Trust Board Paper R

To:	**Trust Board**
From:	**Chief Nurse**
Date:	**26 June 2014**
CQC regulation:	Outcome 16

Title:	**UHL Quality Account 2013/14**

Author/Responsible Director: Director of Clinical Quality/Chief Nurse

Purpose of the Report: The purpose of this report is to share the final draft of the quality account for formal sign off by the Trust Board.

The Report is provided to the Board for:

Decision		Discussion	X
Assurance	X	Endorsement	X

Summary / Key Points:

The quality account has to be produced in line with the Department of Health Toolkit – this mandates the content, who the Quality Account has to be formally shared with (for an invitation to comment) and how the Quality Account has to be published.

Following positive feedback on the format of last years the quality account, a similar 'accessible' document has been produced which includes a balance of quantitative and qualitative data.

The draft quality account has gone through several iterations following feedback from the Executive Quality Board, Quality Assurance Committee and external stakeholders.

The quality account is structured in the following way:

- A review of quality performance over the last year
- Priorities for improvement for 2014/15
- A series of mandated statements

Assurance against the quality account comes from both internal and external sources and the Trust is required to complete the Statement of Directors' Responsibilities in the quality account.

Recommendations:

The Trust Board are asked to:

- Receive and endorse the final draft of the Quality Account which includes Stakeholders commentary and the Statement of Directors' Responsibilities. The draft Quality Account has been discussed at the Quality Assurance Committee and with external stakeholders resulting in amendments ahead of the final draft.
- Note the findings regarding external assurance from KPMG (Appendix I – to be circulated when available).
- Note that the Quality Account needs to be uploaded on NHS Choices website by the 30th June to meet statutory requirements.

Previously considered at another corporate UHL Committee?
Quality Assurance Committee 25/06/14

Board Assurance Framework:	**Performance KPIs year to date:**
Statutory requirement to produce QA	Measures in Quality and Performance Report

Resource Implications (eg Financial, HR):
Costs of preparing the Quality Account

Assurance Implications:
Quality Account reviewed by external stakeholders and external auditors KPMG

Patient and Public Involvement (PPI) Implications:
Quality Account to be loaded onto NHS Choices website by 30/06/14

Stakeholder Engagement Implications:
The draft quality account was shared with the following stakeholders at the end of April 2014:

- NHS Leicester City, East Leicestershire & Rutland and West Leicestershire Clinical Commissioning Group
- Leicester, Leicestershire and Rutland Healthwatch
- NHS England
- Health and Wellbeing Scrutiny Commission at Leicester City Council

Commentary has been included (verbatim) where provided.

Equality Impact:

Information exempt from Disclosure: No

Requirement for further review? No

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

Report to: **TRUST BOARD**

Report from: **CHIEF NURSE**

Report author: **DIRECTOR OF CLINICAL QUALITY**

Date: **26th JUNE 2013**

Subject: **QUALITY ACCOUNT 2013/14**

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1 BACKGROUND

1.1 The quality account is an annual report from providers of healthcare about the quality of service delivered.

1.2 Both the Francis Review and the Keogh Review of outlier trusts identified the role that quality accounts can play in holding providers to account.

1.3 For 2013/14, there is no significant change in the arrangements for producing quality accounts and the Department of Health, the NHS Trust Development Agency and Monitor jointly wrote to all Chief Executives on the 9th January 2014. This confirmed the quality account regulations remain unchanged but requested inclusion of the staff and patient element of the Friends and Family Test in the quality account.

1.4 The draft quality account has gone through several iterations following feedback from the Executive Quality Board, Quality Assurance Committee and external stakeholders.

1.5 The purpose of this report is to share the final draft of the quality account for formal sign off by the Trust Board.

2 STRUCTURE OF THE QUALITY ACCOUNT

2.1 The quality account has to be produced in line with the Department of Health Toolkit – this mandates the content, who the Quality Account has to be formally shared with (for an invitation to comment) and how the Quality Account has to be published.

2.2 The quality account is structured in the following way:

- A review of quality performance over the last year
- Priorities for improvement for 2014/15
- A series of mandated statements

2.3 Following positive feedback on the format of last years the quality account, a similar ‘accessible’ document has been produced which includes a balance of quantitative and qualitative data.

3 STAKEHOLDERS COMMENTARY

3.1 The draft quality account was shared with the following stakeholders at the end of April 2014:

- NHS Leicester City, East Leicestershire & Rutland and West Leicestershire Clinical Commissioning Group
- Leicester, Leicestershire and Rutland Healthwatch
- NHS England
- Health and Wellbeing Scrutiny Commission at Leicester City Council

Commentary has been included (verbatim) where provided.

3.2 Following feedback from NHS Leicester City, East Leicestershire & Rutland and West Leicestershire Clinical Commissioning Group, a number of amendments were made to address the points highlighted and feedback provided to them. The final report has also been reissued to the other stakeholders highlighting the sections added.

4 ASSURANCE FOR THE 2013/14 QUALITY ACCOUNT

4.1 Assurance against the quality account comes from both internal and external sources and the Trust is required to complete the Statement of Directors' Responsibilities in the quality account.

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

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

The content of the quality report is not inconsistent with internal and external sources of information

The quality account reflects information presented in Board minutes and papers, papers relating to quality reported to the Board (and quality committees), feedback from the commissioners and Healthwatch, complaints reports, the national staff survey, the Head of Internal Audit's annual opinion over the Trust's control environment and the CQC Intelligent Monitoring Reports.

The quality account presents a balanced picture of the Trust's performance over the period covered

The 2013/14 Quality Account reports back on performance in relation to the priorities set out in the 2012/13 Quality Account (the Quality Commitment) as well as a variety of other quality indicators.

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 our Commissioners.
- Confirm and Challenge to lead officers by the Director of Clinical Quality where data was incomplete with a clear audit trail of these queries 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

Data in the quality account has been taken from Trust reports (Quality and Performance Report) and the National Information Centre. Trust reporting is subject to a series of control measures.

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: monthly/quarterly Confirm and Challenge meetings, with the Clinical Management Groups, the Finance and Performance Committee, the Quality Assurance Committee, the Executive Quality Board and Trust Board in addition to 'specialist' committees such as the Clinical Audit and the Research and Development Committees.

The quality account has been prepared in accordance with Department of Health guidance.

The Department of Health toolkit has been reviewed and all mandatory statements have been included. The toolkit is accessible via http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_122540.pdf)

5 GENERAL ASSURANCE OF DATA QUALITY

There are a number of internal controls and standards in relation to data quality including:

5.1 Information Quality Policy – this was last reviewed in January 2014 and available on Insite. The policy gives the Trust's standards on maintaining high information quality. This policy has been reviewed and updated and also includes the locally agreed controls assurance process for the 'Data Quality Diamond' standard. A data quality group has been established to provide rigor around the assurance of systems and processes of individual data sets.

5.2 **Payment by Results Audit** – Leicester's Hospitals was subject to the Payment by Results (PbR) clinical coding audit during January 2014. The audit sample was 200 episodes (131 spells); 100 Admissions for Health Resource Group (HRG) sub chapter (Immunology, infectious diseases, poisoning, shock, special examinations, screening and other healthcare contacts) with specified level of complications and co-morbidities and 100 Admissions through HRG sub chapter WA with a primary diagnosis of R29.6 (tendency to fall not elsewhere classified).

5.3 **Case Note Audit compared to Electronic Record -** A regular programme of audit is undertaken to review at least 300 patient records each month. This covers both outpatient and admitted patient data, comparing information held in the paper case notes to the electronic data collected. Validity checks on data show high compliance of national NHS code sets being accurately applied with local information systems.

5.4 **Quarterly reporting to the Executive Quality Board -** On data quality standards for the year.

5.5 **Documentation of routine data quality processes** – This includes daily monitoring of duplicate records created, and checks against current demographic information.

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

6 EXTERNAL AUDIT ASSURANCE OF THE QUALITY ACCOUNT

6.1 NHS organisations are required to seek external assurance against their quality accounts through an auditor appointed by the Audit Commission.

6.2 The scope of the audit opinion (attached at Appendix I) is one of limited assurance and this will be reproduced verbatim on page 60 of the Quality Account.

6.3 As part of the review external auditors review the quality account to determine if national guidance has been followed and test two mandatory indicators.

6.4 The external auditor have confirmed that there are no issues arising with the draft Quality Account and a 'clean' opinion is intended to be issued in this respect.

6.5 However, the auditors have been unable to complete their testing of the two mandated indicators due to incomplete datasets, the full details of which will be presented at the Audit Committee at its next meeting. It is understood that other Trusts have experienced similar problems.

6.6 Within the indicator testing which has been completed, no errors have arisen in the limited sample the auditors have been able to test.

7 RECOMMENDATION TO TRUST BOARD

7.1 The Trust Board are asked to:

- Receive and endorse the final draft of the Quality Account which includes Stakeholders commentary and the Statement of Directors' Responsibilities. The draft Quality Account has been discussed at the Quality Assurance Committee and with external stakeholders resulting in amendments ahead of the final draft.
- Note the findings regarding external assurance from KPMG.
- Note that the Quality Account needs to be uploaded on NHS Choices website by the 30th June to meet statutory requirements.

University Hospitals of Leicester NHS

NHS Trust

Quality Account
2013 / 2014

Caring at its best

Contents

1 Statement on quality from the Chief Executive

Caring at its best

1 Statement from the Chief Executive

Hello and welcome to the Trust's Quality Account for 2013/14. First a reminder of what the Quality Account is here to do. People are familiar with organisations publishing Annual reports and Accounts at the end of their financial year. The quality account as the name suggests is our annual 'stocktake' of all things to do with quality in our hospitals… it's not about money it's about whether what we do for our patients is good, bad or indifferent.

In truth it is a difficult document to preface. Let me explain why…

Leicester's Hospitals operate in excess of 120 different clinical services across 4 separate hospital sites including St Mary's in Melton. When we talk about quality we are therefore not talking about one service or even one hospital but a range of services provided by 10,000 staff treating anything from simple skin conditions through to complex heart surgery. What is more there are any number of ways of measuring quality; mortality and outcomes, waiting times, patient experience, surgical revision rates, discharge processes to name but a few. Exaggerating to make the point; a patient may come to us requiring complex, even ground-breaking surgery, they may have been seen and treated quickly with no complications and their stay on the wards might have been exemplary in terms of post-operative care and compassion BUT when it comes to their discharge home we might make mistakes which cause delay, frustration and concern for the patient and their family… we saved their life but does that alone equate to 'quality'?

These are the judgements that I and my colleagues in clinical and managerial positions make on a daily and sometimes hourly basis about our services. My reason for sharing this with you is so that when I say that I think that Leicester's Hospitals on the whole provide quality services, I hope you understand that within that I mean there are some services which I think are excellent…the best in their field, and then there are some which cause me concern. In between are a host of services which I think are good and could be excellent with a push.

A case in point is our A&E. Recently the Care Quality Commission, (CQC) inspected Leicester's Hospitals and spent a good deal of time talking to staff and patients in the department. Now, if you are familiar with the Trust you will know that our A&E performance is poor in terms of waiting times. I also think that our A&E is poor in terms of the environment in which care takes place. The CQC agreed but they also pointed out that what patients actually said about their experience of A&E put the Trust well above average for patient experience compared to our peers.

So hopefully we can agree that quality means different things to different people. Recognising this we have, over the last 18 months, made much of our 'Quality Commitment'… which aims to define Leicester's approach to quality improvement. The three key strands of our work are…

1. Saving more lives (technically described as "reducing mortality rates")
2. Reducing "avoidable" harm, for example bed sores, falls and infections
3. Improving patient experience.

The Quality Account deals with each of these in turn but I want to pull out a few high and lowlights which I think deserve attention.

In terms of mortality our overall mortality rate has declined year on year, which is absolutely as it should be. However, whilst still being within expectations when compared with peers we know that there is more that we can do to understand the key drivers of mortality and further improve our mortality rates on a service by service basis.

As regards' avoidable harms' we have had a really good year. A strong focus on the causes and prevention of falls, particularly amongst our older patients, has seen a dramatic decrease in the numbers of patients falling on wards and in clinics. Similarly we have ruthlessly pursued our strategy to reduce avoidable pressure ulcers

1 Statement from the Chief Executive

(bed sores) and this too has led to significant decreases in the numbers of patients who have developed a pressure sore whilst in our care. Lastly, Leicester has been one of the very best performing Trusts in terms of the low numbers of patients who pick up infections like clostridium difficile and MRSA. In fact in terms of c-diff I must confess that the reduction target at the start of the year was so ambitious that I really thought we were on a hiding to nothing in terms of achieving it… I am very happy to say that I have been proved wrong.

Turning to 'patient experience' this is another success story for the year. For too long our overall patient experience ratings have been decidedly average. More worryingly they were not getting any better. This year we have seen a marked improvement in our 'friends and family test' scores, (Would you recommend these hospitals to your friends / family?) and though I don't have the evidence to prove this yet I am convinced that this is in no small part down to the focus that our Chief Nurse has brought to ward staffing levels, (including a £6m investment in extra nurses and HCAs), ward leadership and generally supporting nurses to do what they do best.

There have of course also been problems. I have already highlighted emergency care performance and this remains our most urgent quality issue. Elsewhere our ophthalmology service has struggled to keep up with demand and this has resulted in long waiting times for patients and poor patient experience whilst waiting in clinic. And as I write we have just received an external review report, which we instigated and has led to the decision to pause our kidney transplant service whilst we sort out some quality and process issues with the team.

Before I sign off I must mention the Care Quality Commission's, (CQC) inspection which took place in January 2014. Over 40 inspectors spent 4 days at the Trust talking to staff, patients and stakeholders about quality, safety, leadership and effectiveness.

The Chief Inspector of Hospitals for CQC, Professor Sir Mike Richards, said: "We found that the University Hospitals of Leicester NHS Trust was providing services that were safe, effective, responsive, caring and well-led. Staff we spoke to were positive, and patients we spoke to were positive about the care that they had received at the trust."

I think the CQC's report was fair and balanced. They recognised that we were on a journey to fundamentally improve our services and that we are making progress. What leaped off the page when I first read the report and in subsequent readings was this…

"Overwhelmingly we were told that staff were caring… we found emotional support was provided, not only in areas where you would expect it but also that staff in all areas were prepared to go 'the extra mile'".

I think our staff are marvellous. They are passionate and caring and so I will end with saying thank you to them for all that they do as we continue to strive for our goal of "Caring at its Best"

Yours,

John Adler
Chief Executive
University Hospitals of Leicester NHS Trust

Caring at its best

2 Review of quality performance in 2013/14

Our aims for 2013/14: A review of last year's quality priorities

Last year (2012/13) we set the following three priorities for improvement to achieve over the next three years:

- To save 1,000 extra lives
- To avoid 5,000 harm events
- To provide patient centred care so that we achieve a Friends and Family score of 75

	Target Achieved/ On Plan	Behind Plan
SAVE LIVES		
Out-of-hours		☒
Respiratory Pathway	☑	
AVOID HARM		
Falls	☑	
Acting on Results in ED	☑	
Senior Review, Ward Rounds and Notation	☑	
PATIENT CENTRED CARE		
Older People and Dementia	☑	
Discharge Experience		☒

2 Save lives

Out-of-hours

What

1. Reinforce and accelerate roll-out of Hospital We Care 24/7* Initiative.
2. Detailed audit and process mapping to identify cause of higher out-of-hours mortality.
3. Encourage out-of-hours communication between junior doctors and consultants.

*We care 24/7 is a new initiative to ensure Leicester's Hospitals has an out-of-hours multidisciplinary team who possess the full range of skills and competencies required to manage the immediate needs of our patients after 5pm, over-night during the week and 24 hours a day at weekends.

By When: March 2014

Progress: Behind plan ☒

Improvements achieved:

Since January, Hospital 24/7 has been launched successfully at Glenfield Hospital, Leicester General Hospital and Leicester Royal Infirmary. Connectivity issues caused early problems but these were fixed ahead of the launch at the Royal Infirmary. Early response time metrics have been very promising and a handover process form has been successfully carried out.

As the baseline was 'bespoke' it has not been possible to routinely monitor or agree a threshold. Following discussions at the last Mortality Review Committee and subsequently with the Medical Director, it has been agreed we use 'weekend emergency admissions' as a surrogate indicator (as this can be routinely reported from Dr Foster Indicator [DFI] and Ealthcare Evaluation Data (HED) for both the 'in hospital mortality' [Relative Risk/HSMR] and 'within 30 days of discharge' [SHMI]).

The table below indicates there has been a reduction in all mortality parameters during 2013/14.

Weekend Emergency Admissions	2012/13	2013/14
Crude Mortality[1]	3.36%	3.05% (to Oct)
Relative Risk (DFI)[2]	111	92[3] (to Oct)
Hospital Standardised Mortality Ratios (HED)	109	103 (to Oct)
Summary Hospital-level Mortality Indicator (HED)	118	107 (to Sept)

[1] Using the DFI Relative Risk data set.
[2] Includes all admissions.
[3] It should be noted that the DFI Relative Risk for 2013/14 will increase following annual rebasing whereas the HED HSMR is rebased each time the dataset is updated.

2 Save lives

Out-of-hours

Further improvements required:

- Further work needs to be undertaken to properly understand whether the perceived difference in mortality rates between patients admitted in 'working hours' and 'out-of-hours' is clinically significant.
- There is also a need to clarify the scope of the 'out-of-hours' work stream as the original intention was to look at 'out-of-hours admissions'. The baseline data was created from a bespoke report (by BCG) which matched the SHMI data set (provided by HED) with our internal data for 'time of admission' (this is not captured by the national data set).
- Further opportunities have been identified in medical handover processes, phlebotomy cover and culture around calling consultants.
- Whilst there has been some more detailed analysis of 'out-of-hours' data for respiratory diagnosis groups, there has been a delay in rolling this out to other conditions.

2 Save lives

Respiratory pathway

What

1. Redirect more Respiratory Pathway patients to Glenfield Hospital.
2. Reinforce best practice, including respiratory registrar secondments between Glenfield Hospital and Leicester Royal Infirmary.
3. Increase transparency on key metrics.

By When: March 2014

Progress: On plan ☑

- The Respiratory Pathway was successfully launched in July 2013 with exclusion criteria agreed by Glenfield Hospital, Leicester Royal Infirmary, GPs and EMAS (East Midlands Ambulance Service).
- In September 2013, two dedicated pneumonia nurses started in post. Their main role, supported by the Respiratory Pathway consultant lead, is to support implementation of the pneumonia care bundle across both the Royal Infirmary and Glenfield sites.
- Over 300 patients with pneumonia were reviewed by the end of December 2013 (at the Royal Infirmary and Glenfield). Both Pneumonia admissions and the care bundle delivery are audited regularly and are being tracked using an online database tool.

Improvements achieved:

- The Respiratory Pathway has led to an increase of patients with co-morbidity and frailty being admitted to the Royal Infirmary.
- Early results suggest there has been a reduction in mortality for patients admitted with pneumonia, both at the Royal Infirmary and Glenfield.
- Overall mortality for Leicester's Hospitals has fallen for both crude and risk adjusted mortality between Quarter 1 (Q1) and Quarter 2 (Q2) in 2013/14.

Pneumonia	Pre Pathway Implementation Q1 (Apr – Jun 2013)	Pre Pathway Implementation Q2 (Jul – Oct 2013)
Crude Mortality	19%	18%
Relative Risk (DFI)	114	93 (Jul – Oct 13 Un-rebased)
Hospital Standardised Mortality Ratios (HED)	129	105 (Jul – Oct 13 Un-rebased)
Summary Hospital-level Mortality Indicator (HED)	122	109 (Jul – Sept 2013)

2 Save lives

Respiratory pathway

Further improvements required:

- Respiratory Pathway to be further embedded to see if the early impact on mortality rates has been sustained.
- Implement teaching about the pneumonia care bundle through a 'simulation package' via the Clinical Skills Centre.
- An ICM referral document for the 'Respiratory Virtual Clinic' has been designed and will be implemented in 2014.
- Senior clinician-led coding systems using iPads on the senior ward round are due to be field tested on Clinical Decisions Unit (CDU) at Glenfield Hospital.

2 Avoid harm

Falls

What

1. Agree standards and focus roll-out on wards with greatest need.
2. Dedicated staff training; linked to older people and dementia training.
3. Transparent tracking; Older People's team to coach underperforming wards and 'postcards' to celebrate success.

By When: December 2013

Progress: Target achieved ☑

Improvements achieved:

- Trajectory to reduce falls to less than 7.5 per 1000 bed days in patients aged 65 and over has been consistently achieved since August 2013.
- Introduction of a root cause analysis process to validate all falls in wards/clinical areas with the highest number of falls.
- The safety thermometer reported that more patients did not fall or sustain harm from a fall in January 2014 compared to the beginning of the year.

Further improvements required:

- Focus on reducing the amount of harmful falls
- Implementing patient-specific falls prevention actions for all patients aged 65 and over or patients with a clinical condition that increases their risk of a fall
- Ensure consistency in the actions taken when a patient does fall

2 Avoid harm

Acting on results in the Emergency Department

What

1. Agree standards for checking blood results and imaging reporting.
2. Communicate these standards and engage staff.
3. Increase transparency through monthly league table; reward high performers.

By When: December 2013

Progress: On plan ☑

Improvements achieved:

- Implementation of a robust process to ensure all Imaging reports are reviewed after the patient has been discharged from the Emergency Department (ED) and sent home.

Further improvements required:

- Improved Imaging reporting times for ED by use of 'hot reporting' in the department.
- Create an electronic solution for communicating abnormal results directly to clinical teams.

2 Avoid harm

Senior review, ward rounds and notation

What

1. Agree standards for review; conduct spot-checks.
2. Pilot and audit ward-round checklists and template; review and roll-out further.
3. Agree standards for notation; engage doctors and track improvement.

By When: March 2014

Progress: On Target ☑

Improvements achieved:

- Standards for review have been agreed and audited in Medicine
- The scope of current practice in other specialities has been completed to identify areas for improvement
- A 'Ward round safety checklist' and a revised 'medical continuation paper' has been implemented across Leicester's Hospitals with specific versions for Adults, Children's and Obstetrics in February / March 2014.

Further improvements required:

- Ongoing audit programme to monitor compliance with revised documentation
- Education and simulation training for ward teams on ward round structure and process.

2 Patient centred care

Older people and dementia

What

1. Ward-based multi-professional staff training.
2. Expand Older People's Champions; set up resource centre and meaningful activities team.
3. Personal profiles for all patients with dementia; white board communication tool.
4. Increase patient / carer involvement; matrons / allied lead professionals on ward at visiting times; doctors to employ communication tools (e.g. Teach-back).
5. Track and hold to account (e.g. ward net promoter scores on notice board).

By When: March 2014

Progress: On target ☑

Improvements achieved:

- By the end of January 2014, 6,330 members of staff had completed Dementia Awareness 'Category A' training and 2,171 Dementia Awareness 'Category B' training.
- Increased the number of Older Peoples Champions; a further 325 members of staff, including student nurses and volunteers have attended Older People Champions workshops.
- Three Meaningful Activities Facilitators started in September 2013 to support patients with dementia on wards 19, 31 and 32 at LRI. Meaningful activity, such as arts and crafts, reminiscence and music therapy can improve the well being of people with dementia as well as promoting a closer working relationship with their carers. It provides an opportunity for cognitive stimulation, and supports physical, sensory and psychological well-being for people with dementia whilst they are in hospital.
- A 'Carers Support' post has been appointed using Charitable Funds to support carers (including young carers), whilst their family member is admitted to hospital. In partnership with the Alzheimer's Society, 34 local carers of people with dementia attended a 'Carers Information and Support Programme (CRISP)' organised by UHL in 2013.
- Significant improvement has been made in the use of 'Patient Profiles' for people admitted with dementia across all Clinical Management Groups (CMGs). Audit has shown an increase from 6% (September 2013) to over 50% (January 2014).
- In May 2013, with support from the Alzheimer's Society, a Dementia Champion Network was launched. Staff can now access the Dementia Champion workshop.
- Eight wards have signed up to the Quality Mark for Elder-Friendly Hospital Wards. Funding is being explored to support environmental recommendations.

Further improvements required:

- Introduce a Dementia Implementation Plan in line with national and local guidelines.
- Continue to monitor the Quality Mark for Elder-Friendly Hospital Wards scheme and where possible, implement recommendations to enhance ward environments.
- Continue to engage and monitor feedback from older people and people with dementia; ensuring service improvement groups have appropriate representation to reflect the needs of older people and people with dementia.
- Improve access and training for staff in understanding complex needs of frail older people.

2 Patient centred care

Discharge experience

What

1. Agree standards for discharge plans; conduct spot-checks.
2. Employ communication tools; develop 'Ticket Home' and add board round check for communication with family / carer.
3. Increase discharge co-ordinators.
4. Track improvement and hold to account.

By When: March 2014

Progress: Behind plan ☒

Improvements achieved:

- Discharge plans for all patients within medical wards are now tracked on a shared spreadsheet to provide the information necessary for monitoring during the twice daily patient progress team conference calls. This call has attendance from corporate operations team/nursing, pharmacy, Leicestershire Partnership NHS Trust (LPT), social work teams and primary care co-ordinators. The calls provide an opportunity for these teams to assist in ensuring safe and speedy discharge.
- Regular reports from these calls are shared with the multidisciplinary team and also reported to the Emergency Care Action Team (ECAT).
- This process is being rolled out across Leicester's Hospitals, starting with the Renal, Respiratory and Cardiac CMG week commencing 3 March 2014.
- Board rounds are audited quarterly and this includes checking for communication with relatives /carers.

Further improvements required:

- All wards will have available weekly discharge metric reports to be shared within the team, allowing teams to set local improvement targets.

2 Culture, leadership and workforce capability

Our staff are our most important resource in delivering high quality care. Culture can be defined as the values, beliefs and attitudes an organisation and its employees share in 'the way we do things around here'.

We have embedded a set of core values and behaviours enabling us to place quality and safety at the heart of our hospitals and fulfil our purpose to provide 'Caring at its Best'.

We recognise that our staff are our most valuable resource and are key to the delivery of high quality services for the benefit of the population of Leicestershire, Leicester and Rutland.

The vast majority of our staff are on national NHS pay, the terms and conditions of which include a comprehensive set of employment policies and procedures. This year we used two 'Listening Events' to shape and develop a Reward and Recognition Strategy, designed to support the motivation, recruitment and retention of a high quality workforce. This is built around six key themes including pay and reward; benefits; learning and development; health and well-being. Together these form our 'employer brand' which is underpinned by the Trust Values. The strategy will be delivered through a phased implementation plan.

A cornerstone of this strategy is the formal celebration of staff achievements. Our 'Caring at its Best' Awards recognise individual staff and teams who epitomise our values and in so doing directly or indirectly enhance the quality of patient care. Colleagues, patients and visitors help us discover who these staff are through a nomination process. A winner and a 'highly commended' are selected from each category three times a year. These winners and all other nominees are invited to an annual Awards Ceremony each September, where an overall winner for each category is announced, along with the presentation of the 'volunteer of the Year' award.

Our Learning and Organisational Development Awards recognise staff who have invested time and energy in their personal development to enhance the experience of patients and carers. At our 2014 annual event over 140 learners were presented with certificates for successfully completing vocational, skills for life or leadership/management qualifications. Members of the Trust Board also presented seven Special Achievement Awards to learners who had been nominated by their tutors for their exceptional progress, commitment and outstanding achievement

We collect staff views and experiences in the workplace through the annual NHS National Staff Survey (issued by the Care Quality Commission) and internal Listening into Action (LiA) Pulse Check surveys to help improve the working lives of staff and the quality of care we provide. The analysis of survey results helps us identify sustainable change and highlights areas for improvement. We have recently reviewed the 2013 NHS National Staff Survey results for Leicester's Hospitals along with the recent LiA Pulse Check results. The NHS National Staff Survey has historically been completed by a randomly selected sample of staff, however this year all staff were given the opportunity to complete the survey and local questions were also introduced for

2 Culture, leadership and workforce capability

National Staff Survey has historically been completed by a randomly selected sample of staff, however this year all staff were given the opportunity to complete the survey and local questions were also introduced for the first time. After showing some significant improvements last year, the CQC reported only one statistically significant change in 2013 – the completion of Equality and Diversity training the first time. After showing some significant improvements last year, the CQC reported only one statistically significant change in 2013 Ð the completion of Equality and Diversity training.

One of the key measures is overall staff engagement and our results slightly increased from 3.66 in 2012 to 3.68 in 2013. It is disappointing that we slipped from average to below average when compared to other acute trusts for this measure.

In general, we received positive results in relation to staff appraisal and education, training and learning but less positive results in relation to the observation and reporting of incidents and accidents. There were also less positive results than in the previous year in relation to job satisfaction and motivation.

In contrast, the results from local questions and the LiA Pulse Check portrayed a more positive picture. More staff are receiving information from our Chief Executive, cascaded by senior managers and the communications team and almost 70% of staff believe colleagues and managers exemplify the Trust Values. There have been significant improvements in LiA Pulse Check results since the first survey in 2013, particularly in relation to improvements in the provision of high quality services, recognition of staff contribution and role clarity.

* The results described above are based on the Care Quality Commission (CQC) sample of anaylsed results from Leicester's Hospitals NHS National Staff Survey (379 responses from 850 randomly selected by the CQC).

Leadership Qualities and Behaviours

Our Leadership Qualities and Behaviours (outlined on page 18) support our vision to consistently demonstrate leadership excellence and deliver safe high quality pateint-centred health care. Leadership qualities and behaviours are aligned to UHL values and have been developed following extensive consultation with staffand leaders from across the Trust over 2013/14.

2 Culture, leadership and workforce capability

Leadership Qualities and Behaviours

Leadership excellence in delivering safe high quality patient-centred health care

We treat people how we would like to be treated 	Live our values in our actions every day. Set clear expectations. Show empathy and respect. Trust and empower.
We do what we say we are going to do 	Be responsive and accountable. Communicate and feed back. Be transparent and honest. Support and develop.
We focus on what matters most 	Be patient centred. Plan effectively for the short and longer term. Use resources effectively and efficiently.
We are one team and we are best when we work together 	Be visible, available and accessible. Listen to and act on the voice of the front line. Build and maintain relationships and working partnerships.
We are passionate and creative in our work 	Support innovation and creativity. Recognise and celebrate success.

One team shared values

2 Investment in nurse staffing and recruitment

Investment in Nurse Staffing

In 2013, a review of ward nurse staffing levels across the three hospital sites was requested by our Chief Executive following the budget setting process for 2013 /14.

The review needed to address the following issues:

- Actual budgets for 2013/14 did not reflect budgets set in 2012/13
- The 2013/14 budgets did not include the monies required and agreed by the Trust Board following the acuity work completed in 2012.
- Budgets needed to include 0.4 whole time equivalents (wte) funding for supervisory status for Ward managers.

Nurse to Bed Ratio Review (N2BR) Methodology

In May 2013, our deputy director of finance and corporate head of nursing designed and implemented an 'N2BR Establishment Review' to calculate the nursing requirements across our hospitals, using the knowledge and insight of those working on the frontline.

The corporate head of nursing met with lead nurses, matrons and ward managers from each service/area to discuss how many staff they need, by band, per shift to effectively cover a 24 hour period.

Completed reviews were sent to the divisional head of nursing and divisional finance manager to undertake a 'confirm and challenge' process with each lead nurse, before being signed off by the corporate finance and nursing leads.

We have a significant nursing premium expenditure i.e. hire of agency nurses, to try and cover the gaps in staffing levels and recognise this is not sustainable to ensure patient safety or continuity of care.

In July 2013, the Executive Team (approved by the Trust Board) agreed to invest £5.9m into ward nursing budgets. Not only does this recognise the need to bring N2BR to agreed acceptable levels, it also funds additional capacity and recognises increasing acuity of patients.

Recruitment and Advertising

Vacancies at Leicester's Hospitals are primarily advertised through a dedicated nursing recruitment page on NHS Jobs. Other advertising mediums are always used but all applicants are directed to apply via NHS Jobs website which allows a prime opportunity to promote the Trust, its achievements and staff benefits.

To facilitate the ongoing recruitment of Band 5 Nurses and HCA's, bulk recruitment campaigns have operated throughout the year that involved a collaborative approach to the advertising of, and recruitment to, vacant posts. In January 2013, this was supported by a Nursing Open Day in which candidates were offered talks and tours of specialty areas across Leicester's Hospitals. Nursing representatives from Leicester's Hospitals attended Royal College of Nursing (RCN) conferences throughout 2013 and will continue to attend conferences throughout 2014 to promote the unique selling points of Leicester and our specialty areas.

We are currently undertaking a pilot of Health Care Assistant (HCA) Apprentices, through which 23 applicants have already been offered apprenticeships at our hospitals. The successful candidates started in November 2013 with the aim that once they complete their one year apprenticeship, they will be ready to apply for a substantive post through the HCA recruitment process in October / November 2014. Interview panel feedback on the calibre of applicants and the recruitment process has been very positive to date.

2 Investment in nurse staffing and recruitment

In partnership with our supplier for recruitment marketing, we have designed innovative advertising materials for each specialty which reflect both the overarching Trust Values and a have created a 'brand' specific to each specialty. The materials portray our staff describing what they value most about Leicester, our Trust and the specialty in which they work, to give potential applicants an insight into working here.

We are fortunate to have a local university, De Montfort University (DMU), which provides pre-registration nurse and midwifery training. There are two intakes of students a year for adult nursing at DMU (September and January) and two outputs of newly qualified adult nurses (November and March). For children's nursing and midwifery there is only one intake/output a year.

The university offers an employability event for student midwives and nurses in their final semester, which representatives from Leicester's Hospitals attended. Feedback from the two events held to date has been very positive with the students valuing the opportunity to talk to our staff and give assurance that appropriate support and development opportunities will be available to newly qualified nurses and midwives.

Subsequent speciality based recruitment events within the Trust such as 'Tea with Matron' have provided the students with additional assurance. Approximately 90% of all students who qualify are retained within Leicestershire with the majority accepting a job at Leicester's Hospitals; this equates to on average 200 nurses (adult and child) and midwives a year.

International Recruitment

Following a tender exercise, four agencies were commissioned to support the recruitment of Band 5 Nurses internationally. This has involved small teams of senior nurses travelling to Portugal, Ireland, Madrid, Italy and Greece to select candidates for Leicester's Hospitals.

2 Investment in nurse staffing and recruitment

Robust plans have been put in place to support relocation for successful applicants including access to accommodation, a mentorship/buddying arrangement and orientation to support the settling in process. Over 200 Registered Nurses, in cohorts of 50, have been recruited through our international recruitment campaign. We have now undertaken a further tender exercise, with one key international recruitment agency, to support further international nursing requirements over the next three years.

Induction and Support

We have embraced Preceptorship (a mentoring experience to give personal instruction, training, and supervision) for many years. In 2010 this work was streamlined and standardised to ensure that all newly registered Nurses who join the Trust receive the same levels of education and support.

Preceptorship includes three core study days, up to four CMG (clinical management groups) specific study days over a six month period, four weeks supernumerary on gaining their PIN number to support the transition from student to staff nurse and comprehensive Administration of Medicines assessment which incorporates a maths exam. A review of the Preceptorship Policy is currently being undertaken to reflect this work and will also incorporate Allied Health Professional (AHP) colleagues.

For nurses recruited from the EU, the Preceptorship programme will provide a solid foundation of induction and support. It can require some adaptation or bespoke work to meet the specific needs of these staff, which can be undertaken in partnership with the Education and Practice Development teams.

In line with the Francis report[1] recommendations, it is now compulsory for all new HCA's to complete both our corporate and HCA induction prior to commencing in a clinical area. Therefore all new HCA's first working day starts on Day One of our corporate induction.

The HCA induction includes four cross-service days and one speciality-specific day. These days are spread across their first two to three weeks with the rest of the time being spent in their clinical areas in a supernumerary capacity. The Childrens Hospital HCA's and Maternity Care Assistants follow the same standard but run their own programmes which reflect their specific requirements

New HCA's are automatically booked onto HCA induction when the corporate induction is confirmed. The HCA induction runs monthly and has a capacity of 35 to 50 places per course depending on the size of the venues.

[1] On 9 June 2010 the Secretary of State for Health, Andrew Lansley MP, announced a full public inquiry into the role of the commissioning, supervisory and regulatory bodies in the monitoring of Mid Staffordshire Foundation NHS Trust. The full report can be viewed on http://www.midstaffspublicinquiry.com/

2 Our new management structure

Rather than grouping our services in 12 Clinical Business Units under three very large divisions (was Planned Care; Acute Care; Women's and Children's) we have created seven smaller Clinical Management Groups (CMGs) which are:

- Cancer, Haematology, Urology, Gastroenterology and Surgery
- Clinical Supporting and Imaging
- Emergency and Specialist Medicine
- Critical Care, Theatres, Anaesthesia, Pain and Sleep
- Musculoskeletal and Specialist Surgery
- Renal, Respiratory and Cardiac
- Women's and Children's

The two main reasons for these changes were:

Reducing the multi-tiered layers of management

We previously had four layers in our management structure from Executive Team to service provision, whilst most other NHS Trusts of a similar size only have three. By reducing the layers of management we hope to see improvement in both the delay of information being communicated in either direction as well less delay in decisions being made due to unnecessary escalation or confused accountabilities. It was also felt that the Executive Team were too far removed from service provision.

Size and complexity of Divisions

We identified that the Planned Care and Acute Care divisions did not have the Infrastructure to manage the complexity of the services they contained.

We felt the new management structure would support effective working and promote better management across our complex, multi-site, tertiary teaching Trust.

This simpler structure with fewer layers has already demonstrated improved working between the Executive Team and our services. Feedback has also shown that Management visibility has improved with increased clinical engagement and quicker, more effective decision making.

2 Listening into Action

Developing Listening into Action

Introducing Listening into Action (LiA) at Leicester's Hospitals has been an exciting journey. Launched in March 2013, LiA introduced a new and ambitious way of working, mobilising, engaging and empowering staff to transform our hospitals and to deliver 'Caring at its Best'. The foundations of LiA allow us to create a culture for frontline staff to lead and develop services, whilst ensuring services are patient-centred, safe and efficient.

LiA builds strong foundations through:

- Allowing senior leaders to connect with the 'right people' throughout major challenges
- Providing service teams with the opportunity to collaborate and share ideas
- Listening to frontline staff so they 'get on' and deliver actions to benefit patients and fellow staff
- Fostering a sense of collective ownership for the teams themselves through delivery of results.

Frontline staff, and those who help them, are supported and enabled to work differently, in a way that switches them on; links to outcomes they care about; makes them feel valued and gives them 'permission to act'. To date 23 Pioneering teams have adopted LiA at a local level within wards and departments. In addition, 11 Trustwide schemes have also used LiA to make significant changes.

Examples of successful outcomes to date include:

- ***Seamless Out-of-hours Services:*** TTO (To Take Out; prescriptions with hospital discharge) turnaround has improved and is now less than 60 minutes on all sites (50% within 30 minutes) with resultant avoidance of discharge delays.
- ***Equipment Fit for the Job:*** 46% improvement in the use of infusion pumps and 20% reduction in equipment being hoarded by ward / department staff.
- ***Communications:*** More than 100 members of staff signed up to take part in the social media movement, 'Value their Behaviour' campaign. Staff were asked to submit a picture of themselves holding a Value card to demonstrate how they exemplify one of the 16 behaviours that underpin our Values.
- ***Reducing Paperwork and Processes:*** Reduction of Day Case documents from 14 to 1.
- ***Recruitment:*** The development of an online Vacancy Approval process called Route to Recruit (R2R) has reduced tiers of approvers and enables transparent tracking. An estimated £2,500 will be saved on postage with the move to electronic conditional offer letters; 76.4% of all appointable candidates only required one reference in line with NHS Employers standards; and 10.1 saved days on average from initial R2R request through to receipt by recruitment staff.
- ***Car Parking and Travel:*** In December 2013, an agreement was set up with NCP Welford Road car park to offer an 80% reduction in prices for Leicester's Hospitals patients and their visitors. By March 2014, 75% of bike shed locks were replaced at the Royal Infirmary.
- ***IM&T:*** 30% drop in complaints related to IM&T.
- ***Right Staffing:*** Over 200 overseas nurses have been recruited for 2014 and counting.....

2 Culture, leadership and workforce capability

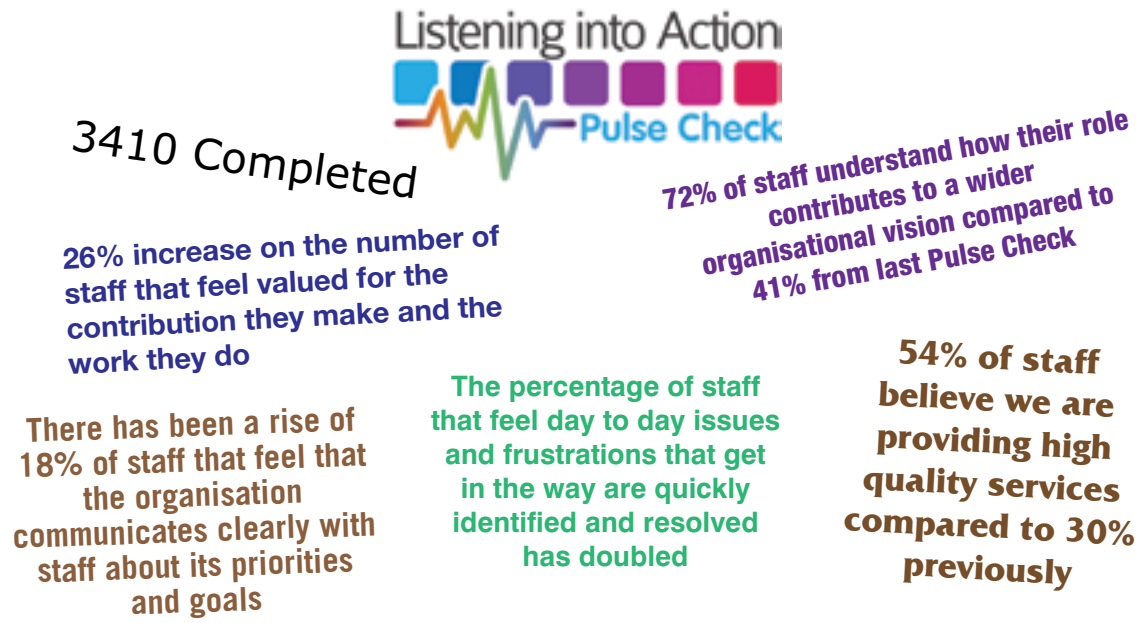
Listening to our staff

A healthy organisation starts with a Pulse Check

The LiA Pulse Check surveys are completed by staff so we can find out how they feel about working for Leicester's Hospitals and ascertain their views on the services we provide.

Our LiA journey started in March 2013 with an organisation-wide Pulse Check survey which was then repeated in January 2014. By comparing the results of the two surveys we can see an upward trend in positive responses and a positive position when compared to other LiA organisations nationally.

In addition, Pioneering teams completed a team-based Pulse Check during the 'listening' phase of their change initiative and repeated this at the end of their 'action' phase. As with the organisational responses, teams responded much more positively after the action phase has been implemented.



Listening into Action Quick Wins

UHL Name Badges

Our patients and staff have told us how important it is that they know who they are talking to, so from 1 January 2014, all new starters along with our leadership teams have been required to wear a University Hospitals of Leicester NHS Trust (UHL) Name Badge. The Name Badge is worn in addition to the more familiar existing photographic ID badge.

Flexible visiting hours for carers

We have added the following message to the back of all ward visiting cards to ensure we have consistency in how flexible visiting is managed across our wards:

"Our set visiting times have been developed with our patients well-being in mind. However, if you would like to visit outside of the visiting hours please speak to us and we will do our best to help you. If you are a patient's main carer please contact the nurse in charge as there are special arrangements that can be made while you are in hospital"

2 NHS outcomes framework indicators

2 NHS outcomes framework indicators

The NHS Outcomes Framework for 2013/14 sets out high level national outcomes in which the NHS should be aiming to improve. The Framework provides indicators that have been chosen to measure these outcomes. All Quality Accounts will report these outcomes.

An overview of the indicators is provided in the table below.

NHS Outcomes Framework Domain	Indicator	2011/12	2012/13	2013/14	National Average	Highest Score Achieved	Lowest Score Achieved
Preventing people from dying prematurely	SHMI value and banding (Dr. Fosters)	105 (Jul 11-Jun 12) Band 2 - as expected	107 (Jul 12-Jun 13) Band 2 - as expected	106 (Oct 12-Sept 13) Band 2 - as expected	100	119	63
	%of admitted patients whose treatment included palliative care (contextual indicator)*	0.76% (Jul 11-Jun 12)	0.8% (Apr 12-Mar 13)	0.9% (Oct 12-Sept 13)	1.2% (Oct 12-Sept 13)	3.1% (Oct 12-Sept 13)	0% (Oct 12-Sept 13)
	% of admitted patients whose deaths were included in the SHMI and whose treatment included palliative care (contextual indicator)	13.5% (Oct 11-Sept 12)	12.8% (Apr 12-Mar 13)	15.2% (Oct 12-Sept 13))	21.2% (Oct 12-Sept 13)	44.8% (Oct 12-Sept 13)	0% (Oct 12-Sept 13)
Helping people to recover from episodes of ill health or following injury	Patient reported outcome scores for groin hernia surgery	0.085	0.085	0.060 (Apr 13-Dec 13)	0.086 (Apr 13-Dec 13)	0.157 (Apr 13-Dec 13)	0.013 (Apr 13-Dec 13)
	Patient reported outcome scores for hip replacement surgery	0.42	0.41	0.430 (Apr 13-Dec 13)	0.430 (Apr 13-Dec 13)	0.530 (Apr 13-Dec 13)	0.300 (Apr 13-Dec 13)
	Patient reported outcome scores for knee replacement surgery	0.33	Data not available	0.330 (Apr 13-Dec 13)	0.330 (Apr 13-Dec 13)	0.410 (Apr 13-Dec 13)	0.190 (Apr 13-Dec 13)
	Patient reported outcome scores for varicose vein surgery.	Insufficient questionnaires submitted					
	% of patients <16 years old readmitted to hospital within 28 days of discharge	Data not available	Data not available	7.55%	7.07%	12.50%	0.00%
	% of patients 16+ years old readmitted to hospital within 28 days of discharge	Data not available	Data not available	11.26%	10.10%	13.55%	0.00%
Ensuring that people have a positive experience of care	Responsiveness to inpatients' personal needs	6.7/10	6.7/10	6.6/10*	Data not available	Data not available	Data not available
	% of staff who would recommend the provider to friends or family needing care	54%	55%	57.3% (Staff Survey 13)	67%	93.9%	39.6%
Treating and caring for people in a safe environment and protecting them from avoidable harm	% of admitted patients risk-assessed for Venous Thromboembolism	No data for this period	94.8% (Q3 2012/13)	96% (Q3 2013/14)	98%	100%	78%
	Rate of C. difficile. Rate per 100,000 bed-days for specimens taken from patients aged 2 years and over (Trust apportioned cases)	21.3	18.1	Data not available	17.3 (2012/13)	30.8 (2012/13)	0 (2012/13)
	Rate of patient safety incidents per 100 admissions	7.9 (local DATIX Data)	9.6 (local DATIX Data)	10.4 (Apr 13-Sept 13)	8.0 (Apr 13-Sept 13)	12.8 (Apr 13-Sept 13)	4.9 (Apr 13-Sept 13)
	% of patient safety incidents reported that resulted in severe harm or death	0.3% (2011/12)	0.25% (2012/13)	0.26%* (2013/14)	0.34%	0.88%	0.03%

Data sourced, where possible, from NSCIC. Where data is not available through NSCIC local information has been sourced (*)

2 NHS outcomes framework indicators

Domain: Preventing people from dying prematurely

The Standardised Hospital Level Mortality Indicator (SHMI) is a measure of mortality developed by the Department of Health, comparing actual number of deaths with predicted number of deaths. Each hospital is placed into a band based upon their SHMI.

Leicester's Hospitals SHMI is 107 for the period July 2012 to June 2013 and is in band 2 as we expected.

The University Hospitals of Leicester considers that this data is as described for the following reasons; we commissioned an in-depth analysis of our SHMI and other mortality data by the Boston Consultancy Group at the beginning of 2013. This work identified two groups of patients that appeared to have the greatest impact on the '>100 SHMI':

- Patients admitted at weekends or 'out-of-hours'
- Patients with a respiratory diagnosis (specifically pneumonia)

The review by the Boston Consulting Group also identified that there were differences between our data and other trusts in respect of the types of co-morbidities recorded and this has affected the outcome of our risk adjusted mortality figure.

The issues relating to 'End of life care' have been a regular theme of most mortality reviews undertaken and also individual Mortality and Morbidity reports. We see a recurring issue with patients who have (or should have had) an advanced care plan being inappropriately sent to our hospitals.

The University Hospitals of Leicester has taken the following actions to improve this indicator, and so the quality of its services with the implementation of the Respiratory Care Pathway and Hospital 24/7. These were both identified as priorities to be taken forward by the 'Saving Lives Quality Action Group' as part of our Quality Commitment plan.

Our risk adjusted mortality (SHMI) is also a step closer to the national average (100) following work undertaken to improve documentation in patients' health care records of diagnoses and other associated illnesses.

Domain: Helping people to recover from episodes of ill health or following injury patient reported outcome scores

A patient reported outcome measure (PROM) is a series of questions given to patients in order to gauge their views on their own health. In the examples of groin hernia, knee replacement, hip replacement and varicose vein surgery, patients are asked to score their health before and after surgery to see if they identify a 'health gain' following surgery.

The University Hospitals of Leicester considers that this data is as described for the following reasons; a case note review has not identified any reason as to why there was a drop in patients' reported outcomes following Groin Hernia in the early part of 2013/14. Following submission of further data, our outcomes are again in line with the national average.

The University Hospitals of Leicester has taken the following actions to improve this, and so the quality of its services, by ensuring patients had a better understanding of the discomfort and abdominal pain they may experience post-surgery. Although patients were advised about possible complications as part of the consent process, the review found that post-operative pain and discomfort was not highlighted in all cases.

The percentage of patients of all ages and genders readmitted to hospital within 28 days of discharge.

The University Hospitals of Leicester considers that this data is as described for the following reasons; readmission rates are reported monthly in the Quality and Performance Report and presented at the Trust Board.

2 NHS outcomes framework indicators

The University Hospitals of Leicester has taken the following actions to improve this, and so the quality of its services, by implementing a number of pathways to reduce readmissions. For example the Heart Failure Specialist Service was developed to enable timely access to specialist care for this group of patients. National and local data has shown that heart failure patients experience improved outcomes if cared for by a specialist during their stay. Hospital readmissions are reduced, improved continuity with community services and an enhanced understanding of managing their condition all link into this improvement in care.

Domain: Ensuring that people have a positive experience of care

Responsiveness to inpatients' personal needs: This indicator provides a measure of quality based on the Care Quality Commission national inpatient survey. The score is a composite of five questions in the inpatient survey.

The University Hospitals of Leicester considers that this data is as described for the following reasons; we have focused upon responding to each ward / department's high level metric of the Friends and Family Test score and the comments from patients relating to their experience of care. We have achieved an increase in FFT scores, rising from 66.4 at the beginning of the year to 69.9 at the end of 2013/14.

The University Hospitals of Leicester intends to take the following actions to improve this score, and so the quality of its services, with the implementation of the Quality Commitment initiatives. There will be a focus on the elements of care that matter most to patients within each of the specific specialty area. We hope these focused patient experience priorities will improve the experience for our patients, results of which will be captured in the 2014 National Patient Survey results.

Percentage of staff who would recommend the provider to friends or family needing care: The NHS Staff Survey is conducted on behalf of the Care Quality Commission (CQC) and is recognised as an important way of ensuring that the views of staff working within the NHS inform local improvements. As previously reported to the Trust Board, analysis by the CQC of the survey results is undertaken through a self-completed questionnaire by a random sample of staff selected from across the whole Trust. All staff received the survey this year either via email or by post and 3988 completed responses were returned, giving a response rate of 39% (2013). From the CQC sample of 850 staff, 379 people giving a response rate of 46%.

The University Hospitals of Leicester considers that this data is as described for the following reasons; our performance is based on the 2013 national staff survey results (February 2014). This information is presented to the Trust Board, summarising analysis of 2013 staff survey results. We also reference the 'full comparison report' compiled by the Care Quality Commission. As required by the CQUIN measures, UHL will be regularly surveying staff and workers regarding whether they would recommend the Trust to friends or family needing care.

Domain: Treating and caring for people in a safe environment and protecting them from avoidable harm

Risk assessing inpatients for Venous Thromboembolism (VTE) is important in reducing hospital acquired VTE. We have worked hard to ensure that not only are our patients risk assessed promptly but that any prophylaxis is given reliably.

The University Hospitals of Leicester considers that this data is as described for the following reasons; data is presented monthly to the Clinical Quality Review Group and matrons and lead nurses undertake a monthly review of VTE assessment rates and VTE occurrence as part of the Safety Thermometer.

The University Hospitals of Leicester has taken the following actions to improve this: we aim to increase VTE assessments to a sustained 95% of eligible patients; provide pharmacological and/or mechanical thromboprophylaxis to all eligible patients; and to carry out root cause analysis for all inpatients who experience a potentially hospital acquired VTE. During the period 2013/14 an average of 95.2% of eligible patients were risk assessed for VTE.

2 NHS outcomes framework indicators

Patient safety incidents are reported to the National Reporting and Learning System (NRLS). The rate of patient safety incidents per 100 admissions reported is 9.9. The National Patient Safety Agency stated that 'organisations that report more incidents usually have a better and more effective safety culture. You can't learn and improve if you don't know what the problems are.' Leicester's Hospitals will continue to encourage a culture of open reporting in order to learn and improve.

The University Hospitals of Leicester considers that this data is as described as staff are positively encouraged and supported in the process of reporting incidents. The NHS Commissioning Board believe "organisations that report more incidents usually have a better and more effective safety culture. You can't learn and improve if you don't know what the problem is". Leicester's Hospitals continue to be in the top third of the highest 25% of reporters.

The University Hospitals of Leicester has taken the following actions to improve this score and so the quality of its services, by working with staff to improve reporting and action learning from incidents.

Rate of clostridium difficile (C. Diff) is a bacterial infection commonly affecting people who are staying in hospital.

The Infection Prevention Team at Leicester's Hospitals works hard to provide training and education, audit and surveillance, and patient education to reduce the risk of healthcare associated infection.

The University Hospitals of Leicester considers that this data is as described for the following reasons; as an organisation our nationally set target for the number of C. Diff cases in 2013/14 was 67. We were able to report 66 cases at the end of the year and we will continue to strive to reduce the number of C-diff infections acquired at our hospitals.

The University Hospitals of Leicester has taken the following actions to improve our C, Diff rates; we have produced an MRSA bacteraemia and CDT reduction action plan for each Clinical Management Groups within the organisation to work towards. This plan is reviewed on a quarterly basis and revised yearly.

2 Performance against national standards

	PERFORMANCE AGAINST 2013/14 NATIONAL TARGETS					
	PERFORMANCE INDICATOR	Target 2013/14	2013/14	2012/13	2011/12	2010/11
Access to A&E	A&E – total time in A&E (4 hour wait)	95%	88.4%	91.9%	93.9%	96.1%
Infection Control	MRSA (Avoidable)	0	1	2	8	12
	Clostridium Difficile	67	66	94	108	200
Access – 18 week wait	RTT waiting times – admitted	90%	76.7%	91.3%	84.0%	92.3%
	RTT waiting times – non-admitted	95%	93.9%	97.0%	96.0%	97.2%
	RTT - incomplete 92% in 18 weeks	92%	92.1%	92.6%	Not Applicable	Not Applicable
	RTT delivery in all specialities	0	14	2	Not Applicable	Not Applicable
	Diagnostic test waiting times	<1%	1.9%	0.5%	Not Applicable	Not Applicable
Access – Cancer	Cancer: 2 week wait from referral to date first seen - all cancers	93%	94.8%	93.4%	94.0%	93.4%
	Cancer: 2 week wait from referral to date first seen, for symptomatic breast patients	93%	94.0%	94.5%	95.9%	95.9%
	All Cancers: 31-day wait from diagnosis to first treatment	96%	98.1%	97.4%	97.4%	97.0%
	All Cancers: 31-day wait for second or subsequent treatment - surgery	94%	96.0%	95.8%	94.5%	95.2%
	All cancers: 31-day for second or subsequent treatment - anti cancer drug treatments	98%	100%	100%	99.9%	100%
	All Cancers: 31-day wait for second or subsequent cancer treatment - radiotherapy treatments	94%	98.2%	98.5%	99.0%	99.5%
	All Cancers: 62-day wait for first treatment from urgent GP referral	85%	86.7%	83.5%	83.8%	86.4%
	All Cancers: 62-day wait for first treatment from consultant screening service referral	90%	95.6%	94.5%	93.8%	91.6%

Red=Target Failed Green=Target Achieved

2 Performance against national standards

Performance indicator: Emergency Department 4hr Wait Performance

In 2013/14 we set a target to treat at least 95% of patients in our Emergency Department (ED) within four hours by implementing a number of jointly agreed actions with our local commissioners. Our actual performance was 88.4%.

Performance against the 4hr Wait is subject to regular detailed reporting at our Trust Board. It is well recognised that the current size of our Emergency Department is too small for the number of patients who attend and as a result a significant scheme for expanding the Emergency Department has been developed. In addition, we are reviewing the number of beds required for emergency admissions with an aim to increase in 2014/15.

Working with our healthcare partners, a 'single front door' process was introduced in July 2013 to guide patients to the most appropriate care from the moment they arrive in the Emergency Department or Urgent Care Centre at Leicester Royal Infirmary.

Executives across the healthcare community have been meeting on a weekly basis to work on sustainable solutions to will improve performance, patient experience and staff satisfaction.

Additional resources have been allocated across the emergency pathway to ensure any delays are addressed. Measures have been put in place to ensure patients who unfortunately remain in our ED for longer than four hours receive appropriate care including prevention of pressure ulcers through the use of aides. There is a suite of ED quality metrics monitored weekly.

Performance indicator: Infection Control

MRSA: Over the last year there has been one unavoidable MRSA bloodstream isolates, a reduction on the previous year. This contrasts with 161 reported cases in 2001.

Clostridium Difficile: There continues to be a reduction in the number of C. Diff cases from 94 reported in 2012/13 to 66 in 2013/14.

Performance indicator: RTT - 18 week performance

In 2013/14 we set out to deliver all three 'referral to treatment' (18 week wait) standards on a monthly basis. The targets set were:-

1. 90% of admitted patients should be treated within 18 weeks. Admitted pathways are those that end in an admission to hospital (either inpatient or day case) for treatment.
2. 95% of non-admitted patients should start consultant-led treatment within 18 weeks of referral. Non-admitted pathways are those who result in treatment that did not require admission to hospital or where no treatment is required.
3. 2% incomplete within 18 weeks. This is proportion of all patients waiting for treatment at any time.

The threshold for RTT admitted and non-admitted performance throughout the year was not achieved, with significant speciality level failures in ENT, General Surgery, Ophthalmology and Orthopaedics.

A RTT recovery action plan has been submitted to our commissioners. Our commissioners have agreed to a significant financial investment during 2014/15 to reduce waiting times in key challenged specialties. It is anticipated that recovery of the Trust level admitted position will be achieved by November 2014.

Performance indicator: Cancer Targets

In 2013-14 we said we would deliver on all cancer targets. We expected to deliver all eight standards for the full year including the 62 day referral to treatment standard.

A Cancer Action Board was set up to monitor our Cancer Action Plan. The Board, chaired by the Cancer Centre Clinical Lead, meets weekly to ensure the actions set out within the plan are being delivered and that there is representation from all of the key tumour sites including Radiology and Theatres. The Board has delivered a more joined up approach to care for our cancer patients by reducing waiting times across the whole patient's cancer pathway.

2 NPSA alert compliance 2013/14

Through analysis of patient safety incident reports and safety information from other sources, the National Patient Safety Agency (NPSA) previously developed advice for the NHS that would help to ensure the safety of patients. As advice became available the NPSA issued alerts on potential safety risks. During 2013 the NPSA's patient safety function transferred to NHS England Patient Safety Domain.

A new reporting process called the *'NHS England Patient Safety Alerting System'* was implemented on 1 January 2014 to disseminate patient safety information at different stages of development to NHS organisations providing care across all settings. This is a three stage system, based on information used in other high risk industries, allowing more rapid dissemination of urgent information as well as encouraging information sharing between organisations. It will also give patients and their carers greater confidence that the NHS is able to react quickly and rapidly to identified risks.

The Risk and Assurance Manager for Leicester's Hospitals ensures the recommended actions from these alerts are monitored, working closely with clinicians and managers to ensure these actions are implemented within prescribed timescales wherever possible.

There are currently two alerts for action in which the deadline for completion has passed. They are being actively managed at a local level and monitored by our Executive Quality Board and Quality Assurance Committee to ensure completion as soon as possible.

Table 1 below lists the status of NPSA alerts with an action date during 2013/14.

Alert reference	Alert title	Response	Deadline
NPSA/2009/PSA/004B	Safer Spinal (intrathecal), epidural and regional devices – Part B	Alert closed (superseded by NHS/PSA/D/2014/002)	1/4/2013
NHS/PSA/W/2014/001	Risk of hypothermia in patients receiving continuous renal replacement therapy	Complete	6/3/2014
NHS/PSA/W/2013/001R	Placement devices for nasogastric tube insertion DO NOT replace initial position checks	Complete	8/1/2014
NHS/PSA/W/2013/001	Placement devices for nasogastric tube insertion DO NOT replace initial position checks	Action not required	8/1/2014

Table 2 shows ongoing NPSA alerts prior to 2013/14

Alert reference	Alert title	Response	Deadline
NPSA/2008/SPN14	Right Patient, Right Blood (Update)	Ongoing	1/5/2010

2 Never events 2013/2014

We have a strong reporting culture for patient safety incidents to ensure lessons are learnt whenever possible. Never Events are serious, largely preventable patient safety incidents that should not occur where the available preventative measures have been implemented.

During the period 2013/14, three incidents that met the definition of a Never Event were reported by Leicester's Hospitals. In all cases a thorough Root Cause Analysis was undertaken with robust action plans developed to prevent further similar occurrences.

The following table shows a description of the reported Never Events together with the primary root causation and key recommendations to prevent reoccurrence. None of the incidents resulted in long term harm to the patient and they were all involved with and kept fully informed during the subsequent investigations.

Never Event 2013/2014	Description	Key Findings Following Recurrence	Key Actions to Prevent Recurrence
Wrong Knee Implant April 2013	Prosthesis for a right sided procedure rather than for a left sided procedure was inadvertently implanted into a patient's knee.	Selection of the incorrect prosthesis from the Store Room. Failure of the checking process to ensure that the correct prosthesis had been selected (there was one incomplete check and then no further checks prior to the prosthesis being implanted). Staff being pre-occupied, interrupted or distracted by other tasks.	To review the signage within the Store Room to indicate shelf placement of Left and Right prostheses. To amend the Management of Surgical Swabs, Instruments, Needles and other Accountable Items within the Operating Theatre Policy and Procedures (2013) in respect of the prosthesis checking section to clarify that: (i) there must be a second, separate check; (ii) LEFT or RIGHT must be stated where applicable and; (iii) the details of the implant must be read out loud by the Scrub Practitioner and Surgeon whilst the rest of the team stop and listen. To re-enforce to staff what is meant by the prompt in ORMIS: 'Insertion of implant, prosthesis, plate or screw – pause and double check by surgeon and scrub'. To implement an education / change of practice campaign to encourage pausing and double checking of a prosthesis prior to cementing into a patient, by the following: Placing a laminated poster in a high visibility area in Orthopaedic Theatres: 'Check before you cement'! & sending an electronic version of the poster to all surgeons and theatre staff. Re-launch of the 'Caring at its Best Theatres Etiquette' package for all staff to complete, to re-enforce the key messages from this incident. Listening into Action project: 'Team Work is Safe Work' to be rolled out in Orthopaedic Theatres.

2 Never events 2013/2014

Never Event 2013/2014	Description	Key Findings Following Recurrence	Key Actions to Prevent Recurrence
Wrong Lens September 2013	An intraocular lens with a power of +24.5 dioptres instead of +21.0 dioptres was inadvertently implanted into the patient's eye.	Inefficiency of the pre-operative systems leading to an increased workload. Human error led to the incorrect lens being selected by the Consultant Ophthalmologist after misreading her handwritten additions to the Theatre List on the wall in Theatre. Weakness of the checking process at the lens selection stage to ensure that the correct prosthesis was taken into Theatre.	Continue to implement the actions contained within the actions contained within the Ophthalmology Action Plan and to progress in line with the recommendations outlined by the Clinical Problem Solving Group (CCG/UHL). To formally notify surgeons that the practice of handwriting the power of lens on the Theatre list must cease. To use the electronic UHL Cataract Waiting List Form to ensure that all information is captured pre-operatively so negating the need to make handwritten additions to the list. For the surgeon to check the biometry results in the anaesthetic room with another member of the theatre team, following which the lens details must be immediately transcribed on to the Theatre white board by the surgeon and the appropriate lens selected from the lens store by the surgeon. During the 'Time Out' phase of the Safer Surgery Checklist, there must be a further confirmation of the patient's biometry results by referring to the medical records. To amend and re-circulate the 'Intra Ocular Lens Protocol' to all staff working in Ophthalmic Theatres to include the two additional checks outlined in recommendations 2 & 3. Placing the revised laminated poster in a high visibility area in Eye Theatres Sending an electronic version of the poster to all surgeons and theatre staff.
Retained Swab February 2014	Vaginal swab retained following an instrumental delivery.	Following an instrumental delivery the episiotomy required suturing and this was commenced by a doctor and almost completed. The doctor was called to urgently assist with another patient in theatre and handed over to a midwife to complete the suturing but there is no evidence to confirm that a swab count was undertaken. Seven weeks post-natally there was on-going offensive discharge and a swab that had been placed in the vagina was removed.	A formal memo was immediately sent to all medical and midwifery staff reminding them of the requirement to undertake a count of all swabs and needles during and at the conclusion of any procedure, to document this on the white boards in the delivery rooms, and for this to be second checked and documented in the medical records.

2 How we keep everyone informed

Leicester's Hospitals has a wide range of communication tools to inform and engage our staff, patients and the wider public about our quality initiatives and service improvements.

We are transparent with the media when responding to complaints and negative issues and provide good news stories which are regularly featuring in local newspapers, radio and television.

Information for the public

We produce a bi-monthly magazine called Together for both staff and the public in which we profile good news, innovations, schemes and initiatives.

Our free 'Medicine for Members' health talks delivered by our leading medical experts each month were given a makeover for 2014 and re-branded 'Leicester's Marvellous Medicine'. To publicise the talks to a wider audience, information is now available online and shared through our social media accounts.

The communications team at Leicester's Hospitals manages several social media accounts such as Twitter, Facebook and Pinterest by which we can quickly and effectively share information and advice.

Along with input from our Patient Advisors and Graphics team, the communications team also monitors and produces all Patient Information leaflets and posters for our services to ensure the information we provide is accurate and accessible.

Our public website provides patients and visitors with information about our hospitals and services and we regularly issue press releases along with 'news alerts' for those who have signed up to receive notifications.

Information for staff

We have a staff intranet hosting a wealth of information, guidance and news specifically for our staff and regularly communicate information via email.

Our chief executive hosts monthly staff briefings for the senior leadership team. This information is then cascaded to members of frontline staff through CMG team meetings and newsletters as well as in the monthly all staff email called the 'Chief Executive's Briefing'.

Staff are also invited to attend monthly informal meetings called 'Breakfast with the Boss' where they can speak on a one-to-one level with our chief executive and another member of the senior team.

2 How we listen

Over the last year our public membership has grown to over 14,500 people. We engage with our members in a variety of ways.

Our bi-monthly Together magazine promotes opportunities for both the public and our staff to get more involved in the work we do with initiatives from teams such as volunteering and fundraising.

We send out opinion surveys giving everyone the opportunity to comment on our services as well as invitations to join specific engagement groups.

We recently met with members of our Prospective Governors group to talk about how it will function in the year ahead. As a result, we have decided to focus the group more explicitly on member engagement. Members will be invited to meet regularly with our senior team and discuss issues that are important to them, our Strategic Direction and the development of our services. For example, in March we invited reflections on our new two year Organisational Development plan put in place to develop the Trust and our services.

In December last year, our chief nurse Rachel Overfield held a special Listening Event to give members of the public time to talk about their recent experience of hospital care. Over fifty people came along to the event and met with both Rachel and members of her senior nursing team. One recurrent theme was raised around ophthalmology processes and as a result an improvement plan was put in place and complaints have since reduced.

We have been developing our relationship with Healthwatch Leicester; Healthwatch Leicestershire and Healthwatch Rutland. Healthwatch has a mandate to act as the consumer's voice in matters of health and social care. To ensure we understand the views and concerns of our local population, we have asked a Healthwatch LLR representative to sit on our Trust Board. Our chief executive also meets every three months with Healthwatch representatives to discuss local issues.

The patient and public voice is also represented at Leicester's Hospitals through our Patient Advisors. Over the last year we have recruited five more Patient Advisors, bringing the total to 16. This is the largest group we have had since we created the role in 2001. Patient Advisors are attached to each of our Clinical Management Groups and provide a lay perspective on many of our Boards and Committees.

2 How we listen

Theatre Arrivals Area – Leicester Royal Infirmary

The purpose:

The unit is designed to provide individual, holistic, multidisciplinary pre-operative care and services for adults undergoing a surgical procedure.

The Theatre Arrivals Area is part of the ITAPS Clinical Management Group, providing an admission consultation/examination rooms pre-operative waiting area before the patient is escorted to the Theatre anaesthetic room.

Specialties include:

- ENT
- Bariatric surgery
- Vascular surgery
- Max Fax
- General Surgery upper/lower GI
- Plastic Surgery
- Hand Trauma.
- Anaesthetics.

Benefits of our purpose built TAA:

- Patients have a definite destination for admission.
- Improved patients care pathway and experience.
- A tranquil and calm environment for patients.
- TV and non TV waiting areas.
- Comply with Trusts Privacy and Dignity policies and procedures.
- Compliance with single sex accommodation.
- Bariatric facilities and equipment
- Disabled access and facilities throughout TAA
- Increased theatre efficiency, theatre list start times and Improved theatre flows.
- Improved patient flow, avoiding mixing of pre and post-operative patients.
- Ability to support 10 elective theatres.
- Reduction in the number of cancelled elective procedures.
- Addresses infection prevention and control risks
- Reduces staff stress on both wards and theatres
- Reduces the need for portering staff
- Improves and reduces medical staff time and as the TAA is within the theatre complex.
- Meet CQC requirements and standards.

Our Philosophy of Care.

Our aim is to promote and maintain a safe, calm and caring environment for our patients by using a patient focused approach to pre-operative care, aimed at meeting all physical, psychological, social and spiritual needs by using the 6 elements of compassion as follows:

Care – staff promote the individuals independence to enhance their recovery and health and well being.

Compassion – care and support is delivered with empathy, kindness, respect and dignity including cultural, religious and ethnic beliefs.

Competence – TAA staff have the knowledge and skills to carry out their role, delivering individual, holistic and research based, patient centred care.

Communication – staff have good communication and listening skills, promote shared decision making, team working involving the Multidisciplinary team.

Courage – staff act as the patients advocate by speaking up and addressing patient concerns.

Commitment – The team is committed in delivering excellent quality care, inline with the UHL's Nursing Strategy.

Measurement of care through Audit and surveys:

- Patient Surveys – involving Patient Advisor
- Environmental Audits – Clinical and Domestic Services
- Postcard to Matron
- Privacy and Dignity Audits
- Infection Prevention and Control including Hand Hygiene Audits.

Nursing Metrics care indicators:

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

2 How we listen

Theatre Arrivals Area – Leicester Royal Infirmary

Before the TAA project:

- 6 curtained cubicles, poor privacy and dignity
- 2 curtained exam consultation rooms
- Too small male and female waiting areas
- 20 chairs in total – insufficient for activity
- Patients walked down public corridor to theatre.
- Many complaints regarding poor facilities.

After the project:

- Reception and waiting area
- 6 exam consultation rooms fully equipped
- 20 admit rooms maintaining privacy and dignity.
- Large area with seating for 40 patients
- Patient designated corridor to walk to theatre
- Compliance with CQC and single sex accommodation.
- Patients more comfortable and happy with environment, facilities.

Old TAA Reception, cubicles and small waiting area.

New TAA Reception

New Waiting area prior to surgery.

The Unit now provides our patients with:

- An holistic, individualised, multidisciplinary approach to their care.
- A safe, secure and relaxing environment
- A calm environment specifically designed to promote a speedy, comfortable admission procedure, enabling patients to wait in comfortable, purposeful surroundings.
- A quality service and a high standard of care in response to the individual needs of our patients by a team of multi-skilled staff.
- TAA allows and assist's the Surgical Specialties / wards to focus on post-operative patient care.
- TAA provides the privacy, dignity and confidentiality at all times.

Patients new Journey in TAA:

•Patient is welcomed in reception and personal details checked – systems updated and new documentation printed if required.

•Asked to take a seat in reception waiting area.

•Nurse collects patient and takes them into a suitable admission/consultation room.

•Nursing assessment and documentation including explanation in detail of their journey.

•Assessed by surgeon and if applicable anaesthetist.

•Physically prepared for surgery.

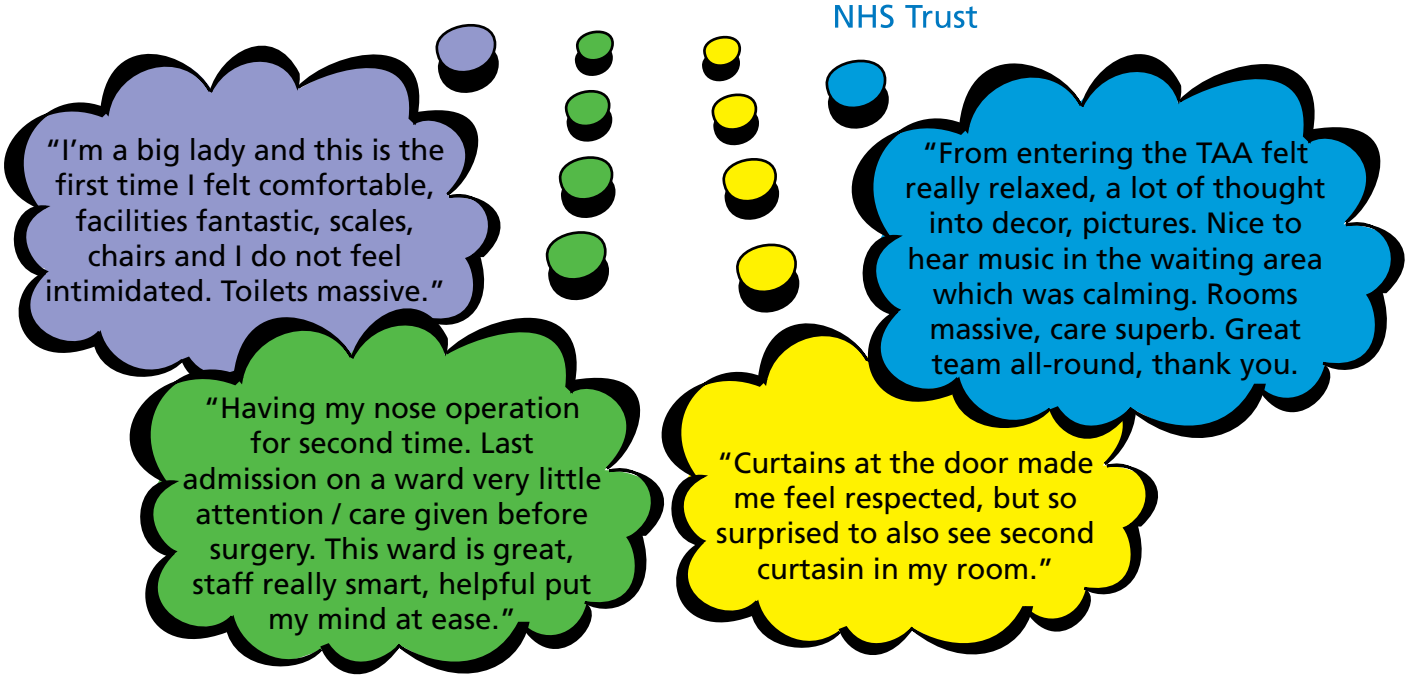
•Encouraged to take a seat in the pre surgery waiting area.

•Escorted to theatre by TAA admitting nurse or nursing / ODP team.

2 How we listen

Theatre Arrivals Area – Leicester Royal Infirmary

Patient feedback about new TAA - March 2014



2 What do our patients tell us?

We receive feedback from a variety of sources and use this to improve our services. The sources include the Friends and Family Test, patient experience surveys, patient complaints and compliments, social media, NHS choices, Patient Opinion and 'Message to Matron'.

Friends and Family Test

Our patients are asked to complete the Friends and Family Test, asking them 'How likely is it that you would recommend this ward to friends and family if they needed similar care or treatment?' Results of the Friends and Family test so far indicate:

- The adult inpatient Friends and Family Test score has shown clear and consistent improvement from a score of 66.4 in April 2013 to a score of 69.9 in March 2014.

	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
UHL	66.4	73.9	64.9	66.0	69.6	67.6	66.2	70.3	68.7	71.8	69.0	69.9

- Data collected between February - May 2013 across all eight wards taking part in the Quality Mark for Elder-Friendly Hospital Wards scheme, identified that patients reported they were treated with dignity and respect and seven of the eight wards had a score of more than 75 points on the Friends and Family Test.
- A number of initiatives including introducing adaptive cutlery and dignity cups are being implemented to help promote dignity on older people's wards.

Patient Stories

The trust encourages patients to share their stories and experiences of care. It has been found that patient's stories can be very powerful in assisting clinical teams in learning from the experiences of patients, their families and carers. Stories are used in a number of forums to prompt discussions and improvements, for example every month the Trust Board hear 'Patient Story', these are presented by the clinical teams who describe the actions taken following the feedback.

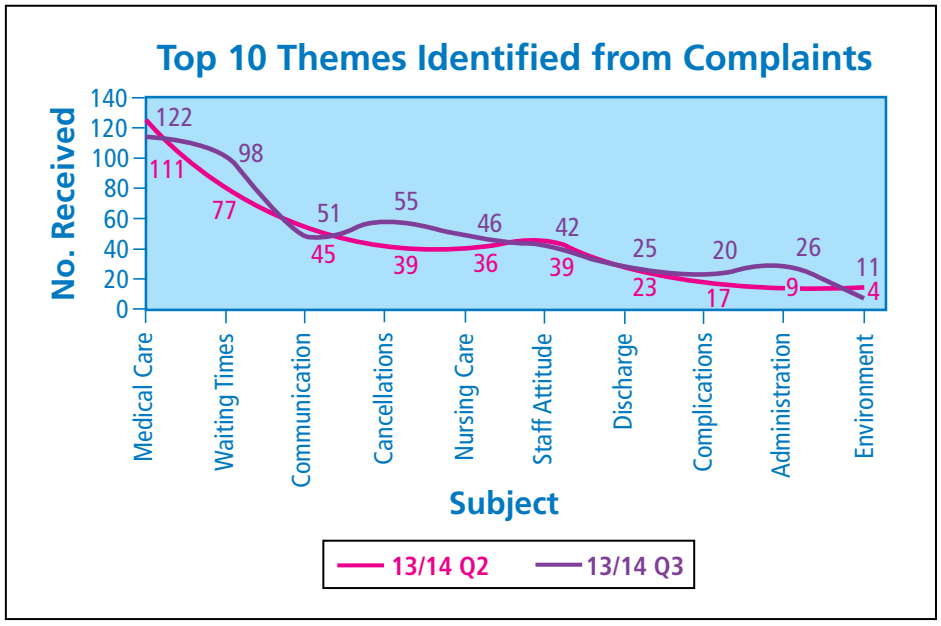
During 2013/14 a monthly story has been shared at the Trust Board and these have ranged from acupuncture services, end of life care experience, the poor experiences of a new mother, through to meaningful activities for patients with dementia, care of a frail older person following a hip fracture and the experience of care within the Emergency Department.

2 What do our patients tell us?

Learning from Complaints

Complaint data is recorded against the clinical management groups (CMGs).

The CMGs performance is monitored against providing a response to the complainant within 25 days (target is 95%). The complaints are themed according to the nature of the complaints as shown below.



The following are some examples of learning from complaints.

Complaint/Concern Raised	Agreed Action
Concerns relating to the administration of morphine.	Existing care plan to be reviewed with input from Consultant in Pain Management. Care plan to be shared with the patient when it is completed.
Concerns relating to management of medication.	Correct inaccuracies identified by patient in the clinical correspondence. Head of Service to discuss discrepancies with Consultant for learning purposes.
Patient took an accidental overdose as did not realise drug he was given on discharge under the generic name was the same drug as he was already taking under the brand name.	Highlighted to Emergency and Specialist wards via complaint newsletter that for patients on short admissions only new medications should be supplied on discharge, as per TTO. Issue and correct practice highlighted to all staff on ward 33.
Fracture clinic waiting times	New information board devised which provides clear indication for each time slot whether patient has been seen and if they have left the department. Patients can at a glance see how many are ahead of them in the system, in real time.

3 Our plans for the future "Caring at its best"

Delivering Caring at its Best includes a whole range of programmes, from the Quality Commitment to our reconfiguration plans, from our IM&T Strategy to Listening into Action. The Quality Commitment has been updated for 2014/15 and the following priorities have been agreed.

The Quality Commitment has been updated for 2014/15 and the following priorities have been agreed.

OUR QUALITY COMMITMENT

	Provide Effective Care – Improve Patient Outcomes	Improve Safety – Reduce Harm	Care and Compassion – Improve Patient Experience
AIM	To deliver evidence based care/best practice and effective pathways and to improve clinician and patient reported outcomes.	To reduce avoidable death and injury, to improve patient safety culture and leadership and to reduce the risk of error and adverse incidents.	To listen and learn from patient feedback and to improve patient experience of care.
2014/15 PRIORITIES	**Implement pathways of care to improve outcomes for patients with** • Community Acquired Pneumonia • Heart failure • Acute Myocardial Infarction (AMI) • Acute Kidney Injury (AKI) **And for** • Out of hours emergency admissions • Intraoperative Fluid Management (IOFM) **Implement actions to meet the National "7 Day Services" clinical standards** **Embed monitoring of clinician and patient reported outcomes across all specialities to include learning and action from:** • Mortality Reviews and Mortality Alerts • Nationally reported outcomes (Everyone Counts) **Implementation of:** • Patient census to improve discharge planning • Consultant assessment following emergency admission • Clinical utilisation review of critical care beds • Breats feeding guidelines for neonates **Embedding best practical:** • Implementation of NICE and other national guidance • Compliance with local policies and guidelines • Performance against national clinical audit	**Implementation of Safety Actions:** • Recognition of immediate management of septic patients • Handover between clinical teams • Acting on test results • Monitoring and escalation of Early Warning Sores (EWS) • Ward Round Standards and Safety Checklist Improve processes relating to resuscitation and 'Do Not Attempt Cardio-Pulmonary Resuscitation' (DNA CPR) consideration **Embed use of Safety Thermometer for monitoring actions to reduce:** • Hospital Acquired Thrombosis (HAT) • Hospital Acquired Pressure Ulcers (HAPUs) • Catheter Associated Urinary Tract Infections (CAUTIs) • In-hospital Falls Implement use of the Medication Safety Thermometer across all wards **Patient Safety Collaborative Topics** • Reduction of Health Care Associated Infections • Meeting Patient's Nutrition and Hydration needs • Safer care for patients with Diabetes (including implementation of Think Glucose Programme)	**Actively seek views of patients across all Services** **Improve the experience of care for older people** • Implement recommendations from national quality mark across all older people's areas • Improve/continue positive feedback across CMGs **Improve experience of carers** **Improve experience of care for patients with dementia and their carers** • Dementia implementation plan **Expand current programme of end of life care processes across Trust** **Triangulation of patient feedback** • Including complaints, NHS Choices, Patient Surveys Embed best practice relating to "Named Consultant / Named Nurse"

SUPPORTING WORK PROGRAMMES

Organising Learning, Culture & Leadership | Staff Numbers, Skills & Competence | Audit & Measurement | Systems & Processes

Depicts inclusion in CQUIN programme | Depicts inclusion in quality schedule | Depicts compliance action/national priority

Provide Effective Care – Improve Patient Outcomes

The aim is to deliver evidence based care/best practice and effective pathways and to improve clinician and patient reported outcomes by delivering the following:

- Improving pathways of care to improve outcomes for
  - Patients with pneumonia, heart failure, acute myocardial infarction (AMI), acute kidney injury (AKI)
  - Patients admitted out of hours
  - Improving intraoperative fluid management for surgical patients
  - Working towards the national "seven day services" to improve quality and access to care
- Embedding monitoring of clinician and patient reported outcomes across all specialties to include learning and action from
  - Mortality Reviews and Mortality Alerts
  - Nationally reported outcomes (Everyone Counts)
- Implementation of
  - A patient census to improve discharge planning
  - Consultant assessment following emergency admission
  - Clinical utilisation review of critical care beds
  - Breast feeding guidelines for neonates
- Embedding best practice including
  - Compliance with NICE standards in 2014/15
  - Reviewing performance against national clinical audit

3 Our plans for the future "Caring at its best"

Improve Safety – Reduce Harm

The aim is to reduce avoidable death and injury, to improve patient safety culture and leadership and to reduce the risk of error and adverse incidents by delivering the following:

- Improving patient safety by
  - Improving earlier recognition of sepsis and ensuring compliance with the Sepsis Care Bundle
  - Providing a systematic, safe and effective handover of care
  - Ensuring all results are reviewed and acted on in a timely manner
  - Improving the care delivery and management of the deteriorating patient
  - Providing timely senior clinical reviews, and to set minimum standards for ward rounds and documentation to meet national guidance
  - Improving resuscitation and 'do not attempt resuscitation' (DNAR) processes
- Collecting data on all elements of the patient safety thermometer to prevent and reduce harm including
  - Hospital acquired thrombosis (HAT)
  - Hospital acquired pressure ulcers (HAPUs)
  - Urinary tract infections in patient with a catheter (CAUTIs)
  - In-hospital falls
  - Medication safety
- Increasing education and awareness of
  - Health care acquired infections (HCAI) such as MRSA
  - Nutrition and hydration to prevent avoidable weight loss and dehydration
  - 'Think Glucose' a programme to improve the management of patients with diabetes as a secondary diagnosis.

Care and Compassion – Improve Patient Experience

The aim is to listen and learn from patient feedback and to improve patient experience of care by:

- Actively seeking the views of patients across all services
- Improving the experience of care for older people by
  - Implementing recommendations from the national Quality Mark across all older people's areas
  - Improving on positive feedback across clinical management groups (CMGs)
- Improving the experience of carers
- Improving the experience of care for patients with dementia and their carers by
  - Ensuring patients aged 75 and over are screened for dementia and referred to appropriate services
  - Ensuring sufficient clinical leadership and training of staff
- Expanding the current end of life care programme across the Trust
- Triangulating patient feedback including complaints, compliments, NHS Choices, and Patient Surveys
- Introducing a named consultant and named nurse who will be accountable for care throughout a hospital stay

Monitorting

Appendix 1 shows how each programme maps to one of our Executive Boards which is supported by a Programme Management Office (PMO). In conjunction with their Executive lead, the PMO will be responsible for ensuring an appropriate level of rigour and standardisation for their Delivering Caring at its Best work programmes.

4 Statements of assurance from the board

Review of Services

During 2013/14 University Hospitals of Leicester NHS Trust provided and / or sub-contracted 395 NHS services. These include:

- Inpatient = 68 specialties
- Day case = 60 specialties
- Emergency = 75 specialties
- Non-elective = 51 specialties
- Outpatient = 83 specialties
- Non Face to Face appointments in 20 specialties
- Out Patient Procedure services in 18 specialties
- Emergency Department and Eye Casualty
- Direct access to 7 services
- Critical care services in Cardiac Intensive Care Unit (CICU), High Dependency Unit (HDU), Intensive Therapy Unit (ITU), Post Anaesthesia Care Unit (PACU), Paediatric Intensive care Unit (PICU), Special care Baby Unit (SCBU) and Neonatal Intensive Care Unit (NICU)
- 4 national screening programmes = retinal screening (diabetes), breast screening including age extension (cancer) bowel screening (cancer) and abdominal Aortic Aneurism AAA (vascular)

The University Hospitals of Leicester are three acute hospitals, the Leicester Royal Infirmary having approximately 963 beds, the Leicester General Hospital (LGH) having 394 beds and Glenfield Hospital having 416 beds. Each hospital has its own specialty. The Leicester Royal Infirmary has the only Accident and Emergency Department, which covers the area of Leicester and Leicestershire. The Leicester General has the Renal Unit and Glenfield has the Cardiac Surgery Unit.

The University Hospitals of Leicester NHS Trust has reviewed the data available to them on the quality of care across the seven clinical management groups.

The income generated by the NHS services reviewed in 2013/14 represents 100% per cent of the total income generated from the provision of NHS services by Leicester's Hospitals for 2013/14.

4 Statements of assurance from the board

Examples of how we reviewed our services in 2013/14

In the last year we have reviewed and strengthened our assurance systems and the work programme of our Quality Assurance Committee. An Executive Quality Board has been introduced and has a number of sub-committees reporting to it, including:

- Mortality Review Committee
- Infection Prevention Assurance Committee
- Safeguarding Committee
- End of Life Committee
- Clinical Ethics Committee
- Clinical Audit Committee
- Health and Safety Committee
- Hospital Transfusion Committee
- Learning from Experience Group
- Medicines Optimisation Committee
- Mortality Review Committee
- New and Innovative Procedures Authorisation Group
- Organ Donation Committee
- Patient Experience Committee
- Resuscitation Committee
- Thrombosis Committee
- Consent Committee

These groups in addition to the Executive Workforce Board, Executive Team and Trust Board, review, monitor and act upon a variety of service level information including (but not exclusively):

- Quality and Performance report
- Ward Performance data
- Patient Safety data
- Quality Schedule and CQUIN indicators
- Safety Thermometer performance
- Patient Experience data (Friends and Family Test, complaints, patient stories)
- Service dashboards
- Results from external peer reviews and accreditations
- Staffing levels
- Operational performance – outcome measures
- Participation in statutory and mandatory training
- Clinical Audit data
- ompliance with the WHO theatre checklist

Participation in Clinical Audits and confidential enquiries

Leicester's Hospitals has a very active clinical audit programme as we know participation in clinical audit is an effective way of monitoring and improving patient care.

Part of the programme includes national clinical audits largely funded by the Department of Health (DH) 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 DH with advice from the National Advisory Group on Clinical Audit and Enquiries (NAGCAE) formerly known as National Clinical Audit Advisory Group (NCAAG).

During 2013-14, Leicester's Hospitals participated in 95% (n=40/42) of national clinical audits and 100% (n=3/3) national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquires that we participated in, and for which data collection was completed during 2013-14 are listed in Appendices 2.1 and 2.2 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).

The reports of 37 national clinical audits and 385 local clinical audits were reviewed by the provider in 2013-14. The results are reviewed at Clinical Management Group Quality Meetings, the Clinical Audit Committee and the Executive Quality Board. All completed audits have an audit planner which includes details of actions required for improvement. These are available to all staff on the intranet.

Appendix 3 provides some examples of these audits and the improvements made to patient care in 2012/13 made as a result.

4 Statements of assurance from the board

Participation in clinical research

The number of patients receiving NHS services provided by or subcontracted by University Hospitals of Leicester NHS Trust in 2013/14 that were recruited to participate in research approved by a research ethics committee.

University Hospitals of Leicester NHS Trust was involved in conducting 920 clinical research studies.

Of these 612 (59%) were adopted and 308 (41%) non-adopted. 220 (24%) of the total were commercially sponsored studies.

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

23% of the studies given approval were established and managed under national model agreements.

In 2013/14 the National Institute for Health Research (NIHR) supported 612 (59%) of the total number of research studies through its research networks.

In 2013/14 there were 323 full papers published in peer reviewed journals.

Goals agreed with commissioners: Use of the CQUIN payment framework

A proportion of Leicester's Hospitals income in 2013-14 was conditional on achieving quality improvement and innovation goals agreed between Leicester's Hospitals and the Commissioners, through the Commissioning for Quality and Innovation payment framework (CQUIN).

For 2013/14 the baseline value of the CQUIN was £14.3m for acute services (i.e. 2.5% of contract value). This means that when Leicester's Hospitals agreed contracts with commissioners it was agreed that 2.5% of contract value would be received upon achieving certain quality indicators. If these quality indicators were not met or the outturn contract value was lower than the baseline contract, then the monies would be withheld.

For 2013/14 we received sign off by the Primary Care Trust for 99% achieved (payment rate of 2.47%) of CCGs CQUIN monies and 100% achieved (payment rate of 2.5%) specialised CQUIN monies.

Further details of the agreed goals for 2013/14 and for the following 12 month period are available electronically on our website: http://www.leicestershospitals.nhs.uk/

In addition to the CQUIN programme, quality of care is also monitored through our Quality Schedule. Two of our Quality Schedule indicators, fractured neck of femur and stroke, are linked to the Best Practice Tariff (BPT). BPTs were introduced in April 2010 in an effort to adequately fund the costs of best practice and to improve performance in selected high-volume clinical treatments in the NHS. BPTs aim to reduce unexplained variation in clinical quality and ensure that best practice is widespread.

Different BPTs have different aims, designed to either:

- change the setting of care, for example from inpatient to day case;
- streamline the pathway of care, for example by reducing the number of outpatient appointments following surgery; or
- increase the provision of high-quality care based on the best evidence available, for example by encouraging trusts to treat patients in a designated stroke unit so as to increase the prospects of recovery.

In 2013/14 47% of patients achieved all seven criteria of the BPT for fractured neck of femur. There are plans in place to recruit additional ortho-geriatricians to help increase this further.

There has been an improvement in stroke performance through better access to stroke beds by 'ring fencing'. This ensures patients suffering a stroke are admitted to an appropriate bed, therefore improving quality of care.

4 Statements of assurance from the board

Data Quality: NHS number of general practice code validity

Good quality information underpins the effective delivery of patient care and is essential to improvements in the quality of care and for patient safety. Data that is accurate, timely and relevant supports efficient patient care and reduces clinical risk. Reliable information on all aspects of performance means planning of future services can be carried out with confidence.

Data quality is managed via an established set of routine daily checks, management reporting and audit.

Daily checks include:

- Researching the identity of all new patients and ensuring new registrations are not duplications of patient records that already exist. This includes checks on records with significant changes to information such as patient name, date of birth and address which are essential to assignment and verification of the NHS number for each patient. Patients with no number are typically overseas visitors or patients who were unable to provide reliable information during their hospital visit.
- Validation of General Medical Practice (GP) is undertaken, by comparing local data against national GP databases. Anomalies are amended to support good communication from the Trust and ensure accurate commissioning of activity. From December 2013 we have been running a scheme through LiA to raise awareness of accurate GP data collection for our patients every time they attend.

Management reports are regularly collated to feedback on data quality to frontline services using local and external sources.

A regular programme of audit is undertaken to review at least 300 patient records each month. This covers both outpatient and admitted patient data, comparing information held in the paper case notes to the electronic data collected. Validity checks on data show high compliance of national NHS code sets being accurately applied with local information systems.

4 Statements of assurance from the board

Leicester's Hospitals submits records to the Secondary Uses Service for inclusion in Hospital Episode Statistics which are included in the latest published data. Data published by the Secondary Uses Service for the period April to December 2013 shows validity of data as follows:

		Leicester's Hospital
NHS Number	Admitted patient care	99.8%
	Outpatient care	99.6%
	Accident and Emergency care	98.3%

The hospital's local coverage of NHS Number is higher than these figures indicate as we do not submit any identifiable information such as NHS number for patients whose attendance data contains sensitive information to the Secondary Uses Services.

		Trust
General Medical Practice	Admitted patient care	100%
	Outpatient care	100%
	Accident and Emergency care	99.9%

		Leicester's Hospital
Ethnicity Code	Admitted patient care	100%
	Outpatient care	97.7%
	Accident and Emergency care	87.0%

Ethnicity data coverage in our Emergency Department is 100%. The Urgent Care Centre data included in the total is collected on a separate GP computer system managed as it is managed by George Eliot Hospital NHS Trust.

Data Quality is now included in the CQC Intelligent Monitoring reports and for Leicester's Hospitals this was scored as 'no evidence of risk' in 2014.

4 Statements of assurance from the board

Clinical coding error rate

Leicester's Hospitals was subject to the Payment by Leicester's Hospitals was subject to the Payment by Results (PbR) clinical coding audit during January 2014. The audit sample was 200 episodes (131 spells); 100 Admissions for Health Resource Group (HRG) sub chapter (Immunology, infectious diseases, poisoning, shock, special examinations, screening and other healthcare contacts) with specified level of complications and co-morbidities and 100 Admissions through HRG sub chapter WA with a primary diagnosis of R29.6 (tendency to fall not elsewhere classified).

The percentage of incorrect primary diagnosis in the sample of 131 spells was 34%. Due to the targeted nature of the PbR audits and the small sample of activity audited it is not recommended that these results be extrapolated further than the actual sample audited. However, they do provide information that will help both commissioners and providers decide if the controls over the accuracy of their activity data are adequate, as well as highlighting areas of concern they may wish to investigate further.

Information Governance Toolkit Requirement No. 11-505

1. a continuous clinical coding audit program comprising of several small audits undertaken throughout the year; or
2. a single one-off audit which should be undertaken every 12 months by an NHS Classifications approved clinical coding auditor

Leicester's Hospitals adheres to both of these requirements. From October 2013 there has been a dedicated Auditor in place. Audits of Dr Foster alerts including Deaths in Low Risk Mortality diagnosis groups and Misadventure rates are undertaken monthly.

Leicester's Hospitals will be taking the following action to improve data quality. The introduction of the site lead role implemented in October has improved localised expert support, closer management of staff and improved team communication. More time spent with clinicians will ensure that complete information to support coding is documented.

Information Governance Attainment Tool Kit Attainment Level 2013/14

The Trust continues to deliver improvements in the level of compliance with the performance standards set in the annual information governance toolkit, building on positive work in the last three years. Improvements have been delivered across all three hospital sites including; updating policy guidance, training all staff as part of our mandatory programme and introducing new approaches to promoting 'privacy and security awareness'.

Our 'Privacy by Design' strategy aims to enhance the security of all our services and the information used to deliver them, leading to improvements in:

- Patient confidentiality via greater focus on awareness-raising amongst key staff groups;
- Knowledge management practices to improve management of key corporate information across services;
- Employee training, development and mentoring to raise information literacy.

Our Information Governance Assessment Report overall score for 2013/14 was 83% and was graded green indicating that it was satisfactory.

4 Statements of assurance from the board

What others say about Leicester's Hospitals NHS: Statements from the Care Quality Commission (CQC)

Leicester's Hospitals is required to register with the Care Quality Commission (CQC) and its current registration status is registered without conditions.

The CQC has not taken enforcement action against Leicester's Hospitals during 2013/14.

We were one of the first Trusts to be inspected under radical changes introduced by the CQC, designed to provide a much more detailed picture of care in hospitals than ever before.

An inspection team including doctors, nurses, hospital managers, trained members of the public, CQC inspectors and analysts, visited Leicester Royal Infirmary, Leicester General Hospital, Glenfield Hospital and St Mary's Birth Centre in January 2014.

The team visited our hospitals as part of an announced inspection and examined the care provided in accident and emergency (A&E), medical care (including older people's care), surgery, intensive/critical care, maternity, children's care, end of life care and outpatients.

Overall, the report concludes that we are providing services that are safe, effective, responsive, caring and well-led; however, there were some areas for improvement.

As a trust, we have been rated as 'good' in three out of five areas and 'requires improvement' in two, equating to an overall rating of 'requires improvement'.

University Hospitals of Leicester NHS Trust	
Are acute services at this Trust safe?	Requires improvement
Are acute services at this Trust effective?	Good
Are acute services at this Trust effective?	Good
Are acute services at this Trust responsive?	Requires improvement
Are acute services at this Trust well-led?	Good

At a site level there are individual reports and ratings which equate to the following:

Leicester Royal Infirmary	Requires improvement
Leicester General Hospital	Requires improvement
Glenfield Hospital	Good
St Mary's Birth Centre	Good

Inspectors made a number of positive findings during their visit and, feedback overwhelmingly showed that our staff are caring.

We have an extensive team of specialist midwives who offer support and care to more vulnerable members of the community.

At Glenfield Hospital, we have a quiet room and sitting room reserved for relatives of people being treated in the intensive care unit. As the unit provides care and treatment for people from across Leicestershire, there is also display giving details about local amenities and facilities.

Action had also been taken as a result of a clinical audit, to enhance the experience of patients across the Trust.

4 Statements of assurance from the board

However, the inspection found some areas where improvements were needed.

For example the CQC have advised that; we review resuscitation practice and equipment to ensure the safety of patients; ensure all staff adhere to infection prevention control and practices; and dirty equipment was found in some medical wards.

Staffing issues were also highlighted in the report. We need to ensure we have an appropriate number of suitably qualified staff available. However, we had a recruitment plan in place prior to the inspection and continue to recruit to fill vacancies our own staffing review has identified.

The inspectors asked us to ensure staff receive the training and support they need which is appropriate to their roles.

The CQC also noted that some areas of our buildings need attention for example, some rooms were seen to be too small; access was difficult to one particular area; and a roof was leaking at the time of the inspection.

Leicester's Hospitals intends to take the following action to address the conclusions or requirements reported by the CQC by working with our partner's to agree an action plan and address the compliance actions by the end of April 2014.

Full copies of the CQC reports can be found on our website www.leicestershospitals.nhs.uk/aboutus/performance/care-quality-commission/

or by visiting www.cqc.org.uk.

CQC Outlier Alerts

The CQC mortality outliers programme looks at patterns of death rates within NHS Trusts. The programme focuses on:

- death rates in NHS trusts
- changes and trends over time
- the deaths of people with specific diseases and those undergoing surgery

Leicester's Hospitals receive an alert if the number of deaths is much higher than normal. However, increased death rates don't always mean that there is a problem with the quality of care provided.

Leicester's Hospitals have received two CQC outlier alerts in 2013/14; one in relation to a maternity indicator (the rates of puerperal sepsis and other puerperal infections within 42 days of delivery) and the other in relation to coronary artery bypass grafts (CABG).

4 Statements of assurance from the board

Puerperal Sepsis

In August 2013 the CQC notified Leicester's Hospitals that analysis of maternity indicators had indicated that rates of puerperal sepsis and other puerperal infections within 42 days of delivery at our Trust have remained significantly high since the previous alert for this indicator was closed in April 2012.

The following action was taken:

A case-note review, the review of audit data regarding serious septic illness and the review of audit data regarding post-caesarean section wound infection all confirmed good clinical outcomes and failed to identify any concerns regarding quality of care. However there were a number of issues identified that need to be addressed including:

- A need to improve coding of septic illness diagnoses to more accurately reflect the clinical diagnoses
- A need to validate and benchmark the data being collected with regard to severe septic illness on our E3 database
- A need to identify and implement at least one Quality Outcome Indicator to be included as a regular item on our maternity dashboard
- A review of pathways of care for women after discharge from hospital in conjunction with primary care colleagues

An action plan has been implemented and the CQC has now closed the alert.

Coronary Artery Bypass Graft (CABG)

The raised mortality alert for this group has been reviewed. All of the deaths which have contributed to this alert have been reviewed case-by-case at the Mortality and Morbidity meetings which are held monthly. No significant cause of concern in the management of these patients was identified. We have identified a query regarding coding and this has been discussed internally and with Dr Fosters Intelligence.

The Trust also regularly reviews its cardiac surgery outcomes using the data base provided by The Society of Cardiothoracic Surgery (NICOR). This calculates risk-adjusted mortality overall and in sub-groups using an adaptation of the 'EuroSCORE' model. The data for the period covered by the

Dr Foster Intelligence alert (2010/13) has now been published by The Society

of Cardiothoracic Surgery and has provided the Trust with further assurance about its cardiac surgery outcomes.

4 Statement of directors' responsibilities in respect of the quality report

University Hospitals of Leicester NHS
NHS Trust

The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content and annual Quality Accounts which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amendment Regulations 2011).

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

- The Quality Account 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, and is subject to appropriate scrutiny and review;
- The Quality Account has been prepared in accordance with Department of Health guidelines.

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

26 / 06 / 14 Richard Kilner, Acting Chair .....

26 / 06 / 14 John Adler, Chief Executive .....

5 Statements from our stakeholders and external auditors

The draft Quality Account was shared with the following stakeholders at the end of April 2014

- NHS Leicester City, East Leicestershire & Rutland and West Leicestershire Clinical Commissioning Group
- Leicester, Leicestershire and Rutland Healthwatch
- NHS England
- Health and Wellbeing Scrutiny Commission at Leicester City Council

Feedback has been received and included from NHS Leicester City, East Leicestershire & Rutland and West Leicestershire Clinical Commissioning Group, Leicester, Leicestershire and Rutland Healthwatch and Health and Wellbeing Scrutiny Commission at Leicester City Council.

As a result of the CCGs commentary amendments have been made to the Quality Account to address the five bullet points detailed in their commentary.

NHS Leicester City, East Leicestershire & Rutland and West Leicestershire CCG Statement for UHL Quality Account

The following statement has been prepared on behalf of the NHS Leicester City, East Leicestershire & Rutland and West Leicestershire CCGs for submission within the University Hospitals of Leicester Quality Account 2013/14.

We would like to take this opportunity to thank University Hospitals of Leicester NHS Trust (UHL) for inviting Commissioners to comment on the Quality Account for 2013/14 regarding the services provided to patients.

As acknowledged in the Chief Executive's opening statement there are challenges for the Trust across urgent and planned care, however, the CQC inspection recognised that staff are both caring and passionate about their work. The increased investment in the nursing establishment of £5.9m and the recruitment plan implemented is seen as a positive and decisive action by the Trust to improve the quality of care for the patients of Leicester, Leicestershire and Rutland. Commissioner quality monitoring visits have continued in 2013/14 and staff have continued to welcome commissioners to the areas visited and we have seen improvements in ward based areas.

It is, however, of concern to Commissioners to note that the Quality Account demonstrates that the Trust has not achieved all their priorities set for 2013/14. However we strongly support the Trust's focus on the UHL Quality and Safety Commitment for 2013 -15, to reduce mortality, avoid harm and patient centred care (dignity and respect). Of particular concern, is the continued challenge in ensuring access for patient across the emergency care and planned care pathways to ensure that UHL can fulfil the pledges to patients set out in the NHS Constitution.

During 2013/14 both Commissioners and the Trust remained focused on improvements required to improve patient experience and outcomes against the 62 day cancer waits pathway of care where we have seen much improvement with time to treatment for patients. Commissioners were encouraged to see continued progress in organisational learning across the Trust to prevent "Never Events" which reduced in number to 3 for 2013/14. Further embedding the learning from all serious incidents was identified within the "5 critical safety actions" work stream however this remains an on-going process and we are pleased to see this continuing in 2014/15. The challenge of ensuring embedding into practice for every practitioner remains a high priority to prevent similar incidents recurring and we feel this needs focussed attention

5 Statements from our stakeholders and external auditors

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

- The establishment / re-establishment within UHL of revised quality governance committees including Quality Assurance Committee, Mortality, Infection Prevention Control, Safeguarding, Workforce etc. which ensure greater scrutiny of the quality of care provided and describe the processes the Trust uses to establish assurance.
- The inclusion of details of CQC alerts received relating to puerperal sepsis and coronary artery bypass grafting and actions taken by the Trust in response.

- The inclusion of performance and actions to improve on areas subject to 'Best Practice Tariff' such as fractured neck of femur and stroke services.
- How the Trust plans to demonstrate progress to achieving the future quality and safety priorities and how these will be monitored and measured given the significant challenge across the emergency care and planned care pathways
- The use of patient stories can be very powerful and could be used to illustrate patient experience more effectively and it would be useful to describe how the Trust embeds the learning from these to improve clinical practice.

5 Statements from our stakeholders and external auditors

healthwatch

May 29, 2014

HW LLR Joint Response
UHL Quality Account 2013 - 2014

This is a joint response on behalf of Leicester City, Leicestershire and Rutland Healthwatches; we consider that the Quality Account for 2013/14 as a whole and the opening Statement from the Chief Executive in particular presents a very balanced picture, explaining exactly what is a Quality Account, and highlighting those things done well and those where performance has fallen short of expectations.

UHL have made much of their 'Quality Commitment', with three key strands of work - saving more lives, reducing avoidable harm and improving patient experience. There is more the Trust needs to do to understand the key drivers of mortality and further improve its mortality rates. UHL has done very well in tackling bed sores, falls and infections, especially clostridium difficicle and MRSA.

Whilst a marked improvement in the 'friends and family test ' is reported, the figure of 57.3% has to be seen against a national average of 67% and some way short of the very best (93.8%). There is clear evidence of an upward trend and the Chief Nurse can take credit for her focus on ward staffing levels with £5.9m being made available for additional recruitment. Media reports and information coming into Healthwatch though suggest some nursing staff still feel under great pressure to deliver a safe service of quality and there is not yet the necessary level of consistency to which everyone aspires.

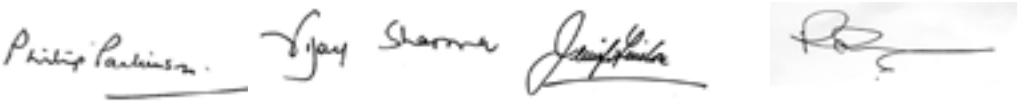
Emergency care remains the most urgent quality issue whilst the ophthalmology service too has struggled to keep up with demand. The Trust is implementing an improvement plan for the latter which us due to be completed by June 2014. Quality performance is reviewed in detail showing targets achieved or near plan and those behind plan. Out of Hours and discharge require more work to improve patient experience. We note the excellent work undertaken with people with dementia. The Trust did not achieve the threshold for 'referral to treatment' (ie 18 weeks) in all specialties.

Complaints look high but the learning taken from "What do patients tell us?" is encouraging and Healthwatch has been working with the Trust on the revision of its Complaints Procedure following the Francis and Clywd Hart reports.

Statements from our stakeholders and external auditors

During the year a new overall management structure has been introduced replacing 12 Clinical Business Units with seven smaller Clinical Management Groups. There is a much more encouraging feel about the organisation than a year ago and the "Listening into Action" initiative has been very well received.

The Chief Executive's Statement concludes with the quotation from the Chief Inspector of Hospitals following the CQC inspection in January, "We found that the University Hospitals of Leicester NHS Trust was providing services that were safe, effective, responsive, caring and well-led." The CQC recognised that more needed to be done in some areas and this is acknowledged in the Trust's Action Plan in response to the inspection. Healthwatch supports the work being done.



Philip Parkinson

Interim Chair of Healthwatch Leicester

(to 31st March 2014)

Vijay Sharma

Interim Chair of Healthwatch Leicestershire

(to 4th February 2014)

Jennifer Fenelon

Chair of Healthwatch Rutland

Rick Moore

Chair of Healthwatch Leicestershire

(appointed 5th February 2014)

healthwatch Leicester

healthwatch Leicestershire

healthwatch Rutland

5 Statements from our stakeholders and external auditors

9th June 2014

To:
Sharon Hotson, Director of Clinical Quality
John Adler, Chief Executive
University Hospitals of Leicester (UHL)

RE: UNIVERSITY HOSPITALS OF LEICESTER TRUST (UHL) - DRAFT QUALITY ACCOUNT 2013/14

Thank you for contacting the Health and Wellbeing Scrutiny Commission at Leicester City Council, to request comments on your draft Quality Accounts 2013-2014.

The Commission welcomed receiving UHL Quality Accounts last year and did provide comments. The Commission has just appointed a new membership this year 2014/15, therefore would like to take up your invitation to make a visit to the hospitals to see how services are provided.

We welcome your offer to attend the Health & Wellbeing Scrutiny Commission to present your current Quality Accounts; however, this has not been possible as the Commission has not met since April 2014. To inform you that the next meeting is planned to take place on 1st July 2014.

Many thanks,

Councillor Michael Cooke
Chair of Health and Wellbeing Scrutiny Commission
LEICESTER CITY COUNCIL.

5 Independent auditors report on annual quality account

To be inserted

5 Independent auditors report on annual quality account

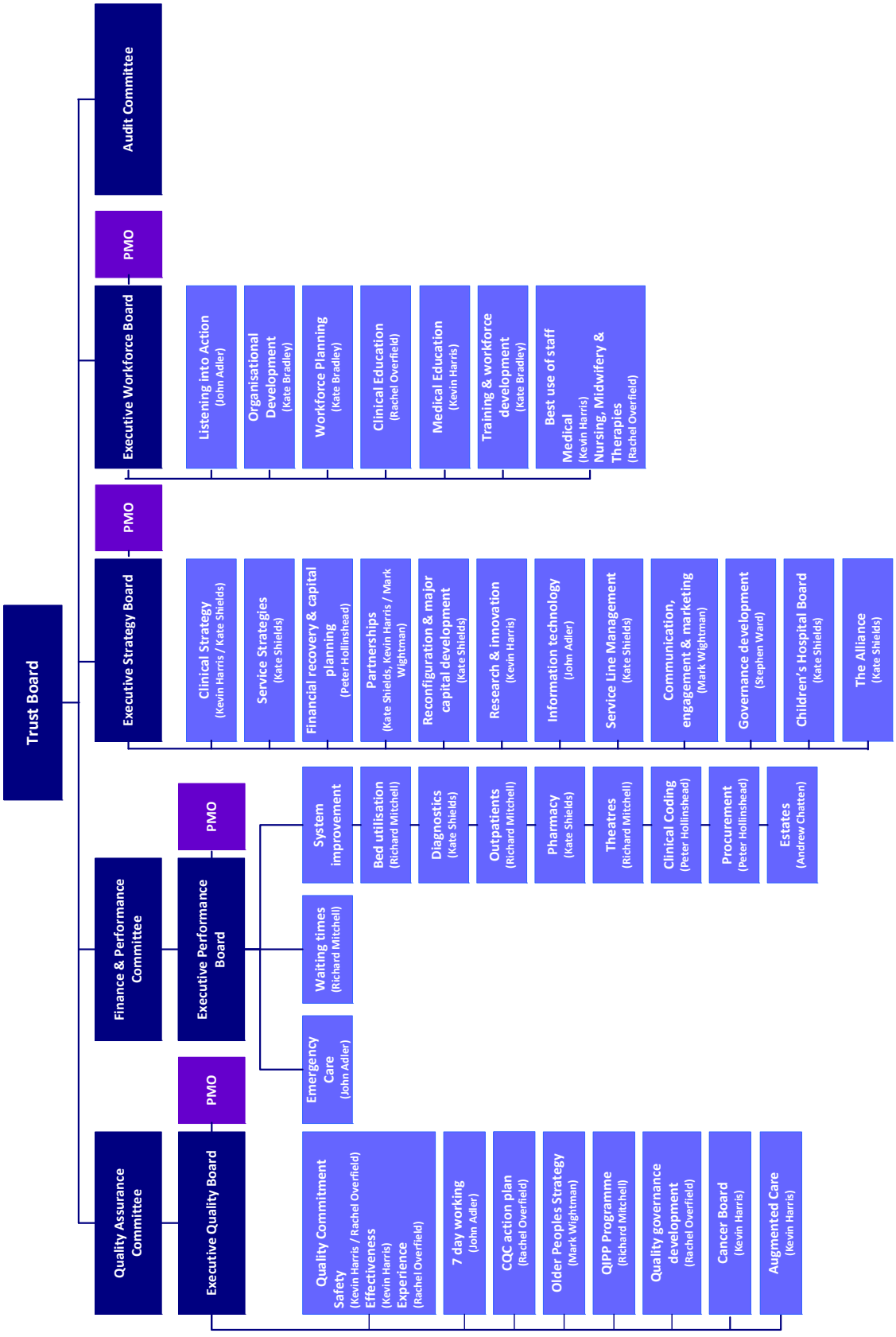
To be inserted

5 Independent auditors report on annual quality account

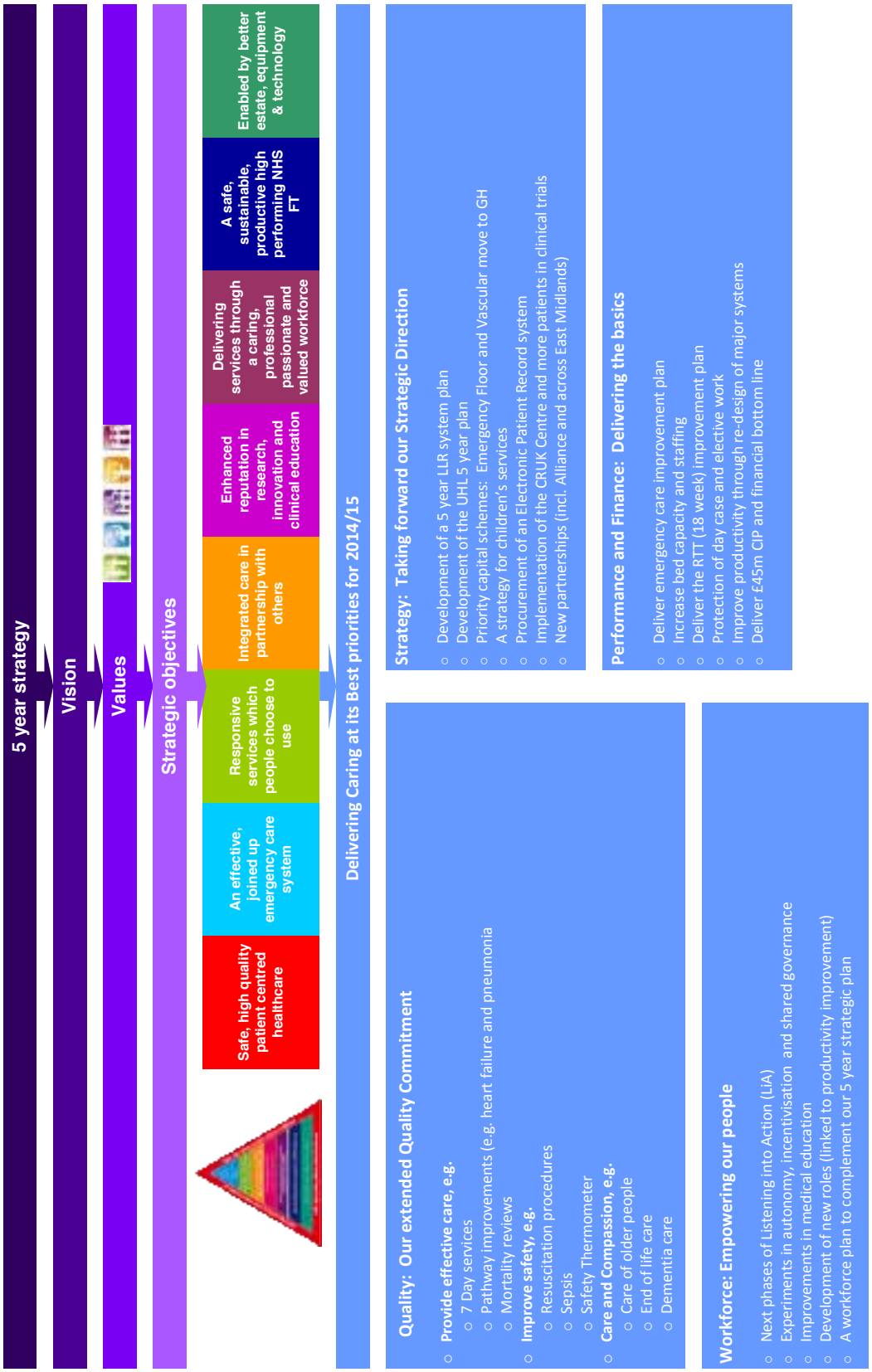
To be inserted

6 Appendices

6 Appendix 1
Caring at its best – structure



6 Appendix 1 continued Caring at its best - content



6 Appendix 2.1

Appendix 2.1 National clinical audits that Leicester's Hospitals was eligible to participate in during 2013/14

Category	Project Title	Did the Trust participate?	Percentage of Cases Submitted	UHL Ref No.
Acute	National Emergency Laparotomy Audit (2013/14)	Yes	Data collection ongoing	6306
Heart	Myocardial ischaemia (MINAP) (heart attack) (UCLH/NCASP) 2013/14)	Yes	Data collection ongoing	6323
Acute	Intensive Care National Audit & Research Centre (ICNARC) Casemix Programme 2013/14)	Yes	Data collection ongoing	6358
Acute	National Joint Registry (NJR) (BOA/Northgate) (2013/14)	Yes	Data collection ongoing	6369
Cancer	National Bowel Cancer Audit (NBoCap) (2012/13)	Yes	100%	6370
Cancer	National Lung Cancer Audit (NCLA) (RCP/NCASP) (2013/14)	Yes	Data collection ongoing	6372
Heart	National CABG and Valvular Surgery Audit (Adult Cardiac Surgery) (2013/14)	Yes	Data collection ongoing	6374
Heart	National Cardiac Rhythm Management Audit (Cardiac Arrhythmia) (2013/14)	Yes	Data collection ongoing	6375
Heart	National Congenitial Heart Disease Audit (Paediatric Cardiac Surgery) (2013 Activity) (2013/14)	Yes	Data collection ongoing	6376
Heart	Adult Cardiac Interventions National Audit (Coronary Angioplasty) (NICOR) (2013 Activity) (2013/14)	Yes	Data collection ongoing	6377
Heart	National Heart Failure Audit (CCAD) (2013/14)	Yes	Data collection ongoing	6378
Long term conditions	National Diabetes Audit (Adult) (2013/14)	Yes	100%	6379
Long term conditions	National Paediatric Diabetes Audit (2013/14)	Yes	Data collection ongoing	6380
Older People	Sentinel Stroke National Audit Programme (SSNAP) (2013/14)	Yes	Data collection ongoing	6384
Older People	National Falls and Fragility Fractures Audit (RCP) (2013/14) (includes National Hip Fractures Database (NHFD))	Yes	98-99% to NHFD	6387
Women's & Children's Health	National Neonatal Audit 2013 (NNAP) (RCPCH) (2013/14)	Yes	100%	6394
Women's & Children's Health	National Paediatric Intensive Care Audit Network (PICANET) (2013/14)	Yes	100%	6395
Long term conditions	BTS Bronchiectasis Audit (Children) (2013/14)	Yes	100%	6397b

6 Appendix 2.1 continued

Category	Project Title	Did the Trust participate?	Percentage of Cases Submitted	UHL Ref No.
Long term conditions	Chronic Obstructive Pulmonary Disease (COPD) (RCP) (2013/14)	Yes	Data collection ongoing	6398
Acute	Emergency Oxygen Audit (British Thoracic Society) (2013/14)	No - (2012 audits results for trust were excellent so service agreed re-audit not required)	None	6400
Women's & Children's Health	Children's Asthma Audit (College of Emergency Medicine/CEM) (2013/14)	Yes	Data collection ongoing	6401
Acute	National Audit of Seizure Management (NASH) (2013/14)	No - (audited not undertaken due to staff shortages – audit rescheduled for April 2014 locally)	None	6402
Women's & Children's Health	Paediatric Asthma Audit (BTS) (2013/14)	Yes	100%	6406
Acute	Paracetamol Overdose (CEM) (2013/14)	Yes	Data collection ongoing	6407
Cancer	National Prostate Cancer Audit (RCS) (2013/14)	Yes	Data collection ongoing	6408
Long term conditions	Renel Replacement Therapy (NHSBT) (2013/14)	Yes	100%	6409
Acute	Severe Sepsis and Septic Shock (CEM) (2013/14)	Yes	Data collection ongoing	6410
Acute	Severe Trauma Audit and Research Network (TARN) (2013)	Yes	100%	6411
Other	Hip 2013/14 Patient Reported Outcome Measures (PROMs)	Yes	Data collection ongoing	6855a
Other	Knee 2013/14 Patient Reported Outcome Measures (PROMs)	Yes	Data collection ongoing	6855b
Other	Groin Hernia 2013/14 Patient Reported Outcome Measures (PROMs)	Yes	Data collection ongoing	6855c
Other	Varicose Vein 2013/14 Patient Reported Outcome Measures (PROMs)	Yes	Data collection ongoing	6855d
Blood & Transplant	National Comparative Audit of Blood Transfusion Programme	Yes	Data collection ongoing	6818
Cancer	National Database for Head and Neck Cancer (DAHNO) (BAHNO/NCASP) (2013/14)	Yes	>95%	6338
Cancer	National Oesophago-Gastric (UGI) Cancer Audit (2013/14)	Yes	100%	6373

6 Appendix 2.1 continued and Appendix 2.2

Category	Project Title	Did the Trust participate?	Percentage of Cases Submitted	UHL Ref No.
Heart	National Cardiac Arrest Audit (2013/14)	Yes	Data collection ongoing	6071
Heart	National Vascular Registry (2013/14)	Yes	Data collection ongoing	6888
Long term conditions	Inflammatory Bowel Disease (IBD) (2013/14) (Paediatric and Adult)	Yes	100%	6160 (Adult 6139 Paed)
Long term conditions	National Audit of Rheumatoid and Early Inflammatory Arthritis (NCAPOP 2013/14)	Yes	Data collection ongoing	6739
Women's & Children's Health	Child Health Clinical Outcome Review Programme (CHR-UK) (2013/14)	Yes	100%	6430
Women's & Children's Health	National Paediatric Epilepsy Audit (Round 2 - 2012/14)	Yes	100%	6244
Mental Health	National Audit of Schizophrenia (NAS)	N/A	–	–
Mental Health	Prescribing Observatory for Mental Health (POMH)	N/A	–	–

Appendix 2.2 National confidential enquiries that Leicester's Hospitals was eleigible to participated in during 2013/14

Name of Audit / Confidential Enquiry	Did the Trust participate?	Percentage of Cases Submitted
NCEPOD Publication 'Measuring the Units' Alcohol related liver disease study	Yes	4 out of 6 questionnaires and 3 out of 6 notes
NCEPOD Publication 'Managing the Flow' Subarachnoid haemorrhage study	Yes	100% (7 out of 7)
NCEPOD Study Tracheostomy Data collection complete. Study not yet published	Yes	86% (42 out of 49)
MBRRACE-UK National Maternal, Newborn and Infant Review Programme (2013/14)	Yes	99% (113 out of 114)
Mental Health Clinical Review Programme National Confidential Inquiry into Suicide and Homicide for People with Mental Illness (NCISH)	N/A	–

6 Appendix 3

Examples of audits and the improvments to patient care as a result

This section gives some detail around the improvements to patient care that have occurred as a result of clinical audits undertaken within each of the 4 clinical divisions. For the purpose of this report a brief overview has been provided however each story has a reference number so if you would like any further details around the audit please contact Carl Walker, Clinical Audit Manager. Email: carl.walker@uhl-tr.nhs.uk

6 Appendix 3

Some like it Hot!

Anaesthetics team take the title for "Patient Warming" Audit.

This year's winner of the clinical audit competition was the Anaesthetics team for their re-audit of "Patient Warming and Perioperative Hypothermia" (#5922). The winning audit - chosen by votes of a panel of audit lead clinicians – was presented by the project lead, Dr Andrew Packham. An initial audit against the NICE guidance (CG65) had shown shortfalls so the team acted by trialling a new system (Inditherm Patient Warming - see NICE MTG7). An audit of the trial showed both an improvement in compliance with the NICE standards, and the potential for significant cost savings. The new equipment will now be introduced across the Trust, with repeated audits to ensure any problems are monitored and addressed.

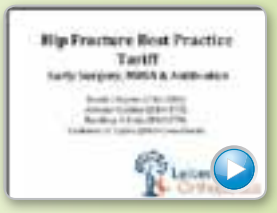
Each specialty put forward their winning audit which went into a Divisional round. Divisional winners were selected by the Divisional management teams. Each Divisional winner was then presented.

Acute Division

The Acute Division winner was the **Cardiology Team** for improvements made as a result of a long-standing national 'MINAP' audit (#6011). Martin Smith explained how the team had used the audit to challenge and change practice.

Planned Division

The Planned Division award went to **Orthopaedics** for their re-audit of 'Antibiotic Prophylaxis in Fractured Neck of Femur Patients'. The audit showed not only an improvement in care, but also the importance engaging colleagues rather than simply changing policy (#5717)



Women's & Children's Division

The Women's and Children's Division winner was an audit of 'Access to Familial Cancer Susceptibility Clinics' - a very newsworthy subject given the recent publicity for Angelina Jolie's decision after discovering her familial cancer risk (#5821)

6 Appendix 3

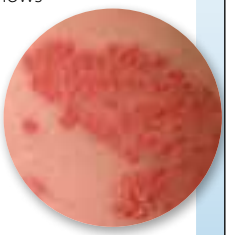
Clinical Audit Successes within the Acute Care Division

Dermatology:

A previous audit in several aspects of ciclosporin monitoring and management of complications had showed deficiencies when compared with the standards set by guidelines.

The implementation of a simple measure (using a ciclosporin sticker in the case notes) has resulted in a very significant improvement in departmental practice. The results of the current audit showed an increase of 20 – 40% in adherence to the published guidelines for each monitoring parameter, as compared with the outcomes of the 1st audit.

Although results for some parameters are still below the National Standards (100%), our audit shows that the simple change in practice has produced a very substantial improvement in patient safety and quality of care (#6061).



Respiratory Medicine:

The national BTS audit of Non-Invasive Ventilation (NIV) shows that Glenfield performs well in its provision of NIV when compared to the national picture, with compliance with standards improving in most areas.

Image source: healthcare-philips.com

Some areas for improvement remain, particularly in the ongoing management of the patient receiving NIV, documentation of patient monitoring and decisions about escalation of care.

The establishment of a specialist NIV ward is firmly in place and the education of the ward nursing staff is an ongoing activity. The major challenge with the operation of the Unit remains the high bed occupancy rates which compromises prompt transfer of appropriate patients to the Unit from assessment units at Glenfield and the LRI.

The team are in the process of appointing a new consultant who will spend some of their time supporting the Acute and Home NIV service and there is a business plan proposing the establishment of a regional IP Weaning Unit currently in preparation and will shortly be submitted to the Trust Board (#5645)

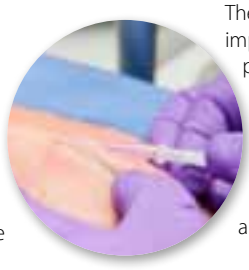
Emergency Department [ED]:

Peripheral intravenous cannulation is one of the most common procedures performed in the Emergency Department (ED), facilitating investigation and treatment by providing direct access for blood sampling, drug and fluid administration or transfusion.

Although it is often considered a simple invasive procedure, refined knowledge, skill and experience are required to ensure accuracy, consistency and efficiency.

A first audit cycle of this area last year highlighted deficits in the overall technique and performance of the procedure; potential interventions to improve these were considered.

The use of the AccuVein AV3003 was chosen and subsequently evaluated in the second audit cycle where a further 100 patients were observed.



A significant reduction in the rate of re-palpation was observed (down from 41% to 24%). All other criteria remained similar.

The results demonstrate that significant improvements can be made in clinical practice, but a combination of approaches is required to target each deficit identified. Inter Professional Education (IPE) has the potential to facilitate change by enhancing collaboration, motivation and consistency. (#5571)

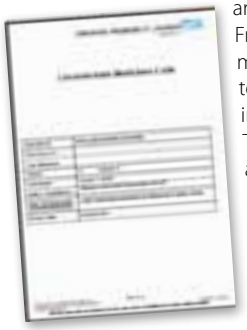
6 Appendix 3

Clinical Audit Successes within the Acute Care Division

Pharmacy:

This year's annual trust wide audit of Leicester Medicine Code showed mixed results.

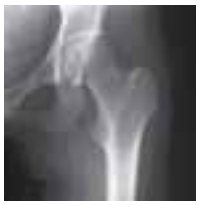
Prescribing continues to be good against most standards.
With the electronic prescribing and administration system being rolled out across the Trust it is hoped that this will improve the legibility of prescribing and provide an audit trail.



The audit showed that there is inadequate storage space in some areas of the Trust.
Fridges particularly are poor with many found to be unlocked and temperature monitoring inadequate.
To address this issue an in-depth action plan has been devised.
Compliance with the administration standards continues to be good across all areas (#5923)

Nutrition and Dietetics:

A MDT audit of Nutritional care of elderly fractured NOF inpatients showed poor nutritional screening, care planning, interventions and monitoring.



To address this a **dedicated nutrition carepathway** was developed and implemented (first in the UK).
A snapshot re-audit post implementation has indicated shorter length of stay and reduced pressure sore incidence.

The audit was also the winner of Trust Caring at its Best Award for 2012 for focus on what matters most (right).

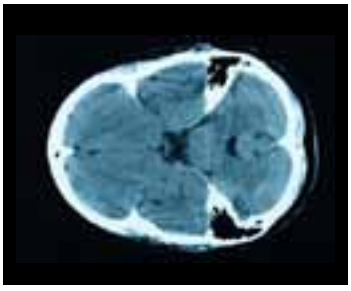
Caring at its best Awards

Neurology:

An audit of Intravenous Immunoglobulin Use and adverse events in patients with peripheral neuropathy highlighted the need for improved risk assessments.

Actions implemented since the audit in 2011 included a review of dosing schedules in current patients, highlighting those receiving 35g or more and exploring alternative regimens for these patients.
In addition, assessment for the presence of other risk factors to be conducted at patient reviews and prior to initiation of therapy in new patients.
Current data indicate we have had only one single case of thromboembolic complication with immunoglobulin therapy over more than 2 years (Jan 2011- Jan 2013), which the team believe is addressed by the actions implemented.

This corresponds to an 80% reduction in thromboembolic complication rate post-immunoglobulin treatment for patients with neuropathy and appears to represent a real improvement in patient care (#5113).



6 Appendix 3

Clinical Audit Successes within the Women's & Children's Division

Women's:

The audit programme within Women's played a key part in helping the Women's Hospital achieve CNST Level 2.

More than 40 audits (all directly linked to providing evidence for the assessment) were undertaken and completed by the team led by Andrea Akkad and Lorraine Matthews, and supported by the Clinical Audit Team. For details of these audits see Women's CBU audit report.

The CBU also held their own Clinical Audit awards afternoon which was organised by CBU Lead - Dr Ibrahim. The event proved to be an excellent way to share good practice across the CBU, meeting different teams and celebrating together.

Neonatal Team:

The Neonatal team (pictured) won the audience vote for their BLEED audit (#6151).

The team's aim is to improve documentation of parental assent for administration of blood components and **provision of parental information regarding risks and benefits of transfusion** (in the form on an information leaflet).

A baseline audit of current practice was undertaken followed by the implementation of a programme of education which raised awareness of best practice UHL/SaBTO Guidelines in order to improve compliance with these guidelines. This was also part of the overall improvement in safety and practice of blood component administration.

6 Appendix 3

Clinical Audit Successes within the Women's & Children's Division

Paediatric Cardiology:

An audit undertaken, because of an apparent increase in wound breakdown following surgery in 2009, showed an increased incidence of wound breakdown. Comprehensive changes were implemented and a re-audit was performed.

The number of wound breakdown cases showed a marked reduction compared with the previous retrospective audit, especially for the serious deep surgical site infection cases. The percentage of wound problems during this audit is within the limits published in the literature, demonstrating the effectiveness of the Wound Care package implemented (#4869).

This year's national results of the **National Congenital Heart Disease Audit** of surgery at the East Midland's Congenital Heart Centre showed that UHL's outcomes are in line with the national standards and, for some conditions, the results are above the national rate (#5335)

East Midlands Congenital Heart Centre

Children's:

Re-Audit of the measurement of blood pressure admitted to the Children's Hospital (>3 years) showed that the team have improved from the previous audit and measuring blood pressure far more frequently, especially in older children (#5600).

A re-audit of Perioribital and orbital cellulitis in children showed that after introducing a new guideline following the 1st audit - children are now better examined, investigated, referred appropriately and treated (#5977).

The latest National Paediatric Intensive Care Audit Network (PICANET) report showed the outcomes of children's intensive care in Leicester are improving and are well within the expected limits (#5989)

PICA Net

Obstetrics and Gynaecology:

There is now a well established audit programme in Obstetrics and Gynaecology with bimonthly departmental audit presentation meetings. An audit newsletter helps disseminate results of audits to all staff.

The audit team have closed a number of legacy audits and action plans have been completed in over 95% of the speciality audits.

The Obstetric audit **'Audit of indication for caesarean section, prophylactic and infection control measures'** was runnerup in the CBU audit forum day on 17th May 2013 (#5613).

Reaudit of antimicrobial prescribing in October 2012 after intensive education of staff showed a significant improvement in results in comparison to the March 2012 audit (#5737c).

6 Appendix 3

Clinical Audit Successes within the Planned Care Division

Vascular:

The National Carotid Interventions Audit focuses on surgical carotid endarterectomy (CEA).

It is important for UHL to participate in this audit, not least because we are the second largest CEA centre in the UK and carry out more CEAs than any London hospital. We performed 32% of all CEAs in the East Midlands and performed a third more cases than the second largest centre (Nottingham)

The results show that UHL performs well, achieving a median delay from symptom to surgery of 9 days against a UK average of 15 days. This is despite having to include the Burton-referred CEAs as they invariably take longer to get to Leicester.

The two statistics where we are at variance with the UK is the median time spent in hospital before surgery (3 days vs 1 nationally), and the median length of inpatient stay (6 vs 3 days). However, this is because we transfer patients directly from the TIA Clinic to the Surgical Admissions Unit (which clearly other centres don't do). Whilst on the Unit, we ensure patients are fit for surgery and get their hypertension, etc, sorted out; (ie we may be getting penalised for our own super-efficiency). Certainly, the rapid access TIA clinic has contributed greatly to getting patients treated quickly.

The 30-day death/stroke rate was 3/123 (2.4%) is pretty impressive when you consider that most underwent expedited surgery following onset of symptoms.

The full report with detailed results can be accessed via this link (#5930)

Musculoskeletal:

Prevalence audits had identified a high incidence of indwelling catheters being used with subsequent catheter-associated urinary tract infections [CAUTIs].

Reduction of these was therefore targeted as a quality indicator for the department.

Following implementation of a **new urinary catheterisation protocol** (which was trialled on the hip fracture ward (R32) at the Leicester Royal Infirmary) we looked at the effect this had on reducing CAUTIs.

We reviewed case notes of 174 hip fracture patients admitted before implementation of the new protocol and 174 hip fracture patients after its implementation.

The overall CAUTI rate was 32% pre-protocol and reduced to 30% post-protocol.

The audit showed that none of the patients treated only by intermittent catheterisation developed a CAUTI, whereas 26% of patients treated with an indwelling catheter did develop a CAUTI.

The audit results therefore support the new protocol, and that intermittent catheterisation is the safer option when treating urinary retention in hip fracture patients and helps reduce the incidence of CAUTIs (#6252)

Urology:

Renal mass biopsies are increasingly performed prior to treatment with tyrosine kinase inhibitors in metastatic renal cancer and in localised renal tumours as part of active surveillance protocols and prior to nephrectomy.

An audit of these biopsies was carried out at LGH supervised by Mr Leyshon Griffiths, and showed excellent results which confirm the biopsies are reliable, accurate and useful in defining further management. All of the standards agreed for the audit were met.

The audit has enabled us to counsel patients about the benefits and limitations of renal mass biopsy in Leicester (#4321)

Audit standard	Target %	Result	No. of pts
Accurate prediction of:			
Malignancy	95%	100%	30/30
Subtype	75%	91%	24/30
Fuhrman grade	50%	52%	11/21
Necrosis	50%	77%	22/30

6 Appendix 3

Clinical Audit Successes within the Planned Care Division

Oncology:

Intensity Modulated Radiotherapy (IMRT) Audit.
IMRT is a specialised way of giving radiotherapy and shaping the radiation dose to the tumour volume.

source: www.radiology.georgiahealth.edu

It allows sparing of normal healthy tissue and treatment of at-risk nodal areas to a prophylactic dose, whilst the visible tumour receives a higher dose. Accurate treatment set up and delivery is essential to avoid missing tumour and nodes, or over treating healthy tissue

This practice was audited and the standard used was that 95% of the volume of the at risk nodal groups should be covered by the radiation field in at least 90% of patients. Treatment toxicity was prospectively recorded for eating and skin reactions.

The audit looked at coverage achieved at the start of treatment and showed that 100% of treatments at the neck nodal levels 1 and 2, and 99% of treatments at neck nodal level 3 achieved 95% coverage as required by the standard. At the end of treatment 100% coverage was achieved. There was substantial treatment-related toxicity.

Weight loss during treatment causes peripheral structures of the neck to shrink into the planned high dose treatment area.
We have implemented assessments by Dietitians to advise on early feeding to help minimise weight loss and are also improving immobilisation of the patient during radiation planning and treatment. Better immobilisation will enable smaller treatment volumes and less toxicity (#6313)

Corporate-led Audits and associated successes

Pathology:

- **A re-audit of xanthochromia collection, transport and handling** following the introduction of xanthochromia collection packs (XanthoPacks) has shown significant improvement to compliance with national standards (#6365)
- **Re-audit of Treatment of Staphylococcus Aureus bacteraemia** showed that compliance to national guidance for minimum of 14 days of antibiotics has improved (81% vs 60% in 2008).

  Although the duration of antibiotics is much better than the previous audit, we are still not achieving our target of 90% compliance rate. It is thought that the standard extra text at the bottom of the blood culture report might have improved the compliance rate from the last audit.

  A microbiology review on the wards following the bacteraemia to advise clinicians about the appropriate duration of antibiotics, as well as giving a code for the antibiotics for the minimum duration of 14 d, might be helpful to increase compliance rate.
- **We have achieved a considerably higher compliance rate of repeat blood cultures at 72 hours.**
  This might be as a result of the extra text at the bottom of the report. This can be reiterated during the microbiology review on the wards (#5388).
- **37 process focused audits were conducted as part of accreditation to CPA Standards in Clinical Microbiology.**
  Compliance with current CPA Standards is monitored and most audits showed an improvement (#5628)

6 Appendix 3

Corporate-led Audits and associated successes

National NHS Safety Thermometer [ST]:

The ST was developed by the NHS for the NHS and is a tool that allows healthcare professionals to measure a snapshot (or prevalence) of harm and the proportion of patients that are 'harm free' in relation to 1) Grade 2, 3 and 4 pressure ulcers, 2) Venous thrombo-embolism (VTE), 3) Catheter Associated Urinary Infections (CAUTI), & 4) Falls.

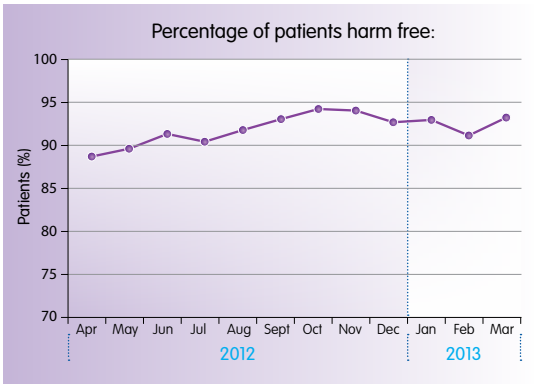
The Department of Health (DH) recommended that all healthcare providers begin to use the NHS Safety Thermometer measurement tool by the end of 2012/13. ST "harms" data is collected for all inpatients on a single day once a month.

The UHL Audit Team administers the paper-based ST survey and supports Ward Managers (or nominated deputy) to complete the ST survey.

The specialist nurses for falls, VTE, tissue viability and infection prevention validate the data for every ward and patient prior to the information being sent electronically to the Health and Social care Information Centre.

The ST tool was designed to measure local improvement and reduction in "harms" over time and the DH have stipulated that 95% of patients should experience harm-free care.

The chart above shows that UHL's results are improving although slightly behind target. The ST steering group, led by Eleanor Meldrum, Assistant Director of Nursing, aims to support the divisions in achieving this target.



Releasing Time to Care (RT2C):

The audits for RT2C work have linked even closer with the UHL clinical and quality priorities this year. With a member of the Clinical Audit team working part-time with RT2C, this has assisted the development of the quality data within the RT2C programme.

Currently registered with the Clinical Audit Team is the monthly Pressure Ulcer (PU) audit (#6130) and Falls Risk Assessment audit.

The PU was devised to support "Ambition 1" and has been adopted by all in patient ward areas [where relevant] within the Trust.

The Falls audit was devised to assist in raising awareness of patient safety and to support improvements regarding the incidence of falls within the Trust. Initially adopted by the Acute Division this has also now been incorporated as necessary in Planned care.

Additional audits have also been developed locally to assist areas with quality improvements around the Safety Thermometer and Nursing metrics. These audits are carried out monthly, helping staff to identify areas in order to progress their quality standards. Further area-specific RT2C audits which CBUs may wish to concentrate on, have also been developed.

All audits provide evidence to assist nursing staff to set realistic goals towards growth that is then re-measured in order to raise their own quality of care.

For further details around any of the RT2C audits or work streams please email Judy Queally.

Trust-wide Antimicrobial Policy Adherence Audit:

This audit is undertaken to provide the necessary assurance of the Trust's performance against the DH antimicrobial prescribing recommendations, and the local Commissioners' performance monitoring.

It also reinforces and highlights within the Trust the importance of adherence to the antimicrobial guidelines and policies which have been instrumental in the Trust's success in reducing its Clostridium Difficile infection rate.

An internal standard of ≥90% has been agreed, which the Trust achieved on the last audit (Nov 2012). The audit and completed actions are formally reported at QPMG (Quality Performance Management Group) and the audit is also reviewed and discussed at the AWP (Antimicrobial Working Party).

The audits are the responsibility of each CBU; data is collected by prescribers (usually FY1's or 2's) and validated by an Antimicrobial Pharmacist. The Clinical Audit Team leads and co-ordinates the audit and the final report is written and presented by the Lead Antimicrobial Pharmacist. (webpage link via #6073)

If you would like this information in another language or format,
please contact the service equality manager on 0116 250 2959

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مع مدير الخدمة للمساواة في 0116 250 2959.

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