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Welcome from the Chairman and Chief Executive

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We are delighted to present our Annual Report and Accounts for the University Hospitals of Leicester NHS Trust (Leicester's Hospitals) for 2017/18.

During the year (between November 2017 and January 2018), the Care Quality Commission (CQC) inspected five core services, across four locations, and carried out a 'well-led' inspection. They inspected urgent and emergency care at the Royal Infirmary, medical care at the Glenfield and Royal Infirmary, diagnostic imaging, maternity and outpatients at the Royal Infirmary and the General Hospital, and maternity services at all three sites, including St Mary's Birthing Centre.

We are really pleased to report that through our commitment to continuous improvement, we have improved in a number of key areas since our last ratings were published in January 2017. The report is available on our website. The CQC Inspectors have improved our ratings for the 'effectiveness' of services overall and for our maternity service, both of which are now rated as good (they were previously rated 'requires improvement'). We are also particularly pleased to see the very significant improvement in our urgent and emergency services ratings, despite continued pressure. In four of the five domains we have seen an improvement.

Overall, the Inspectors have rated our Trust as Requires Improvement; rating us Good for being effective and caring, and Requires Improvement for being safe, responsive and well-led. In addition, no elements of any of our services are now rated as inadequate.

The Inspectors observed good and outstanding practice and compassionate care being carried out by our staff, along with feedback from patients that staff treated them with kindness and provided emotional support to minimise their distress. They paid tribute to our maternity services, particularly our new dedicated Home Birth Team, prenatal and antenatal clinics, both locally and across borders, and the TED (Time, Escalation, Decision making) video created to improve outcomes for babies.

It is regrettable that following their inspection the CQC served us with a warning notice because the care we give diabetic patients in relation to the management of their insulin requires significant improvement. We recognise this shortfall and since the inspection, we have accelerated our programme of work to ensure immediate improvements and safety of our patients. Our actions focus on face to face education and training for our doctors and nurses, improved decision-making tools to aid prompt management and intervention, overseen by enhanced support from the diabetic specialist team. We are pleased to report that the early evidence supports these actions and have delivered improvements in knowledge and care of patients with diabetes.

Overall, we think that the CQC's assessment is accurate, balanced, and fair. In response, we have a robust action plan in place, which clearly maps out the improvements we need to make to our services.

Two very memorable moments in the year were the opening of our new £48m Emergency Floor at 4am on Wednesday 26 April 2017 and the subsequent visit of HRH The Princess Royal, in March 2018. What is clear from feedback is that the new department has not only improved the experience for patients, but also for the staff working in and with the department. Patient satisfaction has risen from around 85 per cent to 97 per cent, even during the peak period of winter pressures.

Regrettably, what our new department has not delivered is an overall improvement in our waiting time performance. This is due to a series of internal and external factors, but predominantly the flow of patients out of the department, through the rest of the hospitals, and into the community. We continue to work with partners in health and social care across Leicester, Leicestershire, and Rutland to tackle this on-going problem, which is sadly not unique to our area.

On completion of Phase 2 of the Emergency Floor in June 2018, we will see all of our assessment units relocate from their current locations across the Royal Infirmary, to right next door to the Emergency Department. Patients referred to these assessment units from the Emergency Department are assessed and diagnosed, and where necessary, immediate acute medical treatment is started. Patients either move to a main ward in our hospitals or are discharged home. Our assessment units include the Acute Frailty Unit and Emergency Frailty Unit, where older, frail patients will be treated in a purpose-built frailty friendly space, by geriatricians and members of the multi-disciplinary clinical team.

The new Department was opened in time for what feels like the most challenging winter in memory, which saw us – along with the rest of the NHS – struggle with operational pressures. In January, all NHS Trusts were instructed to cancel elective operations in a bid to free up capacity to treat the increased number of emergency patients needing care. This instruction was for the whole of January but in reality the situation lasted through February and March. Even more regrettable was the cancellation of some cancer surgery during that operationally challenging time. We do not take these decisions to cancel patients, particularly cancer patients, lightly. We know how distressing this is for everyone involved, but we cannot in good faith bring patients in for surgery if we do not have a bed somewhere to safely look after them following their surgery. In preparation for winter 2018/19 we are working on how we can increase capacity to reduce the chances of cancellations in the future.

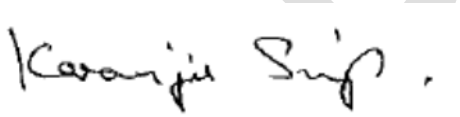
On 30 November, following almost 18 months of uncertainty, NHS England announced that they would continue to commission surgical services at our East Midlands Congenital Heart Centre, allowing us to continue to provide lifesaving surgery for children and adults in our region. The decision was a vote of confidence for our staff and service, and great news for our NHS partners across the East Midlands network. It has allowed the teams to focus on ways of working more effectively to enable more patients to be treated in our centre.

The service continues to see and treat more patients every year and works closely with all of our network hospitals, to ensure that they are able to offer East Midlands Congenital Heart Centre as an option to those patients who live closest to us and want to be cared for by us. We are pleased to report that we are on track to meet the surgical numbers required in the standards and are looking forward to implementing the exciting plans to co-locate the children's element of this service with other children's services at the Royal Infirmary by 2020.

Looking forward to 2018/19, we will continue to progress our plans (Delivering Caring at its Best) whilst we wait for news of national capital funding. These plans will see us relocate our intensive care service from the General, consolidating it on the Royal Infirmary and Glenfield hospital sites, which will trigger a number of moves for services reliant on intensive care. These plans are part of the wider system Sustainability and Transformation Plan or "Better Care Together" as we call it locally.

Finally, we could not end our introduction to this without giving our sincere thanks to the many people and organisations that support our work. To the hundreds of volunteers who give their time freely, every day, to help our patients and visitors; to the Patient Partners who act as critical friends to us and offer advice on our ideas; and to bodies such as Healthwatch, local Clinical Commissioning Groups, Local Authority partners, and GPs for their continued help and support.

Most of all, our unreserved thanks, on behalf of the whole Trust Board, must go to our staff. This past year has seen many challenges and pressures, but when we walk our wards, departments and corridors we are met with smiles and hear stories of people going above and beyond for our patients and their colleagues. We really appreciate you're their dedication to our organisation. We thank them for their on-going commitment to make things better, and we revere them for everything they do day in, day out to provide the best service they can.



Karamjit Singh CBE, Chairman

John Adler, Chief Executive

About Leicester's Hospitals

Our patients are the most important thing to us and we are constantly striving to improve the care they receive, through looking at the ways we work, ensuring our staff are highly trained and encouraging research which allows us to offer our patients the latest technologies, techniques and medicines – and attract and retain our enviable team of more than 15,000 highly skilled staff.

Based in the heart of Leicester, we are one of the biggest and busiest NHS Trusts in the country, serving the one million residents of Leicester, Leicestershire and Rutland – and our specialist services serve another 2-3 million patients from areas across the rest of the country.

Our nationally and internationally-renowned specialist treatment and services in cardio-respiratory diseases, ECMO, cancer and renal disorders reach a further two to three million patients from the rest of the country.

We run three city hospitals, the Glenfield, General and Royal Infirmary, which is home to our Children's Hospital.

Having a role in the development of the next generation of clinical staff is important to us so we work closely with partners at the University of Leicester and De Montfort University to provide world-class teaching to nurture and develop future doctors, nurses and other healthcare professionals, many of whom go on to spend their working lives with us.

We continue to work with many different organisations across the globe to push the boundaries of research and new surgical procedures for the benefit of our patients, with around 1,000 clinical trials taking place every year. We host an NIHR Biomedical Research Centre which supports key research into cardiovascular and respiratory disease, lifestyle and diabetes. We also host an NIHR Clinical Research Facility, which supports early phase clinical trials. Our Research Space has a new dedicated children's research facility catering for our youngest research participants. We are extremely proud that we have an Experimental Cancer Medicine Centre, and our HOPE facility is an instrumental factor in delivering clinical trials of new cancer treatments, generously supported by the locally-based charity Hope Against Cancer. We are helping to pave the way for a new era of personalised medicine for our patients by participating in the 100,000 Genomes Project. All of this means that thousands of our patients are amongst the first to be offered the latest medicines and treatments.

Our heart centre at the Glenfield hospital continues to lead the way in developing new and innovative research and techniques and has 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. Our vascular services are nationally renowned, with more patients surviving longer after following an aneurysm repair (to fix a life threatening bulge in a blood vessel).

Our purpose is to provide 'Caring at its best' by living a set of values created by our staff that embody who we are and what we are 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 is why we are proud to be part of the NHS and we are proud to be Leicester's Hospitals.

Our values and the NHS Constitution

We created our values with staff over five 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 (www.gov.uk/government/news/nhs-constitution-and-handbook-updated) 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.

There have since been a number of amendments and updates to the constitution. The latest version can be found on the gov.uk website.

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.

The Accountability Report

Our Trust Board

Declaration of Interests

	Karamjit Singh CBE Trust Chairman	Family member is a Partner with Lakeside Practice, Corby.
	Vicky Bailey Non-Executive Director	Former Trustee and current Fellow of the Queens Nursing Institute
	Professor Philip Baker and Dean of the University of Leicester Medical School Non-Executive Director	Minority shareholder of Metabolomic Diagnostics – spinout company seeking to develop predictive tests for pregnancy complications Trustee of 'The Bridge' – a charity providing for the homeless in Leicester Dean of Medicine, Pro-Vice-Chancellor and Head of the College of Life Sciences, University of Leicester
	Dr Shirley Crawshaw (until 16.6.17) Non-Executive Director	None to declare
	Colonel (Ret'd) Ian Crowe Non-Executive Director	Member of the Royal British Legion Brother by award of the Order of St John (not active in the organisation) Member of the Royal Army Medical Corps
	Andrew Johnson Non-Executive Director	None to declare
	Richard Moore Non-Executive Director	Director, Peppercorn Services Offices Ltd. Director, EAI 555 Limited Director, Momentum 002 Limited. Director, Momentum Partners Chairman, 555 Fussball Projekt & SoccerWorld Deutschland GmbH. Corporate Director of Finance and Resources, Barnardo's
	Ballu Patel Non-Executive Director	Employment by RNIB
	Martin Traynor Non-Executive Director	None to declare

Our Trust Board

Declaration of Interests

John Adler
Chief Executive

None to declare

Eileen Doyle
Interim Chief Operating Officer

Managing Director of Dunain Health Management, a Limited Company currently in dormancy

Andrew Furlong
Medical Director

None to declare

Tim Lynch
(from 3.7.17 until 31.12.17)
Interim Chief Operating Officer

Director of Camlin Associates

Richard Mitchell
(until 2.7.17)
Chief Operating Officer

None to declare

Julie Smith
Chief Nurse

None to declare

Paul Traynor
Chief Financial Officer

Spouse is employed in a governance role by the LLR Alliance

Directors who provide advice to the Board

Louise Tibbert
Director of Workforce and OD

Member of the NHS Pension Board as an employer representative – 3-year appointment from 1.1.16

Stephen Ward
Director of Corporate and Legal Affairs

None to declare

Mark Wightman
Director of Strategy and Communications

None to declare

What is a Non-Executive Director?

The role of Non-Executive directors is different to that of an Executive Director. They do not have responsibility for the day to day management of the Trust but share the Board's corporate responsibility for ensuring that the Trust is run efficiently, economically and effectively. They will scrutinise the executive management's performance in meeting agreed goals and objectives and monitor the reporting of performance. They must satisfy themselves on the integrity of financial information and that financial controls and a sound system for the management of risk are in place. They will seek to establish and maintain public confidence in the Trust, and must be independent in judgement and constructively challenge and help develop decisions and strategy for which they bear equal responsibility. To be effective 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. Since September 2017 individual Non-Executive Directors have been identified as members of specific Board Committees (rather than attending them all), although papers of all those meetings are available to all Non-Executive Directors if they wish to see them. The Chairman and all Non-Executive Directors are members of our Remuneration Committee.

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

Board member	Chairs
Karamjit Singh, CBE	Trust Board and the Remuneration Committee
Col (Ret'd) Ian Crowe	Quality Assurance Committee (until September 2017 when it was replaced by the Quality and Outcomes Committee) Quality and Outcomes Committee (since September 2017)
Andrew Johnson	Charitable Funds Committee (until September 2017) People, Process and Performance Committee (from September 2017)
Richard Moore	Audit Committee
Ballu Patel	Charitable Funds Committee (since September 2017)
Martin Traynor, OBE	Integrated Finance, Performance and Investment Committee (until September 2017, when it was replaced by the Finance and Investment Committee) Finance and Investment Committee (from September 2017)

Remuneration Committee

Chair	Karamjit Singh, CBE
Members	Professor Philip Baker – Non-Executive Director Vicky Bailey – Non-Executive Director Col (Ret'd) Ian Crowe – Non-Executive Director Andrew Johnson – Non-Executive Director Richard Moore – Non-Executive Director Ballu Patel – Non-Executive Director Martin Traynor, OBE – Non-Executive Director

Audit Committee

Chair	Richard Moore
Members	Dr Shirley Crawshaw – Non-Executive Director Ian Crowe – Non-Executive Director Andrew Johnson – Non-Executive Director Ballu Patel – Non-Executive Director Martin Traynor – Non-Executive Director John Adler – Chief Executive Paul Traynor – Chief Financial Officer Stephen Ward – Director of Corporate and Legal Affairs (non-voting)

Trust Board meetings

Our Trust Board meetings are held in public and details of dates are 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 Annual Public Meeting on Wednesday 20 September 2017 at the Peepul Centre in Leicester, presenting our 2016/17 annual report and accounts and answering questions from the public. There was also a health and wellbeing fair for members of the public.

Partners on our Trust Board

A nominated representative of Leicester, Leicestershire and Rutland Healthwatch attended and contributed to our public Trust Board meetings as a non-voting/co-opted member – Mr Evan Rees took over this role in May 2017. 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.

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 a minimum level 2 standard ('satisfactory') across all the 45 standards.

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

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, where necessary, 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.

From April 2018, the new Data Security and Protection Toolkit (DSP Toolkit) replaces the Information Governance Toolkit and, taking into account the advice of the Chief Information Officer, the Trust Board will self-assess our position against the defined security standards to assure itself that we are meeting our obligations on data protection and data security.

Anti-Fraud and Corruption Statement

The Bribery Act 2010 came into effect on 1 July 2011. Bribery is generally defined as giving someone a financial or other advantage to encourage that person to perform their functions or activities improperly or to reward that person for having already done so. The maximum penalty for bribery is 10 years imprisonment, with an unlimited fine.

In addition, the Act introduces a corporate offence of failing to prevent bribery by an organisation not having adequate preventative procedures in place. The organisation may avoid conviction if it can show that it had procedures and protocols in place to prevent bribery. The corporate offence is not a stand-alone offence, but always follows from a bribery and/or corruption offence committed by an individual associated with the company or organisation in question.

As a result, we confirm that the University Hospitals of Leicester NHS Trust will commit sufficient time and resources to the development and embedding of an appropriate anti-bribery programme to include:

- A commitment to carry out business fairly, honestly and openly
- A commitment to zero tolerance towards bribery
- The consequences of breaching the policies for employees and managers
- The avoidance of doing business with others who do not commit to doing business without bribery as a 'best practice' objective
- The protection and procedures for confidential reporting of bribery (Whistleblowing)
- To support key individuals and departments involved in the development and implementation of the Trust's bribery prevention procedures

Going Concern

International Accounting Standard 1 requires the Board to assess, as part of the accounts preparation process, the Group and Trust's ability to continue as a going concern. In preparing the financial statements the Board of Directors has carefully considered the principle of 'going concern' against the requirements of IAS1.

The Directors concluded that although there are material uncertainties relating to the financial sustainability of the Group and Trust, they have made appropriate enquiries and still have reasonable expectations that the Trust will have adequate resources to continue in operational existence for the foreseeable future. On this basis, the financial statements have been prepared on a going concern basis.

Corporate Governance Report

Directors Report

The Directors are aware of no relevant information of which the auditors are unaware. Each Director has taken all of the steps that they ought to have taken as a Director in order to make themselves aware of any relevant audit information and to establish that the auditors are aware of that information.

Statement of Accounting Officer's responsibilities

The Accounting Officer is responsible for the preparation of the financial statements and can confirm that the annual report and accounts as a whole is fair, balanced and understandable and that he or she takes personal responsibility for the annual report and accounts and the judgments required for determining that it is fair, balanced and understandable.

The Accounting Officer can confirm, as far as he is aware, there is no relevant audit information of which the entity's auditors are unaware, and the Accounting Officer has taken all the steps that he or she ought to have taken to make himself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

Annual Governance Statement 2017/18

TO BE ADDED FOLLOWING BOARD APPROVAL

Signed

Chief Executive (on behalf of the Trust Board)

Date:

Trust Board and Committee attendance 2017/18

Name	**Trust Board** maximum – 15	**Audit Committee** maximum – 6	**IFPIC** maximum – 5	**FIC** maximum - 7	**QAC** maximum – 5	**QOC** maximum - 7	**PPPC** maximum - 7	**Remuneration Committee** maximum – 8	**Charitable Funds Committee** maximum – 6
Karamjit Singh – Chairman	15/15	N/A	4/5	7/7	3/5	6/7	7/7	8/8	6/6
Vicky Bailey – Non-Executive Director **(1)**	4/4	N/A	N/A	N/A	N/A	1/2	2/2	1/2	N/A
Professor Philip Baker – Non-Executive Director	12/15	N/A	0/5	N/A	0/5	4/7	5/7	3/8	N/A
Dr Shirley Crawshaw – Non-Executive Director **(2)**	1/3	0/1	2/2	N/A	2/2	N/A	N/A	1/2	0/2
Ian Crowe – Non-Executive Director	13/15	5/6	5/5	N/A	4/5	7/7	6/7	6/8	3/6
Eileen Doyle – Interim Chief Operating Officer **(3)**	4/5	N/A	N/A	2/3	N/A	N/A	3/3	N/A	N/A
Andrew Johnson – Non-Executive Director	13/15	6/6	4/5	7/7	4/5	N/A	7/7	6/8	5/6
Tim Lynch – Interim Chief Operating Officer **(4)**	7/7	N/A	2/2	2/4	N/A	N/A	3/4	N/A	N/A
Richard Moore – Non-Executive Director	13/15	5/6	4/5	1/7	1/5	N/A	1/7	4/8	1/3
Ballu Patel – Non-Executive Director	15/15	3/3	5/3	N/A	5/5	7/7	7/7	8/8	6/6
Martin Traynor – Non-Executive Director	15/15	6/6	4/5	7/7	4/5	N/A	7/7	7/8	3/3
John Adler – Chief Executive	14/15	1/1	5/5	5/7	5/5	6/7	7/7	7/8	N/A
Mr Andrew Furlong – Medical Director	13/15	N/A	N/A	N/A	4/5	5/7	4/7	N/A	N/A

Name	**Trust Board** maximum – 15	**Audit Committee** maximum – 6	**IFPIC** maximum – 5	**FIC** maximum - 7	**QAC** maximum – 5	**QOC** maximum - 7	**PPPC** maximum - 7	**Remuneration Committee** maximum – 8	**Charitable Funds Committee** maximum – 6
Richard Mitchell – Chief Operating Officer **(5)**	2/3	N/A	2/3	N/A	N/A	N/A	N/A	N/A	N/A
Julie Smith – Chief Nurse	12/15	N/A	N/A	N/A	3/5	5/7	5/7	N/A	N/A
Louise Tibbert – Director of Workforce and OD (non-voting)	15/15	N/A	5/5	N/A	0/5	N/A	7/7	8/8	N/A
Paul Traynor – Chief Financial Officer	14/15	6/6	4/5	7/7	N/A	N/A	6/7	N/A	6/6
Stephen Ward – Director of Corporate and Legal Affairs (non-voting)	15/15	6/6	N/A	N/A	N/A	N/A	N/A	8/8	6/6
Mark Wightman – Director of Marketing and Communications (non-voting) **(6)**	14/15	N/A	N/A	5/6	N/A	N/A	N/A	N/A	4/6

Notes:-

(1) Non-Executive Director from 1 February 2018
(2) Non-Executive Director until 16 June 2017
(3) Interim Chief Operating Officer from 1 January 2018
(4) Interim Chief Operating Officer from 3 July 2017 – 31 December 2017
(5) Chief Operating Officer until 2 July 2017
(6) FIC attendee as of October 2017

Remuneration Report

Salary and Pension entitlements of senior managers – Salary 2017/18

	2017-18					
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						
EXECUTIVE DIRECTORS						
J Adler, Chief Executive	205-210	144*	0	0	12.5-15.0	230-235
R Mitchell, Chief Operating Officer (left 30th June)	35-40.	0	0	0	82.5-85.0	120-125
T Lynch, Interim Chief Operating Officer (from 3rd July 2017 left 31st Dec 2017)	100-105.	0	0	0	0	100-105
E Doyle, Interim Chief Operating Officer (from 29th Nov 2017)	45-50	0	0	0	20.0-22.5	65-70
P Traynor, Chief Finance Officer	185-190	0	0	0	0	185-190
J Smith,Chief Nurse	140-145	0	0	0	0	140-145
A Furlong, Medical Director	180-185	0	0	0	32.5-35.0	215-220
NON EXECUTIVE DIRECTORS						
K Singh, Chairman	35-40.	0	0	0	0	35-40
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.
R Moore, Non-Executive Director	5-10.	0	0	0	0	5-10.
A Johnson, Non-Executive Director	5-10.	0	0	0	0	5-10.
Professor P Baker, Non-Executive Director	5-10.	0	0	0	0	5-10.
B Patel, Non-Executive Director	5-10.	0	0	0	0	5-10.
Dr S Crawshaw, Non-Executive Director (left 16th June)	0-5	0	0	0	0	0-5
V Bailey, Non- Executive Director (from 1st Feb)	0-5	0	0	0	0	0-5
SENIOR MANAGERS						
S Ward, Director of Corporate & Legal Affairs	105-110	0	0	0	5.0-7.5	115-120
M Wightman, Director of Marketing and Communications	125-130	0	0	0	17.5-20.0	145-150
L Tibbert, Director of Workforce and Organisational Development	110-115	0	0	0	0	110-115

* The taxable benefits relate to train, car parking, council tax and rental.

The Executive Medical Director – Andrew Furlong receives remuneration in his other capacity as a Consultant Trauma and Children's Orthopaedic Surgeon banding (in £000) of 60-65 included in the figure above. The Trust has determined that the senior managers shown in the above table are the regular attendees at the Trust Board meetings.There are no benefits in kind, performance related pay, nor severance payments (2016/17 - £nil) paid to any board member.

Salary and Pension entitlements of senior managers – Salary 2016/17

	2016-17					
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						
EXECUTIVE DIRECTORS						
J Adler, Chief Executive	200-205	152	0	0	95.0-97.5	315-320
R Mitchell, Chief Operating Officer	145-150	0	0	0	32.5-35.0	180-185
P Traynor, Chief Finance Officer	185-190	0	0	0	0	185-190
J Smith,Chief Nurse	140-145	0	0	0	0	140-145
A Furlong, Medical Director	180-185	0	0	0	42.5-45.0	225-230
NON EXECUTIVE DIRECTORS						
K Singh, Chairman	40-45	0	0	0	0	40-45.
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 (until 31 July 2016)	0-5	0	0	0	0	0-5
R Moore, Non-Executive Director	5-10	0	0	0	0	5-10.
Professor A Goodall, Non-Executive Director (until 30 June 2016)	0-5	0	0	0	0	0-5
A Johnson, Non-Executive Director	5-10	0	0	0	0	5-10.
B Patel, Non-Executive Director (from 1 August 2016)	0-5	0	0	0	0	0-5
Professor P Baker, Non-Executive Director (from 1 July 2016)	5-10	0	0	0	0	5-10.
Dr S Crawshaw, Non-Executive Director (from 3 January 2017)	0-5	0	0	0	0	0-5
SENIOR MANAGERS						
S Ward, Director of Corporate & Legal Affairs	105-110	0	0	0	15.0-17.5	125-130
M Wightman, Director of Marketing and Communications	120-125	0	0	0	25.0-27.5	150-155
L Tibbert, Director of Workforce and Organisational Development	105-110	0	0	0	27.5-30.0	135-140

Salary and Pension entitlements of senior managers - Pension Benefits

Name and title	Real increase in pension at state pension age (bands of £2500) £000	Real increase in lump sum at pension age (bands of £2500) £000	Total accrued pension at pension age at 31 March 2018 (bands of £5000) £000	Lump sum at pension age related to accrued pension at 31 March 2018 (bands of £5000) £000	Cash Equivalent Transfer Value at 1 April 2017 £000	Real Increase in Cash Equivalent Transfer Value £000	Cash Equivalent Transfer Value at 31 March 2018 £000	Employers Contribution to Stakeholder Pension £000
BOARD MEMBERS								
J Adler, Chief Executive	0.0-2.5	5.0-7.5	80.0-85.0	250.0-255.0	1,688	89	1,795	0
R Mitchell, Chief Operating Officer	0.0-2.5	0.0-2.5	30.0-35.0	65.0-70.0	286	16	354	0
E Doyle, Interim Chief Operating Officer ( )	0.0-2.5	0.0-2.5	5.0-10.0	10.0-15.0	109	3	122	0
A Furlong Medical Director	2.5-5.0	0.0-2.5	45.0-50.0	120.0-125.0	810	33	851	0
SENIOR MANAGERS								
S Ward, Director of Corporate & Legal Affairs	0.0-2.5	2.5-5.0	45.0-50.0	140.0-145.0	947	71	1,027	0
M Wightman, Director of Communications	0.0-2.5	0	30.0-35.0	75.0-80.0	475	47	526	0

J Smith, L Tibbert, T Lynch and P Traynor are not members 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 (VSM) these members of staff are deemed to be on a VSM payscale which is non agenda for change. The remuneration of these individuals is set by our remuneration committee and each case is considered on an individual basis. On an annual basis the remuneration committee decides on any pay uplift or pay award for VSM for the forthcoming year.

Exit Packages

	2017-18							
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	3	9,122	0	0	3	9,122	0	0
£50,001-£100,000	2	141,654	0	0	2	141,654	0	0
	5	150,776	0	0	5	150,776	0	0

	2016-17							
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	8,050	0	0	1	8,050	0	0
	1	8,050	0	0	1	8,050	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 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 taken by staff leaving in the year.

Staff Report

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

	2017/ 2018	2016/ 2017	2015/ 2016	2014/ 2015	2013/ 2014	2012/ 2013	2011/ 2012	2010/ 2011	2009/ 2010
Medical and Dental	1,709	1,753	1,680	1,645	1,570	1,551	1,496	1,477	1,496
Administration and Estates	3,976	3,806	2,500	2,383	2,095	2,066	2,417	2,534	2,624
Healthcare Assistants and other support staff	2,291	2,224	2,042	2,044	1,955	1,811	1,710	1,781	1,882
Registered Nursing and Midwifery	3,567	3,548	3,547	3,531	3,345	3,230	3,195	3,168	3,091
Scientific, Therapeutic and Technical	1,455	1,378	1,306	1,272	1,201	1,202	1,210	1,210	1,328
TOTAL	**12,709**	**12,709**	**11,075**	**10,874**	**10,167**	**9,860**	**10,029**	**10,171**	**10,421**

Staff group by composition				
	31st March 2018		31st March 2017	
Gender	**Heads**	**Wte**	**Heads**	**Wte**
Female	11,892	9,807	11,533	9,566
Male	3,537	3,191	3,450	3,143
Grand Total	15,429	12,998	14983	12709

Staff Costs

The table below shows an analysis of staff costs. Employee charges are included in the social security costs and pension contributions.

	Group			
			2017/18	2016/17
	Permanent	Other	Total	Total
	£000	£000	£000	£000
Salaries and wages	493,618	-	**493,618**	454,606
Social security costs	45,870	-	**45,870**	42,392
Apprenticeship levy	461	-	**461**	
Employer's contributions to NHS pensions	54,568	-	**54,568**	51,024
Pension cost - other	36	-	**36**	33
Other post employment benefits	-	-	**-**	-
Other employment benefits	-	-	**-**	-
Termination benefits	151	-	**151**	8
Temporary staff		21,076	**21,076**	30,053
NHS charitable funds staff	-	-	**-**	-
Total gross staff costs	**594,704**	**21,076**	**615,780**	**578,116**
Recoveries in respect of seconded staff	-	-	**-**	-
Total staff costs	**594,704**	**21,076**	**615,780**	**578,116**
Of which				
Costs capitalised as part of assets	1,296	579	**1,875**	2,299

Reducing staff absence

Absence rates have continued to be proactively managed throughout 2017/18. These are reported retrospectively and an overall Trust sickness absence rate of 3.66 per cent was reported for February 2018 against a 3 per cent Trust target. The CQC Insight Report indicates that Trust sickness rates for all staff groups, with the exception of medical and dental, are better than the national average.

In September 2018, we committed to, and signed, the 'Time to Change' pledge which is a national initiative run by the charities Mind and Rethink Mental Illness. Its aim is to change how we think and act about mental health. Currently, approx. 20 per cent of sickness days lost are due to anxiety and depression.

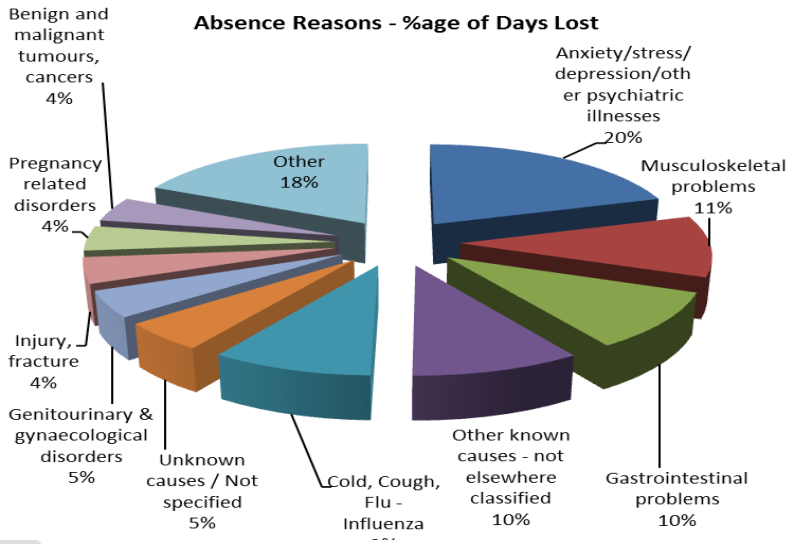
Our pledge is *'We pledge to create a culture where our staff feel they can openly discuss and manage their mental health and wellbeing. We will raise awareness of the importance of mental health and wellbeing at work, encourage staff to share their experience to break down stigma".* During October and November 2017 we recruited 39 Time to Change champions across all the three sites and with the champions have agreed a programme of work, including organising local Time to Talk events, sharing experiences/ case studies and promoting best practice.

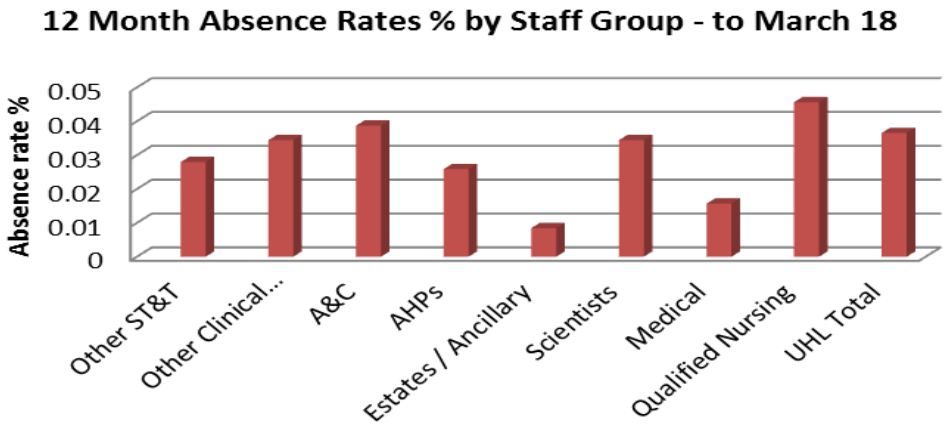
Our sickness absence target is 3 per cent, and our average sickness rate for the year was 3.68 per cent (4.08 per cent excluding Estates and Facilities (Estates and ancillary was under-reported until systems fully implemented post transfer).

The highest sickness rates are in 'Other clinical support and qualified nursing' staff groups. A&C are also above our target of 3 per cent.

Most sickness days lost are due to anxiety/ stress and depression (20 per cent).

The CQC's insight report indicates lower than comparative Trusts for back problems (0.16 per cent: 0.24 per cent) and stress (0.63 per cent: 0.78 per cent).





We have planned the following actions to reduce sickness absence:

- absences recorded using the in-house '***SMART Absence***' tool which facilitates reporting of absences and ensures structured Return to Work discussions are held, prompts Occupational Health referrals , Stress Risk Assessments and further support;
- we have signed the Time to Change pledge and have Time to Change champions in place and are sharing good practice and materials from Time to Change website. We also share stories;
- Health and well-being strategy being implemented with a focus on a different area each month.

Off payroll engagements

We have 51 relevant off-payroll engagements as of 31 March 2018, 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.

For all off-payroll engagements as of 31 March 2018, for more than £220 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2018	187
Of which, the number that have existed:	
for less than one year at the time of reporting	69
for between one and two years at the time of reporting	29
for between 2 and 3 years at the time of reporting	38
for between 3 and 4 years at the time of reporting	32
over 4 years at the time of reporting	19

For all new off-payroll engagements between 1 April 2017 and 31 March 2018, 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 2017 and 31 March 2018; of which the number for whom:	80
assurance has been requested	80
assurance has been received	80

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2017 and 31 March 2018.

	Number
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year.	0
Total no. of individuals on payroll and off-payroll that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure should include both on payroll and off-payroll engagements.	10

Policy in relation to disabled employees

It is our intention to value all staff, treating them fairly and equitably, providing real opportunities for people with a disability to join our organisation, be retained and to have equal access to training and development opportunities. It is also our intention to support employees with disabilities and to ensure their retention in work, thereby enabling us to retain their skills and experience.

We are committed to the 'Positive about Disabled People' initiative, this will include using the Disability 'two ticks' symbol on all job advertisements. We guarantee an interview to anyone declaring a disability providing that they satisfy the minimum essential criteria for the post.

All staff have responsibilities to undertake all mandatory training and comply with this policy by:

- Being aware of this policy and treating all individuals' that have a disability with respect.
- Attending training and awareness sessions offered and familiarising themselves with the contents of our Equality and Diversity web page.

Expenditure on consultancy

We incurred £0.8m on consultancy services.

Pay multiples

The banded remuneration of our highest paid director in the financial year 2017/18 was £205k-£210k (2016/17 £205k-£210k). This was 8.69 times (8.44 times in 2016/17) the median remuneration of the workforce, which was in the banding £20k-£25k (2016/17 £20k-£25k). The salary of the highest paid director has not changed and the median remuneration of the workforce has reduced by £1k.

In 2017/18, three employees received remuneration in excess of the highest-paid director (two employees in 2016/17). Remuneration across the Trust ranged from £7k-£244k (2016/17 £7k-£252k).

Audit Report

TO BE ADDED

The Performance Report

Overview

This section of the report provides an overview of our performance against key national standards, as well as our annual priorities and Quality Commitment for 2017/18.

We – along with the rest of the NHS – have had a very challenging winter labelled by many as the most difficult in NHS history. This means we have continued to struggle with operational pressures that have seen our hospitals in "escalation" for several months. In January all NHS Trusts were instructed to cancel elective operations in a bid to free up capacity to treat the increased number of emergency patients needing care. This instruction was for the whole of January but in reality lasted through February. Even more regrettable was the cancellation of some cancer surgery during that time. We do not take the decision of cancelling patients, particularly cancer patients, lightly. We know how distressing this is for everyone involved, but we cannot in good faith bring patients in for surgery if we do not have a bed somewhere to safely look after them following their surgery. We are working on increasing our intensive and high dependency care capacity to reduce the chances of cancellations in the future. Our work in 2018/19 will stand us in a stronger position for managing those challenges as we enter the coming winter.

Each year for the last few years we have created a set of annual priorities, which includes our Quality Commitment. This allows our organisation to focus on what is needed to delivering our ambition of Caring at its Best and to create services that are safe and high quality for our patients. In this section you will see how we have performed against those, as well as the national performance standards.

John Adler

Chief Executive

Performance Against National Standards

Performance Indicator	Target	2017/18	2016/17	2015/16
A&E - Total Time in A&E (4hr wait)	95%	77.6%	79.6%	86.9%
MRSA (All)	0	4	3	0
MRSA (Avoidable)	0	4	0	0
Clostridium Difficile	61	68	60	60
RTT - incomplete 92% in 18 weeks	92%	85.2%	91.8%	92.6%
Diagnostic Test Waiting Times	1.0%	1.9%	0.9%	1.1%
Cancer: 2 week wait from referral to date first seen - all cancers	93%	94.6%	93.2%	90.5%
Cancer: 2 week wait from referral to date first seen, for symptomatic breast patients	93%	91.9%	93.9%	95.1%
All Cancers: 31-day wait from diagnosis to first treatment	96%	95.2%	93.9%	94.8%
All cancers: 31-day for second or subsequent treatment - anti cancer drug treatments	98%	99.1%	99.7%	99.7%
All Cancers: 31-day wait for second or subsequent treatment - surgery	94%	85.8%	86.4%	85.3%
All Cancers: 31-day wait for second or subsequent treatment - radiotherapy treatments	94%	95.9%	93.5%	94.9%
All Cancers: 62-day wait for first treatment from urgent GP referral	85%	78.4%	78.1%	77.5%
All Cancers: 62-day wait for first treatment from consultant screening service referral	90%	85.8%	88.6%	89.1%

Key Performance Measures

For the Trust Board to assure itself that key performance measures are being met they review monthly at Trust Board meetings a performance report and the Board Assurance Framework (BAF) – both are accessible on our website in our monthly Trust Board papers.

CQUINS, national performance standards, annual priorities incorporating our Quality Commitment are also key performance measures monitored by the Trust Board, and detail on achievements in year can be found throughout this report: national performance standards page 25; CQUINS page 26; annual priorities pages 30-71 and our Quality Commitment pages 33-40. The Annual Governance Statement on page 22 identifies risks and uncertainty and how these are mitigated.

Commissioning for Quality and Innovation payment framework (CQUINS)

A proportion of our income in 2017/18 was conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework (CQUINS).

The current CQUIN schemes will last for two years (2017-19), which will provide greater stability with the aim to improve quality of outcomes for patients.

There are six mandated national CQUINS which each have a minimum weighting of £1,153,949 and ten NHS England Specialised CQUINS with a total value of£ 5,315,312. This means that when we agreed contracts with commissioners and NHS England it was agreed that a percentage of the contract value would be received upon achieving certain quality indicators.

Further details of the agreed goals for 2017/18 and for the following 12 month period are available electronically at: www.england.nhs.uk/nhs-standard-contract/cquin/cquin-17-19/

We did not fully meet the targets set for two of the national CQUINS: Improving staff health & wellbeing and reducing the impact of serious infection. Similarly three of the NHS England Specialised CQUINS were only partially met; Hepatitis C Network, Enhanced Supportive Care and Hospital Medicines Optimisation.

As a consequence of the two year national planning guidance all but one of the national CQUINS are now within year two for 2018/19. NHS England has agreed a temporary relaxation of the 'Supporting Proactive and Safe Discharge' CQUIN on the basis that there are multiple initiatives supporting the discharge agenda. The CQUIN schemes have a total value of £12,004,826. The year-end forecast variance is £1,836,519.38.

Particular challenges where we were not successful included:

- Achieving a 5 per cent point improvement in the NHS annual staff survey in relating to the organisation taking a positive action on health, staff experiencing musculo-skeletal problems and staff feeling unwell as a result of work related stress;
- The overall usage of antibiotics has increased by 7 per cent. Increases are attributable to a change in case mix over winter when elective surgeries were cancelled; emergency admissions contribute significantly more to consumption of antibiotics than elective patients. In addition to this there were very high numbers of admissions of patients with severe respiratory tract infections in quarter 4; a typical pneumonia patient contributes a minimum of 10 DDDs per admission in comparison to 1 DDD contributed by an elective surgery patient. Additionally the overall usage of Meropenam (in the treatment of sepsis) is continuing to increase;
- Work relating to the Enhanced Supportive Care CQUIN started in 2016/17, however, in order to meet the 2017/18 scheme requirements there was a need to increase capacity within the Palliative Care team in order for them to provide services to patients earlier within the pathway. There has been insufficient resource to expand the service and therefore this CQUIN did not continue beyond Q2.

Sustainability Report

Our Estates and Facilities Teams 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 revised 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, safe and welcoming environment from where clinical care of the highest standard can be delivered".

We have Chair representation of the Energy and Sustainability Groups which has been established by the Estates and Facilities Technical Compliance Team and this forum will provide technical and statutory compliance guidance in support of our sustainability strategy.

The Technical Compliance Team have advised and promoted elements of sustainability, to ensure that all new projects, new works and refurbishments incorporate the most effective "Low Carbon Technology" available within limited resources.

We completed the various statutory annual reports as listed below at the required time and are on target for the 2017 deadline for submitting the next set of returns:

a) Estates Return Information Collection (ERIC)
b) Property Assurance Model Report (PAM)
c) European Union Emissions Trading Scheme (EUETS)
d) Carbon Reduction Commitment (CRC)
e) Combined Heat & Power Quality Assurance (CHPQA)

Energy and Sustainability Projects

During 2016/17 Estates and Facilities have successfully built/ refurbished and commissioned the following:

1. New Emergency Department Floor - (Royal Infirmary)
2. Refurbishment of Theatre Recovery with additional bed bays to enhance activity performance (Royal Infirmary) and (Glenfield Hospital)
3. New Hybrid Theatre (Glenfield Hospital) and general refurbishment/ upgrade to the Theatres (Royal Infirmary)
4. Remodel of Ward 23 to a new stage of the art Vascular Investigation and treatment Unit (Glenfield Hospital)
5. Remodel of an area to provide another state of the art Angiology Unit (Glenfield Hospital)
6. Various LED Lighting schemes (General Hospital)

All of the above have included the use of "Low Carbon Technology" and the incorporation energy efficient management strategies, inclusive of LED, variable speed drives, high efficiency pumps and motors, building management systems, insulation, boilers and general application of good working practices and good housekeeping.

Heating and Power

New CHP units have improved their availability as they have been fine tuned to the sites demand.

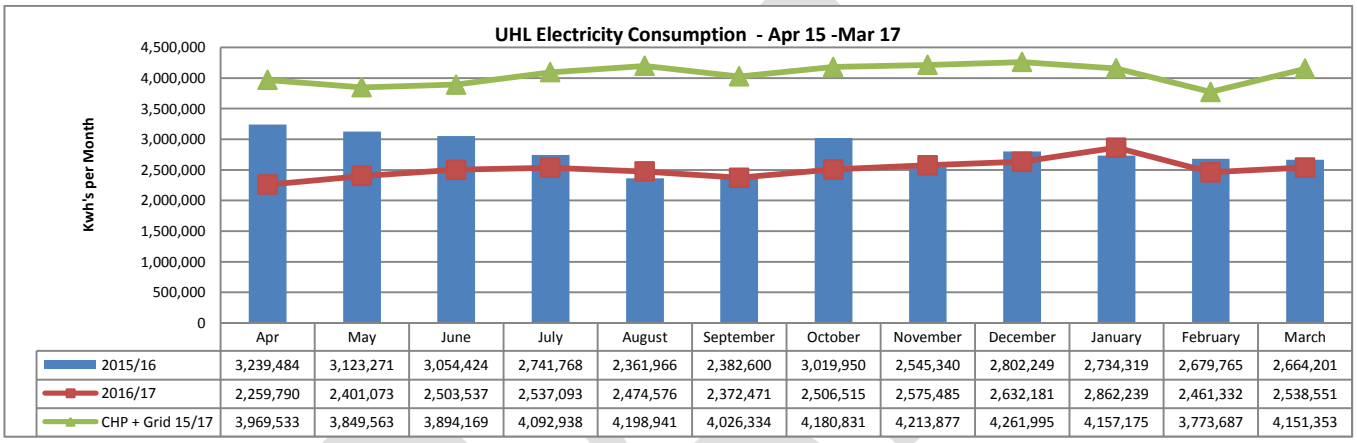
Feb 16 - Jan 17 12 months	**Royal Infirmary**	**Glenfield Hospital**	**Total**
CHP gas used	28,277,817	14,805,964	43,083,781
CHP Elec Generated	12,592,641	5,670,067	18,262,708
CHP Heat Generated	7,658,900	5,846,100	13,505,000
Est. CO2 Saving	**2,721**	**1,394**	**4,116**
hours run	7,855	7,426	15,281
Est. Cost Saving	**£472,193**	**£228,433**	**£700,626**

Description	**Gas**	**Grid Electricity**	**Totals**	**Cost**	**CO2 Emissions**	**CO2 Emissions**
Year	**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

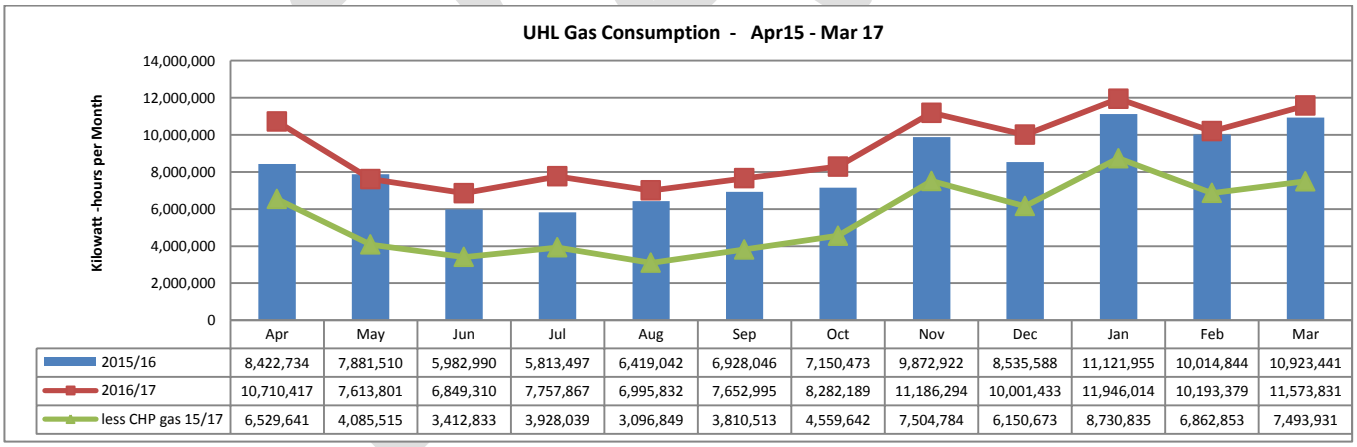
2014/15	92,086,201	38,205,678	130,291,879	£7,072,683	36,950	£281,979
2015/16	101,496,587	32,832,008	134,328,594	£6,390,731	36,138	£291,598
2016/17	109,998,486	30,472,348	140,470,834	£5,624,988	36,441	£300,575
2017/18 6%	103,398,577	28,644,007	132,042,584	TBA	34,254	TBA
2018/19 6%	97,194,662	26,925,367	124,120,029	TBA	32,199	TBA
2019/20 6%	91,362,983	25,309,845	116,672,827	TBA	30,267	TBA
Annual Change	-8,501,900	2,359,660	-6,142,240	£765,743	-303	-£8,977
% age change	-8.38%	7.19%	-4.57%	11.98%	-0.84%	-3.08%
2012/13 Change	-23,396,724	15,917,674	-7,479,050	£1,598,650	4,893	N/A
% age change	-20%	54%	-5%	30%	13%	N/A

Note: TBA is for future costs which have a large reliance on many variables, but predominantly

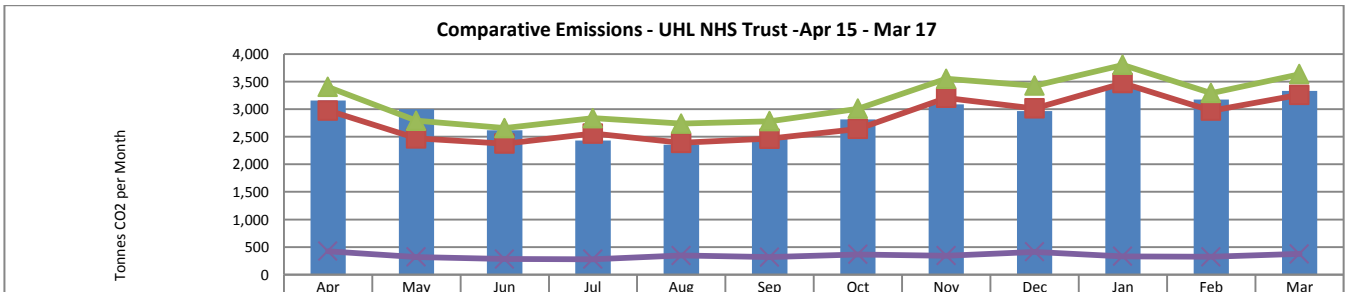
1. Consumption of power and or gas depend on activity, weather and the CHP units – just for volume
2. Cost of the utilities as commodity and non-commodity which is made up of several components plus the activity on the site and the CHP units availability.



	Apr	May	June	July	August	September	October	November	December	January	February	March
2015/16	3,239,484	3,123,271	3,054,424	2,741,768	2,361,966	2,382,600	3,019,950	2,545,340	2,802,249	2,734,319	2,679,765	2,664,201
2016/17	2,259,790	2,401,073	2,503,537	2,537,093	2,474,576	2,372,471	2,506,515	2,575,485	2,632,181	2,862,239	2,461,332	2,538,551
CHP + Grid 15/17	3,969,533	3,849,563	3,894,169	4,092,938	4,198,941	4,026,334	4,180,831	4,213,877	4,261,995	4,157,175	3,773,687	4,151,353



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	8,422,734	7,881,510	5,982,990	5,813,497	6,419,042	6,928,046	7,150,473	9,872,922	8,535,588	11,121,955	10,014,844	10,923,441
2016/17	10,710,417	7,613,801	6,849,310	7,757,867	6,995,832	7,652,995	8,282,189	11,186,294	10,001,433	11,946,014	10,193,379	11,573,831
less CHP gas 15/17	6,529,641	4,085,515	3,412,833	3,928,039	3,096,849	3,810,513	4,559,642	7,504,784	6,150,673	8,730,835	6,862,853	7,493,931



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	3,160	2,999	2,618	2,432	2,355	2,459	2,817	3,085	2,963	3,406	3,174	3,332
2016/17	2,976	2,471	2,376	2,558	2,390	2,465	2,640	3,205	3,012	3,472	2,971	3,259
CHP saving removed 15/17	3,401	2,791	2,657	2,836	2,736	2,781	3,007	3,549	3,426	3,803	3,293	3,635
CHP EST CO2 Saving	425	320	281	278	346	316	367	344	414	331	321	376

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;
- We promote all alternative travel modes to staff, including Park and Ride services;
- We opened a new patient and visitor multi-storey car park on 1st February 2016, this includes over 430 additional spaces which incorporate 21 new disabled bays;
- The main surface level car park at the Royal Infirmary has a dedicated drop off and pick up area;
- We offer a variety of saver tickets for patients and prime carers;
- We are working with the police to promote security of cycles;
- We are working with the City Council and Sustrans to promote cycling across all three sites, this includes a partnership with local schools to decorate the bike shed at the Glenfield and cycle surgeries across all three sites;
- 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 continue to look at the issuing of parking permits;
- Our Hospital Hopper service was re-launched in January 2017, and Centrebus have been awarded the contract for at least another three years.

Achievements against our Annual Priorities, including our Quality Commitment

Our priorities for 2017/18

For 2017/18 we reduced the number of things that we focused on to make it more manageable and achievable. This is what we were focusing on during 2017/18:

Safe, High Quality, Patient-Centred, Efficient Care

- To reduce avoidable deaths
- To reduce harm caused by unwarranted clinical variation
- to use patient feedback to drive improvements to services and care

Organisation of care:

- align our bed capacity with expected demand(including by reducing delays through Red2Green, working more effectively to care for step down patients and increasing the medical bed base)
- Optimise processes in our new Emergency Department
- Work to separate emergency and elective work
- Transform the hospital pathway for frail complex patients
- Improve the efficiency of our operating theatres

Our People

We will have the right people with the right skills in the right numbers in order to deliver the most effective care

In 2017/18:

- We will develop a sustainable workforce plan, reflective of our local community which is consistent with the STP in order to support new, integrated models of care
- We will reduce our agency spend towards the required cap in order to achieve the best use of our pay budget
- We will transform and deliver high quality and affordable HR, OH and OD services in order to make them 'Fit for the Future'.

Education & Research

We will deliver high quality, relevant, education and research

In 2017/18:

- We will improve the experience of medical students at UHL through a targeted action plan in order to increase the numbers wanting stay with the Trust following their training and education
- We will address specialty-specific shortcomings in postgraduate medical education and trainee experience in order to make our services a more attractive proposition for postgraduates
- We will develop a new 5 Year Research Strategy with the University of Leicester in order to maximise the effectiveness of our research partnership.

Partnerships & Integration

We will develop more integrated care in partnership with others

In 2017/18:

- We will integrate the new model of care for frail older people with partners in other parts of health and social care in order to create an end to end pathway for frailty
- We will increase the support, education and specialist advice we offer to partners to help manage more patients in the community (integrated teams) in order to prevent unwarranted demand on our hospitals
- We will form new relationships with primary care in order to enhance our joint working and improve its sustainability.

Key Strategic Enablers

We will progress our key strategic enablers:

In 2017/18:

- We will progress our hospital reconfiguration and investment plans in order to deliver our overall strategy to concentrate emergency and specialist care and protect elective work
- We will make progress towards a fully digital hospital (EPR) with user-friendly systems in order to support safe, efficient and high quality patient care
- We will deliver the year 2 implementation plan for the 'UHL Way' and engage in the development of the 'LLR Way' in order to support our staff on the journey to transform services
- We will review our Corporate Services in order to ensure we have an effective and efficient support function focused on the key priorities
- We will implement our Commercial Strategy, one agreed by the Board, in order to exploit commercial opportunities available to the Trust
- We will deliver financial stability as a consequence of the priorities described here in order to make the Trust clinically and financially sustainable in the long term.

Safe, High Quality, Patient-Centred, Efficient Care

Quality: our 2017/18 Quality Commitment

For 2017/18 we set the following three priorities as a part of our Quality Commitment and to deliver our annual priority Safe, High Quality, Patient-Centred, Efficient Care:

- To reduce avoidable deaths
- To reduce harm caused by unwarranted clinical variation
- To use patient feedback to drive improvement to services

The following shows our achievements against each:

We said we would: Reduce avoidable deaths

In 2017/18 we:

- Rolled out the Medical Examiner Process across the Trust for the deaths of all patients aged 16 or above – the aim of the Medical Examiner process is to improve the quality of death certification and identify those patients that need a further review by the relevant clinical team or as part of the specialty mortality and morbidity review process
- Implemented a Structured Judgement Review (SJR) process – the aim of this process is to identify any problems in care that might have affected the patient's outcome or experience in order to ensure learning and actions are taken to improve the care of all patients

Further improvements we need to make are:

- To recruit additional Medical Examiners and Medical Examiner / Corporate mortality and morbidity administrative and analytical support

Results:

- 92 per cent of adult deaths since April 17 were screened through the Medical Examiner process
- 85 per cent of Quarter 1's adult deaths referred for a SJR were completed
- For the period October 2016 to September 2017, Leicester's Hospitals SHMI was 98. This is below the national average of 100

We said we would: Reduce harm caused by unwarranted clinical variation

In 2017/18 we:

- Through NerveCentre (our clinical information system) we have:
  - Implemented Clinical Rules, alerts and assessments for sepsis
  - Implemented electronic observations across the Trust
  - Automated our Early Warning Score (EWS) and sepsis reporting
  - Made it easier for our clinical teams to identify patients with diabetes
- Moved anticoagulation services into the community under primary care with the anticoagulation nurses now taking on in-reach roles within Leicester's Hospitals to tackle difficult and complex cases on our wards
- Implemented an anticoagulation discharge summary
- Piloted IT solutions to support acting on results, targeting one of our busiest clinical areas, the Clinical Decisions Unit at Glenfield Hospital

Further improvements we need to make are:

- Increase the number of mobile devices available to clinical staff
- Further embed the use of Nervecentre for all medical handovers, ward rounds and board rounds
- Develop an e-learning tool for anticoagulation
- Embed processes in the emergency department to reduce the time to antidote administration in patient who present with anticoagulant related bleeding
- Focus on improving the skills and knowledge of our clinical staff in the recognition and management of hyperglycaemia
- Roll out acting on results IT solutions across the Trust

Results:

- An additional measure of harm was included in the incidents resulting in severe or moderate harm in 2017/18
- YTD (to January 2018) there have been 181 incidents resulting in severe or moderate harm against a YTD target of 110
- YTD, incidents resulting in severe or moderate harm have not reduced by the target 9 per cent - this is set against an overachievement of 41 per cent last year

Patient Safety Improvement Plan – 'Sign up to Safety' campaign

In September 2014 we signed up to the national 'Sign Up to Safety' campaign. The campaign aims to halve avoidable harm and save an additional 6,000 lives over three years.

As part of the 'Sign Up to Safety' campaign, we have pledged to:

- Put patient safety first
- Focus on continuous learning
- Be honest and transparent
- Collaborate with others to share learning and good practice
- Be supportive and help people understand why things go wrong

In 2015 we were allocated £1,581,587 (one of the largest successful bids in England) from the National Health Service Litigation Authority (NHSLA) to support the delivery of our safety improvement plan.

Our 'Sign up to Safety' safety improvement priorities are aimed at improving the recognition, escalation, response and effective on going management of the deteriorating patient.

In 2017/18, as the continuation of the 'Sign up to Safety' campaign we have:

- Recruited a dedicated Sepsis team with the Emergency Department, dedicated to the recognition and management of Sepsis;
- Created the "The Little Voice Inside" obstetric training package (TED) to share best practice and improve patient safety. This has been shared nationally;
- Continued to further develop the Patient Safety Portal functionality and user experience, through valuable feedback received from our stakeholders;
- Implemented the five e-learning modules hosted on HELM (our e-learning suite), which provide a more in-depth understanding of Human Factors and Ergonomics;
- Continued development and roll-out of electronic observations across all specialities within the Trust.

Going forward our Sign up to Safety patient safety improvement plan will be fully integrated into our dedicated Patient Safety improvement work within our Quality Commitment.

We said we would: Use patient feedback to drive improvements to services and care

In 2017/18 we:

- Rolled out training and support in the use of individualised end of life care plans
- Held listening events and developed a future vision for our outpatient services
- Identified cross cutting themes for improving our outpatient services including: correspondence, the outpatient environmental, customer care, training, IT systems and hardware

Further improvements we need to make are:

- Continue to embed and audit the use of individualised end of life care plans
- Focus our efforts on making a demonstrable difference to outpatient service in Ear, Nose and Throat (ENT) and Cardiology as well as the cross cutting service improvements

Results:

- At the end of quarter three, 88 per cent of appropriate patients had an individualised end of life care plan
- Metrics for measuring improvements in our outpatient service have been scoped and take effect from April 2018

Improving the experience of our patients

We actively seek feedback from patients, family members and carers, both negative and positive. The vast majority of the feedback we receive is extremely positive, but to ensure that where we can make improvements based on feedback, services collect data from all of the sources and put displays - "You Said We Did" boards - in ward areas so that it is clear what actions have been taken in response to the feedback they have received.

Feedback is collected in numerous ways including:

- Patient experience feedback forms
- Family, carers and friends feedback forms
- Message to Matron
- NHS Choices/ Patient Opinion
- Patient stories
- Volunteer feedback
- Compliments and complaints provided to the Patient Information and Liaison Service (PILS)
- Our website
- Community conversations held by the Engagement Team.

The Friends and Family Test

The Friends and Family Test is a nationally set question asked by all NHS hospitals. It is offered to patients, carers and family when they are discharged and gathers feedback by asking the following question: *"How likely are you to recommend our ward to friends and family, if they needed similar care or treatment?"*

There are six options ranging from extremely likely to extremely unlikely, including 'do not know'. Following this question there is an opportunity for the respondent to comment on why they have given their answer. Responses of extremely likely and likely are recorded as recommended and extremely unlikely and unlikely responses are recorded as non-recommended. The charts below illustrate the response we have received over the last two years. As you can see there have been more months in the last year where the score has been above our target of 97 per cent people recommending care or treatment, with less than 1 per cent of

people saying they would not recommend care or treatment within our hospitals, which is an improving picture.

Friends and Family Test score - in-patient (incl. day cases) Trust level data												
	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
% Recommend	**97.1**	**97.0**	**97.3**	**96.8**	**96.0**	**96.7**	**96.5**	**96.6**	**96.7**	**96.5**	**96.5**	**96.5**
% Non-recommend	0.8	0.8	0.8	0.9	1.5	1.2	0.9	1.0	1.0	1.0	0.8	1.0

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
% Recommend	**97.3**	**97.2**	**97.2**	**96.8**	**97.0**	**97.3**	**96.7**	**96.9**	**97.2**	**97.2**	**97.4**	
% Non-recommend	0.5	0.7	0.8	0.8	0.8	0.7	0.9	1.0	0.7	0.8	0.7	

The Friends and Family Test feedback can be given via paper forms which are available in our ward areas, and there are also kiosks in the three hospital reception areas, as well as some electronic devices in several clinical areas and outpatients. Feedback can also be given by accessing our website. In some of our outpatient clinics we offer patients the opportunity to give feedback via text. The patient will receive a telephone text survey to encourage them to give their feedback in their own time.

To ensure that non-English speaking patients are given the opportunity to give their feedback, the Friends and Family Test question is available in the top three locally spoken languages in the area, which are Gujarati, Punjabi and Polish. We also make these translated surveys available in paper on the wards and in an electronic format in outpatients, some clinical areas and via the kiosks in the three hospital main entrances.

For patients who have learning disabilities, language or literacy issues, dementia or visual impairment there is an easy read version of the feedback form available, which uses pictures of faces, ranging from very happy to very sad, to ascertain their response to their experience of care. For the children we treat we offer them the option to use the rocket feedback, which shows pictures of faces and the paper version allows the child to draw a picture.

From April 2017 a new feedback form was launched. This form replaced the carers' survey that was carried out at various times throughout the year. It is recognised that many family members and friends have a caring responsibility in the community, but do not recognise themselves, or do not wish to be labelled as a carer.

Meaningful activity co-ordinators and dementia care

Improving care and experience for people living with dementia in Leicester's Hospitals is part of our Dementia Strategy. This year we have been working to support families, carers and people living with dementia through two new initiatives 'Stay With Me' and the Forget ME Not scheme.

'Stay With Me' is one of the key principles of John's Campaign, founded nationally in 2014 and supports families to remain with patients with a known diagnosis of dementia during their time in hospital. 'Stay with Me' builds on our Carers Charter which aims to create a 'welcoming environment' on all hospital wards, where there are no barriers for a family member who wishes to stay beyond visiting times for patients with dementia. Evidence suggests patients with dementia, who are often frail, vulnerable adults, have much more positive outcomes when they are with the people who are familiar.

The Forget ME Not scheme supports national recommendations for hospitals to have a system in place to support all staff to be able to recognise patients with dementia, ensuring the delivery of person centred care. Patients with a known diagnosis of dementia are placed on the scheme during their admission to hospital. A blue forget me not flower poster is placed in the bed space and a small forget me not flower sticker is attached to the patient's medical notes. Both identify the patient to all staff, supporting good communication, allowing more time for each interaction, encouraging additional drinks and snacks to be offered and reminds staff to find out about the patient by reading the Know Me Better Patient Summary.

We continue to increase the number of staff that are dementia champions and over 100 have volunteered to take on this role during the year.

The Meaningful Activity Service support patients with dementia on our older peoples wards at the Royal Infirmary and on some wards at the Glenfield Hospital. The Meaningful Activity Facilitators provide therapeutic activities to help patients with dementia in hospital. Examples of activities include arts and crafts, games, puzzles, reminiscence, and music and the team host special events on the wards to celebrate cultural and religious festivals. Families, friends and carers of patients are encouraged to be involved in all activities with their loved one.

The Meaningful Activity Service is supported by trained Forget Me Not Volunteers, who are passionate about dementia care. In 2017, events have been held inside and outside of our hospitals to promote dementia awareness Meaningful Activities, fundraising to support future activities.

Older people's feedback highlighted how important the small fundamental things are to improve their experience in hospital. Six of our wards have been working on 'Fixing the Fundamentals' to improve older people's experience of care in our hospitals. Patients were encouraged to sit out of bed and wear their own clothes; ward teams promoted and enhanced mealtimes to improve nutrition, making meal times a more sociable experience. Small freezers were introduced to provide ice cream, which was especially welcome on a hot day. Opus, a music therapy group, visited the wards each month to stimulate and entertain patients helping to make the day pass a little quicker. Improving personal care needs for patients included a visit from a barber and additional time set aside to assist patients with all aspects of personal care as this is fundamental to all our patients.

Specialist Palliative Care and Care at the End of Life

Palliative care is the holistic care provided to patients with an illness which cannot be cured. Palliative care is provided alongside other treatments and might be needed early on in a disease when patients may be receiving life prolonging treatment or towards the end of life and into bereavement. It involves managing physical symptoms such as pain, but also the psychological, spiritual and social needs of patients and families.

The Specialist Palliative Care Team provide direct support to our patients, both inpatients and outpatients, as well as providing education and support to staff, which is essential to those who will need to provide both palliative and end of life care.

Patients are described by the General Medical Council as approaching the end of life when they are likely to die within the next twelve months. This group therefore includes:

1. Patients who are imminently dying (in the next few days or hours);
2. Patients with advanced, progressive, incurable conditions (such as cancer which has spread to different organs in the body);
3. Patients with frailty and multiple illnesses which mean that they are expected to die within twelve months;
4. Patients with a condition which puts them at risk of a sudden acute crisis (e.g. a large inoperable abdominal aortic aneurysm); or

5. Life threatening acute conditions caused by a catastrophic event (e.g. an intracranial bleed in a patient who is not well enough for treatment or a patient with major trauma).

We play an important role in supporting and managing patients at the end of life because patients will often have repeated contact with hospital services in their final months of life and for many people (over two fifths) hospital may be where they die.

For some, this is not where they want to be looked after in their last days or hours, but for others this may be a place where they and their families can receive good care and where they can feel safe and looked after.

Whatever the situation, we need to make sure that the care provided is right for that person and as good as it can be as the experience of care makes such a big difference both to the dying and to the bereaved.

The End of Life and Palliative Care Committee has continued to drive forward improvements across the Trust in the last twelve months and work with our partner organisations to ensure that we move forward together with the interests of our local community at the core of what we do.

End of Life Care Hospital Improvement Programme

Over the past year we have been participating in an important programme of work called End of Life Care Hospital Improvement Programme. This is commissioned by Hospice UK and NHS Improvement and supports the work we are doing to improve the experience of care provided to patients who may be in the last few months of life.

Findings have demonstrated that there are significant opportunities to improve the overall experience of care for patients and families. These include:

- Improving the identification of patients who may be in the last months of life, having courageous conversations and involving them in planning their care;
- Improving the recognition of uncertain recovery at admission;
- Better planning for deterioration;
- Improved communication with patients to identify what is important to them;
- Earlier identification of dying patients and use of the Individualised Plan of Care to support their last days and hours.

The process involved a "Fresh Eyes Walkthrough" and feedback from the End of Life Care Hospital Improvement Programme team about the environment at the Royal Infirmary, including general areas, the Emergency Department, Bereavement Office and Mortuary. They had some very positive things to say, as well as some important observations about how we might make small improvements with big impacts for patients which we are currently reviewing.

We have started some quality improvement work alongside the Emergency Department, which has informed the plan of work for the End of Life and Palliative Care Committee for 2018 and beyond.

Care of the Dying Patient and their family

The End of Life Care facilitators (part of the Specialist Palliative Care Team) have continued to roll out education and provide support to colleagues across the organisation.

Although there is more staff still need to learn, there have been many examples of excellent care and our audit of the Five Priorities for Care of the dying person has shown continued improvement across the priorities.

We have signed up the National Audit for Care at the End of Life for 2018 which will allow us to benchmark our care against other trusts. Part of this audit will involve reviewing notes of patients who have died in our care to understand how the care has been provided and where we need to target further education and support.

In addition to this work, feedback from carers about the experience of care will help us to understand what actions we need to prioritise. We expect to have the results of this work in early 2019.

The Individualised Plan of Care for the Dying Patient has been reviewed in line with guidance recently issued by NICE and we have updated our patient information leaflets to ensure that families feel supported and know what to expect and how they might be involved in care if they wish.

Medications to manage symptoms in the last days of life

The Specialist Palliative Care Team have reviewed the guidelines for managing common symptoms in the last days of life and have worked hard with other team members to ensure that staff are trained in using McKinley T34 pumps across the organisation, significantly improving the numbers of staff trained and recorded as safe users.

Fifteen new pumps have been purchased and systems put in place which ensure that staff can access these pumps when they are needed, whether day and night. This is a really important piece of work which will ensure that patients have their symptoms controlled effectively.

Learning Disabilities

The Specialist Palliative Care Team has a core member in the Palliative Care with Learning Disabilities group which meets regularly to discuss how patients with a learning disability can be supported at end of life.

This work brings us together with teams in the community to ensure we all share knowledge and experience during peer support time. The group is currently working on advance care planning workshops that will allow any local people with a learning disability who are thought to be in the last year of life to access the hospice and through support develop a personalised care plan. This also enables their family and carers to see what support is available.

VALE

VALE is a project co- ordinated by members of the Specialist Palliative Care Team, which engages volunteers within the hospital to spend quality time with patients who are dying. They provide support to ward staff by assisting with meals, offering company to patients, and in some cases a hand massage.

They also offer a respite period for families who need some time to care for themselves, but would like to know their loved one is not alone. Use of this service is growing and feedback has been very positive.

Work across Leicester, Leicestershire and Rutland

We continue to engage with, and support, the work in the local Sustainability and Transformation Plan (STP) around end of life care.

Progress is being made and we look forward to being part of new ways of supporting patients and families in the future.

We are talking with local stakeholders about the possible introduction of a new document to record decisions about emergency treatment called ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) and exploring how this might support patients across the healthcare economy.

Ensuring that information can be accessed across organisational boundaries to improve the care of patients is important for many reasons, but particularly where patients are at the end of life. SystmOne provides clinicians and health professionals with a single shared Electronic Health Record available in real time at the point of care. There continue to be challenges, but we continue to work towards this goal.

Bereavement Support Service (for adults)

In December 2015 we launched a pilot Bereavement Support Service, available for all those affected by the death of a loved one aged 18 years or over who died in one of our hospitals.

The service is now an integral part of what we provide to support bereaved families and it links with our 'Learning from deaths' process.

It is recognised that family members, carers and others affected by bereavement may sometimes need further information, support or questions they would like to ask. Having the opportunity to have these questions answered can often help as they begin to come to terms with their loss. If required, the Bereavement Support Service can arrange for individuals or families to meet with a member of the medical or nursing team who cared for their loved one.

The service offers families the opportunity to talk through what matters to them regarding their bereavement. If we are unable to help, the Bereavement Support Nurse signposts people to someone who

can, for example, although the service does not provide counselling, assistance can be offered with directing individuals to counselling or support organisations who can help.

Family members and carers may contact the service at any time and will be offered the opportunity to receive a 'follow up' contact from the Bereavement Support Nurse around six to eight weeks after their bereavement, either by means of a telephone call, letter or another method of their choice. Contact can be made in alternative languages or formats if required, e.g. for those with disabilities.

Providing spiritual and religious care

We offer 24/7 pastoral, spiritual and religious support to patients and families and our diverse team, including the NHS's first full non-religious team member, ensures that they have chaplains from a wide variety of faiths and outlooks to support them. We are on hand to support patients or families in urgent situations, especially around the time of death.

This year we have provided the chaplaincy service to Leicestershire Partnership NHS Trust, seeing patients and families across mental health units and community hospitals of Leicester, Leicestershire and Rutland.

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.

On each of our sites we provide multi-faith chapels and prayer facilities for patients, visitors and staff to use. These provide a place for prayer or quiet contemplation and are in constant use.

Over the year our chaplains and chaplaincy volunteers made about 13,000 visits to patients - an invaluable part of our commitment to delivering "Caring at its Best". We benefitted from about 3,500 hours donated to the Trust by volunteers.

The chaplaincy also organised the third "Celebrating Caring at its Best" event, held in May 2017 which focussed on celebrating positive patient experiences and the motivation of staff and volunteers.

Our People

We will have the right people with the right skills in the right numbers in order to deliver the most effective care

In 2017/18:

- We will develop a sustainable workforce plan, reflective of our local community which is consistent with the STP in order to support new, integrated models of care
- We will reduce our agency spend towards the required cap in order to achieve the best use of our pay budget
- We will transform and deliver high quality and affordable HR, OH and OD services in order to make them 'Fit for the Future'

We will develop a sustainable workforce plan, reflective of our local community which is consistent with the STP in order to support new, integrated models of care

Our overall workforce plan has been focused on reducing gaps in demand and supply and in introducing new and innovative roles and working practices to attract the right people with the right skills into the organisation.

Reflecting the national picture of supply shortages, particularly for nursing staff, we still have challenges in meeting the gaps between demand and supply of nurses. To address some of these challenges we have pioneered the development of a Nursing Associate qualification which has been designed and implemented with our STP partners and to date there are 90 trainee Nursing Associates in place.

We have reviewed our Practice Placement Strategy to support two Higher Education Programmes at both De Montfort and the University of Leicester to enable a better supply of newly qualified nurses. The Practice Placement Strategy includes partners in the private, voluntary and care home sectors and is being led by us.

In addition we continue to have a joint approach to the development of Advanced Clinical Practitioners who are critical to the delivery of a more multidisciplinary approach to the delivery of tasks traditionally undertaken by medics and the emergent STP workforce plans.

We, with Leicestershire Partnership NHS Trust, have worked together on a newly qualified graduate rotation programme specialising in the frail and older person. This 27-month programme provided newly qualified nurses the opportunity to work in both organisations and also carry out insight visits to other areas of care, such as the voluntary sector, mental health, nursing homes, specialist care teams and LOROS to enhance and broaden their knowledge of caring for older people. The nurses were also supported with speciality study days and completed the in house post graduate accredited frail older people module.

Although we have been impacted by Brexit in terms of turnover and attraction to posts, we have continued to successfully recruit internationally for junior doctors and radiographers, and have developed a programme of overseas recruitment for nursing.

Our Pharmacy team have also had success in recruiting into roles at Band 4 and Band 7, which are traditional hotspots, through the introduction of apprenticeships and internal development schemes.

We have progressed a number of reconfiguration scheme workforce plans, which include a multidisciplinary frailty friendly workforce plan for Phase Two of the Emergency Floor, including the introduction of Meaningful Activity Coordinators and an increased presence of therapy staff, the development of a plan for East Midlands Congenital Heart Centre to meet activity requirements and plans for the interim move of Intensive Care Units.

We have developed a robust approach to improving our representation of BAME staff at the leadership level, including drawing candidates for our internal Graduate Training Scheme from the local community and setting trajectories at staff group level for improved representation.

We will reduce our agency spend towards the required cap in order to achieve the best use of our pay budget

The agency cap for 2017/18 was £20.6m and we achieved £20.39m through a robust approach to our management of agency expenditure including reducing rates and volumes.

We have achieved particular success in reducing medical agency spend from £10.1m to £8.85m, which overachieved our national target of a reduction of £718K. This has been achieved through a more robust approach to gap management and authorisation.

We will transform and deliver high quality and affordable HR, Occupational Health and Organisational Development services in order to make them 'Fit for the Future'

We are proud to have developed a new case management approach and electronic tracking system and have now appointed a dedicated Case Management Team in progressing this further during 2018/19. We are beginning to benefit from policy and practice improvements and focused mediation at early stages.

We continue to improve our recruitment services through stronger external collaboration with partners across Leicester, Leicestershire and Rutland and improved Clinical Management Group resourcing plans to strengthen workforce planning.

We have continued our organisational development up-skilling programme to increase organisational development capacity and capability across our service and work closely with system partners on building strong leadership and improvement skills across leaders and managers.

We will continue to work on transforming our services and are committed to providing 'fit for the future' services.

Our Nursing and Midwifery workforce

The national challenge of recruiting nurses is well documented. Through our dedicated nurse recruitment team, we continue to focus on attracting and retaining the best nurses to work in our hospitals.

Our Trust wide open days have been successful and we have been able to recruit nurses to all areas of our organisation, as well as giving us the opportunity to showcase the development opportunities and career pathways we can provide to nurses at all stages of their careers.

In 2017, we official opened of our Centre for Clinical Practice and Leicestershire School of Nursing Associates. The investment in new education and training facilities confirmed our commitment to the development of our clinical nurses and midwives.

We have continued to recruit nurses from the EU, India and the Philippines which have helped with our nursing vacancies. We know that our registered nurses from non-EU countries make a long term commitment to live and work in the UK, and so our recruitment strategy is an investment as it brings experienced and skilled nurses to support and enhance our nursing workforce in delivering care to all of our patients.

We continue to use the RCN (Royal College of Nursing) Jobs Fairs across the country to ensure we are 'on the map' and promote Leicester's as a place to work and live.

Recruitment of newly qualified nurses is also very successful and we remain the main source of employment for De Montfort University (DMU) nursing and midwifery students, which is a testament of our commitment to support learners throughout their training so they can continue their career development as registrants with us.

The Nursing Associate was piloted as a new role by Health Education England in 2017. A Nursing Associate supports the registered nurse in ensuring patients and families receive high quality, compassionate care for adults and children in hospital or community environments, including mental health or learning disability. We are one of the pilot sites for the East Midlands Collaborative and we have developed our own programme for our Leicestershire trainees in partnership with De Montfort University. Our nurse educators now deliver the Nursing Associate Apprenticeship as a Foundation Degree in Science, which is a unique model and the only one of its kind in England. This programme is available to existing care assistants, or a similar caring role in any health or social care setting. Our first group of trainees are due to qualify from our Leicestershire School of Nursing Associates in January 2019 and our second cohort of 53 trainees started their apprenticeship programme in January 2018.

Develop training for new and enhanced roles, i.e. Physician's Associates, Advanced Nurse Practitioners, Clinical Coders and Graduate Management Trainees

Through an integrated People Strategy we will draw together work on education, training, career development, new role development, recruitment and retention and workforce efficiency under a single umbrella to ensure our workforce model supports an overall sustainable workforce plan for Leicester, Leicestershire and Rutland. Work has already started on this approach through such developments as Physician Associates, Nursing Associates and Advanced Clinical Practitioners.

In response to recruitment challenges for the trainee medical workforce and the strategy to create new teams around the patient, we have introduced the Physician Associate role. In June 2016 we had four Physician Associates join us and are proactively promoting the role across both our organisation. In 2017/18, we employed seven Physician Associates. This role has made a positive contribution in the respective clinical areas and enabled a level of continuity of care which is benefitting patients. A new Physician Associate postgraduate qualification delivered through De Montfort University started in September 2017 with a group of 12. Our US Physician Associates have proactively developed the programme and lectured on a number of modules. In addition the Course Leader is jointly employed by us and De Montfort University. We are currently working with the University on the placement programme and have hosted six placements from the Worcester programme. Workforce plans have been developed in Clinical Management Groups which include Physician Associates as part of their workforce model.

On a Leicester, Leicestershire and Rutland wide basis, we continue to host the clinical lead for Advanced Nurse Practitioners. This ensures a consistent approach to education, training and governance to ensure a consistency of role across all organisations. To date we have 40 trainees on programme and eight due to complete this year. There are 36 fully competent Advanced Nurse Practitioners currently in post. These roles have been identified as critical for local workforce transformation as they provide continuity of high quality clinical care for patients and support the supply gap for medical trainees.

The Leicestershire Nursing Associate Programme delivered by us in collaboration with De Montfort University was validated in September 2017 and remains the only model of its kind in the UK.

A second Leicester, Leicestershire and Rutland wide cohort of 52 trainee Nursing Associates started in January 2018 and are now following an apprenticeship standard; 39 of this cohort are from our organisation with the remainder from Leicestershire Partnership NHS Trust.

Nursing have also recruited eight staff with dual registration in both mental health and learning disabilities which provides enhanced patient experience for adult mental health patients and children with such conditions as autism.

The Clinical Coding Team is going through a period of expansion by recruiting trainee Coders. There is a national shortage of Clinical Coders but the Trust has two accredited Clinical Coding Trainers in post. They provide a structured and well-supported training programme which has enabled us to appoint 19 brand new trainee Coders since 2015. This is helping to resolve a long history of under-staffing and has removed the need for use of agency Coding staff to make the workload manageable.

We have an audit programme to review the quality of our Coding for approximately 200 cases per month. The Trust has two Accredited Coding Auditors in post to achieve this. Clinical Engagement is developing very well with Coding staff attending consultants meetings. In 2018 we held our first Clinical Coding conference in which four clinicians presented the intricacies of their specialist areas to the whole Coding Team.

A career framework for pharmacists has been introduced in order to support initiatives around retention. This outlines the scope for future pharmacists as independent prescribers, advanced practitioners and consultant pharmacists which support changing models of care across the Trust. In addition apprenticeship schemes for pharmacy technicians have been expanded to improve recruitment to Band 4 and Band 5 technician roles which have proved challenging in the past.

As well as hosting three National NHS Graduate trainees in 2017/18, we appointed a further six Graduate Management Trainees onto our own training scheme which we successfully piloted in 2015-2017. Eight of the original group of nine have secured their next appointment with us and one person is training as a Physician Associate. This year we have appointed a further six who are following an apprenticeship standard at level 7 as part of their education programme.

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

2017/18 has been a watershed year in respect of the equality and diversity agenda for us. A number of nationally driven standards, such as the Workforce Race Equality Standard, have informed our direction of travel and re-prioritisation of equality issues.

Other factors have also played their part in helping to re-evaluate the way in which we approach equality and diversity in terms of its employment and service delivery.

Workforce Equality

Our second year of WRES data saw a positive increase in the percentage of Black, Asian and Ethnic Minority leadership figures, which rose from 9 per cent in 2015/16 to 12 per cent in 2016/17 - a 3 per cent rise. Early signs demonstrate a further increase in 2017/18 to 13.6 per cent.

Although this is very positive, the overall BAME workforce is 30.96 per cent. Other WRES indicators show less favourable trends, such as the likelihood of BAME candidates being appointed to jobs from applying to the Trust than their White British counterparts.

We take equality and diversity extremely seriously and have taken the following actions:

- Continued Board Development on the race equality agenda via a dedicated 90 minute session on 10 January 2018 with the national WRES Team;
- Set race equality as one of its key priorities for delivery in 2017/18;
- Carrying out equality Learning Needs Assessments of all Executive Directors;
- Established our first BAME staff network (UHL Voice);
- Established an Equality and Diversity board chaired by the Chief Executive;
- Developed a refreshed strategic equality and diversity action plan which is outcome focused;
- Carried out in-depth analysis of rates of turn over to establish realistic race equality targets.

In addition we have:

- Carried out a gender pay gap analysis and set a target to reduce the gender pay gap from 29 per cent to 16 per cent over three years with an associated action plan;
- Working towards providing more support to staff who have been bullied or harassed through the Anti-Bullying and Harassment helpline and working Closely with the Freedom to Speak Up Guardian;
- Secured funds through the Better Care Together Programme to run a system wide Equality and Diversity Conference during May 2018.

Service delivery

We have achieved the following outcomes in respect of improving access for patients:

- Established a new provider of interpretation and translation services following the last provider's withdrawal of service during February 2016;
- Established positive relationships and new arrangements for providing local British Sign Language interpreting services;
- Carried out an audit of leaflets and their accessibility to patients;
- Provided leaflets in community languages and other formats on demand;
- Explored options for the introduction of a "dignity" gown to be trialled in radiography services following a request by one of our faith communities;
- Changed the FFT (Friends and Family Test) monitoring section to reflect comments received from the Transgender and non-binary community.

National NHS staff survey

The NHS Staff Survey was carried out in October and November 2017, 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.

This year we chose to carry out a full census survey – which means every member of staff (14,146) was eligible to take part and would have received a survey to complete. 4808 responses were returned, giving a response rate of 34 per cent. This was a decrease of 2.2 per cent from the previous year; the national average (median) for Acute Trusts stands at 45 per cent.

The results of the NHS Staff Survey showed improvements in some areas relating to patient concerns and feedback, however there was a decline in job satisfaction which mirrors the national picture.

		2014	2015	2016	2017	Position compared to 2016 result	Average (median) for acute trusts
Q21a	"Care of patients / service users is my organisation's top priority"	64%	72%	74%	74%	→	76%
Q21b	"My organisation acts on concerns raised by patients/service users"	67%	75%	74%	75%	↑	73%
Q21c	"I would recommend my organisation as a place to work"	51%	60%	60%	57%	↓	60%

Q21d	"If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"	56%	64%	65%	65%		71%
Q22a	Patient/service user feedback collected within directorate/department	-	93%	85%	90%		89%

IR35

IR35 is tax legislation that is designed to combat tax avoidance by workers supplying their services to clients via an intermediary, such as a limited company, but who would be an employee if the intermediary was not used.

Number assessed as caught/ not caught by IR35	As at 31 March 2018 we had 186 off payroll arrangements : • 19 carrying out regular work • 14 ad-hoc workers • 153 are engaged through Locum Bookers or agencies • There are no off payroll engagements of Board members in 2017/18
Number engaged directly and are on the departmental payroll	From April 2017 the only way to pay workers is: • As employees of the Trust • UHL Bank • The Agency or Intermediary (who will be required to deduct tax and NIC before payment to the worker) • IR35 Payroll (processed through UHL payroll. We will deduct tax and NIC before payment to the worker. This does not provide any other employment rights to the worker) 14 workers are engaged through IR35 payroll
Number of engagements reassessed for consistency/ assurance purposes during the year.	Where workers or the agency/ intermediary believe the worker falls outside IR35, a HMRC on-line assessment must be completed and consistency checked by UHL. Between April 2017 and 31 March 2018, 43 HMRC on-line assessments have been considered, and 10 fell within IR35, 33 outside IR35.
Number of engagements that saw a change to IR35 status following the consistency review	14

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. We, through our Learning and Organisational Development Team, are committed to providing learning and development opportunities to all staff. We offer a wide range of courses and by working together with local colleges and private training providers and have in place a robust process for monitoring performance.

As we entered into 2017/18 we were delighted once again to hold the National Skills Academy Quality Mark for 'superior' delivery of education and training to the health sector. 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. As an organisation we have also regained MATRIX Standard accreditation for our information, advice and guidance provision.

Since gaining main provider status with the Education & Skills Funding Agency we have developed three new lead governing roles during 2017/18 to record, develop and monitor our quality provision and deliver training to Education & Skills Funding Agency and Ofsted requirements. Our team of competent assessors and trainers facilitate and deliver skills, knowledge and behaviours required in new apprenticeship standards and associated qualifications, as well as support and prepare learners on their journey to the end point assessment which is carried out by external independent companies. This works supports us in developing the workforce we need to deliver our services to patients.

As a training provider, and in addition to our own robust monitoring of training provision, we welcome partner organisations to monitor our training delivery, including North Warwickshire South Leicester College, Leicester College, MATRIX, our local Workforce Development Team, City & Guilds, ILM, Pearsons and the National Skills Academy for Health.

A new partnership working arrangement has been set up with Leicester College which further supports our workforce development both through apprenticeships and functional skills. Functional skills allow our staff to access maths and English education programmes from which their new skills impact not only their working lives but home lives and can impact on their families and local communities too.

Appropriate learning and development needs continue to be identified through the appraisal process within CMG's and enables employees to the gain skills and qualifications that will meet both the needs of the organisation to improve patient care and the delivery of services.

During 2017/18, there were seven core business courses led through the team including appraisals and preparing for your retirement etc, which were attended by 954 members of staff. The IT Training Team within Learning and Development continue to deliver training in core clinical system functionality such as HISS and PatientCentre to our staff and staff in the Alliance. Other areas of the training portfolio include INsite (our intranet) and web training. The team continue to support current and future initiatives and projects across the organisation, e.g. Paperless Hospital 2020, replacement to the INsite application and roll-out of Windows 10 and lead on the organisation of the three cohorts of Princes Trust programmes.

We are proud to be the regional provider for the new Public Health England screening qualifications and the national provider for the Level 5 Assistant Practitioner Diploma (Bowel screening). We have completed four New Born Hearing Screening qualifications and have another ten on the screening programmes signed up for completion next year.

The department runs weekly corporate induction events across the year supporting circa 1500 new starters when they join our organisation. This is a good opportunity for new staff to meet the Chief Executive and allows us to set a standard at the start of their time with us around our values and behaviours and essential training such as fire safety, safeguarding and equality alongside receiving their new ID badge.

The Learning and Development Team are responsible for the delivery of Statutory and Mandatory Training. Staff compliance levels have ranged during the year and it is acknowledged that there have been difficulties with reporting and data trends for a significant period within 2017/18. The end of year compliance for staff completing their core mandatory training was 88 per cent against a target of 95 per cent. CMG's are encouraged to ensure that action plans are in place to sustain/ improve performance against all core programmes. Mandatory Training continues to be supported by the provision of e-learning programmes aligned to the national Core Skills Training Framework (Skills for Health) and ten of the eleven subjects within it are included in the above data. Work began to support Prevent training being rolled out by the subject matter expert and will continue to ensure this is included in reports.

During the year a number of eLearning programmes were written for us by the team and full reviews of Infection Prevention and Equality and Diversity Training also took place.

HELM saw the launch of new dashboard functionality and more than 700 managers have been provided with access to this. During 2017/18 we have also moved the reporting parameters from reporting CMG and Corporate data to reporting CMG and individual Directorate Data.

This year the team incorporated 1500 accounts to the learning management system for Estates staff and supported alternative ways of accessing and recording the material and completion of training.

Over 1800 learners attending the various training programmes outside of core mandatory training have been booked through HELM. It is acknowledged that the last 12 months have been very difficult for the functionality of the learning management system, however a number of positive elements have also come through such as the stability and accuracy of the system has improved greatly since launch yet there is more work in scope to do. User feedback suggests they find it very simple and easy to navigate and use. Managers and trainers are finding the Dashboard useful in chasing non-compliance and the CQC were happy with the training data they received from HELM.

Apprenticeships

We took up the mandate to adapt the offer of apprenticeships during 2017/18 to support the Public Duty of Care target (2.3 per cent of the workforce) and new Apprenticeship Levy Funding. We currently have 155 learners following apprenticeship education programmes, with 107 of these starting in 2017/18. We have delivered 54 per cent of our apprenticeships through our Apprenticeship centre and 13 learners on our internal centre programmes from other health and social care organisations. We anticipate the offer of Apprenticeships will continue to grow aligned to the emerging standards and workforce needs across the system.

Through the new Apprenticeship levy, which was introduced nationally in 2017/18, we have supported staff in accessing apprenticeship education programmes. To date we have spent £116,599.06 of the new Levy. It is important to note that the full cost of a programme is not paid 'up front' but paid over the term of the programme. Therefore the actual spend from the levy pot for the duration of the programmes will be significantly more than this. The Levy pot is funded from the government top slicing of our pay budget each month by 0.5 per cent. This money can be spent on solely on apprenticeship education programme costs and there are strict rules around it. At the end of March 2018 we will have access to a further levy pot of £2,255,137.00.

Through the launch of the new Apprenticeship Levy the employer is now more in control of the contracting for educational needs. A significant amount of procurement and contract work was done by the team in 2017/18 to secure training contracts with De Montfort University, University of the West of England in Bristol, City Wolverhampton College and Leicester College, often where no clear guidelines under the new funding rules existed. Discussions within the procurement process are in progress with seven new providers as frameworks and new standards are developed. We have been successful in negotiating Levy saving from the Levy pot totalling £10,350 for programmes costs and £25,650 in End Point Assessment costs.

We have continued our relationship with South Leicester College, (Now North Warwickshire and South Leicester College) who have subcontracted the apprenticeship delivery for us for several years as well as the subcontracting for the delivery of functional skills for those learners who were recruited pre Levy.

Regent College have been a valued partner of ours for many years and deliver our Business Administration apprenticeship. During 2017/18 they continued to work with learners who started pre Levy until the end of their provision in March. The collaborative relationship will continue with the transition of their students who aspire to achieve careers in health with us.

In early 2018 we began to develop relationships with Regent College, Leicester College and South Leicester College to offer careers advice in apprenticeship opportunities to their health students.

It is acknowledged that 2017/18 was a very difficult first year for the new apprenticeship funding rules and readiness across the country of professions, workforces and training providers has taken a long time to start growing and becoming established. Many standards were not ready to use, variations in apprentice pay are unclear, procurement rules were hazy and workforce planning within divisions often lacked apprentice opportunities due to salary funding. Country wide 92 per cent of Levy funds have not been spent. We are not alone in these difficulties and have proactively developed our apprenticeship provision as a centre in spite of the moving landscape. Having more than six versions of the funding rules to date is increasing the clarity; however there is a long way to go. End Point Assessment conversations have started but the readiness of organisations to conduct this leaves employers and training providers with uncertainty.

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.

Celebrating achievements

Our annual training awards ceremony allows us to celebrate staff achievements in learning and development. At our annual event in June 2017, we presented 112 learners 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.

In November 2017, 82 people attended our 25 Year Service Recognition dinner, celebrating their long service with the NHS.

An annual Apprentice Graduation Ceremony took place in June 2017 organised and hosted by the Leicester Apprenticeship Hub. This event is eligible to all learners that have completed an apprenticeship in 2016/17. We had 27 learners in attendance celebrating the completion of their programmes.

Valuing our staff – Reward and Recognition

We recognise that our staff are the most valuable resource we have and they are vital to us delivering high quality services for the benefit of the population of Leicestershire, Leicester and Rutland.

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.

Our 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 following a judging panel made up of variety of key stakeholders chose overall “winners” who were presented with a certificate and trophy.

At the annual ceremony we also present an award for our ‘Volunteer of the Year’ in thanks for the support and commitment they give to our organisation.

Our ‘Above and Beyond’ informal recognition scheme, launched in November 2016, continues to go from strength to strength with 2522 nominations for staff who have been recognised by colleagues or peers as going 'above and beyond'. They receive a special thank you in the form of a pin badge and card.

Attracting and retaining staff – our 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 Salary Exchange schemes continue to very popular, including for attracting and retaining staff with over 6,000 staff participating in one or more schemes. Our ‘***Salary Maxing***’ Car Scheme continues to be very popular with staff. Our unique on-line ‘***Employee benefits Portal***’ continues to develop and facilitate ease of access to our offerings.

NHS Total Reward Statement ('***TRS***') continue to be popular enabling staff to view 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.*

Occupational Health Support

Our occupational health service continues to be an integral part of our organisation and works hard to provide high quality, independent and impartial health and work advice to workers and their managers, as well as strategic advice to the organisation.

The service was recently successful in achieving SEQOHS reaccreditation. SEQOHS stands for Safe, Effective, Quality Occupational Health Service and is a set of standards and a voluntary accreditation scheme for occupational health services in the UK. We received specific commendation for audit, governance, leadership and supporting development of occupational health staff.

The occupational health service responded to a challenging 2017/18 influenza season, giving a higher total number of influenza vaccines to staff than any previous year, covering over 71 per cent of frontline clinical staff.

In other good news, Dr Anne de Bono became President of the Faculty of Occupational Medicine in October 2017, and Dr Charles Goss succeeded her as Head of Service. Dr Harj Kaul remained National Training Programme Director, overseeing trainees in occupational medicine.

We continue to provide occupational health services across the local and regional healthcare community, including healthcare students at Leicester and De Montfort Universities, as well as other NHS and non-NHS organisations.

Health and Safety

The team continue to be involved in the planning and building of new/ relocated services across the Trust. The team were involved in ensuring that Phase 2 of the Emergency Floor is safe and meets the required standards and continue to be involved in the planning for the Intensive Care Unit extension at the Glenfield as well as the proposed modular ward builds, relocation of Medical Records and upgrading of Mansion House.

For the second year, the overall picture for Health and Safety related issues from the Care Quality Commission report was positive. The work the team has done on anti-ligature points, window safety and the Safer Sharps initiative has positively impacted on promotion of a safer environment throughout our organisation

Like all hospitals across the country we have seen increased pressures, particularly across the winter. It is therefore not surprising to see an increase in reported incidents. This is also evidence of a positive reporting culture. This year we are reporting 56 RIDDOR reportable injuries/ incidents compared to 34 last year representing a 58 per cent increase. There are no particular themes or “hot-spots” but rather a general reflection on the unprecedented pressure we have been under.

As part of our work to reduce work staff injuries/ medical conditions, we have designed a bespoke office environment training and assessment room at the Bracken Centre – Glenfield. Here we can assess staff in a variety of settings with the use of the latest technology to aid comfort, promote safer working and reduce work related Musculo-Skeletal disorders.

We have not received any enforcement notices from the Health and Safety Executive this year.

Manual Handling

When the Care Quality Commission visited us earlier this year they were very positive about our safer handling practices, and made particular references to the availability of equipment, training and arrangements for bariatric patients. There were also positive references to the Bed and Equipment contract, with a particular mention by staff of the access of specialist patient surface equipment.

The rise in bariatric admissions has continued this year with more than 200 referrals being made to the team. This represents an increase of 33 per cent compared to last year and, by far the most that have been referred to us in one year. The manual handling advisors have been able to provide expert help, advice, support and equipment to meet the needs of these patients and the staff caring for them. In 2016 we forecast this rise in referrals and put measure in place to ensure we could meet that demand and still work efficiently.

Last year we reported that we had invested in specialist moving equipment for patients weighing more than 250Kgs which has helped us move two patients safely. We continue to forecast and anticipate the future needs of bariatric patients so that working with staff we can provide them with safe care.

Collaborative work with colleagues in Medical Physics we have identified and replaced, or installed new, patient hoists.

Security Management

Following the creation of a bespoke security management training facility we are now able to provide staff with a wide range of security related training on our own premises. We have also partnered with a private training company to widen the Conflict Management training course available and this has helped us maximise our opportunities to income generate.

As part of our commitment to provide a safe and secure working environment for our staff we continue to exercise powers of sanction against members of the public who behave in an aggressive or unacceptable manner. We continue to work in partnership with Leicestershire Police and has relationship has been enhanced with contacts for Leicester City Council. This collaborative approach to crime reduction has led to addressing criminal behaviour, preventing crime and an increase in prosecutions against perpetrators.

In 2017/18 we put in place a local security action management plan which has shown some steady improvements since last year.

Overall we have seen a slight decrease in reported physical and verbal assaults against staff compared to last year. Physical assaults have fallen by 5 per cent; despite an increase in our workforce.

The remit of the Security Management team has expanded since 2016, with the demand for expert security advice and support being sought by staff has increased as our reputation grows.

Deliver the recommendations of "Freedom to Speak Up" review to promote an entirely open and honest culture

Our Freedom to Speak up Guardian, Jo Dawson, has been in post for over a year and, together with the Safety Team, is leading on some of our safety culture work.

During the year we have reviewed the resources available for staff to enable them to raise concerns. These include the 3636 staff concerns reporting line (online form and telephone number) and the junior doctors gripe tool, as well as open access to the Freedom to Speak up Guardian, the safety walkabout programme, and Director breakfast sessions. A dedicated Freedom to Speak up email has also been created for any member of staff to raise concerns.

In 2017/18 58 concerns were raised through the 3636 staff concerns reporting line, 77 direct to the Freedom to Speak Up Guardian and 111 through the Junior Doctor Gripes Tool.

Our Freedom to Speak up Guardian has attended a number of team meetings across our hospitals and offers team drop in sessions. We work closely with the National Guardian's Office and with local and regional colleagues to promote the national Freedom to Speak up agenda across our organisation.

Staff are both encouraged to raise safety issue, and are supported when they have done so. We seek feedback on their experience of raising concerns and provide quarterly reports to Executive and Board Committees on the relevant themes, services, issues and learning.

Number of 3636 Staff concerns received by financial quarter 2014/15 to 2017/18	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
2014/15 Number of concerns received	5	5	5	5	**20**

Number of 3636 Staff concerns received by financial quarter 2014/15 to 2017/18	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
2015/16 Number of concerns received	3	4	9	7	**23**
2016/17 Number of concerns received	6	15	6	2	**29**
2017/18 Number of concerns received	13	23	8	14	**58**

Number of F2SU Staff concerns received by financial quarter 2017/18	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
2017/18 Number of concerns received	20	17	17	23	**77**

Number of Junior Doctor Gripes received by financial quarter 2017/18	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
2017/18 Number of Junior Doctor Gripes received	39	24	21	27	**111**

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 into force in 2015; we continue to take the following actions:

- On-going assessment of our contracts which have the highest risk of modern slavery;
- Use of national MSA compliant supplier Pre-Qualification Questionnaire (PQQ); to support assurance that our suppliers comply with the MSA;
- Inclusion of MSA clause in our standard terms and conditions.

Equality and Human Rights

It is our aim to provide care and services that are appropriate and sensitive to all.

We always ensure that our services promote equality of opportunity, equality of access, and are non-discriminatory.

We are proud of our place in the local community and are keen to embrace the many cultures and traditions that make it so diverse.

The diversity of this community is reflected in the ethnic and cultural mix of our staff. By mirroring the diversity that surrounds us, our staff are better placed to understand and provide for the cultural and spiritual needs of patients.

Patient Information and Liaison Service (PILS)

Feedback from our patients, their families and carers gives us a valuable opportunity to review our services and make improvements. Our Patient Information and Liaison Service is an integral part of the corporate patient safety team and acts as a single point of contact for members of the public who wish to raise complaints, concerns, and compliments or have a request for information.

The service is responsible for co-ordinating the process and managing the responses once the investigations and updates are received from relevant services or individuals. They are contactable by a free phone telephone number, email, website, in writing or in person.

PILS activity (formal complaints, verbal complaints, requests for information and concerns) by financial year - April 2014 to March 2018

PILS Activity by Type & Financial year 2014/15 to 2017/18	14/15	15/16	16/17	17/18	Total
Formal complaints	2,110	1,558	1,445	1,865	**6,978**
Verbal complaints	974	1,449	1,152	840	**4,415**
Requests for Information	234	439	318	140	**1,131**
Concerns (excludes CCG & GP)	493	757	1,284	1,139	**3,673**
Totals:	**3,811**	**4,203**	**4,199**	**3,984**	**16,197**
Percentage change against previous year		**10% increase**	**0.1% decrease**	**5% decrease**	

Complaints

Complaints are a vital source of information from our patients, families and carers about the quality of our services, standards of our care and experiences of those who have used them. Our Patient Information and Liaison service administer all formal complaints and concerns, with concerns received by General Practitioner's (GP) managed by our GP Services team.

From 1st April 2017 to 31st March 2018 we received **1,865** formal complaints and **1,363** concerns.

The table overleaf shows the top five themes of formal complaints received by the Clinical Management Groups from 1st April 2017 to 31st March 2018;

Table showing top 5 subjects of formal complaints by Clinical Management Group for 2017/18

The top five subjects account for 1,382 (74 per cent) of the 1,865 formal complaints we received

Top 5 primary subjects of formal complaints by CMG	CMG 1 (CHUGGS)	CMG 2 (RRCV)	CMG 3 (ESM)	CMG 4 (ITAPS)	CMG 5 (MSK&SS)	CMG 6 (CSI)	CMG 7 (W&C)	The Alliance	Corporate Directorates	Total
Medical care	139	65	110	14	139	8	71	18	1	**565**
Waiting times	39	24	65	9	68	24	7	19	2	**257**
Appointments including delays and cancellations	38	17	29	12	73	7	12	24	8	**220**
Staff attitude	21	20	66	3	19	10	19	8	4	**170**
Communication	36	20	53	2	14	6	27	4	8	**170**
Totals:	**273**	**146**	**323**	**40**	**313**	**55**	**136**	**73**	**23**	**1,382**

10, 25 & 45 day formal complaints performance - April 2017 to March 2018

Throughout 2017/18 we have continued to participate in the Independent Complaints Review Panel process. The purpose of the panel is to review a sample of complaints from the patient perspective and to report back to the PILS team on what was handled well and what could have been done better. The feedback provided by the Independent Complaints Review Panel is used for reflection, learning and improvement both within the PILS and to the Clinical Management Groups.

Actions for 2017/18 to further improve complaints engagement and learning were:

- To carry out a new complaints satisfaction survey using new approaches. We are currently working to identify the best route and format to capture feedback;
- To coach and further develop the skills of the PILS team to improve the quality of call handling and drafting of responses using plain English. The PILS team now all receive monthly one to one coaching sessions to include a review of a telephone call and draft letter;
- To develop further training for staff to enable them to manage and resolve concerns locally and earlier. Improved local management of complaints has been included in the Patient Safety training programme packages.

We continue to strive to improve our complaints process and handling of cases. Actions for 2018/19 are:

- To change current paper triage process to an electronic process;
- To review and improve the PILS patient information leaflet;
- To review and ensure consent within complaints process is in line with best practice and updated national guidance.

RE-OPENED COMPLAINTS

This year (2017/18) we have seen an average of 8.31 per cent of formal complaints reopened per quarter.

2017/18	Formal complaints received	Formal complaints reopened	% resolved at first response
Q1	381	45	**88%**
Q2	475	48	**90%**
Q3	487	29	**94%**
Q4	522	28	**95%**
Totals:	**1,865**	**150**	**92%**

PARLIAMENTARY HEALTH SERVICE OMBUDSMAN

This year we have again had less upheld cases by the Parliamentary Health Service Ombudsman, further details are provided below.

Parliamentary Health Service Ombudsman complaints - April 2014 to March 2018

PHSO Investigations	2014/15	2015/16	2016/17	2017/18	Total
Enquiry only - no investigation	2	2	4	1	**9**
Investigated - not upheld	5	8	12	3	**28**
Investigated - fully upheld	0	0	1	0	**1**
Investigated - partially upheld	7	2	3	0	**12**
Complaint withdrawn	0	0	1	0	**1**
No decision made yet	0	1	0	7	**8**
Total	**14**	**13**	**21**	**11**	**59**

There are no cases received in the current financial year that have been upheld or partially upheld

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 2017/18, we received 682 Freedom of Information requests and/or requests for environmental information, a slight reduction (1.9 per cent) compared to 695 in 2016/17. We responded to **95.3** 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 1093 instances where areas had to provide information (compared to 1036 instances on 2016/17).

The table below shows the number of times that different areas had to provide information during the year to respond to those 682 FOI requests.

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

Freedom of Information/Environmental Information Regulation requests received between 1 April 2017 and 31 March 2018, split by Clinical Management Group (CMG)/Corporate Directorate		
Area	**Number of times asked to provide FOI data in 2017/18**	**Approx % of overall 2017/18 FOI activity (in terms of times needing to provide information)**
Finance and Procurement	157	14.4%

Freedom of Information/Environmental Information Regulation requests received between 1 April 2017 and 31 March 2018, split by Clinical Management Group (CMG)/Corporate Directorate		
Area	**Number of times asked to provide FOI data in 2017/18**	**Approx % of overall 2017/18 FOI activity (in terms of times needing to provide information)**
Operations	139	12.7%
Clinical Support and Imaging CMG	115	10.5%
Human Resources	108	9.9%
Corporate Nursing	78	7.1%
IM&T	73	6.7%
Women's and Children's CMG	58	5.3%
Musculoskeletal and Specialist surgery CMG	56	5.1%
Cancer, Haematology, Urology, Gastroenterology and General Surgery CMG	54	4.9%
Facilities & Estates	52	4.8%
Corporate Medical	52	4.8%
Emergency and Specialist Medicine CMG	48	4.4%
Renal, Respiratory and Cardiac CMG	31	2.8%
Corporate & Legal	31	2.8%
Critical Care, Theatres, Anaesthesia, Pain and Sleep CMG	22	2%
Marketing and Communications	9	0.8%
Strategy	5	0.5%
The Alliance	3	0.3%
Research and Innovation	2	0.2%
Total	1093	

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 1093 times that areas had to provide information) are higher than the total of 682 requests received.

Education & Research

We will deliver high quality, relevant, education and research
In 2017/18:

- We will improve the experience of medical students at UHL through a targeted action plan in order to increase the numbers wanting stay with the Trust following their training and education
- We will address specialty-specific shortcomings in postgraduate medical education and trainee experience in order to make our services a more attractive proposition for postgraduates
- We will develop a new 5 Year Research Strategy with the University of Leicester in order to maximise the effectiveness of our research partnership.

We will improve the experience of medical students at UHL through a targeted action plan in order to increase the numbers wanting stay with the Trust following their training and education

Undergraduate Medical Education: This year has seen the implementation of the new undergraduate curriculum. The new curriculum incorporates a Foundation Assistantship during the final year, which provides the students with the opportunity to work closely with Foundation Doctors in preparation for their first post.

Our Education Fellow has used a technology based approach to seek 'real time' feedback from the medical students. The feedback identifies suggested improvements and changes and resulting actions are communicated directly back to the students.

Working with the University of Leicester, a number of our consultants have been awarded Honorary University titles in recognition of their work in education and training and a number of our Consultants were recognised at the recent University of Leicester Annual Medical School Day.

Physician Associate Students: This emerging workforce will support doctors in the delivery of safe high quality patient care and the education and training of trainees and medical students. We have appointed a Physician Associate Tutor to support students from De Montfort University and Worcester University, whilst they are on placement with us.

We will address specialty-specific shortcomings in postgraduate medical education and trainee experience in order to make our services a more attractive proposition for postgraduates

Postgraduate Medical Education

We continue to use an '**Education Quality Improvement Plan'** which informs Trust and Executive Boards on our performance.

Our bi-annual survey has a high response rate (>50 per cent) from junior doctors and the most recent survey revealed that 79.9 per cent of this staff group would recommend their current post to a colleague. The survey provides us with CMG and specialty level data which is used to identify good practice and drive forward improvement.

In September 2017, the Royal College of Physicians launched a Chief Registrar development programme to support aspiring clinical leaders. We appointed two Chief Registrar's, at the Royal Infirmary and Glenfield Hospitals, to participate in the programme. The Chief Registrars are leading a number of projects in both hospitals to improve the working lives of junior doctors.

One of these projects was to explore levels of morale at work for junior doctors and in October 2017, over 400 junior doctors responded to a local survey. Survey findings were presented to the Chief Executive and Medical Director and we are now using Listening into Action to improve junior doctor morale.

A new cross-specialty Grand Round Meeting for all medical staff will take place from 4th May 2018 on a monthly basis. This meeting is the result of a project between us and the University of Leicester to enhance collaboration between the two organisations.

Recognising the excellent standard of teaching within the Trust is to be celebrated in 2018 with the launch of 'Educator Awards'. The awards will be presented to senior and junior medical staff who teach both undergraduate and postgraduate medicine. There are also a number of awards to acknowledge the crucial role played by those who support the delivery of medical education. The award ceremony will be held in July.

We will develop a new 5 Year Research Strategy with the University of Leicester in order to maximise the effectiveness of our research partnership.

Research and Innovation has developed a five year joint strategy with the University of Leicester that aims to use our existing work as a platform to drive a closer, more robust, integrated and sustainable strategic partnership between the two organisations by 2022. We are doing this because there is extensive evidence to support the observation that highly research active trusts deliver better outcomes for patients.

Research generated £18.7m for the Trust during this financial year, of which £2.6m was from commercial activity. We are proud to be rated as second in the country for clinical trials meeting the 70 day time and target benchmark (94.6 per cent of our research activity met this standard). 12,000 participants were enrolled into 1,025 active trials, 558 of which were interventional trials (assessing drugs or devices).

This year we officially opened our dedicated children's research facility in our Research Space and welcomed the first patients through its doors.

The National Centre for Adherence Testing (NCAT) based at the Royal Infirmary made national headlines with a urine test that confirms whether patients have been taking their blood pressure tablets and encourages them to comply with their prescription (Gupta and Patel).

A generous £5.15m donation was received from philanthropist George Davies for research into peripheral vascular disease, alongside a new Vascular Limb Salvage clinic at the Glenfield.

In December, we signed a Memorandum of Understanding with Nantong University Affiliated Hospitals to promote cooperation in medical research, training and education between the two institutions.

Towards the end of the year, our researchers (Bradding et al) announced that they had identified a way to distinguish between people with mild asthma and those with more severe forms of the disease, which could pave the way for tailored treatments.

NIHR Leicester Biomedical Research Centre and Clinical Research Facility

Both the NIHR Leicester Biomedical Research Centre and NIHR Leicester Clinical Research Facility (CRF) have successfully completed their first years' activities. Most notably the BRC has recruited over 7,500 research participants and has more than 150 studies open and actively recruiting. It has published in excess of 200 journal articles and secured more than £8m of additional external research funding from industry and charity collaborators.

The purpose of a Biomedical Research Centre is to take research findings and move them swiftly into clinical practice for the benefit of patients. The Arming Your Health study (Yates/Davies) showed the benefits of upper body exercise on improving the health of immobile diabetic patients and has implications for the management of the condition in diabetic foot clinics.

The Biomedical Research Centre, through Dr Adlam, is leading the way on developing a global clinical consensus on managing Spontaneous Coronary Artery Dissection, a type of heart attack found predominantly in women of child-bearing age who have no other clinical symptoms.

In the respiratory theme a pioneering urine test developed by UK company Mologic alerts people with Chronic Obstructive Pulmonary Disease that they are about to suffer a life-limiting attack has passed the first stage of development (Brightling et al). If fully implemented in the future, it could save the NHS £40m per year by preventing unnecessary hospital admissions and the over-prescribing of drugs to treat suspected attacks.

The Clinical Research Facility has successfully united several speciality clusters of clinical research activity around the trust into a new federal structure. During this inaugural year, 29 phase 1 and phase 2 studies have been supported, recruiting over 1,500 participants. The Clinical Research Facility has supported the delivery of ground-breaking clinical trials to patients in the Trust's acute units, particularly the EMBER study which looks into the use of novel breathomics (traces of chemicals and biological markers in the breath) in acutely unwell patients with the aim of using this information to swiftly diagnose and help doctors select the best treatment methods for a range of conditions in the future.

Integrating genomics into patient care

We have recruited over 900 patients with rare diseases and nearly 300 patients with cancer into the 100,000 Genomes project.

The project will end later in 2018 when genomic medicine will begin to become closely integrated into routine clinical care for many patients and the clinical genetics department is gearing up for these changes.

A group led by Professor Nigel Brunskill is designing and planning the necessary clinical service developments to support a new era of genomic medicine for us.

Leicester Precision Medicine Institute

The Leicester Precision Medicine Institute is a relatively new partnership (2016) with the University of Leicester led by Professor Martin Tobin. It brings together academia, the healthcare sector and industry to drive discovery and develop new medical interventions. It encompasses the Leicester Drug Discovery and Diagnostics (LD3) group, who translate the University's high quality biomedical research into medicines, therapies and diagnostic tests with 'real world' benefits for patients.

In 2017/18, the Leicester Precision Medicine Institute secured over £1m from the Medical Research Council for translational research and business engagement. Together with additional funding from the University, these awards support projects to develop novel therapeutics, diagnostics and medical devices that will positively impact patient outcomes.

This year, Leicester Precision Medicine Institute has funded nine joint PhD studentships with the Biomedical Research Centre and Cancer Research Centre to support priority research areas in cancer, cardiovascular, respiratory, and diabetes and lifestyle.

A Leicester Precision Medicine Institute Executive Committee has been formed, whose role it is to establish a roadmap to deliver priority precision medicine projects across the tripartite of the university, industry and us.

The Leicester Precision Medicine Institute 'brand' continues to grow and provides a competitive edge that has resulted in significant uplift of successfully funded precision medicine grant applications for both our staff and those at the university.

Looking forward to 2018/19, Research and Innovation will:

- Seek to retain funding from the National Institute for Health Research for our Clinical Research Facility for another three years;
- Strengthen our partnership with the University of Leicester and potentially develop new partnerships with other academic institutions and healthcare providers to support and grow integrated clinical research, education and training in Leicester, Leicestershire and Rutland of the highest standard;
- Look for opportunities to increase academic appointments for Allied Health Professionals, such as physiotherapists and midwives. In addition, we will create a post of Head Nurse for Research;
- Focus on creating a sharp, customer-focused service for research delivery that is responsive to the needs of internal researchers and industry collaborators;
- Develop more opportunities for public engagement with research through a newly-established Public Research Engagement Panel.

Underpinning this work will be a 'bench to ward' ethos with research activities become visible to all staff and patients. Clinical trial activity will increase and patients will have an expectation of enrolment into clinical trials wherever possible.

Partnerships & Integration

We will develop more integrated care in partnership with others

In 2017/18:

- We will integrate the new model of care for frail older people with partners in other parts of health and social care in order to create an end to end pathway for frailty
- We will increase the support, education and specialist advice we offer to partners to help manage more patients in the community (integrated teams) in order to prevent unwarranted demand on our hospitals
- We will form new relationships with primary care in order to enhance our joint working and improve its sustainability.

We will integrate the new model of care for frail older people with partners in other parts of health and social care in order to create an end to end pathway for frailty

There has been some good progress in introducing a focus on frailty into our Emergency Department; reaching out with a frailty focus to the rest of the organisation and wider healthcare community is now in the planning stage.

Delivery of this next stage will receive renewed focus though our 2018/19 priorities along with the introduction of new programme governance arrangements.

We will increase the support, education and specialist advice we offer to partners to help manage more patients in the community (integrated teams) in order to prevent unwarranted demand on our hospitals

We continue to work closely with colleagues in general practice and Clinical Commissioning Groups (CCGs) strengthening our working relationships and communication links, currently focusing particularly on the transfer of patient care between the Hospitals and GPs and responding to feedback regarding issues encountered. Our GP Services Team act as a conduit to facilitate dialogue and provide representation on interface matters. This workload now also includes the receipt and management of GP concerns and queries via an improved feedback system, together with leading on the identification of areas of improvement.

We produce a regular newsletter to update primary care on developments within our organisation; we offer clinical input from consultants and other professionals at CCG events for primary care staff and we also maintain a website for healthcare professionals to easily access key information. We have focused on specific editions of the GP Newsletter which have proved popular; these have included editions on the new Emergency Department, Pathology and Blood Sciences and a planned E-Referral Service and Paper Switch-off.

As part of our on-going engagement we carried out an annual survey of primary care staff which achieved a significant increase in satisfaction with the Trust as a provider of healthcare and also Friends and Family responses. The survey feedback is used to shape our strategy and priorities to further improve our services.

Clinical conversations between GPs and consultants are still being supported through “Consultant Connect” – an acute and immediate telephone access tool and the significant expansion of the NHS e-Referral Service Advice and Guidance facility which enables electronic, written advice from the consultant teams.

We will form new relationships with primary care in order to enhance our joint working and improve its sustainability

We have written and are working to a Primary Care Engagement and Education Strategy and we have set up a Primary Care Oversight Board, chaired by the Director of Strategy and Communication, to ensure that our

integration and professional relationship with primary care is developed and we offer a high standard of provision and support for our referring primary care colleagues.

Patient and public involvement

This year we have successfully carried out three public 'Community Conversation' events across Leicester, Leicestershire and Rutland. The aim of these events is to enable members of the Trust Board to be more visible in local communities, to listen to a diverse range of public views on our services and promote and publicise the work we do. These well-attended events were held at Ulverscroft Manor, Healthwatch Rutland and at the Leicestershire Centre for Integrated Living. We are planning further 'Community Conversations' during 2018.

The Patient and Public Involvement team have also conducted a number of smaller scale community engagement events with a focus on developing relationships with local communities. Engagement activity has included visits to local groups for women, carers, people with autism and learning disabilities, cultural and faith groups. The Team have also increased engagement and networking opportunities with established local community organisations and health partners across Leicester, Leicestershire and Rutland.

In early 2018, we conducted a successful recruitment campaign to increase the number and diversity of Patient Partners who work with us across our organisation. Patient Partners are members of the public who provide a patient's or carer's perspective on all aspects relating to the experience of Leicester's Hospitals by patients and the wider public. By June 2018, we will have 23 Patient Partners working with our teams to champion the patient voice.

We continue to run our monthly 'Leicester's Marvellous Medicine' health talks for member of the public. During 2017/18 these talks continued to be popular events and recent topics include: Sickle Cell Disease, MRI Scanning, The Myths of Arthritis and Bowel Cancer Screening.

Alliance

The Alliance is a collaboration of the main health organisations in Leicester, Leicestershire and Rutland and through a pillar contract they work with three of the partner organisations (us, Leicestershire Partnership NHS Trust and Leicester, Leicestershire and Rutland Provider Company Ltd), to deliver elective patient care.

Highlights for 2017/18:

- 92.2 per cent RTT (Referral to Treatment) in 18-weeks against a target of 92 per cent
- Cancelled operations 0.7 per cent with a target of 0.6 per cent
- DNA (did not attend) rate of 8 per cent against a target of 5 per cent
- Sickness absence rate 4.7 per cent against a target of 3 per cent
- Percentage of staff are in an annual appraisal 94.3 per cent

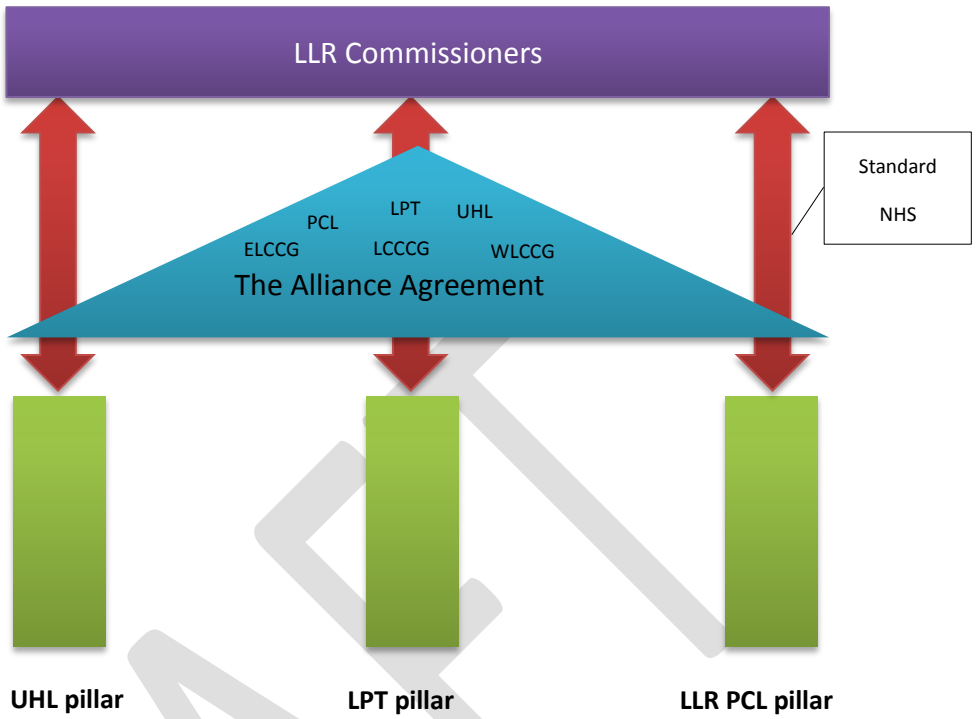
LLR alliance
Providing care around you together

The Alliance seven year contract is now in its fourth year, having started on 1st April 2014, with reviews taking place at years three and five.

Our Trust Board remains accountable for the services provided through the UHL pillar contract and this report serves to provide an overview of performance for the year 2017/18.

ACHIEVEMENTS

Outpatient Correspondence: The outpatient team have made excellent progress in resolving outpatient correspondence delays identified at the beginning of the year. At the year-end the Alliance has successfully achieved the target that no outpatient letters were waiting more than ten days, this is a significant reduction from just over 9,000 letters at the start of the year. The Alliance continues to work towards the reduced timeframe of seven days.



Activity Performance: The Alliance has increased the numbers of endoscopies in gastroenterology and urology and has moved 2,000 endoscopies from our organisation to the Alliance offering care closer to home. We have also increased the number of hernias and general surgery to community hospitals.

Workforce: The Alliance has trained a Nurse Endoscopist and currently has a second training through a Royal College accelerated training programme which will complete in July 2018. Workforce: From September 2017 the Alliance Glaucoma Nurse Specialist commenced clinic activity supporting the care of our Glaucoma Patients. We are expanding our nursing workforce with Trainee Assistant Practitioners and Nursing Apprentices. We are working with PCL to expand our pool of GPs with a special interest and have several new consultants from Leicester's Hospitals appointed (notably in Gastroenterology) who are providing outpatient and endoscopy services across Leicester, Leicestershire and Rutland.

Transformation and Change Activities: The Alliance has increased the focus and energy around the transformation agenda and has created a methodology for delivering change. By engaging staff and patients at the beginning of the process, has helped to improve communication and identify ideas for change that increase efficiency and productivity across services.

A review of admin and clerical processes has resulted in a consolidation of roles and centralising functions to create a more flexible and multi-skilled workforce.

Pathway redesign of Endoscopy services has resulted in a reduction in DNA rates and cancelled on the day procedures due to improved pre-assessment with the introduction of direct booking clinics and pre-assessment telephone and face to face appointments.

The Alliance continues to transform services and will be focusing on day case theatre utilisation and outpatient services to increase productivity and efficiency across all hospital sites.

FINANCIAL PERFORMANCE IN 2017/2018

The Alliance's financial plan 2017/18 is confirmed for both the UHL Pillar and PCL Pillar contracts. The financial plan is based on expected income from contracts and other activity, and planned expenditure to deliver those

levels of service. The plan was set to achieve a breakeven position after delivery of a 3 per cent CIP (£730,000).

The Primary Care Pillar of the Alliance was made live in 2017 and has taken on a number of contracts and is delivering:

- Community non-obstetric ultrasound
- Echo
- Minor hand surgery
- Vasectomy
- Minor general surgery

This has meant that activity has been delivered in local community settings providing quality care and representing value for money.

Key Strategic Enablers

We will progress our key strategic enablers:

In 2017/18:

- We will progress our hospital reconfiguration and investment plans in order to deliver our overall strategy to concentrate emergency and specialist care and protect elective work
- We will make progress towards a fully digital hospital (EPR) with user-friendly systems in order to support safe, efficient and high quality patient care
- We will deliver the year 2 implementation plan for the 'UHL Way' and engage in the development of the 'LLR Way' in order to support our staff on the journey to transform services
- We will review our Corporate Services in order to ensure we have an effective and efficient support function focused on the key priorities
- We will implement our Commercial Strategy, once agreed by the Board, in order to exploit commercial opportunities available to the Trust
- We will deliver financial stability as a consequence of the priorities described here in order to make the Trust clinically and financially sustainable in the long term.

We will progress our hospital reconfiguration and investment plans in order to deliver our overall strategy to concentrate emergency and specialist care and protect elective work

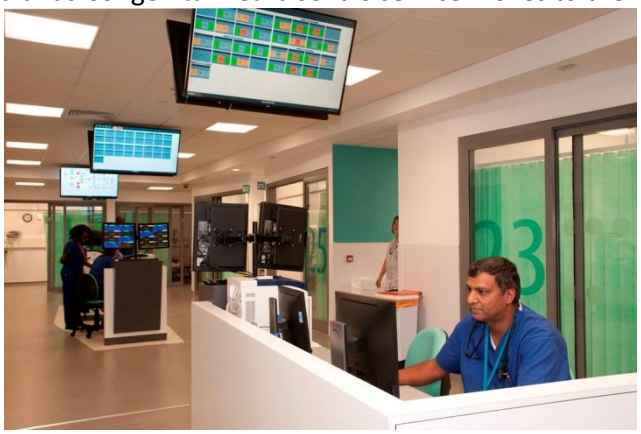
In 2017/18 we successfully delivered Phase 1 of our Reconfiguration Plan, which entailed:

- Opening the new Emergency Department (26th April). A key feature of the new department is the patient friendly signage used throughout. This signage was designed to reduce aggression in the emergency department by clearly explaining what happens at each stage of the patient journey;
- The successful move of vascular services from the Royal to the Glenfield site (5th May) and the opening of a new Angiography Suite;
- Opening of a new hybrid theatre (12th May) offering 'state-of-the-art' imaging equipment to allow a greater proportion of new and complex procedures not previously possible.

The Reconfiguration Plan Phase 2 funding (£30m) was announced by NHS England on 19th July and it will be used to fund the move of the Level 3 intensive care unit from the General Hospital.

The Emergency Floor is due for completion in June 2018, which will see the assessment units relocate to the space vacated in the Balmoral building by the old Emergency Department.

We continue to progress our plans to relocate the East Midlands Congenital Heart Centre from the Glenfield to the Royal Infirmary. Last year work we worked on completing the clinical models, operational policies and schedules of accommodation. Design work has started which will see the delivery of a full business case in autumn 2018; plans are in place to ensure the East Midlands Congenital Heart Centre service moves to the Royal Infirmary site to meet the co-location standard by March 2020.



Over the past year we continued to progress work on the detail of the overall Reconfiguration Programme. This has included further work on key models of care, for example, Women's, Out-patients and Theatres. This work has helped to inform the detail underpinning the STP and will be used to inform the Pre-Consultation Business Case, which is being developed during 2018/19.

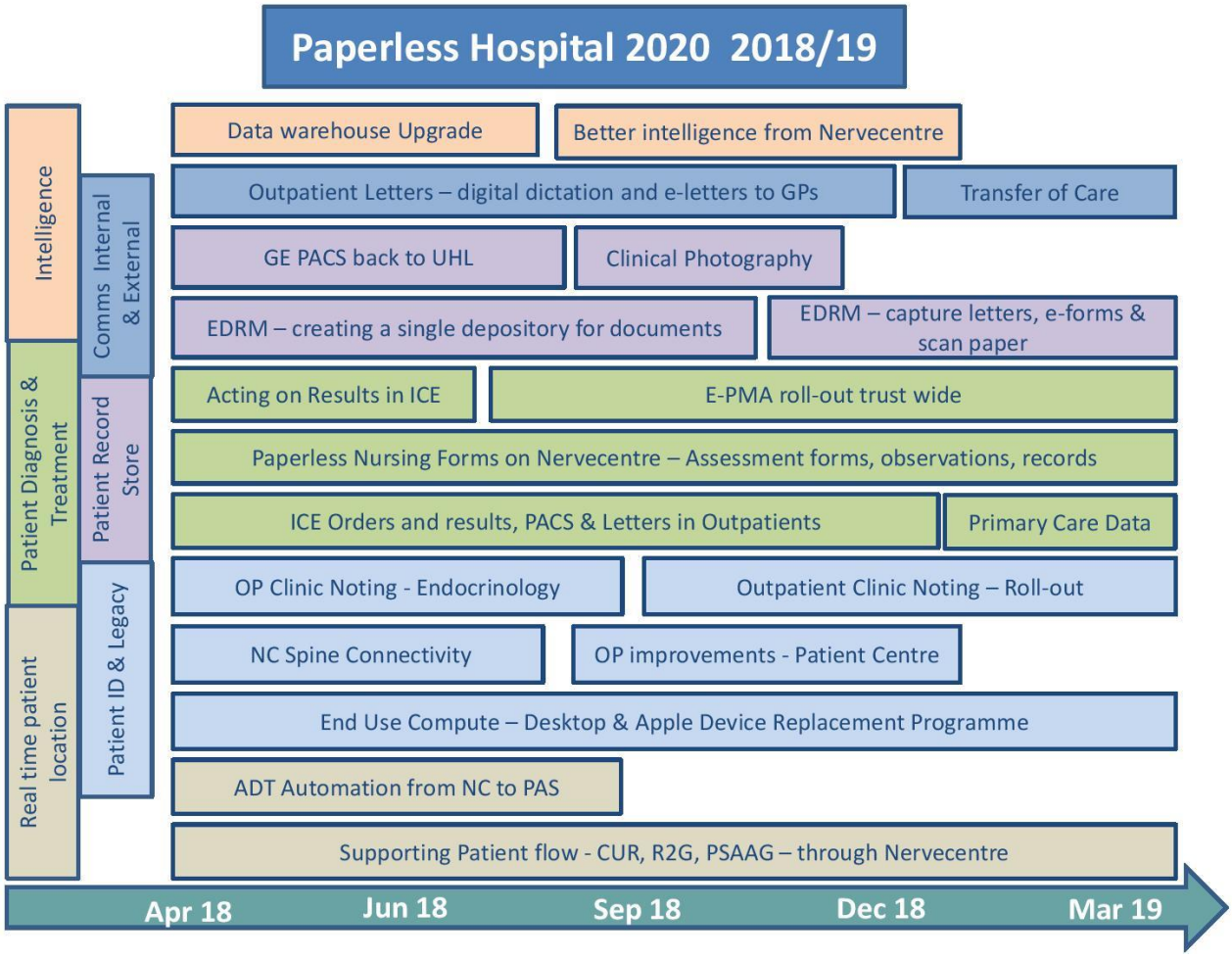
We will make progress towards a fully digital hospital (EPR) with user-friendly systems in order to support safe, efficient and high quality patient care

We have made significant progress with our EPR (electronic patient record) strategy and the implementation of its components. The largest part is centred on the use of Nervecentre, which we have made available to the entire organisation and we were successful in winning a major award for the Best Information/Administration system during 2017/18.

We have increased the amount of mobile devices available for staff and assisted the redesign of workflow to support the new approaches to our emergency floor. The first phase of our paperless hospital strategy was implemented in our new Emergency Department using Nervecentre as the core clinical application.

Thorough 2017/18 we focused on some of our core clinical systems, ensuring we bring them up to the latest versions. This meant some significant upgrades to ICE, ORMIS and Patient Centre; these with Nervecentre provide the heart of the electronic patient record moving forward. We continued to develop Nervecentre across our wards for e-obs and early warning scores, which support our quality commitment as well as creating an e-bed management system to support the allocation of beds and flow of the patient through the hospital.

We have approved the Paperless Hospital 2020 Strategy and the Governance Board to manage the delivery of the programme.



In 2018/19 we will be focussing on creating a new version of ICE (mobile ICE, acting on results, ICE in outpatients), a new version of Nervecentre which will give us better functionality, forms and reporting to support workflow and quality commitment, begin a replacement programme across the Trust of our computers to improve the product staff use; we will introduce electronic prescribing (EPMA) to the whole organisation to ensure we have a single, safe approach to prescribing; we will be bringing all PACS (picture archiving) systems back on site and under our own control and we will continue with our plans to make our

organisation paperless, removing paper through ICE/Nervecentre/new EDRM and through better integration with primary care.

We will deliver the year 2 implementation plan for the 'UHL Way' and engage in the development of the 'LLR Way' in order to support our staff on the journey to transform services

We launched the UHL Way in January 2016. It is the way we 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 in turn improves the quality of care we provide to patients, reduces harm, increases efficiency and effectiveness and supports cost reduction. Over 2016/17, key benefits/ measures of improvement have been set out within individual programmes and overall improvement to staff experience is monitored at quarterly intervals through the Pulse Check and on an annual basis through the national staff survey.

The three components to the UHL Way are:

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

These components are supported by our UHL Academy.

Better Engagement/ Listening into Action – Classic LiA continues to support Pioneering Teams to make changes that benefit our patients and staff. Alongside this Thematic LiA Teams have seen some fantastic achievements including a new way of working in the East Midlands Congenital Heart Centre that increased theatre capacity from 5.6 surgical cases per week to 8.6 surgical cases per week using the same theatre space.

Work also continues with Medics into Action, helping improve support and development for our doctors from students to Heads of Service.

Better Teams

Better team working is important to us as the relationship staff have with their team can make a real difference to their experience at work, and the care patients' experience.

Support has been given to a total of 24 teams during 2017/18.

Better Change

Better Change is our improvement methodology and consists of an online toolkit, with supporting guidance and case studies to ensure that both small and large scale change is led and supported in an optimal way.

The Better Change toolkit is based on the national NHS change methodology and has been developed in consultation with both internal and external stakeholders. The Toolkit is in use and work is continuing during 2018/19 to align change methodologies across the Leicester, Leicestershire and Rutland system. Supporting change in our organisation is the introduction of our LEAN Apprenticeship which will further embed efficiency and change methodologies throughout the organisation.

UHL Academy

Our UHL Academy is designed to provide learning that will equip leaders with the essential skills and behaviours required to engage with, lead and develop their teams. The programmes and modules align with the core values and tools and are designed to support talent management and succession planning processes. Five cohorts completed the programme during 2017 and the programme is planned to continue throughout 2018/19. Further Academy offers have been developed and introduced and will continue to be available to all staff.

The Academy is designed to evolve with the needs of our organisation and the wider Leicestershire, Leicester and Rutland system with programmes and modules introduced and flexed to meet the requirements of all learners as they progress through their leadership journey.

Talent Management/Succession Planning

The Organisational Development Team will be taking a lead role in implementing our Talent Management Strategy. The strategy includes the development of an online talent portal which includes appraisal aligned to a People Capability Framework. During 2018/19 these systems and processes will be developed and all line managers developed to enable effective talent management and robust appraisals to take place.

We will review our Corporate Services in order to ensure we have an effective and efficient support function focused on the key priorities

All of our corporate services have been embracing opportunities to enhance productivity with a rigorous focus on improvement to core business operations.

The "Carter" target for "back office" cost to be no more than 7 per cent of Trust turnover by March 2018 has been achieved and work continues to identify long term sustainable efficiencies across all of our corporate services.

We will implement our Commercial Strategy, once agreed by the Board, in order to exploit commercial opportunities available to the Trust

The Trust Board approved the Commercial Strategy and the initiatives described for implementation within 2017/18 have been achieved. The core element of this programme related to the delivery of a new Partnership to deliver improved healthcare estates and facilities services.

We will deliver financial stability as a consequence of the priorities described here in order to make the Trust clinically and financially sustainable in the long term.

This year we delivered a deficit of £34.5m. This deficit was larger than the planned deficit due to the impact of winter operational pressures and the national directive to cancel elective activity throughout January 2018. With the exception of these winter operational pressures we would have delivered our planned financial deficit as part of our improvement trajectory as described within our 5-year financial strategy.

We continue to revise our 5-year financial strategy on a bi-annual basis integrating this within the wider health economy STP financial plan.

Procurement and supplies

During the year, the Procurement and Supplies team have been working closely with both colleagues and suppliers to deliver on our Procurement Strategy 2015-2018 (http://www.leicestershospitals.nhs.uk/aboutus/departments-services/procurement-and-supplies/doing-business-with-us/).

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

Some particular highlights include:

- Enabling us to reduce its deficit through our work with both colleagues and suppliers. We have continued to enable £8m of cost improvement plan (CIP) savings during the financial year;
- Continuing to play a key role in the national NHS procurement agenda and in particular supporting delivery of the Lord Carter report;
- Successful delivery of the national Carter metrics;

- The team have achieved Level 2 on the NHS Commercial and Procurement Standards – we were the first Trust in the East Midlands to achieve this and are now supporting other Trusts in the area with their assessments;
- Improving our collaboration with NHS Supply Chain and one of 24 Trusts advising on their national procurement strategies;
- Supporting the delivery of our re-configuration programme.

Our plans for 2018/19 include…

- Continuing to improve the procurement and supplies processes in line with our three year Procurement Strategy;
- Refreshing our Procurement Transformation Plan;
- Delivering a further £8m or more of cash savings to the Trust (CIP);
- Continuing to lead and support delivery of the national procurement agenda (Future Operating Model) in the NHS;
- Transition to the Leicester, Leicestershire and Rutland Healthcare Facilities Management Services LLP model of working.

Emergency Planning

Emergency Preparedness, Resilience and Response

The patients and communities that we serve expect us to be there for them when they need it, irrespective of the circumstances we face. As such, we must do all that we can to ensure we are well prepared to respond to any disruptive challenges or emergencies that we might come to face, which could be anything from extreme weather events, outbreaks of infectious diseases, terrorist attacks or major transport accidents.

Over the past year, we have continued to make sure our services are resilient so that high quality patient care can continue uninterrupted, even during an emergency. The opening of our new emergency department at the Royal Infirmary has enabled us to redesign our decontamination procedures as part of the arrangements for responding to incidents involving substances which may be hazardous.

During the year we ran a major incident exercise - "Exercise Soteria" - to test our emergency arrangements for responding to a major incident. The exercise simulated how we would respond to the needs of a large number of casualties presenting to the Royal Infirmary following a hypothetical transport accident at one of the city's sports stadiums. The exercise involved 130+ people including our staff, and representatives from Leicestershire Police, the Army and other NHS providers.

We are required to assess our resilience on an annual basis against "NHS England's Core Standards for Emergency Preparedness, Resilience and Response", which are the minimum standards NHS organisations, like ours, must meet to comply with the requirements of the national framework, the NHS Contract and the Civil Contingencies Act.

The outcome of the self-assessment for 2017/18 showed that of the 90 applicable standards, we were:

- Fully compliant with 80 of the standards;
- Partially compliant with 10 of the standards;
- Non-compliant with 0 of the standards.

Where we were unable to provide full compliance against a given standard, we have begun to develop work plans to improve on these areas.

Emergency Preparedness, Resilience and Response - Looking ahead to 2018/19:

Our emergency planning team is currently carrying out a comprehensive review of our emergency preparedness, resilience and response arrangements, the outcome of which will inform a new programme of work for us to take forward in the coming 12 months.

Risk management

Effective risk management awareness and practice at all levels is an integral success factor for us. At its simplest, risk management is good management practice. It should not be seen as an end in itself, but as part of an overall management approach as risk is inherent in everything we do. The success of our services requires us to identify risks and ensure that these are adequately managed so that we can achieve our objectives and immediate priorities.

A risk management policy is in place to provide a framework for the management and reporting of all types of organisational risks. These risks are assessed and reported on our risk register, subsequently providing a dynamic risk profile to aid with decision-making. The policy includes accountability for managing risks and ensures a clear line of sight for reporting risks from 'ward to board'.

In response to feedback from external sources, including internal audit and CQC inspections, there has been increased emphasis to scrutinise risk treatment plans, by local management boards and at an executive level, to confirm actions are being managed within their specified time frames. Work plans to address the findings from these inspections will be developed and included in the programme of work for the next 12 months.

The Board Assurance Framework (BAF) has been closely monitored during the year by the executive team and at Trust Board, and includes a description about the principal risks which may have the potential to adversely affect the achievement of our strategic objectives and immediate priorities. The highest rated risks and areas of concern recorded on the BAF relate to workforce gaps, demand and capacity capability and management of finances.

Risk Management - Looking ahead to 2018/19:

- Work with CMG/ corporate leadership teams and the executive team to provide specialised support and guidance to help embed enterprise risk management, including acting on the findings from the recent CQC report;
- Focus on quality improvement by monitoring effectiveness of the risk control measures and treatment plans that are described in entries on the risk register;
- Review our training needs analysis and explore alternative methods to deliver our risk awareness training programme to different staff groups;
- Develop a risk assessment toolkit for our staff on our intranet, to describe the risk assessment process and provide advice about risk descriptions, control measures, and treatment plans;
- Explore the feasibility of using a web-based risk register tool to record and report risks.
- Link closely with strategy and quality departments to improve the functionality of the BAF and improve the management and reporting arrangements for the BAF and our objectives/ annual priorities.

Medical Device Incident Management

The Medicines and Healthcare products Regulatory Agency (MHRA) and NHS England/ Improvement have formed a strategic partnership to develop safety alert broadcasts and guidance to improve the reporting of, and learning from, medical device related incidents and near misses.

A number of local actions have been taken to support compliance with the national framework, including implementing the role of Medical Device Safety Officer (MDSO).

We continue to improve data quality in our work programmes in relation to medical device incident reports, subsequently enabling more effective data analysis to provide early indications of prevalent incident trends and opportunity to develop treatment plans to improve patient safety.

Medical Device Incident Management - Looking ahead to 2018/19:

- Strengthen medical equipment governance processes through regular liaison with medical device service providers to seek assurance that there are appropriate control arrangements are in place to mitigate risks to patient safety;
- Include a section on medical device incident reporting in the risk analysis papers to CMGs for review at their monthly board meetings to provide a focus any areas of concern and opportunities for improvement identified by the MDSOs.

Central Alerting System

National patient safety alerts, MHRA medical device alerts, important public health messages and other critical safety information and guidance are issued to NHS Trusts 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 and from 1st April 2017 to 31st March 2018 we received a total of 109 national alerts, with no deadlines for compliance breached.

During 2016/17 the corporate risk management team carried out an internal review of processes for managing safety alert broadcasts at CMG level. Findings from the review support that robust and effective methods are in place to manage compliance with alerts at management and operational level and a small number of recommendations, to strengthen the level of assurance, have been identified and will be applied during 2018/19.

Looking ahead to 2018/19:

- Work with CMGs to improve resilience and record keeping processes at all levels;
- Focus on quality improvement by monitoring effectiveness of the actions that we have signed off in the alert;
- Carry out a further review of CAS management at CMG level to monitor compliance with Trust policy and to review the progress of mitigations recommended in the previous internal reviews.

Financial Statements and notes

The Financial Statements

Overview of 2017/18 Financial Position

We originally planned to deliver an income and expenditure deficit of £26.7m in 2017/18, which was predicated on the delivery of a Cost Improvement Programme (CIP) of £44.1m. This was predicated on the delivery of a planned CIP of £44.1m.

We achieved the revised deficit of £34.5m for the year, which was an increase over the original £26.7m due to the following:

- We received an additional £2.2m of winter pressures funding;
- The increased deficit to £34.5m to include the impact of £9.9m winter operational pressures:
- We achieved £39.3m CIP.

We spent £33.3m of capital against our initial planned capital programme of £54.4m, which matched the available funding and Capital Resource Limits. The capital spend was supported by internally generated funds of £25.6m and £7.7m capital loans from the Department of Health. The key elements of our capital programme were:

- Addressing backlog maintenance and investment within critical infrastructure;
- Phase 2 of our new Emergency Floor project;
- Redevelopments and investments to support the longer term estate reconfiguration plans and;
- Investment in IT and new equipment.

We delivered our other statutory duties.

The above means that we enter 2018/19 in a different place financially than was anticipated within our five year strategic plan. It was not possible for us to sign up to the proposed control total for 2018/19 which will mean that we are not eligible for STF funding for the year.

Financial Review for the Year Ended 31st March 2018

We did not meet all of our financial and performance duties for 2017/18:

Balancing the books	We delivered an income and expenditure deficit of £34.5m
Managing cash	We delivered both the External Financing Limit and Capital Resource Limits
Investment in buildings equipment and technology	We invested £33.3m in capital developments

Performance against our Financial Plan

We delivered a £34.5m deficit for the year against the original planned deficit of £26.7m. Our planned deficit changed in the year as a result of £2.2m income.

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

Total income	£963.5m actual; which was £22.4m above plan which includes £12.5m in relation to implementation of estates strategy together with deferred income release.
Total expenditure	£1000.1m actual; which was £32.3m over plan and includes overspends of £35.6m on pay and underspend of £3.3m on non-pay.
Impairment	£2.7m 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 £34.5m.
Capital expenditure	£33.3m against a revised capital resource limit of £53.8m.
Cash balance	£2.9m closing cash balance against a plan of £1.0m.
Cost Improvement Programme (CIP)	Delivered £39.3m against a £44.1m target.

Balance Sheet

Cash: We ended the year with a cash balance of £2.9m which included the Trust Med Pharmacy cash balance of £1.7m and secured external financing of £66.3m, which included:

- £26.7m to fund our deficit;
- £31.9m for working capital support: and
- £7.7m for capital financing in relation to our emergency floor project.

The total balance of our external financing at the year-end was £198.3m.

Non-current assets: The value of our non-current assets (including property, plant and equipment and intangible assets) increased by £29.4m mainly as a result of:

- £33.3m total net additions; less
- £18.5m upward revaluation; less
- £22.4m depreciation.

Working capital

Our receivables have increased by £15.6 driven by an increase in Non-NHS prepayments and accrued income.

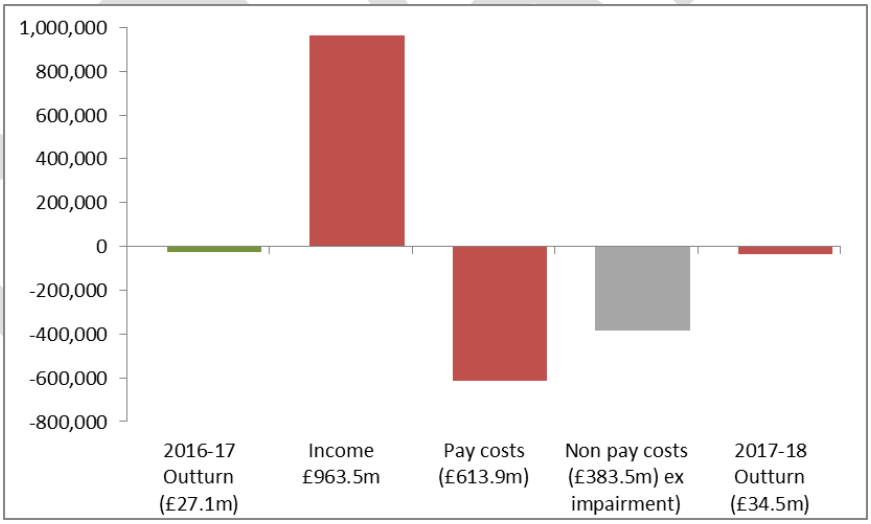
Our payables have increased by £10.5m due to receipt of working capital loans.

Taxpayers equity

This represents the methods of funding our assets and liabilities. The main component of our taxpayers equity is Public Dividend Capital (PDC) which remained consistent from the prior year.

Our retained earnings reduced by £36.3m due to our financial deficit and impairment following an asset revaluation. Our revaluation reserve balance increased by £20.9m due to the asset revaluation.

Key Financial Indicators



Income: We received £963.5m of income which is a £39.2m (4.2 per cent) increase from the £924.3m we received in 2016/17.

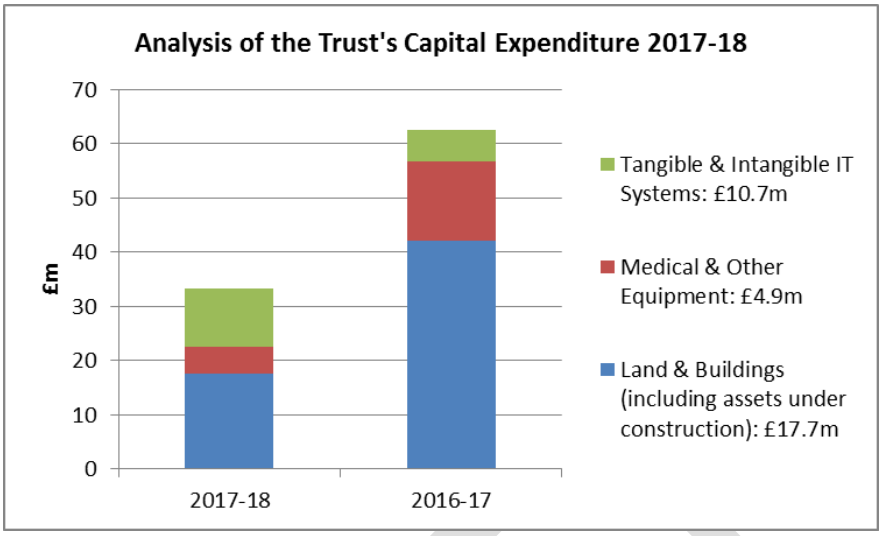
Pay expenditure by staff group: We spent £613.9m on staff costs, which is a £38.1m (6.6 per cent) increase over the 2016/17 total of £575.8m. £9.0m of this increase is due agency costs. £7.0m of this increase is due to increased social security and pension costs.

Non-pay expenditure: We incurred £386.2m of non-pay expenditure which was a £14.6m (3.6 per cent) decrease over the 2015/16 total of £400.7m.

We also had an impairment of our property, plant and equipment of £2.7m following a revaluation of its estate.

Capital expenditure

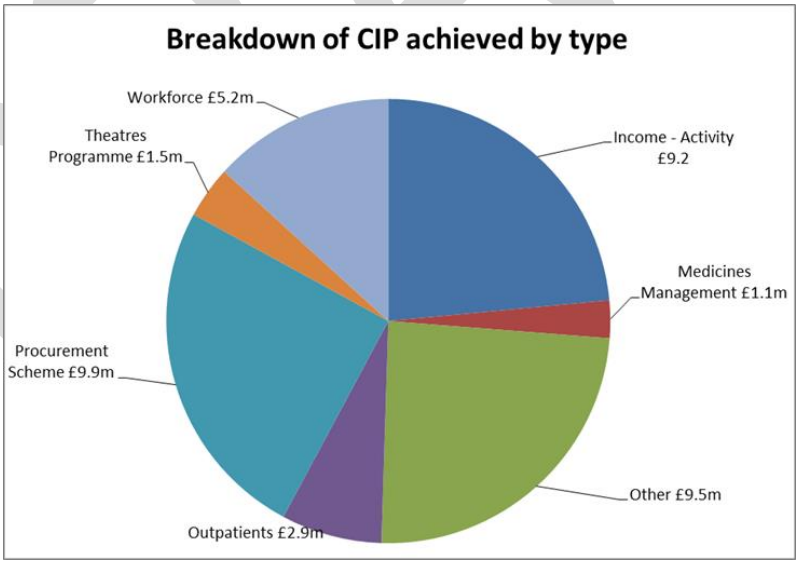
Our capital (excluding adjustments for donated assets) was £33.3m, a £29.3m reduction (47 per cent) on the 2016/17 total of £62.6m. A breakdown of the spend is shown in the graph below.



Capital expenditure for 2017/18 consisted of:

- £13.3m on reconfiguration schemes including £10.3m on the next phase of our new Emergency Floor;
- £5.6m on estates and facilities schemes;
- £3.2m on IM&T schemes;
- £6.5m on medical equipment, both purchased and leased;

Our efficiency programme: We delivered £39.3m against our £44.1m cost improvement programme in 2017/18. The programme focused on productivity whilst maintaining high quality patient services. £5.2m of improvements in the way workforce; £9.2m of savings came from income activity; and £9.9m from procurement schemes. A breakdown of the CIP achieved 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 2017-18, 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 its 2018/19 plan to the NHS Improvement. The key details relating to the plan for 2018/19 are as follows:

- Planned I&E deficit of £29.9m;
- A major CIP plan of £51.5m;
- A capital expenditure plan of £50.4m, including the ICU projects;
- PDC funding of £27.4m to fund the capital programme;
- An external Financing Limit of £52.6m;
- A Financial Risk Rating of three (calculated in accordance with the NHS Improvement planning submission guidelines).

Our financial plan and resulting deficit position is driven by our activity and income assumptions, workforce implications and 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 revenue financing in 2018/19 as follows:

- £29.9m to fund the 2017/18 deficit and
- £34.1m to repay the brought forward interim revenue support loan.

Net overdue payables brought forward totalled £16.4m (overdue receivables of £16.9m and overdue payables of £33.3m).

We are producing an action plan to reduce the level of overdue receivables and payables and this will involve an application for further external working capital funding.

We will further improve our performance against the Better Payment Practice Code in 2018/19 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 2018/19: In 2018/19, we have set a challenging efficiency target of £51.5m. 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 2017/18 and include CIP reporting through the Chief Operating Officer with weekly updates to the NHS Improvement. All CIP schemes are quality and risk assessed and there is 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 which has entered phase two, and our reconfiguration scheme, both of which started in 2014/15.

Our capital programme for 2018/19 involves up to £50.4m of investment. Major schemes include:

- £27.3m for the Interim ICU projects; and
- ff£3.0m for the relocation of the East Midlands Congenital Heart Service

Signed

Chief Executive (on behalf of the Trust Board)

Date:

INSERT FULL ACCOUNTS

Looking forward to 2018/19

Our priorities for 2018/19

Safe, High Quality, Patient-Centred, Efficient Care

- To improve clinical effectiveness
- To improve patient safety
- To improve patient experience

Improve Emergency Care and Cancer Performance:

- We will eliminate all but clinical 4-hour breaches for non-admitted patients in ED
- We will resolve the problem of evening and overnight deterioration in ED performance
- We will ensure timely 7 days a week availability of medical beds for emergency admissions
- We will deliver the 62-day standard for cancer during 2018/19.

Our People

We will have the right people with the right skills in the right numbers in order to deliver the most effective care in 2018/19…

- We will develop a sustainable 5-year workforce plan by the end of Q1 2018/19, with a delivery plan to reduce our nursing and medical vacancy rates and reduce time to hire
- We will launch our People Strategy in Q1 2018/19 to attract, recruit and retain a workforce that reflects our local communities across all levels of the Trust, with a specific focus on meeting the Workforce Race Equality Standards

Education & Research

To deliver high quality, relevant education and research in 2018/19…

- We will improve the experience of our medical students and address specialty-specific shortcomings in postgraduate medical education, improving our local retention rate and our medical student satisfaction score
- We will explore the model for an Academic Health Sciences Partnership as part of our 5-year Research Strategy and align priorities with our local universities

Partnerships & Integration

To develop more integrated care in partnership with others in 2018/19…

- We will integrate the new model of care for frail people with partners in other parts of health and social care in order to deliver an end to end pathway by the end of 2018/19
- We will increase the support, education and specialist advice we offer to our patients and our partners to help them receive/deliver care in the community in order to reduce demand on our hospitals
- We will lead the development of a 5 year regional Specialist Services Strategy which will place us at the heart of a regional network and supporting local District General Hospital services

Key Strategic Enablers

To progress our key strategic enablers in 2018/19…

- We will progress our hospital reconfiguration plans by developing our plans for PACH and the maternity hospital and finalising plans to relocate Level 3 ICU and dependant services at the Royal and Glenfield
- We will make progress towards a paperless hospital with user-friendly systems by replacing all computers over 5 years old, computerising services to outpatient clinics, using technology to support Quality Commitment objectives and implementing an in-house digital imaging solution in 2018/19
- We will deliver the Year 3 implementation plan for the 'UHL Way' to support and develop staff, (medical and non-medical) and offer tailored education programmes focussing on key areas
- We will implement Year 2 of our Commercial Strategy in order to exploit commercial opportunities available to the Trust
- We will improve the efficiency and effectiveness of our key services and our operating theatres and implement our Carter-based LLR corporate consolidation programme
- We will continue on our journey towards financial stability as a consequence of the priorities described here, aiming to deliver our financial target in 2018/19.

Quality Commitment for 2018/19

Our **Quality Commitment** has proven very successful so will remain, updated for 2018/19.

We continue with the three pillars, focussed on continuing to improve effectiveness, safety and patient experience.

One of the particular areas that we want to do better on this year is diagnostic results management, aka "acting on results".

Last year we added a new element to the Quality Commitment, **'Organisation of Care',** bringing together several aspects of operational improvement including maximising the potential of our new Emergency Department and balancing demand and capacity. For 2018/19 this has been renamed Improve Emergency Care and Cancer Performance.

Glossary of terms

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.

Admission the point at which a person begins an episode of care, e.g. arriving at an inpatient ward.

Ambulatory care is medical care provided on an outpatient basis, including diagnosis, observation, consultation, treatment, intervention, and rehabilitation services. This care can include advanced medical technology and procedures even when provided outside of hospitals.

A&E (Accident & Emergency) see Emergency Department.

Board Assurance Framework (BAF) is a key mechanism which Trust Boards should be using to reinforce strategic focus and better management of risk.

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.)

Commissioner is responsible for getting the best possible health outcomes for the local population. This involves assessing local needs, deciding priorities and strategies, and then buying services on behalf of the population from providers such as hospitals, clinics, community health bodies, 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.

CQUIN stands for commissioning for quality and innovation. The system was introduced in 2009 to make a proportion of healthcare providers' income conditional on demonstrating improvements in quality and innovation in specified areas of patient care. This means that a proportion of our income depends on achieving quality improvement and innovation goals, agreed between the Trust and its commissioners. The key aim of the CQUIN framework is to secure improvements in the quality of services and better outcomes for patients, a principle fully supported at all levels of the hospital.

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).

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 England leads the NHS in England. They set the priorities and direction of the NHS and encourage and inform the national debate to improve health and care.

NHS Improvement is responsible for overseeing foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care. We offer the support these providers need to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable. By holding providers to account and, where necessary, intervening, we help the NHS to meet its short-term challenges and secure its future.

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.

Urgent Care Centre is a category of walk-in clinic focused on the delivery of ambulatory care in a dedicated medical facility outside of a traditional emergency department. Urgent care centres primarily treat injuries or illnesses requiring immediate care, but not serious enough to require an emergency department visit. Urgent care centres are distinguished from similar ambulatory healthcare centres such as emergency departments and walk in centres by their scope of conditions treated and available facilities on-site.

Walk-in-Centre (WiC) is a medical centre offering free and fast access to health-care advice and treatment. Centres provide advice and treatment for minor injuries and illnesses and guidance on how to use NHS services.

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

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 2018**.

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	

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 2018/19 annual report is available? If so, please send us 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 or communications@uhl-tr.nhs.uk