ANNUAL REPORT AND ACCOUNTS 2015/16

Author: Nick Sone, Financial Controller Sponsors: Paul Traynor, Chief Financial Officer; Mark Wightman, Director of Marketing and Communications **Trust Board paper F3**

Context

It is a requirement of the "NHS Trust Manual of Accounts" that the Trust produces an Annual Report and Accounts in line with its guidance, which then requires approval by the Trust Board before it is published. This year's Annual Report and Accounts is shaped around our annual priorities for 2015/16, highlighting our achievements and challenges.

We will, as we have done for the last few years, produce a shorter easy read version, (with a larger print run) of the Annual Report and Accounts for distribution to stakeholders and the public. This will be available for our Annual Public Meeting in September 2016.

The Annual Report and Accounts document was presented to the Audit Committee on the 25th May 2016 where it was recommended for approval to the Trust Board.

Questions

1. Does the Board feel that the report reflects the work achieved under the 2015/16 priorities?
2. Does the Board have any amendments to the report?
3. Is the Annual Report and Accounts complete and audited?
4. Did we achieve the statutory targets and our financial plan for 2015-16?
5. Is the Board prepared to approve the report?

Conclusion

1. This will be determined at the Board meeting.
2. This will be determined at the Board meeting.
3. The Annual Report and Accounts is complete, subject to several items of information which are not yet available due to timing such as details of complaints received. These items do not impact on the Accounts. Our Accounts were submitted by the mandatory Department of Health deadline. They have been subject to external audit by KPMG.
4. We met two out of four statutory targets and delivered an I&E deficit of £34.1m against plan of £34.1m.
1. The Annual Report and Accounts can be approved by the Trust Board, as recommended by the Audit Committee on 25th May 2016. To complete the process, members of the Trust Board will be required to sign relevant certificates.

Input Sought

The Board is asked to approve the Annual Report and Accounts and agree delegated authority for the Director of Marketing and Communications to make any final amendments that are requested by the Board or our Auditors, and to include any outstanding information.

For Reference

Edit as appropriate:

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

Safe, high quality, patient centred healthcare	[Yes /~~No /Not applicable~~]
Effective, integrated emergency care	[Yes /~~No /Not applicable~~]
Consistently meeting national access standards	[Yes /~~No /Not applicable~~]
Integrated care in partnership with others	[Yes /~~No /Not applicable~~]
Enhanced delivery in research, innovation & ed'	[Yes /~~No /Not applicable~~]
A caring, professional, engaged workforce	[Yes /~~No /Not applicable~~]
Clinically sustainable services with excellent facilities	[Yes /~~No /Not applicable~~]
Financially sustainable NHS organisation	[Yes /~~No /Not applicable~~]
Enabled by excellent IM&T	[Yes /~~No /Not applicable~~]

2. This matter relates to the following governance initiatives:

Organisational Risk Register	[~~Yes /No /~~Not applicable]
Board Assurance Framework	[~~Yes /No /~~Not applicable]

3. Related Patient and Public Involvement actions taken, or to be taken: As with previous reports, any feedback from the public is incorporated into the following report – hence the feedback form at the end of the report. The public facing, shorter, easy read version with be shared with some key stakeholders prior to publication for some feedback.

4. Results of any Equality Impact Assessment, relating to this matter: None

5. Scheduled date for the next paper on this topic: June 2017

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

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

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **2nd JUNE 2016**

REPORT FROM: **PAUL TRAYNOR – CHIEF FINANCIAL OFFICER**

SUBJECT: **ANNUAL REPORT AND ACCOUNTS 2015/16**

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1. INTRODUCTION

1.1 We are required to publish, as a single document, a three part annual report and accounts (ARA) which includes:

- The Performance Report, which must include:
  - An overview
  - A performance analysis
- The Accountability Report, which must include:
  - A Corporate Governance Report
  - A Remuneration and Staff Report
  - A Parliamentary Accountability and Audit Report
- The Financial Statements

1.2 The Performance Report and Accountability Report are shaped around our annual priorities for the year, highlighting our achievements and challenges.

1.3 We will, as we have done for the last few years, produce a shorter easy read version (with a larger print run) of the ARA (called the Summary Annual Report and Accounts) for distribution to stakeholders and the public. This will be available for our Annual Public Meeting in September 2016.

1.4 The Trust is required to produce annual statutory accounts for the year ending 31st March which are reviewed by the Audit Committee before being presented to Trust Board for approval. The accounts for the year ending 31st March 2016 are attached (appendix 1).

1.5 The Financial Statements have been subject to external audit by KPMG, who will report as a separate agenda item to the Audit Committee. KPMG also review the Performance Report and Accountability Report.

1.6 The ARA is included as appendix 1 and was presented to the Audit Committee on 25th May 2016. The Audit Committee recommended the ARA to the Trust Board for formal approval.

2. STATUTORY & ADMINISTRATIVE TARGETS 2015/16

TARGET	ACHIEVED	NOTES
STATUTORY TARGETS		
Break-even – to generate a surplus of income over spending comparing one year with another	**X**	(£34,051k) retained deficit, against planned (£34,100k) deficit
External Financing Limit – to control cash within the financing limit	√	A permissible undershoot of £366k
Capital Resource Limit – to contain capital spending within an agreed limit	√	A permissible undershoot of £41k
ADMINISTRATIVE TARGET		
Better Payments Practice Code – to pay all valid invoices within 30 days of receipt	**X**	*Non-NHS* value 77%; volume 58% *NHS* value 78%; volume 46%

3. KEY POINTS TO NOTE

3.1 The Trust delivered a year end I&E deficit of £34.1m.

3.2 Our income increased by £31.6m (3.8%) from £834.4m to £866.0m. The key components of this increase are as follows:

- MRET was rebased to 70% (£4.6m)
- NHSE growth (including high cost drugs and devices) is paid at 70% - £3.7m
- Winter monies of £5.5m are made recurrent as these are now included in CCG allocations, with equivalent cost made recurrent
- NHS patient care income is £8.9m above plan at year end
- The work in progress valuation at year end has increased by £3.0m
- Activity and growth development income increased by £20.0m

3.3 Our expenditure increased by £28.9m (3.3%) from £881.9m to £910.8m. This increase reflects:

- An increase in pay spend of £21.1m comprised of:
  - £19.6m increase due to 397 additional WTE;
  - £2.4m in relation to incremental drift;
  - £2.1m in relation to AFC uplift and medical uplift; and
  - £4.0m reduction due to shifting in skill mix.

- An increase in non-pay spend of £7.8m comprised of:
  - £12.5m increase in drug costs of which £9.0m relate to NICE drugs;
  - £3.9m consultancy costs to support the delivery of efficiencies and strategic planning; less
  - £3.9m reduction in premises costs; and
  - £4.9m reduction in other costs.

3.4 Material current asset and liability changes are shown below:

Description	Increase/Decrease	Reason
Cash	Decreased by £5.3m to £3.2m.	This was a planned decrease in line with the drawdown of our capital investment loan and associated Capital Resource Limit.
Inventories	Increased by £4.5m to £18.6m	This is due to a change in how we disclose items of stock that are now managed by our managed equipment service provider, and an increase in the stockholding of high value cardiac devices.
Trade and Other Receivables	Increase of £12.5m to £45.1m	This increase includes a recalculation of year end work in progress of £2,408k; unpaid and overdue invoices with Interserve of £2,314k; and £736k increase in overseas debt due to £422k of this debt which is underwritten by CCGs.
Trade and Other Payables	Increase of £20.5m to £121.0m	This includes a large unpaid balance of £12m with NHS Business Services authority, partly due to the fact that they are invoicing several months in arrears and invoice values are approximately £1.5m each. The increase is also partly due to the reduction in cash caused by the increase in debtors above/.

4 Change in methodology for revaluation of our estate

4.1 The largest material transactions disclosed in our 2015-16 Financial Statements relate to the reduction in value of the Trust's estate. A loss on revaluation of (£26.1m) has been charged to the revaluation reserve and a (£10.4m) impairment has been charged to the Statement of Comprehensive Income within Other Operating Costs. The impairment is adjusted out of the final adjusted retained deficit, which is the final bottom line reported figure.

4.2 The reduction in value followed a revaluation of our estate as at the 31st March 2016 by our valuers, Gerald Eve, who acted in accordance with our instructions. Appendix 1 outlines the background to the revaluation methodology and the instructions that we gave to Gerald Eve. The main points are discussed below.

4.3 The valuation at 31st March 2016 is based on depreciated replacement cost (DRC), on a Modern Equivalent Asset (MEA) basis. This basically means that a value is applied to our hospital buildings which equates to the cost of replacing them with modern equivalents, which are likely to be more efficient and less costly. This valuation can be extended to consider replacing our buildings on an 'alternate site', for example an out of town site which could have lower land prices.

4.4 Our aim was for Gerald Eve to formulate as realistic a valuation as possible, evidenced by our actual Board-approved reconfiguration plans, as this most accurately represents the modern equivalent replacement costs of the estate. We considered that this is a more accurate valuation than a theoretical 'alternate site' type MEA valuation.

4.5 The estates reconfiguration is detailed in our Estates Strategy and we provided this to Gerald Eve, who used this to formulate a valuation based on the two site configuration. Gerald Eve provided us with a valuation report on the above basis and we incorporated their valuation into our financial statements.

5 Accounts approval process for the Trust Board

5.1 To complete the accounting process, members of the Trust Board are required to sign relevant certificates including the following (*signatories are shown in brackets*):-

- **Annual Governance Statement 2015-16** *(Chief Executive)*
- **Statement of the Chief Executive's responsibilities as the Accountable Officer of the Trust** *(Chief Executive)*
- **Statement of Directors' Responsibilities in respect of the Accounts** *(Chief Executive and Chief Financial Officer)*
- **Summarisation Schedules (TRUs) for the University Hospitals of Leicester NHS Trust** *(Chief Executive and Chief Financial Officer)*
- **Letter of Representation** *(Chief Executive)*
- **Statement of Financial Position** *(Chief Executive).*

5.2 These certificate once signed will be passed to KPMG who will submit our accounts to the Department of Health along with their audit opinion.

5.3 The Annual Governance Statement is presented as a separate item to the Audit Committee and Trust Board.

6 Recommendations

6.1 The Trust Board is asked to:

- **Approve** the Annual Report and Accounts, subject to the receipt of outstanding information relating to the Annual Report.

- **Note** that the Annual Governance Statement, which is a key element of the Annual Accounts, is presented separately for review by the Chief Executive.

PAUL TRAYNOR
CHIEF FINANCIAL OFFICER

University Hospitals of Leicester NHS Trust

Annual Accounts for the period

1 April 2015 to 31 March 2016

Statement of Comprehensive Income for year ended 31 March 2016

	NOTE	2015-16 £000s	2014-15 £000s
Gross employee benefits	7.1	**(518,374)**	(497,278)
Other operating costs	5	**(381,894)**	(373,515)
Revenue from patient care activities	2	**744,258**	713,531
Other operating revenue	3	**121,778**	120,845
Operating deficit		**(34,232)**	(36,417)
Investment revenue	9	**56**	83
Other (losses) and gains	10	**(16)**	9
Finance costs	11	**(1,489)**	(799)
Deficit for the financial year		**(35,681)**	(37,124)
Public dividend capital dividends payable		**(9,042)**	(10,369)
Retained deficit for the year		**(44,723)**	(47,493)

Other Comprehensive Income

		2015-16 £000s	2014-15 £000s
Impairments and reversals taken to the revaluation reserve		**0**	(1,454)
Net (loss)/gain on revaluation of property, plant & equipment	12.3	**(26,142)**	44,230
Total Other Comprehensive Income		**(26,142)**	42,776
Total Comprehensive Income For the Year		**(70,865)**	(4,717)

Financial performance for the year

Retained deficit for the year		**(44,723)**	(47,493)
Impairments (excluding IFRIC 12 impairments)	12.3	**10,392**	6,761
Adjustments in respect of donated and government granted assets		**280**	84
Adjusted Retained Deficit		**(34,051)**	(40,648)

Other operating costs includes £10,392k (2014-15 - £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 Adjusted Retained Deficit figure in accordance with Department of Health (DH) Accounting guidance.

Total Comprehensive Income For the Year includes an amount of £280k 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.

Within Total Other Comprehensive Income is an amount of (£26,142k) relating to a reduction in the value of the Trust's assets taken to the revaluation reserve. In 2014-15 the Trust had an increase of £44,230k in its asset valuation that was taken to the revaluation reserve.

We delivered a £34.1m deficit for the year against a planned deficit of £34.1m.

The notes on pages 15 to 42 form part of this account.

Statement of Financial Position as at 31 March 2016

	NOTE	31 March 2016 £000s	31 March 2015 £000s
Non-current assets:			
Property, plant and equipment	12	**391,358**	414,193
Intangible assets	13	**10,452**	10,134
Trade and other receivables	18.1	**2,727**	2,702
Total non-current assets		**404,537**	427,029
Current assets:			
Inventories	17	**18,605**	14,141
Trade and other receivables	18.1	**45,106**	32,602
Cash and cash equivalents	19	**3,178**	8,498
Sub-total current assets		**66,889**	55,241
Total current assets		**66,889**	55,241
Total assets		**471,426**	482,270
Current liabilities			
Trade and other payables	20	**(120,985)**	(100,504)
Provisions	24	**(633)**	(820)
Borrowings	21	**(4,315)**	(4,919)
DH capital loan	21	**(545)**	(545)
Total current liabilities		**(126,478)**	(106,788)
Net current assets/(liabilities)		**(59,589)**	(51,547)
Total assets less current liablilities		**344,948**	375,482
Non-current liabilities			
Provisions	24	**(1,678)**	(1,982)
Borrowings	21	**(3,930)**	(6,869)
DH revenue support loan	21	**(34,100)**	0
DH capital loan	21	**(20,910)**	(11,455)
Total non-current liabilities		**(60,618)**	(20,306)
Total assets employed:		**284,330**	355,176
FINANCED BY:			
Public Dividend Capital		**329,856**	329,837
Retained earnings		**(126,659)**	(82,017)
Revaluation reserve		**81,133**	107,356
Total Taxpayers' Equity:		**284,330**	355,176

The notes on pages 15 to 42 form part of this account.

The financial statements on pages 2 to 42 were approved by the Board on 2nd June 2016 and signed on its behalf by:

Chief Executive: Date:

Statement of Changes in Taxpayers' Equity
For the year ending 31 March 2016

	Public Dividend capital	Retained earnings	Revaluation reserve	Other reserves	Total reserves
	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2015	**329,837**	**(82,017)**	**107,356**	**0**	**355,176**
Changes in taxpayers' equity for 2015-16					
Retained surplus/(deficit) for the year	0	(44,723)	**0**	**0**	**(44,723)**
Net gain / (loss) on revaluation of property, plant, equipment	0	**0**	(26,142)	**0**	**(26,142)**
Transfers between reserves	0	81	(81)	0	**0**
Reclassification Adjustments					
Permanent PDC received - cash	19	0	0	0	**19**
Net recognised revenue/(expense) for the year	**19**	**(44,642)**	**(26,223)**	**0**	**(70,846)**
Balance at 31 March 2016	**329,856**	**(126,659)**	**81,133**	**0**	**284,330**
Balance at 1 April 2014	**282,625**	**(34,542)**	**64,598**	**0**	**312,681**
Changes in taxpayers' equity for the year ended 31 March 2015					
Retained surplus/(deficit) for the year	0	(47,493)	0	0	(47,493)
Net gain / (loss) on revaluation of property, plant, equipment	0	0	44,230	0	44,230
Impairments and reversals	0	0	(1,454)	0	(1,454)
Transfers between reserves	0	18	(18)	0	0
Reclassification Adjustments					
New temporary and permanent PDC received - cash	93,212	0	0	0	93,212
New temporary and permanent PDC repaid in year	(46,000)	0	0	0	(46,000)
Net recognised revenue/(expense) for the year	**47,212**	**(47,475)**	**42,758**	**0**	**42,495**
Balance at 31 March 2015	**329,837**	**(82,017)**	**107,356**	**0**	**355,176**

Statement of Cash Flows for the Year ended 31 March 2016

	NOTE	2015-16 £000s	2014-15 £000s
Cash Flows from Operating Activities			
Operating deficit		**(43,272)**	(36,417)
Depreciation and amortisation	5	**31,518**	33,230
Impairments and reversals	14	**19,432**	6,761
Donated Assets received credited to revenue but non-cash	3	**(18)**	(44)
Interest paid		**(1,463)**	(762)
PDC Dividend paid		**(10,349)**	(10,856)
Increase in Inventories		**(4,464)**	(204)
(Increase)/Decrease in Trade and Other Receivables		**(11,222)**	17,711
Increase/(Decrease) in Trade and Other Payables		**20,326**	(9,658)
Provisions utilised		**(681)**	(1,448)
Increase in movement in non cash provisions		**164**	568
Net Cash Inflow/(Outflow) from Operating Activities		**(29)**	(1,119)
Cash Flows from Investing Activities			
Interest Received		**56**	83
Payments for Property, Plant and Equipment		**(40,746)**	(41,480)
Payments for Intangible Assets		**(2,927)**	(3,719)
Net Cash Outflow from Investing Activities		**(43,617)**	(45,116)
Net Cash Outflow before Financing		**(43,646)**	(46,235)
Cash Flows from Financing Activities			
Gross Temporary (2014/15 only) and Permanent PDC Received*		**19**	93,212
Gross Temporary (2014/15 only) and Permanent PDC Repaid		**0**	(46,000)
Loans received from DH - New Capital Investment Loans		**10,000**	12,000
Loans received from DH - New Revenue Support Loans		**66,419**	0
Loans repaid to DH - Capital Investment Loans Repayment of Principal		**(545)**	0
Loans repaid to DH - Working Capital Loans		**(32,319)**	0
Capital Element of Payments in Respect of Finance Leases		**(5,248)**	(4,994)
Net Cash Inflow from Financing Activities		**38,326**	54,218
NET (DECREASE)/INCREASE IN CASH AND CASH EQUIVALENTS		**(5,320)**	7,983
Cash and Cash Equivalents at Beginning of the Period		**8,498**	515
Cash and Cash Equivalents at year end	**19**	**3,178**	8,498

We received the following external financing in the year:

- £19k PDC for an ultrasound scanner for Maternity Services.
- £34,100k revenue Support Loan to fund our deficit.
- £10,000k Capital Investment Loan to fund our new Emergency Floor.

The £32,319k repaid to DH relates to short term financing drawn down in the year which we utilised prior to the receipt of our Revenue Support Loan.

We repaid £545k of a £12,000k capital loan which was received in 2014-15 to fund essential investment in our hospital buildings.

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 2015-16 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 SOCI, and is disclosed separately from operating costs.

Other transfers of assets and liabilities within the Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

1.4 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 22.

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 1.8.

NOTES TO THE ACCOUNTS

Notes to the Accounts - 1. Accounting Policies (Continued)

1.5 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.

1.6 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.

1.7 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.

NOTES TO THE ACCOUNTS

Notes to the Accounts - 1. Accounting Policies (Continued)

1.8 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 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.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

● Land and non-specialised buildings – market value for existing use

● Specialised buildings – depreciated replacement cost

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. 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. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

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.

NOTES TO THE ACCOUNTS

Notes to the Accounts - 1. Accounting Policies (Continued)

1.9 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 £5000.

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.

1.10 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.

1.11 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.

1.12 Government grants
Government grant funded assets are capitalised at their fair value on receipt, with a matching credit to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

NOTES TO THE ACCOUNTS

Notes to the Accounts - 1. Accounting Policies (Continued)

1.13 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.

1.14 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 lessee

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.

NOTES TO THE ACCOUNTS

1.15 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.

1.16 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.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the NHS trust's cash management.

1.17 Provisions

Provisions are recognised when the NHS trust has a present legal or constructive obligation as a result of a past event, it is probable that the NHS trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate of 1.37% in real terms.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

A restructuring provision is recognised when the Trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

NOTES TO THE ACCOUNTS

Notes to the Accounts - 1. Accounting Policies (Continued)

1.18 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the NHS Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at Note 24. relevant contingent liabilities are shown in note 25.

1.19 Non-clinical risk pooling

The NHS Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the NHS trust pays an annual contribution to the NHS Litigation Authority and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.20 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.

1.21 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.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the NHS trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

1.22 Financial assets

Financial assets are recognised when the NHS trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories: financial assets at fair value through profit and loss; held to maturity investments; available for sale financial assets, and loans and receivables. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

Financial assets at fair value through profit and loss

The Trust does not hold any financial assets at fair value through profit and loss.

Held to maturity investments

The Trust does not hold any held to maturity investments.

Available for sale financial assets

The Trust does not categorise any of its assets as available for sale.

NOTES TO THE ACCOUNTS

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.

1.23 Financial liabilities
Financial liabilities are recognised on the statement of financial position when the NHS Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Loans from the Department of Health are recognised at historical cost. Otherwise, financial liabilities are initially recognised at fair value.

Financial liabilities at fair value through profit and loss
The Trust does not hold any financial assets at fair value through profit and loss.

Other financial liabilities
After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.24 Value Added Tax
Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.25 Foreign currencies
The Trust's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the trust's surplus/deficit in the period in which they arise.

NOTES TO THE ACCOUNTS

Notes to the Accounts - 1. Accounting Policies (Continued)

1.26 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 31 to the accounts.

1.27 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.

In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.28 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).

1.29 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 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.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.30 Accounting Standards that have been issued but have not yet been adopted

The HM Treasury FReM does not require the following Standards and Interpretations to be applied in 2015-16. These standards are still subject to HM Treasury FReM interpretation, with IFRS 9 and IFRS 15 being for implementation in 2018-19, and the government implementation date for IFRS 16 still subject to HM Treasury consideration.

- IFRS 9 *Financial Instruments* – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 15 *Revenue for Contracts with Customers* - Application required for accounting periods beginning on or after 1 January 2017, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 16 *Leases* – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.

2. Revenue from patient care activities

	2015-16 £000s	2014-15 £000s
NHS Trusts	**119**	0
NHS England	**242,171**	229,319
Clinical Commissioning Groups	**492,421**	476,018
Foundation Trusts	**686**	719
NHS Other (including Public Health England and NHS Property Services)	**1,414**	635
Non-NHS:		
Local Authorities	**166**	145
Private patients	**3,038**	2,806
Overseas patients (non-reciprocal)	**1,089**	1,154
Injury costs recovery	**1,645**	1,466
Other	**1,509**	1,269
Total Revenue from patient care activities	**744,258**	713,531

'Non-NHS: Other' includes £1,189k income from health bodies in Wales, Scotland and Northern Ireland (2014-15 - £724k).

3. Other operating revenue

	2015-16 £000s	2014-15 £000s
Recoveries in respect of employee benefits	**9,331**	9,134
Education, training and research	**84,616**	86,241
Receipt of donations for capital acquisitions - Charity	**374**	576
Non-patient care services to other bodies	**7,237**	8,691
Rental revenue from operating leases	**8,521**	8,391
Other revenue	**11,699**	7,812
Total Other Operating Revenue	**121,778**	120,845
Total operating revenue	**866,036**	834,376

Rental revenue from operating leases includes £7.6m of income (2014-15 - £7.6m) from our facilities management service provider, Interserve plc, in relation to car parking and catering. In accordance with International Financial Reporting Standards, we classify these income elements as operating lease income.

Interserve plc and the Trust have agreed that the current contract to provide estates and facilities management services will end on 30th April 2016, from which point the Trust will be responsible for delivering these services. Following the cessation of this contract the income from catering and car parking will be received directly by the Trust rather than being included within operating lease income.

4. Overseas Visitors Disclosure

	2015-16 £000	2014-15 £000s
Income recognised during 2015-16 (invoiced amounts and accruals)	**1,089**	1,154
Cash payments received in-year (relating to receivables at 31 March 2015)	**261**	96
Cash payments received in-year (relating to invoices issued 2014-15)	**130**	487
Amounts added to provision for impairment of receivables (relating to receivables at 31 March 2014)	**131**	46
Amounts added to provision for impairment of receivables (relating to invoices issued 2014-15)	**112**	171
Amounts written off in-year (irrespective of year of recognition)	**183**	567

5. Operating expenses

	2015-16 £000s	2014-15 £000s
Services from other NHS Trusts	**2,956**	3,529
Services from other NHS bodies	**205**	107
Services from NHS Foundation Trusts	**2,619**	2,010
Total Services from NHS bodies*	**5,780**	5,646
Purchase of healthcare from non-NHS bodies	**7,724**	8,998
Trust Chair and Non-executive Directors	**87**	79
Supplies and services - clinical	**199,321**	181,931
Supplies and services - general	**26,035**	25,950
Consultancy services	**3,961**	4,707
Establishment	**6,164**	8,003
Transport	**3,064**	2,982
Business rates paid to local authorities*	**3,378**	
Premises	**38,687**	42,555
Insurance	**54**	19
Legal Fees	**743**	608
Impairments and Reversals of Receivables	**(34)**	614
Depreciation	**28,631**	30,447
Amortisation	**2,887**	2,783
Impairments and reversals of property, plant and equipment	**10,392**	6,761
Internal Audit Fees*	**153**	
Audit fees	**151**	209
Other auditor's remuneration	**16**	0
Clinical negligence	**17,076**	17,562
Research and development (excluding staff costs)	**23,147**	24,569
Education and Training	**1,333**	1,030
Other	**3,144**	8,062
Total Operating expenses (excluding employee benefits)	**381,894**	373,515
Employee Benefits		
Employee benefits excluding Board members	**517,437**	496,288
Board members	**937**	990
Total Employee Benefits	**518,374**	497,278
Total Operating Expenses	**900,268**	870,793

*New expenditure categories in 2015-16. These costs were included within Premises in 2014-15.

Services from NHS bodies does not include expenditure which falls into a category below it in the table.

Supplies and services - clinical includes £91,644k expenditure on drugs (2014-15 - £79,461k).

Establishment costs include printing, stationery, postage and telephone costs.

The Trust has incurred non-material expenditure in 2015-16 in relation to the early cessation of the Interserve facilities management contract.

6. Operating Leases

Of the total minimum lease payments for 2015-16, £4,604k (2014-15 - £4,400k) relates to external 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 in Northamptonshire and Lincolnshire.

6.1. University Hospitals of Leicester NHS Trust as lessee

	Land £000s	Buildings £000s	Other £000s	2015-16 Total £000s	2014-15 £000s
Payments recognised as an expense					
Minimum lease payments				**5,877**	5,670
Total				**5,877**	5,670
Future operating lease expenditure					
No later than one year	0	0	4,418	**4,418**	5,657
Between one and five years	0	0	8,911	**8,911**	8,063
After five years	0	0	169	**169**	306
Total	**0**	**0**	**13,498**	**13,498**	14,026

6.2. University Hospitals of Leicester NHS Trust as lessor

	2015-16 £000	2014-15 £000s
Recognised as revenue		
Rental revenue	8,521	8,391
Total	**8,521**	8,391
Future operating lease revenue		
No later than one year	1,063	7,841
Between one and five years	11	29,233
Total	**1,074**	37,074

Future operating lease revenue between one and five years has reduced due to the impact of the Interserve plc facilities management contract ending in April 2016. In future, income from these services will be received directly by the Trust.

7. Employee benefits and staff numbers

7.1. Employee benefits

	Total	**2015-16 Permanently employed**	**Other**
	£000s	**£000s**	**£000s**
Employee Benefits - Gross Expenditure			
Salaries and wages	**443,261**	408,405	34,856
Social security costs	**30,780**	30,780	0
Employer Contributions to NHS BSA - Pensions Division	**46,571**	46,571	0
Other pension costs	**20**	20	0
Termination benefits	**44**	44	0
Total employee benefits	**520,676**	**485,820**	**34,856**
Employee costs capitalised	**2,302**	842	1,460
Gross Employee Benefits excluding capitalised costs	**518,374**	**484,978**	**33,396**

Employee Benefits - Gross Expenditure (prior year)	Total	2014-15 Permanently employed	Other
	£000s	£000s	£000s
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 - including capitalised costs	498,148	476,892	21,256
Employee costs capitalised	870	477	393
Gross Employee Benefits excluding capitalised costs	497,278	476,415	20,863

Bank staff costs of £6,966k (2014-15 - £5,771k) are included within the 'permanently employed' category in the above note in accordance with Department of Health Guidance.

7.2. Staff Numbers

	2015-16			2014-15
	Total	**Permanently employed**	**Other**	Total
	Number	**Number**	**Number**	Number
Average Staff Numbers				
Medical and dental	**1,607**	1,294	313	1,582
Ambulance staff	**4**	3	1	0
Administration and estates	**2,010**	1,915	95	1,881
Healthcare assistants and other support staff	**322**	278	44	535
Nursing, midwifery and health visiting staff	**3,578**	3,457	121	3,393
Nursing, midwifery and health visiting learners	**1,645**	1,645	0	1,502
Scientific, therapeutic and technical staff	**1,657**	1,632	25	1,616
Social Care Staff	**0**	0	0	2
Other	**209**	178	31	199
TOTAL	**11,032**	**10,402**	**630**	10,710
Of the above - staff engaged on capital projects	**21**	14	7	12

7.3. Staff Sickness absence and ill health retirements

	2015-16 Number	2014-15 Number
Total Days Lost	87,347	86,777
Total Staff Years	10,664	10,433
Average working Days Lost	8.19	8.32

	2015-16 Number	2014-15 Number
Number of persons retired early on ill health grounds	**7**	11
	£000s	£000s
Total additional pensions liabilities accrued in the year	**288**	425

7.4. Exit Packages agreed in 2015-16

2015-16

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	£s	Number	£s	Number	£
Less than £10,000	1	0	0	0	**1**	**0**	0	0
£25,001-£50,000	1	43,710	0	0	**1**	**43,710**	0	0
Total	**2**	**43,710**	**0**	**0**	**2**	**43,710**	**0**	**0**

2014-15

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	£s	Number	£s	Number	£
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
Total	**6**	**196,392**	**57**	**919,805**	**63**	**1,116,197**	**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 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.

This disclosure reports the number and value of exit packages agreed in the year. The expense associated with these departures may have been recognised in part or in full in a previous period.

7.5. Exit packages - Other Departures analysis

	2015-16		2014-15	
	Agreements	Total value of agreements	Agreements	Total value of agreements
	Number	£000s	Number	£000s
Mutually agreed resignations (MARS) contractual costs	0	0	57	920
Total	0	0	57	920
Non-contractual payments made to individuals where the payment value was more than 12 months of their annual salary	0	0	0	0

7.6. Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are 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, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2016, is based on valuation data as 31 March 2015, updated to 31 March 2016 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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) Pension Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account their recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.

The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

8. Better Payment Practice Code

8.1. Measure of compliance

	2015-16 Number	2015-16 £000s	2014-15 Number	2014-15 £000s
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**125,692**	**544,043**	143,784	484,649
Total Non-NHS Trade Invoices Paid Within Target	**72,708**	**416,673**	76,193	329,077
Percentage of NHS Trade Invoices Paid Within Target	**57.85%**	**76.59%**	52.99%	67.90%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**5,130**	**96,952**	4,776	**180,233**
Total NHS Trade Invoices Paid Within Target	**2,381**	**75,903**	2,446	**137,859**
Percentage of NHS Trade Invoices Paid Within Target	**46.41%**	**78.29%**	51.21%	76.49%

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. Although the Trust has been in receipt of cash support in 2015-16 we have not been able to achieve compliance due to a number of factors, including the timing of external cash receipts and other operational issues that have resulted in delays to payments. The Trust has made year on year improvements in its performance and remains committed to achieving this standard and has made significant progress to date in correcting its operational issues.

8.2. The Late Payment of Commercial Debts (Interest) Act 1998

	2015-16 £000s	2014-15 £000s
Amounts included in finance costs from claims made under this legislation	**5**	0
Total	**5**	0

9. Investment Revenue

	2015-16 £000s	2014-15 £000s
Interest revenue		
Bank interest	**56**	83
Total investment revenue	**56**	83

10. Other Gains and Losses

	2015-16 £000s	2014-15 £000s
Gain/(Loss) on disposal of assets other than by sale (PPE)	**(16)**	9
Total	**(16)**	9

11. Finance Costs

	2015-16 £000s	2014-15 £000s
Interest		
Interest on loans	**1,000**	10
Interest on obligations under finance leases	**458**	762
Interest on late payment of commercial debt	**5**	0
Total interest expense	**1,463**	772
Provisions - unwinding of discount	**26**	27
Total	**1,489**	799

Interest has been incurred on the following loans:

Interim revolving working capital facility (3.5% interest rate)	635	0
Interim revenue support loan (1.5% interest rate)	107	0
Interim capital support loans (2.11% interest rate)	258	10
Total	**1,000**	**10**

12.1. Property, plant and equipment

2015-16

	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 2015	47,245	296,009	8,193	15,248	145,786	150	56,964	2,187	**580,980**
Additions of Assets Under Construction				19,872					**19,872**
Additions Purchased	0	13,181	115		4,716	24	2,635	9	**20,680**
Additions - Non Cash Donations (i.e. physical assets)	0	0	0	0	18	0	0	0	**18**
Additions - Purchases from Cash Donations & Government Grants	0	163	0	0	190	0	2	0	**355**
Additions Leased (including PFI/LIFT)	0	0	0		1,705	0	0	0	**1,705**
Reclassifications	0	1,043	0	(3,889)	0	0	2,568	0	**(278)**
Disposals other than for sale	0	0	0	0	(3,420)	(18)	(73)	(36)	**(3,547)**
Revaluation	(3,666)	(44,762)	(126)	0	0	0	0	0	**(48,554)**
Impairment/reversals charged to operating expenses	(1,501)	(8,891)	0	0	0	0	0	0	**(10,392)**
At 31 March 2016	**42,078**	**256,743**	**8,182**	**31,231**	**148,995**	**156**	**62,096**	**2,160**	**560,839**
Depreciation									
At 1 April 2015	0	6,942	210		99,115	102	49,594	1,626	**166,787**
Disposals other than for sale	0	0	0		(3,400)	(16)	(73)	(36)	**(3,525)**
Revaluation	0	(21,779)	(633)		0	0	0	0	**(22,412)**
Charged During the Year	0	14,859	422		10,351	16	2,903	80	**28,631**
At 31 March 2016	**0**	**22**	**(1)**	**0**	**106,066**	**102**	**52,424**	**1,670**	**169,481**
Net Book Value at 31 March 2016	**42,078**	**256,721**	**8,183**	**31,231**	**42,929**	**54**	**9,672**	**490**	**391,358**
Asset financing:									
Owned - Purchased	42,078	250,122	8,183	31,231	24,012	29	9,452	403	**365,510**
Owned - Donated	0	5,884	0	0	1,082	25	48	87	**7,126**
Owned - Government Granted	0	715	0	0	0	0	0	0	**715**
Held on finance lease	0	0	0	0	17,835	0	172	0	**18,007**
Total at 31 March 2016	**42,078**	**256,721**	**8,183**	**31,231**	**42,929**	**54**	**9,672**	**490**	**391,358**

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 2015	12,755	87,380	7,219	0	1	0	0	0	**107,355**
Movements (specify)	(3,665)	(22,982)	507	0	0	0	0	0	**(26,140)**
At 31 March 2016	**9,090**	**64,398**	**7,726**	**0**	**1**	**0**	**0**	**0**	**81,215**

Additions to Assets Under Construction in 2014-15

Land	0
Buildings excl Dwellings	16,156
Dwellings	0
Plant & Machinery	3,716
Balance as at YTD	**19,872**

12.2. Property, plant and equipment prior-year

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 (including PFI/LIFT)	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)**
Revaluation	123	(1,555)	(149)	0	0	0	0	0	**(1,581)**
Impairments/negative indexation charged to reserves	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)**
Revaluation	0	(44,748)	(1,063)		0	0	0	0	**(45,811)**
Impairments/negative indexation charged to operating expenses	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**

12.3. (cont). Property, plant and equipment

Donated assets

The majority of donated assets have been purchased on behalf of the Trust by the Leicester Hospitals Charity.

Asset revaluation

The Trust has revalued its assets with an effective date of revaluation of 31st March 2016.

The Trust's freehold and leasehold property values were updated 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, the International Valuation Standards and IFRS.

The valuation has been prepared in accordance with the Government Financial Reporting Manual (FReM) to comply with IFRS, specifically with regard to IAS 16 'Property, Plant and Equipment' and IAS 40 'Investment Properties'.

The valuer's opinion of Fair Value was primarily derived using the Depreciated Replacement Cost approach to value the service potential, on a Modern Equivalent Asset (MEA) basis. The MEA valuation was based on the Trust's estates strategy, which outlines a five year major reconfiguration for the Trust's estate, and which effectively defines the Modern Equivalent Asset for the valuation.

Our estates strategy is consistent with our clinical strategy and both strategies are intrinsically linked as we must reconfigure our estate in order to deliver our clinical strategy. We provided our estates strategy to Gerald Eve LLP to enable them to provide a more accurate MEA valuation based on our actual plans and future Trust configuration.

As a result of this valuation we have incurred an impairment charge of £10,392k, which is included within Other Operating Costs in the SOCI and is also disclosed in Note 14. This figure is removed from the Adjusted Retained Deficit figure in accordance with Department of Health (DH) Accounting guidance.

Our revaluation reserve has also been reduced in value by £26,142k as a result of the revaluation. The total reduction in our asset valuation is £36,534k.

The reduction in the value of our assets has contributed to a reduction of £1,327k in PDC dividends payable for 2015-16.

Gross carrying value of fully depreciated assets in use at the balance sheet date

	31 March 2016	31 March 2015
	£000	£000
Plant & Machinery (Purchased)	**54,835**	51,898
Plant & Machinery (Donated)	**5,648**	5,442
Transport Equipment (Purchased)	**55**	46
Tangible IM&T (Purchased)	**45,300**	44,067
Tangible IM&T (Donated)	**134**	132
Intangible IM&T (Purchased)	**7,864**	6,019
Intangible IM&T (Donated)	**14**	14
Furniture & Fittings (Purchased)	**1,427**	1,463
Furniture & Fittings (Donated)	**71**	71
	115,348	109,152

Economic Lives of Non-Current Assets

	Min Life Years	**Max Life Years**
Property, Plant and Equipment		
Buildings exc Dwellings	5	62
Dwellings	19	22
Plant & Machinery	0	7
Transport Equipment	0	7
Information Technology	0	7
Furniture and Fittings	0	7

13. Intangible non-current assets

13.1. Intangible non-current assets

	2015-16					
	IT - in-house & 3rd party software	**Computer Licenses**	**Licenses and Trademarks**	**Patents**	**Development Expenditure - Internally Generated**	**Total**
	£000's	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**
At 1 April 2015	**0**	**20,975**	**0**	**0**	**0**	**20,975**
Additions Purchased	0	2,927	0	0	0	**2,927**
Reclassifications	0	278	0	0	0	**278**
At 31 March 2016	**0**	**24,180**	**0**	**0**	**0**	**24,180**
Amortisation						
At 1 April 2015	**0**	**10,841**	**0**	**0**	**0**	**10,841**
Charged During the Year	0	2,887	0	0	0	**2,887**
At 31 March 2016	**0**	**13,728**	**0**	**0**	**0**	**13,728**
Net Book Value at 31 March 2016	**0**	**10,452**	**0**	**0**	**0**	**10,452**
Asset Financing: Net book value at 31 March 2016 comprises:						
Purchased	0	10,452	0	0	0	**10,452**
Total at 31 March 2016	**0**	**10,452**	**0**	**0**	**0**	**10,452**

13.2. Intangible non-current assets prior year

	2014-15					
	IT - in-house & 3rd party software	Computer Licenses	Licenses and Trademarks	Patents	Development Expenditure - Internally Generated	Total
	£000's	£000's	£000's	£000's	£000's	£000's
Cost or valuation:						
At 1 April 2014	0	16,101	0	0	0	16,101
Additions - purchased	0	3,848	0	0	0	3,848
Reclassifications	0	1,050	0	0	0	1,050
Disposals other than by sale	0	(24)	0	0	0	(24)
At 31 March 2015	0	20,975	0	0	0	20,975
Amortisation						
At 1 April 2014	0	8,082	0	0	0	8,082
Disposals other than by sale	0	(24)	0	0	0	(24)
Charged during the year	0	2,783	0	0	0	2,783
At 31 March 2015	0	10,841	0	0	0	10,841
Net book value at 31 March 2015	0	10,134	0	0	0	10,134
Total at 31 March 2015	0	0	0	0	0	0

13.3. Intangible non-current 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

All of the Trust's intangible assets are amortised up to a maximum of 6 years and are not subject to revaluation.

None of the Trust's intangible assets have been acquired by government grant.

The Trust has £7,878k of fully amortised intangible assets still in use.

The Trust has no significant intangible assets which it does not recognise as assets under IAS 38 Intangible Assets.

The Trust has no revaluation reserve balances for intangible assets.

The Trust has no material impairments for any individual intangible assets.

	Total £000s
Property, Plant and Equipment impairments and reversals taken to SoCI	
Changes in market price	10,392
Total charged to Annually Managed Expenditure	**10,392**
Total Impairments of Property, Plant and Equipment changed to SoCI	**10,392**
Total Impairments charged to SoCI - AME	**10,392**
Overall Total Impairments	**10,392**

14. Analysis of impairments and reversals recognised in 2015-16

	Property Plant and Equipment	**Intangible Assets**	**Financial Assets**	**Non-Current Assets Held for Sale**	**Total**
	£000s	£000s	£000s	£000s	**£000s**
Impairments and reversals taken to SoCI					
Changes in market price	10,392	0	0	0	**10,392**
Total charged to Annually Managed Expenditure	**10,392**	**0**	**0**	**0**	**10,392**
Total Impairments of Property, Plant and Equipment changed to SoCI	**10,392**	**0**	**0**	**0**	**10,392**

There are no donated and government granted assets included above. See note 12.3 for full details of the revaluation of our fixed assets..

15. Commitments

15.1. Capital commitments

Contracted capital commitments at 31 March not otherwise included in these financial statements:

	31 March 2016	31 March 2015
	£000s	£000s
Property, plant and equipment	**35,044**	12,335
Intangible assets	**3,090**	0
Total	**38,134**	12,335

Capital commitments for 2015-16 include £20,589k in relation to the Emergency Floor redevelopment.

16. 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	702	0	9,795	0
Balances with Local Authorities	440	0	86	0
Balances with NHS bodies inside the Departmental Group	26,820	0	16,065	55,010
Balances with Bodies External to Government	17,144	2,727	99,899	3,930
At 31 March 2016	**45,106**	**2,727**	**125,845**	**58,940**
Prior period:				
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**

17. Inventories

	Drugs	Consumables	Energy	Loan Equipment	Other	Total	Of which held at NRV
	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2015	**3,392**	**10,603**	**146**	**0**	**0**	**14,141**	10,603
Additions	71,317	33,727	41	0	0	**105,085**	33,727
Inventories recognised as an expense in the period	(71,113)	(29,363)	(145)	0	0	**(100,621)**	(29,363)
Balance at 31 March 2016	**3,596**	**14,967**	**42**	**0**	**0**	**18,605**	**14,967**

18.1. Trade and other receivables

	Current		Non-current	
	31 March 2016	31 March 2015	**31 March 2016**	31 March 2015
	£000s	£000s	**£000s**	£000s
NHS receivables - revenue	**25,351**	18,703	**0**	0
Non-NHS receivables - revenue	**13,097**	10,093	**3,242**	2,915
Non-NHS prepayments and accrued income	**3,068**	2,601	**372**	403
PDC Dividend prepaid to DH	**1,307**	530	**0**	0
Provision for the impairment of receivables	**(764)**	(1,298)	**(887)**	(616)
VAT	**2,622**	1,973	**0**	0
Other receivables	**425**	0	**0**	0
Total	**45,106**	32,602	**2,727**	2,702
Total current and non current	**47,833**	35,304		
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.

18.2. Receivables past their due date but not impaired

	31 March 2016	31 March 2015
	£000s	£000s
By up to three months	**3,074**	2,315
By three to six months	**809**	484
By more than six months	**1,156**	440
Total	**5,039**	3,239

18.3. Provision for impairment of receivables

	2015-16 £000s	2014-15 £000s
Balance at 1 April 2015	**(1,914)**	(1,805)
Amount written off during the year	**229**	505
Amount recovered during the year	**553**	376
(Increase)/decrease in receivables impaired	**(519)**	(990)
Balance at 31 March 2016	**(1,651)**	(1,914)

We have changed our methodology for calculating this provision from the 'expected loss' model to the 'incurred loss model' as required by International Accounting Standard (IAS) 9. We now provide for the impairment of receivables based on a past event rather than generally applying percentages to gross debtor values. The percentage used to calculate the provision for impairment of Injury Cost Recovery debt has increased from 18.9% to 21.99% in 2015-16.

19. Cash and Cash Equivalents

	31 March 2016 £000s	31 March 2015 £000s
Opening balance	**8,498**	515
Net change in year	**(5,320)**	(7,983)
Closing balance	**3,178**	8,498
Made up of		
Cash with Government Banking Service	**3,163**	8,490
Cash in hand	**15**	8
Cash and cash equivalents as in statement of financial position	**3,178**	8,498
Cash and cash equivalents as in statement of cash flows	**3,178**	8,498
Third Party Assets - patients monies	**3**	7

Our year end cash balance is not materially different to the planned balance. Cash was higher at the end of 2014-15 due to the late drawdown of a capital loan.

20. Trade and other payables

	Current		Non-current	
	31 March 2016 £000s	31 March 2015 £000s	**31 March 2016 £000s**	31 March 2015 £000s
NHS payables - revenue	**9,502**	8,116	**0**	0
NHS accruals and deferred income	**5,889**	3,017	**0**	0
Non-NHS payables - revenue	**43,305**	21,312	**0**	0
Non-NHS payables - capital	**14,052**	13,897	**0**	0
Non-NHS accruals and deferred income	**31,368**	36,632	**0**	0
Social security costs	**4,740**	4,575		
Accrued Interest on DH Loans	**126**	0		
Tax	**5,054**	5,030		
Other	**6,949**	7,925	**0**	0
Total	**120,985**	100,504	**0**	0
Total payables (current and non-current)	**120,985**	**100,504**		
Included above:				
Outstanding Pension Contributions at the year end	**6,404**	6,135		

21. Borrowings

	Current		Non-current	
	31 March 2016	31 March 2015	**31 March 2016**	31 March 2015
	£000s	£000s	**£000s**	£000s
Loans from Department of Health	**545**	545	**55,010**	11,455
Finance lease liabilities	**4,315**	4,919	**3,930**	6,869
Total	**4,860**	**5,464**	**58,940**	**18,324**
Total borrowings (current and non-current)	**63,800**	**23,788**		

The balance of Loans from the Department of Health is comprised of

Interim revenue support loan (next repayment due Aug 2017)	0		34,100
Interim capital support loan (next repayment due Sept 2016)	545		20,910
Total	**545**		**55,010**

Within the year the Trust was in receipt of a £34,100k interim revenue support loan to fund its deficit. The prior year deficit was funded via PDC, which is not disclosed in the above note.

Borrowings / Loans - repayment of principal falling due in:

	31 March 2016		
	DH	**Other**	**Total**
	£000s	**£000s**	**£000s**
0-1 Years	545	4,314	**4,859**
1 - 2 Years	945	357	**1,302**
2 - 5 Years	36,935	1,072	**38,007**
Over 5 Years	17,130	2,502	**19,632**
TOTAL	**55,555**	**8,245**	**63,800**

22. Deferred income

	Current		Non-current	
	31 March 2016	31 March 2015	**31 March 2016**	31 March 2015
	£000s	£000s	**£000s**	£000s
Opening balance at 1 April 2015	**13,566**	13,906	**0**	0
Deferred revenue addition	**1,609**	2,179	**0**	0
Transfer of deferred revenue	**(2,031)**	(2,519)	**0**	0
Current deferred Income at 31 March 2016	**13,144**	13,566	**0**	0
Total deferred income (current and non-current)	**13,144**	13,566		

23. 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

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 lease payments**	
	31 March 2016 £000s	31 March 2015 £000s	**31 March 2016 £000s**	31 March 2015 £000s
Within one year	**4,315**	4,919	**4,315**	4,919
Between one and five years	**1,559**	2,724	**1,429**	2,498
After five years	**3,301**	5,770	**2,501**	4,371
Less future finance charges	(930)	(1,625)		
Minimum Lease Payments / Present value of minimum lease payments	**8,245**	11,788	**8,245**	11,788
Included in:				
Current borrowings			**4,315**	4,919
Non-current borrowings			**3,930**	6,869
			8,245	11,788

24. Provisions

	Total	Comprising: Early Departure Costs	Other	Redundancy
	£000s	£000s	£000s	£000s
Balance at 1 April 2015	**2,802**	1,505	1,136	161
Arising during the year	**281**	48	233	0
Utilised during the year	**(681)**	(221)	(412)	(48)
Reversed unused	**(117)**	0	(4)	(113)
Unwinding of discount	**26**	18	8	0
Balance at 31 March 2016	**2,311**	**1,350**	**961**	**0**
Expected Timing of Cash Flows:	**£000s**	**£000s**	**£000s**	**£000s**
No Later than One Year	**633**	221	412	0
Later than One Year and not later than Five Years	**1,431**	882	549	0
Later than Five Years	**247**	247	0	0

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:

	£000s
As at 31 March 2016	251,499
As at 31 March 2015	148,371

Other provisions includes £263k for employer and public liability cases as notified to us by the NHS Litigation Authority; £594k permanent injury benefits and £104k for potential litigation or employment tribunals.

25. Contingencies

	31 March 2016 £000s	31 March 2015 £000s
Contingent liabilities		
Other	**(165)**	(128)
Net value of contingent liabilities	**(165)**	(128)

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 2016-17. Provisions for these are also included at note 24.

The Trust has reached an agreement with Interserve plc for the early cessation of the facilities management contract. As a result of this, a sum has been agreed for the purchase of assets operated by Interserve and this will be transacted on the 1st May 2016.

26. Financial Instruments

26.1. 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.

26.2. Financial Assets

	At 'fair value through profit and loss'	Loans and receivables	Available for sale	Total
	£000s	£000s	£000s	£000s
Receivables - NHS		8,598		**7,213**
Receivables - non-NHS		10,381		**10,381**
Cash at bank and in hand		3,178		**3,178**
Total at 31 March 2016	**0**	**20,772**	**0**	**20,772**
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	0	29,497	0	29,497

26.3. Financial Liabilities

	At 'fair value through profit and loss'	Other	Total
			£000s
NHS payables		3,731	**3,731**
Non-NHS payables		34,950	**34,950**
Other borrowings		55,555	**55,555**
Total at 31 March 2016	**0**	**94,236**	**94,236**
NHS payables		2,087	2,087
Non-NHS payables		16,828	16,828
Other borrowings		12,000	12,000
Total at 31 March 2015	0	30,915	30,915

27. 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.

On 1st May 2016 the Trust took responsibility for facilities management services provided by Interserve Facilities Management to it, Leicester Partnership Trust and NHS Property Services since March 2013. This followed a Deed of Settlement, Early Contract Expiry and Release agreed between these parties on 8th February 2016. There are no adjusting items as all transactions have been appropriately accounted for in the correct year. There are no outstanding payments between the parties other than those arising through the normal course of business. The Trust will be purchasing fixed assets of £1,625k from Interserve in May which are necessary for the continuation of the services. There was a TUPE transfer of more than 1,000 staff from Interserve to the Trust on the 1st May.

28. 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.

Mr K Singh, Trust Chairman, has a family member who is a Partner with Lakeside Healthcare. During the reporting year, the Trust made payments to Lakeside Healthcare amounting to £1,456k.

The Trust has outstanding loans totalling £55,555k at the 31 March 2016 issued by the Secretary of State for Health.

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

CLINICAL COMMISSIONING GROUPS

Cambridgeshire And Peterborough CCG
Corby CCG
Coventry And Rugby CCG
East Leicestershire And Rutland CCG
East Staffordshire CCG
Leicester City CCG
Lincolnshire East CCG
Lincolnshire West CCG
Nene CCG
Newark & Sherwood CCG
Nottingham City CCG
Rushcliffe CCG
South East Staffs And Seisdon Peninsular CCG
South Lincolnshire CCG
South West Lincolnshire CCG
Southern Derbyshire CCG
Warwickshire North CCG
West Leicestershire CCG

NHS TRUSTS

George Eliot NHS Trust
Leicestershire Partnership NHS Trust
Northampton General Hospital NHS Trust
Nottingham University Hospitals NHS Trust
Staffordshire and Stoke on Trent Partnership NHS Trust
United Lincolnshire Hospitals NHS Trust
University Hospitals of Coventry and Warwickshire NHS Trust

NHS FOUNDATION TRUSTS

Burton Hospitals NHS Foundation Trust
Chesterfield Royal Hospital NHS Foundation Trust
Derby Teaching Hospitals NHS Foundation Trust
Derbyshire Healthcare NHS Foundation Trust
Kettering General Hospital NHS Foundation Trust
Lincolnshire Partnership NHS Foundation Trust
Northamptonshire Healthcare NHS Foundation Trust
Nottinghamshire Healthcare NHS Foundation Trust
Oxford Health NHS Foundation Trust
Peterborough & Stamford Hospitals NHS Foundation Trust
Sherwood Forest Hospitals NHS Foundation Trust

OTHER

Central Midlands Commissioning Hub
Central Midlands Local Office
Health Education England
National Health Service Pension Scheme
NHS Blood and Transplant
NHS England
NHS Litigation Authority
NHS Property Services
NHS Supply Chain
North Midlands Local Office
Public Health England

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
Leicestershire County Council
HM Revenue and Customs
Leicester City Council
Welsh Assembly Government

University of Leicester:

During the reporting year, the Trust made payments to the University of Leicester amounting to £11,949k (2014-15 - £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 2016 a sum of £308k (2014-15 - £491k) is included in creditors in respect of the University of Leicester. The University paid us £5,447k (2014-15 - £5,585k) in the year, relating primarily to research work, and £1,426k (2014-15 - £1,714k) was included within debtors at 31st March 2016.

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 £355k (£575k in 2014-15). Full details will be included in the Charity's accounts as submitted to the Charity Commission.

29. Losses and special payments

The total number of losses cases in 2015-16 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses	213,318	402
Special payments	156,906	122
Total losses and special payments	370,224	524

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

30. 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.

30.1. Breakeven performance

	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	2015-16 £000s
Turnover	588,666	615,155	652,159	697,692	696,257	719,154	758,665	770,393	834,376	**866,036**
Retained surplus/(deficit) for the year	61	577	3,018	(3,992)	(2,542)	(27,985)	1,177	(39,514)	(47,493)	**(53,763)**
Adjustment for:										
Timing/non-cash impacting distortions:										
Pre FDL(97)24 agreements	0	0	0	0	0	0	0	0	0	**0**
2007/08 PPA (relating to 1997/98 to 2006/07)	0									
2008/09 PPA (relating to 1997/98 to 2007/08)	0	0								
Adjustments for impairments			0	4,043	3,555	28,073	0	0	6,761	**19,432**
Adjustments for impact of policy change re donated/government grants assets						0	(1,086)	(141)	84	**280**
Consolidated Budgetary Guidance - adjustment for dual accounting under IFRIC12*				0	0	0	0	0	0	**0**
Absorption accounting adjustment							0	0	0	**0**
Other agreed adjustments	0	0	0	0	0	0	**0**	0	0	**0**
Break-even in-year position	**61**	**577**	**3,018**	**51**	**1,013**	**88**	**91**	**(39,655)**	**(40,648)**	**(34,051)**
Break-even cumulative position	**315**	**892**	**3,910**	**3,961**	**4,974**	**5,062**	**5,153**	**(34,502)**	**(75,150)**	**(109,201)**

* Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10, the Trust'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.

	2006-07 %	2007-08 %	2008-09 %	2009-10 %	2010-11 %	2011-12 %	2012-13 %	2013-14 %	2014-15 %	2015-16 %
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	0.09	0.46	0.01	0.15	0.01	0.01	-5.15	0.00	**-3.93**
Break-even cumulative position as a percentage of turnover	0.05	0.15	0.60	0.57	0.71	0.70	0.68	-4.48	0.00	**-12.61**

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.

The Trust has produced a recovery plan to achieve a balanced financial position by 2019-20. Given the size of the expected cumulative deficit for 2015-16 the recovery plan does not guarantee a cumulative break even position within three years, rather that the Trust will be recurrently delivering an in-year break even position within that timescale.

30.2. Capital cost absorption rate

The dividend payable on public dividend capital is based on the actual (rather than forecast) average relevant net assets based on the pre audited accounts and therefore the actual capital cost absorption rate is automatically 3.5%.

30.3. External financing

The Trust is given an external financing limit which it is permitted to undershoot.

	2015-16 £000s	2014-15 £000s
External financing limit (EFL)	**49,260**	50,315
Cash flow financing	**43,646**	46,235
Finance leases taken out in the year	**5,248**	0
External financing requirement	**48,894**	46,235
Under spend against EFL	**366**	4,080

30.4. Capital resource limit

The Trust is given a capital resource limit which it is not permitted to exceed.

	2015-16 £000s	2014-15 £000s
Gross capital expenditure	**45,558**	51,066
Less: book value of assets disposed of	**(22)**	(5)
Less: capital grants	**0**	0
Less: donations towards the acquisition of non-current assets	**(374)**	(576)
Charge against the capital resource limit	**45,162**	50,485
Capital resource limit	**45,203**	50,509
Underspend against the capital resource limit	**41**	24

31. 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 2016 £000s	31 March 2015 £000s
Third party assets held by the Trust	**3**	7

2015/16 Annual Report

Cover in design

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

Contents

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 around 11,000 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.

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 part of the 100,000 Genomes Project. Every year we carry 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 are proud to be part of the NHS and we are proud to be Leicester's Hospitals.

Welcome from the Chairman

#hello my name is… Karamjit Singh, CBE

This year, as I begin my second year with Leicester's Hospitals, I have been struck on numerous occasions by how important the sense of team is to our hands on patient care… regardless of whether people are clinical or not it is clear that the team around the patient is much larger than that which is traditionally portrayed by the media and *every role* is important to the ultimate experience of our patients.

As I have been out and about I have also picked up that at grass roots level there is a real desire to think creatively and be innovative in our working practices but sometimes the good ideas are overlooked because the day to day reality of dealing with demand squeezes out time to consider anything other than immediate problems and their solutions. It is easy to say but far harder to do, but we must all try and create the time and space for people to share new ideas because innovation on every scale is critical to our future. In the time that I have been in Leicester I have seen more of that, and the fact that we can make £35m of cost improvement savings yet still deliver high quality care proves that we can and have been doing it. That work of course spills over into the Better Care Together programme which continues to gather momentum, and will bring about big changes starting in the coming year.

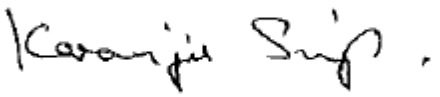
Over the past twelve months there have been a number of changes to our Board members and Directors. Non-Executive Director Richard Moore joined our Board on 1 April as the new financial year began. Richard has experience in the public, private and third sector which compliments the rest of our Trust Board members. He has held senior financial and operational roles with Rolls-Royce plc, BBC Children in Need, Oxfam and SoccerWorld International. He has also been a Non-Executive Director at South Staffs and Shropshire Healthcare NHS Foundation Trust. Andrew Johnson is the most recent Board member to join us. He joined the team in November bringing vast experience of working at Board level in the private sector to our team, having spent over two decades as either a Managing Director or Chief Executive in the food/confectionary sector. Following the departure of our Chief Nurse Rachel Overfield, Julie Smith joined us in August from Mid Cheshire Hospitals NHS Foundation Trust where she had been their Director of Nursing and Quality for four years. On the same day we also welcomed Louise Tibbert as our new Director of Workforce and Organisational Development. Prior to joining us Louise had been Head of HR and OD for Hertfordshire County Council. Darryn Kerr joined us as our new Director of Estates and Facilities on 1 May more recently has been instrumental in leading the change to bring our facilities services back in-house following the end of our contract with Interserve.

As far as I am concerned we exist to serve the public and the quality of experience and outcomes for our patients, their carer's and families is key. We are also part of the community (across Leicester, Leicestershire and Rutland) and we are now the largest employer within it. Over the past year I have actively sought to engage with different parts of the community with groups and individuals to hear about their experiences and how we can be more receptive and responsive to our patients and their families, whilst continuing to reflect the communities we serve.

As I write this we have just received the most generous donation of £2m from the Chairman of Leicester City Football Club giving back to its community. We were shocked and incredibly grateful to receive the donation following their epic win of the premier league title. We, along with the football club, play a key part in our local community and we will continue to develop that relationship into the future for the benefit of our patients.

I would like to extend my thanks to our partners with whom we have worked so closely over the past year and with whom we continue to forge strong relationships to allow us to deliver better services for our patients.

I regularly visit wards and I never ceased to be amazed at the dedication and commitment of our staff to care for our patients. So I would like to end by graciously saying, on behalf of the Trust Board, thank you to all of our staff. No matter what role you have in our organisation I know that you are working hard to ensure that as a Trust we are receptive and responsive to the needs of our patients and their families. This is our core business and what the NHS is about.



Karamjit Singh CBE, Chairman

Welcome from the Chief Executive

#hello my name is… John Adler

Last year I started my summary by saying that we had seen a year with record numbers of people attending our hospitals for treatment. Well, we did not see a change during 2015/16, seeing and treating yet more people. On 9 November we broke all of our previous records when 756 people attended our Emergency Department….the week following we broke the record again with 784 attendances in one single day.

In 2014/15, and for the first time in our 15 year existence, we were working with a deficit (£40m) that we had declared at the end 2013/14. During 2015/16, when other NHS Trusts were also grappling with increasing deficits, we managed to continue to reduce our deficit and find £35m of savings made through improving what we do and how we do it. And given the financial pressures faced across the NHS, we should be proud of that.

Despite financial challenges we have continued to focus on improving the quality of care that we provide to our patients, examples of which you will see throughout this report, and it has not stopped us investing where we have needed to.

We set ourselves some real challenges last year, in fact 44 priorities to help us deliver our 5-Year Plan – Delivering Caring at its Best. We fully achieved 27 priorities, partially achieved 8 and did not achieve 9 of the priorities we set ourselves.

Our real success stories are in infection prevention and the reduction in our mortality rate. Year on year we have seen a reduction in hospital acquired infections taking us from one of the worst performing NHS Trusts in the country to during this past year one of the best with zero avoidable MRSA cases (for the first time ever!) and our lowest ever number of CDiff cases (just 60). In August it was confirmed that our Standardised Hospital Mortality Indicator (SHMI) rate had fallen to its lowest level since records began in 2011. The SHMI is an indicator which reports on mortality at individual trust level across the NHS in England and is worked out by looking at the ratio between the actual number of patients who die in hospital and the number that would be expected to die. The average 'score' across all NHS Trusts is 100 and any trust rated at less than 100 is better than average, conversely a score of over 100 is worse than average. Initially we reported a score of 99 which dropped further in August further to 95, which is significant and without a doubt aligned to our work through the Quality Commitment and following the review called 'Learning Lessons to Improve Care' which was triggered because our SHMI had been consistently above 105 for the previous two years. I think it is clear that the things we said we wanted to improve, like earlier recognition of patients who were deteriorating, faster treatment for patients with pneumonia and more accurate diagnosis of sepsis, are starting to have an effect. There is still much more work to do and we should recognise that the SHMI score can fluctuate, but the overall trend has been one of improvement and in no small part reflects the enormous amount of hard work which has taken place over the last two to three years to improve the quality and effectiveness of the care we provide.

During the year we continued to do well on elective waiting times (Referral to Treatment), but we really struggled with the Emergency Department (ED) 4-hour standard and cancer standards, both of which remain key areas of focus for us during 2016/17.

On 30 November four inspectors from the Care Quality Commission (CQC) arrived in our ED at 7.25pm for an unannounced inspection. At the time of the inspection our ED was under severe pressure and very overcrowded. The inspectors witnessed first-hand the pressure and constraints the ED team work under and the sometimes poor experience of our patients when the department is so very busy. The inspection focussed on the Adults' ED, although at the time there were severe pressures in Children's ED as well.

Since the unannounced CQC inspection the ED team has focussed hard on reducing the time it takes to hand over patients and release ambulances back out onto the road. Those improvements have seen the number of hours lost by EMAS more than halved (56% reduction) and a 76% reduction in handover delays over two hours. Nevertheless, we still have a lot more that we can and are doing. We are expecting our formal CQC inspection on 20 June and I will report on that in forums throughout the year and formally in this report next year.

During the year we continued to make improvements to our estate, despite our financial position. If you have visited the Royal Infirmary recently then not only would you have found it easier to park with our new multi-storey care park, but you would have also seen the massive frame of our new ED appear against the skyline. Phase 1 of the new department should be complete by March 2017, with construction on Phase 2 completing by the end of December 2017.

For the first time this year junior doctors held a number of periods of industrial action as the Government and BMA failed to agree a new contract. Our key priority during these strikes was always to ensure that we provided safe emergency services to our patients, whilst seeking to minimise disruption across our remaining services. Staff worked diligently to plan for these strikes and I have witnessed colleagues pull together to ensure that we had sufficient numbers of consultant colleagues working to provide appropriate cover across our services, for which I remain grateful. There has been a real sense of teamwork throughout, which whilst one of our values, is also something I witness on a daily basis across our hospitals.

Notwithstanding the increased pressures on our emergency services and finances we have seen our Friends and Family test scores improve and stay at 96 and 97 per cent throughout the whole year in line with our Quality Commitment aim. It was also gratifying to see an improvement in our National Staff Survey results, particularly in staff believing that 'Care of patients is a top priority'. I believe this is in part linked to the Quality Commitment and ensuring that we regularly talk about quality improvements, through my monthly briefings with staff. The survey also put us in the best 20 per cent of Trusts for 'Staff motivation'. Again, I never cease to be amazed at the level of motivation shown by staff to do better for patients.

Undoubtedly the coming year will bring its own challenges, but working closely with our partners we hope that we can find innovative solutions to those challenges. I have every faith that my staff will continue to do their best to deliver high quality care for our patients, as they have done this year.

Thank you to our staff and partners for all of their work over the past twelve months. We are delivering services that are safer and of a higher quality and that is something we should be really proud of.

John Adler, Chief Executive

Our Trust Board

Declaration of Interests

Mr K Singh
Trust Chairman

Trustee Joseph Rowntree Foundation, Trustee Joseph Rowntree Housing Trust, Council Member of Justice, Trustee Malaysian Commonwealth Studies Centre Cambridge University, family member works as a Partner in Lakeside Consortium Northamptonshire.

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

Brother, Order of St John (by award, not active in the organisation), part-time Consultant Adviser role with General Dynamics Information Technology Ltd.

Dr S Dauncey
Non-Executive Director

Trustee on the Board of Leicester Grammar School, an Independent School with Charitable Trust Status.

Professor A Goodall
(from 1.7.15)
Non-Executive Director

Non-Executive Director and minority shareholder of Haemostatix Ltd.

Mr A Johnson
(from 1.11.15)
Non-Executive Director

Director Glebe Terriers Ltd, Chairman, Morcott Parish Council Rutland.

Richard Moore
Non-Executive Director

Director of the following private 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 Martin Traynor
Non-Executive Director

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

Ms J Wilson
(up to 31.12.15)
Non-Executive Director

None to declare

Our Trust Board

Declaration of Interests

	Mr J Adler Chief Executive	Trustee of UHL Charity, Occasional Consultant to Guidepoint Consulting.
	Mr R Mitchell Chief Operating Officer	Occasional work for Guidepoint Consulting.
	Mr A Furlong Acting Medical Director	None to declare
	Mr Paul Traynor Chief Financial Officer	None to declare
	Ms C Ribbins (up to 31.7.15) Acting Chief Nurse	None to declare
	Ms J Smith (from 1.8.15) Chief Nurse	None to declare

Directors who provide advice to the Board

	Mrs H Seth (from 15.2.16) Acting Director of Strategy	Exploring the possible establishment of a small consultancy.
	Ms K Shields (up to and including 14.2.16) Director of Strategy	None to declare
	Ms E Stevens (up to 31.7.15) Acting Director of Human Resources	None to declare
	Ms L Tibbert (from 1.8.15) Director of Workforce and OD	Director Public Sector People Managers' Association, Member NHS Pension Board
	Mr S Ward Director of Corporate and Legal Affairs	None to declare
	Mr M Wightman Director of Marketing and Communications	Update awaited

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 an 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 key committees that support accountability. With the exception of the Trust Chairman (who cannot attend the Audit Committee), all Non-Executive Directors are also encouraged to attend any of the Trust Board Committee meetings (Audit Committee, Charitable Funds Committee, Quality Assurance Committee, Integrated Finance Performance and Investment Committee) – those who are not formal members of those groups will attend in a non-voting capacity. The Chairman and all Non-Executive Directors are members of the Trust's Remuneration Committee.

These are the Committee Chairing roles that our Non-Executive Directors carried out over the last 12 months:

Karamjit Singh, CBE chairs Trust Board and Remuneration Committee

Sarah Dauncey chairs Quality Assurance Committee

Richard Moore chairs Audit Committee

Martin Traynor, OBE chairs Integrated Finance, Performance and Investment Committee (since 1 January 2016), and was chair of the Charitable Funds Committee until 31 March 2015

Jane Wilson chaired Integrated Finance, Performance and Investment Committee up to the end of December 2015 (when she left the Trust).

Trust Board meetings

Our Trust Board meetings are held monthly 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.

We held our formal Annual Public Meeting on Thursday 17 September 2015 at "The Big Shed" on Freeman's Common in Leicester, presenting our 2014-15 annual report and accounts and answering questions from the public. There was also a health and wellbeing fair for members of the public in the same venue on the day of the Annual Public Meeting.

Partners on our Trust Board

Dr Nil Sanganee 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:

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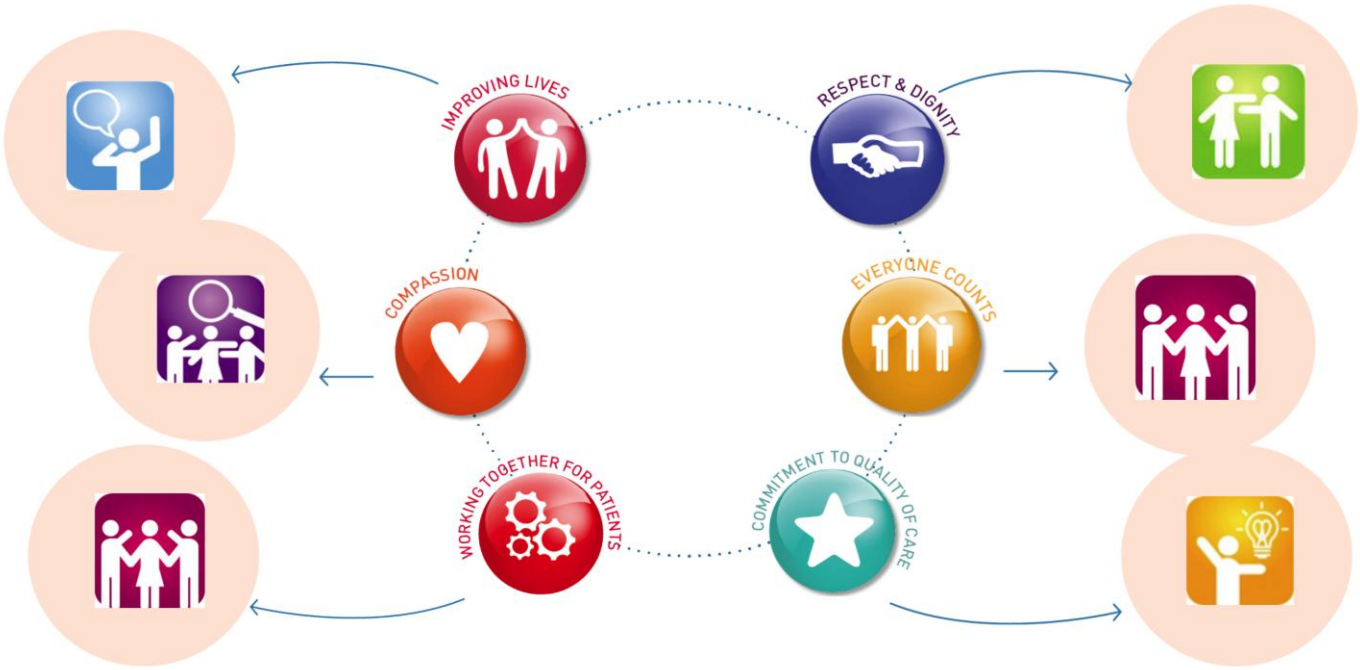
Strategic Report

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.

Delivering Caring at its Best – our 5-year plan

Setting the scene…

As a major acute, teaching Trust there are some very specific issues which we need to solve if we are to deliver on our pledge to provide 'Caring at its Best'.

We last published our Strategic Direction in November 2012; since then much has changed not least the publication of the 'NHS 5 Year Forward View' nationally; and locally, the far greater emphasis on working in partnership with other health and social care colleagues through the 'Better Care Together' programme. Indeed, what is more apparent now than ever before is that we cannot be a strong, sustainable, high quality acute Trust without there being equally strong and sustainable local primary care and social care… in that sense our future and our ability to provide high quality care for the 1.1m people living in the richly diverse communities across the City and Counties is interwoven with that of our partners.

Our commitment to quality is unwavering...

...that means we aim to provide effective care with ever improving outcomes; safe care where the risks of errors is reduced to an absolute minimum and last but by no means least, compassionate care where patients and their families are always treated with respect and tenderness. This is the core of our vision and everything else that we do should be in support of that.

In five years' time we will be smaller, more specialised, and financially sustainable. We will make our specialist expertise available to primary and social care and by exporting more of our non-specialist services to the community we will play a much bigger role in preventing illness and supporting patients before they reach a point of crisis.

This will reduce the need for people to come into hospital, reduce the number of beds we need and ultimately enable us to run our specialist services from two, rather than three, big hospitals. For those patients who do need hospital treatment they will find that our services are quicker, easier to navigate and higher quality, largely as a result of being able to focus on our specialisms, our slicker processes, our better use of technology and because we will no longer expect our staff to spread themselves across three main sites. We will invest in our buildings so that patients and staff feel a sense of pride in their local NHS. We will build a new Emergency Floor; a new daycase centre, a new children's hospital, there will be new investment in our maternity services and a new multi-storey car park.

At the same time we plan, with our health and social care partners to transform the General Hospital from an acute inpatient hospital into a broader health campus. Our specialist services will grow as we create partnerships and networks with other regional hospitals; we will support district hospitals to maintain their services locally and in doing so increase referrals into our tertiary services and expand the potential for population based research.

As a consequence of shifting our focus to specialist work and using our expertise outside hospital we expect to attract increased research funding and clinical talent to our hospitals, making Leicester the regional Trust of choice for people wanting a career in the NHS.

Finally, recognising that quality, safety and compassion are almost entirely reliant on the expertise, behaviour and values of all who work in Leicester's hospitals, we will continue to invest time and resources into building a culture of engagement where people are listened to, problems are confronted and staff feel valued for the tremendous work they do.

This is what we call Caring at its Best.

You can read our 5 year plan in full on our website www.leicestershospitals.nhs.uk or for a hard copy contact communications@uhl-tr.nhs.uk

Our annual priorities in 2015/16

Underpinning the vision are our Strategic Objectives. These encompass all the things we need to do in order to deliver the vision and ultimately our desire to provide Caring at its Best. Our Strategic Objectives are represented in the strategy triangle (below); the fact that 'safe, high quality, patient centred health care' wraps around every objective is not an accident of design but a reflection that safe, high quality care is the ultimate objective of all our endeavours.

Throughout this report you will be able to read in more detail how we achieved against the annual priorities we set ourselves. Over the next couple of pages you can see in the chart what the annual priorities were and our achievements against them at each quarter using a RAG 9Red, Amber, Green) coding system. Overall you will see that we have:

- fully achieved 27 priorities (**green**)
- partially achieved 8 priorities (**amber**)
- not achieved 9 priorities (**red**)

Analysing our performance by strategic objective theme, we made good progress in respect of quality, estates investment and reconfiguration (with the exception of ICU), financial sustainability, research and education, partnerships and workforce. We did not make the expected progress in the areas of emergency care, access, innovation and IM&T (the latter due to delays with the Electronic Patient Record business case approval).

STRATEGIC OBJECTIVE/ ANNUAL PRIORITY	COMMENTS ON PROGRESS	Q1	Q2	Q3	Q4
Safe, high quality, patient centred healthcare					
• Reduce UHL mortality rate (SHMI) to under 100 (Quality Commitment 1)	Latest published SHMI (year to June 2015) shows a further reduction to 95	Q1	Q2	Q3	Q4
• Reduce patient harm events by 5% (Quality Commitment 2)	Q3 report shows reduction in serious harm events well ahead of trajectory (254 vs 387)	Q1	Q2	Q3	Q4
• Achieve a 97% Friends and Family test score (Quality Commitment 3)	Year to date (to Feb 16) at 97% for both inpatients and ED	Q1	Q2	Q3	Q4
• Achieve an overall "Good" rating following CQC inspection	Inspection will not now happen in 15/16. Preparation underway for inspection in June 2016	Q1	Q2	N/A	N/A
• Develop a "UHL Way" of undertaking improvement programmes	UHL Way development now complete. Launched January 16 and 2016/17 implementation plan in place	Q1	Q2	Q3	Q4
• Implement the new PPI Strategy	Allocation of additional resources has meant that implementation plan is on track	Q1	Q2	Q3	Q4
An effective and integrated emergency care system					
• Reduce emergency admissions through more comprehensive use of ambulatory care	Emergency admissions are 6% up YTD. However, ambulatory care portfolio now fully in place. Activity levels have compromised winter delivery	Q1	Q2	Q3	Q4
• Improve the resilience of the Clinical Decisions Unit at Glenfield Hospital	EC improvement plan expanded to include detailed CDU and wider Glenfield actions. Successful pilot of GP led ambulatory care model completed	Q1	Q2	Q3	Q4
• Improve the resilience of the Emergency Department in the evening and overnight	Performance has deteriorated, including overnight. Improvement actions have not brought expected benefits	Q1	Q2	Q3	Q4
• Reduce emergency medicine length of stay through better clinical and operational processes	Evidence of continued improvements, particularly on MAU. Length of stay continued to decline in Q3	Q1	Q2	Q3	Q4
• Substantially reduce ED ambulance turnaround times	Intensive focus has significantly reduced delays from November 2015 peak i.e. total hours lost reduced by 40% (Nov 15 vs Feb 16). However, UHL remains an outlier and delays are still too long.	Q1	Q2	Q3	Q4

STRATEGIC OBJECTIVE/ ANNUAL PRIORITY	COMMENTS ON PROGRESS	Q1	Q2	Q3	Q4
Services which consistently meet national access standards					
• Deliver the three 18 week RTT access standards	Continued compliance being achieved	Q1	Q2	Q3	Q4
• Deliver the three key Cancer access standards	Good progress on underlying issues and 2WW now compliant but progress on 62 days slower than expected. Will not be achieved by year end	Q1	Q2	Q3	Q4
• Deliver the diagnostics access standard	Major in year issues in endoscopy have been rectified. On track to achieve at year end, or very close	Q1	Q2	Q3	Q4
• Implement tools and processes that allow us to improve our overall responsiveness through tactical planning	Will not be delivered in 2015/16 as unaffordable	Q1	Q2	Q3	Q4
Integrated care in partnership with others					
• Deliver the Better Care Together year 2 programme of work	Good progress on many aspects but transitional funding and workforce constraints likely to limit pace of implementation	Q1	Q2	Q3	Q4
• Participate in BCT formal public consultation	Now delayed to 2016/17	Q1	Q2	Q3	Q4
• Develop and formalise partnerships with a range of providers including tertiary and local services (e.g. with Northamptonshire)	Good progress with a variety of partnerships, including Northamptonshire and Nottingham. Vanguard bid unsuccessful. Recent success with Lincolnshire	Q1	Q2	Q3	Q4
• Explore new models and partnerships to deliver integrated care	Frail elderly project has reported but now taken forward. Growing consensus about need for greater integration and should make progress in early 2016/17	Q1	Q2	Q3	Q4
Enhanced delivery in research, innovation and clinical education					
• Develop a robust quality assurance process for medical education	Very positive report from latest HEEM inspection, with exception of cardiology. QA structure specifically praised.	Q1	Q2	Q3	Q4
• Further develop relationships with academic partners	Developing relationships with all three local universities, assisted by new senior liaison role. Recent successful meeting with University of Leicester resulted in several key agreements. Precision Medicine Institute approved.	Q1	Q2	Q3	Q4
• Deliver the Genomic Medicine Centre project	Some issues with initial take on rate. Only just meeting revised trajectory so position fragile.	Q1	Q2	Q3	Q4

STRATEGIC OBJECTIVE/ ANNUAL PRIORITY	COMMENTS ON PROGRESS	Q1	Q2	Q3	Q4
• Comply with key NIHR and CRN metrics	Ahead of target in key metrics. Positive reviews from NIHR	Q1	Q2	Q3	Q4
• Prepare for Biomedical Research Unit re-bidding	Bidding framework issued. Response approach agreed and bids being drafted. Making good progress	Q1	Q2	Q3	Q4

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"

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

Reduce our mortality rate (SHMI) to under 100 (Quality Commitment 1)

We track mortality using various tools, two of which are the Hospitals Standardised Mortality Ratio (HSMR) and the Standardised Hospital Mortality Index (SHMI). These are slightly different, somewhat complicated measures that allow hospitals to compare themselves in terms of mortality. A number of 100 means a hospital is the same as elsewhere, less than 100 means there a fewer deaths than expected, greater than 100 means there are more.

Our 'rolling 12 month' HSMR has been below 100 for the past three years and our latest published SHMI is 96 (covering the 12 months October 2014 to September 2015).

Our SHMI was last above 100 for the 12 months October 2013 to September 2014 and we believe that the work we are doing as part of our Quality Commitment and specifically the changes made to our respiratory pathway, particularly for patients with pneumonia, has played a key part to bringing our SHMI to below 100.

Maintaining our SHMI below 100 and reducing avoidable deaths continues to be a main goal of our Quality Commitment for 2016/17. This work is monitored by our Mortality Review Committee of our senior doctors and nurses.

Reduce patient harm events by 5 per cent (Quality Commitment 2)

The aim of the Patient Safety programme of the Quality Commitment was to reduce the risk of error and adverse events to enable us to see a reduction in harm events by 5 per cent (patient safety incidents graded as moderate harm and above).

Priorities within the Patient Safety programme were;

- Earlier recognition and rescue of the deteriorating patient;
  - ✓ Sepsis
  - ✓ Handover
  - ✓ EWS
  - ✓ Acting on Results
- Consistencies in core practices
  - ✓ Medication safety
  - ✓ Infection Prevention
- Learning and Development
  - ✓ Implementation of safety briefings in wards and departments

For 2015/16 we are very pleased that we have in fact exceeded our target (5 per cent) and have reduced those harm events by 36 per cent.

For 2016/17 we aim to reduce moderate and above harms caused by unwarranted clinical variation by a further 5 per cent.

Achieve a 97 per cent Friends and Family test score (Quality Commitment 3)

The Friends and Family Test is a nationally set question offered to patients, carers and relatives in all NHS hospitals following admission or treatment. The test asks one simple question: "How likely are you to recommend our ward to friends and family if they needed similar care or treatment?" and there is an opportunity to give comments, indicating the reason for their answer.

Patients, family and carers can provide feedback following their discharge from all areas of our hospitals.

For 2015/16 as part of the Quality Commitment our aim was to achieve a 97 per cent score for the Friends and Family Test.

The chart below details the recommended and non-recommended scores for 2015/16.

	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016
% Recommended	**96%**	**96%**	**97%**	**96%**	**97%**	**97%**	**97%**	**96%**	**97%**	**97%**	**96%**	**97%**
% Not Recommended	*0.9%*	*0.7%*	*0.8%*	*0.8%*	*0.8%*	*0.8%*	*0.6%*	*0.9%*	*0.8%*	*0.8%*	*0.9%*	*0.8%*

Each ward displays their Friends and Family Test results alongside a "you said we did board" detailing what actions they have put in place to improve following comments from their patients. We aim to improve the experience of our patients and the care that they receive by listening and learning from the feedback that they give.

The survey is available in Gujarati, Punjabi and Polish and a children's survey is available for them to give us their views on care in areas where they receive treatment. We also provide an easy read version for patients who have visual disturbances, learning disabilities or just need the question in an easier format.

Our Carers Charter was launched in May 2015 and is displayed in all of our ward areas and highlights the importance of family carers. We believe that recognising their knowledge and including carers in the care and discharge planning of their loved one will improve the overall experience for the patient and the carer.

Achieve an overall "Good" rating following CQC inspection

We did not receive a notice of a planned inspection by the Care Quality Commission (CQC) during the 2015/16 financial year. In February we received formal notice that our next planned inspection would take place from 20-24 June 2016, which we will report on for the next annual report.

However, on 30 November 2015 the CQC made an unannounced visit to our adults Emergency Department.

At the time of the inspection our ED was under severe pressure and very overcrowded, and as a result we had declared an Internal Business Continuity Incident. The inspectors witnessed at first-hand the pressures and constraints that our ED team work under and that on some occasions patient experience is not as we would want it to be when the department is so very busy.

During the unannounced inspection the CQC looked at the major injury, resuscitation and assessment areas of the Adults ED. The paediatric, minor injury area and the Urgent Care Centre were not inspected, although they were also very busy at the time. The inspectors focused on the key question of whether urgent and emergency services delivered in the emergency department were safe.

Concerns highlighted during the inspection resulted in the CQC taking immediate action. They highlighted a number of areas where we were to make improvements, including:

- Operating an effective system to ensure patients attending the ED have an initial clinical assessment of their condition carried out by appropriately qualified clinical staff within 15 minutes of the arrival;
- Ensuring at all times that there are sufficient numbers of suitably qualified, skilled and experienced staff with sufficient skills in the ED to ensure people using the service are safe and their health and welfare needs are met;

- That an effective system is in place to deliver sepsis management, in line with the relevant national clinical guidelines.

Notwithstanding these concerns, we want to stress that the inspectors were at pains to point out that they saw overwhelmingly dedicated and hardworking staff doing their best in difficult circumstances.

On Thursday 7 April we formally received the full report of the inspection. You can read that report on our website.

Since the inspection we have co-operated fully with the CQC and reported to them on a weekly basis in line with the notice that they served. We have made real and sustained progress on the time to triage patients and staffing levels. Identifying and quickly treating sepsis remains a key priority for us across the whole of our organisation and is a key part of our Quality Commitment for the coming year. The only element that we have not been able to address is the numbers of patients attending ED on a daily basis, which continues to present very real difficulties. It is therefore more important than ever that we continue to work together as a health community to ensure that the emergency care pathway works as smoothly and quickly as possible. This applies to all our sites, not just the Royal.

The quality of the care we provide and ensuring that our patients have a good experience remains paramount to us, which is why we remain grateful that the CQC recognised that our staff were trying to do their very best in difficult circumstances; namely working in a department that is too small with unprecedented levels of attendance. ED is a tough environment to work in, especially in winter and we too want to recognise that the ED team have responded with commendable professionalism to the CQCs findings.

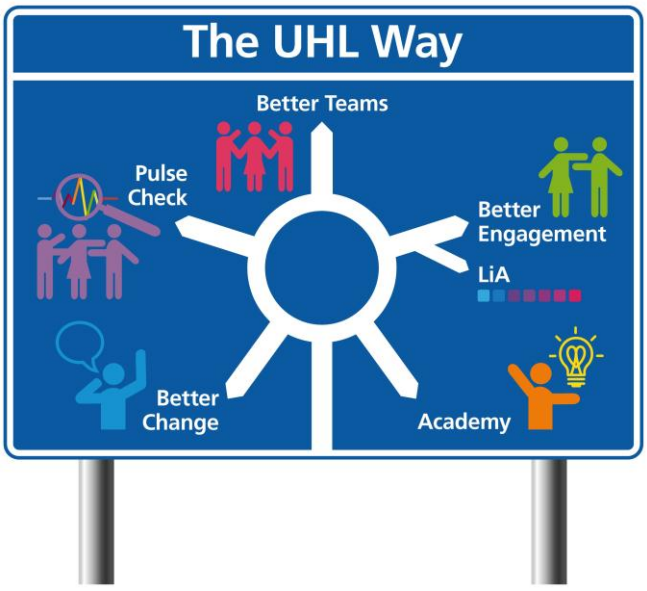
Develop a "UHL Way" of undertaking improvement programmes

The UHL Way was launched across the Trust in January 2016 and is the way we are going to manage change in a consistent and sustainable way, but also in a way that engages and empowers the staff involved in, and affected by that change.

The UHL Way is about embedding a culture of continuous improvement across our organisation, which will in turn improve the quality of care we provide to patients, reduce harm, increase efficiency and effectiveness and support cost reduction. During the coming year key benefits and measures of improvement will be set out within individual programmes and overall improvement to staff experience will be monitored at quarterly intervals through our Pulse Check and on an annual basis through the National Staff Attitude and Opinion Survey.

The three components to the UHL Way are:

1. Better Engagement: Continuing Listening into Action – moving into Year 4;
2. Better Teams: Targeted improvement and development;
3. Better Change: Adopting the best in change and improvement methodology;



These components are supported by the Academy and a Faculty of Experts.

We are pleased to share that Listening into Action will continue and we will build on the good work we have already done. As we move into our fourth year of LiA implementation, we will be doing more of what we have been doing and continuing its expansion to support the UHL Way.

The UHL Way has brought together a wide range of staff and their different skillsets from across our organisation with a desire to help others.

We look forward to celebrating the successes of implementing the UHL Way, at various times during the year (2016/17), and demonstrating the 'so what' difference from exposure to development interventions provided through the UHL Academy.

Implement a new PPI strategy

One of the key ways in which we seek input from patients and the wider public is through our Patient Partner group. Formerly known as Patient Advisers, our Patient Partners are attached to each of our clinical management groups (CMGs) where they work with senior staff to provide a lay perspective on many of our boards and committees. Patient Partners have been very active over the last year and are involved in a wide range of projects across our hospital sites.

Our commitment to Patient and Public Involvement (PPI) was strengthened this year through the approval of a new PPI Strategy in April 2015. The strategy secured another member of staff to support the agenda and promotes an expansion of the Patient Partner model and a greater emphasis on community engagement. Since April we have recruited more Patient Partners and this recruitment will continue into 2016/17.

During the year our public membership has continued to grow with more than 16,000 people now signed up as members of our Trust. Recent analysis shows a close demographic match to our local population and over the last couple of years we have been attracting an increasing number of younger members. We engage with our members in a variety of ways. Our bi-monthly 'Together' magazine promotes opportunities for our members to get more involved in the work we do with initiatives from teams such as volunteering and fundraising. We send out opinion surveys giving everyone the opportunity to comment on our services as well as invitations to participate in specific engagement opportunities. We also run a quarterly "Engagement Forum" meeting where members can meet with our chairman, chief executive and directors to discuss issues affecting us.

In January 2016 we launched a new "ePartner" initiative which will allow members to get involved online, all from the comfort of their own home. We hope this will attract the involvement of busy working age members as well as those who may struggle to get out to events at our hospitals.

Our monthly "Leicester's Marvellous Medicine" talks continue to be popular. The talks provide a great opportunity for senior clinicians to explain how their services are developing. Over the last year we have run sessions on genetic research, obesity, Ebola treatment, conditions of the eye, heart surgery, breast cancer and many more.

Last year's Annual Public Meeting was widely felt to be our best yet, with over forty stall holders from a wide range of services represented. The meeting gave members of the public and our staff an opportunity to meet with our senior team and reflect on our successes and challenges in the year ahead.

We continue to enjoy strong links with our local Healthwatch organisations and a Healthwatch representative sits regularly on our Trust Board. Our Chief Executive also meets every three months with Healthwatch representatives to discuss issues that have emerged through their engagement with local communities. Our Patient and Public Involvement Manager is also in regular contact with Healthwatch representatives and acts as a point of contact for the Trust.

As an adjunct to the Listening in to Action programme we are developing a process called "Involvement in to Action". Patient Partners are involved in this piece of work which aims to create a step by step guide which will support our staff to involve patients in the development of hospital services.

Improving the experience of our patients

Quality Commitment – Patient Experience Care and Compassion

Fixing the fundamentals is all about getting it right for older people, which is a key part of our Quality Commitment. At the beginning of 2015 we spoke to some of our older patients and carers and they told us what they wanted 'fixing'. From that we identified five themes:

- **Communication** – our Emergency and Specialist Medicine Clinical Management Group designed a patient diary for communication and staff were actively encouraged to make introductions to their patients and visitors,
- **Care** - care was observed across our older people's wards and actions put into place to meet the needs of patients.. The Continence Nurses devised a campaign to promote toileting.
- **Entertainment** - The Metro newspaper was introduced to the Royal Infirmary and our volunteers deliver it to wards on the library trolley. Activity Boxes were provided with art, puzzles, books and games and OPUS Music, a therapeutic music group, was introduced on the older people's wards.
- **Privacy and Dignity** - hearing loops and personal amplifiers were introduced.
- **Food and Nutrition** - The housekeepers use the snack menu as finger foods, and there is a large print menu to help people choose what they would like to eat. We also introduced Mealtime Assistant volunteers on the older people's wards.

These are just a few examples of work we did throughout the year. There is still plenty to 'fix' and a further listening event is being planned for April 2016.

Ward 18 at the Royal Infirmaru became the seventh ward to achieve the Quality Mark for Elder Friendly Hospital Wards, a nationally recognised award from the Royal College of Psychiatry Centre for Quality Improvements.

During Older People's Month in September, events and training took place across the older people's wards, culminating in the Older People and Dementia Champions Celebration Conference.

Our Older People's Champion Network continues to expand and more than 100 staff joined the network this year, as well as over 200 nursing students who became champions.

Dementia Care and Meaningful Activity Service

We support patients and carers with dementia, ensuring staff understand and are aware of the impact of dementia. 84 per cent of our staff have received dementia awareness training, and we have 378 Dementia Champions. Champions have a deeper understanding of the experiences of people living with dementia and how care services could impact on their well-being

Every month we collect survey from carers, and the evidence is that they tell us they are feeling more supported this year than they did previously.

During the year we designed a new Dementia Care Pathway to support people admitted with dementia. The new 'Think Delirium Support Tool' was developed which highlights to staff to 'think delirium' if their patient becomes more confused or withdrawn than normal. We have also created new patient information leaflets on Dementia and Delirium.

Our Meaningful Activity Service improves well-being for people with dementia and their carer's. Patients are supported with individual and group activities such as music therapy, arts and crafts, and reminiscence events. The service supports patients and carers on 21 wards across the Royal Infirmary and Glenfield hospitals. There is an additional Outreach Service to provide support and advice to ward areas if a patient with dementia has become distressed or agitated. This service is supported by over 50 Forget me Not Volunteers trained in dementia who become champions for our patients.

End of Life Care

There is a wide range of support for those coming to the end of their life and for those needing palliative care support, whether that is patients or their families and carers.

(1) Advance Care Planning: Emergency Healthcare Plans are available to all clinicians to complete in inpatient and outpatient areas as part of Advance Care Planning to review patients supportive and palliative care needs.

(2) AMBER care bundle: The AMBER care bundle has been a real success and is in use on 45 wards across all three of our hospitals to help staff identify patients with uncertain recovery whose care could be supported with the care bundle, and to support conversations about their care and treatments.

(3) Rapid discharge home: It is important that those patients who are coming to the end of their life and want to die at home are able to. For these patients we are able to implement a rapid discharge home process, either the same day or for the next day.

(4) Priorities for care in the last days of life: Our guidance on end of life care and end of life care plans is used to support individualised care for those dying our hospitals and is based on the priorities for care in the last days of life.

(5) Education about End of Life Care: Clinical Nurse Specialists provide education on end of life care. A particular success has been the training programme "Quality End of Life Care for All (QELCA)". This involves a week's training at LOROS. It has empowered senior nurses to make a sustainable difference to the experience of palliative dying patients and their relatives/ carers.

On 8 December 2015 we launched a new Bereavement Support Service. The service is available to the bereaved families, carers and relevant others of those adults who have died in one of our hospitals. Contact can be made at any time after their bereavement and six to eight weeks after their death the Bereavement Support Nurse will make follow up contact to offer support to talk about what matters to them regarding their bereavement; to answer any questions they may have – they can arrange a meeting with members of the team who cared for their loved one; and for those who are experiencing difficulties in their grief to be signposted to appropriate support agencies e.g. counselling/ support agencies.

Volunteers

We currently have 659 active volunteers in our Volunteer Services who are involved in supporting patients and their families – this does not include the RVS (Royal Voluntary Service) and other organisations providing volunteers within our hospitals.

Volunteers can apply online using the registration of interest form. This enables us select volunteers who show a good understanding of how they might be able to make a difference to our patients.

This year an increased number of volunteers have chosen to do the following training:

- Mealtime Training -120 volunteers
- Dementia Champions – 54 volunteers
- Older Peoples/ Falls Awareness – 36 volunteers
- 'If looks could kill' – 20 volunteers
- RESUS Training – 33 volunteers

Our Buggy Service continues to provide a much needed service for patients and visitors with four buggies across our three sites operating from 9am-4pm Monday to Friday. During this year more than 50 volunteer buggy drivers have carried 31,151 passengers on 19,121 journeys.

Volunteers continue to be an integral part of our services offering additional support to patients and improving their experience within our hospitals.

Providing spiritual and religious care

"We are here for you" is the new strap line on our Chaplaincy publicity. We offer support to patients and families and our diverse team ensures that they have a wider variety of chaplains to speak to. Over the year our chaplains and chaplaincy volunteers made almost 14,000 visits to patients - an invaluable part of our commitment to delivering "Caring at its best".

We are here to support all who face emotional distress arising from questions concerning life, death, meaning and purpose - questions that can be acutely highlighted by illness and suffering. A chaplain is available 24/7 to support patients or families in urgent situations, especially around the time of a death.

We provide multi-faith chapels and prayer facilities on each site, for the use of patients, visitors and staff. These provide a place for prayer or quiet contemplation and are in constant use.

This year we welcomed the UK's first non-religious paid chaplaincy team member. Jane Flint started in January and is already making a valuable contribution. The post is funded by the *Leicester Hospitals' Charity* and will be evaluated over the next two years to measure the demand for the role and how it enhances patient experience.

The chaplaincy also organised the first "Celebrating Caring at its Best" event that was held in Leicester Cathedral in August, attended by about 100 people.

Modern Slavery Act

We are committed to ensuring the absence of slavery in our organisation and supply chain. In line with the requirements of the Modern Slavery Act (MSA) which came in to statute in 2015; we can confirm we have taken the following actions:

- An assessment of our contracts which have the highest risk of modern slavery;
- Introduction as standard a new supplier Pre-Qualification Question (PQQ) relating to a supplier's compliance to the MSA;
- As part of our assurance review this year we asked all the procurement agencies who work on our behalf about their own MSA assurance processes;
- From April an MSA clause will be included in our standard terms and conditions.

Complaints – final data available around 10 June

Complaints are a very important source of information about our patients, relatives and carers views regarding the quality of the services we provide in our hospitals. Throughout 2015/16 we have continued to focus on the experience of the complainant within our complaints process. We have made changes to our management processes to allow a designated lead handler for each and every complaint or concern. This means that the complainant has the benefit of having one lead contact from the start through to final response for their complaint.

The table below shows the top five themes of formal complaints received by the Clinical Management Groups from 1st April 2015 to 31st March 2016.

Table showing top 5 themes of formals by CMG for year

We endeavour to respond as swiftly as possible when any issues are raised in line with our standard for 95 per cent compliance within the agreed 10, 25 and 45working day performance targets. The tables below show our performance for this year. Comment on performance when data available.

Tables showing 10, 25 and 45 day performance for year by CMG

The Clinical Management Groups continue to scruntinise their performance and these are reported and monitored at Clinical Management Group Quality and Safety Boards and presented at Executive Quality Board each month.

An Independent Complaints Review Panel set up last year in partnership with Healthwatch, PoWHer and our own Patient Partners has continued to meet over this year to independently scrutinise the management of our complaints, reviewing four to five randomly selected complaints files on a quarterly basis. The feedback provided by the panel is used for reflection, learning and improvement. A larger feedback session has been provided this year to allow Clinical Management Groups to attend to receive direct feedback on final response letters they provide.

We are continually striving to make further improvements within our complaints management and learning processes. Agreed actions for 2016/17 to further improve complaints engagement and learning are:

- GP engagement event

- Two community based Patient Information and Liaison Service (PILS) clinics
- Collaboration with the University of Leicester with work on the quality of apology in our complaints response letters

We continually strive to improve final responses and offer early meetings to improve resolution of complaints. If complainants remain unhappy after the final response we will 're-open' the complaint and identify if an alternative action can be taken to try and resolve the complaint. This year we have seen between xx-xx% of reopened complaints. This is a reduction on last years figures.

Nationally referrals and investigations taken on by the Parliamentary Health Service Ombudsman (PHSO) have increased. During this year the PHSO have investigated xx of our complaints. Of these xx were fully upheld, xx were partially upheld and xx were not upheld. This is xxxxx compared to last year.

10 and 25 day Performance – 1 April 2015 to 31 March 2016

45 day performance 1 April 2015 – 31 March 2016

Patient information and liaison service (PILS)

Feedback from our patients, their relative and carers is a valuable opportunity to review our services and make improvements. We encourage dialogue with staff, giving an opportunity for immediate action and local resolution. To further support our patients, the Patient Information and Liaison Service (PILS) provides information and advice on how concerns raised can be managed. They are contactable by a freephone telephone number, email, website, in writing or in person.

Overall activity by the PILS has xxxx. Comment on performance when data available.

The activity is reflected in the table below;

PILS table with year on year activity

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.

In 2015/16, we received 592 Freedom of Information requests and/or requests for environmental information, compared to 542 in 2014/15 (an 8.5 per cent rise in requests). We responded to 96 per cent of these requests within the statutory 20 working-day deadline.

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 – this amounted to 918 instances that areas had to provide information. The table below shows the number of times that different areas had to provide information during the year to respond to those 592 FOI requests.

Some information, such as patient information leaflets and Trust Board papers are already publicly available on our FOI publication scheme – you can find this on our external website in the Freedom of Information section.

Freedom of Information/Environmental Information Regulation requests received between 1 April 2015 and 31 March 2016, split by Clinical Management Group (CMG)/Corporate Directorate		
Area	**Number of times asked to provide FOI data in 2015/16**	**Approx % of overall 2015/16 FOI activity (in terms of times needing to provide information)**
Finance and Procurement	134	14.6
Human Resources	124	13.5
Operations	100	10.8
Clinical Support and Imaging CMG	89	9.7
Corporate Nursing	73	8
Corporate Medical	61	6.6
Women's and Children's CMG	51	5.5
Facilities & Estates	50	5.4
IM&T	45	4.9
Cancer, Haematology, Urology, Gastroenterology and General Surgery CMG	43	4.7
Emergency and Specialist Medicine CMG	35	3.8
Musculoskeletal and Specialist Surgery CMG	35	3.8
Corporate & Legal Affairs	26	2.8
Renal, Respiratory and Cardiac CMG	21	2.3
Critical Care, Theatres, Anaesthesia, Pain and Sleep CMG	19	2.1
Strategy	6	0.6
Marketing and Communications	5	0.5
Research and Innovation	1	0.1
The Alliance	0	0

Please note that some requests required a response from all/multiple clinical and corporate areas, which is why the numbers shown above (which add up to 918 times that areas had to provide information) are higher than the total of 592 requests received.

National Health Service Litigation Authority (NHSLA) Bid – Sign up to Safety

In support of the Sign up to Safety campaign in 2015 we submitted a successful bid to the National Health Service Litigation Authority (NHSLA) for funding to support the delivery of our Quality Commitment. The aim of our Quality Commitment is to ensure that every patient receives the right care, at the right place, at the right time, concentrating on the following initiatives:

- Improve patient outcomes – provide effective care by delivering evidence based care/best practice;
- Reduce harm to patients – improve safety by reducing the risk of errors and adverse incidents;
- Provide and compassion – improve patient experience by listening to and learning from patient feedback.

Following successful recruitment of a team of staff to ensure that our plans were delviered successfully, we did the following:

- Trust wide implementation of a new look sepsis pathway and structured consultant-led feedback sessions;
- Development and roll-out of the Patient Safety Portal enabling collaborated working, sharing of knowledge and best practice in an efficient and effective manner;
- Development of IT infrastructure continues to support the upgrades to the electronic handover and e-observation systems rolled-out across the Trust;
- Development and roll-out of e-learning and inter-personal training programmes which include Sepsis and Human Factors.

During the coming year we will move towards the delivery and continual evaluation of the programme.

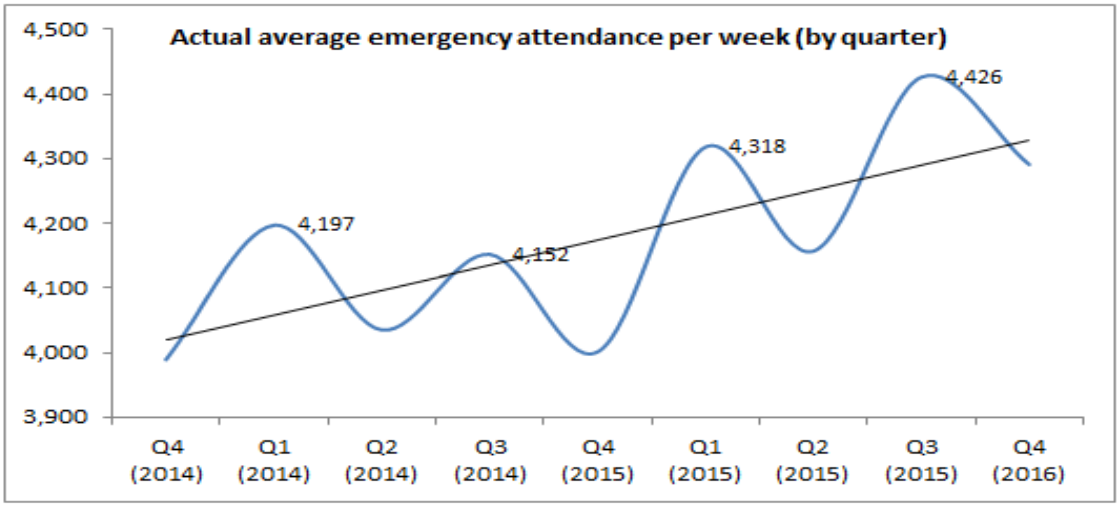
An effective and integrated emergency care system

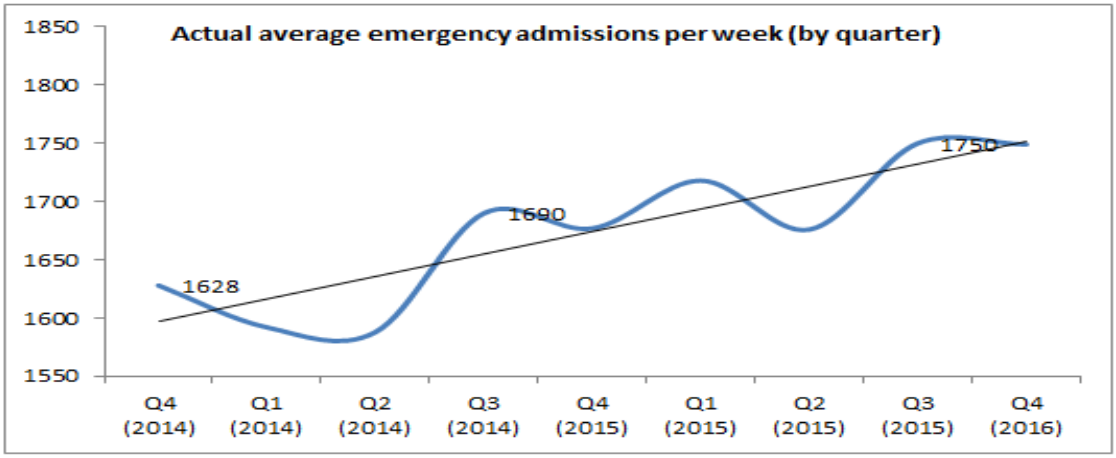
- Reduce emergency admissions through more comprehensive use of ambulatory care
- Improve the resilience of the Clinical Decisions Unit at Glenfield Hospital
- Improve the resilience of the Emergency Department in the evening and overnight
- Reduce emergency medicine length of stay through better clinical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

Reduce emergency admissions through more comprehensive use of ambulatory care

Over the past 12 months we have increased the capacity for delivering ambulatory care services, specifically offering a designated rapid access headache clinic and increasing the hours of the Acute Assessment Unit. Alongside this there has been a focused effort on increasing awareness of the Ambulatory Services that we have available and that are available in the community via the Ambulatory Emergency Care Directory, which is a live document available on our intranet and at all GP practices.

Whilst emergency admissions have continued to rise over the past 12 months, the percentage increase in emergency admissions is significantly less than the percentage increase in emergency attendances, demonstrating that schemes to avoid admitting a patient are having a positive effect. Emergency attendances have risen by 13 per cent (71 patients a day) compared to a 6 per cent increase in admissions (14 patients a day).





Ensuring patients are admitted into the hospital only when absolutely necessary remains a key focus for 2016/17 and we are exploring the benefits of putting more senior decision makers earlier in the patient journey and as part of the way we manage patients at our front door (Emergency Department). This very much links with the wider Leicester, Leicestershire and Rutland Urgent and Emergency Care Vanguard.

Improve the resilience of the Clinical Decisions Unit at Glenfield Hospital

The Clinical Decisions Unit at the Glenfield Hospital is an integral part of the emergency services we provide. The Clinical Decisions Unit has seen an average of 55 patients a day during the past year compared to 46 a day during 2014/15. Despite the increase in activity in the department, the performance metrics have remained positive. Over the past 12 months there has been a particular focus on increasing the numbers of patients who are discharged from the Unit within six hours which improves the experience of our patients.

Improve the resilience of the Emergency Department in the evening and overnight

The significantly increasing attendances to our Emergency Department, especially during the evening peak and into the night continue to put considerable pressure on the Department. Despite the increasing activity, we have been able to make the following improvements:

1. The proportion of patients triaged within 15 minutes has increased from 30 per cent to 90 per cent;
2. Performance against key Sepsis metrics have improved;
3. We have improved our performance against the quality and safety metrics.

We have also been doing an in depth review of staffing levels and skill mix to help reduce overcrowding ahead of the completion of the New Emergency Floor in winter 2016/17.

Reduce emergency medicine length of stay through better clinical and operational processes

Over the past year we have focused on streamlining internal processes to reduce delays when discharging patients. The additional support of Intermediate Care Services pathways for patients out of the hospital have improved and subsequently helped reduce delays in discharge. The length of stay for our patients treated within our Emergency Medicine specialty was 5.7 days in 2014/15 was 5.7 days, which has reduced to an average of 5.2 days (a reduction of almost 9 per cent).

Substantially reduce Emergency Department ambulance turnaround times

We have worked in partnership with EMAS (East Midlands Ambulance Service) to improve the time it takes to handover patients that they bring to our Emergency Department by ambulance.

Since November we have seen a 40 per cent reduction in delays those delays. However, despite these improvements we acknowledge we still have unacceptable delays in this process and this remains one of our top priorities for improvement this year (2016/17).

NHS choices

Improve the resilience of the Emergency Department in the evening and overnight

Anonymous gave Accident and emergency services at Leicester Royal Infirmary a rating of 4 stars

A Sunday visit to A&E

"I feel the need to leave a quick review about my experience at the Leicester Royal Infirmary. My experience yesterday in the A&E department could not have been a more positive one. It's so easy to be negative these days and especially in high anxiety situations, such as any trip to Casualty, but credit where credit is due. I would like to say a big thank you to all the LRI staff who dealt with me and cared for my injury. They were caring, kind, friendly and very professional. From arriving at reception to leaving after my treatment I felt completely at ease, albeit in a fair bit of pain. Thank you LRI, keep up the great work!"

Anonymous gave Accident and emergency services at Leicester Royal Infirmary a rating of 4 stars

Saturday visit to A&E

"My husband damaged his Achilles tendon. At 2.15pm he was booked in for assessment- no queue, he was seen within 30 mins by triage staff, who confirmed the nature of the damage, and the prognosis. He was then wheeled to yellow zone of minors, where we were expecting a wait of up to 2 hours, but he was seen within the hour, by the nurse on duty. The nurse informed him clearly what would happen next, and apart from a delay to find a wheelchair, and the sudden interruption of a fire alarm, we were swiftly transferred to the Fracture clinic, where he was treated respectfully by the staff, who were getting near the end of the shift, but still had a child and an elderly person to treat before finishing hopefully at 5pm. I was able to accompany my husband everywhere. I was glad that I could park in the multi storey car park, and easily pick him up outside A&E. We were well informed about the next stage in the treatment process, and were completed within 3 hours.
Thank you for a decent weekend service."

Improve productivity through re-design of major systems

Over the past year we have redesigned our Theatres and Outpatients services.

Theatres have run more sessions than ever before, and we have found ways to reduce the cost of running those sessions; meaning more patients have been operated on than ever before at a lower cost.

Within outpatients we have been focus on making sure that all of the appointment slots to see a doctor are filled, again meaning that more patients are seen without us having to create more clinic times.

Increasing our bed capacity

During 2015/16 we experienced an increased demand of 4.3 per cent in emergency admissions. Our length of stay reduced for patients staying greater than one day by 8.5 per cent, which would have created 44 more beds to meet this demand, but it was not enough to treat the increased numbers of patients we have been seeing. Coupled with this increase in demand, we have also made some reductions in the numbers of beds that we have because of staffing levels and the strategic reconfiguration programme.

Overall the bed capacity (the numbers of beds we have) has not been at the right level to meet the increases in demand we saw during the year and work has already been done to ensure that we are not in this same difficult position in 2016/17.

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.

Deliver the three 18-week Referral to Treatment (RTT) access standards

Despite the significant increase in the number of patients being admitted as an emergency we have maintained the key elective target of ensuring that not more than 8 per cent of the total waiting list is waiting longer than 18 weeks. We have now achieved this for 14 months in a row.

In the last year we have delivered all three RTT standards. In August 2015 the NHS as a whole decided to drop the admitted and non-admitted standards. We are now measured on how many patients are currently waiting over 18 weeks. This standard has been achieved despite the increase in patients needing emergency care requiring more hospital beds.

Deliver the three key cancer access standards

The number of patients being referred with suspected cancer is 9 per cent higher than last year. This has made it difficult to deliver the key cancer waiting time standards. We are proud that the standard to see all patients within two weeks of a cancer referral is now being delivered sustainably making sure that no patients wait longer than they should for an initial assessment.

Since April 2015 we have halved the number of cancer patients who wait too long for their first treatment. There is more to do to ensure we achieve this standard and from April 2016 we will be piloting a new project through Listening into Action to make sure that no cancer patient leaves our hospital without knowing, what, where and when their next step towards treatment is.

Deliver the diagnostics access standard

Disappointingly we have not achieved the Diagnostic standard for much of the year. This is due to correcting inappropriate waiting list practices which had made the previous performance look better than it actually was. We are now confident that all of the patients who should be recorded as actively waiting are, and we are on track to deliver the standard from April 2016.

Implement tools and processes that allow us to improve our overall responsiveness through tactical planning.

Having evaluated the costs of implementing tactical planning we decided we could not afford to do that last year. This is under review for future years whilst we focus on improving the capacity so we can routinely meet demand.

NHS choices

Deliver the three key cancer access standards

Tanya Smith gave Cancer Services at Leicester Royal Infirmary a rating of 5 stars

Cannot fault

★★★★★

"I was diagnosed with cervical cancer and from the minute I received my diagnosis I was taken under the wing of true professionals not only medically but in every aspect of care. My specialist nurse was compassionate and efficient. My appointments were initially to find out if the cancer had spread. I had 2 scans and an examination and I was treated very well indeed. I had to have a radical hysterectomy and chemo radiotherapy and although it was a whirlwind everything was explained properly and I felt cared for and valued. From consultant to radiographers, reception, even the person that took my blood, everyone was kind and considerate and efficient. After my hysterectomy it came to light that I would need further treatment. I felt devastated and was on the ward. My nurse arranged for me to have the privacy of a side room as I came to terms with my situation. I was able to stay in that room which was a godsend. I'm now all clear and feel so grateful for my treatment from start to finish with the NHS and Leicester Royal Infirmary. Thank you."

Sadia gave Cancer Services at Leicester Royal Infirmary a rating of 5 stars

thankyou to all staff on ward 27

★★★★★

"A personal thank you to the staff on ward 27 and my consultant for all you did for my daughter Batool. She battled with cancer for a long time and everyone one the ward where very supportive. A special thanks to the consultant the most amazing person in the world and you will always be in our hearts wishing you well. He is the most amazing doctor and treated us with the utmost respect. We would not have been able to cope with it all if him and his team weren't there for us."

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.

Deliver the Better Care Together year 2 programme of work

The Better Care Together programme includes a number of work streams led by clinicians that bring partners together to develop shared goals and support the implementation service improvement plans. During 2015/16, year 2 of our programme, we have delivered a number of changes that have directly improved patient and service user outcomes.

Better care together

Key achievements include:

Children's, Maternity and Neonatal

- Introduced Care Navigators that work with families, young people and children in coordinating care based on individual requirements;
- Made the support available to new parents more consistent across Leicester, Leicestershire and Rutland;
- Delivered a new integrated process for assessing, planning and delivering services for children and young people with special educational needs and disability (SEND);
- Secured £1.89m of funding for investment across partner agencies (in Leicester, Leicestershire and Rutland) for children and young people's mental health and well-being;
- Involved and engaged members of the public engagement and agreement of future options for maternity for public consultation.

End of Life

- Embedded 'Learning Lessons to Improve Care';
- Engaged staff on proposals to ensure understanding and support so that best practice is in place across all services.

Frail Older People and Dementia

- Improved and joined-up care for people who are frail and elderly, particularly through initiatives funded by the Better Care Fund (a pooled budget between health and social care);
- Improved crisis and rehabilitation resources for those with mental health issues;
- Introduced a new model of access to Emergency Department at the Royal Infirmary;
- Completed one of the most extensive pieces of engagement nationally work on the topic "What needs to happen to ensure that frail and older people live well in Leicester, Leicestershire and Rutland?";
- Increased the number of patients with care plans that live in care homes.

Learning Disabilities

- New 'step through facility' opened;
- Recruited a new Outreach Team that will be fully operational by April 2016;
- Work-stream broadened its remit and adopted the role of the Leicester, Leicestershire and Rutland Transforming Care Partnership Board.

Long Term Conditions

- Expanded access to the Rapid Access Heart Failure Clinic from Emergency Department and Clinical Decisions Unit began in December 2015;
- Developed four Leicester, Leicestershire and Rutland plans for 2016/17 (Cardiology/ Renal/ Respiratory/ Stroke and Neurology rehabilitation) planned as a unit for the first time;
- About 700 more patients with atrial fibrillation have been anti-coagulated, reducing approximately 20 strokes;
- Business case for Stroke and Neurology Rehabilitation was successful and secured £600,000 for 2016/17 to develop and redesign a new service;
- Leicester, Leicestershire and Rutland have been chosen to be part of a the first wave of the National Diabetes Prevention Programme starting in April 2016;
- Breathlessness pathway pilot started in November 2015.

Mental Health

- A new crisis house for people experiencing mental health distress opened its doors;
- New mental health urgent care clinic established;
- Recovery colleges about to open;
- Acute overspill placements significantly reduced. This means that less patients need to go out of Leicester, Leicestershire and Rutland for a mental health inpatient bed when they need one;
- Mental Health identified as a key part of the Urgent Care Vanguard.

Planned Care

- Increased the amount of care provided in community hospitals and added new services, including ophthalmology laser treatment and more endoscopy clinics, so that more patients are able to be treated closer to where they live;
- Orthopaedic triage pilot service up and running.

Urgent Care

- Work began at the Royal Infirmary on new £43.3m Emergency Department, the UK's first frailty friendly emergency department, with a fully integrated mental health unit;
- CCG's re-tendered and awarded new contracts for several urgent care centres across Leicester, Leicestershire and Rutland, including a new urgent care centre in Oadby;
- Awarded Vanguard status to transform urgent and emergency care.

Service Reconfiguration

- 130 Intensive Community Support beds have opened in the community, providing a more suitable service for patients that would otherwise be in a hospital inpatient bed;
- Avoided admission to hospital for patients who benefited from the Intensive Community Support service (instead of being referred to hospital) and reduced the length of stay for people who were able to be discharged sooner into the Intensive Community Support service.

Participate in Better Care Together formal public consultation

The Better Care Together Partnership between local NHS providers, the clinical commissioning groups, social care and the third sector was established in June 2013 with the aim of creating a single, integrated, 5-year strategy for the whole health and social care economy.

Whilst the vision is relatively simple the enactment is more complex and involves the harmonising of the individual 5-year strategies from six different partner organisations into one coherent plan. And because Better Care Together is all about the difficult task of improving care whilst saving money, there are inevitably difficult decisions along the way.

During 2015/16 an enormous amount of work has taken place to create and refine the Better Care Together plan. Originally the partnership expected to be in a position to consult with stakeholders and the public on the plan in autumn 2015, however in consultation with NHS England it was decided that despite much progress there was still more work to do and a revised date for consultation was set for spring 2016.

During the period that the project was gearing up for consultation the Government announced that the referendum on membership of the European Union to take place in late June 2016 and that there would therefore be a period of 'purdah' in the run up to the referendum. That means that public sector bodies, like the NHS, are restricted from launching any major public consultation activities until the campaigning and vote had taken place. As a consequence the Better Care Together consultation will take place soon after the EU referendum at the end of June 2016.

Develop and formalise partnerships with a range of providers including tertiary and local services

Our partnership with Northampton and Kettering General Hospitals to provide a single oncology service has continued and strengthened as we have appointed more oncologists to provide local services in Northamptonshire. The partnership has allowed us to successfully bid to provide advanced radiotherapy (Stereotactic Ablative Body Radiotherapy or SABR) for our patients.

Working with United Lincolnshire Hospitals, our vascular surgeons and interventional radiologists have shared their expertise and experience to set up an Endovascular Aortic Replacement (EVAR) in Boston, Lincolnshire. Our teams will continue to travel to Boston whilst the local teams build up their skills. Colleagues from Northampton will be joining our specialist vascular Multi-Disciplinary Team (MDT) meetings from April bringing together expertise from three counties for local patients.

Our urology team have just started a new relationship with United Lincolnshire Hospitals to make sure patients will be able to access robotic surgery in Leicester whilst supporting the development and delivery of local expertise in Lincolnshire.

Explore new models and partnerships to deliver integrated care

We have continued to work closely with our partners to look at new and innovative ways to look after patients, both inside and outside of our hospitals.

The Intensive Community Support service, in partnership with Leicestershire Partnership NHS Trust, provides care for patients with complex needs, in their own homes. The multi-disciplinary team of nurses and therapists provide up to four intensive one hour visits a day, and work closely with adult social care and others to ensure patients receive joined up and coordinated care. This is an expansion and enhancement of an existing service; more patients are now being looked after in the community, rather than in a hospital bed.

A 'clinical change team', made up of GPs, public health colleagues, our doctors and Better Care Together leads, is in place at Glenfield Hospital ensuring that, where possible, patients are moved into community services when it is safe to do so. The team is helping to ensure patients are cared for closer to home.

We worked closely with a range of partners (providers and commissioners) to develop a new ambulatory assessment service for walking patients who come to the Royal Infirmary. This forms part of the Leicester, Leicestershire and Rutland Urgent and Emergency Vanguard. We are one of seven Vanguard sites across England, working to improve the coordination of urgent and emergency care services and to reduce the pressure on our Emergency Department.

The new service involves an urgent care streaming service, which is delivered in partnership with Lakeside Healthcare, one of the largest GP 'super-practices' in the country. The service is located at the front of the hospital (next to our current Emergency Department) and is designed to relieve pressure in the department. Our exciting partnership with Lakeside means we now have specialist GPs (known as 'GP extensivists') working

alongside our own clinical team. Our GP partners from Lakeside have specific training in managing urgent, complex, vulnerable and elderly patients. The team assesses all ambulatory (walk in) patients on arrival and either treat or direct people to the most appropriate service, which may be the Emergency Department or a community service. Patients are more quickly and effectively assessed and treated, with high rates of patient satisfaction.

We have done a review of our services to ensure we meet the CQC test of service provision for patients experiencing mental health issues whilst receiving care within our hospitals. We have a responsibility to make sure that patients who come to our hospitals have parity of esteem for both their physical and mental health needs. We have established a Mental Health Board with representatives from inside and outside of our organisation to monitor our progress on this important area of work.

Alliance

Our Alliance is unique in the country and has been formed to provide community Elective Care services innovatively in Leicester, Leicestershire and Rutland. The Alliance has been formed by us, Leicestershire Partnership NHS Trust, LLR Provider Company, East Leicestershire and Rutland Clinical Commissioning Group and West Leicestershire Clinical Commissioning Group.

The contract marked a watershed moment in local health care and the key aim of this contractual arrangement is to provide high quality care to patients in the safest place, close to home, whilst reducing cost. This has meant that parts of some services have moved out of the Royal Infirmary, Glenfield or General Hospitals into the community, with some services moving from the community hospitals into primary care settings.

Over the past 12 months the Alliance has concentrated on developing an enhanced and expanded community offer across the county. Business cases have been approved and are in the implementation phase with services being delivered in community hospitals. The Alliance team have begun to look at opportunities within primary care and work has already started on phase two priorities for 2016/17.

Phase one priorities (2015/2016):	**Phase two priorities (2016/2017):**
Endoscopy/Gastroenterology	Urology
Dermatology	Diagnostics (re-procure imaging including MRI, 24 hour tapes)
Rheumatology	ENT - Tinnitus and hearing services
YAG laser treatment (ophthalmology)	Ophthalmology (intra-vitreal procedures)
Pain management	Community paediatrics
MSK	Medical day cases

Significant progress has taken place as they move from planning into delivering new services:

- Leicester City Clinical Commissioning Group joined the Alliance in January 2016;
- Established an active Clinical Reference Group with both GP and Consultants from across the system focussing on re-design;
- We delivered a financial surplus which we were able to re-invest into transforming our services;
- JAG accreditation approval for three hospital sites;
- Musculo-skeletal triage pilot developed in West Leicestershire.

Clinical pathway shift/progress:The Alliance has seen new, increased and/or enhanced services across community hospitals including:

- Starting to move 6,000 dermatology outpatients from the three main acute hospitals into community settings, supported by pathway change;

- During the year they moved 306 oculoplastic sessions into community hospitals in 2015/16;
- Barrett's oesophagus sessions are in place at Melton and Hinckley Hospitals and form part of the shift in activity for endoscopy and therefore the first in a planned movement of endoscopes to the Alliance;
- Bowel screening started in January and is taking place at Loughborough and Melton and will roll out to St Luke's Hospitals over the next year;
- Commenced the transfer of 2,600 endoscopies from the three main acute hospitals to community hospitals;
- Additional ophthalmology clinics;
- YAG laser treatment has started at Melton and will soon be starting in Loughborough.

Staffing: To ensure the organisation and workforce are fit for the future, several appointments have been made and training and development opportunities, identified including:

- All staff are now using Leicester's Hospitals terms and conditions and clinical policies;
- We have strengthened the leadership of our Clinical and Management team to support the operational delivery of activity;
- Appointment of a Clinical Skills Facilitator Appointment supporting the Alliance in identifying training needs for clinical staff and opportunities for development;
- Two gastroenterologist posts commenced with a further three appointments to start 2016/17;
- Up-skilling of staff in a variety of skills including PUVA (psoralen (P) and ultraviolet A (UVA) therapy), clinical procedures to support the movement of activity onto all of our community sites;
- There has been additional nurse training so that they can now prescribe drugs;
- In order to deliver a transformed suite of elective services closer to home we have developed a graduate rotational training programme for qualified staff wanting to work in endoscopy. The posts are a joint recruitment for a two year rotational post in endoscopy across four sites (two Leicester's Hospitals and two Alliance). A robust programme has been developed along with a competency framework and we will be interviewing candidates in early 2016/17;
- Development of Assistant Core Practitioners using a competency framework to support career progression for the non-qualified staff has started with two band 3 staff appointed within endoscopy. In addition we have recruited a band 4 Assistant Practitioner who is qualified to do plain film as long as a senior radiographer is on site. These new roles have been created because we have been unable to recruit a radiographer and evidences new ways of working;
- Begun up skilling of our workforce through HEEM funding and Leicester's Hospitals training and development opportunities.

As the Alliance approaches its third year there will be greater focus on increasing the delivery of activity from the acute sector into community and primary care settings.

While the initial impetus will be to shift the activity from acute hospitals to the Alliance (be that delivered in a community hospital, primary care or other provider), there will be more emphasis placed upon transforming services and delivering them in a different way. This will include redesigning care pathways and developing a workforce with the right skills fit for the future.

Governance Arrangements: The Alliance has a clear business structure and governance arrangements. The structure was created to ensure that the Alliance is driven by engagement with clinicians, patients and the public, whilst also being accountable to its partners. Each of the Alliance partners is represented through having senior staff on the Alliance Leadership Board, which is responsible for the overall strategic direction of the Alliance and the delivery of its objectives.

The Alliance has a small core team of management staff, who are responsible both for the operational delivery of contracted services and for taking forward the planned changes to elective care.

The Alliance governance structure interfaces with the governance structure of Better Care Together as well as the governance structures of each of its partners

Patient and Public Participation Group (PPPG): The role of the Patient Partnership is unique in contributing a key patient perspective to how, where and why new service design will, and is, improving patient care.

Interested new members are invited to apply, as these will contribute to playing an active role in the consultation and design of treatment systems, requiring views of the locality representatives.

Building on our relationships with GPs

We continue to work closely with our colleagues in general practice and the Clinical Commissioning Groups 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.

Over the past year we have continued to provide a monthly newsletter to GP's to update primary care on developments we have made; we offer educational sessions at Protected Learning Time events for primary care staff; we have released a third series of video based education 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 and we have expanded the number of specialities offering written advice and guidance through the NHS E-Referral Service.

An Annual Temperature Check Survey was conducted which for the first time was extended to all GP Practice staff. The feedback is being used to shape our action plan and priorities to further improve our services.

Finally, a new service is being piloted this year called 'Consultant Connect'. It allows us to offer GPs immediate access to telephone advice from one of our consultants. They can then offer guidance on how best to help patients get seen and treated in the most appropriate setting.

Working with Age UK Leicester Shire and Rutland

Age UK Leicester Shire and Rutland Information Centre

The Age UK Leicester Shire & Rutland Information Centre in the Windsor Building at the Royal Infirmary has now been open for just over eighteen months. The centre aims to provide patients, their carers, friends, family members and staff with information on the range of services available to older people.

Just over 2,100 people have now received support to enable them to either access care or support with many more calling into the centre for information, leaflets or just a friendly chat. As well as patients and relatives an ever increasing number of staff and volunteers are making regular use of the centre to collect information for their patients or wards and in some cases members of their own family. All of the Age UK staff and volunteers have commented on how welcome they have been made to feel by colleagues at the hospital and believe they are now seen as an integral part of the multidisciplinary team.

Age UK is able to provide varying levels of support depending on the older persons individual needs. In some cases it involves talking through the contents of the factsheets they have available on such topics as paying for residential care, lasting powers of attorney or benefits. Other patients or relatives require more intensive support to complete attendance allowance forms or arrangements made for them to see one of the specialist advisers, who can provide a tailor made package of advice on issues such as residential care, accessing help in the home or adaptations and claiming welfare benefits. In some cases we will refer to other services such as the Alzheimer's Society to ensure that patients and their carers receive additional support. All patients and carers are supported and empowered to make informed decisions about future care.

Arrangements are now in place to ensure that wards can access information guides and factsheets as staff have reported how beneficial and useful it is to have them available on the wards.

Anthony Donovan, the Executive Director of Age UK Leicester Shire & Rutland, commented *"We are really pleased at how the Information Centre has developed and believe that it now helps to ensure that older people and their carers have a greater awareness of the range of support, benefits and activities available to them, not*

just from Age UK but from other organisations. We are also delighted that it has enabled us to develop closer working relationships with staff from throughout Leicester's Hospitals."

The Age UK Information Centre is open Monday to Friday 10.00am to 4.00pm and is located opposite the Discharge Lounge on the ground floor of the Windsor Building at the Royal Infirmary.

Local people again make a difference to our older patients with our Make Christmas Special campaign

Again this Christmas Leicester's Hospitals and Age UK Leicester Shire & Rutland joined forces again to raise awareness of those patients who were too ill to leave hospital and celebrate Christmas.

We asked local people to donate a small gift to our older patients so that they have a gift to open on Christmas morning; for some this would have been the only gift they received.

Carole Ribbins, Deputy Chief Nurse at Leicester's Hospitals said: *"We have been overwhelmed by the response of local people, including our own staff; it is tremendous. This year a staggering 1,611 gifts were donated so every one of our older patients had something to open on Christmas morning, which I know meant so much."*

Tony Donovan, Executive Director at Age UK Leicester Shire and Rutland said: *"We are absolutely blown away with the generosity of the Leicestershire public who have really gotten behind this appeal again for the fourth year in a row. Without a doubt, the gifts donated made Christmas special for the older patients in Leicester Hospitals. We were delighted to have been asked to partner with Leicester Hospitals to help make the initiative a success."*

Alison Reynolds, Volunteer Services co-ordinator for Leicester's Hospitals, explains: *"Our volunteers were delighted to be involved in the Making Christmas Special campaign again this year. They really loved being able to give our elderly patients a Christmas to remember even though they were unwell."*

Armed Forces Corporate Covenant

On Thursday 5th November 2015 our Chairman, Karamjit Singh CBE, pledged our support to the Armed Forces by signing the Armed Forces Corporate Covenant

The purpose of the corporate covenant is to encourage support for service men and women, their families and veterans living and working in Leicester, Leicestershire and Rutland and to recognise and remember the sacrifices they have made. It encourages everyone within our organisation to offer support to the local Armed Forces community, making it easier for service personnel, families and veterans to receive help from the Ministry of Defence and other charitable and voluntary sector groups.

Our Trust Board has nominated a Non-Executive Director Col (Retd) Ian Crowe as the Board's Armed Forces Champion, ensuring that engagement is embedded at the highest levels of the Trust.

The covenant will build on the strong ties already demonstrated between ourselves and 2 Medical Army Regiment (Rutland) who in October sent eight Combat Medical Technicians and two registered nurses on clinical placement alongside our teams at the Royal Infirmary.

During their clinical placement they worked alongside some of our doctors and nurses in our Adult Intensive Care Unit and Emergency Department. They were able to develop their specialist clinical skills and knowledge in intensive and emergency care within a hospital environment, to complement their skills in the field.

Lieutenant Colonel Graham Johnson, Commanding Officer from 2 Medical Regiment said: *"This marks the start of an exciting journey for 2 Medical Regiment working in partnership with the Leicester's Hospitals. We look forward to developing a really positive working relationship*

and we are really grateful for the opportunity to work alongside their teams to deliver high quality patient care."

Major Debs Harvey is the Regimental Senior Nursing Officer from 2 Medical Regiment; she added: *"This is a real opportunity for military personnel to work in a clinical setting to maintain the highest clinical standards and ensure patient safety whether we are at home or abroad."*

"I was assigned to 2 Medical Regiment in May 2013 as Clinical Training Officer, to prepare for nearly 150 military medical providers to deploy to Afghanistan during the drawdown of combat operations in Helmand Province. I found this professionally demanding and hugely rewarding. During the seven months I was deployed in Afghanistan, I was providing training; driving forward Quality Improvement and ensuring the sharing of best practise through the Common Assurance Framework. I was really proud to receive the Director of Army Nursing's Annual Award for my endeavours during this operational tour."

"I was recently promoted to Major and am now the Senior Nursing Officer in 2 Medical Regiment providing clinical leadership. I am responsible for helping make sure that our staff are competent and have received the most up to date training so that they are ready to deliver quality patient care. The partnership with Leicester's Hospitals will take us a step closer to delivering our vision of 'patient centred excellence'. I look forward to working with the staff."

Heartsafe

In 2014 the Leicestershire Heartsafe Schools Programme started offering CPR training and the use of an automated external defibrillator (AED) to all year 10 pupils in Leicester and Leicestershire.

heartsafe leicestershire
creating young lifesavers

The aim of the project, run by the organisations listed below, is to create lifesavers in every community and to increase the survival rates of cardiac arrest victims, which currently stand at approximately 10 per cent in the UK, compared with 40 per cent or more in some equivalent countries. Across the UK, this could amount to many thousands of lives being saved by the dissemination of simple skills and awareness.

So far just over 10,000 of the 12,000 year 10 students and over 400 staff have been trained via the Heartsafe module and AED awareness courses.

Heartsafe is funded in the main by the East Midlands Pacemaker Fund and the Leicester Hospitals Charity. Other very significant sources of revenue have been the Joe Humphries Memorial Trust, Leicester City Football Club, Edith Murphy Foundation, Rotary Club, Spire Hospital, Millbrook Conferences and individual donors, and most recently Rothley Park Golf Club named Heartsafe as nominated charity for 2016.

The central element of the project is our volunteer trainers, the majority of whom have been recruited from Leicester's Hospitals. The trainers find the experience of working with the students enjoyable as well as believing the vision that targeting the younger generation systematically will change culture and response to cardiac arrest in the community.

We are trying to make an impact on a very real public health issue and plans to escalate to primary and tertiary education cohorts are in development and are represented in the background papers.

Moving those plans forward for the coming year, we have already received approval from the University of Leicester Medical School to train up the clinical medical students and early experience is very promising. We are also engaging with De Montfort University to explore developing a similar approach to Nursing and Allied Healthcare students. The win-win aspects of training trainers during University years and then including them in community based roll-out of simple but lifesaving skills will increase the impact of the Heartsafe approach on a wider basis. Sustaining the schools work and finding efficient training to offer in other locations are going to need this kind of expansion.

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.

Innovative research, nationally recognised research communications, strengthening academic relationships and UK firsts all form 'Leicester's Research'

Our Research and Innovation team have had a very busy and eventful year! We have continued to develop the approach that we implemented in 2014 with a view to enhancing our reputation as a centre of excellence for clinical research.

Develop a robust quality assurance process for medical education

Health Education Quality Visit

Health Education England (HEE - working across the East Midlands) visited us in November 2015. All visit requirements and recommendations are monitored by the Director of Medical Education and Assistant Chief Nurse as well as being regularly reviewed by the external quality team. There is good progress in all areas. As part of a regional review, we will be visited by the General Medical Council (GMC) in Autumn 2016. The GMC review will involve both undergraduate and postgraduate medical education.

Education Quality Process

Our Department of Clinical Education continues to implement a quality driven approach across our organisation. The role of the Clinical Management Group (CMG) Medical Education Lead is now embedded within the CMG structure and the Education Quality Dashboard is used for our medical education. A validated trainee survey has been carried out to understand their thoughts on the quality of the educational environment we offer. Outcomes from the survey will be reflected on the Dashboard for each CMG.

Trust Grade Project

A project to implement educational improvements for junior doctors that we employ in non-training positions continues to be financially supported by HEE. The project team have organised study days and seminars, a mentoring programme, developed a bespoke e-portfolio, and developed a process for standardising induction.

Further develop relationships with academic partners

As a team, we have always worked very closely with our colleagues who represent our academic partners but within the last year we have met to discuss a new, more collaborative approach. The University of Leicester in particular are reshaping their medical innovation and research strategy and all parties agree that it will be advantageous to align our individual strategies and work-streams where possible.

Academic Partnership with the University of Leicester

We have supported the development of a new Patient Simulation Unit in the Robert Kilpatrick building at the Royal Infirmary which opened early this year. The facility provides an improved environment for simulated patient teaching for undergraduate medical students and postgraduate trainees and is managed jointly by the University and ourselves.

We held a joint Listening into Action event for medical students with the University of Leicester aimed to improve student experience whilst training in Leicester. The event was well received by students and identified some important themes which are being addressed.

The enhanced partnership between us and the University of Leicester has led to the creation of a number of new Honorary Academic Appointments for Consultants with an exceptional commitment to education and training.

Deliver the Genomic Medicine Centre project

You may have also noticed a story about some of our patients who were interviewed on BBC Breakfast with Professor Julian Barwell, a Consultant in Clinical Genetics. Mary, Sandra and Kerry Lloyd are all sisters who were diagnosed with breast cancer. They have all consented to take part in the 100,000 Genomes Project which Professor Barwell leads in Leicester. Their story and Leicester's role in the East of England Genomics Medicine Centre went national after we were mentioned in a Life Sciences Announcement by George Freeman MP; the only NHS Trust to be mentioned in that speech. We are delighted that our hard work to launch this study was so successful and we hope to continue this success as it moves into the next specialty areas.

Comply with key NIHR and CRN metrics

One of our constant key performance indicators is to comply with National Institute for Health Research (NIHR) and Clinical Research Network: East Midlands (CRN: East Midlands) metrics. We are currently the highest recruiting Trust in the East Midlands, recruiting more than 12,000 patients to participate in national portfolio research studies. In terms of the key NIHR metric, we recruit the first patient within seventy days for over 90 per cent of applicable clinical trials.

Prepare for Biomedical Research Unit re-bidding

Bid to be an NIHR Biomedical Research Centre

During March we submitted a bid for a prestigious NIHR Biomedical Research Centre (BRC). This will bring together the existing areas of research strength that our Biomedical Research Units deliver into a single entity. The BRC will be composed of three themes: cardiovascular; respiratory; nutrition and lifestyle, with a cross-cutting theme of precision medicine. The University of Leicester will be our academic partner, but we also want to maintain our relationship with Loughborough University as a sub-contracting partner. The outcome of this bid will not be known until summer 2016.

Develop a Commercial Strategy to encourage innovation within our organisation

Our focus has incorporated the development of a commercial strategy. Our aim has been to not only promote the innovations that our staff have created, but to encourage innovation within our organisation. For the first time we took part in the NHS England Innovation Expo 2015 in Manchester. Not only did we have the most visited stand but we also received a visit from NHS England Chief Executive Simon Stephens who was extremely interested in how our Research and Innovation team are pushing the boundary with UK firsts such as, the Optimed Machine. This machine was introduced to our Pharmacy team and it automatically fulfils orders by providing the exact medication required for each patient rather than issuing packs of medication. Ultimately it will save us a large amount of money by eradicating waste, allowing precise ordering and ensuring that our teams are using the latest cutting-edge technology.

And there's more….

Recognised at national awards

Our approach to develop and focus on embedding and better promoting our innovative research resulted in our being shortlisted for a National Health Service Journal (HSJ) award. We were a finalist in the Clinical Research Impact category. Our Chief Executive John Adler, Professor Nigel Brunskill, Director of Research & Innovation, and few other members of our team were there at the prestigious awards in London to hear that we had made it into the final four from over 1,600 entries! Unfortunately we did not win, but to have gotten that far in the space of a year is a significant achievement and one that we hope to continue to emulate. For Professor Brunskill it was a double recognition of his work as his study IMPAKT which was also shortlisted in the Improving Care With Technology category. This was a collaboration with Leicester Clinical Commissioning Group (CCG) and NIHR Collaboration for Leadership in Applied Health Research and Care (CLAHRC) East Midlands to deliver in the community. A study research team led by our Director of Research and Innovation

Professor Brunskill, developed IMPAKT (IMProving Patient Care and Awareness of Kidney disease progression Together). IMPAKT is a software tool that can identify and risk stratify GP patients with 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 many thousands of people at risk with chronic kidney disease.

The way research is delivered is changing

All this activity is occurring during a period of significant change for us. The Health Research Authority (HRA) is changing the way that clinical research is being delivered in the UK. We have developed a comprehensive suite of processes that involve all research teams from the outset. Authorisation of research will be embedded within specialties and confirmed by the Research and Innovation office. Facilitation of the new processes has been enhanced by fully implementing a new database system to record activity and progress from first idea through to final publication. The EDGE system will be further developed over the next 12 months to enhance and embed processes further.

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

As the host organisation for the Clinical Research Network: East Midlands, we provide appropriate governance arrangements and a supportive environment to foster research collaborations across the region.

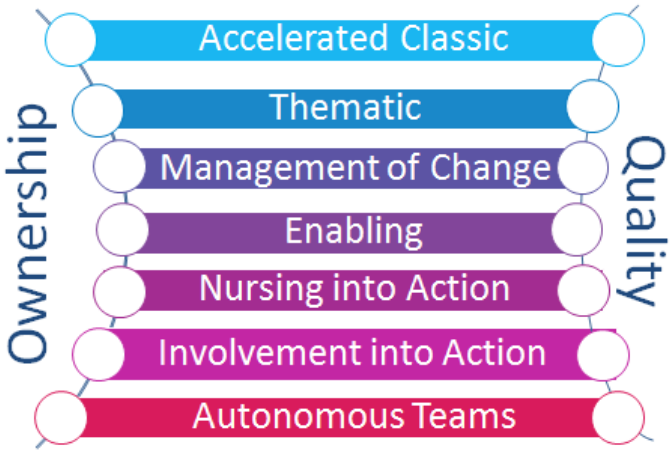
Many of the initiatives which have been implemented over the last two years have contributed to improved performance which means that we will receive a bigger budget for 2016/17. Over the past year we have performed well in delivering research within all 30 clinical specialities and in research settings across hospitals, community and primary care.

Other achievements include continuing our track record of excellent research delivery for the Life Sciences Industry, offering patients the opportunity to get involved in cutting edge research across the East Midlands. Our inaugural Research Awards event in late April, with over 100 nominations, clearly demonstrates that the East Midlands are a growing centre for delivering first class research to a very high standard.

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

Accelerate the roll out of Listening into Action



Since its launch in 2013, Listening into Action (LiA) has been used by teams across our organisation to engage and empower staff to help transform our hospitals and deliver Caring at its Best.

The Year 3 Plan was designed to reach further, faster into the Trust to broaden participation in Listening into Action. Classic LiA has seen the launch of two more waves of Pioneering Teams, along with over 90 nurse led teams that have used Nursing into Action to improve the quality of care and experience that patients receive.

Thematic LiA has been used to tackle some of the issues across the Trust such as making improvements to the apprenticeship programme, improving care for patients on cancer pathways and dealing with the frustrations that staff have around IM&T.

Building on the successes of Year 2, two more work streams were added; Involvement into Action and Autonomous Teams.

The LiA Team are working collaboratively with the Patient and Public Involvement Team to provide a process for engaging and involving patients in changes that we are planning. Using a co-design approach with staff and Patient Partners, resources are being developed that will guide and support the process of involving patients in change from the very beginning.

Listening into Action
Involvement into Action

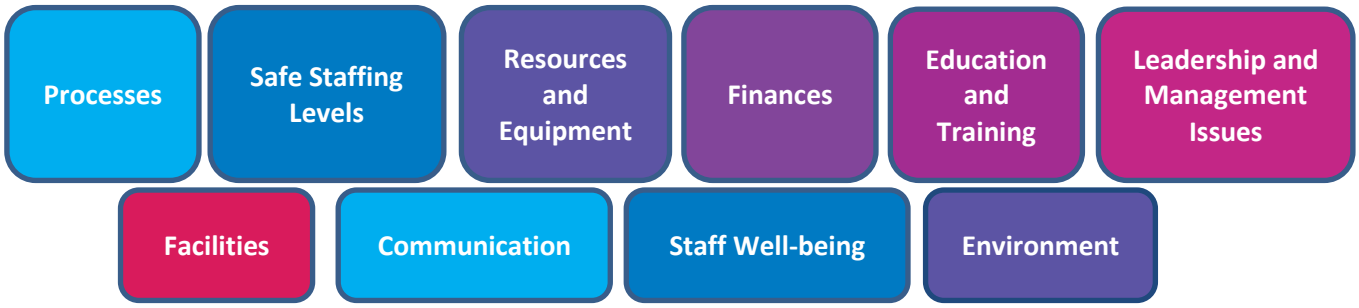
In February 2016 we introduced a new and improved pulse check – a mini survey for staff. The information collected will help inform whether staff feel engaged in their work, their teams and the wider organisation. It is important to understand what works well and what could be improved, to enable us to deliver the best outcomes for patients and make our organisation a place where everyone is happy and proud to work. 25 per cent of all staff will be surveyed every quarter and also included in the new pulse check are the Staff Friend and Family Test questions.

Take Trust-wide action to remove "things that get in the way"

In July 2015 we held five events that staff were invited to attend as we launched Delivering Caring at its Best – our 5-Year Plan. During the events members of staff were asked what gets in the way of them doing their job. All of the answers given were themed and through his briefings the Chief Executive is sharing 'what we are doing about it', 'what we will do about it' and 'what we can't do about it and why'.

Listening into Action
Tackling your day to day frustrations

Themes:



Embed a stronger more engaged leadership culture

Accountability into Action: In November 2014 our Executive Workforce Board and Trust Board agreed that we would commission three key leadership programmes under the overarching framework of 'Accountability into Action', namely, Influencer, Crucial Conversations and Crucial Accountability.

Based on our objectives the 'Influencer' programme was introduced first to 23 of our senior leaders in 2015, to optimise the sustainability of leading change. Influencer highlights 'vital behaviours' that are imperative to achieving results; such as 'being held accountable for behaviour'. Logically the introduction of Crucial Conversations and Accountability follows on from Influencer training.

A Train the Trainer approach was built into the original proposal and eight senior leaders are now trained to teach the Influencer programme across the Trust. The roll out of this training started in August 2015 and we run one programme a month (71 delegates trained to date), with continuous on-going review. Crucial Conversations and Accountability is provided on a monthly basis as the Train the Trainer programme has been completed by a group of Senior Leaders (November 2015). Monthly programmes started in December 2015, and so far we have trained 32 staff.

360 Degree Leadership Appraisal: we have set out a phased approach to implementing the Healthcare Leadership Model launched in July 2015. The model aligns with our values and now forms part of the 'Leadership Appraisal'.

The NHS Leadership Academy Self-Assessment and 360 Assessment Tool provided through the Healthcare Leadership Model Appraisal Hub is a helpful way to better understand leadership behaviours and highlight areas of strength, weakness and areas that may need greater focus.

All executive and senior leaders are required to complete a 360 Assessment by the end of March 2016. The expectation is that the 360 Assessment is repeated every three years or more frequently as appropriate.

All staff in band 5 and above roles are required to complete the self-assessment tool on an annual basis, as part of the appraisal preparation process.

Research into 360° feedback has shown that the provision of quality feedback via a coach or facilitated session plays a crucial role in encouraging managers to accept the results and initiate behavioural change. During July 2015, 15 facilitators were trained to provide quality feedback with further sessions planned in throughout 2016/17.

Develop and implement a Medical Workforce Strategy

The Medical Workforce Strategy is an integrated strategy covering workforce planning and redesign and education and engagement. During 2015/16 significant progress has been made in the implementation of the strategy.

Recruitment and reshaping of the medical workforce

International medical recruitment has expanded to fill vacant training and Trust funded posts and plans are now in place for rolling Trust Grade rotational recruitment programmes across all specialty clusters with joint agreements in place on advertising, shortlisting and interview dates

Five Physician Associates are due to start in post in June 2016 in paediatrics, urology, gastroenterology and orthopaedics and a number of advanced nurse practitioners are being trained to achieve our ambition of creating 'teams around the patient'. Through Health Education East Midlands (HEEM) funding we have been able to increase our capacity to create an Advanced Practice Unit to support the governance and development of such roles.

Development and engagement of the Medical Workforce

The Doctors' in Training Committee has continued this year with expanding representation across specialties and grades. Such committee members are encouraged to participate in Trust wide projects and programmes of innovation and change.

The development of a Simulation training programme, a bespoke e-portfolio, a buddying system and the delivery of an Integration Seminar are some of the outcomes of the Trust Grade project which was supported by Health Education East Midlands funding.

Implement new actions to respond to the equality and diversity agenda

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:

Our Learning Disability Service was successful in securing some funding for the Learning Disability Nursing Service this year. We have improved the care experience of inpatients by implementing a patient record system that allows us to report on a variety of measures that will enhance patient care; purchasing activity items for use for those patients who are highly anxious or stressed by their hospital admission and increasing the numbers of easy read patient information leaflets available.

Visual Impairment Staff Awareness Training was set up over four days by our Equality Team for staff with the aim of increasing awareness of the needs of people with a visual or dual sensory impairment to improve the patient experience. The training was delivered by Vista, our local charity who provides services and support to blind and partially sighted people within our region.

Interpreting and Translation Services have seen a year on year increase in the number or interpreting bookings since 2011 and we are now booking an average of 925 sessions a month, 300 more than in 2011. Of those bookings 350 are for British Sign Language. Despite a rise in the different languages requested over the last four years, the top five languages remain unchanged.

Hearing Loop review of our static hearing loops was carried out and a repair and replacement programme is scheduled to start in April 2016. We have also purchased 53 individual hearing amplifiers for use by individual patients on the wards.

Representation in the Workforce has been a main focus for this year, particularly the representation of Black and Minority Ethnic (BME) staff in senior positions. This issue is of national interest and has resulted in the introduction of a workforce Race Equality Standard that all NHS Trusts have adopted. In response to this, we set up a Diversity Task and Finish Diversity group in August at the request of the Chairman to specifically address the low levels of BME representation at senior levels in our organisation.

Our priorities for 2016/17 are:

- To improve representation in senior management positions, and
- To improve the level of communication support for patients by implementing in full the Accessible Information Standard.

Ensure compliance with new national whistleblowing policies

In February 2015, Sir Robert Francis published his report 'Freedom to Speak Up' which looked at the culture within the NHS and the confidence of patients, relatives and staff to raise concerns about safety and quality.

We have embraced the principles within the report and are actively pursuing a culture of openness, listening and learning. This can be seen in the complaints handling and the establishment of the new Independent Complaints Review Panel, our new Duty of Candour Policy and the transparency of serious incident reports. During the last year we actively promoted staff to raise concerns via a variety of mechanisms including the 3636 staff concerns line, the junior doctor gripe tool, executive safety walkabouts and Breakfast with the Boss, to name a few.

On 1st April 2016, NHS England published a single national integrated whistleblowing policy, recommended by Sir Robert Francis in his Freedom to Speak up review.

The new policy contributes to the need to develop a more open and supportive culture that encourages staff to raise any issue of patient care quality or safety.

We are reviewing our Whistleblowing policy and support mechanisms already in place in light of the recent publications, to enhance current practice and to ensure national requirements are fully incorporated.

Our staff

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

	2015/16	2014/15	2013/14	2012/13	2011/12	2010/11	2009/10
Medical and Dental	1,680	1,645	1,570	1,551	1,496	1,477	1,496
Administration and Estates	2,500	2,383	2,095	2,066	2,417	2,534	2,624
Healthcare Assistants and other support staff	2,042	2,044	1,955	1,811	1,710	1,781	1,882
Registered Nursing and Midwifery	3,547	3,531	3,345	3,230	3,195	3,168	3,091
Scientific, Therapeutic and Technical	1,306	1,272	1,201	1,202	1,210	1,210	1,328
TOTAL	**11,075**	**10,874**	**10,167**	**9,860**	**10,029**	**10,171**	**10,421**

NHS staff survey

The thirteenth National Staff Survey was carried out between September and December 2015. The survey is conducted on behalf of NHS England and the results form a key part of the Care Quality Commission's assessment of NHS Trusts in respect of its regulatory activities such as registration, the monitoring of on-going compliance and reviews. We surveyed a sample of 850 staff and had a response rate of 24 per cent.

In addition to the national staff survey we carried out an independent Pulse Check survey on 25 per cent of all of our staff in February 2016 and 20.4 per cent of those staff responded. The Pulse Check was carried out by Wrightington, Wigan and Leigh who developed the Pulse Check as a result of extensive research into the drivers of staff engagement. Together these surveys indicate not only measures of engagement but also factors which drive engagement.

The results of the National Staff Survey were generally an improvement on the 2014 survey, particularly in relation to factors relating to care of patients, levels of motivation and clarity in relation to roles and responsibilities. Emphasising the importance of our Quality Commitment formed a cornerstone of last year's action plan and has delivered measureable improvement.

The key measure of overall engagement has improved consistently over the last five years; the factors which make up this score and their respective outcomes are summarised below:

	2011	2012	2013	2014	2015
Overall Staff Engagement	3.52	3.66	3.67	3.65	3.77 (3.79)
Staff recommendation as a place to work/receive treatment	3.2	3.44	3.51	3.49	3.68 (3.76 below average)
Staff Motivation	3.79	3.86	3.83	3.83	4.02 (3.94 best 20%)
Staff ability to contribute to improvements at work	62	71	68	65	67 (69, lowest 20%)

Work will continue on improving our Staff Survey results into 2016/17 through incorporation of actions into the implementation of the UHL Way, which focus on staff contribution and involvement in transformation and change.

Experiments in autonomy, incentivisation and shared governance

In February we launched our new Autonomous Teams Pilot Programme. The aim of the pilot is to explore whether allowing an Autonomous Team to operate with significant decision-making powers and freedoms (as defined within the terms of reference) could provide the potential benefits of improved staff engagement and patient experiences and outcomes.

It will be based within our Orthopaedics Service for the purpose of operating our Elective Orthopaedics, Trauma and Theatres Team. The team will be known as the Trauma, Orthopaedics and Theatres Leadership Board with membership supported by front-line staff. It will remain within the confines of the existing Clinical Management Group governance structure, but being ring-fenced as its own business unit; reporting to the relevant Clinical Management Group Boards.

Improvements will come from an active involvement of staff in decision-making and therefore having more control over their affairs; creating a virtual sense of ownership.

In February 2015, we published the Autonomous Team handbook and have created a newsletter to help spread the word. The next stage will see us supporting the team by providing 'Train the Facilitator' sessions to key personnel to ensure that that the team is appropriately equipped to host engagement events.

Recruiting more nursing staff

We monitor our nursing staff vacancies on a monthly basis, which are then reported to Nursing Executive, shared with our commissioners, and reported to our Trust Board. Alongside this, our nurse to bed ratio is calculated and reported monthly in all nursing workforce reports. There is a detailed action, reviewed monthly focusing on our nursing recruitment activity.

This year we have introduced a dedicated nursing recruitment team to ensure a proactive and rapid response to demand and manage bulk recruitment drives. Our recruitment activity is detailed within the workforce report, alongside our temporary staffing spend and use of temporary staffing to fill the vacancies.

We have implemented weekly pay for Bank nursing staff, and our focus has remained on reducing/ filling our nursing vacancies. We also introduced Recruitment and Retention premia in areas where it is particularly difficult to fill, such as the Emergency Department.

We are proactively recruiting international nurses, as well as continuing with our national recruitment. We are maximising our opportunities by attending national jobs fairs, and recruiting our local university nursing and midwifery students.

We have invested significantly in a learning and development programme to support the recruitment of International nurses. Over the last two years we have recruited over 400 nurses, and of those 58 have chosen to leave our organisation. The main reasons for leaving are returning home and relocating to London. However, many of these nurses are now pursuing further professional education and mentorship modules via the Learning Beyond Registration contract demonstrating a long term commitment to our organisation.

To improve the quality and training of new recruits and reduce turnover levels we have introduced an apprenticeship programme for healthcare assistants. It is also important that we attract people the capability and drive to complete the Care Certificate that healthcare assistants are now required to complete.

When advertising nursing vacancies, our primary advertising media is NHS jobs, where there is a dedicated nursing recruitment page. Any other advertising that we do, either through press, trade press or social media, directs all applicants to this dedicated web page which gives us a prime opportunity to promote the Trust, our achievements and staff benefits. We also have a Reward and Recognition Strategy in place to support the recruitment and retention of staff.

In partnership with our supplier for recruitment marketing, we have designed innovative advertising materials for each specialty which reflect both our overarching values and a brand specific to each specialty. The materials portray staff describing what they value most about Leicester, our organisation and the specialty in which they work to give potential applicants an insight into working here. A number of services use this to have a programme of rolling adverts that are service specific.

We are in a fortunate position of having a local university (De Montfort University) that provides pre-registration nurse and midwifery training. There are two intakes of students a year for adult nursing at De Montfort University (September and January) and two outputs of newly qualified adult nurses (November and March). For children's nursing and midwifery there is now support for two intakes/outputs a year (previously only one).

De Montfort University offers an employability event for student midwives and nurses in their final semester which we have attended. Feedback from the two events held to date has been very positive with the students valuing the opportunity to talk to our staff and get the assurance that they want about appropriate support and development opportunities available to newly qualified nurses and midwives. Subsequent speciality based recruitment events, such as 'Tea with Matron', have also provided the students with additional assurance. Approximately 90 per cent of all students who qualify stay within Leicestershire, with the majority accepting a job in one of our hospitals; this equates to on average 200 nurses (adult and child) and midwives a year.

We have embraced Preceptorship for many years. In 2010 this work was streamlined and standardised to ensure that all newly registered nurses joining us received the same education and support. Preceptorship includes three core study days and up to four Clinical Management Group specific study days over a six month period, four weeks supernumerary on gaining their PIN number to support the transition from Student to Staff Nurse and comprehensive Administration of Medicines assessment which incorporates a maths exam. We are currently carrying out a review of the Preceptorship Policy to reflect this work and will also incorporate Allied Health Professional colleagues.

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

Development of new roles (linked to productivity improvement)

This year we have started a training programme for Assistant Practitioners and currently have a cohort of over 40 participants. These individuals will be placed across a number of areas of nursing and following a QCF level 5 education programme, they will be able to carry out more autonomous decision making in their area of work. We have requested to be a pilot site for the development of the Nursing Associate role and work has started to ensure there is a career pathway in place for those currently participating in the assistant practitioner programme. Our first fully qualified Assistant Practitioners will be in place for 2017.

Over the past 18 months we have been working with De Montfort University to develop a local master's in Advanced Clinical Practice.

Healthcare providers across Leicestershire now have a programme that can help to train and develop Advanced Practitioners and we have nine senior nursing students studying to become Advanced Practitioners to enable them to see, diagnose and discharge patients. These nurses will be fully qualified in 2017.

A further cohort of approximately ten nurses will start the next programme in September 2016, mainly in cardiology. Currently there are 23 qualified Advanced Practitioners in post and through the development of an Advanced Clinical Practice Unit we have developed robust systems for competency development, supervision and appraisal following NMC (Nursing and Midwifery Council) revalidation principles.

We have participated in the National Physician Associate Expansion Programme, which aimed to recruit a cohort of very experienced Physician Associates to the UK. We have been allocated six to start in July 2016 in Orthopaedics, Paediatrics, Gastroenterology and Urology. These individuals will not only support history taking and diagnosis, normally carried out by junior doctors, but will also support the development of a locally delivered programme.

Reducing staff absence

In 2014 we saw a small increase in sickness absence to 3.72 per cent, against the 3 per cent target. This was in part due to significant organisational changes affecting staff working hours, site and roles during 2014, and improved reporting of sickness absence and reasons through the full implementation of an in-house sickness monitoring and reporting system (SMART). SMART monitors the completion of 'return to work' discussions and ensure compliance with our Sickness Absence Policy. In 2015/16, we saw a reduction in sickness absence to 3.61 per cent (January 2016).

Recognising that our staff are our most valuable resource, the approach that we have taken to reduce sickness absence in the last year goes hand in hand with promoting staff wellbeing. In response to the sickness absence data various initiatives have been implemented and evaluated to improve staff health and wellbeing. These include the increased provision of self-referral and fast track physiotherapy, emotional resilience workshops, self-care at work 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 training for line managers.

Managers are supported by Human Resources, Occupational Health and when required AMICA (our confidential counselling service) to manage sickness absence in line with our policy and supporting staff to attend work regularly or sustain a return to work following a period of absence. We are currently reviewing our Sickness Absence Policy following staff and management feedback, and will provide greater clarity and an increased focus on supporting staff on long term sickness absence.

Our Health and Well-being Steering Group is held quarterly 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 our taff Lottery) can use funds to improve the health and well-being of staff.

We recognise that there are many positives benefits from improving employee health and well-being, including 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 attending work regularly. This is closely supported by our staff lottery-funded health and well-being programme which provides a range of holistic activities for staff, including a Family Fun Day, exercise classes focusing on different abilities, 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. Staff are also able to bid for funds to enhance their working life/ environment.

We are developing a Health and Well-being Strategy in partnership with key stakeholders, and have recently obtained a designated Executive Board Member to oversee staff health and wellbeing.

Learning and development

Ensuring all of our staff have access to the right skills and knowledge is crucial if we are to deliver Caring at its Best, and we are committed to providing learning and development opportunities to all staff. 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 NHS needs.

This 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, where we competed 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 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, in addition to our own robust monitoring of the training we provide.

Through an annual grant from Health Education East Midlands that we received during the year, we invested £233,475 in learning and development to support employees in Agenda for Change pay bands 1-4 (support staff). It was used to fund appropriate learning and development needs identified through the appraisal process and enabled these staff to the gain skills and qualifications that we need to improve patient care and the delivery of our services.

We are responsible for the delivery of Statutory and Mandatory Training to all of our staff. Impressively this year we moved from just 40 per cent of our staff fully compliant, to 93 per cent of staff fully compliant across ten core programmes – the best improvement regionally. This improvement has been supported by an increase in training provision and the provision of e-learning programmes aligned to the national Core Skills Training Framework (Skills for Health). We have also introduced a more robust process for monitoring performance.

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

Apprenticeships

Following a decision to increase the offer of apprenticeships, 125 Intermediate, Advanced and Higher Apprenticeships joined us during 2015/16, an increase of 75 per cent on the previous year.

Half were new recruits completing an Intermediate Apprenticeship and half were existing staff developing new skills at all levels. Of these 26 started the new two-year Higher Apprenticeship Assistant Practitioner that we delivered internally. The new Apprentice recruits joined us in roles such as Health Care Assistants, Maternity Care Assistants, Physiotherapy Assistants, Pharmacy Assistants, Communication Administrators, Medical Records Assistants, Clinic Coordinators and Ward Clerks. During 2015/16 38 of our 2014/15 cohort completed their apprenticeships and many were offered permanent roles within our organisation.

Based on our success, we anticipate the offer of Apprenticeships will continue to grow.

Work experience

We currently offer work experience for varying durations for Year 12 and 13 students, degree graduates on clinical programmes and those doing health and social care related courses. In 2015/16 we supported 265 placements, 34 in Nursing and Midwifery, 50 in Radiography and Theatres, 80 in Physiotherapy and 96 medical observation sessions in all departments across all three of our hospitals.

Prince's Trust get into hospital services programme

We continue to work in conjunction with The Prince's Trust to deliver our 'Get into Hospital Services' scheme. The purpose of this scheme is to provide four weeks work based training and classroom learning within the hospital 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 take part in induction training, employability skills sessions, role related training and practical experience. In 2015/16 we delivered our first three 'Get into Hospital Services' programmes jointly with The Princes Trust, which proved to be very popular with the 40 local young people who got involved.

Celebrating achievements

Our annual training awards ceremony allows us to celebrate staff achievements in learning and development. At our annual event in March 2015, 124 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

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. The 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.

The Caring at its Best Awards reflect six categories, one for each of our values (nominated by staff) and one public nominated award.

All winners and highly commended staff from throughout the year were invited to the annual dinner hosted by our chairman in September. At the event all of our winners were celebrated and a judging panel made up of Rt Honourable Keith Vaz MP, Chief Constable Simon Cole, Tony Donovan from Leicestershire and Rutland Age UK, Professor Mayur Lakhani, Chair of West Leicestershire CCG, Deputy Mayor Rory Palmer, Jim Davis and Jo Hayward from BBC Radio Leicester, Peggy O'Donnell, Royal Volunteer Service, Rick Moore, Chair of Healthwatch Leicester and Kevin Booth, Editor from the Leicester Mercury who chose overall "winners" who were presented with a certificate and trophy. We also presented an award in the category "Volunteer of the Year" in thanks for the support and commitment they give to our organisation.

You can watch the videos of those shortlisted via our website.

Retaining our staff

We have been doing a lot of work to encourage our staff to stay with us.

We have developed an online approach to pulling together data gathered when leavers have exit interviews. This provides much richer data on the reasons for leaving the organisation and is simple to analyse at both staff group and Clinical Management Group level. For the first time we have also introduced a retention survey to understand what factors may drive people to leave the organisation. This has been introduced in two of our Clinical Management Groups, ITAPS (Critical Care, Theatres, Anaesthesia, Pain and Sleep) and ESM (Emergency and Specialist Medicine).

Across the Better Care Together Programme, we have started work on an attraction strategy which will focus on retaining the clinical workforce within Leicester, Leicestershire and Rutland by offering development and secondment opportunities across organisational boundaries

Within nursing, we have re-introduced the Senior Staff Nurse role 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 De Montfort University 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 2016.

Our Nurse Educators are reviewing their job plans to increase the amount of clinical time with newly qualified Nurses, Midwives and newly appointed Health Care Assistant's providing additional support for mentors, particularly within our Emergency and Specialist Medicine Clinical Management Group.

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') with the vast majority of staff being members.

Our range of six Salary Exchange schemes continues to very popular with over 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. Our unique on-line 'Employee Benefits Portal' continues to develop and facilitate ease of access what is available to staff.

In March 2016 we welcomed around 1,100 staff to our third highly successful Staff Benefits Fair where we showcased all of the benefits available to staff, supported by experts all in one place.

NHS Total Rewards Statement continues to be popular with staff viewing a personalised summary of their employment detailing their full employment package throughout the year including basic pay, allowances, Salary Exchange schemes and pension benefits (for NHS Pension Scheme members only).

Despite all of these additional benefits we recognise that it is still important that we recognise the individual successes of our staff, their innovations, quality care and exceptional work for patients.

Occupational health support

Our in-house Occupational Health Service remains an integral part of our 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 enables us to keep our staff in employment, including rehabilitation in work programmes for those who have suffered significant illness or injury. Our remit includes occupational health provision for all healthcare staff and students in Leicestershire and has recently expanded to include clinics at Northampton General Hospital and University of Leicester, assisted by the appointment of two new consultant physicians.

The Occupational Health Service maintains a national profile with our Head of Service Dr Anne de Bono also acting as Chair of the NHS Health at Work Board, representing NHS Occupational Health Services across England. Dr Harj Kaul has just been appointed as National Training Programme Director for Occupational Health, to oversee training for doctors, nurses and Allied Health Professionals in the first multidisciplinary national postgraduate training school.

Alongside these new ventures we continue our core role, which is to help our staff deliver the best care possible for our patients.

Staff raising concerns

3636 Staff Concerns Reporting Line

We are committed to dealing openly, promptly and efficiently with any genuine safety concerns raised by staff. To this end we operate a staff concerns reporting line whereby any member of staff can dial 3636 from any internal telephone or submit an online form via our intranet 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.

Over the past year we have received 23 calls, all of which were followed up on and reported to our Executive Quality Board. As a consequence of staff raising these concerns, actions have been implemented and systems strengthened.

Junior Doctors Gripe Tool

As an organisation, we recognise that to improve quality and safety of patient care it is essential to enable staff to report concerns. Although junior doctors often have such concerns, barriers to reporting these include difficult to use reporting systems, a perception that reporting results in no action, and a lack of feedback.

In the spring last year a web-based tool called the Gripes reporting tool was developed and piloted to provide our junior doctors with a simple and effective mechanism of reporting their concerns. Following a successful pilot and focus group evaluation, the project was re-launched in December 2015 and the tool is now open permanently for submissions.

Since re-launch we have received 50 gripes through the reporting tool, covering a wide range of topics. The gripes are divided into six categories with an associate medical director responsible for each. Every gripe submitted is reviewed by a member of the gripes team and a personal email of acknowledgement sent in reply if contact details are provided. They are then discussed with the appropriate associate medical director, if necessary, investigated and actions taken to try to resolve the concerns and improve systems and processes.

We recognise that for the Gripes tool to be successful it is crucial to provide the junior doctor cohort with feedback about the Gripes submitted and actions taken to address the concerns raised. In May 2016 we will pilot and subsequently evaluate feedback that we gather about the tool and how we might further improve it.

Health and safety

We are really pleased that 96 per cent of our staff completed their health and safety training, continuing our excellent compliance rate.

This year we recruited a Health and Safety technician, who has been invaluable in supporting our work plan.

For the fifth year running we have seen a reduction of RIDDOR reportable injuries

Health and Safety Services led a £400,000 investment programme to change over to "Safer Sharps" alternatives in line with national policy. This involves some 180 million items a year, mainly needles, and we completed the changeover within just six months. During a recent visit from Health and Safety Executive they said they *"were pleased we had put in place robust and sustainable Sharps safety management systems for the Trust to build upon."*

The Health and Safety Environmental Audit has been completed which has allowed us to target priorities for the 2016/17 work plan. We have now conducted a review of services and put in plans of action to enhance and take the service forward.

Manual Handling

Manual Handling training compliance for this year is 94 per cent, continuing our year-on-year improvement.

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

We have instituted a fixed price rental agreement that has seen our stock of specialist equipment double whilst producing savings of £60,000 a year.

We have invested in specialist moving equipment for patients over 250kgs, which has greatly assisted the care of patients and been a significant factor in promoting safer handling safety for staff.

Security Management

Conflict Management training compliance for the year reached 96 per cent.

Unfortunately this year we have had to take sanctions out against 60 members of the public due to behaviour issues. This continues our commitment to maintaining a safe and secure environment for our staff and patients.

We are now actively involved with our partners in the Overall Crime Reduction working group. This is a multi-agency approach that formulates partnerships with community agencies and allows the sharing crime intelligence.

The Local Security Action management plan for NHS Protect standards has been submitted showing steady progress since last year.

This year saw the creation of a bespoke security management training facility which has allowed us to conduct the full remit of security related training on our premises.

Risk management

Risk Management is an integral element of our management processes. The success of our services requires us to identify risks and ensure that these are adequately managed so that we can achieve of our objectives.

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. These risks are assessed and reported on our risk register, subsequently, providing a dynamic risk profile to aid decision-making.

During 2015/16 a strengthened risk reporting process was introduced to provide greater accountability for risk and to ensure a clear line of sight for risks from 'ward to board'. Increased emphasis continues to ensure that risk treatments are regularly reviewed to confirm actions are completed within their specified time frame.

These reviews are performed by local management boards and also by the executive team and 'closing the loop' on these actions has brought about a reduction in the number of long-term risks recorded on the risk register.

We also identified a number of principal risks during the year that may have had the potential to adversely affect the achievement of our strategic objectives. These risks were assigned to an executive lead and reported on the Trust Board Assurance Framework. The Assurance Framework is reviewed by the Trust Board on a monthly basis to provide assurance that these principal risks continue to be mitigated as far as practicable.

Medical Device Incident Reporting and the Central Alerting System (CAS): The Medicines and Healthcare products Regulatory Agency (MHRA) and NHS England have formed a strategic partnership to develop safety alerts and guidance to improve the reporting of, and learning from, medical device incidents.

We have taken a number of local actions to ensure we are compliant with the national framework, including:

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

Work programmes continue to improve data quality in relation to medical device incident reports which enable more effective data analysis to provide early indications of prevalent incident trends.

NHS England also 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 has led to changes in the way in which we manage patient safety alerts and the following recommendations were implemented to provide a more effective governance structure in relation to the management of 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 national alerts have been taken within specified timescales. We consistently achieve a high level of compliance with deadlines. Between 1 January and 31 December 2015 we received a total of 108 alerts, with only one deadline for compliance breached, which equates to 99 per cent of alerts received being acted upon within their specified due date.

Looking ahead….corporate risk team priorities for 2016/17

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

- Working closely with local management teams and the Executive Team to provide specialised support and guidance to help embed risk;
- Reviewing our risk management framework ensuring it is 'fit for purpose' and continue to reflect best practice including strengthening our arrangements for the identification of 'emerging risks';
- Continuing to develop our internal risk management web pages to provide a risk management resource for all our staff via the newly developed 'Patient Safety Portal';
- Continuing to provide bespoke risk awareness training to local teams and managers;
- Exploring the feasibility of using a web based risk register tool to record and report risks;

- Carrying out annual audits in relation to CAS alerts to measure the effectiveness of local management controls;
- Implementing local safety standards for invasive procedures based on the national framework of safety standards to further reduce the risk of 'Never Events' associated with surgical procedures.

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).

Deliver the actions required for year 2 of the 5-Year Plan (develop Site Development Control Plans for all three sites)

Site Development Control Plans are maps of our hospital sites that clearly show where buildings are, what services are in each building, and how those buildings will change as we move forward with our ambitious reconfiguration plans.

Site Development Control Plans have been completed for our three main hospital sites, the General, Royal Infirmary and Glenfield, and will be updated in the coming year to reflect the very latest position as we move forward with our five year strategy.

Improve ITU capacity issues including transfer of Level three beds from the General Hospital

Last year we reported that we were seeking to commit 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, as part of our 5-Year Plan, will involve the creation of two specialist Intensive Care Units (ICUs). This will see a consolidation of level three 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.

In the interim, level three intensive care services will relocate from the General Hospital in 2016/17, to ensure that we can continue to provide a sustainable service.

Full business cases for the relocation of the level three ICU service from the General were approved by our Board in December 2015, and will be implemented following receipt of national capital funding during 2016/17. This will see the relocation of not only the level three ICU service, but also a number of services that need access to intensive care to safely carry out operations on patients:

- Major complex elective Hepatobiliary and emergency service will move to Glenfield. All day case activity will remain at the General;
- Renal transplant service will move to Glenfield;
- Complex elective and emergency general surgery will move to the Royal Infirmary. All day case activity will remain at the General;
- Gynaecology/Gynae-Oncology which requires joint operating with general surgery will move to the Royal Infirmary. All other elective activity will remain at the General.

To prepare for these moves, a number of enabling works have taken place this year, including:

- The reconfiguration of ward 34 at Glenfield Hospital to create an ICU step-down facility for use during building works to extend the main ICU facility
- The detailed design and tender for an 11 bed extension to the ICU at Glenfield.
- The creation of a six bed ICU facility within the theatre recovery area at the Royal Infirmary.

Commence Phase 1 construction of the Emergency Floor

Following national approval of the full business case in May 2015, construction started to create the new emergency floor, designed to dramatically improve facilities for our patients and staff. Working within a much larger department also means that we will be able to change and update our processes, making us more efficient and productive in our care of patients.

Phase one will be completed in early 2017, with phase two – a suite of assessment units located right next door – finished later on in 2017.

- Our new emergency department will have with a separate front door for children and adults;
- We have designed the new emergency department to flex to meet the future demands of our population;
- The new department will have an integrated mental health facility so adults and children who are in crisis will be assessed more rapidly, in a safe and suitable environment.

Complete Vascular Full Business Case

The creation of a cutting-edge cardiovascular service on one site has been an ambition for us for a number of years; we are pleased that this is now becoming a reality. Following approval of the full business case by the Trust Board in November 2015, construction has begun to create space that will allow the vascular service, currently based at the Royal Infirmary, to relocate to Glenfield, creating a comprehensive cardiovascular service for our patients.

The following services will be provided at Glenfield:

- Vascular ward;
- Vascular studies unit;
- Angiography suite;
- Hybrid Theatre – this new operating theatre means that we will be able to provide highly specialised care to our patients.

The vascular service will move to Glenfield during 2016/17.

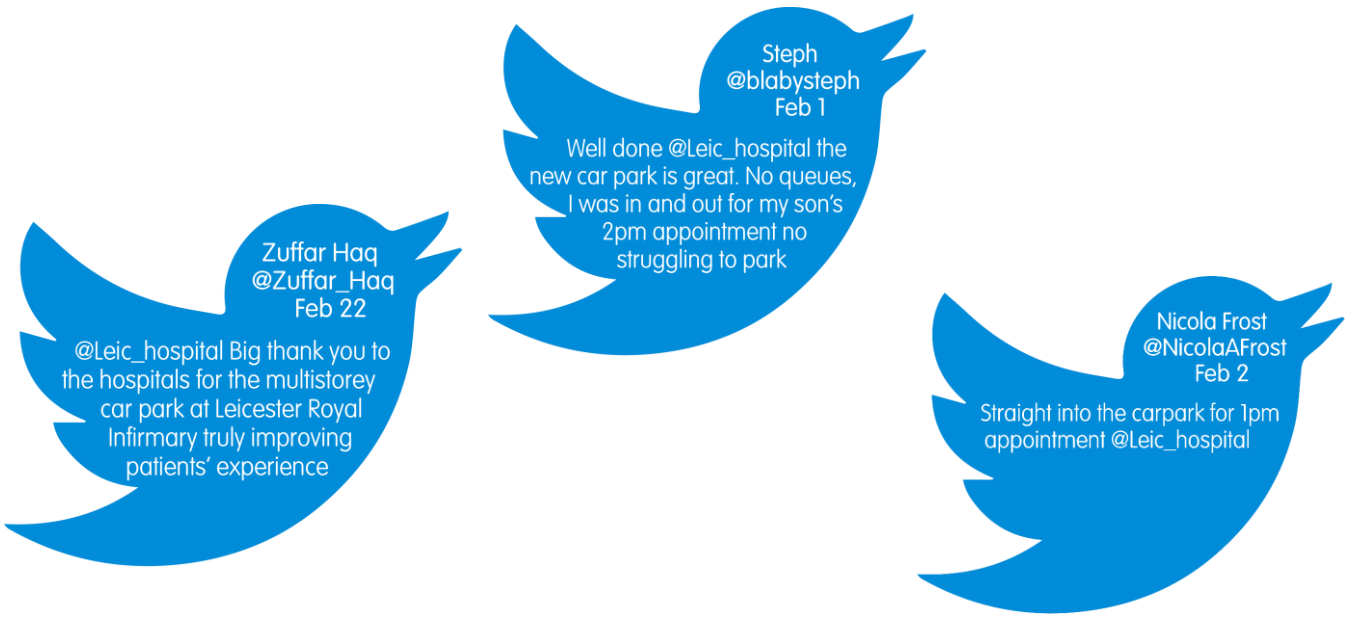
Deliver key operational estates developments (multi-storey car park; infrastructure improvements at the Royal Infirmary and Glenfield Hospitals; Phase 1 refurbishment of wards and theatres).

Opening of the Multi-Storey Car Park

With 438 spaces, the new multi-storey car park at the Royal Infirmary opened this year, giving much needed additional spaces for patients and their families when they come to hospital, as well as relieving congestion around the hospital site.

Key features of our new five storey car park include:

- 21 disabled spaces on the ground floor;
- Lifts for easy access to the upper levels;
- A north exit onto Welford Road, and a south exit onto Havelock Street, making it easier to exit the hospital site;
- An electronic vehicle management system on Havelock Street, showing you how many spare spaces are available;
- Different coloured walls and footpaths on each level, to assist with way finding;
- CCTV on every floor.



Theatre Recovery Project

This was a £3m scheme to deliver an additional 35 recovery beds. This state of the art theatre recovery was delivered next to to a live operating theatre environment and has been well received by the clinical team.

"This area now provides the highest quality built environment allowing clinical staff to provide the highest standards of care and monitoring to patients after surgery." Dave Kirkbride, Consultant Anaesthetist

Wards and Public Areas

Wards 10, 19, 29 and 30 at the Royal Infirmary have received a makeover which has improved the ward environment for patients and staff. Replacement of 35 year old cupboards and worktops in clinical areas has also addressed infection prevention issues.

We have improved the look and feel of many public areas including Balmoral reception, X-ray in both the Windsor and Balmoral buildings and 1.2 miles of public corridors at the Royal Infirmary and General Hospitals.

Left: The new Balmoral Reception

Medical Equipment Replacement Programme

A number of pieces of medical equipment have been replaced as part of a rolling programme. These include a Catheter Lab at the Glenfield, a CT scanner, Pharmacy Robot and a Gamma Camera at the Royal Infirmary.

Right: Catheter Lab B at Glenfield Hospital

Estates Infrastructure Investment

We have continued with investment 'behind the scenes' in equipment replacement which will ensure that our hospitals continue to provide warm, reliable and safe environments for patients. This investment includes new boilers, replacement ventilation and air conditioning plant, electrical switchgear, new lighting and extensive replacement of vinyl and carpet

Deliver outline business cases for Planned Treatment Centre, Maternity, Children's Hospital, theatres and beds

It is no small task to produce one outline business case, so it was always going to be a challenge to deliver outline business cases for five major capital projects this year, largely due to the sheer scale of work and input required from our own staff and external stakeholders into the process.

Even though the OBC's are not yet fully complete, there has been a great deal of groundwork going on to get all the required information ready. This includes working with the doctors, nurses and support staff from different services across our hospitals to look at the way care is currently provided for patients, and what it might be like in the future. This good work will continue into 2016.

Business case development for the Planned Ambulatory Care Hub and Women's hospital projects has been furthered delayed by the Better Care Together (BCT) consultation; according to the current BCT timeline, outline business cases will be presented to our Trust Board for approval in February 2017 at the earliest.

East Midlands Congenital Heart Centre

Following approval of the Full Business Case in October, work has begun on the interim expansion of the East Midlands Congenital Heart Centre (EMCHC) at Glenfield.

The interim works will see an additional four beds added to the existing EMCHC inpatient accommodation, alongside the replacement of displaced parents' overnight accommodation and staff office accommodation.

The EMCHC will ultimately move from Glenfield to the Royal Infirmary to join the integrated Children's Hospital, but we need to increase capacity now to cope with demand and help secure the service's future in line with the NHS England standards for congenital heart disease (CHD) services. The expansion will be completed by August 2016.

Develop a major charitable appeal to enhance the investment programme

LEICESTER HOSPITALS CHARITY
enhancing your hospitals

Leicester Hospitals Charity is devoting much of its time to planning for a major appeal to support the work of the different clinical specialties, with a particular focus on children, and frail older people.

In 2015 we secured pledges and gifts of £650,000 to enhance the new Emergency Department (£350,000 from RVS for the adult Emergency Department; £300,000 pledge from Thomas Cook Children's Charity for Children's Emergency Department).

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.

Deliver the agreed 2015/16 I&E control total - £36m deficit

We have delivered a deficit of £34.1m representing a £2m improvement against its original 2015/16 I&E control total. We were asked to deliver this £2m improvement following a worsening of the national financial position of the provider sector.

Fully achieve our £41m CIP target for 2015/16

We have achieved a £43m cost improvement programme (CIP), mainly through improving productivity in Theatres and in Outpatients, the activity growth that the hospitals have seen, alongside purchasing products at cheaper prices.

Revise and sign off by Trust Board and TDA of the Trust's 5-year financial strategy

Our 5-year financial strategy has been revised and approved by our Trust Board and it continues to be reviewed and will be refreshed on a bi-annual basis.

Continue the programme of service reviews to ensure their viability

The service review programme continues and is progressing through the remaining specialities. An outcome of the service reviews has led to the development of the Autonomous Team initiative with the Orthopaedic service being the first team to pioneer this initiative.

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.

2015/16 was a transitional year, ensuring we have the base technology in place for the exciting years ahead as well as delivering key improvements to our current systems. Society is changing and we will see much more use of technology to both communicate with and treat our patients.

We have been improving our IT systems for our frontline clinical staff. Through the year we have been increasing our mobile solutions, making working with IT easier for clinical staff.

We have made improvements to how we capture and use clinical information from nurses and doctors. These systems focus on providing clinical benefits for patients and making clinical teams life easier. Improvements in Blood tracking, nursing observations and clinical handover have helped in the delivery of quality and safety.

We have started to remove paper notes; the first large area to move on to the system is paediatrics. We have been planning for our Electronic Patient Record solution in 2017 and this project is a key start to that process.

We are part way through key improvements that will improve the care and treatment of patients. A significant part of this is the new East Midlands Radiology system which will connect up the majority of organisations and allow us to better share information and images. This will be available in June 17.

We are now into the third year of our partnership with IBM and we are committed together in delivering the national aim of being paperless, as much as you can be, by 2020.

Prepare for delivery of the Electronic Patient Record in 2016/17

In last year's report we had completed the procurement and selected through IBM, Cerner as our preferred supplier for our Electronic Patient Record. In the last year we have been working with the NHS Trust Development Agency to obtain central approval for our business case. We have re-visited the financial and benefits case and hope to obtain approval subject to capital money constraints during 2016/17. This project is off key importance to replace our legacy patient information systems and to move us significantly towards achieving the paperless NHS target in 2020.

Due to the delays in getting approval for the EPR many of our legacy systems now need upgrading this includes our HISS system (Patient Centre /Clinicom), the theatres system (ORMIS) and the ED system (EDIS) . We have just undertaken a major upgrade on the HISS application and the servers will be changed later in the year 2016. We plan to upgrade ORMIS and EDIS during 2016/17.

Ensure that we have a robust IM&T infrastructure to deliver the required enablement

Electronic Document Records Management Programme

Our Managed Business Partners (MBP) installed the infrastructure to support Electronic Document Records Management system to enable the scanning of patient records and remove the need for paper medical records. The paediatrics department went live in October 2015 with historic notes being scanned and accessed via IPADS or PCs for patient care on the wards and in clinics. Clinical experience in this project, depending on the size and structure of the records has been mixed. Lessons have been documented and will feed into the next stage for adult notes for consideration during 2016.

Managed Print

Our Managed Business Partners completed the roll-out of managed print at the Glenfield Hospital and the Royal Infirmary. This has meant that staff have much better quality and access to printing services, and more recently scanning and fax services, across both sites. Plans are in place to role this out to the General Hospital subject to the funding and assessing the benefits so far at these two sites.

Desktop PCs

Two years ago we started testing virtual desktop technologies, a replacement for the desktop PCs which are aging and degrading in terms of performance. In the last year we have been building the back end infrastructure and converting the many applications to run on this new technology and in the summer we started to use this across the pioneer wards at the Royal Infirmary. The technology is changing rapidly and we are now ensuring the system is able to support the next phase for roll-out across all of our wards during 2016. This together with managed print supports mobile working across our organisation, allowing clinicians to tap on/ tap off with smartcards onto any desktop across our hospitals continuing with the same desktop session and print documents from any managed printer.

Data Centre - Power Outage

Last May we had to make provision for new power for the new Emergency Floor build. The Royal Infirmary data centre was on the same circulate and for the first time ever we had to carry out a complete shutdown of our data centre which runs all our major IT systems.

Although the whole team pulled together to prepare plans and rehearse this shut down, it was still an anxious period waiting for all of the systems to come back into live and start to synchronize with each other. The weekend was a complete success and adds confidence for our major disaster and business continuity plans

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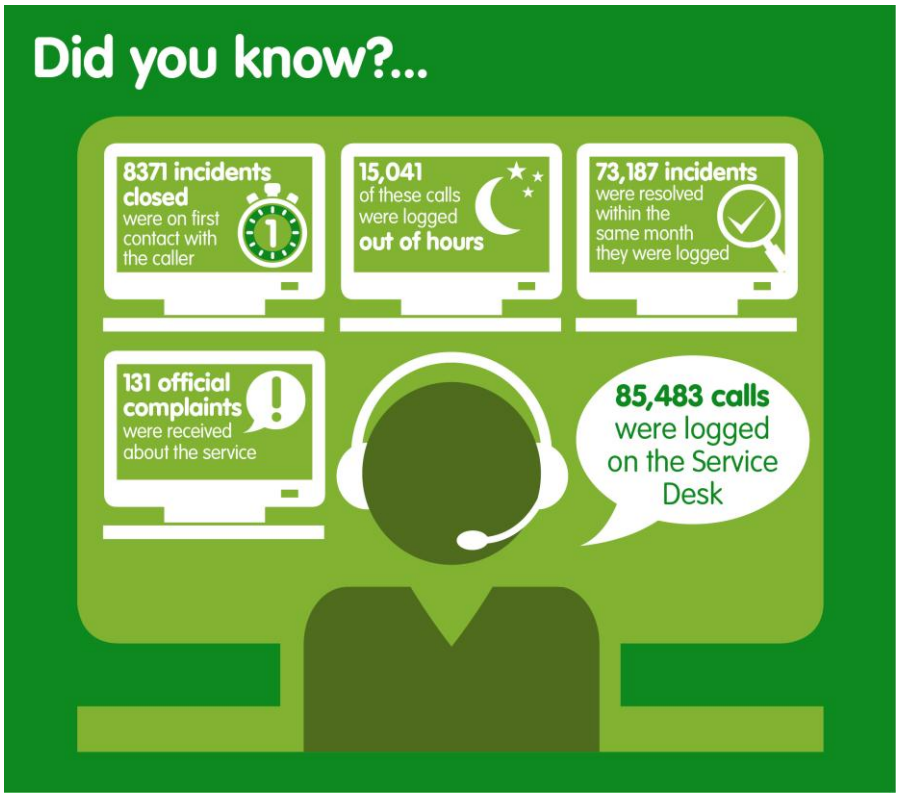
Review IBM support to ensure that we have the right resources in place to enable IM&T excellence

We are now into the third year of our partnership with IBM. Through the last year, we have been reviewing what we do together to ensure we have the right resources in the right places. This has led to a service improvement plan, which continues into 2016/17, with additional resources being brought in to ensure we effectively support front line services.



Quality and performance: how did we do?

We are monitored by the NHS Trust Development Authority, now NHS Improvement, against a range of standards and thresholds.

Performance Against 2015/16 National Targets

	Performance Indicator	Target	2015/16	2014/15	2013/14	2012/13
Access to A&E	A&E - Total Time in A&E (4hr wait)	95%	86.9%	89.1%	88.4%	91.9%
Infection Control	MRSA (All)	0	1	6	3	2
	MRSA (Avoidable)	0	0	1	1	2
	Clostridium Difficile	61	60	73	66	94
Access - 18 week wait	RTT - incomplete <18 weeks	92%	92.6%	96.7%	92.1%	92.6%
	6 week - Diagnostic Test Waiting Times	<1%	1.1%	0.9%	1.9%	0.5%
Access - cancer	2 week wait from referral to date first seen - all cancers	93%	90.2%	92.2%	94.8%	93.4%
	2 week wait from referral to date first seen - symptomatic breast patients	93%	95%	94.1%	94%	94.5%
All cancers	31-day wait from diagnosis to first treatment	96%	94.9%	94.6%	98.1%	97.4%
	31-day wait from diagnosis to first treatment - anti cancer drug treatments	98%	99.6%	99.4%	100%	100%
	31-day wait for second or subsequent treatment - surgery	94%	85.7%	89%	96%	95.8%
	31-day wait for second or subsequent cancer treatment - radiotherapy treatments	94%	94.7%	96.1%	98.2%	98.5%
	62-day wait for first treatment from urgent GP referral	85%	77.4%	81.4%	86.7%	83.5%
	62-day wait for first treatment from consultant screening service referral	90%	89.8%	84.5%	95.6%	94.5%

Green = target achieved

Red = target failed

4 hour wait performance standard

Whilst 2015/16 has been a challenging year for our Emergency Department, there have also been some positives with progress on the new Emergency Floor and the return of the Urgent Care Centre under our management.

We have not met the target to treat and discharge a minimum of 95 per cent of our patients within four hours, with attendances and admissions rising by 7 per cent and 6 per cent respectively. The high attendances and admissions have inevitably had an effect on the quality of care provided for patients and in particular this has impacted on ambulance handover times. This has been recognised as a very serious concern by both us and East Midlands Ambulance Service NHS Trust; the handover delays are the subject of a joint action plan, which is being monitored closely by our Executive Team.

Also, as detailed elsewhere in the report, inspectors from the Care Quality Commission arrived on Monday 30 November for an unannounced inspection.

Work continues on the new Emergency Floor, which is due to open in February 2017, will give the Emergency Department the space it needs and enhance patient and staff experience considerably. We also continue to improve our processes internally.

During 2015/16 the Urgent Care Centre transferred back under our management from George Eliot Hospital NHS Trust. Since then the service has been delivered in partnership with Lakeside Plus, an innovative GP partnership. This gives us more flexibility in terms of the service it is delivering and its ability to better support the main Emergency Department. We continue to develop this service, including the introduction of a GP based at reception to assess all admissions from the Urgent Care Centre in January 2016.

We continue to work with partners across Leicester, Leicestershire and Rutland to improve our emergency performance and the quality of care we provide to patients needing emergency care. During 2016/17 will see the first full year of the Vanguard plans and we are optimistic that this coupled with our pre-existing plans will result in further improvements. Ensuring that we deliver capacity in line with our activity plans for next year is a key focus both for our hospitals and the wider health system.

Cancer standards update for Cancer performance in table above w/c 9th May

As in the previous year, we have struggled with cancer performance during 2015/16 and this area remains one of our highest priorities. One of the reasons behind this is increasing demand. We have seen an 11 per cent increase in 2-week wait urgent cancer referrals and a 9 per cent increase in patients needing treatment for cancer. This has meant that we need to continue to work closely with GPs to ensure the suitability of cancer referrals and is plan for continued growth in the coming year.

In the past year we have invested in more staff to help support cancer patients, including a new cancer surgeon in urology and clinical nurse specialists in a number of services. We have also invested in administrative and management resources to help pull cancer patients through the hospital systems as quickly as possible, including expanding the number of cancer navigators who track patients on a cancer pathway, as well as appointing three cancer service managers to support the most pressured tumour sites: urology, lung and gastrointestinal.

In November we held a Listening into Action event focused on improvements to cancer services. This was well attended by both staff and patient representatives and the outcome of this is a programme of work which aims to ensure that patients leave every appointment knowing what is going to happen next and with an appointment booked. This will be implemented by three pilot tumour sites (prostrate, lung and lower gastrointestinal) in late 2015/16 with the intent to roll this out across the rest of our cancer services.

A sustainable recovery of the 2-week waiting time standard of 14 days from GP referral was planned to be delivered in 2015/16, and that was achieved in December 2015 and February 2016. Recovery of the more complex 62-day standard, from referral to treatment for cancer patients is anticipated by September 2016 and is the subject of a detailed hospital wide plan.

Healthcare-associated infections

Infection Prevention continues to challenge all Healthcare Organisations. One of the benchmarks used to reflect performance of trusts is the mandatory reporting of MRSA Bacteraemia and Clostridium difficile infections.

MRSA

Between 1 April 2015 and 31 March 2016 we identified only one patient with an MRSA bacteraemia against a national target of zero. This one infection upon investigation was deemed to be unavoidable and was identified in a patient that was extremely unwell with multiple co-morbidities.

In these instances it was agreed that we could have done nothing to prevent this 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 Post Infection Reviews and any identified action plans that have resulted from the investigation are presented to the CMG Infection Prevention Groups and CMG Quality and Safety Boards to ensure that lessons are learnt and shared with staff.

Clostridium Difficile

Last year we managed 332 cases (hospital and community attributed) of Clostridium Difficile (CDI) disease. Of the cases that are required to be reported, we have recorded 60 cases of CDI against a plan of no more than 61 for the whole year (1 April 2015 to 31 March 2016). We are pleased to be within our plan but recognise that there can be absolutely no complacency with regard to our management of this group of patients.

Our trajectory for 2016/17 remains the same at 61. This is a stretching target for an organisation of our size and complexity.

Sustainability Report

Our Estates and Facilities Team are fully committed to supporting and implementing sustainability across a wide and diverse range of services and procurement initiatives and this was reinforced within the Estates and Facilities 5-Year Plan. The plan outlines the main projects that have been designed to provide the necessary deliverables required to implement an effective sustainable environment and foundation for our future, ensuring our quality commitment to *"Providing a sustainable, welcoming environment from where clinical care of the highest standard can be delivered*".

We are a key member of the Leicester, Leicestershire and Rutland Facilities Management Energy and Sustainability group which has been established by the Estates and Facilities Management Collaborative (EFMC) and Interserve and this forum will provide technical and statutory compliance guidance in support of our sustainability strategy.

The Estates and Facilities Management Collaborative and Interserve enabled a series of events promoting sustainability, leading up to the NHS Sustainability Day on the 26 March 2015 and will continue to do so.

We complete an annual Estates Returns Information Collection (ERIC) and the Estates and Facilities Management Collaborative have started the process for gathering data for the 2016 ERIC return and are on course for to meet the mid June 2016 deadline for submitting the return.

Energy and Sustainability Projects

Heating and power

During the year we replaced two Combined Heat and Power (CHP) units - one at the Royal Infirmary and the other at Glenfield Hospital - has reduce carbon emissions by a total of 3,842 tonnes and generated 14,364,544 kWh of electricity which is 30 per cent of our total consumption. The estimated savings are in the region of £450,000.

New multi-story car park

The car park though still attracting cars into the city has removed the issue of stationary vehicles that were emitting CO_2 while waiting for spaces this is no longer the case and has improved local air quality, reduced the noise and air pollution and may have an additional calming effect as being able to find a car parking space. There is also a living wall with a variety of insect habitation, bat and bird boxes incorporated into its base structure.

Minor works/ refurbishment projects

Lighting upgrades have introduced low energy LED technology at the General and the Glenfield Hospitals.

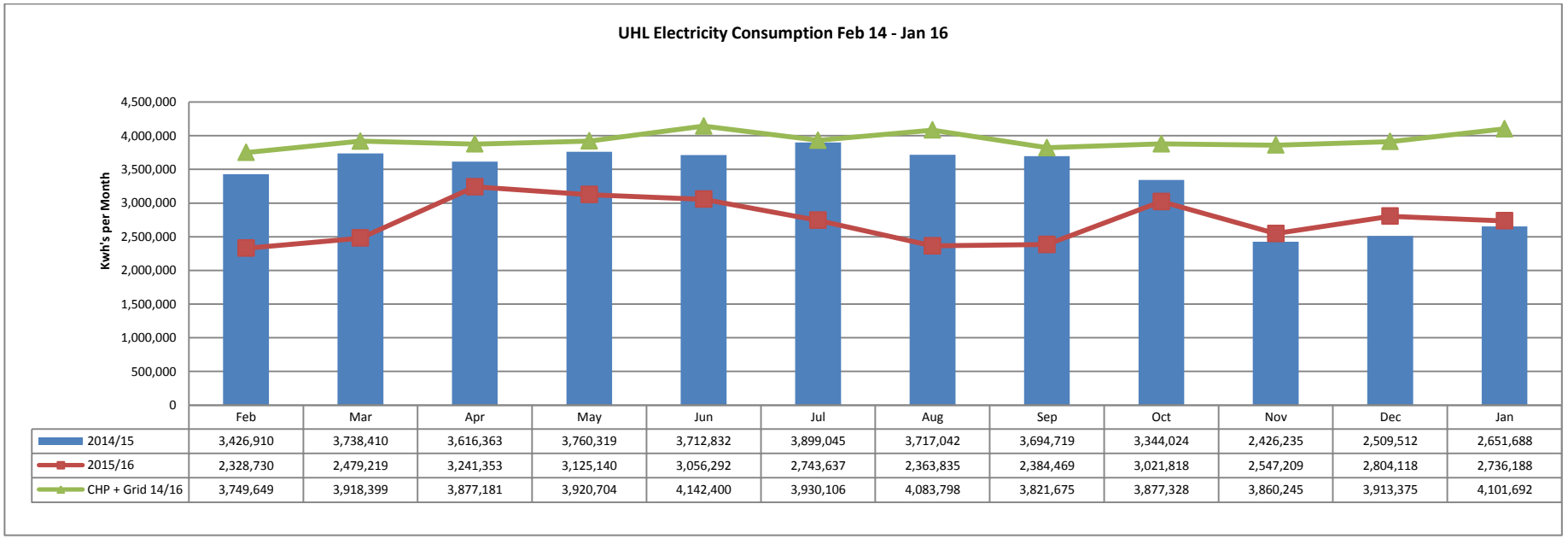
At the Royal Infirmary, the Emergency Department flooring and Theatre Recovery projects have both received a very good BREAM rating for the sustainable designed of the building and development. This will continue to be developed to attain a better rating.

LED lighting has been installed within various project including Wards 10, 19, 29, and 30.

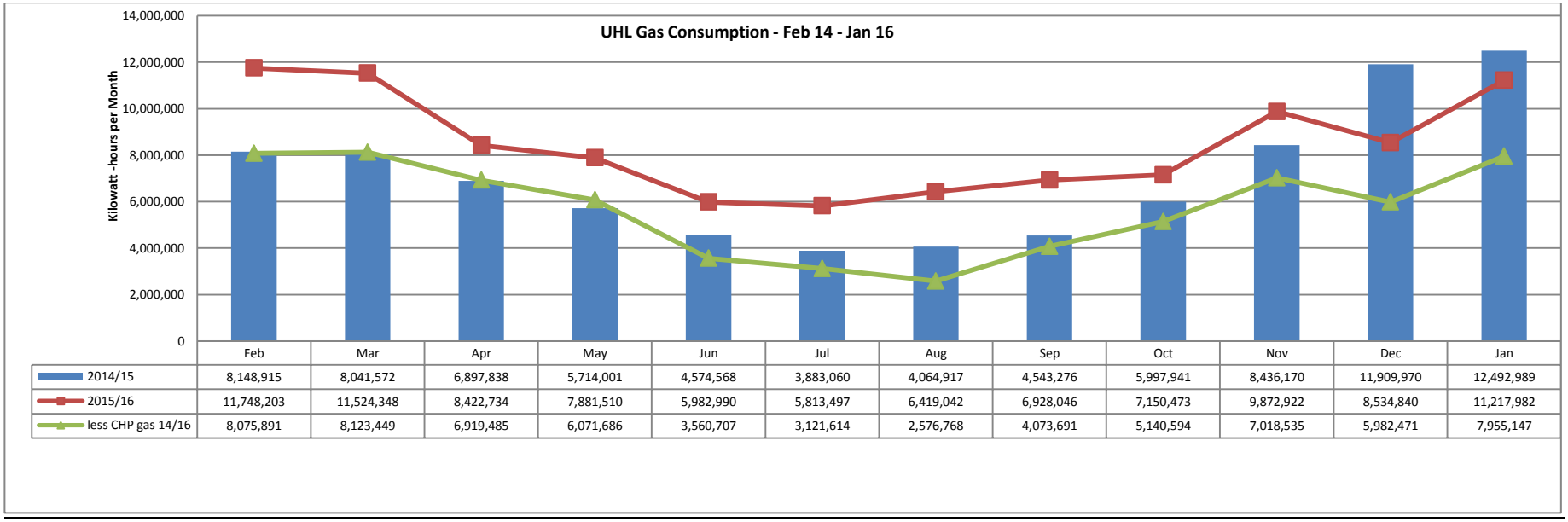
The steam condense main at the Royal Infirmary has been upgraded to reduce waste and improve the systems overall performance, and we have improved ventilation for patients in the Osborne building.

Energy and Carbon Performance Tracker 2006 – 2016

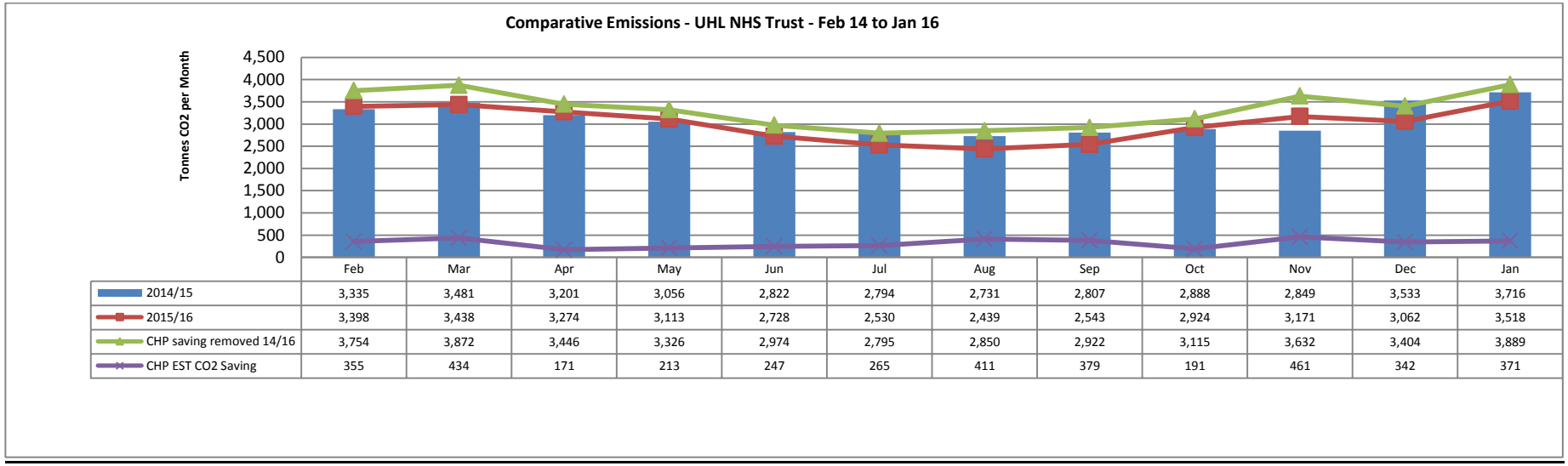
	Gas	Grid Electricity	Totals	Cost	CO2 Emissions	CO2 Emissions
Description	**Usage (KWh)**	**Usage (KWh)**	**(KWh)**	**Costs (£)**	**(Tonnes)**	**(CRC Cost)**
2006/07	116,873,611	29,357,222	146,230,833	£5,252,319	37,531	N/A
2007/08	99,831,667	30,681,111	130,512,778	£4,403,428	35,090	N/A
2008/09	109,781,944	33,822,222	143,604,167	£7,320,137	38,633	N/A
2009/10	93,697,272	36,426,819	130,124,091	£5,136,734	36,910	N/A
2010/11	96,694,476	39,489,130	136,183,606	£5,282,765	39,236	N/A
2011/12	85,673,210	42,535,080	128,208,289	£6,479,603	38,881	£376,571
2012/13	86,601,762	46,390,022	132,991,784	£7,223,638	41,334	£404,539
2013/14	83,164,032	48,522,097	131,686,129	£7,995,022	40,724	£400,777
2014/15	92,086,201	38,205,678	130,291,879	£7,072,683	36,950	£281,979
2015/16	101,496,587	32,832,008	134,328,594	£6,390,731	36,138	£291,598
Annual Change	**-9,410,386**	**5,373,670**	**-4,036,715**	**£681,952**	**812**	**-£9,619**
% age change	**-10.22%**	**14.07%**	**-3.10%**	**9.64%**	**2.20%**	**-3.41%**
Overall Change	**15,377,024**	**-3,474,786**	**11,902,239**	**-1,138,412**	**1,393**	**N/A**
% age change	**13%**	**-12%**	**8%**	**-22%**	**4%**	**N/A**



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2014/15	3,426,910	3,738,410	3,616,363	3,760,319	3,712,832	3,899,045	3,717,042	3,694,719	3,344,024	2,426,235	2,509,512	2,651,688
2015/16	2,328,730	2,479,219	3,241,353	3,125,140	3,056,292	2,743,637	2,363,835	2,384,469	3,021,818	2,547,209	2,804,118	2,736,188
CHP + Grid 14/16	3,749,649	3,918,399	3,877,181	3,920,704	4,142,400	3,930,106	4,083,798	3,821,675	3,877,328	3,860,245	3,913,375	4,101,692



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2014/15	8,148,915	8,041,572	6,897,838	5,714,001	4,574,568	3,883,060	4,064,917	4,543,276	5,997,941	8,436,170	11,909,970	12,492,989
2015/16	11,748,203	11,524,348	8,422,734	7,881,510	5,982,990	5,813,497	6,419,042	6,928,046	7,150,473	9,872,922	8,534,840	11,217,982
less CHP gas 14/16	8,075,891	8,123,449	6,919,485	6,071,686	3,560,707	3,121,614	2,576,768	4,073,691	5,140,594	7,018,535	5,982,471	7,955,147



	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2014/15	3,335	3,481	3,201	3,056	2,822	2,794	2,731	2,807	2,888	2,849	3,533	3,716
2015/16	3,398	3,438	3,274	3,113	2,728	2,530	2,439	2,543	2,924	3,171	3,062	3,518
CHP saving removed 14/16	3,754	3,872	3,446	3,326	2,974	2,795	2,850	2,922	3,115	3,632	3,404	3,889
CHP EST CO2 Saving	355	434	171	213	247	265	411	379	191	461	342	371

Travel management

Our approach to transport is to provide a mixture of sustainable travel options along with parking facilities for those that need. The following list provides some of the main initiatives:

- Our travel plan incorporates environmental initiatives, which is being used and acted upon during all of our estates developments;
- All park and ride now services and linked initiatives are promoted to all of our staff and to the public;
- We opened a new patient and visitor multi-storey car park on 1 February 2016, this includes over 430 additional spaces which incorporates 21 new disabled bays;
- The bike shed located within the new multi storey footprint has been re-provided in an alternative area;
- We continue to promote the Cycle to Work scheme i.e. purchasing a bike through salary sacrifice;
- 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 the inter-site shuttle bus service;
- Alternative staff travel including cycling and walking initiatives are being actively promoted.

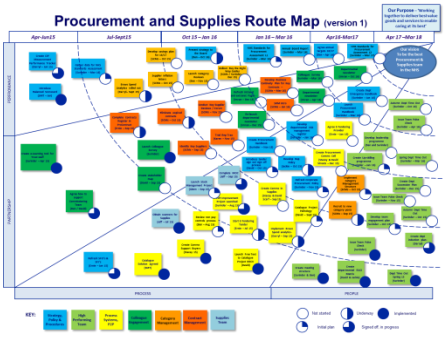
Procurement

In November 2016 the Board approved a new and extensive Procurement and Supplies Strategy for 2015-18. You can read the full strategy on our website (Procurement & Supplies Strategy).

During the year the Procurement and Supplies team have been working closely with both colleagues and suppliers to deliver on our ambition of providing the 'best value goods and services to enable caring at its best'.

In line with this we have made significant progress towards delivering our annual improvement plan (route map).

Some particular highlights include:



- Enabling us to reduce our deficit through our work with both colleagues and suppliers. In 2015/16 we have made over £4m of in-year cash savings;
- Working with our colleagues to significantly increase the amount of orders through our internal catalogue; this has risen from 54 per cent in February 2015 to over 70 per cent in December 2015;
- This work has been supported by introducing a brand new e-learning tool for staff on 'how to buy goods and services';
- Improving our materials management processes through changing working practices and trialling an automated stock management system in two key departments;
- Playing a key role as one of 32 NHS Trusts involved in developing the **Lord Carter** proposals for procurement. The results of which were announced in February 2016 (Lord Carter Report).

Our exciting plans for 2016/17 include:

- Delivering £7m or more of in year cash savings to the Trust;
- Continuing to improve the procurement and supplies processes;
- Implementing the Lord Carter proposals for procurement, including achieving Level 1 on the NHS Standards of Procurement by the end of the year;
- Supporting both the re-configuration programme and the new facilities management model;
- Working closely with NHS Supply Chain to help lead the national procurement strategy for key product areas.

Information governance

We recognise the importance of robust information governance. During the year the Director of Corporate and Legal Affairs retained the role of Senior Information Risk Owner and the Medical Director continued as our Caldicott Guardian.

All NHS Trusts are required to carry out an information governance self-assessment every year using the NHS Information Governance Toolkit. This contains 45 standards of good practice, spread across the domains of:

- information governance management;
- confidentiality and data protection assurance;
- information security assurance;

- clinical information assurance;
- secondary use assurance; and
- corporate information assurance.

We achieved (at least) a minimum level 2 standard across all of the 45 standards, except in the case of:

- training: 89 per cent of staff were trained in information governance in 2015/16 against the toolkit requirement that all staff be trained;
- data quality: we need to document and implement procedures for using both local and national benchmarking to identify and investigate possible data quality issues;
- corporate information assurance: we need to carry out an audit of corporate records in at least four corporate areas of the organisation.

An information governance improvement plan for 2016/17 has been prepared for approval by the Executive Team. Implementation will be overseen by the Information Governance Steering Group, chaired by the Senior Information Risk Owner.

During the year we reported to the Information Commissioner's Office one serious untoward incident involving a lapse of data security. Patient care was not put at risk and the data was retrieved.

In respect of other personal data related incidents during the year, we have carried out investigations to ensure that the root causes are properly understood and addressed. In those cases 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.

Emergency planning

Our Emergency Planning and Business Continuity Team have continued to make vast improvements to our organisation's overall resilience this year.

This year has been particularly busy. The team were asked on behalf of the East Midlands Trauma Network to test the collective response to a mass casualty scenario of the hospitals and Ambulance Service based in the East Midlands. This took place in early October, prior to the terrorist attacks in Paris, and most recently Brussels. The exercise followed a similar scenario to those attacks and identified a number of key recommendations for local, regional and national responders. The team are continuing to work with relevant partner agencies and represent at national conferences to ensure that lessons are shared as widely as possible. To further validate our own arrangements, service specific exercises are being arranged. We also continue to work closely with other health and security agencies to ensure that we are prepared to respond to a similar incident in Leicestershire.

Each year NHS England assesses us on a number of core standards relating to emergency planning. At the time of the review (October 2015) we were 98 per cent compliant with the standards and 2 per cent partially compliant, not fully compliant, but an action plan was put in place to resolve in the next 12 months. As a result NHS England has since assessed us as "fully compliant."

We, like all NHS Trusts, have had to mitigate the impact of the industrial action by junior doctors over their dispute with the Secretary of State for Health over their new contract. The action withdrew junior doctors from any work not classified as emergency cover. For us this included some elective operations and outpatient appointments as well as research and other non-critical areas. We were able to ensure that our critical areas, including the Emergency Department, Emergency Theatres, Assessment Areas, Maternity and Inpatient areas were all safely staffed and high levels of care were maintained. As the dispute continues, we will continue to work with the services and unions to ensure safe delivery of services.

Below is a summary table that outlines the impact on staffing and patient appointments

Staffing Impact					
	Base Line	**09/03/2016 % change**	**10/03/2016 % change**	**10/02/2016 % change**	**12/01/2016 % change**
Total	792	-12%	-16%	-27%	-27%
Consultants	400	19%	16%	-3%	-3%
Junior Doctors	392	-43%	-48%	-51%	-51%
Cancellations					
	Base Line	**% of cancellations**	**% of cancellations**	**% of cancellations**	**% of cancellations**
Total	5356	7%	8%	7%	8%
Outpatient	4916	7%	8%	7%	8%
Inpatient	63	10%	11%	11%	17%
Daycase	377	11%	3%	1%	3%

The next year looks to be as busy as ever with the team working on hospital evacuation, cyber resilience, region/nation-wide response exercises 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:

Our priorities for 2016/17

1. Safe, high quality, patient centred care – 2016/17 Quality Commitment

a) Reduce avoidable mortality and re-admissions through screening of deaths and use of the re-admissions toolkit *(Andrew Furlong)*

b) Reduce harm through core 7-day standards, new Early Warning System and observation processes and safer use of insulin *(Andrew Furlong)*

c) Improve patient experience through involving them in their care, better end of life planning and improvements in outpatients *(Julie Smith)*

d) Prepare effectively for the 2016 Care Quality Commission inspection *(Julie Smith)*

e) Develop a high quality in-house Estates and Facilities service *(Darryn Kerr)*

2. An excellent, integrated emergency care system

a) Reduce ambulance handover delays in order to improve patient experience, care and safety (*Richard Mitchell*)

b) Fully utilise ambulatory care to reduce emergency admissions and reduce length of stay (including Intensive Community Support) *(Richard Mitchell)*

c) Develop a clear understanding of demand and capacity to support sustainable service delivery and to inform plans for addressing any gaps *(Richard Mitchell)*

d) Diagnose and reduce delays in the in-patient process to increase effective capacity *(Richard Mitchell)*

3. Services which consistently meet national access standards

a) Maintain 18-week RTT and diagnostic access standard compliance *(Richard Mitchell)*

b) Deliver all cancer access standards sustainably *(Richard Mitchell)*

4. Integrated care in partnership with others

a) Work with partners to deliver year 3 of the Better Care Together programme to ensure we continue to make progress towards the Leicester, Leicestershire and Rutland vision (including formal consultation) *(Mark Wightman)*

b) Develop new and existing partnerships with a range of partners, including tertiary and local service providers to deliver a sustainable network of providers across the region *(Mark Wightman)*

c) Progress the implementation of the EMPATH strategic outline case *(Paul Traynor)*

5. An enhanced reputation in research, innovation and clinical education

a) Deliver a successful bid for a Biomedical Research Centre *(Andrew Furlong)*

b) Support the development of the Genomic Medical Centre and Precision Medicine Institute *(Andrew Furlong)*

c) Develop and exploit the OptiMeD project, scaling this up across the Trust *(Paul Traynor)*

d) Improve the experience of our medical students to enhance their training and improve retention, and help to introduce the new University of Leicester Medical Curriculum *(Andrew Furlong)*

e) Develop and implement our Commercial Strategy to deliver innovation and growth across both clinical and non-clinical opportunities *(Paul Traynor)*

f) Launch the Leicester Academy for the Study of Ageing (LASA) *(Julie Smith)*

6. A caring, professional, passionate and engaged workforce

a) Develop an integrated workforce strategy to deliver a flexible multi-skilled workforce that operates across traditional organisational boundaries and enhances internal sustainability *(Louise Tibbert)*

b) Deliver the Year 1 Implementation Plan for the UHL Way, ensuring an improved level of staff engagement and a consistent approach to change and development *(Louise Tibbert)*

c) Develop training for new and enhanced roles, i.e. Physician's Associates, Advanced Nurse Practitioners, Clinical Coders *(Louise Tibbert)*

d) Deliver the recommendations of "Freedom to Speak Up" Review to further promote a more open and honest reporting culture *(Louise Tibbert)*

e) Developing a more inclusive and diverse workforce to better represent the communities we serve and to provide services that meet the needs of all patients *(Louise Tibbert)*

7. A clinically sustainable configuration of services, operating from excellent facilities

a) Complete and open Phase 1 of the new Emergency Floor *(Darryn Kerr)*

b) Deliver our reconfiguration business cases for vascular and level 3 ICU (and dependent services) *(Paul Traynor)*

c) Develop and deliver a new model of care that support our reconfiguration plans *(Richard Mitchell)*

d) Develop outline business cases for our integrated Children's Hospital, Women's Services and planned ambulatory care hub *(Paul Traynor)*

8. A financially sustainable NHS Trust

a) Deliver our CIP target in full *(Richard Mitchell)*

b) Reduce our deficit in line with our 5-Year Plan *(Paul Traynor)*

c) Reduce our agency spend to the national cash target *(Louise Tibbert)*

d) Implement service line reporting through the programme of service reviews to ensure the ongoing viability of our clinical services *(Paul Traynor)*

e) Deliver operational productivity and efficiency improvements in line with the Carter Report *(Paul Traynor)*

9. Enabled by excellent IM&T

a) Improve access to and integration of our IT systems (John Clarke)

b) Conclude the EPR business case and start implementation (*John Clarke*)

Operating and financial review

Overview of 2015/16 Financial Position

In 2015/16 we originally planned to deliver an income and expenditure deficit of £36.1m that was predicated on the delivery of a Cost Improvement Programme (CIP) of £43.0m. However on 31 July 2015, and in response to the worsening of the national financial position of the provider sector, we were asked to develop a plan for a deficit of £34.1m, representing a £2m improvement on the original plan.

A revised plan was submitted to the NHS Improvement on 11th September 2015 with an income and expenditure deficit of £34.1m, predicated on the delivery of a CIP of £43.0m. At the same time, we had to carry out a review of the ambitious capital programme that had been originally planned at £107m, supported by internally generated funds and external funds in the form of capital loans from the Department of Health. The key elements of the original capital programme were:

- Addressing backlog maintenance and investment within critical infrastructure;
- Investment in medical equipment;
- Redevelopments and investments to support the longer term estate reconfiguration plans and;
- Investment in an Electronic Patient Record (EPR).

Following a strategic review and recognising the limitations around external capital funds, the final capital expenditure plans were set at £49.5m supported by £10m of capital loans from the Department of Health.

We have delivered the £34.1m deficit in 2015/16 (subject to external audit) and our other statutory duties.

The above means that we enter 2016/17 in a different place financially than was anticipated within our 5-Year Strategic Plan. In addition to this, and following communication from the NHS Improvement in January 2016, we have been offered Sustainability and Transformation Funding (STF) of £23.4m on the understanding that we will deliver a deficit in £8.3m for 2016/17. Excluding STF, this implies that we will deliver an underlying deficit position of £31.7m within 2016/17 compared to the 2015/16 deficit of £34.1m.

Financial Review for the Year Ended 31st March 2016

We have not met all of our financial and performance duties for 2015/16:

- Balancing the books: We delivered an income and expenditure deficit of £34.1m;
- Managing cash: We delivered both the External Financing Limit (EFL) and Capital Resource Limits (CRL);
- Investment in buildings, equipment and technology: We invested £49.5 million in capital developments.

Performance against our Financial Plan

We delivered a £34.1m deficit for the year against a planned deficit of £34.1m.

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

Total income	£866.0m actual; which was £13.6m over plan relating to favourable settlements with commissioners and additional RTT work.
Total expenditure	£900.1m actual; which was £13.2m over plan and includes overspends of £5.8m on pay and overspends of £29.3m on non-pay.

Impairment	£10.4m impairment was incurred which was not planned at the beginning of the year. This is adjusted out of the adjusted deficit for the year of £34.1m.
Capital expenditure	£45.2m against a revised capital resource limit of £45.2m
Cash balance	£3.2m closing cash balance against a plan of £3.0m
Cost Improvement Programme (CIP)	Delivered £43.1m against a £43.0m target

Balance Sheet

Cash

We planned to have a year-end cash balance of £3.2m at the end of March 2015 and secure external financing of £44.1m, comprised of:

- £34.1m to fund our deficit; and
- £10.0m for capital financing in relation to our emergency floor project.

This funding was received in the year and our total external financing at the year-end was £55.55m, which includes £11.45m in relation to capital loans brought forward.

Non-current assets

Total non-current assets have decreased by £22.5m mainly as a result of

- £45.5m total net additions; less
- (£36.5m) downward revaluation; less
- (£31.5m) depreciation.

Working capital

Our debtors have decreased by £17.7m mainly due to an £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.

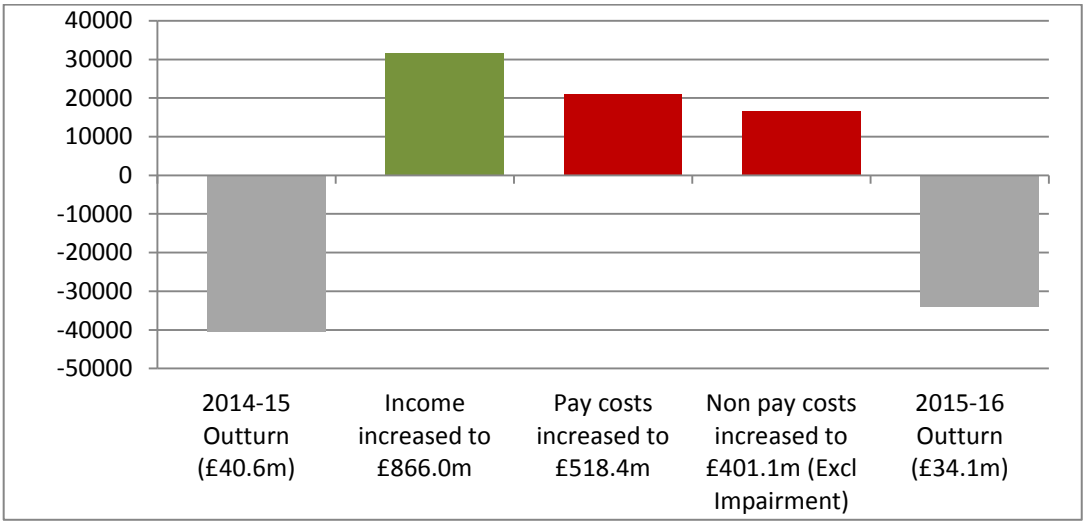
Our creditors have decreased by £8.6m since the last year-end mainly due to due to the impact of the additional external financing received in year and the improvements this has led to in terms of our payment performance.

Taxpayer's equity

This represents the methods of funding our assets and liabilities. The main balance is Public Dividend Capital and this increased by £19k in the year as we received additional funding for a maternity ultrasound machine.

Our retained earnings reduced by £44.6m due primarily to our financial deficit and impairment. The revaluation reserve balance has reduced by £26.1m due to the downward revaluation.

Key Financial Indicators



Income

We received £866.0m of income (excluding donated assets), which is a £31.6m (3.8%) increase from the £834.4m received in 2014/15.

Pay expenditure by staff group

We spent £518.4m on staff costs, which is a £21.1m (4.2%) increase over the 2014/15 total of £497.3m. The majority of this increase is due to inflation.

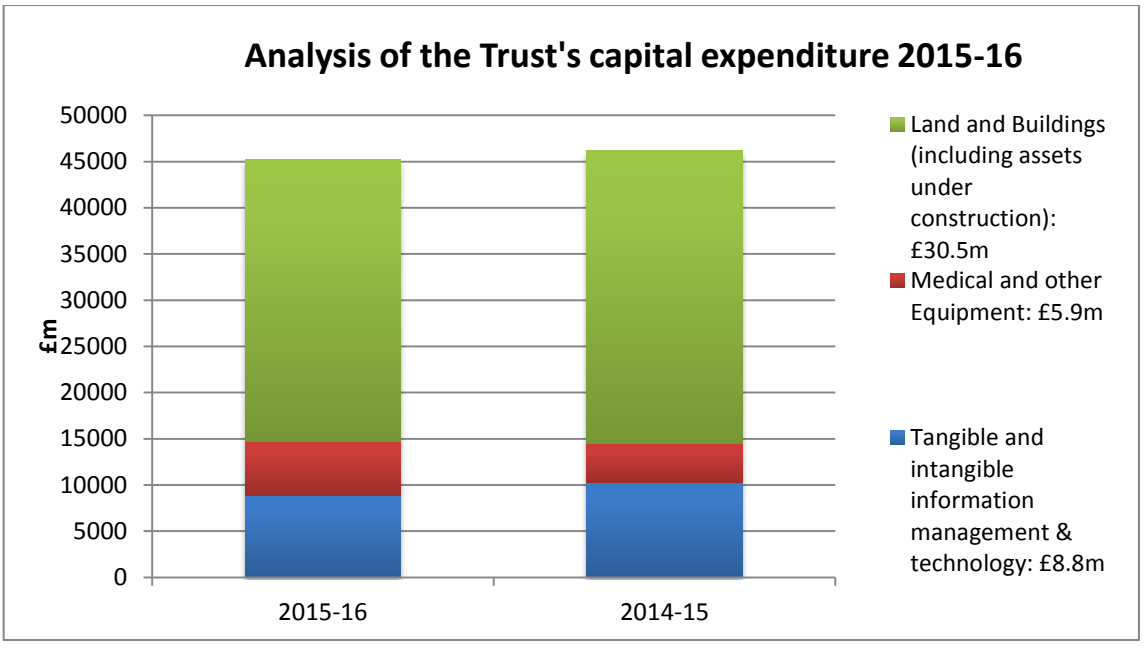
Non-pay expenditure

We incurred £381.7m of non-pay expenditure which was a £4m (1.1%) increase over the 2014/15 total of £377.7m. £17m of this increase relates to an increase in clinical supplies and services costs, including drugs (£12.5m) and other clinical supplies (£4.5m).

Research costs have reduced by £1.4m. We also had an impairment of our property, plant and equipment of £10.4m following a revaluation of our estate.

Capital expenditure

Our capital expenditure (excluding adjustments for donated assets) was £45.2, a £1m (2.2%) decrease over the 2014/15 total of £50.4m. A breakdown of the spend is shown in the graph below.

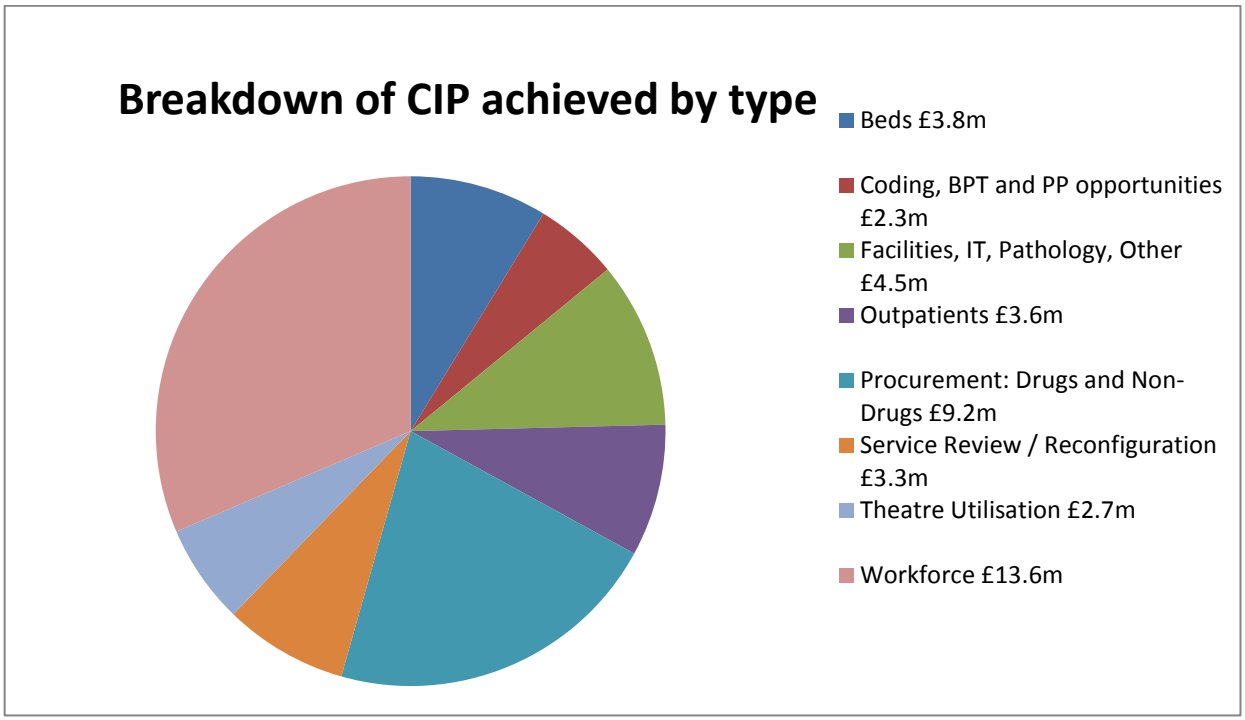


Capital expenditure for 2015/16 consisted of:

- £19.5m on reconfiguration schemes including £10.2m for our Emergency Floor; and £4.2m on the multi-storey car park development;
- £8.6m on estates and facilities critical infrastructure works;
- £5.3m on various IM&T schemes;
- £4.1m on medical equipment; and
- £3.5m for the Electronic Patient Record Programme.

Our efficiency programme

We delivered £43.1m against our £43.0m cost improvement programme in 2015/16. The programme focused on productivity whilst maintaining high quality patient services. The improvements include £13.6m on workforce improvements, savings of £9.2m through procurement initiatives, and £2.3m saving from improved counting and coding. A breakdown of the cost improvements that we made is shown in the chart 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 2015/16, 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 2016/17 plan to NHS Improvement, which includes:

- Planned I&E (income and expenditure) deficit of £8.3m after receipt of £23.4m S&T funding;
- A major CIP plan of £35.0m;

- A capital expenditure plan of £108.3m, including the Emergency Floor development and the Electronic Patient Record system;
- External funding of £48.5m to fund the capital programme;
- An external Financing Limit (EFL) of £49.2m;
- A Financial Risk Rating (FRR) of 4 (calculated in accordance with the NTDA 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 capital and revenue financing as follows:

- Sustainability and Transformation Funding (STF) of £23.4m on the understanding that we will deliver a deficit of £8.3m;
- £25.5m Department of Health loans and fund the capital programme; and
- £22.9m financing arrangement relating to our Electronic Patient Record system.

We plan to further improve our performance against the Better Payment Practice Code (BPPC) in 2016/17 as a result of the financing outlined above. Sufficient liquidity therefore will exist or can be made available to support our operations in the coming twelve months from the date of annual accounts.

Efficiency programme for 2016/17

In 2016/17, we have set an efficiency target of £35.0m. 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 proved effective in 2015/16 and include CIP reporting through the Chief Operating Officer with weekly updates to the NTDA.

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.

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 started in 2014/15.

The capital programme for 2016/17 involves up to £108.3m of investment. Major schemes include:

- £21.7m for the new Emergency Floor;
- £22.9m for the Electronic Patient Record system; and
- £31.3m to continue developing vascular services at Glenfield and to provide an Intensive Care Unit interim solution.

Signed 

Chief Executive (on behalf of the Trust Board)

Date:

Remuneration Reports

Salary and pension entitlements of senior managers – salary 2015/16 (subject to audit)

	2015 - 16					
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	TOTAL (bands of £5,000) £000
BOARD MEMBERS						
K Singh, Chairman	40 - 45	179	0	0	0	40 - 45
J Adler, Chief Executive	195 - 200	0	0	0	290-292.5	485-490
R Mitchell, Chief Operating Officer	145 - 150	0	0	0	55-57.5	200-205
P Traynor, Chief Finance Officer	165 - 170	0	0	0	95-97.5	260-265
C Ribbins, Acting Chief Nurse (until 2 August 2015)	35 - 40	0	0	0	0	35-40
J Smith,Chief Nurse (from 3 August 2015)	90 - 95	0	0	0	0	90 - 95
A Furlong, Medical Director (from 1st April 2015)	180-185	0	0	0	0	180-185
NON EXECUTIVE DIRECTORS						
M Traynor, Non-Executive Director	5 -10	0	0	0	0	5 - 10
Colonel (retired) I Crowe, Non-Executive Director	5 - 10	0	0	0	0	5 - 10
Dr S Dauncey, Non-Executive Director	5 - 10	0	0	0	0	5 - 10
J E Wilson, Non-Executive Director (until 31 December 2015)	0 - 5	0	0	0	0	0 - 5
R Moore, Non-Executive Director (from 1 April 2015)	5 - 10	0	0	0	0	5 - 10
Professor A Goodall, Non-Executive Director (from 1 July 2015)	0 - 5	0	0	0	0	0 - 5
A Johnson, Non-Executive Director (from 1st November 2015)	0 - 5	0	0	0	0	0 - 5
SENIOR MANAGERS						
K Shields, Director of Strategy (until 14th February 2016)	100 - 105	0	0	0	35-37.5	140-145
S Ward, Director of Corporate & Legal Affairs	105 - 110	0	0	0	40-42.5	150-155
M Wightman, Director of Marketing and Communications	105 - 110	0	0	0	35-37.5	145-150
E Stevens, Acting Director of Human Resources (until 13 September 2015)	40 - 45	0	0	0	370-372.5	415-420
L Tibbert, Director of Workforce and Organisational Development (from 3 August 2015)	75 - 80	0	0	0	17.5-20.0	95-100

Andrew Furlong (Medical Director) receives remuneration in his other capacity as a Consultant Trauma and Children's Orthopaedic Surgeon banding which is in the banding (in £000) of 55-60 included in the figure above.

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	TOTAL (bands of £5,000) £000
BOARD MEMBERS						
K Singh, Chairman (from 1 October 2014)	20 - 25	7	0	0	0	20 - 25
R Kilner, Chairman (until 30 September 2014)	10 - 15	1	0	0	0	10 - 15
J Adler, Chief Executive	185 - 190	142	0	0	57.5-80.0	245-250
R Mitchell, Chief Operating Officer	140 - 145	0	0	0	70.0-72.5	210-215
A Seddon, Director of Finance and Procurement (until 13 April 2014)	80 - 85	0	0	0	0	80 - 85
P Hollinshead, Interim Director of Financial Strategy (from 20 Jan 2014 to 18 July 2014)	85 - 90	0	0	0	0	85 - 90
S Sheppard, Acting Director of Finance and Procurement (from 19 July 2014 to 31 October 201	35 - 40	0	0	0	100.0-102.5	135-140
P Traynor, Director of Finance (from 3 November 2014)	65 - 70	3	0	0	35.0-37.5	100-105
C Ribbins, Acting Chief Nurse (from 1 March 2015)	5 - 10	3	0	0	10.0-12.5	15-20
R Overfield, Chief Nurse (until 28 February 2015)	125 - 130	0	0	0	50.0-52.5	175-180
K Harris, Medical Director	210-215	2	0	0	0	210 - 215
NON EXECUTIVE DIRECTORS						
M Traynor, Non-Executive Director (from 2 October 2014)	0 - 5	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 - 5
D Wynford-Thomas, Non-Executive Director (until 28 February 2015)	5 - 10	0	0	0	0	5 - 10
Colonel (retired) I Crowe, Non-Executive Director	5 - 10	0	0	0	0	5 - 10
Dr S Dauncey, Non-Executive Director	5 - 10	0	0	0	0	5 - 10
J E Wilson, Non-Executive Director	5 - 10	0	0	0	0	5 - 10
P Panchal, Non-Executive Director (until 31 March 2015)	5 - 10	0	0	0	0	5 - 10
K Jenkins, Non-Executive Director (until 30 June 2014)	0 - 5	0	0	0	0	0 - 5
SENIOR MANAGERS						
K Shields, Director of Strategy	115 - 120	0	0	0	152.5-155.0	270-275
S Ward, Director of Corporate & Legal Affairs	105 - 110	0	0	0	17.5-20.0	120-125
M Wightman, Director of Communications	105 - 110	0	0	0	30.0-32.5	135-140
E Stevens, Acting Director of Human Resources (from 1 January 2015)	25 - 30	0	0	0	0	30 - 35
K Bradley, Director of Human Resources (until 31 December 2014)	95 - 100	28	0	0	7.5-10.0	105-110

Salary and pension entitlements of senior managers – Pension Benefits (subject to audit)

Name and title	Real increase in pension at state pension age (bands of £2500) £000	Real increases in lump sum at state pension age at 31 March 2016 (bands of £2500) £000	Total accrued pension at state pension age at 31 March 2016 (bands of £5000) £000	Lump sum at state pension age related to accrued pension at 31 March 2016 (bands of £5000) £000	Cash Equivalent Transfer Value at 31 March 2016 £000	Cash Equivalent Transfer Value at 1 April 2015 £000	Real Increase in Cash Equivalent Transfer Value £000	Employers Contribution to Stakeholder Pension To nearest £100
BOARD MEMBERS								
J Adler, Chief Executive	12.5-15.0	40.0-42.5	75.0-80.0	225.0-230.0	1,493	1,195	284	0
R Mitchell, Chief Operating Officer	2.5-5.0	2.5-5.0	20.0-25.0	60.0-65.0	260	227	30	0
P Traynor, Director of Finance	2.5-5.0	10.0-12.5	45.0-50.0	135.0-140.0	732	653	71	0
C Ribbins, Acting Chief Nurse (until 2 August 2015)	0	0	10.0-15.0	40.0-45.0	261	667	-140	0
J Smith Chief Nurse (from 3 August 2015)	0	0	0	0	0	0	0	0
A Furlong Medical Director (from 1 April 2015)	0	0	30.0-35.0	95.0-100.0	597	663	-74	0
SENIOR MANAGERS								
K Shields, Director of Strategy (until 14 February 2016)	0.0-2.5	0	45.0-50.0	130.0-135.0	774	742	20	0
S Ward, Director of Corporate & Legal Affairs	0.0-2.5	5.0-7.5	45.0-50.0	135.0-140.0	894	828	55	0
M Wightman, Director of Communications	0.0-2.5	0.0-2.5	25.0-30.0	75.0-80.0	442	408	29	0
E Stevens, Acting Director of Human Resources (until 13 September 2015)	5.0-7.5	20.0-22.5	25.0-30.0	75.0-80.0	421	156	119	0
L Tibbert, Director of Workforce and Organisational Development (from 3 August 2015)	0.0-2.5	0	0.0-5.0	0	16	0	10	0

J Smith is not a member of the NHS Pension Scheme.

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 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. CETVs are calculated in accordance with the Occupational Pension Schemes (Transfers Values) Regulation 2008.

Real Increase in CETV reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Directors and Senior Managers Remuneration

We classify our Directors and Senior Managers as Very Senior Managers (VSMs). These members of staff are deemed to be on a VSMs pay scale which is non agenda for change. The remuneration of these individuals is set by our remuneration committee. On an annual basis the remuneration committee decides on any pay uplift or pay award for VSMs for the forthcoming year.

Analysis of Staff Number (subject to audit)

The table below shows the staff composition by group.

Staff Group	Female	Male	Grand Total
Scientific and Technical	285	86	371
Clinical	1,749	294	2,042
Administrative and Clerical	1,877	428	2,305
Allied Health Professionals	410	120	530
Estates and Ancillary	137	59	195
Healthcare Scientists	235	169	405
Medical and Dental	674	1,005	1,680
Nursing and Midwifery Registered	3,194	354	3,547
Board Members	1	5	6
Non Executive Directors	1	5	6
Senior Managers	1	2	3
Grand Total	**8,564**	**2,526**	**11,090**

Exit packages 2015/16 and 2014/15 (subject to audit)

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
	2015-16							
	Number	£'s	Number	Number	Number	£'s	Number	£'s
Less than £10,000	1	0	0	0	1	0	0	0
£10,000-£25,000	0	0	0	0	0	0	0	0
£25,001-£50,000	1	43,710	0	0	1	43,710	0	0
£50,001-£100,000	0	0	0	0	0	0	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	2	43,710	0	0	2	43,710	0	0

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
	2014-15							
	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

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 scheme. Ill-health retirement costs are met by the NHS pension 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 has seven 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 following table shows all off-payroll engagements as of 31 March 2016, for more than £220 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2016	7
Of which, the number that have existed:	
for less than one year at the time of reporting	1
for between one and two years at the time of reporting	4
for between 2 and 3 years at the time of reporting	1
for between 3 and 4 years at the time of reporting	1

The following table shows all new off-payroll engagements between 1 April 2015 and 31 March 2016, for more than £220 per day and that last longer than six months:

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2015 and 31 March 2016	1
Number for whom assurance has been requested	1
Of which:	
assurance has been received	1

Expenditure on consultancy

We incurred £3.9m on consultancy services.

Pay multiples (subject to audit)

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 2015-16 was £185k - £190k (2014-15: £210k - £215k). This was 7.41 times (8.82 times in 2014-15) the median remuneration of the workforce, which was in the banding £25k - £30k (2014-15: £25k - £30k).

In 2015-16, 4 employees received remuneration in excess of the highest-paid director (5 employees in 2014-15). Remuneration across the Trust ranged from £1k - £250k (2014-15 £1k - £265k).

The movement from the prior year figures is due to a refinement of our approach to calculating the figures, the use of more accurate data from the payroll system and the application of guidance from the Hutton Review of Fair Pay which was not applied in the previous year.

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind but not 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

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. We recognise that the internal control environment can always be strengthened and this work will continue in 2016/17, as described below.

We have identified below a number of significant control issues which have impacted on our performance in 2015/16. 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 (now NHS Improvement), 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 a 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 at the University Hospitals of Leicester NHS Trust for the financial year ended 31 March 2016 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 2015/16.

Mr Richard Moore joined the Trust formally as a Non-Executive Director on 1 April 2015 and has served as Chairman of the Audit Committee since that date. Professor Alison Goodall, nominated by the University of Leicester, took up her role as a Non-Executive Director on 1 July 2015. Mr Andrew Johnson took up his position as a Non-Executive Director on 1st November 2015. Ms Jane Wilson stood down as a Non-Executive Director on 31st December 2015.

Having served in the role as Acting Medical Director from 1 April 2015, Mr Andrew Furlong was appointed to the substantive role of Medical Director from 15 January 2016.

Ms Julie Smith and Ms Louise Tibbert took up their roles as Chief Nurse and Director of Workforce and Organisational Development on 1 and 3 August 2015, respectively.

Ms Kate Shields, Director of Strategy left the Trust on 14 February 2016. On an interim basis, the responsibilities of this post have been reallocated to the Chief Financial Officer, Mr Paul Traynor, and Director of Marketing and Communications, Mr Mark Wightman. It is anticipated that a substantive appointment will be made to the post of Director of Strategy during 2016/17.

One post of Non-Executive Director remains vacant and it is anticipated that NHS Improvement will make an appointment to this post in 2016/17.

The Board is supported in its work by the Director of Workforce and Organisational Development, Director of Marketing and Communications and Director of Corporate and Legal Affairs who each have a standing invitation to attend all meetings, but not in a voting capacity.

In summary, although there has been significant turnover at Board level in 2015/16, 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

The Chief Executive reports on key issues to each public Board meeting and a Quality and Performance Dashboard forms part of this report.

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 meeting of the Board's Integrated Finance, Performance and Investment Committee (IFPIC) and Quality Assurance Committee (QAC). This report is also published as part of our Trust Board papers.

The monthly report:

- is structured across several domains: 'safe'; 'caring'; 'well-led'; 'effective'; 'responsive'; and 'research';
- includes information on our performance against the NHS Trust Development Authority Accountability Framework;
- 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'. Never events are serious, largely preventable incidents that should not occur if the available preventative measures have been implemented.

During 2015/16, two such incidents were reported at the Trust which met the definition of a never event. These related to (a) a patient falling from an inadequately restricted window, and (b) a patient undergoing a skin excision procedure on the incorrect ear. In both cases, the patients and their relatives were informed by the Trust of the errors and the Trust apologised for its failings.

Thorough root cause analysis of both incidents was undertaken to identify key actions to prevent recurrence. Implementation of these actions is tracked by the Quality Assurance Committee on behalf of the Trust Board.

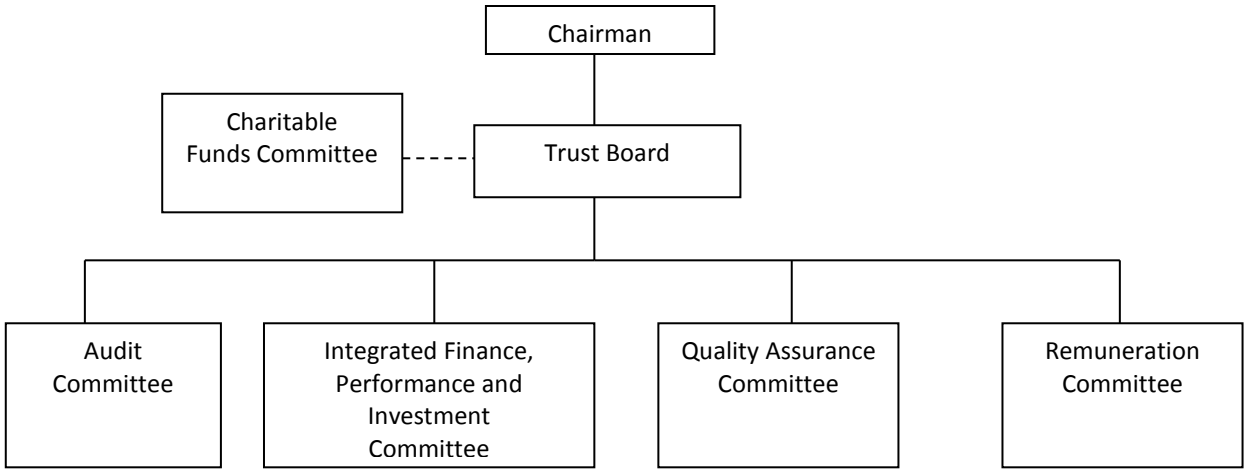
The formal Board performance management reporting framework is accompanied by a series of measures to achieve a more interactive style of governance, moving beyond paper reporting. Examples include:

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

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 Trust 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 by our Chairman 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 three Non-Executive Directors and has met on five occasions throughout the 2015/16 financial year. It has discharged its responsibilities for scrutinising the risks and controls which affect all aspects of our organisation's business. The Audit Committee receives reports 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 to oversee 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 Trust Board meeting for consideration. Recommendations made by the committees to the Trust Board are clearly identified on 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 minutes at the Board meeting, highlighting material issues arising from the work of the committee to the Board. 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.

Every meeting of the Trust Board and each Board committee meeting was quorate during 2015/16.

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 2015/16 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 attendees 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 necessary steps to improve. The Board is keen to ensure that it is:

- operating at maximum efficiency and effectiveness;
- adding value; and
- providing a yardstick by which it can both measure its own effectiveness and prioritise its activities for the future.

Building on the findings of a third party external adviser carried out in 2014/15, during the year the Trust Board has implemented a programme of work (supported by external consultants) to improve Board and Board committee reporting. This work has helped us to:

- align the Board agenda to our priorities and the things that matter most;
- stimulate more forward-looking and strategic conversations in the boardroom;
- 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.

Outside of its formal meetings, the Board has held development sessions ('Thinking Days') each month throughout the year. Amongst the topics considered were our reconfiguration programme; risk management; workforce equality and diversity; workforce planning and organisational development; and stakeholder engagement.

Our Chairman set objectives for the Chief Executive and Non-Executive Directors for 2015/16. In turn, the Chief Executive set objectives for the Executive Directors and Corporate Directors in relation to the delivery of the Annual Plan for 2015/16. 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, most recently in October 2015. 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 2015/16, the Director of Corporate and Legal Affairs retained the role of Senior Information Risk Owner and the Medical Director continued as our Caldicott Guardian.

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, spread across the domains of:

- information governance management;
- confidentiality and data protection assurance;
- information security assurance;
- clinical information assurance;
- secondary use assurance; and
- corporate information assurance.

We achieved a minimum level 2 standard across all of the 45 standards, except in the case of:

- training : 89% of staff were trained in information governance in 2015/16 against the toolkit requirement that all staff be trained;
- data quality : the Trust needs to document and implement procedures for using both local and national benchmarking to identify and investigate possible data quality issues;
- corporate information assurance : the Trust needs to carry out an audit of corporate records in at least four corporate areas of the organisation.

An information governance improvement plan for 2016/17 has been prepared for approval by the Executive Team. Implementation will be overseen by the Information Governance Steering Group, chaired by the Senior Information Risk Owner.

During the year we reported to the Information Commissioner's Office one serious untoward incident involving a lapse of data security. Patient care was not put at risk and the data was retrieved.

In respect of other personal data related incidents experienced during the year, 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 Policy clearly describes our approach to risk management and the roles and responsibilities of the Trust Board, management and all staff.

All 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 reviews 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, the controls in place and assurance sources, along with any gaps in assurance, are identified and reviewed . The Chief Executive highlights key issues in his monthly report to the public meeting of the Trust Board, appended to which are the Board Assurance Framework Dashboard and Organisational Risk Register Dashboard, respectively. A copy of the full Framework is also published monthly with the Board papers.

During 2015/16, the Trust Board has considered how best to strengthen our risk management arrangements at two development sessions ('Thinking Days').

Agreement has been reached to implement a revised approach in quarter one 2016/17, the principal aims of which are to ensure:

(a) firstly, within the Board itself, that an informed consideration of risk and risk tolerance underpins organisational strategy, decision-making and the allocation of resources; and

(b) secondly, that the organisation has appropriate risk identification and risk management processes in place to deliver the Annual Operational Plan and comply with the registration and licensing requirements of key regulators.

Our Annual Operational Plan 2016/17 responds to and addresses the strategic risks we face. The current Board Assurance Framework is to be updated to reflect risks in the 2016/17 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 Trust Board during the year.

I comment below (under 'Significant Control issues') on the findings of an unannounced inspection by the Commission of the Emergency Department at the Leicester Royal Infirmary in November 2015.

The Care Quality Commission is to conduct a full inspection of our Trust in June 2016. As part of the planning for the inspection, we are carrying out self-assessments against the Commission's key lines of enquiry during quarter one 2016/17 and the findings will inform improvements during this financial year. It is anticipated that the Commission's report will be available in Autumn 2016.

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 2015/16, the Quality Assurance Committee has noted our internal controls and standards which underpin the Statement of Directors' responsibilities in respect of the Quality Account – the Statement is to be reviewed and signed by the Chairman and Chief Executive on behalf of the Board on 2 June 2016.

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 2015/16 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 note that, in their Annual Audit Letter issued in July 2015, External Audit stated that the Trust has generally sound processes for the production of the financial accounts and in relation to the use of resources.

Arising from their 2014/15 audit of the Trust, External Audit raised one high priority recommendation for the Trust, to strengthen the quality assurance procedures in relation to the valuation of land and assets. We accepted this recommendation and have acted upon it in 2015/16.

I have also 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 2015/16, 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 2015/16, the Head of Internal Audit notes that Internal Audit have carried out fourteen reviews during the year which have resulted in one high-risk rated report – Review of compliance with NHS immigration requirements.

The review considered the processes and controls to ensure compliance with Home Office requirements for employing Tier 2 and Tier 5 migrant workers which focus on:

a) right to work checks;

b) recruitment processes for visa requirement checks for Tier 2 and Tier 5 workers;

c) management information, record keeping and reporting; and

d) arrangements for bank staff.

Internal Audit's review identified that senior members of staff in the Recruitment Services Team had a good level of awareness of Home Office requirements and had implemented controls to ensure compliance. However, the review also identified that some of these processes could be strengthened in the following areas:

i. Disclosure and Barring Service (DBS) checks for migrant workers, and risk assessments for the period before the DBS check was obtained;

ii. evidence of robust Right to Work checks;

iii. accuracy of the recording of visa dates;

iv. monitoring of bank staff weekly hours; and

v. record keeping within files.

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 2016/17.

The Head of Internal Audit is satisfied that sufficient internal audit work has been carried out in 2015/16 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 2015/16 is that governance, risk management and control in relation to business critical areas is generally satisfactory. However, there are some areas of weakness and non-compliance in the framework of governance, risk management and control which potentially put the achievement of objectives at risk. Some improvements are required to enhance the control framework. I accept this finding and am committed to strengthening the internal control environment, as detailed in this Statement.

Using our Board Assurance Framework, 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. increasing emergency attendances and admissions;
c. transferring elective activity into community settings, developing patient referral pathways and cancer care;
d. the provision of specialised services;
e. delivering integrated care in partnership with others;
f. attaining Biomedical Research Centre status;
g. delivering consistently high standards of medical education;
h. delivering the Genomic Medicine Centre project;
i. our relationships with partner organisations;
j. staff engagement and workforce recruitment and retention;
k. implementing the major estate transformation programme;
l. limited capital resources to deliver estate reconfiguration;
m. statutory compliance of the estate;
n. delivering clinically sustainable services;
o. delivering the 2015/16 programme of service reviews;
p. delivering our financial control total in 2015/16;
q. approving an updated five-year financial strategy;
r. the Electronic Patient Record programme;
s. delivering information management and technology services.

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.

During quarter one 2016/17, and in response to the Committee's request, the Quality Assurance Committee is to receive a report from the Director of Safety and Risk setting out details of the Trust's compliance with statutory requirements. Appropriate corrective actions will be taken to address any identified gaps in compliance, with progress reported to the Committee.

Significant Control Issues

Key Financial Duties

In respect of performance in 2015/16 against the key financial duties, we have:

a. delivered the planned deficit of £34.1m; this represents a £2m improvement against the original income and expenditure control total which we were asked in year to deliver by the NHS Trust Development Authority;
b. achieved the External Financing Limit (the limit placed on net borrowing) of £45.2m;

c. achieved the Capital Resource Limit (the limit placed on net capital expenditure) of £49.2m.

At its meeting in May 2015, the Audit Committee assessed the 'going concern' position of the Trust. The Committee's deliberations were aided by the preparation of a 2015/16 Working Capital Strategy, authored by the Chief Financial Officer.

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

i. maintain the cash balance as planned during 2015/16, 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 accepted the 2015/16' going concern' position statement at its meeting in June 2015, on the recommendation of the Audit Committee.

The Board has agreed plans to deliver the agreed 2016/17 control total – a £8.3m deficit (after including Sustainability and Transformation funding of £24.3m), which includes the delivery of a £35m Cost Improvement Programme.

Emergency Care

Unfortunately, we failed to meet the A&E 4-hour standard in 2015/16, achieving a performance of 86.9 per cent (89.1 per cent 2014/15) against a target of 95 per cent.

We have also performed poorly in terms of the time it takes to transfer to our care patients who are brought to our Emergency Department by ambulance. However, since November 2015 and as a result of our work in partnership with the East Midlands Ambulance Service, we have seen a 29 per cent reduction in these delays (total delay time). Nevertheless, despite the improvement, we acknowledge we still have unacceptable delays in this process and remedying this issue is one of our key priorities for 2016/17.

As a member of the Leicester, Leicestershire and Rutland Urgent Care Board, we are fully committed to working with our partners across the health and social care sectors to improve emergency care performance in 2016/17, and our key priorities are as follows:

a. reduce ambulance handover delays in order to improve patient experience, care and safety;

b. fully utilise ambulatory care to reduce emergency admissions and reduce length of stay;

c. develop a clear understanding of demand and capacity to support sustainable service delivery and to inform plans for addressing any gaps; and

d. diagnose and reduce delays in the inpatient process to increase effective capacity.

Cancer waiting time targets

This year we have seen a significant increase in the number of patients being referred with cancer and, as a consequence, we have struggled to deliver the national cancer standards sustainably. Delivering all of the cancer standards sustainably is one of our priorities for 2016/17 and performance will remain under review on a monthly basis by the Trust Board.

Enforcement action by the Care Quality Commission

On 30 November 2015, the Care Quality Commission (CQC) carried out an unannounced inspection of the Emergency Department at the Royal Infirmary. The CQC identified areas of poor practice and, because of concerns about potential risks to patient safety, issued an urgent Notice of Decision to the Trust on 4 December 2015. This imposed conditions on the Trust's registration as a service provider.

The CQC required the Trust to report weekly and monthly on the actions being taken to address the identified concerns. We have complied with this requirement and co-operated fully with the CQC.

Reports submitted to the CQC since their inspections have shown that we have made significant progress and we continue to focus on sustainable improvements. Performance will continue to be overseen on a monthly basis by the Quality Assurance Committee, acting on behalf of the Trust Board.

Waiting list management arrangements

In July 2015, the Executive Team was alerted to the existence of three planned waiting lists (with a total of 347 patients) in the Orthodontics department. These waiting lists had been inappropriately managed with the patients not becoming 'live' when clinically ready for treatment. The incident sparked wider concerns about the use of planned waiting lists across the Trust. In consequence, a thorough review of waiting list management arrangements was undertaken across the Trust. Local processes were strengthened following the review and now each waiting list has a named clinical and managerial lead who provide assurance on the accuracy of the waiting lists.

The 231 orthodontic patients who have waited over 52 weeks continue to be a focus for the local health system. We are committed to providing these patients with suitable treatment either within the NHS or via the independent sector at the earliest opportunity. Our aim is to ensure that, by 31 March 2017, no patients have been waiting longer than one year and the Trust therefore continues to source orthodontic capacity, in collaboration with NHS Improvement and NHS England.

Health and Safety Executive Improvement notice relating to sharps safety

On 21 September 2015, the Health and Safety Executive (HSE) made a planned visit to the Leicester Royal Infirmary. The HSE identified that we were in contravention of the Sharp Instruments in Healthcare Regulations 2013 and served an Improvement Notice on the Trust requiring:

- substitution of unprotected medical sharps with a 'safer sharp' where reasonably practicable;
- prevention of recapping of needles;
- effective investigation of needlestick/sharps injuries.

We took action to ensure we met the requirements of the Improvement Notice and following re-inspection on 7 April 2015, the HSE confirmed that we are in compliance with our legal duties.

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. We recognise that the internal control environment can always be strengthened and this work will continue in 2016/17, as described above.

In addition to the specific issues identified above, further work will also be carried out in 2016/17 to review and strengthen our governance, risk management and internal control systems, policies and procedures as part of our commitment to continuous improvement.

Signed 

Chief Executive (on behalf of the Trust Board)

Date:

Trust Board and Committee attendance 2015/16

Name	**Trust Board** maximum – 13	**Audit Committee** maximum – 5	**Integrated Finance, Performance and Investment Committee** maximum – 12	**Quality Assurance Committee** maximum – 12	**Remuneration Committee** maximum – 7	**Charitable Funds Committee** Maximum – 4
Karamjit Singh – Chairman	13/13	N/A	11/12	11/12	7/7	1/1
Ian Crowe – Non-Executive Director	13/13	4/5	12/12	12/12	7/7	3/3
Sarah Dauncey – Non-Executive Director	11/13	5/5	11/12	10/12	5/7	3/4
Alison Goodall – Non-Executive Director **(1)**	10/11	0/5	0/12	0/9	1/5	N/A
Andrew Johnson – Non-Executive Director **(2)**	6/6	3/3	5/5	5/5	3/3	N/A
Richard Moore – Non-Executive Director	13/13	5/5	12/12	12/12	7/7	1/1
Martin Traynor – Non-Executive Director	12/13	5/5	12/12	11/12	6/7	4/4
Jane Wilson – Non-Executive Director **(3)**	10/10	2/3	9/9	9/9	5/5	1/1
John Adler – Chief Executive	13/13	2/2	8/12	8/12	7/7	N/A
Andrew Furlong – Medical Director **(4)**	12/13	N/A	N/A	7/12	N/A	N/A
Richard Mitchell – Chief Operating Officer	13/13	N/A	9/12	N/A	N/A	N/A
Julie Smith – Chief Nurse **(5)**	9/9	N/A	N/A	7/8	N/A	1/3
Emma Stevens - Acting Director of Human Resources **(6)**	4/4	N/A	N/A	N/A	2/2	N/A
Louise Tibbert – Director of Workforce and OD **(7)**	7/9	N/A	N/A	N/A	4/5	N/A
Paul Traynor – Chief Financial Officer	13/13	5/5	11/12	N/A	N/A	3/4
Carole Ribbins – Acting Chief Nurse **(8)**	3/4	N/A	N/A	1/4	N/A	1/1
Helen Seth – Acting Director of Strategy **(9)**	1/1	N/A	1/2	N/A	N/A	N/A
Kate Shields – Director of Strategy **(10)**	8/12	N/A	5/10	N/A	N/A	0/1
Stephen Ward – Director of Corporate and Legal Affairs	13/13	5/5	N/A	N/A	7/7	4/4
Mark Wightman – Director of Marketing and Communications	12/13	N/A	N/A	N/A	N/A	2/4

Notes:

(1) Non-Executive Director from 1 July 2015
(2) Non-Executive Director from 1 November 2015
(3) Non-Executive Director until 31 December 2015
(4) Substantive Medical Director from 15 January 2016 (Acting Medical Director from 1 April 2015)
(5) From 1 August 2015
(6) Until 31 July 2015
(7) From 3 August 2015
(8) Until 31 July 2015
(9) From 13 February 2016
(10) Until 14 February 2016

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

Chartered Accountants
One Waterloo Way
Leicester
LE1 6LP

DATE

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) 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.

Mortality means death rate. In the NHS it is used when referring to the expected death rate for conditions or procedures.

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.

NHS Improvement support foundation trusts and NHS trusts to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable.

NHS Trust Development Authority (TDA) is the organisation that provides support, oversight and governance for all NHS Trusts on their journey to delivering what patients want; high quality services today, secure for tomorrow. From 1 April 2016, the NHS Trust Development Authority will be part of NHS Improvement.

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 2017**.

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.

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b. Is there any category you think we should leave out?

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2 Were there any areas of the annual report which you found most useful, please feel free to list and explain why

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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?

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If you would like to be notified when the 2015/16 annual report is available? If so, please give your email address

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Completed questionnaires can be sent to:

Communications Team, University Hospitals of Leicester NHS Trust, Medical Illustration, Level 2 Windsor Building, Leicester, LE1 5WW

Back cover design and language statement

APPENDIX 2

Methodology for the revaluation of the Trust's Estate as at 31 March 2016

This appendix sets out the methodology for the revaluation of our estate as at 31st March 2016.

As set out in the DH Manual for Accounts, DH group bodies apply the principles of the HM Treasury Financial Reporting Manual (FReM) to asset valuations. This means that the accounting policy for valuation of specialised properties (such as hospital buildings) is to use depreciated replacement cost to value the service potential, on a modern equivalent asset basis.

Within this policy, valuation experts base their work on a number of valuation assumptions as agreed with the NHS body. One of which is whether the MEA valuation is prepared on a 'no-alternative site' or an 'alternative site' basis.

The former means that the valuation is based on replacing the asset's service potential on a modern equivalent basis, on approximately the same geographic site as currently. This is commonly the default approach. The latter approach means that the modern equivalent might be constructed on an alternative site. This tends to consider an alternative cheaper site, so usually leads to a lower valuation.

In many cases this is a valuation of a "theoretical" asset and the valuation can be applied even though a Trust may have no plans to actually reconfigure or rebuild their estate on the alternative site. In our case we have fully developed, clinically led plans to reconfigure our estate.

Our aim was to apply the MEA valuation to our estate using our approved plans rather than applying a theoretical valuation, in order to give a more accurate and realistic valuation.

Our Estates Strategy outlines our planned estates reconfiguration, which includes consolidating the estate from the current three main acute sites to two. The strategy is consistent with our clinical strategy and both strategies are fundamentally linked as we cannot achieve our clinical strategy without reconfiguring our services and estate.

We provided the estates strategy to our valuers to enable them to provide a more accurate MEA valuation based on our actual plans and future Trust configuration. The issue of estates valuation has been discussed in several forums including a session held with the Non-Executive Directors in February, and in the Integrated Finance and Performance Committee.

Summary

- Our valuation applies the DRC valuation methodology on an MEA basis.
- The valuation reflects the future planned configuration of the Trust's estate, based on our Board approved estates strategy and reflecting the reconfiguration from three to two sites.