/08/2011
Date Printed: 31/08/2011

Pink Panther
GH Ward 15

Affix Patient Label Here

Prepared by ☐ Checked by ☐ Medicines explained to patient ☐

Page 1 of 2

Source: clinical support division quality and safety manager

The production of the card is by ward based clinical teams, who know why the medicine has been prescribed. This is important because for some medicines there may be more than one indication. The patient is then counselled using the card prior to discharge.

The implementation of the medicines information card is a positive development which clearly demonstrates it's usefulness in enabling patients to understand their medications. It is envisaged that training of nurses and pharmacists will continue so that all patients who require the service will have access to a card when appropriate.

The success of the improvements of the initiative will be monitored and measured through the monthly patient polling survey.

Electronic prescribing and medicines administration

We have started to implement a safer and more effective way of prescribing and administering medicines by introducing an electronic Prescribing and Medicines Administration (ePMA) system to the haematology and oncology wards. Our staff have told us the system is saving them time looking for prescribing information and also making it very clear what has been prescribed and given to the patient. The new electronic system has the following benefits:

- Removes any issues associated with poor handwriting because it replaces the paper chart with an electronic system
- Saves time not having to find paper drug charts
- Patient's medication history will now be recorded electronically and available for future referencing and future drug charts
- Clinical support module aids clinicians in the safe prescribing of medications for patients by alerting them to medications the patient may be allergic to and reducing dosage errors

- Reduces inappropriate prescribing and improves adherence to the medicines formulary
- Availability of electronic formulary* to aid decision-making with prescriptions
- Accurate electronic notification and recording of drug administration
- Improved communication between clinicians through the use of electronic review requests
- Instant notification to pharmacy of any new medications prescribed
- Instant appropriate ordering of medications to pharmacy
- Ensures we are meeting CQUIN targets in regard to Venous Thromboembolism (VTE) compliance, by making necessary to carry out a VTE assessment prior to prescribing
- In the near future there will be automatic transcription.

There are also financial savings from not using paper drug charts and VTE forms, less drug wastage from overstocking and achieving Department of Health targets.

We plan to roll ePMA out across the rest of our hospitals over the next 12-24 months.

Maternity assessment centre
We have set a standard that all patients are assessed within 15 to 20 minutes of arrival in maternity. We have introduced a “red dot” system to inform medical staff of any patient who needs reviewing as a priority and we use an admission book so we are always aware of who is waiting.

We have ensured that when patients ring the unit only midwives, or student midwives under direct supervision, take the history to make sure that the patient is then triaged appropriately.

This followed a patient safety incident after there was a delay in assessing a woman in labour. The patient had been asked to wait in the waiting room but the midwifery staff were not informed which meant the woman’s assessment was delayed.

Children’s admissions documents
Concerns were raised that the admission documentation did not provide the essential information required when children were transferred to the ward.

In response to this a multidisciplinary team reviewed the documentation and agreed with the initial concerns that it did not meet the current needs of the children, families and other health care workers. A team created new documentation which covered the different age ranges of children, all of which have specific needs:

- Under 1 years
- 1 -2 years
- 2- 5 years
- 5- 12 years
- Over 12 years

It was decided that being an assessment unit the documentation should be multidisciplinary reducing the need to repeat the same questions and ensure the whole team was aware clinical plans, investigations undertaken and any results.

As a result children are able to be reviewed and assessed using the same documentation and it gives a comprehensive overview of the care provided, medications and investigations undertaken to be recorded prior to transfer of the children to the wards.

Findings to date indicate that there has been a reduction in the incidents relating to documentation when children are transferred from the assessment unit.

Improving communication with mental health services

In the medicine clinical business unit a patient safety incident was reported in relation to a patient who was receiving care under section two of the Mental Health Act who had died whilst on an acute medical ward.

A review of his care was undertaken by the quality and safety team and the corporate patient safety team in conjunction with the clinical teams from both medicine and mental health services to ascertain if there were any shortfalls in the care provided to him. His cause of death was established as a natural one following the post mortem. However, the investigation identified some shortfalls in the communication processes between the physicians and the Mental Health Team. As a result of this the following actions were taken:

- The referral process between acute and mental health services was reviewed from both perspectives
- The referral process was strengthened and this is described in our Mental Health Act Policy
- Learning from the review was incorporated into our Mental Health Act Policy.

Management of patients with anorexia nervosa

A complaint was received in relation to a young female, who had been diagnosed with anorexia nervosa and who was, on admission to our hospitals, significantly medically unwell as a result of her long term anorexia and who later died in hospital.

Her parents raised some concerns about her treatment with us, and also her treatment in other centres across the region, because of these worries a multi organisational review was carried out.

Our review demonstrated that whilst her care would not have prevented her tragic death there were areas for improvement within our hospitals.

As a result our guidance for the management of medically unwell patients with anorexia was updated. It now reflects new MARSIPAN guidance, with assistance from dietetics, the gastroenterology ward matron, the consultant gastroenterologist, mental health consultant and quality and safety manager.

The UHL Guidance, once ratified, will be used to raise the profile for care of such patients in our hospitals.

Effectiveness

Clinical effectiveness is made up of a range of quality improvement activities and initiatives including:

- Evidence, guidelines and standards to identify and implement best practice
- Quality improvement tools, (such as nursing metrics, and clinical audit)
    - the views of patients, relatives and staff
    - evidence from incidents, near-misses, clinical risks and risk analysis
    - outcome measures from treatments or services
    - measurement of performance to assess whether the team, department and organisation is achieving the desired goals
    - identifying areas of care that need further research

- Information systems to assess current practice and provide evidence of improvement
- Assessment of evidence, in collaboration with our commissioners, as to whether services/treatments are cost effective
- Development and use of systems and structures that promote learning and learning across the organisation

The quality of care depends on:

- The skills and competencies our staff
- How they work together in teams or across a department or the whole trust
- The support our clinical leaders and managers to encourage staff to achieve best practice.

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.leicestershospitals.nhs.uk

Working with our local GPs
Over the past year we have been working hard to improve our communication with local GPs about their patients. One of the major improvements we have made, which has reflected in the quality of care patients receive, is electronic discharge letters.

One hundred and ten out of 155 GP practices are now receiving discharge letters electronically, and within 24 hours of the patient leaving hospital. This has improved quality for our patients as their GP now, in almost real time, know that a patient of the practice has been discharged and knows what actions if any, they need to take to ensure the patient has the care they need.

Letters are also being copied to patients so they can see what has been sent to their GP, thus improving their understanding of what has happened during their visit to hospital. They are also available to any clinician who may see the patient at home.

More recently we also began the electronic transmission of outpatient letters from three services within our hospitals. This has drastically improved care for patients and will continue to, as more services are brought on board. GPs are now receiving these letters within days of the appointment. Helping GPs to communicate with their patients about their visit to hospital and deliver any care the hospital may have asked the GP to become involved in. GPs also now have access electronically to review tests undertaken on their patients in our hospitals. This has improved patient outcomes dramatically.

Finally, we have begun a more intensive GP education programme which aims to educate GPs in areas they specify. Areas are focused on improving the care they give to their patients and improving or gaining new skills in a particular field of medicine. We have recently launched a series of 10 minute video education sessions that support GPs and their education.

A&E performance – 4hr target
The final 2011/12 year to date figure for Leicester Hospitals including the Urgent Care Centre was 93.9%. In response to a consistent underachievement of the 4 hour target, new clinical roles have been introduced and a new pathway commenced in November 2011 called “Right Place, Right Time”. This initially resulted in a considerable improvement in our emergency department performance. However, following a number of challenging weeks of activity (with ED attendances 5% higher and emergency

admissions 7% higher this quarter compared to the same period last year) achievement of the 4 hour target has deteriorated. An action plan has been developed to strengthen internal processes in addition to external support.

Specific actions in relation to ED include:

- Ensuring that the Medical and Nursing rotas and skill mix is optimum on every shift.
- Continuing to refine ED process's
- Ensuring that ED staff perform individually and as a team to the best of their ability
- Continuing to develop and implement a cogent recruitment strategy to reduce in our locum usage.

Plans for improvement outside of ED include:

- Improving the blood chute system
- Long waits for bloods and imaging and including CT reports
- Improving outflow in particular Monitored, Acute Care Bay and side room beds.
- Reducing delays with inpatient teams attending ED upon referral
- Reducing transport Delays

Cancer waits

We achieved eight of the nine cancer targets during 2011/12.

In response, additional focus was given to the 62 day referral to treatment target where small patient numbers can disproportionately affect the breach position. Supported by a visit from the National Intensive Support Team, we undertook a review of the patient journey during 2011/12 in order to reduce waits and improve overall patient waiting times and performance. Additional clinics, theatre sessions and diagnostic activity were also introduced during the year to improve the position. As a result the 62 day target has been delivered each month since January 2012.

Referral to Treatment (18 week wait)

The Referral to Treatment (18 week wait) standards are that 90 per cent of admitted* and 95% of non-admitted* patients should start consultant-led treatment within 18 weeks of referral.

Admitted pathways are those that end in an admission to hospital (either inpatient or day case) for treatment. There was a deliberate reduction in admitted performance as we agreed a plan with our commissioners to increase activity in Quarter 3 and Quarter 4 to reduce the number of patients on an 18 week backlog and 26 week backlog.

Non-admitted pathways are those that end in treatment that did not require admission to hospital or where no treatment is required. All non- admitted performance targets were achieved. Additional focus has been placed on validating patients that are waiting over 18+ weeks and 26+.

Clinical effectiveness within our divisions

Some services have specific needs when it comes to clinical effectiveness and we have projects all over our hospitals to address these needs, some are detailed below.

Quality metrics within outpatient departments

We have created and introduced a comprehensive suite of quality metric indicators for use within all of our outpatient departments. These metrics are now embedded and areas have been audited.

Significant actions taken as a consequence of the quality metrics data:

- Introduction of a formalised system for recording checks on all emergency and near patient testing equipment
- Introduction of cleaning rotas to record all cleaning tasks performed
- Recording time delays in clinics and half-hourly verbal announcements to keep patients informed
- Introduction of formalised system for checking domestic and drugs fridges on a daily basis
- Use of dignity posters on consulting and examination room doors to improve privacy and dignity
- Provision of pressure relief cushions for chairs in waiting rooms for high risk patients
- Introduction of a volunteer into the Royal Infirmary outpatients department to support our patients and staff in a number of required duties, including escorting patients, cleaning resources or equipment such as toys, giving out the "postcards from Leicester" and provision of refreshments to vulnerable patients.

New nurse led service to support babies with jaundice

New born babies often present with high bilirubin levels, yellowing of the skin or whites of the eyes. This is due to the immaturity of the liver at birth. This condition is known as physiological jaundice and is commonly found in newborns, affecting over half (50 - 60%) of all babies in the first week of life. For the majority of babies, the jaundice will gradually reduce on its own. However there are a number of babies who are still jaundiced at 14 days (prolonged jaundice). For these babies a paediatric review and investigations are required.

Previously this service was provided on the assessment unit in the children's hospital, however it often meant that the baby and family could be waiting on the unit for up to six hours for the investigations to be completed. The development of a nurse led service now means that the baby and family are seen and treated within one hour of arrival on the day care unit. This service meets the recommendations of the NICE guidelines for jaundice in the newborn 2011.

The nurse led clinic has been established on children's day care with dedicated nursing time to review the general well being of the baby, check their blood level, advise on breast and bottle feeding and check their weight.

The creation of the clinic means that mothers and babies have better access to the service, it has increased the numbers of appointments available and it ensures advice to mothers is consistent.

Baby friendly initiative

Our maternity services joined the baby friendly initiative, a worldwide programme launched by the World Health Organisation and UNICEF in 1992.

Breastfeeding contributes to long term health of women protecting against breast cancer, and helps protects babies against infections, allergies and obesity. Parents need help to breastfeed; they need consistent advice, practical help, active support and encouragement.

The UNICEF baby friendly initiative provides a framework for the implementation of best practice standards and ensures a high standard of care that has been proven to increase breastfeeding rates. It is achieved via assessment over a number of stages.

In February 2011 we were awarded stage one of the baby friendly initiative accreditation process and commended.

The next stage assessment is due in October 2012 with a view to achieving full baby friendly accreditation. Since establishing an infant feeding team, breastfeeding initiation

rates have risen 3.1%. More than 95% of all our staff have been trained in supporting families who wish to breastfeed.

Surgical triage
A surgical triage service which began in January 2011 has been rolled out to urology patients at the General and surgical patients at the Royal Infirmary.

Patients who are admitted after concerns from their GP that they might need surgery are assessed by a senior nurse, and if appropriate a senior doctor, to see whether they need to be admitted. Often patients are fit enough to be sent home or booked in for an outpatient appointment, rather than spending the night in hospital

This triage process enables a fast collaborative assessment of patients and rapid decision making. Our aim is to improve the patient experience by providing a streamlined service, reducing hospital stay, provide timely senior intervention and a safe environment to meet our patient's needs.

Developing radiotherapy services
Three new replacement linear accelerators have now been commissioned which allow us to deliver the most up to date radiotherapy treatments.

The department has made significant progress in the delivery of advanced radiotherapy. Intensity modulated radiotherapy (IMRT) is standard for all locally advanced prostate cancer cases, allowing us to treat the prostate and the pelvic lymph nodes in combination. Other complex cases, including head and neck cancer, localised prostate cancer and sarcoma, can be treated with IMRT if required and the role of IMRT will expand significantly over the next two years. RapidArc technology allows us to deliver incredibly complex patterns of radiation without increasing treatment times or reducing throughput. This is important as we are committed to maintain our position with no waiting list.

Image guided radiotherapy (IGRT) places patient imaging systems at the point of treatment, allowing changes in patient shape or the movement of internal organs to be monitored throughout a course of treatment. This gives increased confidence that radiation dose is only delivered to where it is needed with the possibility to correct any observed changes before they are a problem. We have appointed an IGRT team to oversee the expansion of this capability to all patients who would benefit.

We continue to treat 125 patients a day without a waiting list and achieve compliance for the cancer treatment waiting times. Our patients are supported through treatment with radiographer review clinics, medical review and dietician advice.
We are proud to receive excellent feedback from our patient polling. Despite all this technology it is the high level of care and support that patients tell us they receive in our department that gives us the greatest satisfaction.

The developments for 2012 include:
- Continue to roll out IMRT to further sites, aiming for 15% of all patients receiving inverse IMRT with a further 15% receiving forward IMRT
- Increase proportion of inverse IMRT treatments delivered using rapid arc
- Increase proportion of patients receiving on-treatment CT imaging
- Upgrade brachytherapy service to image-guided high dose rate brachytherapy
- Develop methods for high precision treatments of lung tumours.

Establishing a new dedicated clinical trials unit
There are two clinical trials units in oncology the NCRN* Group and the Commercial Trials Group.

These two groups are merging as there is more and more overlap between them. For example, NCRN* Group are being encouraged by the NIHR to participate in more commercial trials.

The Clinical Trials Unit is a new dedicated facility for delivering clinical trial treatment which both groups will use. The new Clinical Trials Unit has been funded by the Hope Foundation, a local cancer charity, and other sources. The Clinical Trials Unit will be on the top floor of the Osborne Building

The development of this unit will ensure that we consolidate our position as a leading research and trial provider within the East Midlands. It will provide the basis for further development in partnership with Cancer Research UK (CRUK) and commercial companies.

Patients will be given the opportunity to participate in a far greater range of studies, leading to improvements in patient care, outcomes, in recruitment and in the revenue generated

We expect to see an increase in recruitment each year spanning the next five years. The focus will be to engage with industry with a specific focus on randomised controlled trials and earlier phase studies designed through the NCRN Alliances with Industry. The development of the unit is key to the renewal of our ECMC* status by CRUK. The infrastructure provided by the unit will ensure that ECMC study activity progresses.

Oncology assessment unit
Patients admitted to cancer and haematology in an emergency can now go directly to a dedicated assessment unit, where decisions are made as to whether they need to be admitted or discharged.

The unit draws medical and nursing expertise into one clinical area thus providing a more efficient and effective service that benefits patients.

We have developed a satellite pharmacy service to enable an improved discharge for patients requiring medication to take home. We have also redesigned the day care services so that all patients receive their care in one centralised place.

Single site elective orthopaedic service
All planned orthopaedic surgery now takes place at the General, meaning patients receive the majority of their orthopaedic care on one site.

The move means that all patients having planned operations on the hip, knee, shoulder, elbow, ankle and joints will have their procedure in one specially designated area.

The refurbished laminar flow theatres, which have been designed by the orthopaedic teams, are more spacious than their predecessors and contain air filters that greatly reduce the risk of infection.

There is also a patient waiting area near theatres, which was never available before and all of the specialist consultants will now be based at the General meaning that patients treated have quicker access to them.

All trauma patients will continue to receive their treatment at the Royal Infirmary.

Nutritional support project
Nutritional support has been provided to patients with fractured hips after we identified this group of patients have poor appetites due to constipation, immobility and the effects of medication.

On average there are about 80 patients with fractured hips in trauma each month. They are often older people and can be vulnerable, often struggling to manage before their fall.

With the help of the ward dietitian a dedicated nutrition care pathway was developed and implemented after training 85 members of staff on three wards, possibly the first in the country.

A new nutrition supplement was trialled which, when chilled, is much more palatable and when given twice a day helps ensure our patients are receiving the calories required for growth and repair.

Patients not wanting a big meal have benefited from a snack menu which has also increased their intake of calories.

The main meal menu has also been revamped and includes more items familiar to older people with higher energy and protein values such as a roast chicken dinner.

With the help of the older people's team funding was secured for specially adapted cutlery to help to patients to feed themselves.

Ongoing evaluation is taking place but early indicators include a shorter length of stay by one day and reduced pressure sore incidence in this inpatient group.

Overnight stay model of care for mastectomy patients
Women who have mastectomies can often now go home after just one overnight stay, compared to up to five days previously.

Speedy discharge happens because patients are now able to go home with their surgical drains in place rather than waiting in hospital until they can be removed. Patients are taught how to look after their drains at home and then come back to a dedicated clinic to have them removed.

The changes have enabled nearly 40% of patients who had a mastectomy go home within one day. Previously, less than 10% of patients went home after just one overnight stay.

Part four our staff and patients

Public and patient engagement

A senior member of staff leads patient and public involvement (PPI) in each clinical business unit. They are supported by the trust-wide PPI manager and take responsibility for coordinating and monitoring patient involvement, acting as a local PPI resource.

Each clinical business unit also has a patient advisor linked to it. Patient advisors are members of the public who provide a non clinical, or patient's perspective, in a number of decision making and operational groups.

We are also creating "service improvement volunteers" a new role to focus on gathering feedback from patients through surveys and focus groups as well as encouraging public involvement in audits.

Outside of our hospitals we have well established working relationships with our local involvement networks (LINks). A Trust representative attends monthly LINk board meetings and a dedicated LINk working group meet with our chief executive bi-monthly to discuss issues raised by LINk members. We also work collaboratively with LINks, for

example, staff from our children's hospital recently worked with the LINk to explore school children's experience of hospitals.

Both city and county LINks have been active partners in a recent programme of engagement with people from black and minority ethnic backgrounds.

Equality

We became an early adopter of the Equality Delivery System (EDS) in 2011. The EDS is a new Department of Health framework which has been introduced as a means by which all trusts can deliver their public sector equality duty.

Mainstreaming equality

Our governance arrangements for equality have altered to ensure a more streamlined approach. We have amalgamated the equality board with the existing patient experience and patient engagement group in order to further embed equality within our divisions.

Workforce

During 2011 there have been only a minimal number of managerial posts recruited to due to our reorganisation and financial position. There has therefore only been limited opportunity provided through external recruitment to change the make up of the senior management of the organisation. Improving the general representation of our workforce, which in turn is reflected in our senior management structures, remains our primary workforce objective.

Project search

We became a project search site providing work trials and potential employment for students aged 18-25 with learning disabilities.

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.

So far three students have secured permanent employment.

Engagement

We ran several events over the year following the original BME Symposium in 2010. Representatives from local black and minority ethnic communities attended and were asked to identify their equality priorities for the 2012-2016 equality work programme.

These included better access to language support, improving our written information, increasing the availability of equality training and working to improve access to services. Work has already begun in all of the areas put forward.

Equality across our services

The learning disability nurse specialist team have supported over 200 patients with complex needs this year. There is now a new care pathway for patients who have a learning disability and require a general anaesthetic for their feeding tube replacement.

We have increased the use of our interpreting service and the increased number of patient information leaflets available in an easy read format and alternative languages. We have also replaced, and installed new, hearing loops at all receptions at all three hospitals.

Human Resources

Learning and development
There have been a number of developments in the recording of training, mainly, we have moved to a single training platform (eUHL). The eUHL System has been completely developed and maintained in house by a dedicated team of developers and designers to directly address the needs of staff, organisation and external regulators. There is an ongoing programme to move all existing stand alone databases and spreadsheets onto the eUHL platform. Currently we are in the process of transferring Trust wide corporate induction data and radiation and laser safety databases.

To enable better monitoring and reporting of staff compliance with statutory and mandatory training, two new developments are being built in eUHL. The first of these is the ability to build training plans for individuals directly within the system. This will also allow a line manager to see the compliance status of their team with regards to statutory and mandatory training. There will also be a top level 'dashboard' showing the compliance across the Trust against the primary mandatory and statutory courses (fire safety, hand hygiene, etc) providing our senior teams with training compliance performance reports specific to divisions, clinical business units and corporate directorates.

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

We were a pathfinder pilot site for medical revalidation and a system is being procured this year to provide a new IT system for delivery of strengthened medical appraisal. Processes are being implemented in line with developing national revalidation requirements to provide strengthened medical appraisal that is fit for purpose.

Workforce planning
Workforce planning is a continuous exercise in divisions and clinical business units and formally links with the business planning process and cost improvement plans.

There are a number of key work streams that will continue to support the workforce planning process. These include consultant job planning processes, expanded roles, development of assistant and advanced nurse practitioners and our plans that review agency, locum and bank expenditure.

Staff engagement
A staff engagement programme was agreed in 2009 that covered leadership development, appraisal, shared values and strategic vision.

In 2010 we began local quarterly staff polling, to enable us to gather more frequent data on staff engagement. This enables us to act appropriately with interventions to improve staff morale, such as, our '8 point staff experience action plan.' The plan was developed following the feedback from the Staff Attitude and Opinion Survey (SAOS) and local polling. Progress is reviewed and monitored through both the staff engagement steering group and Workforce and Organisational Development Committee.

Health and well being
The health and well being programme includes actions relating to sickness absence, well being activities, health and safety, stress at work, employee assistance/counselling and occupational health. The programme is supported by a number of specific steering groups, training and communication, all of which have staff side involvement.

Our sickness absence average figure remains the lowest for acute trusts in the East Midlands.

Leadership

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

We have a 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. To identify potential leaders at all levels of the organisation our most talented employees are identified through their appraisal.

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

Empowering staff

We work hard to engage staff and have a recognition agreement with more than ten 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. There are site based medical staff committees and a bi monthly Medical Local Negotiating Committee which is chaired by a member of the consultant medical staff.

Staff pointed out in the annual staff survey and our recent polling that they wanted to see more recognition for staff across the hospitals. In September 2011 we launched our Caring at its Best Awards, a new awards system to reward our inspirational staff who live our values and deserve recognition for their amazing success and commitment. The new scheme will see us rewarding more staff than ever before by moving to quarterly awards as well as an annual ceremony.

The nomination process opened in September 2011 and saw the first six outstanding winners announced in December. This will be followed by more worthy winners in March and then June. Every winner will then go on to the annual ceremony where the overall ‘winner of winners’ for each of the categories will be awarded a trophy and prize. Our exceptional volunteers will also be recognised with a ‘volunteer of the year award’ at the annual ceremony.

Conclusion

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

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

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.

We look forward to reporting back in June 2013.

Part five
Commentary from Stakeholders

5.1 NHS Leicester, Leicestershire and Rutland PCT Cluster.
5.2 Leicestershire Adults, Communities and Health Overview Scrutiny Committee
5.3. Leicestershire LINks

NHS Leicester, Leicestershire & Rutland PCT Cluster Statement for UHL Quality Account

The following statement has been prepared for the NHS Leicester City/NHS Leicestershire County and Rutland Cluster Board for approval for 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 2011-12.

It is disappointing to note that the Quality Account demonstrates that the Trust has not achieved the priorities for 2011/12. Commissioners are therefore supportive of the Trust in focussing on the additional work required to improve the experience of patients receiving care in the Trust, reducing avoidable readmissions and improving mortality. However, the ambition for these areas for 2012/13 could be more stretching, particularly in relation to mortality and readmissions.

In 2011/12 we agreed specific areas of quality improvement with the trust through the contractual 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, but we note that there have been key areas of challenge for the organisation that the Trust needs to focus on; particularly relating to the acute care pathway.

As commissioners we have expressed concern regarding the experience and outcome for patients in two areas of activity in the Trust; compliance with the 62 day cancer wait target and the acute care pathway. Investigations into the delays for patients with cancer waiting for treatment have been undertaken and we have asked the Trust to continue to undertake these reviews to ensure that there are no adverse effects for patients. We also require the Trust to continue to work on plans to deliver sustainable improvements in this area and for the extension of breast screening.

In addition to our concerns regarding the emergency care pathway, the Trust have reported in their Quality Account that the CQC issued a Warning Notice to the Trust regarding the care of patients. We will continue to require the Trust to make improvements to the acute care pathway in order to deliver a better quality of care for patients.

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 PCT and CCG staff. Such visits have given us the opportunity to talk to patients, carers, relatives and staff to hear first hand their experiences of UHL.

As commissioners we feel that the Quality Account would benefit from further elaboration on the achievements and challenges faced in the following areas:

- The account needs to be more balanced with achievements and challenges
- A greater emphasis on reviewing individual issues to understand the themes and trends across whole systems.
- A focus on the actions needed to improve the issues across the Acute Care Pathway
- Where data is presented, this should include trends and benchmark data wherever possible
- 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."

LEICESTERSHIRE ADULTS, COMMUNITIES AND HEALTH OVERVIEW AND SCRUTINY COMMITTEE

COMMENTS ON THE UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST QUALITY ACCOUNT FOR 2011-12

27 APRIL 2012

The Adults, Communities and 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 24 April 2012. 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.

Although the Committee is not aware of any major issues that have been omitted from the Quality Account, there are concerns that the presentation of the Quality Account prevents it from providing a clear reflection of the healthcare services provided. The document is difficult to read and although officers speak with passion about the improvements that have been made this passion is not reflected in the Quality Account. There is a focus on process and the collection of data rather than outcomes and a lack of case studies. The Committee recommends that an Executive Summary of the Quality Account is produced and this sets out the headline priorities. Where data is included in the Quality Account, it should show that improvement has been made or where more work is still to be done.

The Committee has made comments on a number of areas included in the Quality Account and these are set out below.

The Committee is pleased that improving patient experience is a priority for UHL during 2012/13 and welcomes the developments made in collecting feedback from patients. Ensuring consistency of patient experience across the three hospital sites should be a key part of that priority and to that end the Committee is reassured to note that patient feedback is broken down to the level of individual wards on a quarterly basis. The Committee is pleased that the four clinical divisions are involved in ensuring consistency of patient experience. However, the Committee feels that a measure of progress for this priority should be how feedback is used to make improvements to patient care. The measures set out on page 6 of the Quality Account appear to relate to process and data collection rather than making changes.

The Committee welcomes the progress that has already been made in improving quality of care as a result of patient feedback, such as arrangements to reduce noise at night. The Quality Account would benefit from initiatives such as these being set out as case studies.

The Committee is concerned that the Accident and Emergency Department is still not meeting the four hour wait target. It is reassuring to note that plans are in place to address this such as the appointment of new consultants and the managing of patients in a timely manner to reduce internal waiting times. However, these plans are not detailed in the Quality Account and therefore provide no reassurance to members of the public.

The Committee is disappointed to see that UHL reported two never events during 2011/12. However, the responses as set out in the Quality Account provide

reassurance that lessons have been learnt. A section could be added to show that the implementation of lessons learnt is subject to internal scrutiny.

The currently awaited formal warning notice and full report from the Care Quality Commission is a cause for concern although the response made by UHL to the critical feedback from the Care Quality Commission is welcomed. The Committee hopes that the changes that have been made since the Care Quality Commission made its unannounced inspection will mean that the Acute Medical Unit is fully compliant with care quality standards in the future.

In conclusion, based on the Committee's knowledge of the provider, the Committee is of the view that the Quality Account reflects the healthcare services provided but feels that the information could have been better presented and that, in the areas detailed above, the additional information suggested should be included in the Quality Account.

Leicestershire Local Involvement Network (LINK) response to the University Hospitals of Leicester NHS Trust Quality Account for 2011/2012

Leicestershire LINk welcomes the opportunity to comment on the University Hospitals of Leicester NHS Trust Quality Account. Over recent years the LINk has valued the close working relationship that has been established between the Trust and the LINK, which has grown in its significance and impact. This has been continued during the last year and can best be seen in the meetings held on a quarterly basis with the Chief Executive and members of his team with LINk members. This provides good communication opportunities on current issues and concerns raised by the members and general public, and provides the excellent vehicle for getting answers and learning how the Trust works. Members greatly appreciate the fact that the CEO is prepared to meet with them and 'is very open and transparent' in the answers given to concerns, views or opinions raised.

The engagement of LINk representatives on a number of Boards and working groups also provides evidence of the desire to include public and patient views at the forefront of the many decisions, which are being taken at a time of enormous change of NHS provision.

Throughout the year, there have been a number of actions that have needed addressing by the Trust and these have been approached very constructively and with very satisfactory outcomes

The LINk is fully aware of and has been kept informed about the difficult financial situation, which the Trust is working hard to reverse. However, the LINk's interest remains the quality of services that patients receive and we would not want to see this compromised or services that are needed to be reduced.

With regard to Priority three, the LINk considers that this is an honest report. From the LINk's experience of talking to patients and families, one of the most crucial aspects of patient experience relates to good and clear information, which is consistent throughout all the departments. We believe further work is required on this matter.

The LINk welcomes the definitions of mortality, together with the glossary of terms. We would like to see more evidence of health and social care agencies working together to support end of life care, which would fulfil most people's wishes to die at home.

The 'walkabouts' are also welcomed, which have provided patients with access to the Directors and an opportunity to discuss their issues, which have been evident in some changes that have been brought about.

The LINk also commends the work that the Trust is doing to engage with patients, such as the touch screens. However, it would have been useful to have more information on the steps being taken to engage with black and minority ethnic groups. We would recommend that when patients are discharged, they and their families should be reminded and encouraged to provide comments, perhaps given a leaflet with a Freepost tear-off slip.

We have concerns regarding the exchange of information with GPs and the fact that systems are not compatible. This can lead to delays, confusion and difficulties in relation to medication.

We would like to see a process introduced where patients are asked if they use a regular pharmacy and note should be taken of the contact address. The Medicine Card is very positive and a useful tool.

We feel there needs to be more specialist training for all staff caring for people with dementia. If releasing staff is a problem a 'cascade' training programme could be introduced.

In spite of the financial problems referred to earlier, the LINk recognise much of this is not the sole responsibility of the Trust, but relates to other Community Health services playing their role, in for example, reducing the level of attendance at the A&E when alternative and more appropriate services could be given.

Part Six
Glossary of terms

Admitted patients - admitted pathways are those that end in an admission to hospital (either inpatient or day case) for treatment.

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).

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.

Comparative Health Knowledge System (CHKS) - an information system which 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 information and drills down into each division, clinical business unit and service levels.

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.

Chronic obstructive pulmonary disease (COPD) - chronic obstructive pulmonary disease (COPD) is the name for a collection of lung diseases including chronic bronchitis, emphysema and chronic obstructive airways disease. People with COPD have trouble breathing in and out. This is referred to as airflow obstruction. Over many years, the inflammation leads to permanent changes in the lung. The walls of the airways get thicker in response to the inflammation and more mucus is produced. Damage to the delicate walls of the air sacs in the lungs means the lungs lose their normal elasticity. It becomes much harder to breathe, especially when you exert yourself. The changes in the lungs cause the symptoms of breathlessness, cough and phlegm associated with COPD.

Crude mortality rate - a hospital's crude mortality rate looks at the number of deaths that occur in a hospital in any given year and then compares that against the amount of people admitted for care in that hospital for the same time period. The crude mortality rate can then be set as the number of deaths for every 100 patients admitted.

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 peritoneal dialysis.

Direct access - direct access (DA) is where a GP refers a patient for a test or a procedure without the need to go via a UHL consultant appointment an example would be DA Physiotherapy.

Dr Fosters - Dr Foster is a provider of comparative information on UK health and social care services. Dr Foster's online tools and consumer guides aim to enable both health and social care users and providers to make better informed decisions. Dr Fosters produce an annual report (known as the Hospital Guide) which summarises their key findings. This is available via http://www.drfosterhealth.co.uk/

Experimental cancer medicine centre (ECMC) - launched in October 2006, the Experimental Cancer Medicine Centre (ECMC) Network is jointly supported by Cancer Research UK and the Departments of Health for England, Scotland, Wales and Northern Ireland, providing a total of £35 million over five years to fund a network of 19 Experimental Cancer Medicine Centers across the UK

Formulary - the main function of formularies is to specify which medicines are approved to be prescribed for specific conditions. The development of formularies is based on evaluations of efficacy, safety, and cost-effectiveness of medcines.

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.

Hospital-acquired thromboses (HAT) - any patient with a VTE confirmed as occurring 3 days post admission or earlier if they had been discharged from hospital within the previous12 weeks.

The Hospital Standardised Mortality Ratio (HSMR) - is an indicator of healthcare quality that measures whether the death rate at a hospital is higher or lower than you would expect.

Methicillin-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.

Morbidity - the incidence or prevalence of a disease or of all diseases in a population.

National cancer research network (NCRN) - the National Institute for Health Research Cancer Research Network (NCRN) provides researchers with the practical support they need to make cancer clinical studies happen in the NHS, so that more research takes place across England, and more patients can take part.

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

Net Promoter Score – NHS Midlands and East are developing a standardized approach with a single metric to obtain real time monitoring of patient experience. The Net Promoter Score captures perceptions of the local population about the health care that they have received. The scores is the difference between the proportion of people

surveyed (on a scale of 1 – 10) who said that they would recommend the local service and the proportion who said they would not.

New Interventional Procedures Advisory Group (NIPAG) - role is to give advice to medical staff considering introducing a new interventional procedure. The NIPAG chairman is appointed by the Medical Director, to whom he is responsible.

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.

Non admitted patients - non-admitted pathways are those that end in treatment that did not require admission to hospital or where no treatment is required

Oesophagectomy - is the surgical removal of all or part of the oesophagus (foodpipe). It is normally done to remove cancerous tumors from the body.

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 five 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.

Pressure ulcers - a pressure ulcer, sometimes referred as pressure or bed sore, is an area of skin that breaks down and can affect up to 20 per cent of patients who are acutely ill. All pressure ulcers are graded one to four in accordance with their severity and hospitals are required to monitor and report all grade three and four pressure ulcers as serious incidents to the Strategic health Authority (SHA).

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.

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.

STEMI - is an acronym meaning "ST segment elevation myocardial infarction," which is a type of heart attack. This is determined by an electrocardiogram (ECG) test. Heart attacks occur when a coronary artery suddenly becomes at least partially blocked by a blood clot, causing at least some of the heart muscle being supplied by that artery to become infarcted (that is, to die). Heart attacks are divided into two types, according to their severity. A STEMI is the more severe type.

Summary Hospital-Level Mortality Indictor (SHMI) - is a hospital level indictor which reports mortality at trust level across the NHS in England using standard and transparent methodology. Mortality in a trust is described as 'expected', 'lower than expected' or 'higher than expected'. Trusts are required to investigate areas which are identified as 'higher than expected'.

Type II diabetes - type 2 diabetes occurs when not enough insulin is produced by the body for it to function properly, or when the body's cells do not react to insulin. This is called insulin resistance. Type 2 diabetes is far more common than type 1 diabetes, which occurs when the body does not produce any insulin at all. Around 90% of all adults in the UK with diabetes have type 2 diabetes. Type 2 diabetes may be controlled by eating a healthy diet however, as type 2 diabetes is a progressive condition, it may eventually need to be treated with insulin medication, usually in the form of tablets.

UNIFY - the system for hospitals to share and report NHS and social care performance information . This is a monthly census and allows performance in VTE risk assessment to be reported and monitored nationally.

Venous thromboembolism (VTE) - all hospital patients are potentially 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).

Venous thromboembolism (VTE) exemplar site - to share best practice and improve patient care through more effective prevention and treatment of VTE. The Kings thrombosis website hosts the National VTE Exemplar Centre Network, the National Nursing & Midwifery Network and the National VTE Prevention Programme, providing a single resource for healthcare professionals involved in thrombosis management - www.kingsthrombosiscentre.org.uk

Part seven

Statement of Directors' Responsibilities in Respect of the Quality Account

STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE QUALITY ACCOUNT

The directors are required under the Health Act 2009, National Health Service (Quality Accounts) Regulations 2010 and National Health Service (Quality Account) Amendment Regulation 2011 to prepare Quality Accounts for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporate the above legal requirements).

In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

- the Quality Accounts presents a balanced picture of the Trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Account has been prepared in accordance with Department of Health guidance.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.
By order of the Board
NB: sign and date in any colour ink except black

.....Date.....Chairman
.....Date.....Chief Executive

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 ।

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