UHL ANNUAL REPORT AND ACCOUNTS 2014/15

Author: Stephen Ward, Director of Corporate and Legal Affairs
Sponsor: Richard Moore, Non-Executive Director and Chair, Audit Committee

Executive Summary Paper J

Context

1. NHS Trusts are required to publish, as a single document, an Annual Report and Accounts.

2. This document includes:

   - the annual report,comprising the:
     - Directors' report,
     - Strategic report,
     - Remuneration report,
     - Sustainability report
   - A statement of the Accountable Officer's responsibilities,
   - A Governance Statement,
   - The primary financial statements and notes to the accounts,
   - The audit opinion and report.

3. At its meeting on 4th June 2015 (Minute 119/15 refers), the Trust Board considered and adopted the Annual Accounts 2014/15 formally, on the Audit Committee's recommendation (Minute 32/15/1 - 27 May 2015 refers).

4. At its meeting on 2nd July 2015 (Minute 144/15/3 refers), the Trust Board considered and provisionally approved the UHL Annual Report 2014/15, subject to its review by the Audit Committee ahead of the Trust's Annual Public Meeting on 17th September 2015.

5. In the event, the Audit Committee meeting which was programmed for 3rd September 2015 has been postponed to 17th September 2015, immediately before the Trust's Annual Public Meeting.

6. In discussions between the Chairman and Audit Committee Chair, it has therefore been agreed that the Trust Board should consider and approve formally the Annual Report and Accounts 2014/15 at this meeting of the Trust Board, with the Audit Committee Chair leading the Trust Board's discussion of this item.

7. A copy of the Trust's Annual Report and Accounts 2014/15 is attached. Subject to

formal approval by the Trust Board, the Annual Report and Accounts will be available for presentation at the Trust's Annual Public Meeting on 17th September 2015.

Questions

1. Is the Trust Board content to approve the Annual Report and Accounts 2014/15 appended to this report?
2. Do the Annual Report and the Annual Accounts present a consistent view of the outcome for the year 2014/15?

Conclusion

1. The Trust Board is **recommended** to approve the Annual Report and Accounts 2014/15 appended to this report.

For Reference

Edit as appropriate:

1. The following **objectives** were considered when preparing this report:

Safe, high quality, patient centred healthcare	[Yes]
Effective, integrated emergency care	[Yes]
Consistently meeting national access standards	[Yes]
Integrated care in partnership with others	[Yes]
Enhanced delivery in research, innovation & ed'	[Yes]
A caring, professional, engaged workforce	[Yes]
Clinically sustainable services with excellent facilities	[Yes]
Financially sustainable NHS organisation	[Yes]
Enabled by excellent IM&T	[Yes]

2. This matter relates to the following **governance** initiatives:

Organisational Risk Register	[Not applicable]
Board Assurance Framework	[Not applicable]

3. Related **Patient and Public Involvement** actions taken, or to be taken: The Annual Report and Accounts is a publicly available document.

4. Results of any **Equality Impact Assessment**, relating to this matter: N/A

5. Scheduled date for the **next paper** on this topic: N/A

6. Executive Summaries should not exceed **1 page**. [My paper does not comply]

7. Papers should not exceed **7 pages.** [My paper does not comply]

Everybody Counts...
Playing your part

Annual Report & Accounts 2014-2015

University Hospitals of Leicester NHS
NHS Trust

Caring at its best

University Hospitals of Leicester NHS
NHS Trust
Caring at its best

Our Values

We treat people how we would like to be treated

- We listen to our patients and to our colleagues, we always treat them with dignity and we respect their views and opinions
- We are always polite, honest and friendly
- We are here to help and we make sure that our patients and colleagues feel valued

We do what we say we are going to do

- When we talk to patients and their relatives we are clear about what is happening
- When we talk to colleagues we are clear about what is expected.
- We make the time to care
- If we cannot do something, we will explain why

We focus on what matters most

- We talk to patients, the public and colleagues about what matters most to them and we do not assume that we know best.
- We do not put off making difficult decisions if they are the right decisions
- We use money and resources responsibly

We are passionate and creative in our work

- We encourage and value other people's ideas
- We seek inventive solutions to problems
- We recognise people's achievements and celebrate success

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

- We are professional at all times
- We set common goals and we take responsibility for our part in achieving them
- We give clear feedback and make sure that we communicate with one another effectively

One team shared values

Contents

Leicester's Hospitals year at a glance

In 2014/15…

We treated **1,229,500** patients – that's **3,368** patients each day and 97 more each day than in 2013/14

We spent **£497.3m** on wages for our **10,876** staff; that is 57 per cent of our total budget

We earned **£834.4m** and spent **£875m**, with a planned deficit of **£40.6m**

89,300 patients (**76,807** adults and **12,493** children) were admitted in an emergency which is a **9** per cent increase on last year

284,100 patients had a new outpatient appointment and **593,900** patients had follow-up outpatient appointments

We treated **149,800** patients in our emergency department and eye casualty; **22,300** patients had elective operations; and **90,100** patients had a day case procedure

We have **997** beds at the Royal Infirmary, **429** beds at the Glenfield and **383** at the General

There are around **600** volunteers helping our staff and patients

We spent **£79.462m** on drugs, a £5.9m increase from 2013/14

We have **10,004** women and **2,642** men working for our organisation

Our midwives delivered **10,700 babies**; that's **29** babies every day

We spent **£19.3m** on research and development

Around 600 patients had their blood taken by one of our phlebotomists every day

There were almost **1.3m** requests from staff for patient records

Our volunteers made **21,946** buggy journey's helping **36,207** patients get around our hospitals

About us

Our patients are the most important thing to us and we are constantly striving to improve the care they receive, through looking at the ways we work, ensuring our staff are highly trained and encouraging research which allows us to offer our patients the latest technologies, techniques and medicines – and attract and retain our enviable team of more than 10,000 highly skilled staff.

We are one of the biggest and busiest NHS Trusts in the country, serving the one million residents of Leicester, Leicestershire and Rutland – and increasingly specialist services over a much wider area. Our nationally and internationally-renowned specialist treatment and services in cardio-respiratory diseases, cancer and renal disorders reach a further two to three million patients from the rest of the country.

Spread over the General, Glenfield and Royal Infirmary hospitals, we also have our very own Children's Hospital and work closely with partners at the University of Leicester and De Montfort University providing world-class teaching to nurture and develop the next generation of doctors, nurses and other healthcare professionals, many of whom go on to spend their working lives with us.

We continue to work with many different organisations throughout the world to push the boundaries of research and new surgical procedures for the benefit of our patients. Areas of world-renowned expertise include diabetes, genetics, cancer and cardio-respiratory diseases. We are now home to three NIHR (National Institute of Health Research) Biomedical Research Units and during the year we carried out more than 800 clinical trials, involving thousands of our patients who are among the first to try the latest medicines and techniques.

Our heart centre at the Glenfield hospital continues to lead the way in developing new and innovative research and techniques, such as surgery with a Robotic Arm, TAVI (Trans-Catheter Aortic Valve Insertion) and the use of the suture less valve in heart surgery. It has also become one of the world's busiest ECMO (extra corporeal membrane oxygenation) centres and the only hospital in the UK to provide ECMO therapy for both adults and children.

We have one of the best vascular services nationally, with more patients surviving longer after following an aneurysm repair (to fix a life threatening bulge in a blood vessel). And we are proud to continue to have some of the lowest rates of hospital-acquired infections, such as C.Difficile and MRSA, in the country.

Our purpose is to provide 'Caring at its best' and our staff have helped us create a set of values that embody who we are and what we're here to do. They are:

- We focus on what matters most
- We treat others how we would like to be treated
- We are passionate and creative in our work
- We do what we say we are going to do
- We are one team and we are best when we work together

Our patients are at the heart of all we do and we believe that 'Caring at its Best' is not just about the treatments and services we provide, but about giving our patients the best possible experience. That's why we're proud to be part of the NHS and we're proud to be Leicester's Hospitals.

Welcome from the Chairman

#hello my name is… Karamjit Singh, CBE

This is my first opportunity as the new Chairman of Leicester's Hospitals to welcome you to our Annual Report for 2014/15.

I joined the Trust Board in October 2014 and since then have tried to spend as much of my time as possible meeting staff and patients as well as different stakeholders, including those who focus on advocating change in the NHS and ensuring positive experiences for patients all the time. Both of these issues are central to my own belief that our mind-set and performance should focus on delivering continuous improvement in our services, taking into account feedback from our patients, their carer's and families.

The people I have talked to are aware of their local hospitals which make up our NHS Trust and have a lot of goodwill and appreciation towards us, but have very little understanding of what we do in our organisation. I hope this Annual Report will partly help to address this.

As Chairman of the Trust Board I know that my fellow Board colleagues are also committed to ensuring that local people and our staff understand who we are and what we want to do in order to enable us to improve the services we provide. The role of the Trust Board is to set out a clear strategy for the future, to monitor and hold senior management to account for the organisations performance and use of resources, to listen to and communicate with our partners in the health economy and other stakeholders, to focus on the experiences of patients, and also be accountable to the Secretary of State for its own performance.

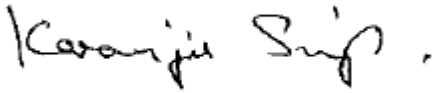
As a fresh pair of eyes I have been immediately struck by the diversity in population and geography which this Trust covers. Leicester, Leicestershire and Rutland have one of the most complex social mosaics in the country in terms of the make-up of our community with its many differing health needs and a wide range of urban and rural environments. What has struck me is how important it is that we, in partnership with others, are receptive and responsive to those differing needs and focused on improving health outcomes for local people. An emphasis on effective partnership working with our local health and social care colleagues and other stakeholders is essential if all of us are to deliver these improvements over the coming year and beyond. Sharing Delivering Caring at its Best, which is the 5-Year Plan agreed by the Trust Board, will be part of that, and this has been aligned with the system-wide Better Care Together programme that we have all committed to.

As Chairman, it also falls to me to mark the changes that have occurred in the Board over the last year. I would like to thank my predecessor Richard Kilner (as acting Chairman) for his important contributions before my arrival. We said goodbye to Non-Executive Directors Kiran Jenkins, Prakash Panchal and Professor David Wynford-Thomas, who had come to the end of their terms, and welcomed Richard Moore, Dr Sarah Dauncey and Martyn Traynor, OBE as new appointees. There have been some changes to the Executive Board members. Chief Nurse Rachel Overfield left us in February 2015 and my thanks go to Carole Ribbins who is acting Chief Nurse until Julie Smith joins us in August 2015 to take up this role. We also welcomed a new Director of Finance, Paul Traynor, in November 2014 and my thanks go to Simon Sheppard who was acting Director of

Finance until Paul's arrival. I believe, that with these arrivals we will have a strong team in place to take us forward to chart a new course and to deliver not only the ambitious and challenging priorities that we have set ourselves for 2015/16, but also over the next five years following the plan recently agreed by the Trust Board.

I would like to thank our stakeholders and partners for their continued support and as an organisation we look forward to working closely with them over the coming year to continue to improve health care services for local people.

Finally I wanted to thank our dedicated staff and volunteers. We have been busier than ever before and our success is due to the commitment and dedication of these people who continually look for new and innovative ways to improve patient care. The activities and achievements outlined in this report recognise their hard work and I wish to extend my personal thanks to all of them, who have, at times, worked under some degree of pressure during the year, particularly over the winter months. Both I and my Board colleagues value them and thank them for their contributions.



Karamjit Singh CBE, Chairman

Welcome from the Chief Executive

#hello my name is… John Adler

Today, along with the rest of the NHS, we face immense challenges — an ageing population which is living longer, often with more illnesses (long-term complex conditions such as diabetes and heart and kidney disease) all of which need ongoing treatment and specialist care, combined with funding which is now only just keeping pace with inflation – and immense opportunities, which include breakthroughs in technology, drugs, science and the way we deliver care.

Leicester's Hospitals has seen a year with record numbers of people attending our hospitals for treatment; Record numbers of people being admitted for care and for the first time in our 15 years of existence we have been working with a deficit (£40m) that we declared at the end 2013/14. This is set against what we know about the £398m funding gap predicted locally by 2018/19 through our work with partners on Better Care Together. Change is essential. Change is a must.

Although we are in financial deficit, we have continued to focus on improving the quality of care that we provide to our patients and on making investments where we need to. Working to improve our staffing levels, we continued to recruit nurses at scale both at home and in Europe. We still have vacancies though, particularly on our medical wards, and we continue to work to fill these gaps.

We have maintained high quality safe services. We saw a reduction in serious incidents, falls, and grade 2 and 3 pressure ulcers. In terms of incidents overall, we are one of the highest reporters in the country (which indicates a strong reporting culture), yet we have seen our incidents dropping, indicating that our efforts on patient safety are working.

By improving the quality of care we provide we can often see the benefit of reduced costs. For example we have reduced the number of people who do not attend their appointments and increased the number of people seen in clinics, thus cutting waiting times and saving money. We have also overhauled the way outpatient clinics are run to make them more efficient which will save £3.5m over two financial years. Another focus of our cost improvement programme has been cutting the number of operations cancelled at the last minute. In 2013/14 there were 1,739 operations cancelled on the day, and in the past year this was down 43 per cent with 996 cancelled on the day. One cancelled operation can cost in excess of £1,000, so doing what is best and right for patients saves us money.

Patients are telling us that their experiences are better. We saw our Friends and Family Test scores improve during the year, particularly so in our Emergency Department, despite the increase in attendances and the continuing service pressures seen in the department. This assures me, and the rest of the Board, that staff continue to focus on the quality of the experience that our patients are receiving.

And less people are dying in our care. Our Summary Hospital-level Mortality Indicator (SHMI) has reduced from 105 to 103. As part of our priorities within the Quality Commitment for the coming year, we intend to lower it further to 100. This feels more achievable given the work that has been done to bring it down already.

We by no means get it right every time. There are still areas where we can, and will, do better.

For the first time in a long time we saw an increase in cases of Clostridium Difficile. We had fewer cases (73) than the target (81), but more than in 2013/14. The target for this year is no more than 60 cases so we must be more vigilant, particularly when it comes to cleaning standards.

Emergency performance is something that you will have read about in the local and national news, and it has been a challenging time for everyone. Our performance against the 4 hour standard was still below the required 95 per cent, but we definitely moved in the right direction. If we look at our performance of the first 9 weeks of 2015/16 versus same point last year (2014/15) we have seen a +5.0 per cent increase in attendances, a +6.9 per cent increase in admissions with our performance at 92.1 per cent (+7.1 per cent), which means that 4,181 more patients were cared for within four hours.

Linked to improving emergency care, and part of our priorities for the coming year, is ambulance handover times. We are one of the worst performing Trust's in the country and have simply got to make improvements this year. It is at least partially within our gift to do so, as well as an expectation from our commissioners and partners. We are looking to other organisations that do this well and will be learning from them.

Last year showed a disappointing picture for our cancer services, not in terms of clinical quality but waiting times. We are still not where we need to be, but having said that, in recent months we have started to move in the right direction again. It is crucial for our cancer patients that we maintain this progress.

I am pleased with the significant progress we have made over the past year following concerted efforts by teams to improve our Referral to Treatment (RTT) waiting times. By May we had achieved all the required standards, for the first time in over two years.

So in summary, a lot of hard work went into improving the quality of care we provide for our patients over the past year and we have made progress in many areas. Having said that, over the coming year we need to maintain our efforts to tackle those areas which have so far proved more difficult to resolve.

Our successes over the past year are the result of working together and everybody playing their part. Our strength is the strength of individuals working in teams with a common cause and putting patients our first. Every member of our staff is committed to giving every one of our patients the best outcome and experience they can.

I would like to reiterate the Chairman's thanks to all of our staff and volunteers for their continued hard work and dedication.

John Adler, Chief Executive

Our Trust Board

Declaration of Interests

Mr K Singh CBE
Trust Chairman
(from 1 October 2014)

Trustee, Joseph Rowntree Foundation.
Trustee, Joseph Rowntree Housing Trust.
Council Member of Justice. Trustee, Malaysian Commonwealth Studies Centre, Cambridge University.

Col (Ret'd) I Crowe
Non-Executive Director

Brother, Order of St John (by award).

Dr S Dauncey
Non-Executive Director

Ward Volunteer at LOROS Leicestershire Hospice.

Mrs K Jenkins
Non-Executive Director
(until 30 June 2014)

Provision of interim management services for Serco plc.

Mr R Moore
Non-Executive Director Designate
(from 5 February 2015 to 31 March 2015)

Director of the following companies: Momentum Advisers Ltd, Momentum 002 Ltd (trading as Soccer City), Momentum 003 Ltd (trading as Lutterworth Soccer Centre), Momentum 004 Ltd, 555 Fussball Projekt GmbH (Germany), SoccerWorld China Ltd (Hong Kong), SoccerWorld Shanghai Ltd (China), Peppercorn Serviced Offices Ltd, EAI 555 Ltd.

Mr P Panchal
Non-Executive Director
(until 31 March 2015)

None to declare.

Mr R Kilner
Acting Chairman
(until 30 September 2014)

Managing Director of Deltex Consulting Ltd.
Non-Executive Director of Triconnex Ltd.
Non-Executive Chairman of SHS Integrated Services Ltd.
Director of Glebe Meadow Developments Ltd.

Mr M Traynor OBE
Non-Executive Director
(from 2 October 2014)

Partner, Traynor Consulting & Training LLP. Non-Executive Chairman, the Forest Experience Ltd. Non-Executive Chairman, King Richard III Visitor Centre Trust Ltd. Non-Executive Director, Leicestershire Promotions Ltd. Trustee, the National Forest Charitable Trust Ltd. Trustee, Leicestershire Rural Community Council Ltd. Trustee, LOROS Ltd. Trustee, Menphys. Member, HM Govt's Regulatory Policy Committee.

Mr M Williams
Interim Non-Executive Director
(from 30 October 2014 to 31 March 2015)

Non-Executive Director, Coventry and Warwickshire NHS Partnership Trust. Trustee, Badley Charitable Trust. Trustee, Midlands Arts Centre. Trustee, Black Country Living Museum. Board Member, Warwickshire Cricket Board. Member, Management Board Warwickshire County Cricket Club.

Ms J Wilson
Non-Executive Director

Board Chair, Leicestershire and Rutland Probation Trust (currently holds the contract for the provision of criminal justice drug and alcohol treatment services in Leicester [clinical aspects of that service provided by Inclusion Healthcare]).

Professor D Wynford-Thomas
Non-Executive Director (until 28 February 2015)

Dean of the University of Leicester Medical School and Pro-Vice Chancellor, Head of College for Medicine, Biosciences and Psychology, University of Leicester.

Our Trust Board

Declaration of Interests

Mr J Adler
Chief Executive

None to declare.

Dr K Harris
Medical Director
(until 31 March 2015)

Member (MD) of the NICE Interventional Procedures Advisory Panel

Mr R Mitchell
Chief Operating Officer

None to declare.

Ms R Overfield
Chief Nurse
(until 28 February 2015)

None to declare.

Ms C Ribbins
Acting Chief Nurse
(from 1 March 2015)

None to declare.

Mr A Seddon
Director of Finance and Busines Service
(until 13 April 2014)

Spouse is an Equity Partner in Morgan Cole Solicitors, who conduct work for the NHS.

Mr P Hollinshead
Interim Director of Financial Strategy
(until 18 July 2014)

Ownership of Brandhill Financial Services. EMPATH Non-Executive Board member.

Mr S Sheppard
Acting Director of Finance
(from 21 July 2014 to 31 October 2014)

None to declare.

Mr P Traynor
Director of Finance
(from 3 November 2014)

None to declare.

Directors who provide advice to the Board

Ms K Bradley
Director of Human Resources
(until 31 December 2014)

None to declare.

Ms E Stevens
Acting Director of Human Resources
(from 1 January 2015)

None to declare.

Ms K Shields
Director of Strategy

None to declare.

Mr S Ward
Director of Corporate and Legal Affairs
(post acts as adviser to the Board as of January 2007)

None to declare.

Mr M Wightman
Director of Communications and External Relations
(post acts as adviser to the Board as of January 2007)

None to declare.

What is a Non-Executive director?

The role of Non-Executive directors is different to that of an executive director. They do not have responsibility for the day to day management of the Trust but share the Board's corporate responsibility for ensuring that the Trust is run efficiently, economically and effectively. They will scrutinise the executive management's performance in meeting agreed goals and objectives and monitor the reporting of performance. They must satisfy themselves on the integrity of financial information and that financial controls and a sound system for the management of risk are in place. They will seek to establish and maintain public confidence in the Trust, and must be independent in judgement and constructively challenge and help develop decisions and strategy for which they bear equal responsibility. To be effective a effective Non-Executive director needs to be well-informed about the Trust and have a good grasp of the relevant issues.

Our Non-Executive directors bring independence, external perspectives, skills and challenge to strategy development and hold our Executive Team to account for the delivery of the strategy. They actively support and promote a healthy culture for the organisation and this reflects in their own behaviour. It is imperative that they provide visible leadership in developing a healthy culture so that staff believe Non-Executive directors provide a safe point of access to the Board for raising their concerns.

Some of the Non-Executive Directors chair or participate as members of key committees that support accountability. These are the roles that our Non-Executive Directors carried out over the last 12 months:

Karamjit Singh, CBE chairs Trust Board and Remuneration Committee and attends meetings of the Integrated Finance, Performance and Investment Committee, Quality Assurance Committee and Charitable Funds Committee (in a non-voting capacity);

Richard Kilner chaired Trust Board and Remuneration Committee and attended meetings of the Integrated Finance, Performance and Investment Committee;

Ian Crowe chaired the Audit Committee (between June 2014 and September 2014), and is a member of Charitable Funds Committee, Integrated Finance, Performance and Investment Committee and Remuneration Committee;

Sarah Dauncey chairs Quality Assurance Committee and is a member of Audit Committee, Integrated Finance, Performance and Investment Committee and Remuneration Committee;

Kiran Jenkins chaired Audit Committee (until May 2014) and was a member of Integrated Finance, Performance and Investment Committee, Charitable Funds Committee and Remuneration Committee;

Richard Moore has been attending all Board-level meetings in his role as Non-Executive Director Designate (in a non-voting capacity) and will chair Audit Committee with effect from the date of his substantive appointment in April 2015;

Prakash Panchal chaired Charitable Funds Committee and was a member of Audit Committee, Integrated Finance, Performance and Investment Committee, Quality Assurance Committee and Remuneration Committee;

Martin Traynor, OBE is a member of Charitable Funds Committee, Integrated Finance, Performance and Investment Committee and Remuneration Committee;

Mike Williams chaired Audit Committee and attended Integrated Finance, Performance and Investment Committee, Quality Assurance Committee and Remuneration Committee (all between November 2014 and March 2015);

Jane Wilson chairs Integrated Finance, Performance and Investment Committee and is a member of Quality Assurance Committee and Remuneration Committee, and

David Wynford-Thomas was a member of Quality Assurance Committee and Remuneration Committee.

In addition to the formal committee membership arrangements outlined above, all Non-Executive directors are encouraged to attend the remaining Board-level committee meetings in a non-voting capacity.

Trust Board meetings

Our Trust Board meetings are held in public and details of dates are available on our public website. The meetings move between our three hospital sites, and both staff and members of the public are welcome to attend the public session of each meeting. In March 2014 and July 2014 (respectively), our Trust Board meetings were held in external venues at the offices of Voluntary Action Leicestershire (in Leicester) and Age UK (in Melton Mowbray). We held our Annual Public Meeting on Tuesday 9 September 2014 at "The Big Shed" on Freeman's Common in Leicester, presenting our 2013-14 annual report and accounts and answering questions from the public. There was also a health and wellbeing fair for members of the public.

Partners on our Trust Board

Dr Richard Palin is a nominee of the three Leicester, Leicestershire and Rutland Clinical Commissioning Groups (CCGs) who attends and contributes at our monthly public Trust Board meetings as a non-voting/co-opted member. The idea behind having such a person at our Board meetings is to help forge more collaborative working between the Trust and Commissioners on matters of mutual interest for the benefit of our patients.

Mr David Henson is a nominee of the three Leicester, Leicestershire and Rutland Healthwatch organisations who also attends and contributes at our public Trust Board meetings as a non-voting/co-opted member. We hope that by having a representative of Healthwatch at the Board table, it opens up the Board to a different perspective – that of the patient/public voice – which serves to enrich the Board's deliberations and decisions.

Openness and accountability

We have adopted the NHS Executive's code of conduct and accountability, and incorporated them into our corporate governance policies (Trust's Standing Orders, Standing Financial Instructions and Scheme of Delegation, and Code of Business Conduct for Staff).

Signed 

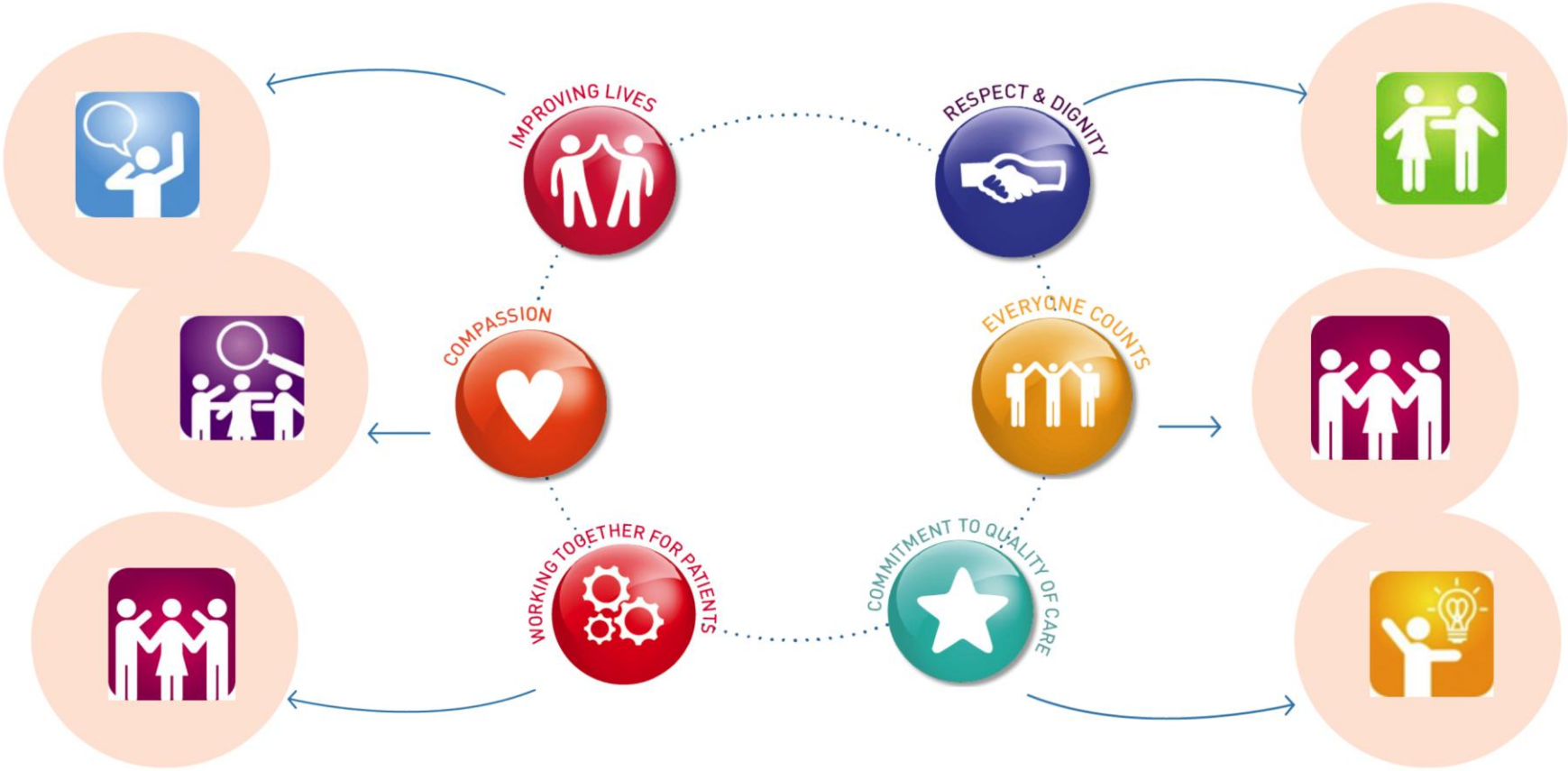
Chief Executive (on behalf of the Trust Board)

Date: 4 June 2015

Strategic Report

Our values and the NHS Constitution

We created our values with staff over three years ago and made sure that they were in line with, and supported, the NHS Constitution, which was put in place by the Government on 1 April 2010. This diagram shows how our values map to the NHS Constitution.



The NHS Constitution establishes the principles and values of the NHS in England. It sets out rights to which patients, public and staff are entitled, and pledges which the NHS is committed to achieve, together with responsibilities which the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively. All NHS bodies and private and third sector providers supplying NHS services are required by law to take account of this Constitution in

their decisions and actions.

The Constitution will be renewed every ten years, with the involvement of the public, patients and staff. It is accompanied by the Handbook to the NHS Constitution that is renewed at least every three years, setting out current guidance on the rights, pledges, duties and responsibilities established by the Constitution. These requirements for renewal are legally binding. They guarantee that the principles and values which underpin the NHS are subject to regular review and recommitment; and that any government which seeks to alter the principles or values of the NHS, or the rights, pledges, duties and responsibilities set out in this Constitution, will have to engage in a full and transparent debate with the public, patients and staff.

In March 2012 the NHS Constitution was updated and strengthened in a new commitment to support whistle blowing and tackle poor patient care. Then on 26 March 2013 as part of the Government's response to the Francis Enquiry into the events at the Mid Staffordshire NHS Trust, the Government strengthened the Constitution by including an expectation that staff will raise concerns and that their employers will support them. All NHS organisations will have 'whistle blowing' policies and procedures which allow staff to raise concerns about issues that are in the public interest without the risk of suffering at work – for example, victimisation or losing the chance to be promoted.

In March 2014 the Expert Advisory Group to the NHS Constitution (a group of clinicians, patient representatives' voluntary sector representatives' and others from the health field, including frontline staff) wrote to the Minister of State for Care and Reform with their feedback following a request from the Minister on how the NHS Constitution might be strengthened. The Expert Advisory Group suggested: *To be of real practical use, the Constitution needs much greater visibility and ownership across the health world. It should be the framework for the values and behaviours expected and against which those delivering NHS-funded services are recruited, trained, managed and held to account. Effort is needed to track whether and to what extent the rights and commitments in the Constitution are delivered in practice. Significant levers of accountability – such as the NHS Outcomes Framework, the Department of Health's mandate to NHS England and the CQC's new fundamental standards – must reinforce and be aligned with the Constitution.* You can read their report and recommendations here.

Here at Leicester's Hospitals we will always endeavour to make sure that we live up to the pledges set out in the Constitution. We will ensure that we 'live our values' and create an environment where those who do not can be challenged to ensure that we provide better care.

Our priorities in 2014/15

In November 2012 we set out our plans in our Strategic Direction. Over the last few months we have been working to update our plans in line with our two and five year strategies.

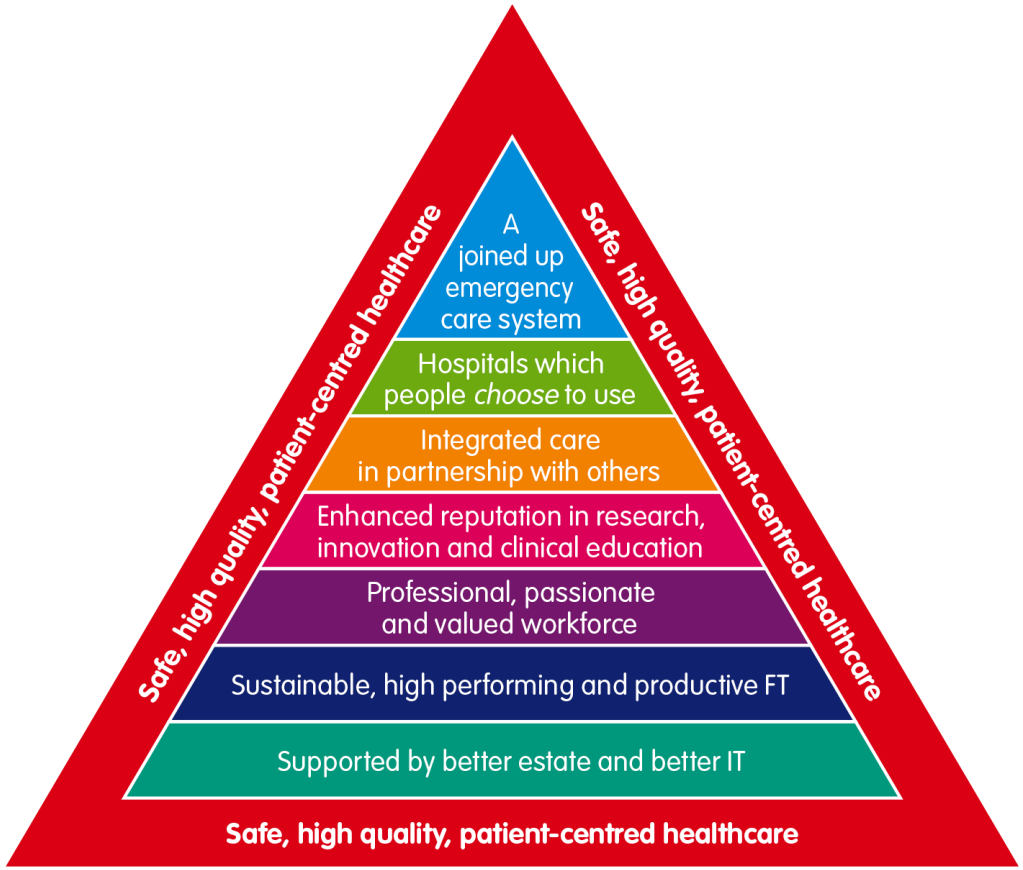
Delivering Caring at its Best pulls together all the major things we are doing to take us to our vision of Caring at its Best and how these plans will take shape over the next couple of years, the specific things that we will be looking to achieve within this in 2014/15.

Delivering Caring at its Best (DCAB) includes a whole range of programmes, from the Quality Commitment to our reconfiguration plans, from our IM&T Strategy to Listening into Action. Because it is so complicated, it's very important to be able to see the whole picture.

This triangle first appeared in our original Strategic Direction at the end of 2012, and we have recently updated it keeping the same goals that we originally set out. Encompassing our strategic objectives is our aim to deliver 'Safe, high quality, patient-centred care' which is our main purpose.

DCAB is a whole range of programmes, which we have sorted into four categories: Quality Commitment, Performance and Finance, Strategy and Workforce.

The chart over the page details our priorities for the coming year and how they will help us achieve our vision of Delivering Caring at its Best.



Our plans to become an NHS Foundation Trust

We aspire to achieve Foundation Trust status but recognises that our first priority has to be to get the basics right (e.g. achieving sustainable delivery of emergency care standards) whilst addressing our underlying financial deficit. This is in line with our five year strategy and will provide the firm foundations necessary to form the basis of a credible plan for future Foundation Trust status.

5 year strategy

Vision

Values

Strategic objectives

- Safe, high quality patient centred healthcare
- An effective, joined up emergency care system
- Responsive services which people choose to use
- Integrated care in partnership with others
- Enhanced reputation in research, innovation and clinical education
- Delivering services through a caring, professional passionate and valued workforce
- A safe, sustainable, productive high performing NHS FT
- Enabled by better estate, equipment & technology

Delivering Caring at its Best priorities for 2014/15

Quality: Our extended Quality Commitment

- **Provide effective care, e.g.**
  - 7 Day services
  - Pathway improvements (e.g. heart failure and pneumonia
  - Mortality reviews
- **Improve safety, e.g.**
  - Resuscitation procedures
  - Sepsis
  - Safety Thermometer
- **Care and Compassion, e.g.**
  - Care of older people
  - End of life care
  - Dementia care

Workforce: Empowering our people

- Next phases of Listening into Action (LiA)
- Experiments in autonomy, incentivisation and shared governance
- Improvements in medical education
- Development of new roles (linked to productivity improvement)
- A workforce plan to complement our 5 year strategic plan

Strategy: Taking forward our Strategic Direction

- Development of the a 5 year LLR system plan (by June)
- Development of the UHL 5 year plan (by June)
- Priority capital schemes: Emergency Floor and Vascular move to GH
- A strategy for children's services
- Procurement of an Electronic Patient Record system
- Implementation of the CRUK Centre and more patients in clinical trials
- New partnerships (incl. Alliance and across East Midlands)

Performance and Finance: Delivering the basics

- Deliver emergency care improvement plan
- Increase bed capacity and staffing
- Deliver the RTT (18 week) improvement plan
- Protection of day case and elective work
- Improve productivity through re-design of major systems
- Deliver £45m CIP and financial bottom line

Quality: our extended Quality Commitment

This strategic priority includes:

- Provide effective care, e.g.
  - 7-day services
  - Pathway improvements (e.g. heart failure and pneumonia)
  - Mortality reviews
- Improve safety, e.g.
  - Resuscitation procedures
  - Sepsis
  - Safety Thermometer
- Care and Compassion, e.g.
  - Care of older people
  - End of life care
  - Dementia care

Provide effective care

7-day services

The NHS Services, Seven Days a Week Forum published its initial findings in December 2013. This report contained ten clinical standards based on clinical evidence and best practice from around the world which if introduced, were felt would improve patient outcomes and experience and reduce the variability of care out of hours and at weekends.

In response to the report, the East Midlands Chief Executives Group, working with East Midlands Strategic Clinical Networks and Senate, started the Seven Day Services East Midlands Collaborative project in March 2014. We, along with nine other acute trusts in the East Midlands, have been involved in this project which established a set of principles and enabling behaviours to support clinical collaboration across organisational boundaries. The project sought to evaluate 7-day service requirements and the current models of provision across the East Midlands (including North Lincs. and Peterborough and Stamford) at clinical service, site and Trust level with a view to establishing the potential financial and workforce gap if all ten clinical standards were introduced. The baseline assessment and gap analysis was presented to the Collaborative in November 2014.

In addition to this work, we have been getting on with introducing these clinical standards particularly in areas where it was felt this would make the biggest difference to patient care such as on our acute medical assessment units and medical base wards. This has included:

- Monitoring our patient experience information over 7-days. Collecting data across 7-days will enable us to understand and act to ensure patient experience is equitable across seven days;
- Work through the Acute Medical Units to ensure 80 per cent of patients are seen by a consultant within six hours of arrival on the Assessment Unit (Monday – Friday 8am – 9pm and Saturday/ Sunday 8am – 5pm);
- An additional consultant cardiologist in our Clinical Decisions Unit and a consultant of the week working on our Oncology wards and assessment unit, including Saturday and Sunday ward rounds;
- Embedding electronic handover in nursing with a plan to roll this out to medical staff in 2015/16 allowing a more transparent and formal record of handover.

Further work in 2015 and 2016 will build on the previous years' work and we have identified five of the ten clinical standards to specifically embed in 2015/16.

As well as this work we have now permanently increased on site senior management presence at weekends to support the move to seven day services, and to assist with handling emergency pressures and elective throughput, following a three month trial period which started in January 2015.

The executive director on-call is now required to work on site every weekend (instead of just being available on the phone) with two senior managers/ nurses from the Clinical Management Groups to support the pre-existing senior manager on-call and duty managers at weekends.

This has enabled practical actions such as supporting discharge calls and Gold Command meetings and ensuring an oversight of capacity pressures across all three sites. They also take the opportunity to do more walkabouts as their diaries are not full of meetings!

Hospital 24/7

This service, run through Nervecentre software, is now active on all three of our sites in all adult wards except for our Emergency Department.

The service is designed to create a timely response to patients by prioritising and distributing a doctor's workload evenly throughout the hospital out of hours (6pm to 8am and weekends). They are further supported by specialist nurses who co-ordinate the workload and clinical aides who perform some of the tasks requested such as cannulation.

All of this is done via mobile devices that allow the doctor to remain with the patient rather than have to answer a bleep.

Calls are classified as red, amber and green. The aim is to respond to all red calls within 30 minutes and during the year the service met 96 per cent of red calls; there are on average in the region of 600 calls a month.

On average 25,000 tasks are generated through the system every month, a massive increase from 6,000 a month when the service started in 2012.

The top two requests are for cannulation and drug prescribing, which account for 4,000 of the requests that go through the system every month.

Pathway improvements (e.g. heart failure and pneumonia)

Pneumonia

This year we have introduced two new services to support the after care of patients discharged following a diagnosis of pneumonia. The first is a telephone follow up service for those patients discharged within 24 hours of admission. This is to ensure that they are taking their antibiotic treatment correctly and to provide any other advice they might need. The second is a nurse-led chest x-ray service which involves the pneumonia nurse arranging for patients to have a 'check-up' chest x-ray 6 weeks after they have been discharged and then organising appropriate follow up dependent upon the results.

The introduction of these services has been as well as the continued improvements made with recognising the severity of pneumonia when patients are admitted, and instigating appropriate treatment (85 per cent of patients received all parts of the care bundle in Quarter 3).

There has also been a further improvement in the number of patients who receive all aspects of the heart failure care bundle before discharge (75 per cent by end of March 15).

Academic Heart failure Service

Our heart failure service has enjoyed a successful year. Heart failure is responsible for 5 per cent of all emergency medical admissions to hospital and the risk of readmission or death within 60 days is 30-50 per cent. The outcomes for people diagnosed with heart failure are often compared to those of the worst cancers; while this is true for sub-optimally treated patients; early specialist treatment has a considerable impact on survival and symptoms. Treatment of heart failure patients is a considerable challenge because of the increasing numbers and the complexity of management.

Our heart failure service works closely with GPs and community services to cope with the challenge. In particular an initiative with Leicester West Clinical Commissioning Group, urgent heart failure clinics, has now moved beyond the pilot phase and has also been commissioned by Leicester East Clinical Commissioning Group. This service aims to avoid admitting a patient by ensuring they are seen by one of our consultants or senior registrars within 72 hours of being referred. In most cases ensuring that a patient is seen early is enough to avoid a hospital admission.

Heart failure admissions were projected to increase by 4.1 per cent across Leicestershire and Rutland between 2013/14 and 2014/15; however in West Leicestershire heart failure admissions decreased by 3.5 per cent, the first time we have seen a reduction. During 2015/16 we are hoping to see further expansion of this service to Leicester City Clinical Commissioning Group and then to the Emergency Department.

Our heart failure service has expanded with the appointment of Dr Will Nicolson, Consultant Cardiologist with a special interest in heart failure, who joins Dr Loke and Professor Squire. An expanding specialist nursing team lead by Louise Clayton provide an outreach service across the Trust to over 70 per cent of patients admitted with a diagnosis of heart failure.

During the year we ensured that over 1000 patients had care plans in place; this is best practice in management of acute decompensated heart failure. Our practice is in line with the new NICE acute heart failure guidelines and this is evidenced through the national heart failure annual audit report.

A new outpatient heart failure unit opened in spring 2015 funded by Listening into Action and supported by funds from Leicester Hospitals Charity. Support for Leicestershire's heart failure community is not limited to teams within our organisation. The community heart failure team, GP's, patients and their families can find ongoing specialist care through a number of schemes including the heart failure multi-disciplinary teams, virtual wards and global e mail.

This is an exciting time for the service as we look towards further developments in the coming year.

Mortality reviews

This year we jointly commissioned a review (Learning Lessons to Improve Care) with local CCGs and Leicestershire Partnership NHS Trust. The review involved a study of the primary and secondary care case notes of 381 patients who died in hospital or up to 30 days post discharge between March 2012 and July 2013.

In starting this process we actively looked for problems rather than hoping to seek comfort. The review focused on those admissions which were most likely to demonstrate clinical systems issues which may exist, most of these issues related to patients on the emergency care pathway.

As a result, some care was deemed to be "exemplary"; in a significant minority of cases it was deemed to be "unacceptable".

Reviewers found that communication between different parts of the local health system and within hospital was poor which sometimes meant that diagnosis was delayed or test results were not acted upon in a timely manner. Reviewers also commented that doctors, nurses and other clinicians and managers were *'struggling to fix the emergency care pathway as individuals rather than as part of a system'*

As part of this process we wrote and apologised to the relatives of the 381 patients and a helpline was available to them. In the seven days after the announcement we received 53 calls, with 31 of those calls from relatives of the 81 who it had been deemed had received unacceptable care. Meetings were set up with many of them so that they could discuss the report and the care of their relative.

Since the review was carried out we have already made changes.

- We asked Dr Ian Sturgess, a national expert in emergency care, to work with GPs, hospital doctors and other professionals on 'root and branch' change to emergency care pathways;
- We have recruited 200 more ward based nurses and continue to recruit to vacancies (more about that later in the report);
- End of Life care was raised as a major issue. Since April 2013, more than 1,000 patients on the palliative care register in their last 12 months of life have benefitted from having an Emergency Healthcare Plan (EHP). As a result, 85 per cent of patients who had a care plan died in their place of choice and their wishes were carried out – almost double the national average of 45 per cent;
- There is a multi-disciplinary team in place out of hours to ensure continuity of care for patients;
- There are many actions underway across all of the organisations, with much of ours contained in our extended Quality Commitment.

But there is still more to do, so we have put in place a system-wide action plan. Individual care plans have been introduced following identification of risk stratification (risk stratification is a clinical evaluation used to determine a person's risk when suffering a particular condition) and MDT (multi-disciplinary team)

planning for older people shared with health and social care providers. In additional to specialities carrying out reviews of individual cases, our mortality review committee also carries out or commissions reviews looking at diagnosis groups or specific time frames.

We now have a standardisation of End of Life care plans and a process for sharing key information across organisations. The Electronic Patient Record is being fast tracked in development to share End of Life/ discharge and patient management plans seamlessly across all organisations.

We held listening events across Leicester, Leicestershire and Rutland for patients, the public and staff – with a particular focus on end of life care – and we brought together local GPs and our clinicians at a clinical summit to encourage better communication and to identify what more we need to do to ensure seamless care for patients. Where this involves changing care pathways this will form part of Better Care Together.

This is by no means everything that has happened as a result of this review. You can read more about the actions and the report in full on our website. Our Trust Board regularly reviews actions to ensure that they are being completed.

In terms of our mortality rate, we saw an increased mortality rate for December 2014, but reviews identified that this was due to the increased complexity and frailty of patients being admitted, which was a similar picture to that seen in other trusts across the country.

Our latest published SHMI (Summary Hospital-level Mortality Indicator) is 105, which whilst above 100 is still "within expected" and has reduced slightly from the 106 previously reported. Our SHMI for 2014/15 is predicted to be closer to the national average of 100 (due to be published October 2015).

Stop smoking service

The Bedside Project funded by Leicester City Clinical Commissioning Group and run by Stop at Leicester's Hospitals has been a real success this year. Funders of the service have recognised it as a successful way of impressing upon patients who smoke that there is help and support available for them, and based on that the funding has been extended for a further year.

The Stop service is non-judgemental and flexible and develops a good rapport with patients who may have thought it was too late to stop smoking. Those who have quit have said they wished they had done it sooner, and have gone on to encourage their family and friends to get support from Stop.

Stop 0116 454 4000 - new number, same great service!

Improve safety

Resuscitation procedures

We have made significant improvements with our resuscitation Procedures. Record numbers of clinical staff now have up-to-date training, and we have made special efforts to start to train our non-clinical staff as well.

We have standardised the resuscitation trolleys across the three hospitals, so staff at any site will be familiar with their layout. All three hospitals are now taking part in the National Cardiac Arrest Audit, which provides external assurance about outcomes after a cardiac arrest.

Importantly we also now have a separate "Do Not Attempt Resuscitation" policy, for cases where patients do not wish to have a cardiac arrest team called, or where they will not benefit from it. We have also introduced a new training package for this.

Sepsis

The Parliamentary and Health Service Ombudsman released a report in September 2013 entitled “Time to Act” which highlighted that the NHS needed to do more to recognise and treat patients with sepsis.

We responded by appointing medical and nurse leads for sepsis who during the year launched a number of initiatives to help improve sepsis care. They recruited a total of 120 “sepsis champions” who went on to help train over 2,000 clinical staff about the importance of sepsis as well as how to recognise and how to manage it.

“Sepsis boxes” have been put in all of our clinical areas to help deliver prompt treatment to patients with sepsis. A strong promotional campaign has also been put in place to support these initiatives. Clinical staff now receives structured feedback on how well they manage patients with severe sepsis.

During the year we have collected audit data that has shown an increase in documented prompt recognition of severe sepsis from 40 per cent to 80 per cent of patients. There has also been a marked improvement in the delivery of the six key interventions for severe sepsis in the first hour (oxygen, blood culture sampling, intravenous antibiotics, intravenous fluid, lactate measurement and urine output measurement) with five of the interventions exceeding the target set of 75 patients of patients. Notably, administration of intravenous antibiotics has risen from a baseline figure of 27 per cent to 84 per cent of patients as of March 2015. During the year ahead we will seek to consolidate the achievements that our staff have made.

Safety Thermometer

"Harm Free Care" is a Department of Health initiative and describes the absence of four of the most common harms to patients or service users:

1. Pressure Ulcers
2. Falls
3. Urinary Tract Infections (UTIs) in patients with a catheter and,
4. New Venous Thromboembolisms (VTEs or blood clots).

These four harms were selected as the focus because they are common and because it is believed that they are largely preventable through appropriate patient care. A patient may have all, some, one, or none of the harms.

The NHS Safety Thermometer is a measurement tool that monitors and records the presence of any one of these four harms on a set day every month. The tool is used in a wide range of care settings across England such as NHS hospitals and community settings, care homes and patients’ own homes.

Harm Free Care has challenged all care providers to deliver harm free care to all patients, but with a target of at least 95 per cent of patients being ‘harm free’. The data is collected by our nursing and midwifery staff and then sent on to the NHS Information Centre who collate and analyse the data on our behalf.

Over the last year our clinical teams have continued to work together to share best practice around the prevention of the four harms and the table below shows that we have regularly achieved the 95 per cent threshold for Harm Free Care. This tells us that the actions we have put in place to prevent harm, particularly pressure ulcers and falls have worked.

The plans now are to maintain these improvements throughout 2015/16 with an increased focus of the prevention of VTEs and urinary catheter acquired infections in our patients

Table– Percentage of Harm Free Care at Leicester's Hospitals in 2014/15

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
% Harm Free	95%	95%	94%	95%	94%	94%	95%	93%	94%	95%	92%	94%

Care and Compassion

Care of older people

During the year, six of our wards were awarded 'The Quality Mark Award for Elder Friendly Hospital Wards' from the Royal College of Psychiatry Centre for Quality Improvement. A quality project for older people was developed to improve quality, dignity and patient experience for older people and an information pack is available to wards who would like to implement learning from the Quality Mark to improve the service they provide for their older patients.

In June 2014, Age UK LeicesterShire and Rutland opened a Resource Centre at the Royal Infirmary for patients, carers and staff to access information. They have been helping around 100 people a month who would not have previously accessed their support. People with dementia and their carer's can directly access Dementia information and support programmes across Leicester, Leicestershire and Rutland led by the Alzheimer's Society.

Future work

- Deliver the key work streams of the Frail Older People's Strategy;
- Improve experience for carers;
- 'Fix the Basics' for older people to improve their experience.

Meaningful activities

Our Meaningful Activity Service provided additional support for 672 patients with dementia during the past year. Carers reported they have seen a significant improvement in their relative's well-being whilst they were in hospital. Plans are in place to introduce an 'out-reach' advisory service in the coming year.

End of life care

The AMBER care bundle is supporting patients and families on 41 of our wards. The AMBER care bundle contributes to people being treated with dignity and respect at the end of their life and enables them to receive consistent information from their healthcare team. Staff continue to attend specialised training by

ourselves and LOROS to support patients and families helping staff to change and improve their practice. To help support and sustain the use of the AMBER care bundle we run AMBER champion education days once a month for HCA's and trained nurses, these have been well attended and evaluated.

Priorities of care for the dying person

We are now using new guidance and individualised End of Life Care plans throughout the organisation and we raised the profile of the priorities of care throughout the whole month of March by running drop in teaching sessions for all staff groups. In total we ran 12 days which were spread across all of our hospital sites, which were attended by over 200 staff.

Throughout March we also presented the priorities of care for the dying person at a variety of meetings and teaching sessions such as Respiratory, Oncology, Hepatobilary, Renal, Geriatrics as well as the Grand Round at the Royal Infirmary. This was supported by a staff leaflet about the priorities of care and distributed it to every member of staff with their March payslip.

Thanks to the support of Leicester Hospitals Charity we have been able to purchase some voile bags which are being used in all of our hospitals once someone has died to return jewellery to family members.

Education

The End of Life Care team regularly deliver education packages on End of Life Care for preceptee and international nurse training programmes, as well as to ward staff forming part of their essential to role training. Working in partnership with LOROS, they have also run four Quality End of Life Care for All (QELCA) courses.

A key piece of work being developed for 2015 will be a guide for staff to help in supporting relatives at a time when someone is dying. This includes considering a meal and drink, car parking, accommodation, washing facilities etc.

Dementia care

The Dementia Champion Network increased to over 300 champions and in January 2015 the network was successfully launched in De Montfort University and 84 student nurses have since become champions. We also have 28 'Forget me not' volunteers trained to support patients and staff.

Over 95.2 per cent of staff have now been trained in dementia. In March 2015, Leicester Hospitals Charity funded staff to attend the Inside Out of Mind production based on 'life on a dementia ward' and workshops at The Curve. This was well received by everyone who attended and the overall response was that the production and workshops were thought provoking. Also as part of our ongoing commitment to dementia care we have signed up to Carers Call to Action. So far we have asked over 200 carers of people with dementia for their feedback to help us understand how we can better support them.

Improving the experience of our patients

We aim to listen and learn from patient feedback and to improve patient experience of care. We set out to:

- Seek the views of patients and learn from feedback across all services;
- Improve the experience of care for older people and patients with dementia and their carers;
- Expand end of life care processes;
- Ensure each patient knows the name of the consultant and nurse caring for them.

Achievements

A minimum of 30 per cent of in-patients now provide feedback on their experiences on discharge from the hospital. The accessibility to feedback has been expanded to include smart phone scanning, electronic feedback through touch screen devices and text messaging. Electronic feedback is also accessible in Gujarati, Punjabi and Polish.

We have focused on ensuring a wider population of in-patients have had opportunity to provide feedback regarding their experience of our care. The high level metric of the composite score and Friends and Family Test score identifies that in our hospitals we are maintaining consistent performance, whilst achieving increased feedback of 30 per cent of our in-patient population.

We are delighted by the increase in monthly response rates of patient experience surveys from inpatients, which equally assure greater validity to the data and improvements made:

- 2013-14 average surveys per month1,504*
- 2014-15 average surveys per month 2,160*

**data based on April to December*

We aim to continue to listen to our patients and respond to meet the needs of people in Leicester, Leicestershire and Rutland by prioritising key improvements based on keeping Friends and Family Test percentage if not recommends to a minimum.

The indicator, *responsiveness to in-patients' personal needs* provides a measure of quality, based on the Care Quality Commission's national in-patient survey. The composite score is based on five questions.

Another change we have made to improve communication between patients/relative and the staff caring for them was to ensure that each in-patient has their name, the nurse's name caring for them on each shift and the name of the Consultant whose care they are under written on a board above their bed. Details of how patients and relatives can contact their consultant if they need to are available from the nurse looking after them and on the ward information board.

Friends and Family Test

We welcome all feedback from patients, carers, families and friends. Positive and negative feedback is actively listened and responded to by making improvements in care to meet the needs of the people we care for. Patient feedback is collected in a number of ways including:

- Talking directly to staff and the Ward Sister;
- Message to Matron cards;
- Message through a volunteer;
- Patient experience surveys;
- Online through the website 'How did we do' questionnaire;
- Compliments and complaints provided to Patient Information and Liaison Service (PILS);
- NHS Choices/ Patient Opinion;
- Friends and Family Test question.

Every NHS hospital provides patients, and their families and friends the opportunity to give feedback by completing the nationally set Friends and Family Test. The question asks *"How likely are you to recommend our ward to friends and family if they needed similar care or treatment?"* This is a high level metric used to measure improvements in experience of care. Historically the Friends and Family Test has been reported as a net promoter score, but since November 2014 the results have been nationally displayed as a percentage of recommend and not recommend.

The Friends and Family Test score consistently shows an overwhelming majority of patient would recommend our adult inpatient services. A small percentage would not and these direct key areas for development priorities.

	Apr- 14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
% recommend	95.7%	96.5%	96.7%	96.5%	96.2%	96.6%	95.6%	95.8%	95.9%	96%	96%	97%
% not recommend	0.9%	0.7%	0.6%	0.9%	1%	1%	1.2%	1%	1.2%	1%	1%	1%

Out-patients

We provide out-patient services across our three sites and in a number of other sites across the city and counties seeing around 700,000 patients every year and we are committed to continually creating a first class experience of care and working towards improvements based on patient feedback. We began collecting patient feedback in out-patient areas in October 2014. Electronic devices situated in out-patient clinics and soon to be installed in hospital reception areas will allow us access to feedback more quickly and give us the ability to respond sooner. Electronic feedback devices enable the Friends and Family Test to be offered in alternative languages (Gujarati, Punjabi and Polish) and patients with visual impairment can increase the font size to allow easier reading.

Volunteers Survey

Every month our volunteers visit clinical areas and conduct surveys as another method to find out the opinions of our patients and visitor's. These allow us to focus our efforts towards improvements. This year volunteers have been involved in a number of surveys which have resulted in the following improvements:

- Carers perception of their stay in our hospitals has enabled the development of our Carers Charter;
- Patient experience surveys ensured that the survey is fit for use and asking the correct questions;

- Patients knowing who their consultant and nurse caring for them has initiated the introduction of the name boards above in-patients beds;
- Understanding who doctors are is important so we have developed clearer identification with coloured lanyards;
- Visiting times has been expanded and opened up for carers in response to opinions.

Celebrating Success
The first Celebrating Success booklet outlined our priorities around improving patient experience; the second highlights changes made in response to patient feedback. Creative ideas are shared to inspire all areas to continue to respond to patient feedback and deliver 'Caring at its Best'. All wards display responses to patient feedback with the use of the patient feedback chart.

Involving our members and the wider public

This year our public membership grew to over 15,000 people - the largest it has ever been. Over the year the number of our younger members has also increased, with many joining as a first step to volunteering within our hospitals.

Members are invited to participate in a range of engagement opportunities, as well as coming along to our monthly "Leicester's Marvellous Medicine" talks. Attendance at these talks has grown over the past 12 months and members have enjoyed sessions on a wide range of topics including the management of chronic pain, volunteering in our hospitals and the growing problem of antibiotic resistance.

Our Annual Public Meeting in September 2014 invited members to learn more about our five year plan and talk to staff from our Clinical Management Groups about how they planned to develop their services the coming years.

As well as our regular events, members are approached to get involved in specific pieces of work which aim to improve our services. For example, some of our older members recently took part in a focus group run by DeMontfort University to examine nursing care on our wards; members who have experienced cancer care at the Trust are being supported to form a service user group which looks at ways in which that service could be improved and our members have also been invited to take part in a consultation on developments in our hospital chaplaincy.

We have continued to develop our relationship with local Healthwatch organisations, and a Healthwatch representative sits on our Trust Board as a non-voting participant and Healthwatch representatives meet with our Chief Executive every three months. In January 2015 Healthwatch Leicestershire conducted four informal visits to departments in the Trust and will share their feedback in due course.

One of the key ways in which we involve members of the public is through our Patient Advisor group. Patient Advisors are members of the public who work closely with us to bring a patient's perspective to our day to day activity. We currently have 12 Patient Advisors, each of whom is attached to one of our CMGs. This year some of our Patient Advisors have been facilitating focus groups with other patients, whilst others have been involved in specific projects such as developing patient letters. Patient Advisors also sit on CMG boards and on our main committees. Over the coming year we aim to increase the number of Patient Advisors to 20 to give our services more access to this valuable "lay" perspective.

Providing spiritual and religious care

Over the year our chaplains and chaplaincy volunteers made over 14,000 visits to patients. This is an invaluable part of our commitment to deliver "Caring at its best" to patients and their relative's right up to the end of life. Chaplains support those who face emotional distress arising from questions concerning life, death, meaning and purpose - questions that can be acutely highlighted by illness and suffering. We ensure that a chaplain is available day and night for when patients or families ask to see one urgently (especially around the time of death).

We provide multi-faith chapels and prayer facilities on each site, for the use of patients, visitors and staff. This year we opened a new Interim Chapel at the Royal Infirmary and extensively remodelled the prayer rooms used by all faiths and those with no chosen faith but who want a quiet place to reflect.

Our chaplains, who are from various faiths, help patients to be able to continue to perform their religious rituals while they are in hospital, but the team are not only there to support "religious" people. This year we have secured funding to appoint a non-religious member of the chaplaincy team in the coming year. We will be evaluating how this service enhances the experiences of patients.

Volunteering

Volunteer Services has spent this year consolidating the involvement of volunteers within the Trust. There are currently around 600 active volunteers registered with us helping across our hospitals and many others who are part of other voluntary and community groups who come in to our hospitals to offer their support. Volunteer Services work closely with other organisations to make sure that all volunteers are subject to the same level of checking and training and receive support and recognition for their involvement.

Our most important task is to make sure that volunteers are carefully selected and supported to find the right role for each individual. Everyone has their own unique reasons for wanting to volunteer and we choose their role to meet their needs.

The profile of volunteers continues to be of paramount importance. As new developments are happening within our hospitals volunteers are needed more than ever to help patients and visitors find their way around and receive the support they need to access services.

We have now been awarded the Investing in Volunteers Quality Mark for excellence in supporting and working with volunteers. The Trust has made a genuine and total commitment to the long term involvement of volunteers in the delivery of our services and we are very proud to have achieved this.

We continue to recruit new volunteers through our membership and have amended and adapted our recruitment process to make sure that everyone has an opportunity to apply, but that we also select the most committed and enthusiastic volunteers for our service.

Our volunteers continue to go above and beyond to improve the experience of our patients. From running the indoor buggy at the Royal Infirmary at the weekends to assist transporting patients to x-ray whilst it is refurbished, to accompanying people to relocated clinics along ever changing routes; they are always there to help with a smile.

Volunteers are now an integral part of our organisation and are firmly established in our plans for the future.

Safeguarding adults and children

Protecting people from harm and abuse remains one of our highest priorities; one that we remain highly committed to ensuring we meet. In the past year we have continued to work with partner agencies to ensure that learning from local and national developments in safeguarding practice are embedded within the organisation.

We have an internal performance framework and report on quality indicators to our local Clinical Commissioning Groups (CCG) and Safeguarding Boards. In the past year there were improvements to all areas which enabled us to report compliance in key areas of practice, notably training.

Locally and nationally there has been increased attention being paid to compliance with the Mental Capacity Act, the findings from investigations relating to Jimmy Savile sexual abuse and exploitation and preventing radicalisation. Work has taken place in all these areas, and where appropriate changes have been made to practice.

From 1 April 2015 the Care Act will come into force which for the first time places safeguarding adults onto a statutory footing in health. Work has already taken place to ensure that from this date we will meet these new statutory requirements.

Preventing terrorism and people being subject to radicalisation is an area of practice where it is anticipated further work will take place in the forthcoming year. This is in response to highlighted national concerns and increased expectations from the Department of Health.

Patient information and liaison service (PILS)

Feedback from our patients, their relatives and carers is a valuable opportunity for us to review our services and make improvements. We encourage dialogue with staff, giving an opportunity for immediate action and resolution.

To further support our patients, the Patient Information and Liaison Service (PILS) provides information and advice on how concerns can be managed. They can be contacted via a free phone telephone number, email, website, in writing or in person.

Overall activity through the PILS has reduced by 3.9 per cent, although the number of formal complaints has risen slightly which is a reflection in part of the ease in reporting, as well as the increased profile for complaints management and issues of patient safety within the media.

The increase is reflected in the table below:

PILS Activity	10/11	11/12	12/13	13/14	14/15	Total
Concern	-	66	341	343	474	**1224**
Formal	1531	1723	1513	2030	2126	**8923**
Requests for information	356	434	292	203	234	**1519**
Verbal	1289	1152	1054	1391	977	**5863**
Totals:	**3176**	**3375**	**3200**	**3967**	**3811**	**17529**

Complaints

Throughout 2014/15 we have focused on putting things right, in real time, before the service user feels a formal complaint is necessary. To achieve this dialogue is established as soon as possible ensuring that the patient's expectations lie at the heart of complaints handling. We view any feedback we receive as an opportunity to improve our services and continue to work on making it easier for users of our services to give us feedback.

We endeavour to respond as quickly as possible to all issues that are raised with us, with a standard for 95 per cent compliance within the agreed 10, 25 and 45 working day performance targets. The table over the page identifies, by Clinical Management Group and speciality, how we achieved against this target during the year. Monthly performance has been above 90 per cent since November 2014 which is reflected within the overall performance. Increasingly we seek to respond real time to concerns raised to prevent these escalating. We have also developed a complaints e-learning module for all staff.

The Clinical Management Group's continue to scrutinise their performance and ensure that support from clinicians and final responses letters are provided within the required timescales. Improved compliance with complaints performance continues be monitored through the Clinical Management Group Quality and Safety Board meetings, with poor performance escalated to the Executive Quality Board. An improvement trajectory of >90 per cent compliance for 10, 25 and 45 day complaints was set for all Clinical Management Group's to achieve by May 2014; however due to an increase of activity across the service this was not met. We are pleased that a compliance of 95 per cent is now being achieved.

We have created a Complaints Review Panel following a successful 'Complaints Engagement Event' that we hosted in June 2014. The event was supported by HealthWatch, POhWER, and people who have used our complaints or Patient Information & Liaison Service (PILS). The purpose of this group is to provide independent oversight of randomly selected closed complaints files considering their management from beginning to end, including timelines, plain English, communication and complainant satisfaction. It is anticipated that the service will continue to improve with the feedback it receives which will greatly assist with the embedding of complaints management across our organisation.

Following the event we have also agreed and implemented the following for our complaints/PILS services:

- An identified case lead contact;
- Early contact with complainant to offer appropriate apologies;
- On-going and timely contact with complainant if/when there are delays with responses;
- Actively encourage meetings;
- Establish an independent complaints review panel.

The table (overleaf) displays the Top 10 Subjects of Formal Complaints received by Clinical Management Groups from April 2014 to March 2015.

We listen carefully to all the feedback we receive and continually strive to improve services. In addition we actively encourage the collaboration of all staff working together to improve the way concerns and complaints are handled.

	Cancer, Haematology, Urology, Gastroenterology and Surgery	Renal, Respiratory and Cardiac	Emergency and Specialist Medicine	Intensive Care, Theatres, Anaesthesia, Pain Management and Sleep	Musculoskeletal and Specialist Surgery	Clinical Support and Imaging	Women's and Children's	The Alliance	**Total**
Medical Care	107	42	125	21	120	11	67	4	497
Waiting times	92	25	37	14	140	24	48	9	391
Staff attitude	34	14	50	11	39	19	40	5	222
Communication	43	30	42	3	26	12	29	3	197
Appointments including delays and cancellations	31	7	13	9	90	7	17	10	184
Nursing care	31	15	61	0	18	0	21	1	147
Integrated Care/Discharge	11	12	58	0	12	4	4	0	105
Administration	20	1	10	6	23	3	10	5	80
Complications	9	2	2	3	6	1	14	2	39
Medication	5	4	13	1	1	7	1	0	32

In reaching a satisfactory resolution the Clinical Management Groups have done much to improve the quality of complaint responses and offer face to face meetings as appropriate. If complainants remain unhappy following an initial response we will 're-open' the complaint and identify if an alternative action can be taken to try and resolve the complaint, such as that of a telephone call or meeting. Currently between 11-13 per cent of formal complaints re-open, however we are working hard to lower this and always aim to ensure that the patient's expectations lie at the heart of complaint handling.

During the year the Ombudsman investigated 13 of our complaints. Of these one was upheld and two were partly upheld. A further two were not investigated any further as we agreed to send further information to the complainant. Five of the complaints were not upheld and we are still awaiting the Ombudsman's decision on the final three complaints.

10 and 25 day Performance – 1 April 2014 to 31 March 2015

	10 day				25 day			
CMG	**Number received**	**No. replied within 10 days**	**No. replied over 10 days**	**% replied within 10 days**	**Number received**	**No. replied within 25 days**	**No. replied over 25 days**	**% replied within 25 days**
Cancer, Haematology, Urology, Gastroenterology and Surgery (CHUGGS)	105	103	2	**98%**	286	265	21	**93%**
Renal, Respiratory and Cardiac	34	34	0	**100%**	124	121	3	**98%**
Emergency and Specialist Medicine	89	77	12	**87%**	337	286	51	**85%**
Intensive Care, Theatres, Anaesthesia, Pain Management and Sleep (ITAPS)	25	22	3	**88%**	45	41	4	**91%**
Musculoskeletal and Specialist Surgery	224	170	54	**76%**	254	194	60	**76%**
Clinical Support and Imaging	35	31	4	**89%**	71	64	7	**90%**
Women's and Children's	45	43	2	**96%**	213	201	12	**94%**
The Alliance	14	12	2	**86%**	29	27	2	**93%**
Communications	1	1	0	**100%**	0	-	-	**-**
Corporate and Legal Affairs	1	0	1	**0%**	0	-	-	**-**
Finance and Procurement	0	-	-	**-**	3	3	0	**100%**
Human Resources	0	-	-	**-**	3	3	0	**100%**
Medical Director	2	1	1	**50%**	1	0	1	**0%**
IM&T	1	1	0	**100%**	1	1	0	**100%**
Interserve	4	2	2	**50%**	3	2	1	**67%**
NHS Horizons	12	10	2	**83%**	9	9	0	**100%**
Nursing	4	4	0	**100%**	5	5	0	**100%**
Operations Directorate	0	-	-	**-**	10	8	2	**80%**
Totals	**596**	**511**	**85**	**86%**	**1394**	**1230**	**164**	**88%**

45 day performance 1 April 2014 – 31 March 2015

CMG	Number received	No. replied within 45 days	No. replied over 45 days	% replied within 45 days
CMG - Cancer, Haematology, Urology, Gastroenterology and Surgery (CHUGGS)	25	21	4	84%
CMG - Renal, Respiratory and Cardiac (RRC)	10	10	0	100%
CMG - Emergency and Specialist Medicine	34	21	13	62%
CMG - Intensive Care, Theatres, Anaesthesia, Pain Management, Sleep (ITAPS)	1	1	0	100%
CMG - Musculoskeletal and Specialist Surgery	24	21	3	87%
CMG - Clinical Support and Imaging	2	2	0	100%
CMG - Women's and Children's	17	16	1	94%
Trust Medical Director	1	1	0	100%
Operations Directorate	1	1	0	100%
Totals:	**115**	**94**	**21**	**82%**

Freedom of information

The Freedom of Information (FOI) Act was passed on 30 November 2000, and the full Act came into force on 1 January 2005. The Act applies to all public authorities including us. The purpose of the Act is to allow anyone, no matter who they are, to ask whether information on a particular subject is held by us and to ask to see that information. The Act sets out exemptions from that right, covering any information that may not have to be released.

During the year we received 542 Freedom of Information requests and/ or requests for environmental information, compared to 500 in 2013/14 (an 8.4 per cent rise in requests). We responded to 95 per cent of these requests within the statutory 20 working-day deadline in 2014/15. Many of these requests contained multiple individual questions, with information needing to be obtained from more than one clinical or corporate area of our organisation. The table below shows the number of times that different areas had to provide information during the year to respond to those 542 FOI requests (as the main FoI Lead).

Some information (such as patient information leaflets and Trust Board papers) is already publicly available on our FOI publication scheme – you can find this on our website (www.leicestershospitals.nhs.uk) in the Freedom of Information section.

Freedom of Information/Environmental Information Regulation requests received between 1 April 2014 and 31 March 2015, split by Clinical Management Group (CMG)/Corporate Directorate		
Area	**Number of times asked to provide FOI data in 2014/15 (as the main FoI Lead)**	**Approx. % of overall 2014/15 FOI activity**
Human Resources	80	14.8%
Strategy	71	13%
Finance and Procurement	65	11.9%
Corporate Nursing	53	9.8%
Clinical Support and Imaging CMG	44	8.1%
Cancer, Haematology, Urology, Gastroenterology and General Surgery CMG	34	6.3%
Information Management & Technology	33	6.1%
Women's and Children's CMG	27	4.9%
Facilities & Estates	25	4.6%
Emergency and Specialist Medicine CMG	22	4.1%
Corporate & Legal Affairs	21	3.9%
Corporate Medical	21	3.9%
Operations	20	3.7
Musculoskeletal and Specialist Surgery CMG	20	3.7
Critical Care, Theatres, Anaesthesia, Pain and Sleep CMG	9	1.7%
Renal, Respiratory and Cardiac CMG	5	0.9%
Marketing and Communications	5	0.9%
Research and Innovation	3	0.5%
The Alliance	1	0.2%

Equality and diversity

Our equality ambitions, based upon the Equality Delivery Framework, are to improve health outcomes and to improve patient access and experience for all of our patients, visitors, carers and staff. In essence we need to ensure that in all of the services we provide.

We continue to declare legal compliance with the Public Sector Equality Duty and we have a range of activities to evidence our position. Highlights for patients and staff include:

- Greater use of our interpreting service;
- More patients seen by the specialist learning disability service;
- The successful retendering of our Interpretation and Translation service;
- The development of guidance for managing patients with hearing loss;
- The delivery of sensory awareness training for some of our staff;
- The completion of an on line hate crime awareness programme for emergency staff.

Mainstreaming equality continues to be a priority. Across all areas there is genuine commitment to the principles of fairness, equality of access for patients, carers and visitors as well as equal of opportunity for staff. There is also a good understanding of how to access the various services that are in place to make sure those patients with additional needs are well cared for and not disadvantaged. These include meeting the religious, spiritual, dietary and communication needs of all of our patients.

Our priorities for the coming year are to:

- Adopt best practice data collection for patients and staff;
- To implement the National Race Equality Standard;
- To ensure that staff and patients from all backgrounds report positive experiences of care from our staff and services;
- To develop a Non-Executive apprenticeship programme;
- To monitor patient access to the most commonly used care pathways and experience to ensure that everyone can expect the same quality of experience;
- To ensure that our Board and senior management team are representative of race, gender, disability and sexual orientation. To achieve this we will be implementing the new national workforce equality standard from April 1st. In addition we will be implementing a range of initiatives that will support all of our staff with their career development;
- Work with the deaf community to improve access to British Sign language interpreting within our emergency service.

Performance and finance: Delivering the basics

This strategic priority includes:

- Deliver emergency care improvement plan
- Increase bed capacity and staffing
- Deliver the RTT (18 week) improvement plan
- Protection of day case and elective work
- Improve productivity through re-design of major systems
- Deliver £45m CIP and financial bottom line

Deliver emergency care improvement plan

During 2014, the NHS struggled to meet the target whereby 95 per cent of patients should wait no longer than four hours in A&E to be treated, discharged or transferred. The challenge of achieving the A&E target continued throughout spring and summer, and deteriorated further during winter 2014. Performance deteriorated sharply towards the end of the year, with NHS A&E waiting times reaching their highest levels for a decade this winter.

We also experienced unprecedented emergency care pressures during the year, with 76,807 adult emergency admissions between 1st April 2014 and 31st March 2015, an average of 210 of emergency admissions per day. Delivery of the 95 per cent target in our Emergency Department remained a challenge but also one of our key aims, and led to a focused programme of work to improve and sustain our emergency care performance.

Working in partnership with our CCG, primary care, community and social care colleagues through the Urgent Care Board, a system-wide plan to improve emergency care performance for the people of Leicester started in December 2014. The programme reflects three distinct areas for improvement and the organisations within each that are best placed to make those changes:

Inflow	Ensuring that patients are supported to make the right choices regarding urgent and emergency care, and have access to seven day primary and community care services (e.g. pharmacy, dentistry and mental health)
Flow	Delivering improvements within secondary care to ensure patients are turned around promptly within our Emergency Department, and that any in-patient stay is appropriately shortened through proactive discharge planning and avoiding any delayed transfers of care
Discharge	Aiming to support the pull of patients into the community the same day as the patient is medically stable, and supported by the necessary care packages provided through social care

We identified three areas for improvement within our organisation, each clinically-led and supported by programmes of work reporting through to an executive-led steering group tasked with improving emergency performance:

Priority Work-streams		Clinical Lead
1	ED work stream	Dr Ben Teasdale
2	AMU (Acute Medical Unit) work stream	Dr Lee Walker
3	Base wards and discharge work stream	Dr Ian Lawrence

A series of Key Performance Indicators (KPI's) set out the improvements required to build system resilience:

Key Performance Indicators (KPI's)	
1	90 per cent of patients triaged within 20 minutes
2	50 per cent reduction in waits over 30 minutes, and 50 per cent reduction in waits over one hour
3	5 per cent reduction in admissions (approximately 4 patients per day)
4	70 per cent of time Emergency Department occupancy less than 55, and
5	No more than one hour wait to be seen by a consultant
6	Greater than 40 per cent in Q3 and greater than 70 per cent in Q4 of GP referrals go directly to our Acute Medical Unit
7	Greater than 40 per cent in Q3 and greater than 70 per cent in Q4 of patients are seen by a consultant within 6 hours
8	Supports 5 per cent (total) reduction in medical bed occupancy by the end of Q4

The Emergency Care Quality Steering Group (EQSG) provides governance and oversight to the work streams and delivery of the key performance indicators. EQSG is chaired by the Chief Executive, and membership includes the Chief Operating Officer, Medical Director, Chief Nurse, and Clinical Leads for each of AMU, Emergency Department, base wards and Glenfield Hospital, as well as the Senior Site Manager - reflecting the importance of this programme of work.

There are signs of recent recovery in the emergency care system. Following the height of winter pressures at the end of December, A&E 4-hour performance has improved steadily throughout January, February and into March – often exceeding the NHS average each week. Our weekly performance as at 28th February 2015 was 91.1 per cent, ranking us third out of eight trusts in the East Midlands and 55th overall out of 139 trusts nationally.

The scale of the challenge faced by our Emergency Department means further work still needs to be done. Sustained improvements, supported by evidence, will also be rolled-out at Glenfield and General Hospitals. A continued focus will remain on each of the AMU, Emergency Department and base wards in support of the improvements and changes already in place. We will also work through the LLR CCG Urgent Care Board to ensure that appropriate and complimentary improvements are made in each of the inflow and discharge areas. This will ensure that patients within the system not only benefit from the prompt care afforded to them by our teams when they access our emergency services, but that our services are part of a wider system that also provides appropriate options including seven day primary care and community care services, and timely discharge back to the community supported by any necessary care packages.

Increase bed capacity and staffing

Increasing our bed capacity

During the past year we have worked with commissioners to calculate the right number of beds (bed capacity) for the needs of our patients. There is more work to be done, and this is being carried out through the Better Care Together programme.

Before Christmas we opened ward 42 (16 beds in a new modular ward) at the Royal Infirmary due to the continuous emergency activity we were seeing. We did this whilst keeping ward 2 at the General Hospital open. Whilst this gave us extra beds and a short-term benefit of improving flow out of our Emergency Department, we could not keep these beds open permanently because of the pressures it placed on medical and nurse staffing. We also know that patients who transfer to ward 2 are likely to have a longer length of stay than if they stay if they stayed on a medical bed ward at the Royal Infirmary.

Following conversations with our commissioners and our Emergency and Specialist Medicine Clinical Management Group, we agreed to shut ward 2 by the 16 January 2015. This was undoubtedly a challenge and took the concerted efforts of staff to ensure that patients were transferred to an appropriate ward at the Royal Infirmary and that any patients that were suitable for discharge to community beds and other discharge destinations were discharged within 24 hours.

Recruiting more nursing staff

Nursing and midwifery staff comprises a significant component of the total workforce within our Trust so it is important to take the opportunity to emphasise all of the work that has been going on to increase our nursing staff across the Trust over the past 18 months, since the Trust Board agreed to invest £5.9m, and this funding is now embedded within annual nursing budgets.

Since then we have been working hard to increase numbers to bring our nurse to bed ratio to agreed acceptable levels, manage the additional numbers of patients we have been treating and recognise their increasing acuity.

In 2014 we saw a total of **1164** whole time equivalent registered nurses join our organisation. That includes **234** international registered nurses who have joined our team from Portugal and Spain. We will continue this recruitment during 2015 with a plan to recruit a further 240 nurses from Europe.

Alongside this international nurse recruitment programme we continue to proactively recruit from our provider university, and alongside this we advertise monthly for Registered Nurses, and attend all RCN jobs fairs across the country.

Despite this intense activity to recruit more nursing staff, we still have circa 300 (whole time equivalent) nursing vacancies. However we need to recognise the investment during 2013/2014, which fundamentally increased the nursing vacancies, alongside the proactive approach taken to nursing recruitment, supported by our Executive Team.

Retention

There is a lot of work also being done to encourage staff to stay with us. We will re-introduce Senior Staff Nurses for experienced band 5 nurses who have significant mentor responsibilities for learners and newly qualified staff.

The Corporate Nurse Education team is now a formal educational partner with DMU following a validation event in December. 2014. We have a Nursing Academy that can provide flexible degree level education to our nurses. We will increase the number of degree modules available to nurses and midwives throughout 2015.

Our Nurse Educators are reviewing their job plans to increase the amount of clinical time with newly qualified nurses, midwives and newly appointed HCAs providing additional support for mentors, particularly in Emergency and Specialist Medicine.

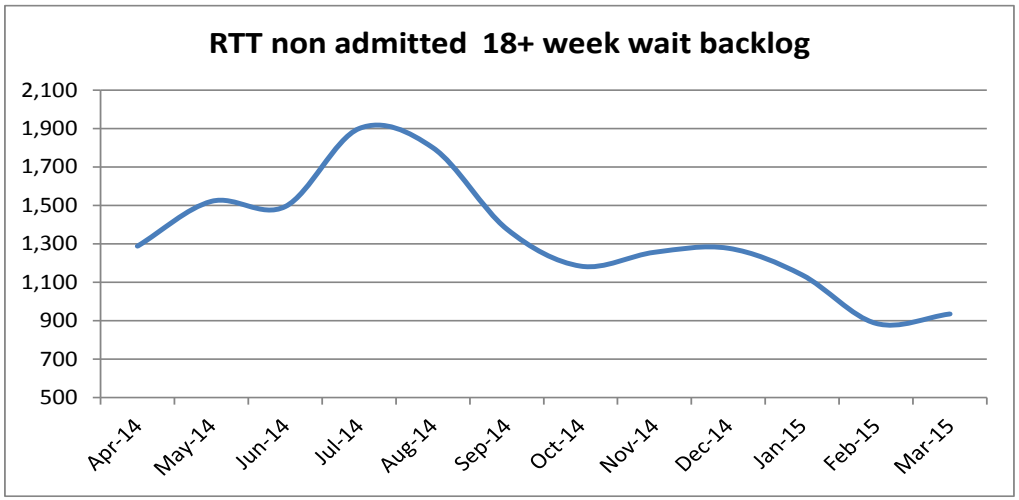
In addition, we are doing more joint working with Leicestershire Partnership NHS Trust through Better Care Together to ensure we have the right skill mix of staff in the right place as new models and settings of care are introduced.

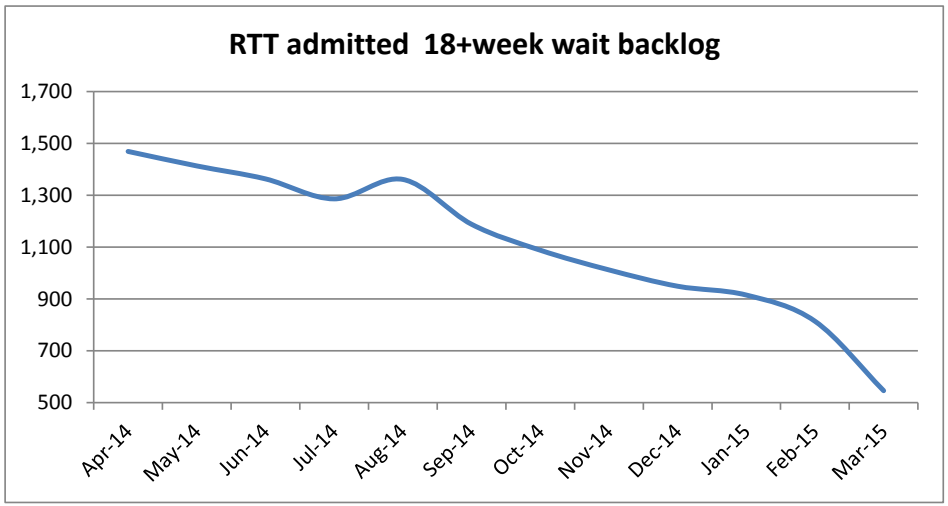
As you can see, we are continuing to make good progress in getting our nurse staffing to the right levels to allow delivery of high quality care. Ultimately, even with our best efforts to recruit to our vacancies there also needs to be good management of rostering, sickness absence and leave to ensure that we have enough staff on the ground.

Deliver the RTT (18-week) improvement plan

All NHS Trusts are required to ensure that:

- 90 per cent of admitted patients are treated within 18 weeks. Admitted pathways are those that end in an admission to hospital (either inpatient or day case) for treatment;
- 95 per cent of non-admitted patients start consultant-led treatment within 18 weeks of referral. Non-admitted pathways are those that end in treatment that did not require admission to hospital or where no treatment is required;
- 92 per cent incomplete within 18 weeks: this is proportion of all patients waiting for treatment at any time.





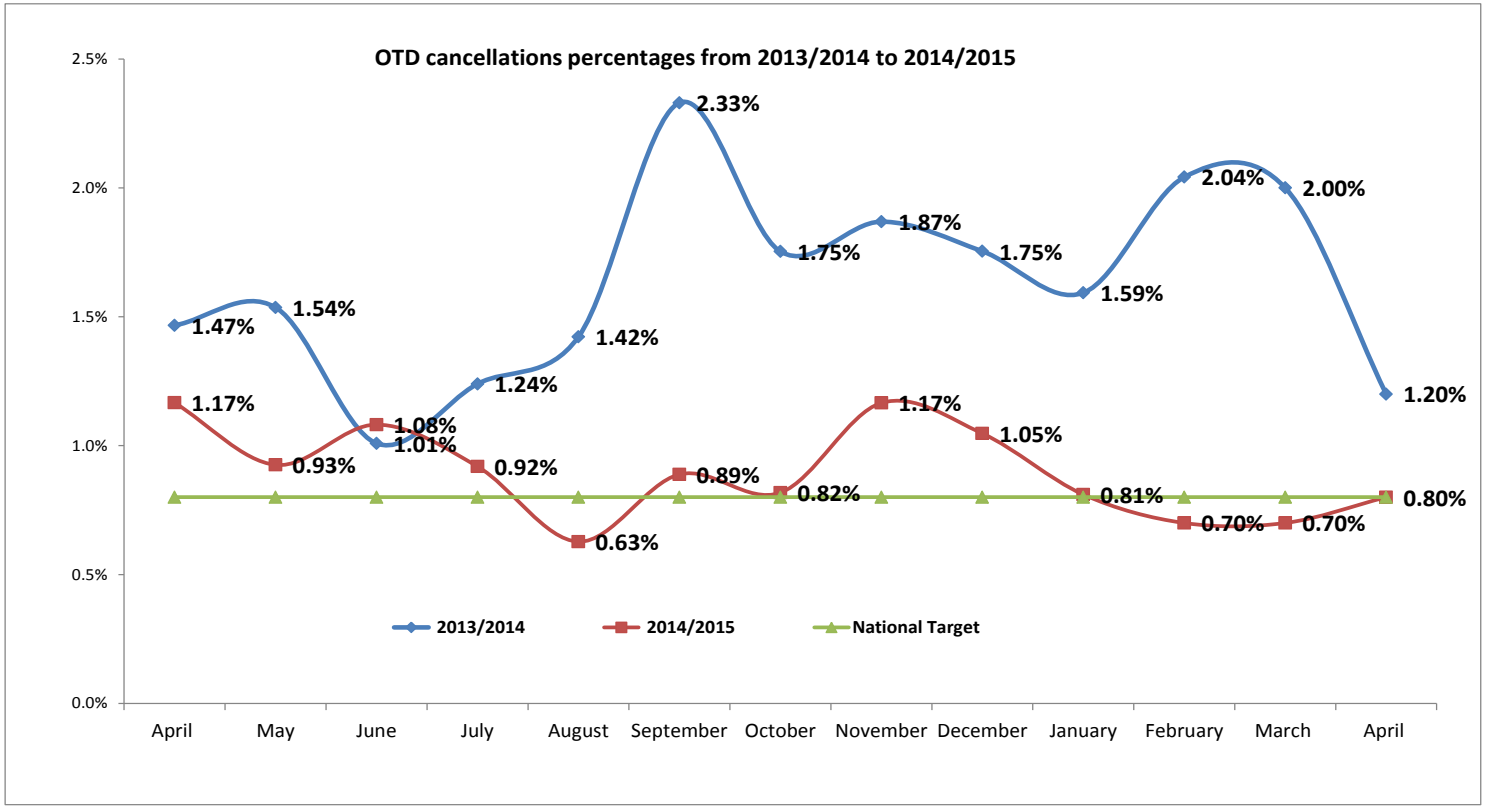
During the year we have consistently delivered performance against the non-admitted and incomplete standards. We have made significant progress in year to reduce the number of patients who are currently waiting too long for surgery. One of the challenges faced this year has been that we started in a very difficult place with far too many people waiting too long for surgery. In order to make sure we treated everybody fairly we started treating those patients who had waited the longest. Despite our best efforts of planning to treat those patients this year it has taken longer than we had expected. It has been more difficult to get the required staff we needed and due to the very high emergency demand experienced this year we have had to divert some of our theatre time to caring for emergency patients. At the start of the year that number was in 2945; March 2015 the number was less than 1650. There is still more to do but we have made significant progress during the year.

Protection of day case and elective work

We have done a lot during the past year to reduce the number of cancelled operations. A comparison with last year's performance shows that cancellations on the day due to hospital reasons have reduced significantly. Alone we have delivered the 0.8 per cent national target for four consecutive months, and with our partners have delivered the target for the last two months. This national target has not been achieved in a winter month, since 2010.

In January and February 2015, there were 71 and 110 fewer cancellations respectively compared to last year. A tightening up of our policy and processes around cancellations along with the appointment of a project manager for 'on the day' cancellations have made a significant difference to our performance particularly in the last six months.

A number of pieces of work aimed at reducing 'on the day' cancellations have completed, including a Listening into Action project led by the project manager for 'on the day' cancellations. A successful LIA event with 48 staff from all three sites was held and since then the team have been working hard to implement the suggested changes.



Improve productivity through re-design of major systems

During 2014/15 we focussed on three cross cutting themes to improve our productivity; beds, theatres and out-patients with the greatest improvements so far in the out-patient theme.

As the biggest acute services provider in the NHS (source: MAR Total FFCEs April - September 2014) we see an average of 800,000 outpatient attendances per year and bring in around £80m worth of out-patient income.

Before the launch of our Out-patient Transformation Programme in April 2014, we were only treating 93.4 per cent of out-patients within 18 weeks and had 1,286 patients waiting longer than 18-weeks for an appointment. The initial focus for service improvement was across four key problem specialties. Due to the success of the first cohort, in less than twelve months, the scale of the programme grew rapidly and was extended to reviewing twenty four clinical specialties in total.

As part of its agenda, the Outpatient Transformation Programme set up a Programme Board involving key stakeholders such as a patient representative, clinical representation and service managers. One of the key reasons that outcomes from this programme have been so effective is due to strong commitment from consultants to drive forward the change process from the onset, and strong leadership from service managers. For example, improvements made across our haematology out-patient service are reliant on Dr Mamta Garg consultant lead for Haematology: *'We analysed our capacity and demand for clinics and have designed clinic templates that are more realistic to achieve aiming to reduce waiting times for patients and reducing anxiety levels in clinic staff when clinics run late. We were mindful of not reducing activity but spreading it out more evenly through the clinic day. PIFU patient initiated follow-up is also currently a work in progress looking at well-informed patients who will be discharged with assurance of doors remaining open for them to come back if they need at a short notice.'*

The Out-patient Programme followed a structured process to review a number of key performance areas and objectives. The first area was to ensure that there was adequate reporting information. This saw the development of an out-patient scorecard with nine key performance indicators to drive efficiency. This was fully automated with our IM&T department readily able produce 65 scorecards on a monthly basis to support service improvement in every one of our specialties.

The next key area of the programme was optimising out-patient capacity. We set booking slot utilisation improvement targets at 95 per cent across all specialities and DNAs (Do not attend) needed to reduce to 5 per cent or less. These targets were achieved by ensuring improved throughput and numbers of patients seen per clinic from standardised clinic templates and by eliminating clinical variation. The final productivity area was looking at improved new to follow-up ratios in line with national and other peer group benchmarks. The Out-patient Programme Board developed its own review process for each of these areas as part of a 'productivity review'. This was later simplified and automated so that the reviews could be carried out across multiple specialties at a time, with a lead time of six weeks.

The Out-patient Programme Board developed a reporting structure for tracking and evidencing benefits to show how we were optimising our capacity whilst ensuring we maintained quality improvements. A clear set of key performance indicators were created to track improvements and a robust reporting mechanism was put in place through Out-patient Programme Board. All of the 24 specialty service managers report at the programme board monthly from a trajectory document which tracks progress against each key performance indicator; performance target and CIP/QIPP targets in a red, amber green (RAG) rating.

Quality metrics and more user friendly policies for staff were created as part of the out-patient programme with a review of nursing ratios to support patient acuity (the measurement of the intensity of care required for a patient delivered by a registered nurse). Support and wider training to the out-patient multi-professional teams was developed to help deliver agreed targets, for example data training to use the information reports available. Most recently e-learning modules have been developed to train outpatient teams on improved RTT performance.

Example of feedback from Matron Michelle Scowen on the dissemination of the Out-patient nursing metrics, attitudes and behaviours standards: "*From the nursing metrics, we can demonstrate improvements. From the standards, patients are encouraged to (and regularly do) contact the Out-patients matron directly to raise concerns and seek solutions immediately to any problems they may be encountering in clinic at that time. We have been able to respond to patient feedback by addressing and rectifying many of the issues they have raised."*

Improvements in out-patients were also helped by developments and greater use of information technology. We have implemented an automated reminder service; call plus a follow-up text message to support a reduction in DNA rate. There is a roll out plan for automated out-patient letters which could also be employed more widely for all GP letters. Also plans for a centralised out-patient booking centre have been put in place.

Key examples of other positive outcomes include:

- A significant improvement in RTT performance (now at 96.0 per cent Trust wide);
- 31 per cent fewer patients waiting over 18-weeks for their first appointment;
- Increased booking slot utilisation of scheduled appointments for ENT which rose from 87 per cent to 96 per cent;
- Improvements in the capture of mobile phone numbers meaning that tens of thousands of additional patients are sent SMS reminders per year. DNA rates have fallen in many specialties as a result; for example 1,080 more patients a year will now be seen in Urology.

Finally, our out-patient work is a key component of the local health economy 'Better Care Together' Programme. This programme has brought together health and social care organisations across the patch to develop a collective plan to the system's financial challenge, and improve the quality and sustainability of services delivered to the population. For out-patients, the Better Care Together plan seeks to enable this change and improve care pathways across specific specialties.

In 2015/16 we will focus in particular on further improvements in the beds and theatres cross cutting themes whilst now also including workforce and procurement as a fourth and fifth cross cutting theme.

Deliver £45m CIP and financial bottom line

Our 2014/15 financial plan assumed in-year savings (CIP) of £45m. The programme has delivered £47.9m, representing a £2.9m overachievement on target and reflecting the hard work of staff across the organisation. These savings have been made alongside improvements in access and the quality of services. For example

- General surgery have improved their rates of day surgery by 13 per cent for patients undergoing laparoscopic cholecystectomy, which is nationally recognised best practice;
- ENT (Ear, Nose and Throat) have increased the number of patients in their clinics by 9 per cent, helping reduce the time patients wait for an appointment;
- Orthopaedics have made improvements in the way they schedule, increasing the number of patients treated each week by 4;
- During the year Emergency and Specialist Medicine have shortened the average length of stay for patients by 0.4 days per patient, meaning that 2500 more patients have been able to be cared for in the same number of beds; and
- Patient attendance rates have risen in Urology, equating to 1080 more patients seen per year.

This year has seen the review and redesign of the Cost Improvement Programme and components of its success include:

- A new governance and accountability framework;

- Use of data and analytics to inform decision making and performance improvement;
- Designated delivery resource for Clinical Management Groups; and
- A number of high impact cross cutting work streams led by members of the Executive team.

We are very proud of our productivity achievements this year and the outpatient programme is currently being considered for a national award.

Finally, we have invested in permanent and designated resource for the CIP/Transformation programme. Six people have been appointed this year and come with a wealth of skills and experience to support clinicians to make ongoing improvements and implement new models of care in line with the Better Care Together strategy.

Next year we have a cost improvement target of £41m and this will be underpinned by five cross cutting programmes of work; bed utilisation, theatre productivity, out-patient productivity, procurement and workforce productivity.

Quality and performance: how did we do?

We are monitored by the NHS Trust Development Authority against a range of targets and thresholds.

University Hospitals of Leicester

Performance Against 2014/15 National Targets

	Performance Indicator	Target	2014/15	2013/14	2012/13
Access to A&E	A&E - Total Time in A&E (4hr wait)	95%	89.1%	88.4%	91.9%
Infection Control	MRSA (All)	0	6	3	2
	Clostridium Difficile	81	73	66	94
Access - 18 week wait	RTT waiting times – admitted	90%	84.4%	76.7%	91.3%
	RTT waiting times – non-admitted	95%	95.5%	93.9%	97.0%
	RTT - incomplete 92% in 18 weeks	92%	96.7%	92.1%	92.6%
	Diagnostic Test Waiting Times	<1%	0.9%	1.9%	0.5%
Access - Cancer	2 week wait from referral to date first seen - all cancers	93%	92.2%	94.8%	93.4%
	2 week wait from referral to date first seen, for symptomatic breast patients	93%	94.1%	94.0%	94.5%
All cancers (April 14 to Feb 15)	31-day wait from diagnosis to first treatment	96%	94.6%	98.1%	97.4%
	31-day for second or subsequent treatment - anti cancer drug treatments	98%	99.4%	100.0%	100%
	31-day wait for second or subsequent treatment - surgery	94%	89.0%	96.0%	95.8%
	31-day wait for second or subsequent cancer treatment - radiotherapy treatments	94%	96.1%	98.2%	98.5%
	62-day wait for first treatment from urgent GP referral	85%	81.4%	86.7%	83.5%
	62-day wait for first treatment from consultant screening service referral	90%	84.5%	95.6%	94.5%

4-hour performance

In a year when emergency care received high levels of national media coverage, our comparative performance improved significantly. At the end of the year last year we were 128th out of 140 trusts - this year we were 70th.

Our performance would have been better if it was not for particularly poor performance in April and May 2014 and November and December 2014. We have seen further improvement since December with our Q4 performance up 1.5 per cent compared to last year, when nationally it is down by 3.5 per cent.

The table below details our emergency care performance:

	2013/14	**2014/15**	**Change**
Attendance	210,434	213,310	Increased by 1.4%
Admissions	77,946	85,094	Increased by 9.2%
Days of +95%	60 (365)	76 (365)	Improved by 16 days
Months of +90%	4	7	Improved by 3 months
Medical length of stay	5.9	5.6	Reduced by 5%
Overall performance	88.4%	89.1%	Improved by 0.7%
National performance year end	128 (out of 140)	70 (out of 140)	Improved by 58 places

What this shows us is that the emergency care we provide has improved slightly in 2014/15 compared to the previous year, despite record levels of patients attending and being admitted. We had more days above 95 per cent and more months above 90 per cent than the previous year despite the 1.4 per cent increase in attendance and 9.2 per cent increase in admissions.

More important than the above information is how our patients view our services. A recent survey completed by Healthwatch Leicestershire in our Emergency Department found that *84 per cent of patients said their expectations of the service were met 'very much' or 'extremely'*.

It is clear that our emergency care provision remains too erratic and too many patients are receiving care that is of variable quality. We have reviewed our emergency plans for 2015/16 and working with partners we have set ourselves the following goals:

1. Emergency Department attendance needs to drop by a minimum of 5 per cent in the first half of the year compared to 2014/15. We then need to it drop by 10 per cent in total. This will involve earlier primary care intervention and patients choosing to access other services rather that our Emergency Department;
2. Emergency Department admissions to reduce by 10 per cent this year compared to 2014/15. Leicester's Hospitals have a key role to play in this and we are currently reworking our plans to support this;

3. Medical length of stay to reduce by 10 per cent this year compared to 2014/15. It dropped by 5 per cent last year. The Emergency and Specialist Medicine Clinical Management Group have been working on identifying specific groups of patients, in particular the frail elderly, who would receive an improved quality of care if they were cared for in a non-acute improvement;
4. A reduction in the out of hours variability in Emergency Department performance;
5. An improvement in flow through our Cardio-respiratory Decisions Unit (at the Glenfield) and reduction in occupancy. Lots of time, effort and money has been spent improving Emergency Department emergency care and we now need to support Cardio-respiratory Decisions Unit in the same way;
6. Continued improvement in the discharge function, in particular discharges supported at home by Leicestershire Partnership NHS Trust.

Emergency care is a marker of the functionality of the whole health system. Emergency performance is slowly improving but we want to see much quicker and more dramatic improvements in 2015/16.

Cancer waits

This year has been a challenging year with regard to our cancer performance.

- The six standards have been achieved in year but this has been inconsistent;
- The cancer service has seen an unprecedented growth in the number of patients being referred to the services with suspected cancer.

In January, February and March 2015 we began to achieve these standards in most of the tumour sites. The standard to see all patients within 2-weeks and to start their first treatment in 31-days have been achieved in all but one tumour site with currently only patients with urology related cancers being seen outside this time. This is now improving and all tumour sites will be achieving the standard in 2015/16.

The most challenging standard to achieve is the 62-day standard because this standard relates to the whole time we are treating patients for cancer. That means that delays in hospitals that send their complex patients to us impacts on our performance, and also patients who are not well enough to have every aspect of their cancer treatment. This is an important standard for patients and we have agreed a recovery plan with our local commissioners who are supporting us to deliver this standard by July 2015.

Healthcare-associated infections

Infection Prevention continues to challenge all healthcare organisations. This year our biggest challenge came from the Ebola virus outbreak in West Africa. This was first reported in March 2014, and has rapidly become the deadliest occurrence of the disease since its discovery in 1976. In fact, the current epidemic across the region has now killed five times more than all other known Ebola outbreaks combined.

More than a year on from the first confirmed case recorded on 23 March 2014, more than 10,602 people have been reported as having died from the disease in six countries; Liberia, Guinea, Sierra Leone, Nigeria, the US and Mali. The total number of reported cases is more than 25,556.

In July 2014 most NHS organisations began to plan for the potential threat that the virus could be imported into the UK and potentially spread. The first national alert was released on August 1st 2014, by which time we were well underway with plans to train and educate our frontline staff in the measures that would be required to protect them from this virus and also to provide care to any potential patients that may be admitted.

The direction from our Board was clear - 'do what you have to do to ensure our staff and patients are safe'. This made the work of the Infection Prevention Team far more effective than it otherwise might have been. The collaboration from our Emergency Planning lead and colleagues within the Emergency Department and the Infectious Diseases Unit collectively ensured that robust plans were created and tested - and there were two occasions when we tested our staff to see how prepared they were! The colleagues caring for these patients (who thankfully had not acquired the virus) were commended for the care they received.

Our Infection Prevention Team were both pleased and proud that the plans had worked so well. In truth this work plan with subsequent robust education and training of colleagues on the enhanced use of Personal Protective Equipment has taken much of the time of the team.

We continue to provide both initial and refresher training for staff albeit in a reduced numbers of sessions to date and this will continue until the global threat of this virus reduces.

One of the benchmarks used to reflect performance of NHS Trusts within England is the mandatory reporting of MRSA Bacteraemia and Clostridium difficile infections.

MRSA

For the year 2014/15 (April 2014 to February 2015) we have seen six patients with an MRSA bacteraemia against a national target of zero. Of the six infections that have been identified, five were deemed to be unavoidable and were found in patients that were extremely unwell with multiple co-morbidities. In these instances it was agreed that we could have done nothing to prevent these occurring. Post Infection Reviews (PIR) are carried out by our Clinical Management Groups with support from the Infection Prevention Team in accordance with the NHS Commissioning Board Guidance on the 'reporting and monitoring arrangements and post infection review process for MRSA bloodstream infection from April 2013'.

The PIR reviews and any identified action plans that have resulted from the investigation have been presented to the Clinical Management Groups Infection Prevention Groups and Quality and Safety Boards to ensure that lessons learnt can be disseminated.

CDI

For the year 2014/15 (April 2014 to February 2015) we managed 100 more cases (hospital and community attributed) compared with the previous year. Of the cases that are required to be reported we have recorded 73 cases of CDI against a trajectory of 81. We are pleased to be within our trajectory but recognise that there can be absolutely no complacency with regard to our management of this group of patients. Our trajectory for next year is 61 and this is a stretching target for an organisation of our size and complexity.

The governance and assurance arrangements for infection prevention will be reviewed again in 2015/16 to ensure that we continue to keep pace with the national requirements of the Health and Social Care Act. Infection prevention has been included within our Quality Commitment for this year to ensure that the core business that is required to ensure continued patient safety remains firmly on the agenda of the organisation.

Strategy: Taking forward our Strategic Direction

This strategic priority includes:

- Development of the a 5 year LLR system plan (by June)
- Development of the UHL 5 year plan (by June)
- Priority capital schemes: Emergency Floor and Vascular move to Glenfield
- A strategy for children's services
- Procurement of an Electronic Patient Record system
- Implementation of the CRUK Centre and more patients in clinical trials
- New partnerships (incl. Alliance and across East Midlands)

Development of the a 5 year LLR system plan (by June)

In June 2014 Leicester, Leicestershire and Rutland (LLR) health and social care partners, patients and members of the public agreed a five year "directional" plan to improve care for our patients both now and in the future.

The key objective is the delivery of high quality, joined up pathways, delivered in the appropriate place and at the appropriate time by the appropriate person resulting in a reduction in the time spent avoidably in hospital. Early examples include:

Maternity services - From what mums have told us we know that they want more choice about where they give birth and the reassurance that there is specialist expertise close by if anything should go wrong. We will be working with partners to look at how we can support expectant mothers to have their babies at home; how we can give mums the option of a midwife-led birth; and how we can better support new families in the first year of having a baby.

Frail older people - We know that people want to live independently for as long as possible, in their own homes. We will support them to do this by working more closely between acute hospital and community services to make sure that an older patient can return to their home, with support as the earliest opportunity.

Development of the UHL 5 year plan (by June 2014)

The LLR plan complements our own 5-year plan (also approved in June 2014) which sets out our vision to become smaller and more specialised as more care is delivered closer to, or in, the home.

As people get older we know there is a greater risk of them having one or more long term condition at a time. We need to be able to respond to that in a patient focused way. An early example is the move of our vascular surgical services from the Royal Infirmary to the Glenfield Hospital. Many people with heart disease also have vascular problems. If a patient needs an operation on their blood vessels in their stomach or legs having services all in one place means we can also make sure that we closely monitor their heart condition.

Priority capital schemes: Emergency Floor and Vascular move to Glenfield

Emergency Floor

Since 2013 we have been planning a new emergency floor that will dramatically improve facilities for our patients and staff, and that will allow us to change our processes to become more efficient.

During the past year we have made great progress in getting the approval needed to progress our plans. The first stage of the business case was approved by the National Trust Development Authority (NTDA) in March 2015. The full business case, which enables the scheme to be funded, will hopefully be approved in May 2015, following which we will begin construction.

- Our new emergency department will have a separate front door for adults and children;
- We have designed the new emergency department to flex to meet the future demands of our population;
- We will be the UKs first geriatric frailty friendly emergency floor;
- There will be more space for patients;
- The new department is to have an integrated mental health facility that will mean adults and children's in crisis will be assessed more rapidly.

Vascular

The project objectives involve the relocation of vascular services from the Royal Infirmary across to the Glenfield Hospital. As part of the project we will be providing the following services:

- Vascular in-patient ward;
- Vascular studies unit;
- Angiography suite;
- Hybrid theatre.

The vascular scheme presents an exciting development for the Trust which will provide our clinicians with advanced medical technology.

We have made progress during the year with the development of an outline business case, which is currently being reviewed by NTDA is programmed for approval in summer 2015.

Early enabling works will start in June and it is hoped that construction will begin in autumn 2015 following approval by the NTDA of the full business case.

Intensive Care Unit (ICU)

We are seeking to commit to a significant investment to improving our intensive care services, which will ultimately see intensive care for the sickest patients consolidated at the Royal Infirmary and Glenfield hospitals. The suggested programme will involve the creation of two specialist Intensive Care Units (ICUs). This represents a consolidation of level 3 capacity (dealing with our most critically unwell patients) and will have the following benefits:

- Fewer cancelled operations, currently driven by the shortage of ICU beds on the emergency sites;
- Faster access to theatre and ICU for emergency cases;
- Sustainable 24/7 consultant cover in both ICUs;
- More attractive service for recruitment, again ensuring sustainability.

Continued patient safety and quality of care are central to the planning process, as such a new retrievals pathway is to be introduced in 2015. This will ensure that those patients who need unplanned access to level 3 care at the General Hospital can be rapidly stabilised by a dedicated and specialist team before they are transferred to either Glenfield Hospital or Royal Infirmary.

Multi Storey Car Park

As has been widely publicised, we are excited to announce that work has progressed in 2014/15 to improve the experience of patients and their families and friends visiting the Royal Infirmary site. We are planning a new multi-storey car park which will double the patient and visitor car parking capacity.

Work is planned to start in April 2015 following planning approval from Leicester City Council in April, with completion by the end of 2015.

Once approved, the main construction programme will take place over 7 - 8 months to create the new five level multi-storey car park building. This will include:

- Ground Floor exclusively for disabled parking, providing 21 bays;
- Five further floors with 380 additional standard parking bays;
- New exit points for easier exit of hospital site (both north and south of city);
- Pay machines in the car park;
- Lifts for easy access to upper levels.

We will also be changing the layout of the existing Havelock Street car park at some point during the main construction to improve the current facilities.

A strategy for children's services

We have embarked on an exciting and challenging project to create a new children's hospital on the Royal Infirmary site. We have appointed a project manager to work with our clinical staff, patients and key stakeholders to create a design that will be taken forward as a business case for consideration in the summer/autumn of 2015.

Back in September 2014, NHS England launched a twelve week consultation on the draft standards and service specifications for congenital heart disease (CHD) services. The review requires two new standards for us -a minimum number of 500 surgical procedures carried out by four surgeons and the co-location of children's heart surgery with other paediatric services. We are committed to meeting both standards and are working to develop robust plans. The development of the children's hospital business case is to include the re-location of children's heart services to the Royal Infirmary.

To address the immediate needs of the East Midlands Childrens Congenital Heart Centre (EMCHC) we have recognised there is a requirement for some capital and revenue investment prior to co-location with the rest of children's services at the Royal Infirmary. Over the last six months, we have brought in additional project support to work with the Glenfield children's team to develop the necessary plans. Alongside this important planning work we have invested in more staff; for example we now have additional consultant medical and nursing posts and have invested in support function roles.

Procurement of an Electronic Patient Record system

We have been on a journey to get a new digital system that will replace the mountains of paper which we create every week across our organisation, as well as allowing us to transform the way that patient information is recorded and shared to aid clinical decision making.

This Electronic Patient Record will allow us to transform how we support our clinical teams to provide care to our patients. However, these systems are neither simple nor cheap, and we have to be assured that it will really add value to our patients care and experience. We end the year in good shape to be able to use the new services in the autumn of 2016.

Implementation of the CRUK Centre and more patients in clinical trials

Having achieved Cancer Research UK status, the Leicester Centre was formally opened in October 2014. The establishment of a comprehensive biomedical and clinical cancer centre in which scientists and clinicians are working together to improve the detection and management of cancer is the result of a partnership between the University of Leicester, University Hospitals of Leicester NHS Trust, local charity HOPE Against Cancer and the Leicester-based MRC Toxicology Unit.

Work is currently focused on understanding the genetic and biological basis of the disease, identifying novel biological markers for detecting and monitoring the disease and devising new interventional approaches for disease prevention and treatment. Particular expertise lies in the management and treatment of thoracic cancers, both lung cancers and mesotheliomas, as well as lymphoid malignancies. The appointment of a dedicated nurse funded by CRUK working within the Hope Clinical Trials Unit now helps to support the delivery of trials associated with these disease areas.

The centre aims to continue to carry out research of the highest quality and to ensure the local community is engaged in both the centres progress and activities. An interactive and dynamic atmosphere has developed providing an ideal environment for training and inspiring the next generation of cancer researchers.

New partnerships (incl. Alliance and across East Midlands)

We have agreed, with the support of NHS England and local commissioners in Northamptonshire, a strategic alliance for specialised services with Kettering General Hospital and Northampton General Hospital. The principles behind this collaboration is to focus on improving services and access to specialised services for patients, securing sustainable services into the future delivered locally wherever possible and sharing resources and clinical expertise between organisations. Early work has included successful joint appointments in cancer services to support the delivery of a single oncology service across Leicestershire, Northamptonshire and Rutland, which, serving a population in excess of 1.5 million will be one of the largest oncology services in England.

Clinicians from our children's hospital and Nottingham University Hospitals, working with the strategic clinical network, are building on the success of the joint children's cancer treatment centre to look at other services where closer collaborations will result in better services for patients. A website containing a directory of children's services across both hospitals is currently under construction and when complete will form a valuable resource for clinicians, parents and carers.

Early talks around a new partnership have begun with the John Van Geest Cancer Research Centre in Nottingham, which is leading research into potential new cancer treatments. If successful this will complement the current portfolio of work at Hope Clinical Centre based at the Royal Infirmary and will mean that more patients will be able to access novel treatments as part of clinical trials in Leicester.

Alliance

The Alliance to provide community Elective Care services in Leicester, Leicestershire and Rutland has been formed between ourselves, Leicestershire Partnership NHS Trust, LLR Provider Company, and the Clinical Commissioning Group's in West Leicestershire and East Leicestershire and Rutland.

The key aim of this new contractual arrangement is to provide high quality care to patients in the safest place, close to home. This means parts of some services move out of the Royal Infirmary, Glenfield or General hospitals into the community and some services may move from the community hospitals into primary care settings.

The Alliance are working with doctors, other NHS staff, patients and carers to look at a number of different conditions and specialisms to see where improvements can be made.

The Alliance has already started to redesign a number of care pathways (the way patients move through the NHS system to receive treatment) and working with local providers to make sure services are joined up and that patients can access treatments in local communities, for example in community hospitals and even for some conditions in GP surgeries and in their own homes, rather than just in large acute hospitals.

Better Care Together

Better Care Together is a significant programme of work which will transform the health and social care system in Leicester, Leicestershire and Rutland (LLR) by 2019.

Better Care Together brings together **partners**, including local NHS organisations and councils, to ensure that services change to meet the needs of local people. We are also working closely with public and patient involvement representatives to develop plans for change.

Both Better Care Together and our 5-Year Plan align quite closely to the document 'NHS Five Year Forward View' published in October 2014 by Simon Stevens the new head of NHS England. As a key partner in Better Care Together we have throughout the year, and will continue to, ensure that our staff work alongside others to create and deliver the plans set out in the Better Care Together and our own 5-Year Plan.

Why we need to change

People are living longer as a result of improvements in health and social care over the past twenty years. This is contributing to pressure on local health and social care services as more of us than ever before require help.

Locally we have some brilliant services which would be the envy of many places, but there are also some things which do not work well for people and their families. We have world class diabetes and heart services, but we also struggle with some of the basics, such as getting a GP appointment, overcrowding in our Emergency Department and above all, gaps between different parts of the NHS and social care.

One of the key issues we need to address is that too many people find themselves in hospital. This is often because we have not done enough to keep them well and supported before hospital becomes the only option.

We know that we can do better, which is why we are developing plans to improve health and care.

The Better Care Together vision

The Better Care Together vision is for a local health and social care system that supports you through every stage of life, which

- supports children and parents for the very best start in life;
- helps people stay well in mind and body throughout their life;
- knows your history and can plan your health needs;
- cares for the most vulnerable and the most frail;
- has services available when it matters and especially in a crisis;
- helps support patients and their loved ones when life comes to an end;
- provides faster access, shorter waits and more services out of hospital.

In order to manage this scale of change, we have created eight work streams (plus one 'behind the scenes') to allow us to review and reshape health and social care services to meet the changing needs of people in Leicester, Leicestershire and Rutland.

Maternity, neonates, children and young people

From what mums have told us we know that they want more choice about where they give birth and the reassurance that there is specialist expertise close by if anything should go wrong. We will be looking at how we can support expectant mothers to have their babies at home; how we can give mums the option of a midwife-led birth; and how we can better support new families in the first year of having a baby. We also understand that older children and young people sometimes require services which are different to adults, so we will plan services that are available in the community and which look after our young people's state of mind as well as their physical health. Find out more…

Mental health

Everyone knows that prevention is better than cure, but we still spend most of our time and money treating illness. We all need to focus more on wellness. We want local people to have the best education and support to stay healthy regardless of their age or background. This means more time and effort spent on training and educating people to overcome issues which will affect their health and wellbeing… so, whether it's support to eat more healthily, lose weight, drink less, stop smoking or get active… we want to help people to do the right thing. Find out more…

Long term conditions

Often a crisis, like a fall for an older person or a worsening of an existing illness, is predictable. Yet for too many people the result is a hospital visit. In future we are going to work with carers and their patients who we know are at risk to make sure they have personal care plans completely focused on them and their needs. And we will make more services which have traditionally been based in the city hospitals, available in the community. This will mean that a spell in hospital becomes the exception in all but the most complex situations. Find out more…

Frail and older people

We know that there are more older people living locally than ever before. While many people enjoy healthy and independent lives, for some old age is lonely and beset by health problems. We know people want to live independently, preferably in their own homes, for as long as possible and we will support them to do this. We will make sure we know who are the most vulnerable and give them the most support. We will work with carers, and especially those who are looking after people with dementia, to make sure they get the help they need. We will respond to calls for help from the most vulnerable quickly to avoid them reaching the point where a stay in hospital is the only option. Find out more…

Urgent care

A lot of our plans are about avoiding a health crisis by getting the right services to people more quickly, but even then some people will still become poorly. When they do our community crisis response teams will be there quickly. They will discuss the options with people and where possible organise specialist teams to care for people in their own homes rather than hospital. If a trip to hospital is required then from winter 2016 patients will be looked after in the UK's only purpose built 'frailty friendly' A&E. And when it is time for them to go home we will make sure that all the services they need to continue to live independently are in place. Find out more…

Planned care

For procedures and treatments which are planned in advance and therefore not an emergency - like hip replacements and cataracts - the end results are often good. However patients can spend too long waiting for their first appointment, the procedure itself or even in hospital before being allowed home. We are also cancelling too many planned operations at the last minute because of emergency demand. In future we will start to separate planned or 'elective' care from emergency care by moving some services into community hospitals and creating a dedicated centre for procedures that can be completed in a day. Find out more…

Learning disabilities

There are around 1.5million people with a learning disability in England, and people with learning disabilities can now expect to lead longer and fuller lives than in the past. Like many other groups, people with learning disabilities often need support in a crisis. We will work with people and their carers to make sure that they get preventative care when they need it. We also want to work with carers to ensure that services for them are comprehensive to enable them to have a break from caring, and ensure that people with learning disabilities can continue to live independently at home for as long as possible. Find out more…

End of life

It happens to us all and yet it is a subject which patients, doctors and nurses sometimes struggle to talk about. Most people at the end of life would prefer to die at home with friends and family around them, but they need support to make that choice. They also need support in their last days for them to have the best death possible. We will make sure that doctors, nurses and other professionals are properly trained to have these difficult conversations with carers too, so that the patient's wishes are honoured at the end of their life. Find out more…

Buildings, beds and technology

As well as changing care and support through the eight pathways, we can also improve care and provide a more efficient service for people by looking our buildings, our staff and the technology we use. Find out more...

Workforce: Empowering our people

This strategic priority includes:

- Next phases of Listening into Action
- Experiments in autonomy, incentivisation and shared governance
- Improvements in Medical Education
- Development of new roles (linked to productivity improvement)
- A workforce plan to complement our 5 year strategic plan

Our staff

This chart shows the number of whole time equivalent (wte) staff employed by our organisation:

	2014/15	2013/14	2012/13	2011/12	2010/11	2009/10
Medical and Dental	1,645	1,570	1,551	1,496	1,477	1,496
Administration and Estates	2,236	1,982	1,924	1,953	2,054	2,104
Healthcare Assistants and other support staff	2,088	2,016	1,832	2,033	2,117	2,284
Registered Nursing and Midwifery	3,688	3,499	3,375	3,338	3,301	3,261
Scientific, Therapeutic and Technical	1,219	1,099	1,179	1,208	1,222	1,278

Next phases of Listening into Action

Listening into Action (LiA) is becoming 'the way we do things at Leicester's Hospitals'.

When we repeated our organisational Pulse Check at the start of Year 2 we saw a 26 per cent increase in the number of staff who felt valued for their contribution and the work that they do. Another significant improvement was the percentage of staff that felt day to day issues and frustrations that that get in the way are quickly identified and resolved, which doubled.

The second year of LiA aimed to reach parts of our organisation yet untouched by LiA to allow front line staff to make fundamental improvements to the way we work and deliver our services. This has been rolled out across our organisation under five distinct work streams:

- **Classic LiA** – pathways, divisions, wards or support services are supported and taken through a 'journey' of adoption to help realise their visions and lead their own priority changes;

- **Thematic LiA** – these are requested and hosted by an Executive Director or the Chief Executive. During 2013/14 examples included, meals, cleaning and Junior Doctors;
- **Enabling LiA** – this supports our strategic priorities, such as the Alliance, where employee engagement and action is required;
- **Management of Change** – these are to be held as a precursor to change projects associated with service transformation and for HR Management of Change initiatives;
- **Nursing into Action** – this work stream supports all nurse and midwife led wards or departments to host listening events and implement actions that focus on improving care and experience for patients, carers and staff. The first set of wards have recently had their celebratory event to showcase work that they had done, which included one ward significantly cutting the length of stay (from 11 days in April 2014 to 7 days in December 2014) for their patients by improving the discharge process.

Patients and service users have continued to provide a central role in many of the LiA service improvement work projects and each team is encouraged to liaise with them prior to implementing any changes. A tremendous example of this is the work from the Cystic Fibrosis Team who having listened to parents, patients and multidisciplinary staff and have successfully implemented a process for children to receive intravenous antibiotics at home with supported physiotherapy.

The plan and key underpinning driver for LiA in year three is to accelerate spread of Classic LiA, reaching further and faster across our organisation. Classic LiA empowers local teams to find solutions to issues which impact on the quality of services provided to our patients and improves the working lives for our staff. In addition we will be continuing to work with the "Alliance" to replicate how we introduced LiA within Leicester's Hospital.

Supporting staff through change will remain a focus with the inclusion of a listening event for any Management of Change (MoC) programme affecting more than 25 members of staff. The LiA Team will respond proactively to thematic issues which executive and senior leaders wish to address which may arise in 2015/6.

We will continue to unblock the way to success for teams introducing LiA in their local areas through available capital investment. During 2014/15 we introduced Nursing into Action with a commitment to reach all nurse led areas within three years and during the coming year we will continue to support ward managers to tackle the quality issues they wish to address for the improvement of services to their patients.

We have held a number of events to celebrate teams 'passing on the baton' of LiA to other teams, including a Nursing & Midwifery Conference and Pass It On events. We plan to introduce three further work streams, called *Involvement into Action* which will support the new Patient and Public Involvement Strategy; *Autonomous Teams LiA*, which will build on the work carried out as part of the Mutuals in health pathfinder Programme and finally, we will be working with the executive team to support the re-launched *Quality Commitment.*

NHS staff survey

Our 2014 National NHS staff survey was carried out towards the end of 2014 and we have recently reviewed our results. For the second year running we gave the opportunity for all staff to complete the survey and share their views. The results show very little change on the previous year, with the exception of the number of staff completing statutory and mandatory training, which was one of our core priorities last year.

Top 5 2013	Top 5 2014
KF26 % having equality and diversity training in the last 12 months	**KF26** % having equality and diversity training in the last 12 months
KF5 % working extra hours (lower better)	**KF10** % receiving health and safety training in the last 12 months
KF7 % appraised in the last 12 months	**KF7** % appraised in the last 12 months
KF6 % receiving job relevant training, learning or development in the last 12 months	**KF5** % working extra house (lower better)
KF18 % experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	**KF17** % experiencing physical violence from staff in the last 12 months (lower better)

Bottom 5 2013	Bottom 5 2014
KF14 fairness and effectiveness of incident reporting procedures	**KF4** effective team working
KF4 effective team working	**KF20** % feeling pressure in the last 3 months to attend work when feeling unwell (lower better)
KF13 % reporting errors, near misses or incidents witnessed in the last month	**KF22** % able to contribute towards improvements at work
KF20 % feeling pressure in the last 3 months to attend work when feeling unwell (lower better)	**KF3** work pressure felt by staff (lower better)
KF1 % feeling satisfied with the quality of work and patient care they deliver	**KF23** staff job satisfaction

In general we have more work to do on improving levels of teamwork and engagement which will enable us to build on steady improvements in staff feeling more satisfied with that the quality of work and patient care that they are able to deliver. We have seen 4 per cent less staff witnessing potentially harmful incidents and 2 per cent more staff reporting errors, near misses or incidents witnessed. This is because we continue to develop a culture of openness and transparency.

In the forthcoming year, we will focus on actions to accelerate Listening into Action as a way of working and ensure that we work towards removing day to day frustrations in the workplace. We will also adopt the Healthcare Leadership Qualities Framework to set out standards for ensuring well led teams and ensure our commitment and approach to quality is understood.

The Healthcare Leadership Model is to help those who work in health and care to become better leaders. It describes the things you can see leaders doing at work and is organised in a way that helps everyone to see how they can develop as a leader, and applies to the whole variety of roles and care settings that exist within health and care.

Experiments in autonomy, incentivisation and shared governance

In October 2013, Norman Lamb and Francis Maude asked Professor Chris Ham, Chief Executive of the King's Fund, and a panel of experts including our own Chief Executive to carry out an independent review of options for strengthening NHS employee's engagement in their organisations.

The review began in October 2013 and was published by the King's Fund at an event on 15 July 2014. The launch event was attended by Care and Support Minister Norman Lamb, Minister for the Cabinet Office, Francis Maude and Hazel Blears MP.

The objective of the review was to identify options for empowering staff to deliver better care via mechanisms such as improved working practices through to potential alternative provider models.

The review found compelling evidence that NHS organisations with high levels of staff engagement, where staff are strongly committed to their work and involved in decision-making, deliver better quality care. These organisations report:

- lower mortality rates;
- better patient experience;
- lower rates of sickness absence and staff turnover.

Organisations with low levels of staff engagement are more likely to provide poor-quality care; the failures in care at Mid Staffordshire NHS Foundation Trust are a high-profile example of this.

While staff engagement levels have increased across the NHS in recent years, the review found significant variations between organisations. The report calls on all NHS organisations to make staff engagement a key priority in order to improve care at a time of unprecedented financial and service pressures.

The review found emerging evidence that a staff-led mutual can deliver higher levels of staff engagement. The Mutuals in Health Pathfinder Programme is a joint Cabinet Office and Department of Health initiative designed to help NHS organisations consider the potential advantages of the mutual model.

Participation in the Pathfinder Programme will enable us to understand what mutualisation could mean for us, the potential benefits and issues and to identify solutions to practical barriers. The scope and vision of our mutual pathfinder proposal comprises of three main elements:

1. Explore the whole Trust mutual
    a. develop a business case, i.e. "this is how it can be done here";
2. Autonomous Teams
    a. develop the framework and rules of engagement;
    b. work with pilot teams to get them up and running;
3. Embed staff engagement and a sense of ownership
    a. research best practice;

b. develop plans to further embed staff engagement in the Trust's structure.

In relation to element 1 above, the mutuals approach has not yet been tried in the acute sector, this is why the government has established the Pathfinder Programme. We would emphasise that this programme is intended to help further explore the potential and the issues involved and does not commit us to following any particular course, i.e. no decisions to go down this route have been made.

There has been a great deal of interest in the pilot team work described in element 2 above. We confirm that at the initial phase, we will be working with Elective Orthopaedics and Trauma and Orthopaedic Theatres and we will be exploring ways of getting them up and running as Autonomous Teams.

We will continue to use Listening into Action to develop exemplary levels of staff engagement and we intend to continue to embed the voice of front-line staff in the structure of the organisation to "institutionalise" engagement and add to the sense of ownership and a shared agenda. There are a variety of ways in which this could be pursued and we wish to develop these as part of the programme.

As part of the programme, we have been provided with bespoke technical, legal and consultancy support to the value of £120,000 (136.5 days) funded by Cabinet Office and Department of Health. Our external programme contractors bring together highly experienced advisers and social entrepreneurs from Hempsons, Albion Care Alliance and Stepping Out (HASO), co-operating over three core work streams, i.e. business case development, stakeholder engagement and legal:

- ***Stepping Out*** have overseen the development of over 30 mutuals, many in social care and a number under the Department of Health's *Transforming Community Services* (TCS) / *Right to Request* (R2R) programmes. Stepping Out have also produced the leading text on mutualisation titled '*How to Step Out';*
- ***Albion Care Alliance CIC*** is an alliance of mutual or co-owned organisations comprising Provide CIC, Medway Community Healthcare CIC and Your Healthcare CIC. All these organisations left the NHS under TCS/R2R and continue to deliver public services. Albion has inspiring leaders who have built sustainable businesses with a combined turnover of £150m. Between them, they have grown their businesses by over 40% in two years; and
- ***Hempsons*** are the leading national health social enterprise law firm, with a team who have advised on the establishment of 12 NHS mutuals under TCS/R2R (including Inclusion Healthcare CIC in Leicester) and on setting up pioneering local authority and Foundation Trust (FTs) models. They have in-depth understanding of NHS Trusts and relevant risks and challenges and have advised NHS Trusts and FTs on mutualisation.

Our contract started with a 'kick off' meeting on 5 January 2015, followed by a three month intensive period of work which was concluded on 31 March 2015. In consultation with HASO we have developed a proposal approved by Cabinet Office and Department of Health to enable further support in taking a significant step forward in developing the Autonomous Team Programme and reducing the time required to implement this. Additional HASO support, equating to 34 days and costing £24,000, will be fully funded by Cabinet Office and Department of Health.

Improvements in Medical Education

Health Education Quality Visit

The process for the quality management of education is overseen by Health Education East Midlands and the first multi-professional visit took place in October 2014. In association with HR and our Nursing colleagues, the Department of Clinical Education organised and hosted the two day visit. Outcomes were largely

positive and an action plan has been drawn up to monitor requirements and recommendations that were included in the visit report. The action plan is monitored throughout the year and we continue to make progress against it.

Education Quality Dashboard

The Department of Clinical Education works closely with the Clinical Management Groups medical education leads promoting educational quality, sharing good practice and ensuring local accountability. The key resource used by the leads is our Educational Quality Dashboard which provides an overview of educational activity across the Clinical Management Groups. This Dashboard has generated interest across the country, after presentation of its use at both international and national education conferences.

IT Strategy

Keeping up to date with educational technology is a priority for the Department of Clinical Education. Our Educational IT Strategy describes how the use of mobile devices, video-conferencing and social media will support medical education in the future. The new Odames Library meeting room is equipped with state of the art audio-visual equipment to enable educational technology to be integrated into this new facility.

Odames Project

A new library at the Royal Infirmary opened in March 2015. This facility, created in the old Odames nightingale ward, provides staff with a library facility which we are very proud of. Its design was informed by a survey in autumn 2013 to which 849 people responded.

The temporary library, which was in the Education Centre, lacked the facilities that the users needed and wanted and in handing back these rooms to the Education Centre, we have also improved the teaching space at the Infirmary. The Odames Library contains a quiet study room, bookable training room, large meeting room, vending machines and a plentiful supply of IT equipment.

Initial feedback has been extremely positive and the facility seems to have been succeeded in its aim of being a space that is enjoyable and pleasant to spend time in.

Ensuring funding for education follows the trainee

Our Department of Clinical Education have worked with the Finance team to clearly identify undergraduate and postgraduate medical education tariff income in the Clinical Management Group budgets and have provided advice and templates to support the documentation of expenditure to ensure funding is being appropriately used to support teaching.

Trust Grade Project

Health Education East Midlands (HEEM) is financially supporting a 12-month 'Trust Grade Doctor' project. This project will identify and implement educational improvements for junior doctors who are employed by us in non-training positions. This group of doctors are fundamental to the delivery of service within all NHS Trusts. Plans are underway to review induction, supervision, resources and to develop a bespoke teaching programme. The project group includes a number of Trust Grade doctors as well as members of the Medical Education team and Consultant Physicians.

Medical Workforce

In January we appointed an Associate Medical Director with a portfolio to review and improve junior medical workforce issues across our organisation. Many services are running with significant gaps both at ST1 and ST2 and also in higher speciality training posts. The initial focus has been around reviewing our recruitment and retention of international doctors and those who are not in traditional training roles. This will require the need to standardise induction and supervision, provide study leave allowance and increase the scale and pace of recruitment by developing more managerial support in this area. We are also planning to recruit up to 20 physicians associates from the USA to increase the number of people with new roles into the workforce in order to complement existing medical staff and strengthen the workforce.

Clinical Skills Unit

The Clinical Skills Unit aims to provide high quality, innovative and cost effective clinical skills, resuscitation training and education to our staff, undergraduate medical students and the wider health care community. The team have increased clinical procedural skills and resuscitation training to our own staff and also for medical students. We have adopted the National Skills for Health mandate that all non-clinical staff should receive basic life support training and over 49% (circa 1500) of this staff group have been instructed in the last six months. We also have a planned teaching programme and many who have taken part have responded positively to this, reflected by one comment that the training was *"vital and important to everyday life"*.

In September 2014, the Clinical Skills Unit co-hosted with the University of Leicester, the Intercollegiate Speciality Examination in Plastic Surgery. It was commented at the *"staff and patients were warm and friendly which helped greatly in reducing the heightened anxiety levels of the candidates".*

National Courses

The Clinical Skills Unit delivers many Resuscitation Council UK (RC UK) and Advanced Life Support Group (ALSG) nationally accredited resuscitation and trauma courses. Amongst others, courses are delivered to meet the foundation curriculum needs of medical staff, including 'advanced life support' and 'care of the critically ill medical patient'. We are keen to develop internal faculty to support the on-going delivery of these courses.

Simulation Training

The Clinical Skills Unit is recognised by Health Education East Midlands as one of the four simulation training providers within the region and has secured a contract to deliver Foundation Training simulation.

They are also working with the other providers to expand on its existing successful 'simulation faculty' course and to develop a regionally agreed and accredited 'simulation faculty' course. The group were successful in securing funds from Health Education East Midlands to support this. A Simulation Strategy has been developed and a Simulation Steering Group organised which includes a range of professionals to support the need to provide simulation training to a growing number of multi-professional staff.

Junior Doctors Gripes Reporting Tool

Feedback from the national training survey suggested doctors had workplace concerns that affected patient safety, but they were not reporting these using our IT systems, such as Datix. The Gripes Reporting Webpage was developed in collaboration with the University of Leicester and we launched a pilot project in February 2015. It has already received over 60 concerns many of which we have been able to action immediately. This has resulted in improved working conditions for doctors or addressed urgent safety concerns. Early feedback from users has been very positive and we are aiming to scale up the use of the page after the pilot period, to allow staff (not just doctors) to use the site. This will continue our aim to have an open and transparent working environment where staff feel able to report concerns easily. This project has been entered into the Patient Safety Awards Competition.

Educational Innovation

Following a disappointing audit in 2012 on the use of asthma guidelines amongst junior doctors and nurses, a project team from Glenfield created a musical version of the guidelines on the internet, following the British Thoracic Society Guidelines for asthma. The video, 'Breakfast at Glenfield' was placed on YouTube and has had almost 78,000 views.

After the video was released a repeat audit was carried out and showed huge improvements in the use of the guidelines. The video got coverage on the BBC, ITV, NBC, Time Magazine, Reuters, Microsoft and over 200 online news sites across 20 countries and was awarded the Network Casebook Innovation Award on NHS Change Day. In July 2014 NHS England's Regional Innovation Fund Award supported one of our education fellow's, Dr Tapas Mukherjee, to develop another video which will be released later this year. You can watch 'Breakfast at Glenfield' here.

New contracts

Over the past year we started a trial contract to provide library services to the public health staff of Leicester City Council, which they have appreciated and helps us with our aim of providing information services to the whole of the Leicestershire Health Economy. In addition the Clinical Librarian team secured a contract to support Public Health England's diabetes team with the production of systematic reviews.

Development of new roles (linked to productivity improvement)

We have set up a group to look at new roles in our organisation and participants have been involved in the development of education pathways for these new roles, including assistant and advanced practitioners, to deliver new models of care. We will also be a pilot site for hosting Physician Associates trained in the USA to embed the principles and practices of such roles in the UK workforce.

The first cohort of assistant practitioners will work within the bowel screening team and some of our High Dependency Unit areas (eight on the first cohort started in March). Assistant practitioners provide support to professional Allied Health Professionals, nurses and healthcare scientists and carry out more skilled procedures, but have the educational support to enable them to be more autonomous decision makers than healthcare assistants and therefore able to action if things don't happen in a normal routine way.

Approximately six months after they have completed initial competencies they will be upgraded to a band 3; that will allow them to work more autonomously throughout the remainder of their training programme (12-18 months). Then they will secure a band 4 assistant practitioner post. During training they are working towards a QCF level 5 qualification which they must achieve. They are assessed by our occupationally competent in-house assessors.

They will work under the indirect supervision of registered staff admitting and discharging patients. After specific training, assistant practitioners are able to administer drugs alongside other tasks that support patient flow and help registered nurses manage the intensity of their workload.

In February five people started on the advanced practitioner programme, mainly in medicine (Emergency Department and Acute Frailty Unit) where they see, diagnose and discharge patients helping to free up pressures on medical staff. We plan to use them more flexibly in other areas around the Trust. The education model for advanced practitioners is partially formal (delivered in partnership with DMU and accredited by them) and partly competencies signed off by medics and senior advanced practitioners in the workplace. We are also in discussions with the medical school to see how they can support the programme in terms of assessment processes because we would like to use the same processes used for fifth year medical students.

We have created a career pathway for specialist nurses who may wish to progress to advanced practitioners. The next intake of advanced practitioners will be in June 2015 – subject to funding of education packages. We are also working closely with Leicestershire Partnership NHS Trust to create rotation programmes and share costs.

Physician Associates are able to take histories and support the diagnosis of undifferentiated patients, i.e. carry out the same level of work as a foundation doctor. They do not necessarily need to have a healthcare professional background and frequently come from science degree backgrounds. They currently do not have a registration body, but ours will be required to be on their voluntary register. Working at a band 7 level the pilot will see around 20-24 of them working in trauma and orthopaedics and children's, on Acute Medical Unit and within areas of the CHUGGS clinical management group.

Finally, our succession planning sees us building on the success of the internship programme and we are developing a local trainee management scheme to build our managerial capacity to deliver our strategic direction.

A workforce plan to complement our 5-year strategic plan

This year we have developed a comprehensive 5-year workforce plan which describes how our workforce will need to change and adapt to meet the needs of our strategic direction. This strategy has six components to ensure we deliver the highest quality of patient care and deliver this in the most appropriate setting at the right time:

- Safe Staffing – to meet the acuity and dependency needs of our patients;
- Reduction in the use of the non-contracted workforce to ensure quality and better use of financial resources;
- Development of new ways of working to support seven day service provision;
- Development of workforce models to improve the flow of emergency patients including plans for a new emergency floor;
- Movement of care out of the acute setting where appropriate;
- Increased specialisation.

All elements of this work are supported by the introduction of new roles. The principle roles we are introducing include physician associates (who can support doctors in history taking and initial diagnosis of patients); advanced practitioners (who have skills to see, treat, diagnose and discharge a patient) and assistant practitioners (who have training in some skilled procedures and can make more autonomous decisions than a healthcare assistant). All of these roles are supported by appropriately qualified professionals to ensure the safety of our patients.

In developing these roles we are working with community colleagues so that we have similar standard of training and education and ensure that such staff can work in a range of settings in order to follow the patient pathway. These roles also provide important opportunities for career development and therefore support recruitment and retention of staff.

Reducing staff absence

Over the past couple of years we have seen a reduction in sickness absence rates, 2012 (3.49 per cent) and 2013 (3.40 per cent), which meant we had the lowest rates of all acute trusts in the East Midlands. Unfortunately in 2014, we saw an increase in sickness absence to 3.72 per cent against a target of 3 per cent.

Over the past year we have seen significant organisational changes that have affected staff working hours, changes to their role and where they work which will have contributed. We have also improved the way we report sickness absence and the reasons for the absence through the full implementation of an in-house sickness monitoring and reporting system (SMART) to monitor the completion of 'return to work' discussions and ensure compliance with our Sickness Absence Policy.

Recognising that our staff are our most valuable resource, the approach we have taken to reduce sickness absence in the last year goes hand in hand with promoting staff well-being. In response to the sickness absence data we have introduced various evaluated initiatives to improve staff health and well-being. These include self-referral and fast track physiotherapy, emotional resilience workshops and self-care at work. That programme was designed and developed to motivate and empower staff to promote self-care approaches that will help them to improve their lifestyle and lead to positive health behaviours, and line managers training.

Managers are supported by Human Resources, Occupational Health and when required AMICA (our confidential counselling service) to manage sickness absence through our robust policy, and we support staff through a return to work process following a period of absence.

We have signed up to the 'Public Health responsibility deal' and will be making three further pledges this year for supporting mental health conditions, young people and domestic violence.

We recognise that there are many positive benefits by improving employee health and well-being; these include increased staff productivity, better morale and improved communication between teams. This, in turn, leads to better quality services, improved patient satisfaction and a decrease in staff turnover.

Our Health and Well-being Group continues to support staff and meets every three months and is attended by key stakeholders involved in supporting staff. The group receives data from a variety of sources to determine how best 'Well-being at Work' (an initiative funded solely from the Staff Lottery) can use funds to improve the health and well-being of staff. The programme continues to provide a range of holistic activities for staff, including exercise classes, a five-a-side football league, cricket league, badminton club, regular Fitbug and walking challenges, health awareness and screening road shows for staff to understand their BMI, smoking and healthy eating habits. There are also alternative therapies such as reflexology and aromatherapy.

We will be continuing with our very popular seasonal coach trips to Christmas markets and seaside resorts and look forward to our Family Fun Day in the summer. Staff can also bid for funds to enhance their working life/ environment.

Learning and development

We are committed to providing learning and development opportunities to all of our staff, so that they have the right skills and knowledge to help us deliver Caring at its best. Our learning and organisational development team co-ordinates a wide range of courses working together with local colleges and private training providers.

We are delighted to lead the way for the health sector and be amongst the first organisations nationally to have been awarded the National Skills Academy Quality Mark for 'superior' delivery of education and training to the health sector. Achieving this quality benchmark demonstrates our passion and enthusiasm for learning excellence and 'making a difference' across our organisation and the wider health community. This also recognises that we have been innovative in the way we put together our learning programmes and we have sought to reflect that our programmes really do focus on what we and the wider NHS needs.

The past year has been an exciting time for us as we were selected as finalists for the Learning Awards 2015, held by the national Learning and Performance Institute, competing with international companies. We were proud to win the Silver Award for 'Learning Team of the Year' *'demonstrating exceptional vision and depth in providing learning solutions with a proven business impact'*.

As a training provider we not only provide our own robust monitoring of the training we provide, we also welcome partner organisations to monitor training delivery including South Leicester College, MATRIX, our local Workforce Development Team, City & Guilds and the National Skills Academy for Health. High level findings from a recent on-line survey conducted by the National Skills Academy confirm that 65 per cent of respondents rated our training provision as excellent and 35 per cent rated as good. The employer survey found that employers/ commissioners of training would all recommend our training and stated that our delivery team were *'extremely competent and supported the learners to a high degree'* and that *'the flexibility offered in delivery was excellent'.*

During the year we invested £228,000 in learning and development, supported through the regional wider Workforce Development Fund, which aims to provide skills, learning and qualifications to improve patient care and the delivery of services. We are keen to support staff both personally and professionally with learning opportunities from the day they join us. We offer a diverse range of learning opportunities from a comprehensive induction training to annual refresher updates.

We are responsible for the delivery of Statutory and Mandatory training to our staff. We started the year in a fairly poor position, having only achieved 76 per cent compliance in 2013/14. Impressively thanks to the commitment of staff and managers we achieved a 95 per cent of our staff are now fully compliant across ten core programmes (as of 31 March 2015). This improvement has been supported by an increase in training provision and the introduction of e-learning programmes aligned to the national Core Skills Training Framework (Skills for Health) and a more robust process in place for monitoring performance.

We have worked hard on developing performance appraisal recognising the importance of this protected time for development conversations. Our recent national staff survey results show that our appraisal performance is in the best 20 per cent of comparable NHS Trusts. Our appraisal process has been further improved to enhance the quality of the appraisal and align it with pay progression. Over 1,000 appraisers have been trained on the new process.

Development of our Nursing Academy in order to support the on-going learning and development needs of nursing staff

Our nurse education teams were awarded 'collaborative partnership status' with De Montfort University in 2014, which means that we are now a recognised accredited learning centre where staff complete education programmes, for example in nutrition and chemotherapy, and are awarded credits at post graduate level.

Education and development for our new nurses

We are delighted to have recruited 272 nurses from Spain, Portugal and Ireland alongside nurses trained at our local university in support of our commitment to increase nursing numbers on the wards. Recognising the diversity of Leicester and the challenges of working in a different country the Nursing and Midwifery Education and Practice Development Team implemented a robust eight week Trust-wide induction programme for our international nurses similar to our existing induction programme that already runs for our newly qualified nurses. This programme focuses on the key areas of clinical and healthcare information that new nurses need to know to work in our hospitals and to care for our patients. We believe this has contributed to the fact that we have a significantly lower numbers of international nurses leaving our employment compared to other Trusts around the UK

Apprenticeships

We introduced our apprenticeship scheme in September 2009 and since then we have employed 277 apprentices. The roles vary and include administrators, porters, maternity care assistants, medical records assistants, ward clerks and plaster technicians. In the coming year we anticipate a significant growth in apprentices in line with national Health Education England targets. In 2014/15 70 per cent of our apprentices completed their frameworks and secured employment in our organisation or other local healthcare organisations. We are proud to be the first NHS provider to deliver Advanced Apprenticeships to support the introduction of new 'Assistant Practitioner' roles.

Work experience

We have a group that leads on accelerating work experience opportunities in all areas across our organisation. Its aim is to improve the opportunities we provide and centralise the application process. We currently offer work experience for Year 12 and 13 students, degree graduates on clinical programmes and those doing health and social care related courses. During the past year we supported more than 95 placements and worked closely with our health ambassadors to support educational establishments at career fairs in promoting the NHS as a career choice.

Prince's Get into Hospital Services Programme

We are working in conjunction with The Prince's Trust to deliver our new 'Get into Hospital Services' scheme. The purpose of this scheme is to provide four weeks work based training and classroom learning within our administration and customer service environment. The scheme is aimed at unemployed 16-25 year olds who are not in any education or training at all or for less than 12 hours a week and not in employment at all or in employment less than 16 hours a week. During the scheme the young people will carry out induction training, employability skills sessions, role related training and practical experience. The scheme will start on April 28th 2015 with a Taster Day for applicants.

Celebrating achievements

Our annual training awards ceremony allows us to celebrate staff achievements in learning and development. We held our event in March 2015 and 204 learners were presented with certificates for successfully completing vocational, skills for life, information technology or management qualifications; a number of special achievement awards were also presented by executive and Non-Executive directors.

Valuing our staff – reward and recognition

In 2013 we developed a Reward and Recognition Strategy which was designed to support recruitment and retention as well as supporting staff to feel valued in the workplace. We have developed our approach to pay progression which will see staff rewarded through incremental pay for delivery of their objectives and demonstrating behaviours linked to our values. We are also developing the 'Work for Us' area of our website to showcase the benefits that are available to staff who chose to work in our team. This year we also developed a number of career frameworks to show staff the skills and competencies they need to achieve progression.

Our Caring at its Best Awards were launched in 2011 and have enabled us to recognise and reward more staff than ever before by moving to quarterly awards with an annual ceremony held every September. Our Caring at its Best Awards reflect six categories, one for each of our values (nominated by staff) and one public nominated award. The nomination process involves asking not only staff, but also our patients and visitors to help us find those exceptional staff that are living our values and providing excellent care. All winners and highly commended staff from throughout the year were invited to the annual dinner hosted by our chairman in September. An independent judging panel, last year made up of Tony Donovan from LeicesterShire and Rutland Age UK, MP's Nicky Morgan and Liz Kendall, BBC Radio Leicester DJ Ben Jackson, Deputy Mayor Rory Palmer, Richard Bettsworth, Leicester Mercury Editor and colleagues from our clinical commissioning groups, select the overall winners who are then presented with a certificate and trophy. We also take the opportunity to recognise our volunteers for their contributions with a "Volunteer of the Year" category.

Attracting and retaining staff – our staff benefits scheme

The vast majority of our staff are on national NHS pay, terms and conditions which include a comprehensive set of employment policies and procedures. We operate two pension schemes, the NHS Pension Scheme ('*NHSPS*') and the National Employment Savings Trust ('*NEST*').

We have continued to enhance our range of salary exchange offerings, now totalling six, which are proving to attract and retain staff with around 6,000 staff participating in one or more schemes. Our '*Salary Maxing*' Car Scheme continues to be very popular with staff, as do our cycles and IT schemes. Recognising our position we were 'Highly Commended' in the National Pay and Benefits Awards 2014 for our unique '*Salary Maxing*' Car Scheme.

During 2014, a range of staff took up the opportunity to test drive our sponsored '*Salary Maxing*' Electric Vehicle experiencing "green travel" and in March 2015 we showcased all of our benefits at the second successful Staff Benefits Fair which brought together all our staff benefits and experts in one place.

Staff are now also able to view a personalised summary detailing their full employment package throughout the year including basic pay, allowances, salary exchange savings and pension benefits *(for NHS Pension Scheme members only)* via their NHS Total Rewards Statement ('*TRS*') which has proved popular. However, it is also important that we recognise the individual successes of our staff, their innovations, quality care and exceptional work for patients.

Staff raising concerns

This year we signed up to NHS England's Sign up to Safety campaign (www.england.nhs.uk/signuptosafety), launched in June 2014.

The Secretary of State for Health set out the ambition of halving avoidable harm in the NHS over the next three years, and saving 6,000 lives as a result. This is supported by this campaign that aims to listen to patients, carers and staff, learn from what they say when things go wrong and take action to improve patient's safety helping to ensure patients get harm free care every time, everywhere.

All NHS Trusts are being invited to join this new campaign 'Sign up to Safety', which is the brainchild of Sir David Dalton, Chief Executive of Salford NHS Trust.

Organisations signing up to the campaign need to set out what they will do to strengthen patient safety by describing what they will do against the five sign up to safety pledges. The five pledge domains are:

1. Put Safety First;
2. Continually Learn;
3. Honesty;
4. Collaborate;
5. Support

Trusts are expected to publish plans on their public websites for staff, patients and public to see, committing to turn proposed actions into a safety improvement plan and identify patient safety improvement areas to focus upon. We will do this once our plan is complete.

We will use these pledges to shape our plan, which we be integrated with existing safety programmes in the Quality Commitment which will lead to a reduction in avoidable harm.

It will also support the actions required in response to the Leicester, Leicestershire and Rutland (LLR) "Learning Lessons to Improve Care" review and improvements to the LLR Emergency Care System.

3636 Staff Concerns Reporting Line

We are committed to dealing openly, promptly and efficiently with and genuine safety concerns raised by staff. To this end we operate a staff concerns reporting line whereby any member of staff can call to report safety issues or concerns. These are picked up by the Director on Call for that day and investigated to remedy issues and improve safety. We are also reviewing the recently published Francis 'Freedom to Speak up' report and will be implementing further systems to encourage staff to speak up about quality and safety matters.

Twenty calls were made to this concerns line in 2014/15, all of which were followed up on and reported to our Executive Quality Board. As a consequence of staff raising these concerns, safety actions have been implemented and systems strengthened.

Occupational health support

Our Occupational Health Service continues to be an integral part of the Trust's overall health and well-being strategy. The links between strong occupational health support and staff engagement and performance are well recognised. Occupational health helps our staff to cope with the health risks of their work and facilitates the retention of employment, including rehabilitation in work programmes for those who have suffered significant illness or injury.

Our work in helping staff to return to work following a diagnosis of breast cancer demonstrated a return to work rate of over 90 per cent and has been published in a national peer reviewed journal, Occupational Medicine.

Our service has been re-accredited as a SEQOHS service and continues to promote training and development for both nurses and specialist trainees in occupational health medicine. Dr Kaul is Training Programme Director for Occupational Medicine in the East Midlands, a position he has held for several years, supporting medical trainees in commercial industry in this region as well as those in the NHS.

Our Head of Service, Dr Anne de Bono, has been elected as Chair of the national NHS Health and Work Network for a further term. She wrote a guest editorial on '*Occupational Health in the NHS post the Francis report*' for the journal, Occupational Medicine.

Health and safety

This year saw the consolidation of our health and safety function with manual handling and security management under the one umbrella of Health and Safety services. The realignment of these services has allowed us to best meet the challenges in all three services by embedding a more efficient and collaborative approach. As a result we now have:

- Two qualified local security management specialists to spearhead the security management brief;
- Brought training in-house by employing an experienced security management trainer to better support the training programme and offer expert hands-on advice;
- Developed and started work on an ambitious security management action plan that systematically prioritises and addresses the needs of our organisation;
- We have seen a significant reduction in RIDDOR reportable injuries this year with a 30 per cent drop in the most serious of reported accidents and incidents.
- Conducted a review of services and put in plans of action to enhance and take the service forward.

Manual Handling

The rise in bariatric admissions has continued this year yet the manual handling advisors have risen to the challenge to provide the expert help advice support and equipment to meet the needs of both patient and staff.

The equipment rental system has been streamlined to remove the unnecessary delay in getting vital equipment in a timely manner. We have received additional support from our partners, Medstrom Ltd, with the provision of a bed and equipment support worker to enhance the manual handling service.

Plans for 2015/16

- The recruitment of a health and safety technician;
- The recruitment of an additional health and safety officer with a particular remit to support the strategic plan and 5-year capital works programme;
- Launch our security management training programme that will offer a range of conflict resolution related training based on an organisation wide training needs analysis;
- To progress the work of a fixed price bariatric rental agreement with our partners Medstrom Ltd to reduce costs and enhance the provision of specialist equipment further.

Risk management

The success of our risk management service requires us to identify any risks to us achieving our strategic objectives and to ensure that these risks are adequately controlled.

A risk management policy is in place to provide a framework with responsibility for the management of operational risks delegated to managers at a local level. Risk assessments are recorded on the Trust's risk register, subsequently providing a risk profile to the Board to aid decision-making.

A strengthened risk reporting process has been set up to provide greater accountability for risk and to ensure a clear line of sight of risks from 'ward to board'. Increased emphasis continues to ensure that risks are regularly monitored and reviewed to confirm actions are completed within specified deadlines. These reviews are performed by local boards and also by our executive team. 'Closing the loop' on these actions has brought about a reduction in the number of long-term risks recorded on the risk register.

During 2014/15 a number of principal risks were identified that may have had the potential to adversely affect the achievement of our strategic objectives. These risks were assigned an executive lead and added to our Board Assurance Framework, which is subsequently reviewed monthly by the Trust Board to provide assurance that these risks continue to be mitigated as far as practicable.

Medical Device Incident Reporting and the Central Alerting System (CAS)

In January 2014 the Medicines and Healthcare products Regulatory Agency (MHRA) and NHS England formed a strategic partnership to develop safety alerts and guidance to improve the reporting of, and learning from, medical device incidents. To meet national recommendations we put in place a number of actions:

- Enhancing governance systems in relation to medical devices;
- Implementing the role of Medical Device Safety Officer (MDSO);
- Supporting the role of the local MDSO through board-level responsibility for medical device safety and governance;
- Implementing a multidisciplinary medical devices group.

We are currently working on improving the data quality around medical device incident reporting, which will subsequently enable more effective data analysis to provide early indications of incident trends.

Also during January 2014, NHS England launched the National Patient Safety Alerting System (NPSAS), an improved system for highlighting patient safety risks in NHS organisations, and implementing actions to reduce risk. This was part of the government's response to the Francis report and provides a speedier issue of alerts to healthcare organisations. This also meant changes were required to the way in which we manage patient safety alerts and in April 2014 the following recommendations were implemented to provide effective governance in relation to these alerts:

- The Medical Director and/ or Chief Nurse have responsibility for allocating appropriate medical and /or nursing lead for NPSAS alerts;
- Where local actions are required, CMG senior management teams consider the alerts and provide assurance that the relevant actions to reduce risk have been taken;
- Personal oversight of compliance with recommended actions is via the Chair of the Executive Quality Board.

NPSAS alerts, MHRA medical device alerts, important public health messages and other critical safety information and guidance are issued via the national Central Alerting System (CAS). This is a web-based system that provides a mechanism for healthcare organisations to confirm that actions to comply with alerts have been taken within specified timescales. Between 1st January 2014 and 31st December 2014 we received a total of 137 alerts, with 128 (93 per cent) being completed within the required timescales.

Looking ahead….priorities for 2015/16

Our risk management team will continue to strive to improve risk management processes by:

- Continuing to work closely with local management teams to provide specialised support and guidance to help develop more effective and streamlined processes;
- Continuing to develop our internal risk management web pages to provide a risk management resource for all our staff;
- Perform a training needs analysis to identify staff groups requiring specific levels of risk management training;
- Develop e-learning risk management training packages making it easier for staff to access the required training.

Building on our relationships with GPs

We continue to work closely with our colleagues in general practice and the Clinical Commissioning Groups (CCG's) to strengthen our communication links.

Our Head of Services for GPs and GP Engagement Co-ordinator act as a conduit to facilitate dialogue and provide representation on interface matters. We provide a monthly GP newsletter to update primary care on developments within the Trust; we offer educational sessions to GP staff through practical sessions and clinical guidance; a second series of GP educational podcasts was released this year and we also maintain a website for healthcare professionals to easily access key information. A GP Hotline is available to arrange a 'call back' service for GPs wishing to speak with a consultant as well as some specialities offering written advice and guidance through Choose and Book (CAB).

Improving our estate

5 Year Investment Strategy

As part of the existing 5-year Strategic Plan to reconfigure services across Leicester, Leicestershire and Rutland and our complementary clinical strategy, we are continuing to deliver a range of schemes and developments that are necessary to achieve the quality of patient care and the capacity to respond to future demands and challenges. The following gives a summary of what we have accomplished over the year**.**

Estates Infrastructure Investment

To support the significant investment needed for our estate identified within our 5-year plan, it is essential that the building and engineering infrastructure is maintained and improved to enable these changes to take place. Important investment has also taken place to improve the patient environment across all three acute sites.

In 2014/15 we have invested in the following areas:

- £1.0 million - Public and Patient Environment
- £3.5 million - Building and Engineering Infrastructure
- £1.0 million - Essential and Emergency Repairs
- £2.4 million - Combined Heating and Power Plant

Improving Information Management & Technology

We have delivered multiple successful projects, a selection of them are:

- **Electronic Document and Records Management** (EDRM) pilot within Clinical Genetics has proven that the document solution enables clinicians to access scanned patient records that can be securely viewed and used in patient care;
- **Managed Print** has been deployed across the Glenfield Hospital making printing easier across the site with easy access to multiple printers wherever required (follow me printing). This will be rolled out across our other sites during 2015/16;
- **SystmOne EPR Core** has enabled clinicians to view GP records, after gaining permission from the individual, for patients attending our hospitals;
- **Nerve Centre Handover** has been implemented across the Trust to ensure safer handover between doctors;
- **The national Smartcard system** has been changed so that authorisation of cards is now all electronic removing paper forms;
- **Phonebook** to provide up to date information about people working in our organisation, their contact details and where they work within our organisational structure.

We have been investing in the infrastructure that will enable the organisation to transform its services. We have made significant investments in:

- Internal/external wireless networking (staff can now use their Trust issued laptops in the majority of public sector organisations, GP practices and the University of Leicester);
- We have delivered over 200 new Computers on Wheels (COWs) to support ward based computing;
- Data Centre technology refresh;
- Development of iPad/iPhone access to systems;
- Replacement of the remote access from home tool.

We are in the second full year of our partnership with IBM and all the intended services have been moved to IBM. We jointly aim to get everything right first time and we are achieving the agreed SLAs. However, for the occasions we fall short of our ambitions we are planning improvement works during 2015/16.

A key focus for our team and the wider clinical community has been the selection of an Electronic Patient Record solution. This significant investment has taken us to the approval stage and our plan is to be operational in 2016/17.

Developing research

Innovative research, influencing international guidelines, cutting-edge technology and world-firsts all form 'Leicester's Research'

Over the last year we have made significant developments in our research and innovation work, establishing ourselves as a centre of excellence for clinical research.

In June 2014 we appointed a Research Communications Manager to create and deliver an effective strategy to better promote clinical research within and outside of our organisation. As part of this strategy, we have re-branded our directorate from Research and Development to Research and Innovation to reflect the breadth of our work-streams.

We have created a website 'Leicester's Research', due to formally launch at the end of April 2015, which is designed as a one-stop shop for researchers, and as a source of information for commercial organisations and members of the public who are interested in healthcare research.

To support better and more cohesive promotion of clinical research, we have also secured a regular feature in our bi-monthly magazine, Together. This has been very successful in not only providing more information about what the teams are doing, but has also generated a significant amount of media interest. We are also addressing this at a grass-roots level by working with individual research teams to better promote their studies.

National guidelines require that all studies must recruit their first patient within 70 days of a study going live. Our team created the '70 days' campaign and logo which has contributed to a significant increase in meeting these targets. Furthermore, the campaign has been noticed by a great number of other trusts within the UK who have asked for permission to adopt the campaign. We have also been requested to present our campaign at the national Research and Development Forum.

We have been extremely successful in bidding for, and hosting, some new prestigious national studies. The Life Study, which was formally launched at the House of Lords early 2015, is a very large antenatal and early years study looking at environmental and hereditary development. The Social Club at the General Hospital site is currently being renovated to host this centre. The 100,000 Genome Project is another national study which Leicester successfully bid for in conjunction with NHS Trusts in Cambridge and Nottingham. This study is looking to map the genome sequence of people with certain conditions in the hope of identifying specific genes that may lead to individually personalised treatment plans.

In the last year, we were awarded Cancer Research UK (CRUK) Centre status – a significant and important achievement for our organisation. This centre status encompasses both the Hope Unit and Experimental Cancer Medicine Centre with the University of Leicester as a key partner.

Our researchers have also had a successful year as many were shortlisted for and won several awards. One example - published in the HSJ (Health Service Journal) - is the Entertainment Learning in Health Education team led by Dr Tapas Mukherjee, who won the Acorn Challenge Award at the NHS Innovation Awards. When the team realised that hospital information in emails and on posters was failing to grab the attention of its target audiences, it decided it needed to bring its messages to life by spicing them up with music and video imagery. Entertainment Learning was launched to provide patients with fun, informative guidance on how to choose and use the right asthma inhaler.

We are lucky at Leicester's Hospitals to have such dedicated researchers who are nationally and internationally renowned in their fields. Not only is their work significant within our research portfolio, but they are also making an impact overseas. The results of the CvLPRIT study, led by Professor Tony Gershlick and Dr Gerry McCann, prompted the American College of Cardiology (ACC) to revise its advice for the treatment of heart attack victims.

A particularly notable highlight from 2014/15 was the recruitment of the first global patient to two research studies! A global patient is the first patient to be recruited into an international clinical trial. The IgA Nephropathy team, led by Dr Jonathan Barratt and the COMMAND team, led by Dr Dean Fennell, made Trust history by recruiting these patients whilst meeting the 70-day target.

Finally, our innovation work-stream continues to gain momentum by securing firsts for the UK. The Optimed Machine was introduced to our Pharmacy team. This machine automatically fulfils orders by providing the exact medication required for each patient rather than issuing packs of medication. This will ultimately save Leicester's Hospitals a large amount of money by eradicating waste, allowing precise ordering and ensures that our teams are using the latest cutting-edge technology.

We have also worked with our researchers to successfully commercialise their products and release them to the open market. An example of this is the Professor Sally Singh's Pulmonary Rehabilitation team's project, www.spaceforcopd.co.uk. This is an online, self-management tool which allows patients to manage their rehabilitation therapy from home on a daily basis which reduces the need for weekly appointments.

Clinical Research Network: East Midlands (CRN: East Midlands)

Following the recent national reorganisation of research networks, the newly formed Clinical Research Network: East Midlands, hosted by Leicester's Hospitals, has had a productive first year. Delivering research across six clinical divisions that cover a total of thirty disease-specific speciality groups, CRN: East Midlands has consistently ranked fifth out of the fifteen branches of the National Institute of Health Research (NIHR) CRN in terms of volunteer recruitment. This means that through the funding received to support the infrastructure required to support research activity, we are continuing to increase research opportunities for people living within the East Midlands. In addition, in line with the government's strategy to support the Life Science Industry, we have successfully contributed to this agenda by attracting new companies to work with us based on our reputation.

Much of the year has also been spent setting up new systems and processes, merging old with systems new, allowing the opportunity to be creative and produce efficiencies. Firm relationships have also been established with our partner organisations and academic partners.

Collaboration for Leadership in Applied Health Research and Care East Midlands (CLAHRC EM)

Many of our researchers are contributing to projects in the new CLAHRC for the East Midlands. We have an ongoing, positive working relationship with the CLAHRC and with its Director, Professor Kamlesh Khunti, who is also co-Director of the Leicester Diabetes Centre. We provide matched funding to assist CLAHRC EM in its goal of engaging and implementing world class research across the East Midlands.

A research team, led by our Director of Research and Innovation, Professor Nigel Brunskill, developed IMPAKT (IMProving Patient Care and Awareness of Kidney disease progression Together). IMPAKT is a software tool that can identify GP patients at risk of Chronic Kidney Disease (CKD). IMPAKT has been implemented in the whole of the LNR region (Birmingham, Bradford, Manchester, North Yorkshire and North Wales) where it has identified more than thousands of people at risk from CKD. IMPAKT was developed with funding from the National Institute of Health Research (NIHR), through CLAHRC.

The tool has also significantly informed the National CKD audit tool project. IMPAKT is being used by the Healthcare Quality Improvement Partnership to describe the quality improvement specification for the national CKD audit. Locally the project team have been involved in training GP practice staff from all three Clinical Commissioning Groups in Leicestershire and Rutland, involving a total 160 staff in 21 training sessions. The tool continues to identify patients at risk from CKD preventing early onset and potentially saving the NHS millions.

Hope Against Cancer – Clinical Trials Unit

Our Clinical Trials Unit, which opened three years ago, continues to develop and progress. The team has significantly expanded over the last 12 months with dedicated staff now appointed to support our work as a CRUK Centre.

We continue to offer a broad portfolio of studies in line with our Cancer Strategy which has a special emphasis on early phase trials associated with our Experimental Cancer Medicine Centre status. A total of 98 studies have been open to recruitment throughout the course of the year (April 2014 – February 2015), of which 19 were newly opened in year. As the nature of cancer research is changing, many of our trials are focused around targeted therapies relating to specific cell mutations; our portfolio therefore allows patient's access to the latest novel treatments available.

Whilst the majority of patients are drawn from within the region, we are seeing an increasing number of patients referred to us from outside of the region on the basis that the studies we offer are not available to them locally. By March 2015 the team had recruited 552 patients to trials.

A total of 2789 attendances at the unit have been recorded throughout the year, compared to 1751 for the same period (up to March 2014) in 13/14. This represents a 59 per cent increase in overall attendance and relates directly to the increase in the number of clinics conducted on the unit which in turn, is allowing patients a more streamlined approach to their care throughout the research pathway. Whilst essentially a day-case environment, overnight stays for research have also increased. This is primarily as a result of our ability to attract research studies that have specific requirements which with our facilities we can complete.

An International Organisation for Standardisation (ISO) inspection earlier in the year resulted in continued accreditation until the next cycle of inspection will begin in 2015. Having introduced the Trust's first dedicated research patient experience survey, we are also assured that our unit is fit for purpose; patients consistently describe the unit and the care they receive as excellent. We are however in the process of developing our survey further to see how we can better understand how we can encourage more people to participate in research.

Our researchers have also been recognised as making notable contributions. Professor Martyn Dyer has been awarded one of our Caring at its best Award following a nomination by one of our patients. Other team members also received nominations. Dr Samreen Ahmed and Professor Dean Fennell have received a prestigious National Institute of Health Research Award, presented by Dame Sally Davies, for their contribution to consistently recruiting to 'time and target' and for achieving first global patient recruitment status in relation to trials that have been conducted within our unit.

Our dedicated Hope funded Research Nurse, Pam Fermahan, in her capacity as a member of an international nurse advisory board, has presented at meetings in both Germany and Prague to give insight of her experience of administering a novel therapy (now licensed) in a series of trials that has potentially revolutionised the treatment of chronic Lymphocytic Leukaemia.

Student placements for medical and nursing staff continue. We have recently improved the opportunities available to student nurses with a view to increasing oversight of the research pathway and the multiple departments we liaise with. Our internal teaching programme has also been updated and expanded.

NIHR Leicester Cardiovascular Biomedical Research Unit

Leicester Cardiovascular Biomedical Research Unit (LCBRU) conducts pioneering research into cardiovascular disease based around its two research themes: Genetics & Biomarkers; and Novel Cardiovascular Interventions.

The unit is involved in a range of studies, including early phase research, devices and large-scale genetic studies. Building on our earlier work in the GRAPHIC study (Genetic Regulation of Arterial Pressure in Humans in the Community), a large community-based study that involved over 2,000 participants and investigated the heritability and genetic determinants of blood pressure in the general population. We are currently near completion of a follow-up study, GRAPHIC 2.

The purpose of GRAPHIC 2 is to re-evaluate the original GRAPHIC participants, some 8-10 years after their participation in the original study. This is to identify genetic and environmental determinants of age-related changes in blood pressure and how these might interact with lifestyle and other factors in increasing risk of high blood pressure, heart disease and stroke. To date over 1,000 of the original GRAPHIC participants have been followed up. The data provided from this follow-up study will help provide a foundation leading to a greater understanding of cardiovascular diseases, which in turn will help towards better methods of prevention and treatment.

Progress in the Genetics and Vascular Health Check study (GENVASC), which is being run across Leicestershire in conjunction with the Clinical Commissioning Groups and Primary Care practices, continues at a pace. The study aims to determine whether the addition of genetic information can improve risk prediction of Coronary Artery Disease (CAD) and to date, has recruited almost 10,000 participants in just two years and won an award from the National Institute for Health Research Clinical Research Network for its innovative recruitment strategy.

We have recently completed recruitment for the Diastolic Heart Failure (DHF) study, recruiting 180 patients with heart failure with preserved ejection fraction, 50 patients with reduced ejection fraction and 50 healthy controls (a healthy control is a healthy patient who is recruited to a clinical trial so that their readings can be used as a comparison against those with a particular condition). Patients have been extensively phenotyped, including echocardioraphy and MRI and data analysis is underway.

Within the Novel Interventions theme, the CvLPRIT study, a British Heart Foundation funded Leicester led multi-centre trial, which assessed the value of treating either the occluded (obstructed) artery alone, or the occluded artery plus any narrowed ones in patients with acute coronary syndromes has been completed. The trial showed that by treating both arteries at the same time, it improved the outcome of the procedure for patients. The results of the trial are so conclusive that the current guidelines which recommended that one artery be treated at a time for this type of heart attack, have been withdrawn to allow for the implementation of this method of treatment; the first time a “Do not treat” guideline has been revised.

The SCAD (Spontaneous Coronary Artery Dissection) study, a patient-initiated British Heart Foundation funded study, has recruited over 200 patients (around 40 per cent of the estimated SCAD population within the UK) and will soon begin detailed data collection, including genotyping and imaging data.

We look forward to continuing this work and initiating a number of exciting new studies during 2015/16. This will help us ensure that Leicester Cardiovascular BRU is at the forefront of cardiovascular research bringing benefits to patients both locally and nationally.

NIHR Leicester Respiratory Biomedical Research Unit

NIHR Leicester Respiratory Biomedical Research Unit (BRU) conducts first class research into respiratory diseases such as asthma and Chronic Obstructive Pulmonary Disease (COPD). Research focuses around three research areas: translational molecular discovery; phenotyping and biomarkers; and clinical interventions. The BRU is involved in a range of studies, including early phase research, clinical trials of investigational medicinal products (CTIMP), observational studies and large-scale genetic studies.

The EXCEED (Extended Cohort for E-health, Environment and DNA) study is a large community-based study that has recruited over 3,000 of its target 5,200 participants to date. The study aims to collect routine healthcare data and to collect DNA saliva samples from participants. It will examine the effects of genetic variation on COPD risk and disease progression in COPD; the effect of genetic variation on smoking behaviour and smoking cessation; and the genetic determinants of disease, multiple morbidity and response to health interventions.

The genetic associations will provide insights to inform the prevention, diagnosis and treatment of illnesses such as chronic obstructive pulmonary disease, asthma, kidney disease, diabetes, cardiovascular disease, cancers, joint problems and combinations of different diseases (multiple morbidity). The study will not be restricted to the study of genetic associations, for example, it will be possible to investigate the influence of smoking or alcohol consumption on multiple morbidity.

Extensive work continues within the unit's longitudinal studies, which are involved in the identification of phenotypes and biomarkers that are central to the concept of individualised medicine. Such work stems from collaborations including AirPROM and the MRC/ABPI COPD consortium; that aims to extend existing cohorts of patients with difficult asthma and advanced COPD, enhancing the range of data collected. The unit will also embark upon a new work-stream that will extend the patient research base even further to those recruited from the acute admissions unit.

The BRU recently completed a ground-breaking CTIMP research study in partnership with Novartis, investigating a new tablet for treatment of people with asthma. The study outcomes were presented at the world's largest respiratory meeting at the European Respiratory Society Conference in Germany, and received the award for best research. The study revealed that the new drug was safe and well tolerated, improved the control of asthma, quality of life and lung function. This was an important break-through for asthma, and further studies will need to be carried out to confirm the positive findings and to test whether the drug can reduce asthma attacks in studies of longer duration.

The BRU continues to boast good relationships with commercial companies and carries out many commercial studies. The unit has recently started recruiting for a commercial study with Quintiles, investigating a new treatment in asthma. The research team were successful in recruiting the first participant in the EU.

The MATCH study (Mitochondrial quality, density and function in response to Aerobic Training and detraining in patients with CHronic obstructive pulmonary disease) is a study investigating the effects of cycling exercise training on how the mitochondria work in people with COPD. Reduced mitochondrial density and function are recognised to be important components of skeletal muscle dysfunction in COPD, and reduced oxidative capacity at a skeletal muscle level is likely to contribute to exercise limitation in this group of patients. This study will help to examine whether COPD patients need special treatments targeted at the muscles in order to make exercise easier for them. The MATCH study is part of a major UK research initiative called COPD MAP (Chronic Obstructive Pulmonary

Disease Medical Research Council/ Association of the British Pharmaceutical Industry). The MATCH study has now finished recruiting 60 participants and is currently completing follow up visits and data analysis. The results should be available towards the end of the summer 2015.

NIHR Leicester- Loughborough, Diet, Lifestyle and Physical Activity Biomedical Research Unit

Leicester - Loughborough Activity Biomedical Research Unit (LCBRU) conducts pioneering research into long-term health conditions, principally diabetes. These are based around its two research themes: physical activity and sedentary behaviour, and physical activity, appetite regulation, diet and metabolic health.

The unit is involved in a range of studies, including early phase research, devices and large-scale studies. It has been a busy year at the Leicester Diabetes Centre; we have two new large school based projects - Girls Active and PreStart - the latter, with our European partners in Greece, Portugal, Spain, and Germany. This builds on our international reputation for delivering high quality lifestyle interventions for behaviour change in groups at risk of developing diabetes in later life.

Pre-Start - This project has two phases. Phase 1 is developing a risk tool for the identification of adolescents aged 12-14 years who are at increased risk of developing Type 2 Diabetes in the future. Phase 2 will see the development and evaluation of a lifestyle intervention for diabetes prevention in 12-14 year olds at risk. This will be in collaboration with teachers, parents, adolescents, and community physical activity co-ordinators.

Girls Active*:* This project recognises that girls' needs differ and change as they mature and that girls themselves are uniquely positioned to 'sell' physical education and sport to other girls. Girls Active offers a simple flexible action planning framework to help teachers and girls work together to address their particular issues. It is based on the Youth Sport Trust-developed principles of student engagement, such as student voice and leadership, alongside innovative approaches to marketing.

International Health Care Professional Training*:* The Leicester Diabetes Centre has also continued to build its international reputation and profile by hosting several visits from Spanish and Middle-Eastern healthcare providers, in order to train and develop their skill and knowledge base in treating and managing patients with type 2 diabetes.

Impact on Healthcare*:* With the Leicester Diabetes Prevention Pathway we have developed a range of evidence-based tools and programmes that are targeted at the prevention of type 2 diabetes. These include:

1) a freely available tool that enables primary care and public health commissioners to estimate the number of individuals with a high risk of diabetes in their locality;
2) a freely available paper-based and web-based (http://riskscore.diabetes.org.uk/2013) risk score that allows individuals to categorise their risk of having some form of impaired glucose regulation;
3) a freely available practice-based risk score tool that can be downloaded onto GP practice databases which automatically ranks all registered patients for their risk of impaired glucose regulation;
4) a patient booklet designed for anyone who has been told by their GP that they have a high risk of type 2 diabetes (or anyone who is otherwise interested) which includes specific advice on diet and physical activity. This booklet has been widely used by GP practices within the East Midlands;

5) a suite of evidence-based quality-assured lifestyle intervention programmes which are available to commissioners for referring those found to have a high risk of type 2 diabetes onto effective prevention programmes. To date, our flagship Walking Away from Type 2 Diabetes prevention programme has been commissioned within nine CCGs locally and nationally as well as in parts of Ireland and Australia.

Our Leicester Diabetes Prevention Pathway was launched at the Saving Lives Conference in Leicester in May 2014 and we plan on finalising a dedicated website and resource pack for health care professionals, patients and commissioners by the end of 2015.

CCG and Health Care Professional Training – Eden: Our new model of healthcare professional diabetes training is known as the EDEN project - Effective Diabetes Education Now. This training has been commissioned by Leicester City Clinical Commissioning Group as part of their Transformation Project and will run for three years. There has been considerable cross-talk between the EDEN management team and our senior BRU staff to ensure that the importance of lifestyle promotion sits alongside more traditional approaches to chronic disease prevention and management.

Our priorities for 2015/ 16

For 2015/16 we have slightly amended our Strategic Objectives (in bold) and beneath them lie our priorities for 2015/16. This is undoubtedly a huge agenda….

Safe, high quality, patient centred healthcare

- Reduce our mortality rate (SHMI) to under 100 (Quality Commitment 1)
- Reduce patient harm events by 5 per cent (Quality Commitment 2)
- Achieve a 97 per cent Friends and Family test score (Quality Commitment 3)
- Achieve an overall "Good" rating following CQC inspection
- Develop a "UHL Way" of undertaking improvement programmes
- Implement the new PPI Strategy.

An effective and integrated emergency care system

- Reduce emergency admissions through more comprehensive use of ambulatory care
- Improve the resilience of the Clinical Decisions Unit at Glenfield Hospital
- Improve the resilience of the Emergency Department in the evening and overnight
- Reduce emergency medicine length of stay through better clinical and operational processes
- Substantially reduce Emergency Department ambulance turnaround times.

Services which consistently meet national access standards

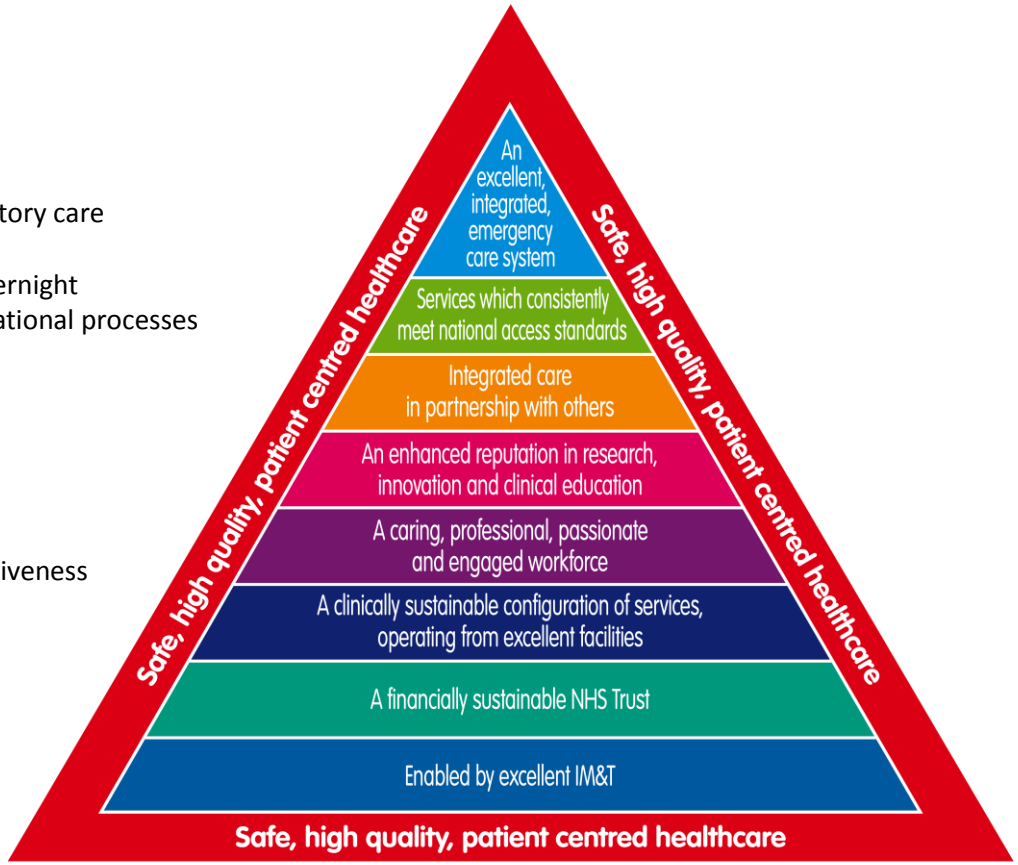
- Deliver the three 18-week Referral To Treatment (RTT) access standards
- Deliver the three key cancer access standards
- Deliver the diagnostics access standard
- Implement tools and processes that allow us to improve our overall responsiveness through tactical planning.

Integrated care in partnership with others

- Deliver the Better Care Together year 2 programme of work
- Participate in Better Care Together formal public consultation
- Develop and formalise partnerships with a range of providers including tertiary and local services
- Explore new models and partnerships to deliver integrated care.

Enhanced delivery in research, innovation and clinical education

- Develop a robust quality assurance process for medical education
- Further develop relationships with academic partners



- Deliver the Genomic Medicine Centre project
- Comply with key NIHR and CRN metrics
- Prepare for Biomedical Research Unit re-bidding
- Develop a Commercial Strategy to encourage innovation within our organisation.

A caring, professional and engaged workforce

- Accelerate the roll out of Listening into Action
- Take Trust-wide action to remove “things that get in the way”
- Embed a stronger more engaged leadership culture
- Develop and implement a Medical Workforce Strategy
- Implement new actions to respond to the equality and diversity agenda
- Ensure compliance with new national whistleblowing policies.

A clinically sustainable configuration of services, operating from excellent facilities

- Deliver the actions required for year 2 of the 5-Year Plan (develop Site Development Control Plans for all three sites)
- Improve ITU capacity issues including transfer of Level 3 beds from the General Hospital
- Commence Phase 1 construction of the Emergency Floor
- Complete vascular full business case
- Deliver outline business cases for Planned Treatment Centre, Maternity, Children’s Hospital, Theatres, Beds
- Develop a major charitable appeal to enhance the investment programme
- Deliver key operational estates developments (multi-storey car park; infrastructure improvements at the Royal Infirmary and Glenfield Hospitals; Phase 1 refurbishment of wards and theatres).

A financially sustainable NHS organisation

- Deliver the agreed 2015/16 I&E control total - £36m deficit
- Fully achieve our £41m CIP target for 2015/16
- Revise and sign off by Trust Board and TDA of the Trust's 5-year financial strategy
- Continue the programme of service reviews to ensure their viability.

Enabled by excellent IM&T

- Prepare for delivery of the Electronic Patient Record in 2016/17
- Ensure that we have a robust IM&T infrastructure to deliver the required enablement
- Review IBM support to ensure that we have the right resources in place to enable IM&T excellence.

Over the page you can see our updated Quality Commitment which highlights our focus for 2015/16.


Caring at its best
University Hospitals of Leicester NHS
NHS Trust
QUALITY COMMITMENT
AIM
KPI
2015/16 PRIORITIES
Clinical Effectiveness
Improve Outcomes
Patient Safety
Reduce Harm
Patient Experience
Care and Compassion
To reduce preventable mortality
To reduce the risk of error and adverse incidents
To improve patients' and their carers' experience of care
UHL's SHMI =/<100 by March 2016
Reduction in Harm Events by 5%
Trust level F&FT score to 97% by March 2016
Improve pathways of care:
• Review of all in-hospital deaths
• Use of clinical benchmarking tools
• Identify actions and work-streams where greatest potential for preventable mortality
Improve Consistency of 7 Day Services
• In line with Keogh 10 Clinical Standards
Earlier Recognition and Rescue of the Deteriorating Patient
• Sepsis
• Handover
• EWS
• Acting on results
Consistencies in Core Practices
• Medication Safety
• Infection Prevention
Further expand end of life care processes
• Early identification of patients requiring supportive and palliative care (SPICT)
• Strengthen bereavement support
Improve the experience of care for older people across the trust
• 'Fixing the Basics'
• Improve the Environment
Learning and Development
Implementation of Trust M&M Database for shared learning across all areas
Learning and Development
Implementation of Safety Briefings in wards and departments
Learning and Development
Triangulation and review of feedback from all sources and all key characteristic groups
UNDERPINNING WORK STREAMS
I.T. Enablers - Guidance and Monitoring
Adequate Resources - Time in Job Plan and Admin Support
Trained and Motivated Workforce - "Team Around the Patient"

Sustainability Report

Sustainable development is the achievement of a better quality of life through the efficient use of resources and meets the needs of the present without compromising the ability of future generations to meet their own needs.

We are committed to sustainability and have in place a sustainability development strategy which aims to meet national NHS targets. The main areas covered are transport, procurement, energy consumption and CO2 emission reductions and new buildings.

Energy and Sustainability Projects

***Heating and Power*:**

Description	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	Annual Change		Overall Change	
Gas Usage (KWh)	116,873,611	99,831,667	109,781,944	93,697,272	96,694,476	85,673,210	86,601,762	83,164,032	**92,086,201**	-8,922,169	-10.73%	24,787,410	21.21%
Electricity Usage (KWh)	29,357,222	30,681,111	33,822,222	36,426,819	39,489,130	42,535,080	46,390,022	48,522,097	**38,033,214**	10,488,883	21.62%	-8,675,992	-29.55%
Totals (KWh)	146,230,833	130,512,778	143,604,16	130,124,091	136,183,606	128,208,289	132,991,784	131,686,129	**130,119,416**	1,566,713	1.19%	16,111,418	11.02%
Costs (£)	£5,252,319	£4,403,428	£7,320,137	£5,136,734	£5,282,765	£6,479,603	£7,223,638	£7,995,022	**£7,053,682**	941,340	11.77%	-£1,801,363	-34.30%
CO2 Emissions (Tonnes)	37,531	35,090	38,633	36,910	39,236	38,881	41,334	40,724	**36,859**	3,865	9.49%	672	1.79%
CO2 Emissions (CRC Cost)	N/A	N/A	N/A	N/A	N/A	£376,571	£404,539	£400,777	**£280,678**	120,099	29.97%	-£280,678	-100.00%

Reducing CO2 Emissions, energy consumption and waste

The Estates and Facilities Management Collaborative are responsible for the effective management of energy, waste, recycling, use of water and the reduction of carbon emissions through the Interserve Facilities Management Contract.

- Our commitment to continue to reduce CO2 emissions has seen a reduction of 4.74 per cent over the last year. This supports our pledge within the national NHS Carbon Reduction Strategy 'Saving Carbon, Improving Health', part of the Climate Change Act 2008;
- All designated premises displaying energy certificates;
- Our energy consumption has reduced resulting in an overall cost saving of 3.2 per cent;
- The Combined Heating and Power (CHP) plant is now fully operational which has seen benefits in reduced electricity usage from the UK electricity grid and anticipated further reduction in carbon emissions annually of approximately 4700 tonnes;
- Our waste recycling has increased from 2013/14 which now represents 41 per cent of all waste produced;

- We hosted a series of roadshows for NHS Sustainability Day to engage with staff and the public and promote sustainable travel, home and workplace improvements and sustainable food. The day was also used to recruit 'Sustainability Champions' within our organisation;
- We complete an annual Estates Returns Information Collection (ERIC) report on our use of energy (fossil fuels and electricity) in buildings, volumes of waste produced and volume of water used. We also use this information for benchmarking purposes, ensuring that our performance is in line with other NHS Trusts.

New Building Developments

We use the Building Research Establishment Environmental Assessment Method (BREEAM) which sets the standard for best practice in sustainable building design, incorporating many aspects related to energy and water use, the internal environment (health and well-being), pollution, transport, materials, waste, ecology and management processes.

Travel management

We are benefiting from a more sustainable approach to transport with the following initiatives:

- Our Travel Plan incorporates environmental initiatives, which we are using during all of our estates developments;
- The Enderby Park and Ride now stops outside the Royal Infirmary and we are working with the council on further opportunities;
- A new bike shed has been installed on the Royal Infirmary site with another to follow soon. These new facilities will provide a greater capacity supporting the use of 'peddle power';
- We have launched a Cycle to Work scheme – staff can purchase a bike through a salary sacrifice scheme;
- We have reviewed staff parking arrangements reissuing permits based upon a new criteria that focuses on work related travel;
- We are actively working with bus operators to ensure the continuation of our inter-site shuttle (Hopper) bus service;
- We continue to promote to staff alternative travel, including cycling and walking initiatives.

Procurement

Working in partnership with PASA, the NHS procurement and supplies agency, we have developed a sustainable approach to ensure the purchase of goods and services results in more positive benefits with minimal effect on society, the economy and the environment.

Information governance

Protecting patient privacy continues to be one of our key objectives and has been supported by a range of new activities to ensure that risks arising from the management of personal data are managed to the highest standards.

With changes across the NHS impacting on our services there needs to be a drive to protecting patient's privacy. Sharing information remains an important part of the way in which the NHS operates as whole but we can only provide information where there is a clear legal basis. A new project to secure sharing of information has been introduced and will deliver improvements during 2014/15.

Our performance with all compliance targets continues to improve during this year. We achieved a related objective to train all staff to understand information rights. Our privacy strategy is now focused on making the most of the technologies and services that allow information to be managed to the greatest benefit of the public.

Information Governance incidents **Category**		
1	Loss of inadequately protected electronic equipment, devices or equipment from secured NHS premises	2
2	Loss of inadequately protected electronic equipment, devices or equipment from outside secured NHS premises	2
3	Insecure disposal of inadequately protected electronic equipment, devices or paper documents	2
4	Unauthorised disclosure	4
5	Other	0

Emergency planning

This year has been particularly busy, but seen the Emergency Planning and Business Continuity Team continue to make big improvements to our overall resilience.

Last year the team completed the Major Incident Plan and in July we tested it via our three yearly validation exercise, involving over 80 members of staff "role playing" a major incident to manage a fictitious train crash in Leicester. During the exercise they successfully managed to deal with the patients, so much so that the exercise directors had to create new patients to keep the pressure on! As with any event there are undoubtedly areas to improve on which we have done so throughout the year. One of the main areas to come from this is training, which we continue to make year on year improvements on and we expect to continue to do so. We have also been developing and improving our response to Pandemic Flu and Chemical, Biological, Radiological and Nuclear (CBRN) incidents.

When national health care unions announced a series of national strikes, the team were able to work with our services to ensure that on the day of the strikes there was little to no impact to normal services. When the news of the Ebola outbreak came, the team worked with frontline staff to ensure we had in place relevant plans and training so that we are prepared to deal with any cases of Ebola Virus that might present at any of our hospitals.

They have also been heavily involved in the design of the new Emergency Department to ensure that it is fit for purpose for responding and managing future incidents that the Trust may face.

2015 looks to be as busy as ever with the team working on; hospital evacuation, resilience of new IT systems, region-wide and service area response exercises whilst assuring NHS England of our continued commitment and development of resilience arrangements.

Signed 

Chief Executive (on behalf of the Trust Board)

Date: 4 June 2015

Operating and financial review

2014/15 was another challenging year both financially and clinically and we delivered a planned deficit for the year, which was only the second deficit we have delivered since we were formed in 2000.

We provide hospital and community based healthcare services to patients across Leicester, Leicestershire and Rutland and specialist services to patients throughout the UK.

As such, our main sources of income are derived from Clinical Commissioning Groups, NHS England, and education and training levies. We are actively engaged with key stakeholders to implement NHS policy to improve health services in the local area through a range of formal and informal partnerships.

Financial review for the year ended 31st March 2015

We have not met all of our financial and performance duties for 2014/15:

- Balancing the books — We delivered an income and expenditure deficit of £40.6m
- Managing cash — We delivered both the External Financing Limit (EFL) and Capital Resource Limits (CRL)
- Investment in buildings, equipment and technology — We invested £46.2 million in capital developments

Performance against our Financial Plan

We delivered a £40.6m deficit for the year against a planned deficit of £40.7m. The plan included income of £817.3m (excluding the impact of donated assets) and expenditure of £858.0m.

The final year end position included the following (excluding the impact of donated assets):

- Total income — £834.4m actual; which was £17.1m over plan relating to favourable settlements with commissioners and additional RTT (Referral to Treatment) work
- Total expenditure — £875.0m actual; which was £17.0m over plan and includes overspends of £1.2m on pay and overspends of £15.8m on non-pay
- Capital expenditure — £46.2m against a revised capital resource limit of £46.2m
- Cash balance — £8.5m closing cash balance against a plan of £0.3m
- Cost Improvement Programme (CIP) — Delivered £48m (5.2 per cent of total expenditure) against a £45m (5 per cent) target

Balance Sheet

Cash

We planned to have a year-end cash balance at the end of March 2015 of £0.3m and secure external financing of £58m, comprised of:

- £40.7m to fund our deficit;
- £5.3m to improve liquidity; and
- £12m for capital financing.

We applied to the Department of Health for this financing in October 2014 and expected that it would be given to us in the form of Public Dividend Capital (PDC) which has historically been the main form of long term financing in the NHS. Our application was successful, and we received £46m as PDC and the remaining £12m in the form of a capital investment loan.

We were required to draw down the full £12m loan to enable us to fund our capital expenditure for the year however we did not pay all of the capital invoices in 2014/15. As a result our year-end cash balance of £8.5m was £8.2m above plan.

Non-current assets

Total non-current assets have increased by £53.4m mainly as a result of

- £44.2m total net additions; plus
- £39.1m revaluation; less
- £30.4m depreciation.

Working capital

Our debtors have decreased by £17.7m. This is mainly due to a £18.5m decrease in NHS debtors as a result of a reduced level of invoicing for winter pressure and performance income at the year-end compared to the prior year.

Our creditors have decreased by £8.6m since the last year-end mainly due to the impact of the additional external financing received in year and the improvements this has led to in terms of our payment performance.

Taxpayer's equity

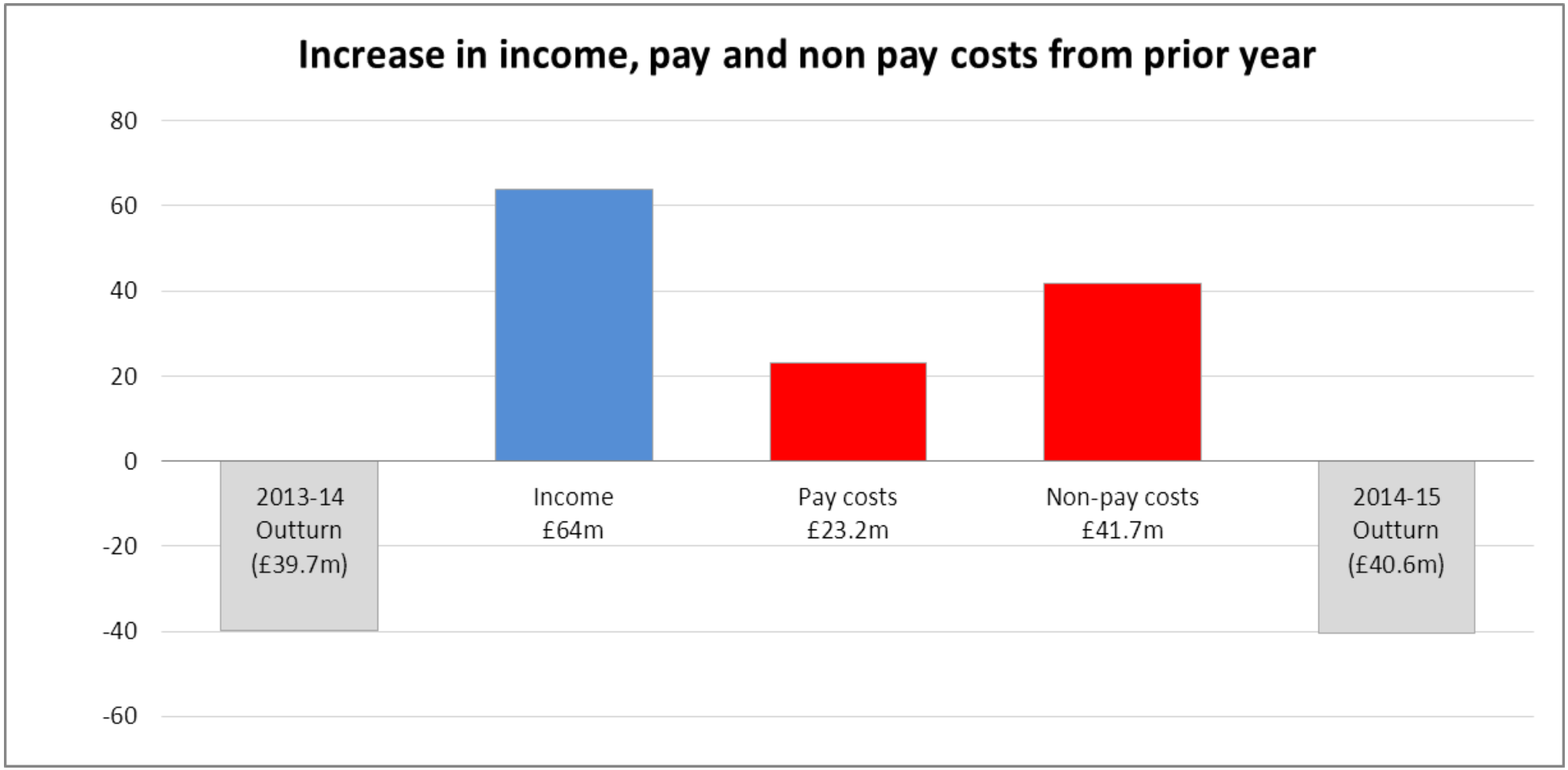
This represents the methods of funding our assets and liabilities. The main balance is Public Dividend Capital and this increased by £47.2m in the year as we received additional funding for the following areas:

- £0.1m Improving maternity care settings schemes

- £1.1m Safer hospitals technology fund schemes
- £5.3m To fund improvements to liquidity
- £40.7m To fund our deficit

Our retained earnings reduced by £40.6m due primarily to our financial deficit. The revaluation reserve balance is consistent with the prior year.

Key Financial Indicators



Income

We received £834.4m of income (excluding donated assets) which is a £64m (8 per cent) increase from the £770.4m received in 2013/14. £21m of this increase is due to additional income from the LLR Alliance which we now host.

The Alliance took over from another local NHS Trust to provide elective care services in the local health region. £9.4m of the increase is due to coding and counting changes and £8.0m is due to an increase in income for excluded drugs and devices.

Pay expenditure by staff group

We spent £497.3m on staff costs, which is a £23.2m (5 per cent) increase over the 2013/14 total of £474.1m. The majority of this increase is due to inflation. £5.2m of the increase is due to the costs of staff transferred in for the LLR Alliance.

Non-pay expenditure

We incurred £377.7m of non-pay expenditure which was a £41.7m (15 per cent) increase over the 2013/14 total of £336.0m. £16m of this increase relates to an increase in clinical supplies and services costs, including drugs (£5.9m), medical and surgical equipment (£4.3m) and other clinical supplies (£4.8m).

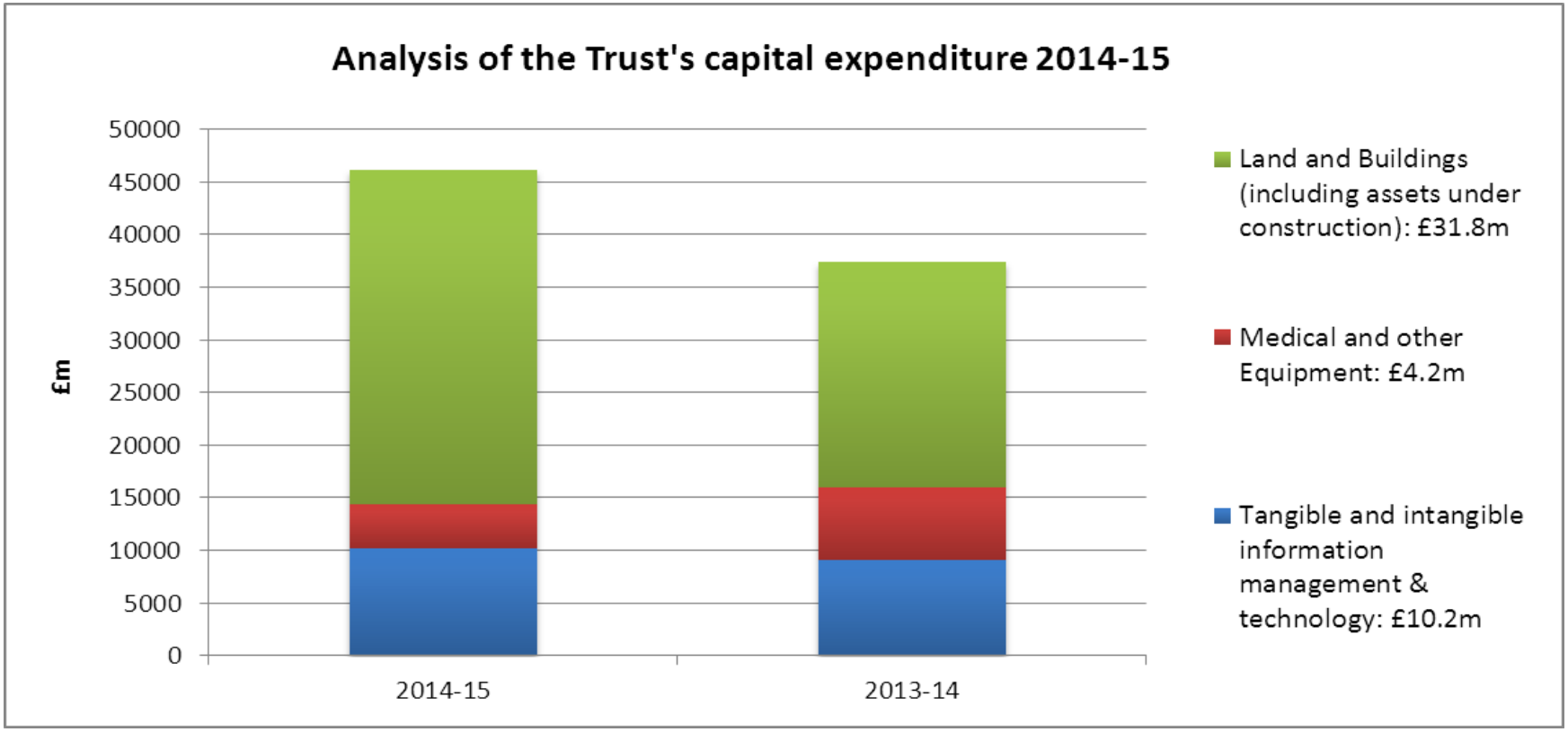
Research costs have increased by £10.4m as we are now responsible for hosting the NIHR Clinical Research Network: East Midlands. We also had an impairment of our property, plant and equipment of £6.7m following a revaluation of our estate. External general services contracts have increased by £6.0m mainly as a result of the LLR Alliance (£2.9m).

Capital expenditure

Our capital expenditure (excluding adjustments for donated assets) was £46.2m, an £8.7m (23 per cent) increase over the 2013/14 total of £37.5m. A breakdown of the spend is shown in the graph overleaf.

Capital expenditure for 2014/15 consisted of:

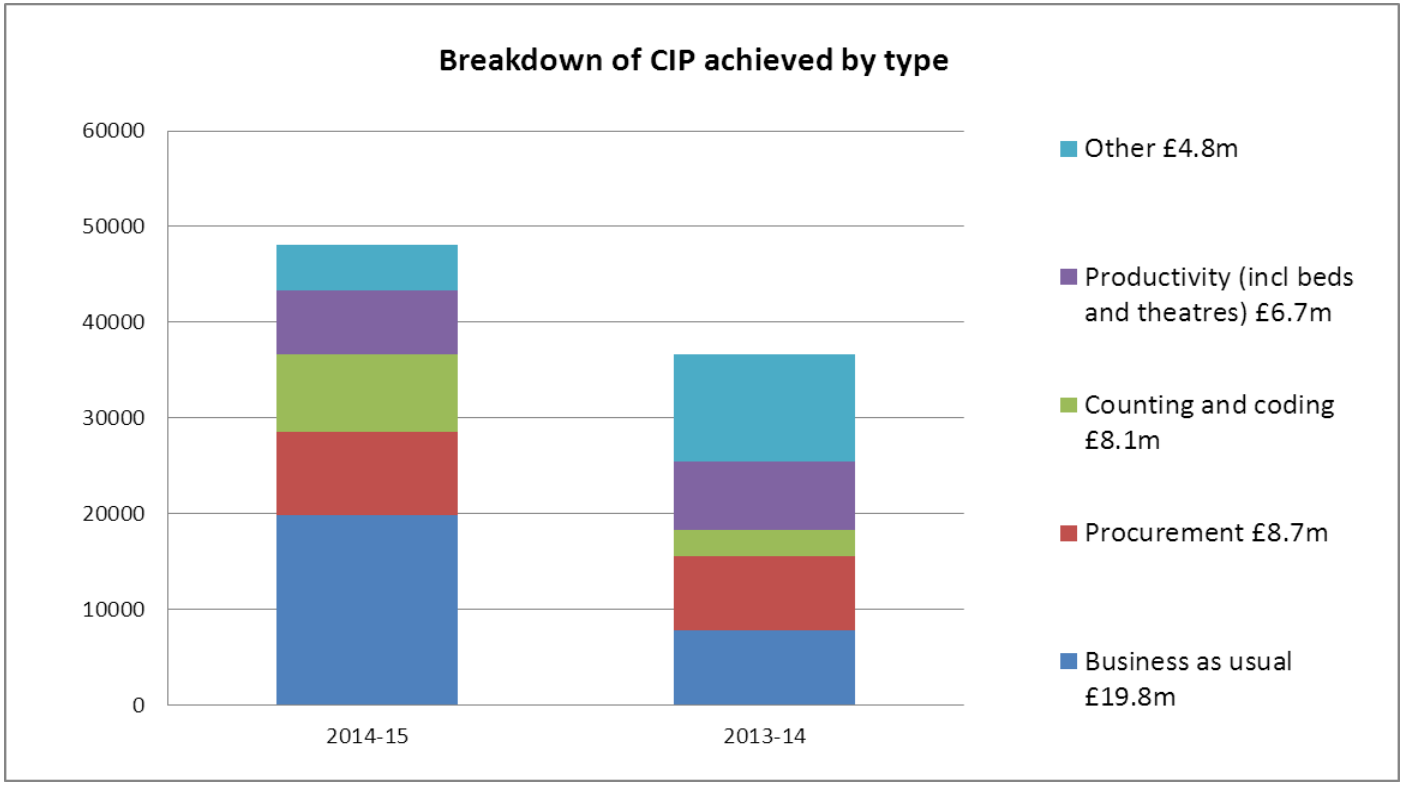
- £22.1m on reconfiguration schemes including £6m relating to our Emergency Floor and £4.5m on modular wards which are providing additional capacity;
- £12.5m on estates including £5.5m on backlog maintenance;
- £11.8m on various IM&T schemes; and
- £4.4m on medical equipment.


Analysis of the Trust's capital expenditure 2014-15
£m
50000
45000
40000
35000
30000
25000
20000
15000
10000
5000
0
2014-15
2013-14
Land and Buildings (including assets under construction): £31.8m
Medical and other Equipment: £4.2m
Tangible and intangible information management & technology: £10.2m

Our efficiency programme

We delivered £48m against our £45m cost improvement programme in 2014/15. The programme focused on productivity whilst maintaining high quality patient services.

£19.8m of these savings came from improvements in the way we carry out our day to day activities; £8.7m of savings came from specific procurement initiatives; £8.1m from counting and coding; and £5.7m from productivity improvements. A comparison of the cost improvement plan achieved with the previous year is shown in the graph below.



Managing Risk

We operate within the regulatory framework determined by the Department of Health. Comprehensive risk management is monitored through the Trust Board's assurance framework, which regularly reviews all key risks and action plans. These plans cover clinical as well as corporate and business risks.

As in 2013/14, we will continue to manage key risks linked to management and control of infection, the patient experience, delivery of national waiting time targets, and delivery of financial balance.

Future Challenges

Financial planning

We have submitted our 2015/16 plan to the National Trust Development Authority. The key details relating to the plan for 2015/16 are as follows:

- Planned I&E deficit of £36.1m;
- A major CIP plan of £38.7m;
- A capital expenditure plan of £106.7m, including the Emergency Floor development and the vascular services move;
- External funding of £109m to fund the deficit plan and part fund the capital programme;
- An external Financing Limit (EFL) of £114.1m;
- A Financial Risk Rating (FRR) of 4 (calculated in accordance with the TDA planning submission guidelines).

Our financial plan and resulting deficit position is driven by our activity and income assumptions, workforce implications and the Cost Improvement Programme (CIP). We have a clear process for delivering against these areas, and to ensure a realistic monthly profile of income and expenditure.

Cash management

We will require both temporary borrowing and permanent financing as follows:

- £22m temporary borrowing from April to fund the deficit plan until permanent financing is received mid-year; and
- £109m permanent revenue financing to fund the £36.1m deficit plan for the full year; £5m to improve liquidity; and provide £67.9m funding for the capital programme that cannot be funded through internally generated cash.

We will further improve our performance against the Better Payment Practice Code (BPPC) in 2015/16 as a result of the financing outlined above. Sufficient liquidity therefore will exist or can be made available to support our operational costs in the coming twelve months from the date of annual accounts.

Efficiency programme for 2015-16

In 2015/16, we have set a challenging efficiency target of £38.6m. Delivery of this total will be challenging and our processes will continue to give assurance over the schemes and their quality impact. These processes have proven effective in 2014/15 and include cost improvement programme reporting through the Chief Operating Officer with weekly updates to the National Trust Development Authority. All CIP schemes are quality and risk assessed and there will be regular reporting to the Executive Performance Board; Integrated Finance, Performance & Investment Committee; and Trust Board.

This target reflects the minimum 4 per cent (£30m) required through the national tariff (Payment By Results) plus an additional amount to reduce our underlying financial deficit. The key themes, as in previous years, include

- procurement - buying goods and services;

- reducing agency pay costs;
- improvement in our theatre efficiency; and
- reducing outpatient cancellations and non-attenders (DNAs).

Capital programme

We are continuing to invest in our buildings and equipment. We have a major capital agenda over the medium term, including the Emergency Floor project and the reconfiguration scheme, both of which commenced in 2014/15.

The capital programme for 2015/16 involves up to £106.7m of investment. Major schemes include:

- £17.7m for the new Emergency Floor;
- £24.4m for the Electronic Patient Record (EPR) system; and
- £11.4 to continue developing vascular services at Glenfield and to provide an ICU interim solution.

Signed 

Chief Executive (on behalf of the Trust Board)

Date: 4 June 2015

Remuneration Reports

Salary and pension entitlements of senior managers – salary 2014/15

	2014 - 15						
Name and Title	Salary (bands of £5,000) £000	Expense payments (taxable) total to nearest £100 £00	Performance pay and bonuses (bands of £5,000) £000	Long term performance pay and bonuses (bands of £5,000) £000	All pension-related benefits (bands of £2,500) £000	Other remuneration (bands of £5,000) £000	TOTAL (bands of £5,000) £000
BOARD MEMBERS							
K Singh, Chairman (from 1 October 2014)	20 - 25	7	0	0	0	0	20 - 25
R Kilner, Chairman (until 30 September 2014)	10 - 15	1	0	0	0	0	10 - 15
J Adler, Chief Executive	185 - 190	142	0	0	25.0 - 27.5	0	225 - 230
R Mitchell, Chief Operating Officer	140 - 145	0	0	0	17.5 - 20.0	0	160 - 165
A Seddon, Director of Finance and Procurement (until 13 April 2014)	80 - 85	0	0	0	0.0 - 2.5	0	80 - 85
P Hollinshead, Interim Director of Financial Strategy (from 20 Jan 2014 to 18 July 2014)	85 - 90	0	0	0	0	0	85 - 90
S Sheppard, Acting Director of Finance and Procurement (from 19 July 2014 to 31 Octol	35 - 40	0	0	0	5.0 - 7.5	0	40 - 45
P Traynor, Director of Finance (from 3 November 2014)	65 - 70	3	0	0	7.5 - 10.0	0	75 - 80
C Ribbins, Acting Chief Nurse (from 1 March 2015)	5 - 10	3	0	0	0.0 - 2.5	0	10 - 15
R Overfield, Chief Nurse (until 28 February 2015)	125 - 130	0	0	0	17.5 - 20.0	0	145 - 150
K Harris, Medical Director	120 - 125	2	0	0	0	90 - 95	210 - 215
NON EXECUTIVE DIRECTORS							
M Traynor, Non-Executive Director (from 2 October 2014)	0 - 5	0	0	0	0	0	0 - 5
M Williams, Interim Non-Executive Director (from 30 October 2014 until 31 March 2015)	0 - 5	0	0	0	0	0	0 - 5
D Wynford-Thomas, Non-Executive Director (until 28 February 2015)	5 - 10	0	0	0	0	0	5 - 10
Colonel (retired) I Crowe, Non-Executive Director	5 - 10	0	0	0	0	0	5 - 10
Dr S Dauncey, Non-Executive Director	5 - 10	0	0	0	0	0	5 - 10
J E Wilson, Non-Executive Director	5 - 10	0	0	0	0	0	5 - 10
P Panchal, Non-Executive Director (until 31 March 2015)	5 - 10	0	0	0	0	0	5 - 10
K Jenkins, Non-Executive Director (until 30 June 2014)	0 - 5	0	0	0	0	0	0 - 5
SENIOR MANAGERS							
K Shields, Director of Strategy	115 - 120	0	0	0	15.0 - 17.5	0	135 -140
S Ward, Director of Corporate & Legal Affairs	105 - 110	0	0	0	12.5 - 15.0	0	120 - 125
M Wightman, Director of Communications	105 - 110	0	0	0	12.5 - 15.0	0	120 - 125
E Stevens, Acting Director of Human Resources (from 1 January 2015)	25 - 30	0	0	0	2.5 - 5.0	0	30 - 35
K Bradley, Director of Human Resources (until 31 December 2014)	95 - 100	28	0	0	12.5 - 15.0	0	110 - 115
N Brunskill, Director of Research and Development	10 - 15	0	0	0	0	65 - 70	80 - 85

Salary and pension entitlements of senior managers – salary 2013/14

	2013-14						
Name and Title	**Salary (bands of £5,000) £000**	**Expense payments (taxable) total to nearest £100 £00**	**Performance pay and bonuses (bands of £5,000) £000**	**Long term performance pay and bonuses (bands of £5,000) £000**	**All pension-related benefits (bands of £2,500) £000**	**Other remuneration (bands of £5,000) £000**	**TOTAL (bands of £5,000) £000**
BOARD MEMBERS							
R Kilner, Chairman (from 1 Oct 2013); Non-Executive Director (until 30 Sept 2013)	10-15	3	0	0	0	0	15-20
M Hindle, Chairman (until 30 Sept 2013)	10-15	31	0	0	2.0-2.5	0	15-20
J Adler, Chief Executive	175-180	199	0	0	22.5-25.0	0	220-225
R Mitchell, Chief Operating Officer (from 10 Jul 2013)	100-105	0	0	0	12.5-15.0	0	115-120
S Hinchliffe, Chief Operating Officer (until 30 Jun 2013)	20-25	7	0	0	2.5-3.0	0	25-30
P Hollinshead, Interim Director of Financial Strategy (from 20 Jan2014)	60-65	0	0	0	0	0	60--65
A Seddon, Director of Finance and Procurement	140-145	11	0	0	17.5-20.0	0	160-165
R Overfield, Chief Nurse (from 9 Sept 2013)	75-80	0	0	0	10.0-12.5	0	90-95
K Harris, Medical Director	40-45	7	0	0	0	165-170	200-205
NON EXECUTIVE DIRECTORS							
Colonel (retired) I Crowe, Non-Executive Director (from 1 Jul 2013)	0-5	20	0	0	0	0	5-10
Dr S Dauncey, Non-Executive Director (from 1 May 2013)	0-5	0	0	0	0	0	0-5
J E Wilson, Non-Executive Director	5-10	8	0	0	0	0	5-10
P Panchal, Non-Executive Director	5-10	12	0	0	0	0	5-10
K Jenkins, Non-Executive Director	5-10	5	0	0	0	0	5-10
Mr I Sadd, Non-Executive Director (from 1 Oct 2013 until 31 Dec 2013)	0-5	0	0	0	0	0	0-5
I Reid, Non-Executive Director (until 30 Sept 2013)	0-5	1	0	0	0	0	0-5
SENIOR MANAGERS							
K Shields, Director of Strategy (from 4 Nov 2013)	50-55	0	0	0	7.0-7.5	0	55-60
K Bradley, Director of Human Resources	125-130	45	0	0	17.0-17.5	0	145-150
S Ward, Director of Corporate & Legal Affairs	105-110	19	0	0	14.0-14.5	0	120-125
M Wightman, Director of Communications	100-105	23	0	0	14.0-14.5	0	120-125
N Brunskill, Director of Research and Development (from 22 Jun 2013)	10-15	0	0	0	0	65-70	75-80
D Wynford-Thomas, Non-Executive Director	5-10	2	0	0	0	0	5-10
Prof D Rowbotham, Director of Research & Development (until 22 Jun 2013)	5-10	0	0	0	0	170-175	175-180

Salary and pension entitlements of senior managers – Pension Benefits

Name and title	Real increase in pension at age 60 (bands of £2500) £000	Real increases in lump sum at age 60 at 31 March 2015 (bands of £2500) £000	Total accrued pension at age 60 at 31 March 2015 (bands of £5000) £000	Lump sum at age 60 related to accrued pension at 31 March 2015 (bands of £5000) £000	Cash Equivalent Transfer Value at 31 March 2015 £000	Cash Equivalent Transfer Value at 31 March 2014 £000	Real Increase in Cash Equivalent Transfer Value £000	Employers Contribution to Stakeholder Pension To nearest £100
BOARD MEMBERS								
J Adler, Chief Executive	0.0 - 2.5	2.5 - 5.0	60.0 - 65.0	180.0 - 185.0	1,195	1,104	61	0
R Mitchell, Chief Operating Officer	0.0 - 2.5	5.0 - 7.5	15.0 - 20.0	55.0 - 60.0	227	190	32	0
P Traynor, Director of Finance (from 3 November 2014)	0.0 - 2.5	0.0 - 2.5	40.0 - 45.0	120.0 - 125.0	653	601	15	0
S Sheppard, Acting Director of Finance and Procurement (from 19 July 2014 to 31 October 2014)	0.0 - 2.5	2.5 - 5.0	25.0 - 30.0	75.0 - 80.0	367	302	16	0
A Seddon, Director of Finance and Procurement (until 13 April 2014)	(0.0 - 2.5)	(0.0 - 2.5)	20.0 - 25.0	60.0 - 65.0	423	410	0	0
C Ribbins, Acting Chief Nurse (from 1 March 2015)	(0.0 - 2.5)	(0.0 - 2.5)	35.0 - 40.0	110.0 - 115.0	667	633	1	0
R Overfield, Chief Nurse (until 28 February 2015)	0.0 - 2.5	2.5 - 5.0	50.0 - 55.0	155.0 - 160.0	944	895	25	0
SENIOR MANAGERS								
K Shields, Director of Strategy	5.0 - 7.5	17.5 -20.0	40.0 - 45.0	130.0 - 135.0	742	607	119	0
S Ward, Director of Corporate & Legal Affairs	0.0 - 2.5	0.0 - 2.5	40.0 - 45.0	125.0 - 130.0	828	779	28	0
M Wightman, Director of Communications	0.0 - 2.5	0.0 - 2.5	25.0 - 30.0	75.0 -80.0	408	376	21	0
E Stevens, Acting Director of Human Resources (from 1 January 2015)	(2.5 - 5.0)	(7.5 - 10.0)	5.0 - 10.0	25.0 - 30.0	156	351	-50	0
K Bradley, Director of Human Resources (until 31 December 2014)	(0.0 - 2.5)	(0.0 - 2.5)	40.0 - 45.0	120.0 - 125.0	751	740	-7	0

As Non-Executive members, including the Chairman, do not receive pensionable remuneration there will be no entries in respect of pensions for Non-Executive members.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and from 2004-05 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Exit packages 2014/15

Exit package cost band (including any special payment element)	2014-15							
	*Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	Number	£'s	Number	Number	Number	£'s	Number	£'s
Less than £10,000	0	0	22	128,130	22	128,130	0	0
£10,000-£25,000	3	49,102	21	330,224	24	379,326	0	0
£25,001-£50,000	1	30,000	13	390,000	14	420,000	0	0
£50,001-£100,000	2	117,290	1	71,451	3	188,741	0	0
£100,001 - £150,000	0	0	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0	0	0
Totals	6	196,392	57	919,805	63	1,116,197	0	0

Exit packages 2013/14

	2013-14							
Exit package cost band (including any special payment element)	*Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	Number	£'s	Number	Number	Number	£'s	Number	£'s
Less than £10,000	0	0	0	0	0	0	0	0
£10,000-£25,000	2	44,652	0	2	2	44,652	0	0
£25,001-£50,000	1	47,087	0	1	1	47,087	0	0
£50,001-£100,000	1	90,252	0	1	1	90,252	0	0
£100,001 - £150,000	0	0	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0	0	0
Totals	4	181,991	0	4	4	181,991	0	0

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Scheme. Exit costs in this note are accounted for in full in the year of departure. Where the NHS Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS pension's scheme. Ill-health retirement costs are met by the NHS pension's scheme and are not included in the table.

This disclosure reports the number and value of exit packages taken by staff leaving in the year.

Off payroll payments

The Trust had no off-payroll engagements as of 31 March 2015, for more than £220 per day and that last longer than six months.

All off-payroll engagements have been subject to a risk based assessment and assurance has been sought as to whether the individual is paying the right amount of tax.

The Trust has had no new off-payroll engagements between 1 April 2014 and 31 March 2015, for more than £220 per day and that last longer than six months:

Pay multiples

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director in the University Hospitals of Leicester NHS Trust in the financial year 2014/15 was £210,000 - £215,000 (2013/14: £210,000 - £215,000). This was 8.8 times (8.3 times in 2013/14) the median remuneration of the workforce, which was in the banding £20,000 - £25,000 (2013/14: £25k - £30k).

In 2014/15, five employees received remuneration in excess of the highest-paid director (five employees in 2013/14). Remuneration across the Trust ranged from £1,000 - £265,000 (2013/14 £1,000 - £310,000).

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Signed 

Chief Executive (on behalf of the Trust Board)

Date 4 June 2015

Annual Governance Statement

Executive Summary

The annual governance review confirms that University Hospitals of Leicester NHS Trust has a generally sound system of internal control that supports the achievement of its policies, aims and objectives. The Trust recognises that the internal control environment can always be strengthened and this work will continue in 2015/16, as described below.

We have identified below significant control issues which have impacted on performance in 2014/15: this Statement gives an account of remedial action which has been, and is being, taken.

Scope of Responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports adherence to our policies and achievement of our aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Trust Accountable Officer Memorandum.

In undertaking this role I, and my team, have developed strong links with the NHS Trust Development Authority, local Clinical Commissioning Groups and other partner organisations.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness.

The system of internal control is based on an ongoing process designed to:

- identify and prioritise the risks to the achievement of policies, aims and objectives of the Trust; and
- evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control has been in place in University Hospitals of Leicester NHS Trust for the financial year ended 31 March 2015 and up to the date of the approval of the annual accounts.

The Governance Framework of the Organisation

Trust Board composition and membership

Our Trust Board comprises 13 members: a Chairman, seven Non-Executive Directors and five Executive Directors. There have been a number of changes in the composition of the Board during 2014/15. Mr Richard Kilner stood down as Acting Trust Chairman on 30 September 2014 and was succeeded by Mr Karamjit Singh as substantive Chairman.

Dr Sarah Dauncey and Mr Martin Traynor joined the Trust as Non-Executive Directors on 2nd October 2014. Mr Mike Williams served as an Interim Non-Executive Director from 30th October 2014 until 31st March 2015. Richard Moore has succeeded Mike as a Non-Executive Director and as Chairman of the Audit Committee from 1 April 2015.

Ms K Jenkins' term of office as a Non-Executive Director ended on 30th June 2014. Professor David Wynford-Thomas stood down as a Non-Executive Director on 28th February 2015, and Mr Prakash Panchal, Non-Executive Director left the Trust on 31 March 2015. Two substantive replacement Non-Executive Directors will be appointed by the NHS Trust Development Authority during 2015/16.

Mr Andrew Seddon, Director of Finance left the Trust in April 2014. Mr Peter Hollinshead and Mr Simon Sheppard served, respectively, as Acting Directors of Finance during 2014 and Mr Paul Traynor joined the Trust as substantive Director of Finance on 3rd November 2014. Ms Rachel Overfield left her role as Chief Nurse on 28th February 2015 and Ms Carole Ribbins assumed the role of Acting Chief Nurse from 1 March 2015. Ms Julie Smith has been appointed as substantive Chief Nurse and will take up her appointment on 3 August 2015. Dr Kevin Harris stood down as Medical Director on 31st March 2015: Mr Andrew Furlong is currently the Acting Medical Director, a post he took up on 1st April and which is due for review in December 2015.

The Board is supported in its work by the Director of Human Resources, Director of Marketing and Communications, Director of Corporate and Legal Affairs and Director of Strategy who have standing invitations to attend its meetings, but not voting rights. Ms Emma Stevens became Acting Director of Human Resources on 1 January 2015 following the departure of Mrs Kate Bradley. Ms Louise Tibbert has been appointed Director of Workforce Organisational Development and will take up her appointment on 3 August 2015.

In summary, although there has been significant turnover at Board level in 2014/15, the process of making substantive appointments is now almost complete, creating a well-balanced Board to provide continuity of leadership going forward.

Performance Management Reporting Framework

To ensure that the Board is aware to a sufficient degree of granularity of what is happening in the hospitals, a comprehensive quality and performance report is reviewed at each monthly public Board meeting.

The monthly report:

- is structured across several domains: quality and patient safety; patient experience; operational performance; human resources; estates and facilities management; and research delivery;

- includes information on our performance against the NHS Trust Development Authority outcome and quality governance measures;
- includes performance indicators rated red, amber or green;
- is complemented by exception reports and commentaries from the accountable Executive Directors identifying key issues to the Board and, where necessary, corrective actions to bring performance back on track.

Importantly, the quality and performance report includes information on 'never events' and the Trust Board receives information on follow-up action.

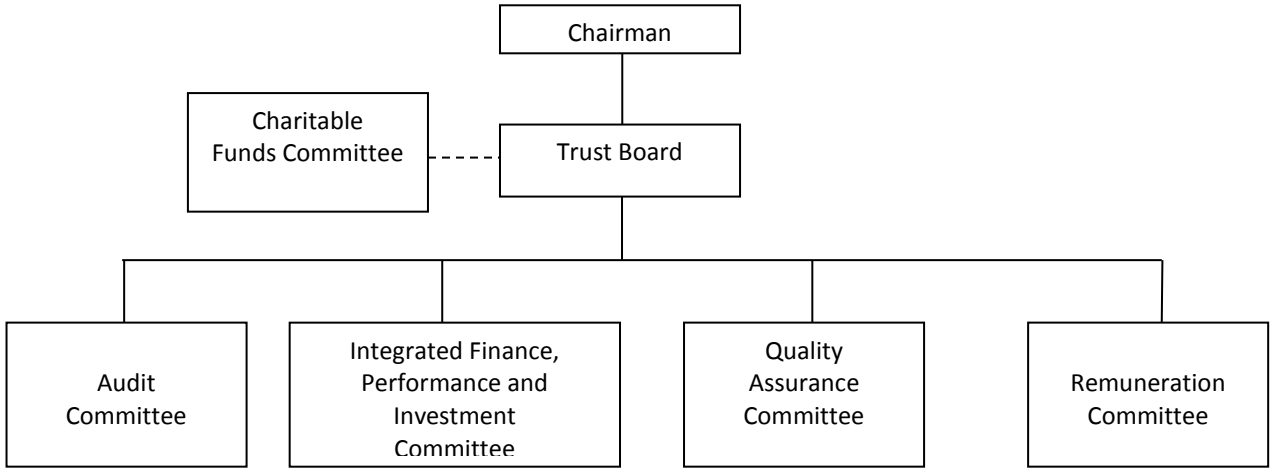
This formal Board performance management reporting framework is accompanied by a series of measures to achieve a more interactive style of governance, moving beyond paper reporting. Examples include:

- patient stories, which are presented in public at each Board meeting. These shine a light on individual experiences of care provided by the Trust and act as a catalyst for improvement; and
- Board members carry out patient safety walkabouts regularly.

These arrangements allow Board members to help model our values through direct engagement, as well as ensuring that Board members take back to the boardroom an enriched understanding of the lived reality for staff, public and patients.

Committee Structure

We have operated a well-established committee structure to strengthen our focus on quality governance, finance and performance, and risk management. The structure has been designed to provide effective governance over, and challenge to, our patient care and other business activities. The committees carry out detailed work of assurance on behalf of the Board. A diagram illustrating the Board committee structure is set out below.



All of the Board committees are chaired by a Non-Executive Director and comprise a mixture of both Non-Executive and Executive Directors within their memberships. The exceptions to this are the Audit Committee and the Remuneration Committee, which (in accordance with NHS guidance) comprise Non-Executive Directors exclusively. All Non-Executive Directors are encouraged to attend all Board level Committee meetings, even if they are not voting members of those Committees.

The Audit Committee is established under powers delegated by the Trust Board with approved terms of reference that are aligned with the NHS Audit Committee Handbook. The Committee consists of four Non-Executive Directors and has met on five occasions throughout the 2014/15 financial year. It has discharged its responsibilities for scrutinising the risks and controls which affect all aspects of the organisation's business. The Audit Committee receives a report at each of its meetings from the External Auditor, Internal Audit and the Local Counter-Fraud Specialist, the latter providing the Committee with assurance on our work programme to deter fraud.

The Integrated Finance, Performance and Investment Committee meets monthly and oversees the effective management of our financial resources and operational performance across a range of measures. The Quality Assurance Committee also meets monthly and seeks assurances that there are effective arrangements in place for monitoring and continually improving the quality of healthcare provided to patients.

The minutes of each meeting of our Board committees are submitted to the next available Board meeting for consideration. Recommendations made by the committees to the Trust Board are clearly identified in a cover sheet accompanying the submission of the minutes to the Board; the Chair of each committee personally presents a summary of the Committee's deliberations and the minutes at the Board meeting, highlighting material issues arising from the work of the committee to Board members. In particular, the Chairs provide feedback to the Trust Board on their committees' scrutiny of that month's quality and performance report, thereby complementing the commentaries of the Executive Directors.

Each meeting of each Board committee was quorate during 2014/15.

Attendance at Board and committee meetings

The attendance of the Chairman, individual Non-Executive Directors, Executive Directors and Corporate Directors at Board and committee meetings during 2014/15 is set out in an appendix to this Statement. The table reflects instances of attendances for either the whole or part of the meeting, and applies to formal members and/or regular attenders as detailed in the terms of reference for each committee.

Board Effectiveness

On joining the Board, Non-Executive Directors are given background information describing the Trust and its activities. A full induction programme is arranged.

Our Board recognises the importance of effectively gauging its own performance so that it can draw conclusions about its strengths and weaknesses, and take steps to improve. The Board therefore undergoes regular assessment using third party external advisers to ensure that it is:

- operating at maximum efficiency and effectiveness;
- adding value; and

- providing a yardstick by which it can both prioritise its activities for the future and measure itself.

During 2014/15, the Trust Board embarked on a programme of work (supported by external consultants that we appointed) to improve Board and Board committee reporting. The aims of this work are to:

- align the Board agenda to our priorities and the things that matter most;
- stimulate more forward-looking and strategic conversations in the board room;
- reduce duplication and size of the Board pack whilst increasing visibility and insight;
- embed the tools, skills and capability to deliver high quality reports and executive summaries that meet the Board's information needs.

The Trust Board has held a workshop to explore these issues and extensive development work has been carried out during the year. Final recommendations were presented to the Board through a 'Thinking Day' in May 2015.

Outside of its formal meetings, the Board has held development sessions ('Thinking Days') throughout 2014/15. Amongst the topics considered were refreshing our organisation's vision and strategic objectives, quality governance; the development of our two year operational plan 2014/15 – 2015/16; refreshing our quality and safety commitment; and stakeholder engagement.

Our Chairman set objectives for the Chief Executive and Non-Executive Directors for 2014/15. In turn, the Chief Executive set objectives for the Executive Directors and Corporate Directors in relation to the delivery of the Annual Plan for 2014/15. Performance against objectives is reviewed formally on an annual basis by the Chairman and Chief Executive, respectively.

Corporate Governance

In managing the affairs of the Trust, the Board is committed to achieving high standards of integrity, ethics and professionalism across all areas of activity. As a fundamental part of this commitment, the Board supports the highest standards of corporate governance within the statutory framework.

We have in place a suite of corporate governance policies which are reviewed annually and updated as required. These include standing orders, standing financial instructions, a scheme of delegation, policy on fraud and code of business conduct.

The Board subscribes to the NHS Code of Conduct and Code of Accountability and has adopted the Nolan Principles, 'the seven principles of public life'. We have also adopted the Code of Conduct: "Standards for NHS Board members and members of Clinical Commissioning Group governing bodies in the NHS in England" (Professional Standards Authority : November 2012).

Information Governance

We recognise the importance of robust information governance. During 2014/15, the Director of Corporate and Legal Affairs assumed the role of Senior Information Risk Owner and the Medical Director continued as our Caldicott Guardian.

We took further actions during the year to secure improvement in our information governance arrangements. A Privacy Board monitors and oversees compliance with information governance requirements and we have adopted a 'Privacy by Design' approach to support improved performance in this field.

All NHS Trusts are required annually to carry out an information governance self-assessment using the NHS Information Governance Toolkit. This contains 45 standards of good practice. Our overall percentage score for 2014/15 was 90 per cent, compared to 83 per cent in 2013/14. This score is deemed to be a 'satisfactory – minimum level 2' standard across all of the information governance standards.

During the year we reported to the Information Commissioner's Office two serious untoward incidents involving lapses of data security. These related to the theft of medical records from a hospital site; and the loss of ward documentation. In both instances, full investigations were completed and actions implemented to prevent recurrence.

In respect of other personal data related incidents experienced during 2014/15, we have carried out investigations to ensure that the root causes are properly understood and addressed; in addition, patients have been contacted to inform them of the lapses and to provide them with assurance about the actions we have taken to prevent recurrence.

The Risk and Control Framework

Our Board-approved Risk Management Policy describes an organisation-wide approach to risk management supported by effective and efficient systems and processes. The Strategy clearly describes our approach to risk management and the roles and responsibilities of the Trust Board, management and all staff.

Key strategic risks are documented in the Trust's Board Assurance Framework. Each strategic risk is assigned to an Executive Director as the risk owner and the Executive Team and Trust Board review the Framework on a monthly basis to identify and review our principal objectives, clinical, financial and generic. Key risks to the achievement of these objectives, controls in place and assurance sources, along with any gaps in assurance, are identified and reviewed.

Our Annual Operational Plan 2015/16 responds to and addresses the strategic risks we face. The current Board Assurance Framework has been updated to reflect risks in the 2015/16 plan and will continue to be reviewed at regular intervals by both the Executive Team and Trust Board.

Following the inspection of our hospitals by the Care Quality Commission in January 2014, the Trust Board approved a formal action plan to address the findings: progress against this plan has been monitored regularly by the Quality Assurance Committee on behalf of the Board during the year.

Risk Assessment

We operate a risk management process which enables the identification and control of risks at both a strategic and operational level. Central to this is our Risk Assessment Policy which sets out details of the risk assessment methodology used across the Trust. This methodology enables suitable, trained and competent members of staff to identify and quantify risks in their respective area and to decide what action, if any, needs to be taken to reduce or eliminate risks. All risk assessments must be scored and recorded in line with the procedure set out in the Risk Assessment Policy. Completed risk assessments are held at Clinical Management Group and Corporate Directorate level and when they give rise to a significant residual risk must be linked to our risk register.

We use a common risk-scoring matrix to quantify and prioritise risks identified through the risk assessment procedure. It is based on the frequency or likelihood of the harm combined with the possible severity or impact of that harm. The arrangement determines at what level in the organisation a risk should be managed and who needs to be assured management arrangements are in place.

Annual Quality Account

We are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. The Department of Health has issued guidance to NHS Trusts on the form and content of annual Quality Accounts which incorporates the above-mentioned legal guidance.

The Director of Clinical Quality, on behalf of the Chief Nurse, co-ordinates the preparation of our Annual Quality Account. This is reviewed in draft form by our Quality Assurance Committee, ahead of its eventual submission to the Trust Board for final review and adoption. In reviewing the draft Quality Account 2014/15, the Quality Assurance Committee has noted our internal controls and standards which underpin the Statement of Directors' responsibilities in respect of the Quality Account – which Statement is to be reviewed and signed by the Chairman and Chief Executive on behalf of the Board on 4th June 2015.

Review of the Effectiveness of Risk Management and Internal Control

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the Internal Auditors, Clinical Audit and the Executive Managers and clinical leads within the Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the draft Quality Account 2014/15 and other performance information available to me. My review is also informed by comments made by the External Auditors in their management letter and other reports. I have been advised on the implications of the results of my review of the effectiveness of the system of internal control by the Board, the Audit Committee, Integrated Finance, Performance and Investment Committee and Quality Assurance Committee. During 2014/15, each of these bodies has been involved in a series of processes that, individually and collectively, has contributed to the review of the effectiveness of the system of internal control.

In the Head of Internal Audit Opinion 2014/15, the Head of Internal Audit notes that Internal Audit have carried out eighteen reviews during the year which have resulted in one high-risk rated report – Governance around hosted services – Empath.

Empath was established by ourselves in partnership with Nottingham University Hospitals NHS Trust in 2013 to deliver pathology services through a Joint Venture Agreement.

Internal Audit's review identified concerns relating to non-compliance with a number of requirements stipulated within the Joint Venture Agreement; and in relation to financial management processes not working effectively.

We are taking action to address the high risk findings of Internal Audit and implementation of the actions in question will be reviewed by the Audit Committee during 2015/16.

The Head of Internal Audit is satisfied that sufficient internal audit work has been undertaken in 2014/15 to allow an opinion to be given as to the adequacy and effectiveness of governance, risk management and control. In giving this opinion, the Head of Internal Audit notes that assurance can never be absolute – the most the Internal Audit service can provide is reasonable assurance that there are no major weaknesses in the system of internal control.

The Head of Internal Audit Opinion for 2014/15 is that improvement is required to enhance the adequacy and/or effectiveness of governance, risk management and control. I accept this finding and am committed to strengthening the internal control environment, as detailed in this Statement.

Using our Board Assurance Framework, which it reviews at each of its monthly public meetings, the Trust Board has also identified actions to mitigate other risks in the year in relation to:

(a) progress in implementing our Quality Commitment;

(b) implementing the Leicester, Leicestershire and Rutland emergency care improvement plan;

(c) implementing our emergency care quality programme;

(d) approving the emergency floor business case;

(e) delivering the 'Referral to Treatment' improvement plan;

(f) achieving effective patient and public involvement;

(g) effectively implementing the Better Care Together strategy;

(h) responding appropriately to specialised services specifications;

(i) implementing network arrangements with partners;

(j) developing an effective partnership with primary care and the Leicestershire Partnership NHS Trust;

(k) meeting National Institute for Health Research performance targets;

(l) retaining Biomedical Research Unit status;

(m) providing consistently high standards of medical education;

(n) a lack of effective partnership with universities;

(o) adequately planning our workforce needs;

(p) recruiting and retaining staff with appropriate skills;

(q) improving levels of staff engagement;

(r) effective leadership capacity and capability;

(s) delivering our financial strategy (including cost improvement programmes);

(t) delivering internal efficiency and productivity improvements;

(u) maintaining effective relationships with stakeholders;

(v) delivering the service and site reconfiguration programme and maintain the estate effectively;

(w) implementing the IMT strategy and key projects effectively;

(x) effectively implementing the Electronic Patient Record Programme.

Any changes in the current or target risk scores are highlighted to the Trust Board, and the Board also reviews and seeks assurances on the management actions in place to mitigate the identified risks.

Significant Control Issues

Key Financial Duties

In respect of performance in 2014/15 against the key financial duties, we have:

(a) delivered the planned deficit of £40.6m;

(b) underspent against the (revised) External Financing Limit of £50.3m;

(c) achieved the (revised) Capital Resource Limit of £50.5m.

At its meeting in July 2014, the Finance and Performance Committee (now Integrated Finance, Performance and Investment Committee) assessed the 'going concern' position of the Trust. The Committee's deliberations were aided by the preparation of a 2014/15 Working Capital Strategy, authored by the Interim Director of Finance.

The Committee endorsed the Working Capital Strategy, the key objectives of which were to:

(i) maintain the cash balance as planned during 2014/15, including drawing down temporary and permanent borrowing and managing our other working capital balances;

(ii) improve performance against the 'Better Payment Practice Code';

(iii) achieve the External Financing Limit and Capital Resource Limit; and

(iv) further develop monitoring and reporting processes to ensure that there were robust linkages between cash balances; revenue income and expenditure; and capital expenditure.

The Trust Board subsequently adopted the 2014/15 Working Capital Strategy at its meeting in August 2014, on the recommendation of the Finance and Performance Committee.

The Trust Board has also approved a 2015/16 Working Capital Strategy, at its meeting on 2nd April 2015.

The Board has agreed plans to deliver the agreed 2015/16 control total – a £36m deficit, which includes the delivery of a £43m Cost Improvement Programme. During 2015/16, the Board is to consider and approve our updated 5-year financial strategy which will set out the plan for the Trust to return the financial balance over the next four years.

Emergency Care

We failed to meet the A&E 4 hour standard in 2014/15, achieving performance of 89.1 per cent (88.4 per cent 2013/14). As a member of the Leicester, Leicestershire and Rutland Urgent Care Board, we are committed to working with our partners to improve performance against this standard in 2015/16, and have approved an action plan which includes components relating to:

(a) demand management;

(b) patient flow within A&E;

(c) reducing emergency length of stay;

(d) delayed transfers of care;

(e) reducing ambulance turnaround times.

In parallel, the Trust Board has approved a Full Business Case for the development of a new Emergency Floor. This will significantly increase capacity to treat the number of patients attending the Trust and, subject to approval by the NHS Trust Development Authority, work will start in the Summer of 2015.

Referral to Treatment Times (RTT)

We have a Referral to Treatment (RTT) 18-week target. The target is that 90 per cent of admitted patients (patients requiring inpatient or day case treatment), 95 per cent of non-admitted patients (patients treated in an outpatient setting) and 92 per cent 'incompletes' (patients still waiting for treatment) are treated within 18 weeks.

We have faced challenges in meeting the targets during the year. Plans have been implemented by the Clinical Management Groups to address the delivery challenges which are being supported by additional use of the independent sector; ongoing validation of all RTT records; and additional in-house activity within hours and at weekends.

The plans agreed with the local Clinical Commissioning Groups for 2014/15 involved us treating considerably more patients than previously. Nevertheless, at the end of the financial year we achieved the 18-week targets for non-admitted and 'incompletes'; and we expect to achieve compliance with the admitted standard in quarter one 2015/16.

The accuracy of reporting RTT performance against targets is important not just for patient care and for monitoring by ourselves and by NHS England, but also for discussions with commissioners in the wider health economy.

Accordingly, we commissioned Internal Audit to carry out a review of the quality and accuracy of elective waiting time data and the risks to the quality and accuracy of this data.

Internal Audit's review has identified opportunities to make improvements in our processes and actions have been agreed to implement Internal Audit's recommendations during 2015/16.

Cancer waiting time targets

This year we have seen a significant increase in the number of patients being referred with suspected cancer. This has caused us a major challenge to delivering the national cancer standards. At the end of the financial year, we were almost compliant with the two week wait cancer standard (92.2 per cent performance against a target of 93 per cent); while compliance with the 31 day and 62 cancer waiting times standard is projected for June and July 2015, respectively.

Contractual dispute

We are in dispute with our facilities management contractor, Interserve, in respect of a number of issues. The contractual process for resolving these issues is in progress. We have reviewed our position and we are obtaining legal advice to inform our approach.

Conclusion

My review confirms that the University Hospitals of Leicester NHS Trust has a generally sound system of internal control that supports the achievement of its policies, aims and objectives. The Trust recognises that the internal control environment can always be strengthened and this work will continue in 2015/16, as described above.

In addition to the specific issues identified above, further work will also be carried out in 2015/16 to review and strengthen our governance, risk management and internal control systems, policies and procedures. This work will contribute to our aim of submitting an application for authorisation as an NHS Foundation Trust in accordance with a timetable to be agreed with the NHS Trust Development Authority.

Signed 

Chief Executive (on behalf of the Trust Board)

Date: 4th June 2015

Trust Board and Committee attendance 2014/15

Name	**Trust Board** maximum – 13	**Audit Committee** maximum – 6	**Finance and Performance Committee** maximum – 12	**Quality Assurance Committee** maximum – 12	**Remuneration Committee** maximum – 6	**Charitable Funds Committee** Maximum – 5
Trust Board Members						
Karamjit Singh – Chairman **(1)**	6/6	N/A	5/6	5/6	2/2	0/2
Richard Kilner – Acting Chairman **(2)**	7/7	N/A	6/6	N/A	4/4	1/3
Ian Crowe – Non-Executive Director **(3)**	12/13	5/6	11/12	4/6	6/6	2/5
Sarah Dauncey – Non-Executive Director **(4)**	11/13	3/4	4/5	11/12	5/6	0/5
Kiran Jenkins – Non-Executive Director **(5)**	4/4	2/2	N/A	N/A	2/2	0/2
Richard Moore – Non-Executive Director Designate **(6)**	1/1	1/1	1/1	0/1	0	0/2
Prakash Panchal – Non-Executive Director **(7)**	12/13	6/6	1/5	8/12	3/6	5/5
Martin Traynor – Non-Executive Director **(8)**	6/6	3/3	5/6	2/6	2/2	0/2
Mike Williams – Interim Non-Executive Director **(9)**	6/6	3/3	3/6	2/6	2/2	0/3
Jane Wilson – Non-Executive Director	10/13	3/3	11/12	10/12	4/6	1/5
David Wynford-Thomas – Non-Executive Director **(10)**	6/13	0/3	0/6	3/11	2/6	0/5
John Adler – Chief Executive	11/13	N/A	11/12	10/12	5/6	N/A
Kevin Harris – Medical Director **(12)**	12/13	N/A	N/A	N/A	N/A	N/A
Rachel Overfield – Chief Nurse **(14)**	12/12	N/A	N/A	9/11	N/A	2/5
Carole Ribbins – Acting Chief Nurse **(18)**	1/1	N/A	N/A	1/1	N/A	N/A
Richard Mitchell – Chief Operating Officer	12/13	N/A	11/12	N/A	N/A	N/A
Andrew Seddon – Director of Finance and Business Services **(19)**	-	-	-	-	-	-
Peter Hollinshead – Interim Director of Financial Strategy **(13)**	4/4	2/2	3/3	N/A	N/A	1/2
Simon Sheppard – Acting Director of Finance **(15)**	4/4	1/1	4/4	N/A	N/A	1/2
Paul Traynor – Director of Finance **(17)**	5/5	3/3	5/5	N/A	N/A	1/2

Name	Trust Board maximum – 13	Audit Committee maximum – 6	Finance and Performance Committee maximum – 12	Quality Assurance Committee maximum – 12	Remuneration Committee maximum – 6	Charitable Funds Committee Maximum – 5
Directors in attendance						
Kate Bradley – Director of Human Resources **(11)**	10/10	N/A	N/A	N/A	5/5	N/A
Emma Stevens Acting Director of Human Resources **(16)**	3/3	N/A	N/A	N/A	2/2	N/A
Kate Shields – Director of Strategy	13/13	N/A	7/12	N/A	N/A	0/5
Stephen Ward – Director of Corporate and Legal Affairs	13/13	5/6	N/A	N/A	6/6	4/5
Mark Wightman – Director of Marketing and Communications	13/13	N/A	N/A	N/A	N/A	4/5

Notes:

(1) Trust Chairman from 1 October 2014
(2) Left the Trust 30 September 2014
(3) Audit Committee member from 30 January 2014
(4) Non-Executive Director from 2 October 2014
(5) Non-Executive Director until 30 June 2014
(6) Joined as a Non-Executive Director designate February 2015,substantively from 1 April 2015
(7) Non-Executive Director until 31 March 2015
(8) Non-Executive Director from 2 October 2014
(9) Left the Trust 31 March 2015
(10) Non-Executive Director until 28 February 2015
(11) Left the Trust 31 December 2014
(12) Stepped down as of 31 March 2015
(13) Left the Trust 18 July 2014
(14) Left the Trust 28 February 2015
(15) Left the Trust 31 October 2014
(16) Acting Director of Human Resources from 1 January 2015
(17) Joined the Trust 3 November 2014
(18) Acting Chief Nurse from 1 March 2015
(19) Left the Trust 13 April 2014

Independent auditor's statement to the Board of Directors of the University Hospitals of Leicester NHS Trust

We have audited the financial statements of the University Hospitals of Leicester NHS Trust for the year ended 31 March 2015 on pages 1 to 38 (appendix to this annual report). These financial statements have been prepared under applicable law and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to NHS Trusts in England. We have also audited the information in the Remuneration Report that is subject to audit.

This report is made soley to the Board of Directors of the University Hospitals of Leicester NHS Trust, as a body, in accordance with Part II of the Audit Commission Act 1998. Our audit work has been undertaken so that we might state to the Board of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board of the Trust, as a body, for our audit work, for this report of for the opinions we have formed.

Respective responsibilities of Directors and auditor

As explained more fully in the Statement of Director's Responsibilities, the Directors are responsible for the preparation of financial statements which give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness if significant accounting estimates made by Directors; and the overall presentation of the financial statements.

In addition we read all the financial and non-financial information in the annual report to identify any material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the

knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Opinion of financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2015 and of the Trust's expenditure and income for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to NHS Trusts in England.

Emphasis of Matter – financial position

In forming our opinion on the financial statements, which is not qualified, we have considered the adequacy of the disclosure made in the Statement of Comprehensive Income to the financial statements concerning the Trust's financial position. The Trust incurred a deficit of £40.6 million during the year ended 31 March 2015 and will require significant injection of Public Dividend Capital and loans in 2015/16 to fund the budgeted deficit and support the capital plan.

These conditions and the other matters explained in the Statement of Comprehensive Income indicate the existence of a material uncertainty which may place significant doubt on the Trust's ability to achieve its long-term financial targets.

Opinion on other matters prescribed by the Code of Audit Practice 2010 for local NHS bodies

In our opinion:

- the part of the Remuneration Report subject to audit has been properly prepared in accordance with the accounting policies directed by the Secretary of State within the consent of the Treasury as relevant to NHS Trusts in England; and
- the information given in the Strategic Report and Director's Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

We have nothing to report in respect of the following matters where the Code of Audit Practice 2010 for local NHS bodies requires us to report to you if:

- in our opinion, the Governance Statement does not reflect compliance with the NHS Trust Development Authority guidance;
- any referrals to the Secretary of State have been made under section 19 of the Audit Commission Act 1998; or
- any matters have been reported in the public interest under the Audit Commission Act 1998 in the course of, or at the end of the audit.

Conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

Trust's responsibilities

The Trust is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources,

to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

Auditor's responsibilities

We are required under Section 5 of the Audit Commission Act 1998 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The Code of Audit Practice 2010 for local NHS bodies issued by the Audit Commission requires us to report to you our conclusion relating to proper arrangements, having regard to relevant criteria specified by the Audit Commission.

We report if significant matters have come tour attention which prevent us from concluding that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in is use of resources are operating effectively.

Basis for conclusion

We have undertaken our work in accordance with the Code of Audit Practice 2010 for local NHS bodies, having regard to the guidance on the specified criteria, published by the Audit Commission in October 2014, as to whether the Trust has proper arrangements for:

- securing financial resilience; and

- challenging how it secures economy, efficiency and effectiveness.

The Audit Commission has determined these two criteria as those necessary for us to consider under the Code of Audit Practice 2010 for local NHS bodies in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2015.

We planned and performed our work in accordance with the Code of Audit Practice 2010 for local HS bodies. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all material respects, the Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Basis for adverse conclusion

In considering the Trust's arrangements for securing financial resilience, we identified the following:

- the Trust incurred a deficit for 2014/15 of £40.6m;
- the Trust has submitted a draft financial plan to the NHS Trust Development Authority (NTDA) for a planned deficit of £36.1m in 2015/16, and cash requirement of £130m; and
- the NTDA reset the Trust's External Financing Limit (EFL) during 2014/15 from £20.7m to £50.3m.

In considering the Trust's arrangements for challenging how it secures economy, efficiency and effectiveness, we also identified the following:

- the Trust has set a Cost Improvement Programme of £43m for 2015/16 in order to improve efficiency and productivity and support its financial plan;
- the Trust required £58m of funding from the Department of Health's Independent Trust Financing Facility (ITFF) during the financial year in order to fund the deficit and improve liquidity; and
- the Trust has failed to effectively deliver on a number of operational targets throughout 2014/15, particularly the A&E wait target, Referral to Treatment target for admitted wait times, as well as a number of cancer targets.

The Trust is working with local health economy partners and the Trust Development Agency in developing a whole health economy solution, through Better Care Together programme, which encompasses the Trust's clinical strategy and wider reconfiguration.

Adverse conclusion

On the basis of our work, having regard to the guidance on the specified criteria published by the Audit Commission in October 2014, the matters reported in the basis for adverse conclusion paragraph above prevent us from being satisfied that in all significant respects the University Hospitals of Leicester NHS Trust put in place proper arrangements to secure economy, efficiency and effectiveness, in its use of resources for the year ending 31 March 2015.

Certificate

We certify that we have completed the audit of the accounts of the University Hospitals of Leicester NHS Trust in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice 2010 for local NHS bodies issued by the Audit Commission.

Jonathan Brown for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants
One Waterloo Way
Leicester
LE1 6LP

4 June 2015

Glossary of terms

Admission the point at which a person begins an episode of care, e.g. arriving at an inpatient ward.

Acute Care is specific care for diseases or illnesses that progress quickly, feature severe symptoms and have a brief duration.

Acuity The measurement of the intensity of care required for a patient delivered by a registered nurse. There are six categories ranging from minimal care to intensive care.

Cannulation intravenous cannulation involves putting a "tube" into a patient's vein so that infusions can be inserted directly into the patient's bloodstream.

Care Plan a plan is a written plan that describes the care and support staff will give a service user. Service users should be fully involved in developing and agreeing the care plan, sign it and keep a copy.

Care Quality Commission the organisation that make sure hospitals, care homes, dental and GP surgeries, and all other care services in England provide people with safe, effective, compassionate and high-quality care, and we encourage them to make improvements.

CCG (Clinical Commissioning Group) Clinical commissioning groups (CCGs) are NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England.

CIP (Cost Improvement Programme) a Cost Improvement Programme (CIP) is the identification of schemes to increase efficiency/ or reduce expenditure. CIPs can include both recurrent (year on year) and non-recurrent (one-off) savings. A CIP is not simply a scheme that saves money. The most successful CIPs are often those based on long-term plans to transform clinical and non-clinical services that not only result in a permanent cost savings, but also improve patient care, satisfaction and safety.

Clinical Governance is a framework that ensures that NHS organisations monitor and improve the quality of services provided and that they are accountable for the care they provide.

Clinical Negligence Scheme for Trust (CNST) is a scheme for assessing a Trust's arrangements to minimise clinical risk for service users and staff. Trusts need to pay 'insurance' which can offset the costs of legal claims against the Trust. Achieving CNST Levels (1, 2 or 3) shows the Trust's success in minimising clinical risk and reduces the premium that the Trust must pay.

Clinician is a person who provides direct care to a patient such as a doctor, nurse, therapist, pharmacist, psychologist etc.)

Commissioning is the process of identifying a community's social and/or health care needs and finding services to meet them.

Community Care aims to provide health and social care services in the community to enable people live as independently as possible in their own homes or in other accommodation in the community.

Co-morbidity is the presence of two or more disorders at the same time. For example, a person with depression may also have diabetes.

Diagnosis is identifying an illness or problem by its symptoms and signs.

Discharge is the point at which a person formally leaves services. On discharge from hospital the multidisciplinary team and the service user will develop a care plan (see Care plan).

Emergency Admission when a patient admitted to hospital at short notice because of clinical need or because alternative care is not available.

Emergency Department is a hospital department that assesses and treats people with serious and life-threatening injuries and those in need of emergency treatment. Also sometimes called A&E (Accident & Emergency)

Foundation Trusts are a type of NHS hospital run by local managers, staff and members of the public, which are tailored to the needs of the local population.

Friends and Family Test (FFT) launched in April 2013, the FFT question asks people if they would recommend the services they have used and offers a range of responses. When combined with supplementary follow-up questions, the FFT provides a mechanism to highlight both good and poor patient experience

General Practitioner (GP) is a family doctor, usually patient's first point of contact with the health service.

Health Care Assistants (can also be referred to as Health Care Support Workers) are non-qualified nursing staff who carry out assigned tasks involving direct care in support of a registered/qualified nurse. There are two grades of Health Care Assistants, A and B grade. A grades would expect to be more closely supervised, while B grades may regularly work without supervision for all or most of their shift, or lead on A grade.

Human Resources is a department found in most organisations that works to recruit staff, assist in their development (e.g. providing training) and ensure that staff work in good conditions.

Information Management and Technology (IM&T) refers to the use of information held by the Trust, in particular computerised information and the department that manages those services.

Intermediate Care Services are services that promote independence, prevent hospital admission and/or enable early discharge. Intermediate care typically provides community-based alternatives to traditional hospital care.

Multidisciplinary denotes an approach to care that involves more than one discipline. Typically this will mean that doctors, nurses, psychologists and occupational therapists are involved.

NICE is the National Institute for Health and Clinical Excellence, an independent organisation responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health.

Non-Executive Director is a member of the Trust Board. They act a two way representative. They bring the experiences, views and wishes of the community and patients to the Trust Board. They also represent the interests of the NHS organisation to the Community.

Out of Hours (OOH) is the provision of GP services when your local surgery is closed, usually during the night, at weekends and Bank Holidays.

Palliative care is an area of healthcare that focuses on relieving and preventing the suffering of patients.

Peri-natal mortality is the number of stillbirths and deaths in the first week of life per 1,000 live births, after 24 weeks gestation.

Primary Care is the care will receive when you first come into contact with health services about a problem. These include family health services provided by GPs, dentists, pharmacists, opticians, and others such as community nurses, physiotherapists and some social workers.

QIPP (Quality Innovation Productivity and Prevention) In July 2010, the White Paper 'Equity and excellence: Liberating the NHS' set out the government's vision for the future of the NHS. The White Paper outlined the government's commitment to ensuring that QIPP supports the NHS to make efficiency savings, which can be reinvested back into the service to continually improve quality of care.

Risk assessment identifies aspects of a service which could lead to injury to a patient or staff member and/or to financial loss for an individual or Trust.

Secondary care is specialist care, usually provided in hospital, after a referral from a GP or health professional. Mental Health Services are included in secondary care (see also tertiary care).

Serious Untoward Incidents (SUI) is to describe a serious incident or event which led, or may have led, to the harm of patients or staff. Members of staff who were not involved in the incident investigate these and the lessons learned from each incident are used to improve care in the future.

SHMI (Summary Hospital-level Mortality Indicator) The Summary Hospital-level Mortality Indicator (SHMI) is an indicator which reports on mortality at trust level across the NHS in England using a standard and transparent methodology. It is produced and published quarterly as an official statistic by the Health and Social Care Information Centre (HSCIC) with the first publication in October 2011. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.

Stakeholders are a range of people and organisations that are affected by or have an interest in, the services offered by an organisation.

Tertiary Care is when a hospital consultant decides that more specialist care is needed. Mental Health Services are included in this (see also Secondary care).

TTO (To-take-out) are medicines supplied by the hospital pharmacy for patients to take with them when they are discharged (see discharge) from hospital.

Triage a system which sorts medical cases in order of urgency to determine how quickly patients receive treatment.

Walk-in-Centre (WiC) an NHS medical centre patients can attend without an appointment.

Whistle-blowing is the act of informing a relevant person in an organisation of instances or services in which patients are at risk.

Please help us to improve the way we share information with people

We would like your views on the presentation of our annual report and accounts.

We would be very grateful if you could answer the questions below and send your response to us by 31 December 2015.

The answers you give will help us to ensure we present, not only the annual report, but other information in a way people find useful.

1 The information we give:

a. Have we missed anything out? Please tell us any area you would like to see covered.

.....

.....

.....

.....

b. Is there any category you think we should leave out?

.....

.....

.....

.....

2 Were there any areas of the annual report which you found most useful, please feel free to list and explain why

.....

.....

.....

.....

.....

3 What do you expect to achieve from reading this annual report? Please tick

	Gain a broad understanding	**Gain a detailed understanding**
The Trust and its achievements		
The Trust's performance against targets		
The Trust's plans for the future		
The Trust's financial position		

4 Do you have another comments or suggestions about our annual report or any of our other publications?

.....

.....

.....

.....

.....

If you would like to be notified when the 2015/16 annual report is available? If so, please give your email address

.....

Completed questionnaires can be sent to:

Communications Team, University Hospitals of Leicester NHS Trust, Medical Illustration, Level 2 Windsor Building, Leicester, LE1 5WW

Everybody Counts...
Playing your part

University Hospitals of Leicester NHS
NHS Trust

Caring at its best

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

إذا كنت ترغب في الحصول على هذه المعلومات في شكل أو لغة أخرى ، يرجى الاتصال مع مدير الخدمة للمساواة في 0116 250 2959.

আপনি যদি এই লিফলেটের অনুবাদ - লিখিত বা অডিও টেপ'এ চান, তাহলে অনুগ্রহ করে সার্ভিস্ ইকুয়ালিটি ম্যানেজার ডেভ বেকার'এর সাথে 0116 250 2959 নাম্বারে যোগাযোগ করুন।

如果您想用另一种语言或格式来显示本资讯，请致电 0116 250 2959 联系"服务平等化经理" (Service Equality Manager)。

જો તમને આ પત્રઇકાનું લેખિત અથવા ટેઈપ ઉપર ભાષાંતર જોઈતુ હોય તો મહેરબાની કરી સર્વિસ ઈક્વાલિટી મેનેજરનો 0116 250 2959 ઉપર સંપર્ક કરો.

यदि आप को इस लीफलिट का लिखती या टेप पर अनुवाद चाहिए तो कृपया डेब बेकर, सर्विस ईक्वालिटी मेनेजर से 0116 250 2959 पर सम्पर्क कीजिए।

Jeżeli chcieliby Państwo otrzymać niniejsze informacje w tłumaczeniu na inny język lub w innym formacie, prosimy skontaktować się z Menedżerem ds. równości w dostępie do usług (Service Equality Manager) pod numerem telefonu 0116 250 2959.

ਜੇਕਰ ਤੁਹਾਨੂੰ ਇਸ ਲੀਫਲਿਟ ਦਾ ਲਿਖਤੀ ਜਾਂ ਟੇਪ ਕੀਤਾ ਅਨੁਵਾਦ ਚਾਹੀਦਾ ਹੋਵੇ ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਡੈਬ ਬੇਕਰ, ਸਰਵਿਸ ਇਕੁਆਲਿਟੀ ਮੈਨੇਜਰ ਨਾਲ 0116 250 2959 'ਤੇ ਸੰਪਰਕ ਕਰੋ।

Ak by ste chceli dostat túto informáciu v inom jazyku, alebo formáte, kontaktujte prosím manažéra rovnosti sluzieb na tel. čísle 0116 250 2959.

Haddaad rabto warqadan oo turjuman oo ku duuban cajalad ama qoraal ah fadlan la xiriir, Maamulaha Adeegga Sinaanta 0116 250 2959.

Cover Design and Photography by UHL Medical Illustration 0116 258 5904

STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTABLE OFFICER OF THE TRUST

The Chief Executive of the NHS Trust Development Authority has designated that the Chief Executive should be the Accountable Officer to the Trust. The relevant responsibilities of Accountable Officers are set out in the Accountable Officers Memorandum issued by the Chief Executive of the NHS Trust Development Authority. These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;

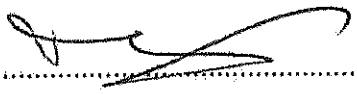
- value for money is achieved from the resources available to the Trust;

- the expenditure and income of the trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;

- effective and sound financial management systems are in place; and

- annual statutory accounts are prepared in a format directed by the Secretary of State with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

Signed.....  .....Chief Executive

Date...4th June 2015

STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of the Treasury, directs that these accounts give a true and fair view of the state of affairs of the Trust and of the income and expenditure, recognised gains and losses and cash flows for the year. In preparing those accounts, directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;

- make judgements and estimates which are reasonable and prudent;

- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the Trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

By order of the Board

Date...4th June 2015 .....Chief Executive

Date...4th June 2015 .....Finance Director

Data entered below will be used throughout the workbook:

Trust name	University Hospitals of Leicester NHS Trust
This year	2014-15
Last year	2013-14
This year ended	31 March 2015
Last year ended	31 March 2014
This year commencing:	1 April 2014
Last year commencing:	1 April 2013

Accounts 2014-15

Statement of Comprehensive Income for year ended 31 March 2015

	NOTE	2014-15 £000s	2013-14 £000s
Gross employee benefits	10.1	**(497,278)**	(474,090)
Other operating costs*	8	**(373,515)**	(325,181)
Revenue from patient care activities	5	**713,531**	675,045
Other operating revenue	6	**120,845**	95,348
Operating deficit		**(36,417)**	(28,878)
Investment revenue	12	**83**	66
Other gains and (losses)	13	**9**	(51)
Finance costs	14	**(799)**	(263)
Deficit for the financial year		**(37,124)**	(29,126)
Public dividend capital dividends payable		**(10,369)**	(10,388)
Deficit for the year		**(47,493)**	(39,514)

Other Comprehensive Income

	2014-15 £000s	2013-14 £000s
Impairments and reversals taken to the revaluation reserve	**(1,454)**	0
Net gain on revaluation of property, plant & equipment	**44,230**	0
Total comprehensive income for the year**	**(4,717)**	(39,514)

Financial performance for the year

Retained deficit for the year	**(47,493)**	(39,514)
Impairments (excluding IFRIC 12 impairments)	**6,761**	0
Adjustments in respect of donated and government granted asset reserve elimination	**84**	(141)
Adjusted retained deficit	**(40,648)**	(39,655)

* Other operating costs includes £6,761k relating to the impairment of property, plant and equipment following a revaluation of the Trust's estate. This figure is removed from the final retained deficit figure in accordance with Department of Health (DH) Accounting guidance.

** Included within the total comprehensive income for the year of (£4,717k) is an amount of £84k relating to the receipt of donated assets (net of donated asset depreciation). This figure is removed from the final retained deficit figure in accordance with DH accounting guidance. This removes the effect on the Trust's financial performance of no longer having a donated asset or government granted asset reserve and ensures that performance can be measured consistently.

Statement of Financial Position as at 31 March 2015

	NOTE	31 March 2015 £000s	31 March 2014 £000s
Non-current assets:			
Property, plant and equipment	15	**414,193**	362,465
Intangible assets	16	**10,134**	8,019
Trade and other receivables	22.1	**2,702**	3,123
Total non-current assets		**427,029**	373,607
Current assets:			
Inventories	21	**14,141**	13,937
Trade and other receivables	22.1	**32,602**	49,892
Cash and cash equivalents	26	**8,498**	515
Total current assets		**55,241**	64,344
Total assets		**482,270**	437,951
Current liabilities			
Trade and other payables	28	**(100,504)**	(109,135)
Provisions	35	**(820)**	(1,585)
Borrowings	30	**(4,919)**	(6,590)
DH capital loan	30	**(545)**	0
Total current liabilities		**(106,788)**	(117,310)
Net current liabilities		**(51,547)**	(52,966)
Total assets less current liablilities		**375,482**	320,641
Non-current liabilities			
Provisions	35	**(1,982)**	(2,070)
Borrowings	30	**(6,869)**	(5,890)
DH capital loan	30	**(11,455)**	0
Total non-current liabilities		**(20,306)**	(7,960)
Total assets employed:		**355,176**	312,681
FINANCED BY:			
Public Dividend Capital		**329,837**	282,625
Retained earnings		**(82,017)**	(34,542)
Revaluation reserve		**107,356**	64,598
Total Taxpayers' Equity:		**355,176**	312,681

The notes on pages 16 to 38 form part of this account.

The financial statements on pages 1 to 38 were approved by the Board on 4th June 2015 and signed on its behalf by

Chief Executive: Date: 4th June 2015

Statement of Changes in Taxpayers' Equity
For the year ending 31 March 2015

	2014-15			
	Public Dividend capital	Retained earnings	Revaluation reserve	Total reserves
	£000s	£000s	£000s	£000s
Balance at 1 April 2014	**282,625**	**(34,542)**	**64,598**	**312,681**
Changes in taxpayers' equity for 2014-15				
Retained deficit for the year	0	(47,493)	0	**(47,493)**
Net gain on revaluation of property, plant and equipment	0	0	44,230	**44,230**
Impairments and reversals	0	0	(1,454)	**(1,454)**
Transfers between reserves	0	18	(18)	**0**
Reclassification Adjustments				
New temporary and permanent PDC received - cash	93,212	0	0	**93,212**
New temporary and termanent PDC repaid in year	(46,000)	0	0	**(46,000)**
Net recognised revenue/(expense) for the year	**47,212**	**(47,475)**	**42,758**	**42,495**
Balance at 31 March 2015	**329,837**	**(82,017)**	**107,356**	**355,176**

The net new Public Dividend Capital (PDC) received in 2014-15 of £47.2m relates to the following schemes:

	£000s
Safer Hospitals Technology Fund	1,150
Improving Maternity Care Settings	62
Funding for the Trust's deficit and to improve working capital	46,000
	47,212

	2013-14			
	Public Dividend capital	Retained earnings	Revaluation reserve	Total reserves
	£000s	£000s	£000s	£000s
Balance at 1 April 2013	277,733	4,960	64,628	347,321
Changes in taxpayers' equity for the year ended 31 March 2014				
Retained deficit for the year	0	(39,514)	0	(39,514)
Transfers between reserves	0	30	(30)	0
Transfers under Modified Absorption Accounting - PCTs & SHAs	0	(18)	0	(18)
Reclassification Adjustments				
New temporary and permanent PDC received - cash	5,219	0	0	5,219
New PDC received/(repaid) - PCTs and SHAs legacy items paid for by DH	50	0	0	50
New temporary and permanent PDC repaid in year	(377)	0	0	(377)
Net recognised revenue/(expense) for the year	4,892	(39,502)	(30)	(34,640)
Balance at 31 March 2014	**282,625**	**(34,542)**	**64,598**	**312,681**

Statement of Cash Flows for the Year ended 31 March 2015

	NOTE	2014-15 £000s	2013-14 £000s
Cash Flows from Operating Activities			
Operating deficit		**(36,417)**	(28,878)
Depreciation and amortisation		**33,230**	31,245
Impairments and reversals		**6,761**	0
Donated Assets received credited to revenue but non-cash		**(44)**	(114)
Interest paid		**(762)**	(468)
Dividend paid		**(10,856)**	(10,232)
(Increase)/Decrease in Inventories		**(204)**	(873)
(Increase)/Decrease in Trade and Other Receivables		**17,711**	(4,211)
(Increase)/Decrease in Other Current Assets		**0**	40
Increase/(Decrease) in Trade and Other Payables		**(9,658)**	24,835
Provisions utilised		**(1,448)**	(1,229)
Increase/(Decrease) in movement in non cash provisions		**568**	458
Net Cash Inflow/(Outflow) from Operating Activities		**(1,119)**	10,573
Cash Flows from Investing Activities			
Interest Received		**83**	66
(Payments) for Property, Plant and Equipment		**(41,480)**	(26,342)
(Payments) for Intangible Assets		**(3,719)**	(3,503)
Net Cash Inflow/(Outflow) from Investing Activities		**(45,116)**	(29,779)
Net Cash Inform / (outflow) before Financing		**(46,235)**	(19,206)
Cash Flows from Financing Activities			
Gross Temporary and Permanent PDC Received		**93,212**	5,269
Gross Temporary and Permanent PDC Repaid		**(46,000)**	(377)
Loans received from DH - New Capital Investment Loans*		**12,000**	0
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT		**(4,994)**	(5,157)
Net Cash Inflow/(Outflow) from Financing Activities		**54,218**	(265)
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS		**7,983**	(19,471)
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period		**515**	19,986
Effect of exchange rate changes in the balance of cash held in foreign currencies		**0**	0
Cash and Cash Equivalents (and Bank Overdraft) at year end		**8,498**	515

*We received a £12m capital investment loan as part of a total of £59.2m external financing received in the year. This loan will fund essential investment in our hospital buildings and we will repay it in instalments every six months for 22 years from September 2015. We have included interest relating to 2014-15 within finance costs in note 14 and the loan is shown as DH Capital Loan in the Statement of Financial Position.

NOTES TO THE ACCOUNTS

1. Accounting Policies

The Secretary of State for Health has directed that the financial statements of NHS Trusts shall meet the accounting requirements of the Department of Health Group Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DH Group Manual for Accounts 2014-15 issued by the Department of Health. The accounting policies contained in that manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted by the trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.2 Acquisitions and discontinued operations

Activities are considered to be 'acquired' only if they are taken on from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one public sector body to another.

1.3 Movement of assets within the DH Group

Transfers as part of reorganisation fall to be accounted for by use of absorption accounting in line with the Treasury FReM. The FReM does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the SOCNE/SOCNI, and is disclosed separately from operating costs.

Other transfers of assets and liabilities within the Group are accounted for in line with IAS20 and similarly give rise to income and expenditure entries.

For transfers of assets and liabilities from those NHS bodies that closed on 1 April 2013, Treasury agreed that a modified absorption approach should be applied. For these transactions and only in the prior-period, gains and losses are recognised in reserves rather than the SOCNE/SOCNI.

1.4 Charitable Funds

Under the provisions of IAS 27 *Consolidated and Separate Financial Statements*, those Charitable Funds that fall under common control with NHS bodies are consolidated within the entity's financial statements. In accordance with IAS 1 *Presentation of Financial Statements*, restated prior period accounts are presented where the adoption of the new policy has a material impact.

Following Treasury's agreement to apply IAS 27 to NHS Charities from 1 April 2013, the Trust has established that as the Trust is the Corporate Trustee of the linked NHS Charity (Leicester Hospitals Charity), it effectively has the power to exercise control so as to obtain economic benefits. However the transactions are immaterial in the context of the group and transactions have not been consolidated. Details of the transactions with the Charity are included in the related parties' notes.

1.5 Pooled Budgets

The Trust has no pooled budget arrangements.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.6 Critical accounting judgements and key sources of estimation uncertainty

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

In the preparation of these Financial Statements, judgements, estimates and assumptions have been made by the Trust's management concerning the selection of useful lives of fixed assets, provisions necessary for certain liabilities and other similar evaluations. Actual amounts could differ from those estimates.

Deferred income
The value of deferred income included in the Statement Of Financial Position is based on management's judgement around the deferability of income at the Statement Of Financial Position date. More detail is provided in note 32.

Provisions
Provisions included in the Statement Of Financial Position are estimated using appropriate professional advice and are based on circumstances prevailing at the Statement Of Financial Position date.

Valuation of assets
There are judgements around the valuation of assets, of which more detail is provided in note 1.10.

1.7 Revenue
Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. The main source of revenue for the Trust is from commissioners for healthcare services.

Revenue relating to patient care spells that are part-completed at the year end are apportioned across the financial years on the basis of length of stay at the Statement Of Financial Position date compared to expected total length of stay.

Revenue from education, training and research is recognised in the period in which services are provided. Interest revenue is accrued on a time basis, by reference to the principal outstanding and interest rate applicable.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

The Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

1.8 Employee Benefits

Short-term employee benefits
Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees.

The cost of leave earned but not taken by employees at the end of the period is recognised in the Financial Statements to the extent that employees are permitted to carry forward leave into the following period.

Retirement benefit costs
Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the Trust commits itself to the retirement, regardless of the method of payment.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.9 Other expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.10 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to the [NHS body];
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has cost of at least £5,000; or
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

Valuation

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value.

Land and buildings used for the University Hospitals of Leicester NHS Trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any impairment.

Notes to the Accounts - 1. Accounting Policies (Continued)

Subsequent expenditure
Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.11 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the trust; where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use
- the intention to complete the intangible asset and use it
- the ability to sell or use the intangible asset
- how the intangible asset will generate probable future economic benefits or service potential
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it
- the ability to measure reliably the expenditure attributable to the intangible asset during its development

Measurement
The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.12 Depreciation, amortisation and impairments

Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the NHS trust expects to obtain economic benefits or service potential from the asset. This is specific to the NHS trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives

At each reporting period end, the NHS Trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

Impairments are analysed between Departmental Expenditure Limits (DEL) and Annually Managed Expenditure (AME). This is necessary to comply with Treasury's budgeting guidance. DEL limits are set in the Spending Review and Departments may not exceed the limits that they have been set.

AME budgets are set by the Treasury and may be reviewed with departments in the run-up to the Budget. Departments need to monitor AME closely and inform Treasury if they expect AME spending to rise above forecast. Whilst Treasury accepts that in some areas of AME inherent volatility may mean departments do not have the ability to manage the spending within budgets in that financial year, any expected increases in AME require Treasury approval.

1.13 Donated assets

Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to Income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.14 Government grants

The value of assets received by means of a government grant are credited directly to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.15 Non-current assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when the sale is highly probable, the asset is available for immediate sale in its present condition and management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification. Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the asset on the revaluation reserve is transferred to retained earnings.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.16 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

The University Hospitals of Leicester NHS Trust as lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the Trust's surplus/deficit.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

The University Hospitals of Leicester NHS Trust as lessor

The University Hospitals of Leicester NHS Trust has no income from finance leases.

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

1.17 Private Finance Initiative (PFI) transactions

The Trust has no PFI schemes.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.18 Inventories

Inventories are valued at the lower of cost and net realisable value using the weighted average cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.19 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.23 Carbon Reduction Commitment Scheme (CRC)

CRC and similar allowances are accounted for as government grant funded intangible assets if they are not expected to be realised within twelve months, and otherwise as other current assets. They are valued at open market value. As the NHS body makes emissions, a provision is recognised with an offsetting transfer from deferred income. The provision is settled on surrender of the allowances. The asset, provision and deferred income amounts are valued at fair value at the end of the reporting period.

1.24 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the NHS trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

Notes to the Accounts - 1. Accounting Policies (Continued)

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

At the end of the reporting period, the Trust assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced directly.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.29 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the trust has no beneficial interest in them. Details of third party assets are given in Note 44 to the accounts.

1.30 Public Dividend Capital (PDC) and PDC dividend

Public dividend capital represents taxpayers' equity in the NHS Trust. At any time the Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received. As PDC is issued under legislation rather than under contract, it is not treated as an equity financial instrument.

An annual charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities (except for donated assets and cash balances with the Government Banking Service). The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets.

1.31 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Trust not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.32 Subsidiaries

Material entities over which the NHS Trust has the power to exercise control are classified as subsidiaries and are consolidated. The NHS Trust has control when it is exposed to or has rights to variable returns through its power over another entity. The income and expenses; gains and losses; assets, liabilities and reserves; and cash flows of the subsidiary are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the NHS trust or where the subsidiary's accounting date is not co-terminus.

Subsidiaries that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.33 Associates

Material entities over which the NHS trust has the power to exercise significant influence so as to obtain economic or other benefits are classified as associates and are recognised in the NHS trust's accounts using the equity method. The investment is recognised initially at cost and is adjusted subsequently to reflect the NHS trust share of the entity's profit/loss and other gains/losses. It is also reduced when any distribution is received by the NHS trust from the entity.

Associates that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'

The University Hospitals of Leicester NHS Trust had no Associates in 2014-15.

1.34 Joint arrangements

Material entities over which the University Hospitals of Leicester NHS Trust has joint control with one or more other parties so as to obtain economic or other benefits are classified as joint ventures.

The University Hospitals of Leicester NHS Trust had no Joint Arrangements in 2014-15.

1.35 Research and Development

Research and development expenditure is charged against income in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the SOCNE/SOCI on a systematic basis over the period expected to benefit from the project. It should be revalued on the basis of current cost. The amortisation is calculated on the same basis as depreciation, on a quarterly basis.

1.36 Accounting Standards that have been issued but have not yet been adopted

The Treasury FReM does not require the following Standards and Interpretations to be applied in 2013-14. The application of the Standards as revised would not have a material impact on the accounts for 2013-14, were they applied in that year:

IAS 27 Separate Financial Statements - subject to consultation
IAS 28 Investments in Associates and Joint Ventures - subject to consultation
IFRS 9 Financial Instruments - subject to consultation - subject to consultation
IFRS 10 Consolidated Financial Statements - subject to consultation
IFRS 11 Joint Arrangements - subject to consultation
IFRS 12 Disclosure of Interests in Other Entities - subject to consultation
IFRS 13 Fair Value Measurement - subject to consultation
IPSAS 32 - Service Concession Arrangement - subject to consultation

2. Pooled budget

The Trust does not participate in any pooled budgets.

3. Operating segments

The core principle of IFRS 8 *Operating Segments* is that information should be disclosed to enable users of an organisation's Financial Statements to evaluate the nature and financial effects of the types of business activities in which it engages and the economic environments in which it operates. IFRS 8 also requires that the amounts reported for each operating segment should be the amounts reported to the Board.

The Trust operates in one material segment, which is the provision of healthcare services and the reporting to the Board is at a total Trust level. The provision of healthcare (including medical treatment, research and education) is within one main geographical segment, the United Kingdom.

4. Income generation activities

The Trust does not undertake any income generation activities which meet the conditions set by the Department of Health for income generation. The Trust does not run any commercial schemes with a view to achieving a profit, and does not market commercial goods or services outside of the NHS.

5. Revenue from patient care activities

	2014-15 £000s	2013-14 £000s (restated)*	2013-14 £000s
NHS Trusts	**0**	0	7,948
NHS England	**229,319**	222,614	222,614
Clinical Commissioning Groups	**476,018**	431,416	431,416
Foundation Trusts	**719**	2,659	2,659
NHS Other (including Public Health England and Prop Co)	**635**	509	509
Non-NHS:			
Local Authorities	**145**	3,547	3,547
Private patients	**2,806**	3,002	3,002
Overseas patients (non-reciprocal)	**1,154**	975	975
Injury costs recovery	**1,466**	1,271	1,271
Other*	**1,269**	1,104	1,104
Total Revenue from patient care activities	**713,531**	667,097	675,045

* "Non-NHS: Other' includes £724k income from health bodies in Wales, Scotland and Northern Ireland (2013-14 - £726k).

6. Other operating revenue

	2014-15 £000s	2013-14 £000s (restated)*	2013-14 £000s
Recoveries in respect of employee benefits	**9,134**	10,290	6,595
Education, training and research**	**86,241**	71,502	71,502
Receipt of donations for capital acquisitions - Charity	**576**	765	765
Non-patient care services to other bodies	**8,691**	7,094	3,481
Rental revenue from operating leases	**8,391**	8,857	8,857
Other revenue****	**7,812**	4,788	4,148
Total Other Operating Revenue	**120,845**	103,296	95,348
Total operating revenue	**834,376**	770,393	770,393

* We have restated the above note following an internal reclassification of income from NHS Trust's from 'revenue from patient care activities' to 'other operating revenue'. Overall income from Trusts has reduced by £4.6m. From 2014-15 the Trust hosts the LLR Alliance, which took over from another local NHS Trust to provide elective care services in the LLR region. Previously the Trust provided staff to the other local Trust and received income from it. This arrangement has ceased with the new LLR Alliance arrangements.

** From 2014-15 the Trust is responsible for hosting the *NIHR Clinical Research Network: East Midlands* and as host, is responsible for ensuring the effective delivery of research in the Trusts, primary care organisations and other qualified NHS providers throughout the East Midlands area. This arrangement has contributed to the material increase of £14,739k in the education, training and research costs shown in the above note. The Trust's total research network income has increased by £15,152k from 2013-14.

*** Rental revenue from operating leases includes £7.4m of income from our facilities management service provider in relation to car parking and catering. This arrangement commenced in March 2013 and, in accordance with International Financial Reporting Standards, we classify these income elements as operating lease income.

**** Other revenue includes all other income which does not fall within the specific categories listed above, including staff car parking £1.1m (2013-14: £1.0m) and accommodation £1.6m (2013-14: £1.6m).

7. Overseas Visitors Disclosure

	2014-15 £000	2013-14 £000s
Income recognised during 2014-15 (invoiced amounts and accruals)	**1,154**	975
Cash payments received in-year (re receivables at 31 March 2014)	**96**	35
Cash payments received in-year (iro invoices issued 2014-15)	**487**	163
Amounts added to provision for impairment of receivables (re receivables at 31 March 2014)	**46**	0
Amounts added to provision for impairment of receivables (iro invoices issued 2014-15)	**171**	0
Amounts written off in-year (irrespective of year of recognition)	**567**	656

8. Operating expenses

	2014-15 £000s	2013-14 £000s
Services from other NHS Trusts	**3,529**	4,353
Services from other NHS bodies	**107**	833
Services from NHS Foundation Trusts	**2,010**	2,002
Total Services from NHS bodies*	**5,646**	7,188
Purchase of healthcare from non-NHS bodies	**8,998**	7,678
Trust Chair and Non-executive Directors	**79**	73
Supplies and services - clinical**	**181,931**	164,900
Supplies and services - general	**25,950**	27,288
Consultancy services	**4,707**	2,439
Establishment***	**8,003**	5,812
Transport	**2,982**	2,626
Premises	**42,555**	35,308
Insurance	**19**	38
Legal Fees	**608**	500
Impairments and Reversals of Receivables	**614**	1,135
Depreciation	**30,447**	29,484
Amortisation	**2,783**	1,761
Impairments and reversals of property, plant and equipment	**6,761**	0
Audit fees	**209**	209
Clinical negligence	**17,562**	17,733
Research and development (excluding staff costs)****	**24,569**	14,340
Education and Training	**1,030**	1,084
Other	**8,062**	5,585
Total Operating expenses (excluding employee benefits)	**373,515**	325,181
Employee Benefits		
Employee benefits excluding Board members	**496,288**	473,222
Board members	**990**	868
Total Employee Benefits	**497,278**	474,090
Total Operating Expenses	**870,793**	799,271

* Services from NHS bodies does not include expenditure which falls into a category below it in the table.

** Supplies and services - clinical includes £79,461k expenditure on drugs (2013-14 - £73,601k).

*** Establishment costs include printing, stationery, postage and telephone costs.

**** From 2014-15 the Trust is responsible for hosting the *NIHR Clinical Research Network: East Midlands*. This arrangement has contributed to the increase of £10,229k in the research and development costs shown in the above note. The Trust's total research network expenditure has increased by £13,878k from 2013-14 and this is offset by a reduction in expenditure relating to other grant funded research and development schemes which ended in 2013-14.

9 Operating Leases

Of the total minimum lease payments for 2014-15, £4,400k (£4,333k in 2013-14) relates to three contracts for the provision of haemodialysis services as defined under IAS 17 *Leases.* The Trust is provided with haemodialysis services from private sector suppliers from sites at Boston, Leicester and Corby.

9.1 University Hospitals of Leicester as lessee

	2014-15		2013-14
	Other	**Total**	Total
	£000s	**£000s**	£000s
Payments recognised as an expense			
Minimum lease payments		**5,670**	5,391
Contingent rents		**0**	0
Sub-lease payments		**0**	0
Total		**5,670**	5,391
Payable:			
No later than one year	5,657	**5,657**	4,433
Between one and five years	8,063	**8,063**	12,164
After five years	306	**306**	689
Total	**14,026**	**14,026**	17,286

No future sublease payments are expected to be received.

9.2 University Hospitals of Leicester as lessor

The Trust leases two properties to a local NHS Trust following the exchange of land and buildings with that Trust.

The Trust also receives lease income from its facilities managed service provider in relation to catering and car parking.

	2014-15	2013-14
	£000	£000s
Recognised as revenue		
Rental revenue	8,391	8,857
Total	**8,391**	8,857
Receivable:		
No later than one year	7,841	7,999
Between one and five years	29,233	37,185
After five years	0	0
Total	**37,074**	45,184

10 Employee benefits and staff numbers

10.1 Employee benefits

	2014-15		
	Total £000s	Permanently employed £000s	Other £000s
Employee Benefits - Gross Expenditure			
Salaries and wages	423,163	401,907	21,256
Social security costs	29,887	29,887	0
Employer Contributions to NHS BSA - Pensions Division	43,964	43,964	0
Other pension costs	18	18	0
Termination benefits	1,116	1,116	0
Total employee benefits	498,148	476,892	21,256
Employee costs capitalised	870	477	393
Gross Employee Benefits excluding capitalised costs	497,278	476,415	20,863

	2013-14		
Employee Benefits - Gross Expenditure 2013-14	Total £000s	Permanently employed £000s	Other £000s
Salaries and wages	403,871	373,199	30,672
Social security costs	29,137	29,137	0
Employer Contributions to NHS BSA - Pensions Division	42,133	42,133	0
Other pension costs	0	0	0
Termination benefits	182	182	0
TOTAL - including capitalised costs	475,323	444,651	30,672
Employee costs capitalised	1,233	703	530
Gross Employee Benefits excluding capitalised costs	474,090	443,948	30,142

Bank staff costs for 2014-15 totalling £5,771k are included within the 'permanently employed' category in the above note in accordance with Department of Health Guidance. Bank staff costs totalling £7,175k were included within the 'other' category in 2013-14.

10.2 Staff Numbers

	2014-15			2013-14
	Total Number	Permanently employed Number	Other Number	Total Number
Average Staff Numbers				
Medical and dental	1,582	1,140	442	1,583
Administration and estates	1,881	1,832	49	1,667
Healthcare assistants and other support staff	535	533	2	634
Nursing, midwifery and health visiting staff	3,393	3,352	41	3,311
Nursing, midwifery and health visiting learners	1,502	1,410	92	1,363
Scientific, therapeutic and technical staff	1,616	1,554	62	1,541
Social Care Staff	2	0	2	0
Other	199	128	71	301
TOTAL	10,710	9,949	761	10,400
Of the above - staff engaged on capital projects	12	8	4	18

10.3 Staff Sickness absence and ill health retirements

	2014-15	2013-14
	Number	Number
Total Days Lost	86,777	73,616
Total Staff Years	10,433	9,966
Average working Days Lost	8.32	7.39

	2014-15	2013-14
	Number	Number
Number of persons retired early on ill health grounds	11	14

	£000s	£000s
Total additional pensions liabilities accrued in the year	425	748

10.4 Exit Packages agreed in 2014-15

Exit package cost band (including any special payment element)	2014-15 *Number of compulsory redundancies	2014-15 *Number of other departures agreed	2014-15 Total number of exit packages by cost band	2013-14 *Number of compulsory redundancies	2013-14 *Number of other departures agreed	2013-14 Total number of exit packages by cost band
	Number	Number	Number	Number	Number	Number
Less than £10,000	0	22	22	0	0	0
£10,000-£25,000	3	21	24	2	0	2
£25,001-£50,000	1	13	14	1	0	1
£50,001-£100,000	2	1	3	1	0	1
Total number of exit packages by type (total cost	**6**	**57**	**63**	4	0	4
Total resource cost (£s)	**196,392**	**919,805**	**1,116,197**	181,991	0	181,991

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Scheme. Exit costs in this note are accounted for in full in the year of departure. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table.

Other departures shown in the note above includes costs and numbers associated with the Trust's Voluntary Severance Scheme (VSS).

This disclosure reports the number and value of exit packages agreed in the year. Note: The expense associated with these departures may have been recognised in part or in full in a previous period.

10.5 Exit packages - Other Departures analysis

	2014-15 Agreements	2014-15 Total value of agreements	2013-14 Agreements	2013-14 Total value of agreements
	Number	£000s	Number	£000s
Voluntary Severance Scheme contractual costs	57	920	0	0
Total	57	920	0	0

The Trust made no non-contractual payments to individuals where the payment value was more than 12 months of their annual salary.

This disclosure reports the number and value of exit packages agreed in the year. Note: the expense associated with these departures may have been recognised in part or in full in a previous period.

As a single exit packages can be made up of several components each of which will be counted separately in this Note, the total number above will not necessarily match the total numbers in Note 10.4 which will be the number of individuals.

The Remuneration Report includes disclosure of exit payments payable to individuals named in that Report.

10.6 Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

The scheme is subject to a full actuarial valuation every four years (until 2004, every five years) and an accounting valuation every year. An outline of these follows:

a) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date. The conclusion from the 2004 valuation was that the scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004.

In order to defray the costs of benefits, employers pay contributions at 14% of pensionable pay and most employees had up to April 2008 paid 6%, with manual staff paying 5%.

Following the full actuarial review by the Government Actuary undertaken as at 31 March 2004, and after consideration of changes to the NHS Pension Scheme taking effect from 1 April 2008, his Valuation report recommended that employer contributions could continue at the existing rate of 14% of pensionable pay, from 1 April 2008, following the introduction of employee contributions on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings.

On advice from the scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities.

b) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period by updating the results of the full actuarial valuation.

Between the full actuarial valuations at a two-year midpoint, a full and detailed member data-set is provided to the scheme actuary. At this point the assumptions regarding the composition of the scheme membership are updated to allow the scheme liability to be valued.

The valuation of the scheme liability as at 31 March 2011, is based on detailed membership data as at 31 March 2008 (the latest midpoint) updated to 31 March 2011 with summary global member and accounting data.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Resource Account, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year.

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the statement of comprehensive income at the time the Trust commits itself to the retirement, regardless of the method of payment.

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

11 Better Payment Practice Code

11.1 Measure of compliance

	2014-15		2013-14	
	Number	**£000s**	Number	£000s
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**143,784**	**484,649**	128,364	396,204
Total Non-NHS Trade Invoices Paid Within Target	**76,193**	**329,077**	59,150	271,621
Percentage of NHS Trade Invoices Paid Within Target	**52.99%**	**67.90%**	46.08%	68.56%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**4,776**	**180,233**	4,654	**163,108**
Total NHS Trade Invoices Paid Within Target	**2,446**	**137,859**	2,549	**133,356**
Percentage of NHS Trade Invoices Paid Within Target	**51.21%**	**76.49%**	54.77%	81.76%

The Better Payment Practice Code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

The Trust has been in a deficit position since 2013-14, which means that the Trust does not generate sufficient operational cash without external financial support. Note 26 outlines the external financing that the Trust received in 2014-15. Our financing application made it explicit that the final value of our external revenue funding would only allow us to make an incremental improvement in our payments performance and achieve a maximum of 72% against the BPPC target by value. This was accepted by the Department of Health and our final outturn is shown in the above table. The combined NHS and non-NHS performance was 70.23% by value.

11.2 The Late Payment of Commercial Debts (Interest) Act 1998

The Trust has paid several non-material amounts in interest for late payment of commercial debts.

15.1 Property, plant and equipment

2014-15	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Cost or valuation:									
At 1 April 2014	52,734	272,820	8,804	7,542	141,940	148	55,281	1,973	541,242
Additions of Assets Under Construction				12,403					12,403
Additions Purchased	0	22,463	12		5,010	0	2,176	274	29,935
Additions - Non Cash Donations (i.e. physical assets)	0	0	0	0	44	0	0	0	44
Additions - Purchases from Cash Donations & Government Grants	0	206	0	0	285	11	30	0	532
Additions Leased	0	0	0		4,302	0	0	0	4,302
Reclassifications	0	3,518	0	(4,568)	0	0	0	0	(1,050)
Disposals other than for sale	0	0	0	0	(2,672)	(9)	(523)	(60)	(3,264)
Upward revaluation/positive indexation	123	(1,555)	(149)	0	0	0	0	0	(1,581)
Impairments/negative indexation	0	(1,443)	(11)	0	0	0	0	0	(1,454)
At 31 March 2015	52,857	296,009	8,656	15,377	148,909	150	56,964	2,187	581,109
Depreciation									
At 1 April 2014	5,612	29,701	1,309	129	93,384	96	46,905	1,641	178,777
Disposals other than for sale	0	0	0		(2,666)	(9)	(523)	(60)	(3,258)
Upward revaluation/positive indexation	0	(44,748)	(1,063)		0	0	0	0	(45,811)
Impairments	0	6,759	2	0	0	0	0	0	6,761
Charged During the Year	0	15,230	425		11,520	15	3,212	45	30,447
At 31 March 2015	5,612	6,942	673	129	102,238	102	49,594	1,626	166,916
Net Book Value at 31 March 2015	47,245	289,067	7,983	15,248	46,671	48	7,370	561	414,193
Asset financing:									
Owned - Purchased	47,245	281,397	7,983	15,248	23,205	15	6,457	474	382,024
Owned - Donated	0	6,757	0	0	1,157	33	56	87	8,090
Owned - Government Granted	0	913	0	0	0	0	0	0	913
Held on finance lease	0	0	0	0	22,309	0	857	0	23,166
Total at 31 March 2015	47,245	289,067	7,983	15,248	46,671	48	7,370	561	414,193

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2014	12,633	45,630	6,316	0	40	0	0	0	64,619
Movements (specify)	122	41,750	903	0	(39)	0	0	0	42,736
At 31 March 2015	12,755	87,380	7,219	0	1	0	0	0	107,355

Additions to Assets Under Construction in 2014-15

Land	0
Buildings excl Dwellings	7,779
Dwellings	0
Plant & Machinery	4,624
Balance as at YTD	12,403

15.2 Property, plant and equipment prior-year

2013-14	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Cost or valuation:									
At 1 April 2013	52,734	277,502	8,723	5,896	138,448	137	52,245	1,923	**537,608**
Transfers under Modified Absorption Accounting - PCTs & SHAs	0	0	0	0	0	0	2	0	**2**
Additions of Assets Under Construction				7,243					**7,243**
Additions Purchased	0	14,888	81		6,285	0	3,538	191	**24,983**
Additions - Non Cash Donations (i.e. Physical Assets)	0	0	0	0	114	0	0	0	**114**
Additions - Purchases from Cash Donations & Government Grants	0	313	0	0	320	11	7	0	**651**
Additions Leased	0	0	0		4,353	0	0	0	**4,353**
Reclassifications	0	5,517	0	(5,597)	22	0	41	13	**(4)**
Disposals other than for sale	0	0	0	0	(7,602)	0	(552)	(154)	**(8,308)**
At 31 March 2014	**52,734**	**298,220**	**8,804**	**7,542**	**141,940**	**148**	**55,281**	**1,973**	**566,642**
Depreciation									
At 1 April 2013	5,612	39,735	885	129	91,397	82	43,340	1,770	**182,950**
Disposals other than for sale	0	0	0		(7,551)	0	(552)	(154)	**(8,257)**
Charged During the Year	0	15,366	424		9,538	14	4,117	25	**29,484**
At 31 March 2014	**5,612**	**55,101**	**1,309**	**129**	**93,384**	**96**	**46,905**	**1,641**	**204,177**
Net Book Value at 31 March 2014	47,122	243,119	7,495	7,413	48,556	52	8,376	332	**362,465**
Asset financing:									
Owned - Purchased	47,122	236,450	7,495	7,413	25,410	26	6,792	245	**330,953**
Owned - Donated	0	5,870	0	0	1,107	26	41	87	**7,131**
Owned - Government Granted	0	799	0	0	0	0	0	0	**799**
Held on finance lease	0	0	0	0	22,039	0	1,543	0	**23,582**
Total at 31 March 2014	**47,122**	**243,119**	**7,495**	**7,413**	**48,556**	**52**	**8,376**	**332**	**362,465**

15.3 (cont). Property, plant and equipment

15.3.1 Donated assets

The majority of donated assets have been purchased on behalf of the Trust by the Leicester Hospitals Charity.

The most notable donated additions from the Leicester Hospitals Charity have included:

- £206K of building works including £72k to continue the creation of bereavement facilities within the maternity areas.
- £295k for medical and dental equipment including £78K for an Idxa scanner for Diabetes research, £37K for a urology ultrasound and £37k for Haemodialysis monitoring.

15.3.2 Revaluation

The Trust re-values its assets on a regular basis.

The Trust's freehold and leasehold property values were updated in 2014-15 by an external valuer, Gerald Eve LLP, a regulated firm of chartered surveyors. The valuation was prepared in accordance with the requirements of the RICS Professional Standards, January 2014, the International Valuation Standards and IFRS. The valuation of each property was on the basis of Fair Value, equivalent to Market Value, subject to the following assumptions:

- for owner occupied property: the property would be valued as part of the continuing business; and
- for surplus property and property held for development: the property would be valued with vacant possession in its existing condition.

The valuer's opinion of Fair Value was primarily derived using the Depreciated Replacement Cost approach, because the specialised nature of the assets means that there are no market transactions of this type of asset except as part of the business or entity. For non-specialised assets regard has been had to comparable recent market transactions and/or an estimate of the future potential net income generated by the use of the property.

The valuations have been prepared in accordance with the Government Financial Reporting Manual 2013-2014 (FReM) to comply with IFRS, specifically with regard to IAS 16 'Property, Plant and Equipment' and IAS 40 'Investment Properties'.

15.3.3 Property plant and equipment

The accounting policies in relation to depreciation, amortisation and impairments are included in accounting policies note 1.10.

15.3.4 Temporarily idle asset values

The Trust does not hold any temporarily idle assets.

15.3.5 Gross carrying value of fully depreciated assets in use at the balance sheet date

The following totals represent total gross carrying value of all assets which have been fully depreciated.

	31 March 2015	31 March 2014
	£000	£000
Plant & Machinery (Purchased)	51,898	40,921
Plant & Machinery (Donated)	5,442	5,593
Transport Equipment (Purchased)	46	39
Tangible IM&T (Purchased)	44,067	38,716
Tangible IM&T (Donated)	132	106
Intangible IM&T (Purchased)	6,019	4,085
Intangible IM&T (Donated)	14	0
Furniture & Fittings (Purchased)	1,463	1,520
Furniture & Fittings (Donated)	71	73
	109,152	91,053

15.3.6 Compensation for assets impaired, lost or given up

The Trust has no compensation from third parties for assets impaired, lost or given up, which it needs to include in its surplus.

16.1 Intangible non-current assets

2014-15	Computer Licenses £000's	Total £000's
At 1 April 2014	**16,101**	**16,101**
Additions Purchased	3,848	**3,848**
Reclassifications	1,050	**1,050**
Disposals other than by sale	(24)	**(24)**
At 31 March 2015	**20,975**	**20,975**
Amortisation		
At 1 April 2014	**8,082**	**8,082**
Disposals other than by sale	(24)	**(24)**
Charged during the year	2,783	**2,783**
At 31 March 2015	**10,841**	**10,841**
Net Book Value at 31 March 2015	**10,134**	**10,134**
Asset Financing: Net book value at 31 March 2015 comprises:		
Purchased	10,134	**10,134**
Total at 31 March 2015	**10,134**	**10,134**

The Trust's intangible assets all relate to IT licences, and are not revalued.

16.2 Intangible non-current assets prior year

2013-14

	Computer Licenses £000's	Total £000's
At 1 April 2013	**11,754**	**11,754**
Additions - purchased	4,468	**4,468**
Reclassifications	4	**4**
Disposals other than by sale	(125)	**(125)**
At 31 March 2014	**16,101**	**16,101**
Amortisation		
At 1 April 2013	**6,446**	**6,446**
Disposals other than by sale	(125)	**(125)**
Charged during the year	1,761	**1,761**
At 31 March 2014	**8,082**	**8,082**
Net Book Value at 31 March 2014	**8,019**	**8,019**
Asset Financing: Net book value at 31 March 2014 comprises:		
Purchased	8,018	**8,018**
Donated	1	**1**
Total at 31 March 2014	**8,019**	**8,019**

16.3 Intangible non-current assets

The accounting policies in relation to intangible assets are included in note 1.11.

16.3.1 Internally generated assets

Expenditure on research activities is recognised as an expense in the period in which it is incurred.

All of the Trust's intangible assets are either purchased or donated, and none have been internally generated.

16.3.2 Amortisation

All of the Trust's intangible assets are amortised up to a maximum of 5 years and are not subject to revaluation.

16.3.3 Acquisition

None of the Trust's intangible assets have been acquired by government grant.

16.3.4 Fully amortised assets

The Trust has £6.0m of fully amortised intangible assets still in use.

16.3.5 Recognition

The Trust has no significant intangible assets which it does not recognise as assets under IAS 38 *Intangible Assets*.

16.3.6 Revaluation reserve balance for intangible assets

The Trust has no revaluation reserve balances for intangible assets.

16.3.7 Impairments

The Trust has no material impairments for any individual intangible assets.

18 Investment property

The Trust has no investment property.

19 Commitments

19.1 Capital commitments

Contracted capital commitments at 31 March not otherwise included in these financial statements:

	31 March 2015	31 March 2014
	£000s	£000s
Property, plant and equipment	12,335	7,812
Total	**12,335**	7,812

19.2 Other financial commitments

The Trust has no other financial commitments such as non-cancellable contracts (which are not leases or PFI contracts or other service concession arrangements).

20 Intra-Government and other balances

	Current receivables	Non-current receivables	Current payables	Non-current payables
	£000s	£000s	£000s	£000s
Balances with Other Central Government Bodies	476	0	9,617	0
Balances with Local Authorities	272	0	175	0
Balances with NHS bodies inside the Departmental Group	19,233	0	11,678	11,455
Balances with Bodies External to Government	12,621	2,702	84,498	6,869
At 31 March 2015	**32,602**	**2,702**	**105,968**	**18,324**
prior period:				
Balances with Other Central Government Bodies	36,037	0	22,447	0
Balances with Local Authorities	76	0	237	0
Balances with NHS Trusts and FTs	2,970	0	4,346	0
Balances with Bodies External to Government	10,682	3,123	86,968	0
At 31 March 2014	**49,765**	**3,123**	**113,998**	**0**

21 Inventories

	Drugs	Consumables	Energy	Loan Equipment	Of which held at NRV
	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2014	**3,325**	**10,388**	**224**	**0**	10,388
Additions	79,462	30,955	79	0	30,955
Inventories recognised as an expense in the period	(79,395)	(30,740)	(157)	0	(30,740)
Balance at 31 March 2015	**3,392**	**10,603**	**146**	**0**	**10,603**

22.1 Trade and other receivables

	Current		Non-current	
	31 March 2015	31 March 2014	31 March 2015	31 March 2014
	£000s	£000s	£000s	£000s
NHS receivables - revenue	**18,703**	37,243	**0**	0
Non-NHS receivables - revenue	**10,093**	10,758	**2,915**	3,148
Non-NHS prepayments and accrued income	**2,601**	1,660	**403**	372
PDC Dividend prepaid to DH*	**530**			
Provision for the impairment of receivables	**(1,298)**	(1,408)	**(616)**	(397)
VAT	**1,973**	1,265	**0**	0
Other receivables	**0**	374	**0**	0
Total	**32,602**	49,892	**2,702**	3,123
Total current and non current	**35,304**	53,015		
Included in NHS receivables are prepaid pension contributions:	**0**			

The great majority of trade is with CCGs, as commissioners for NHS patient care services. As CCGs are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary.

* Amounts prepaid to DH were included within 'other receivables' in 2013-14.

22.2 Receivables past their due date but not impaired

	31 March 2015	31 March 2014
	£000s	£000s
By up to three months	**2,315**	2,162
By three to six months	**484**	441
By more than six months	**440**	476
Total	**3,239**	3,079

22.3 Provision for impairment of receivables

	2014-15	2013-14
	£000s	£000s
Balance at 1 April 2014	**(1,805)**	(1,520)
Amount written off during the year	**505**	850
Amount recovered during the year	**376**	241
(Increase)/decrease in receivables impaired	**(990)**	(1,376)
Balance at 31 March 2015	**(1,914)**	(1,805)

The Trust makes a general provision on non NHS debts over 90 days old, increasing from 25% at 90 days to 100% for debts over a year old. Certain debts incur a higher or lower provision dependent on a risk assessment approved by the Trust. The Trust has provided for 18.9% of injury cost recovery debts based on Department of Health guidance and this is an increase from 12.6% used by the Trust in the prior year. The total injury cost recovery provision is £715k (2013-14: £484k).

23 NHS LIFT investments

The Trust has no NHS LIFT investments.

24.1 Other Financial Assets - Current

The Trust has no other financial assets.

24.2 Other Financial Assets - Non Current

The Trust has no other financial assets.

25 Other current assets

The Trust has no other current assets.

26 Cash and Cash Equivalents

	31 March 2015	31 March 2014
	£000s	£000s
Opening balance	**515**	19,986
Net change in year	**7,983**	(19,471)
Closing balance	**8,498**	515
Made up of		
Cash with Government Banking Service	**8,490**	503
Cash in hand	**8**	12
Cash and cash equivalents as in statement of financial position	**8,498**	515
Cash and cash equivalents as in statement of cash flows	**8,498**	515
Patients' money held by the Trust, not included above	**7**	2

We initially planned to reduce cash from £515k at the end of 2013-14 to £277k at the end of 2014-15. We received a total of £58.0m in external financing in 2014-15, which funded capital expenditure of £12.0m, the deficit of £40.7m and liquidity improvements of £5.3m.

The £12m of capital funding was finally confirmed as a loan rather than PDC in February 2015 and the loan can be seen on the Statement of Financial Position.

An implication of loan financing is that we could only receive Capital Resource Limit (CRL) cover for our capital expenditure when we drew down the full amount of cash. The CRL is a limit on the amount of capital expenditure we incur in a year and we must not incur expenditure in excess of the CRL. As we achieved the full capital programme for 2014-15 we needed the full CRL in 2014-15. We therefore drew down the whole loan in March even though we did not spend all of the cash. Our performance against the CRL target is shown in note 43.4.

As a result of this we had a cash balance of £8.5m at the year-end instead of the planned £0.3m.

27 Non-current assets held for sale

The Trust has no non-current assets held for sale.

28 Trade and other payables

	Current		
	31 March 2015	31 March 2014	prior fig.
	£000s	£000s	
NHS payables - revenue	**8,116**	5,697	9,235
NHS accruals and deferred income	**3,017**	5,517	5,423
Non-NHS payables - revenue	**21,312**	36,227	20,633
Non-NHS payables - capital	**13,897**	12,907	
Non-NHS accruals and deferred income	**36,632**	30,053	
Social security costs	**4,575**	4,458	
Tax	**5,030**	4,951	
Other	**7,925**	9,325	7,769
Total	**100,504**	109,135	103,194
Total payables (current and non-current)	**100,504**	**109,135**	103,194
Included above:			
Outstanding Pension Contributions at the year end	**6,135**	5,898	

29 Other liabilities

The Trust has no other liabilities.

30 Borrowings

	Current		Non-current	
	31 March 2015	31 March 2014	31 March 2015	31 March 2014
	£000s	£000s	£000s	£000s
Loans from Department of Health	**545**	0	**11,455**	0
Finance lease liabilities	**4,919**	6,590	**6,869**	5,890
Total	**5,464**	**6,590**	**18,324**	**5,890**
Total other liabilities (current and non-current)	**23,788**	**12,480**		

Borrowings / Loans - repayment of principal falling due in:

	31 March 2015		
	DH	Other	Total
	£000s	£000s	£000s
0-1 Years	545	4,919	**5,464**
1 - 2 Years	545	625	**1,170**
2 - 5 Years	1,635	1,873	**3,508**
Over 5 Years	9,275	4,371	**13,646**
TOTAL	**12,000**	**11,788**	**23,788**

31 Other financial liabilities

The Trust has no other financial liabilities.

32 Deferred revenue

	Current	
	31 March 2015	31 March 2014
	£000s	£000s
Opening balance at 1 April 2014	**13,906**	8,650
Deferred revenue addition	**2,179**	8,765
Transfer of deferred revenue	**(2,519)**	(3,509)
Current deferred income at 31 March 2015	**13,566**	13,906
Total deferred income (current and non-current)	**13,566**	13,906

33 Finance lease obligations as lessee

Managed Equipment Service (MES) finance lease

The Trust has a finance lease in relation to its managed equipment service as defined by IAS 17 *Leases.*

Commencement date: 2007-2008
End date: 2025-2026

Picture Archiving and Communications Service (PACS)

The Trust has a finance lease in relation to its PACS system as defined by IAS 17 *Leases.*

Commencement date: 2011-2012
End date: 2016-2017

Payment for the fair value of the services received

The annual unitary payment is applied to meet the annual finance cost and to repay the lease liability over the contract term.

Interest costs charged to revenue

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Income.

Property plant and equipment assets recognised on the balance sheet

The finance lease assets are recognised as property, plant and equipment. The asset values, life and depreciation for the MES scheme are provided to the Trust by the Lessor. The asset lives for the PACS system are calculated by the Trust.

Depreciation on the property, plant and equipment is charged to revenue.

Liability

A liability is recognised at the same time as the assets are recognised. It is measured initially at the same amount as the fair value of the assets and is subsequently measured as a finance lease liability in accordance with IAS 17 *Leases.*

Asset replacement

Any assets, or asset components replaced by the operator during the contract are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

Assets contributed by the Trust to the operator for use in the scheme (MES only).

Assets contributed for use in the scheme are recognised as items of property, plant and equipment in the Trust's Statement of Financial Position.

Amounts payable under finance leases (Other)	**Minimum lease payments**		**Present value of minimum**	
	31 March 2015	31 March 2014	**31 March 2015**	31 March 2014
	£000s	£000s	**£000s**	£000s
Within one year	**4,919**	6,590	**4,919**	6,590
Between one and five years	**2,724**	7,680	**2,498**	5,890
After five years	**5,770**	0	**4,371**	0
Less future finance charges	(1,625)	(1,790)		
Minimum Lease Payments / Present value of minimum lease payments	**11,788**	12,480	**11,788**	12,480
Included in:				
Current borrowings			**4,919**	6,590
Non-current borrowings			**6,869**	5,890
			11,788	12,480

34 Finance lease receivables as lessor

The Trust has no finance lease receivables.

35 Provisions

	Total	Comprising: Early Departure Costs	Other	Redundancy
	£000s	£000s	£000s	£000s
Balance at 1 April 2014	**3,655**	1,509	1,241	905
Arising during the year	**726**	198	366	162
Utilised during the year	**(1,448)**	(221)	(479)	(748)
Reversed unused	**(158)**	0	0	(158)
Unwinding of discount	**27**	19	8	0
Balance at 31 March 2015	**2,802**	**1,505**	**1,136**	**161**
Expected Timing of Cash Flows:				
No Later than One Year	**820**	221	438	161
Later than One Year and not later than Five Years	**1,582**	884	698	0
Later than Five Years	**400**	400	0	0

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:

As at 31 March 2015	148,371
As at 31 March 2014	123,061

Other provisions includes £275k for employer and public liability cases as notified to us by the NHS Litigation Authority; £644k permanent injury benefits and £218k for potential litigation or employment tribunals.

36 Contingencies

	31 March 2015	31 March 2014
	£000s	£000s
Contingent liabilities		
Other	**(128)**	(147)
Net value of contingent liabilities	**(128)**	(147)

The Trust's contingent liabilities relate to property, employer and public liability cases. All of these are administered by the NHS Litigation Authority and are expected to be resolved in 2014-15. Provisions for these are also included at note 35.

The Trust is involved in a contractual dispute with its facilities management provider, Interserve. The Trust does not expect that it will incure any significant financial costs in relation to this dispute in any future period.

The Trust has a contingent asset in relation to assets which will be transferred from Interserve to UHL at the completion of the facilities management contract, or at any point the contract is terminated. We have not disclosed a value for these assets as we will not know the net book value of these assets until the point of transfer but the value is not expected to be material.

37 PFI and LIFT - additional information

The Trust has no PFI or LIFT contracts.

38 Impact of IFRS treatment - current year

The Trust is fully compliant with IFRS and therefore there are no transitional impacts under IFRIC12.

39 Financial Instruments

39.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with commissioners and the way those commissioners are financed, the NHS trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk
The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk
The Trust borrows from government for capital expenditure, subject to affordability as confirmed by the strategic health authority. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk
Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at the 31st March 2014 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk
The Trust's operating costs are incurred under contracts with Clinical Commissioning Groups, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

39.2 Financial Assets

	Loans and receivables £000s	Total £000s
Receivables - NHS	11,500	**11,500**
Receivables - non-NHS	9,499	**9,499**
Cash at bank and in hand	8,498	**8,498**
Total at 31 March 2015	**29,497**	**29,497**
Receivables - NHS	18,952	18,952
Receivables - non-NHS	7,881	7,881
Cash at bank and in hand	515	515
Total at 31 March 2014	27,348	27,348

39.3 Financial Liabilities

	Other £000s	Total £000s
NHS payables	2,087	**2,087**
Non-NHS payables	16,828	**16,828**
Other borrowings	12,000	**12,000**
Total at 31 March 2015	**30,915**	**30,915**
NHS payables	429	429
Non-NHS payables	16,961	16,961
PFI & finance lease obligations	12,480	12,480
Total at 31 March 2014	29,870	29,870

40 Events after the end of the reporting period

There are no material adjusting post balance sheet events arising subsequent to the date of these financial statements.

41 Related party transactions

During the year none of the Department of Health Ministers, Trust Board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with the University Hospitals of Leicester NHS Trust.

Material Department of Health entities

The Department of Health is regarded as a related party. During the year the University Hospitals of Leicester NHS Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are listed below:

Cambridgeshire And Peterborough CCG
Chesterfield Royal Hospital NHS Foundation Trust
Corby CCG
Coventry And Rugby CCG
Derby Hospitals NHS Foundation Trust
Derbyshire Community Health Services NHS Trust
Derbyshire and Nottinghamshire Area Team
East Leicestershire And Rutland CCG
East Staffordshire CCG
Health Education England
Kettering General Hospital NHS Foundation Trust
Leicester City CCG
Leicestershire and Lincolnshire Area Team
Leicestershire Partnership NHS Trust
Lincolnshire East CCG
Lincolnshire West CCG
National Health Service Pension Scheme
Nene CCG
NHS Blood and Transplant
NHS England
NHS Litigation Authority
NHS Pension Scheme
NHS Supply Chain
NHS Property Services
Northampton General Hospital NHS Trust
Northamptonshire Healthcare NHS Foundation Trust
Northern Lincolnshire And Goole NHS Foundation Trust
Nottingham University Hospitals NHS Trust
Nottinghamshire Healthcare NHS Foundation Trust
Peterborough & Stamford Hospitals NHS Foundation Trust
Public Health England
Rushcliffe CCG
South Lincolnshire CCG
South West Lincolnshire CCG
Southern Derbyshire CCG
Staffordshire and Stoke on Trent Partnership NHS Trust
United Lincolnshire Hospitals NHS Trust
Warwickshire North CCG
West Leicestershire CCG

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with the following organisations:

Department of Energy and Climate Change
National Insurance Fund
HM Revenue and Customs
Leicester City Council
Leicestershire County Council
Welsh Assembly Government

University of Leicester:

During the reporting year, the Trust made payments to the University of Leicester amounting to £12,376k. The majority of these payments relate to the provision of services to the Trust by medical staff employed by the University of Leicester, and research payments. As at 31st March 2015 a sum of £491k is included in creditors in respect of the University of Leicester. The University paid us £5,585k in the year, relating primarily to research work, and £1,714k was included within debtors at 31st March 2015.

Leicester Hospitals Charity

The Trust is the Corporate Trustee for Leicester Hospitals Charity which is an independent charity registered with the Charity Commission. In 2014-15 the Trust received total asset donations of £575k (£1,423k in 2013-14). Full details will be included in the Charity's accounts as submitted to the Charity Commission.

42 Losses and special payments

The total number of losses cases in 2014-15 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses	816,214	683
Special payments	165,108	176
Total losses and special payments	981,322	859

The total number of losses cases in 2013-14 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses	835,314	614
Special payments	183,389	174
Total losses and special payments	1,018,703	788

There were no cases individually over £300,000

43. Financial performance targets

The figures given for periods prior to 2009-10 are on a UK GAAP basis as that is the basis on which the targets were set for those years.

43.1 Breakeven performance	2005-06 £000s	2006-07 £000s	2007-08 £000s	2008-09 £000s	2009-10 £000s	2010-11 £000s	2011-12 £000s	2012-13 £000s	2013-14 £000s	2014-15 £000s
Turnover	556,656	588,666	615,155	652,159	697,692	696,257	719,154	758,665	770,393	834,376
Retained surplus/(deficit) for the year	60	61	577	3,018	(3,992)	(2,542)	(27,985)	1,177	(39,514)	(47,493)
Adjustment for:										
Adjustments for impairments				0	4,043	3,555	28,073	0	0	6,761
Adjustments for impact of policy change re donated/government grants assets							0	(1,086)	(141)	84
Break-even in-year position	60	61	577	3,018	51	1,013	88	91	(39,655)	(40,648)
Break-even cumulative position	254	315	892	3,910	3,961	4,974	5,062	5,153	(34,502)	(75,150)

Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10, NHS [organisation]'s financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring Departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to IFRIC 12 schemes (which would include PFI schemes), which has no cash impact and is not chargeable for overall budgeting purposes, is excluded when measuring Breakeven performance. Other adjustments are made in respect of accounting policy changes (impairments and the removal of the donated asset and government grant reserves) to maintain comparability year to year.

	2005-06 %	2006-07 %	2007-08 %	2008-09 %	2009-10 %	2010-11 %	2011-12 %	2012-13 %	2013-14 %	2014-15 %
Materiality test (i.e. is it equal to or less than 0.5%):										
Break-even in-year position as a percentage of turnover	0.01	0.01	0.09	0.46	0.01	0.15	0.01	0.01	-5.15	-4.87
Break-even cumulative position as a percentage of turnover	0.05	0.05	0.15	0.60	0.57	0.71	0.70	0.68	-4.48	-9.01

The amounts in the above tables in respect of financial years 2005/06 to 2008/09 inclusive have not been restated to IFRS and remain on a UK GAAP basis.

43.2 Capital cost absorption rate

The dividend payable on public dividend capital is based on the actual (rather than forecast) average relevant net assets and therefore the actual capital cost absorption rate is automatically 3.5%.

43.3 External financing

The Trust is given an External Financing Limit (EFL) which it is permitted to undershoot.

	2014-15	2013-14
	£000s	£000s
External financing limit (EFL)	**50,315**	20,655
Cash flow financing	**46,235**	19,206
Unwinding of Discount Adjustment		154
External financing requirement	**46,235**	19,360
Under/(over) spend against EFL	**4,080**	1,295

The Trust's closing cash balance of £8.5m was £8.2m above the planned value of £0.3m. The Trust's External Financing Limit (EFL) was adjusted by the NTDA following the receipt of the £12m capital investment loan. The Trust underspent against its revised EFL target, which it is permitted to do. The excess cash will be used primarily to pay capital creditors carried forward at the year end.

43.4 Capital resource limit

The Trust is given a capital resource limit which it is not permitted to exceed.

	2014-15	2013-14
	£000s	£000s
Gross capital expenditure	**51,066**	37,459
Less: book value of assets disposed of	**(5)**	(46)
Less: capital grants	**0**	0
Less: donations towards the acquisition of non-current assets	**(576)**	(765)
Charge against the capital resource limit	**50,485**	36,648
Capital resource limit	**50,509**	36,700
(Over)/underspend against the capital resource limit	**24**	52

The Capital Resource Limit (CRL) is a limit on the amount of capital expenditure we can incur in a year and we must not overspend against it. As stated in note 26, as we achieved the full capital programme for 2014-15 we needed to draw down our full capital investment loan for 2014-15 in order to receive the CRL cover.

The CRL was also increased in-year by a further £4.3m above the initial plan to cover IFRIC 4 spend relating to capital additions within our managed equipment service finance lease.

The £24k underspend was caused by a small underspend on several schemes within our capital programme.

44 Third party assets

The Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2015	31 March 2014
	£000s	£000s
Third party assets held by the Trust	**7**	2