University Hospitals of Leicester NHS
NHS Trust

Cover report to the Trust Board meeting to be held on 6 June 2019

	Trust Board Paper L revised
Report Title:	**Quality and Outcomes Committee – Committee Chair's Report** (formal Minutes will be presented to the next Trust Board meeting)
Author:	Stephen Ward – Director of Corporate and Legal Affairs

Reporting Committee:	**Quality and Outcomes Committee**
Chaired by:	Col (Ret'd) Ian Crowe–Non-Executive Director
Lead Executive Director(s):	Carolyn Fox – Chief Nurse Andrew Furlong – Medical Director
Date of meeting:	30 May 2019

Summary of key public matters considered by the Committee and any related decisions made:

This report provides a summary of the key issues considered at the Quality and Outcomes Committee on 30 May 2019:

RECOMMENDED ITEMS

- **UHL Quality Account 2018/19** – the Committee received paper C, enclosing the final version of the UHL Quality Account 2018/19. The document had been updated from the first draft version seen by the Committee in March 2019 to include year-end data, and incorporate stakeholder feedback (included at section 5.1 of the document). External Audit's ('limited assurance') opinion on the Quality Account was included at section 5.2. External Audit had confirmed that the Quality Account had been prepared in line with the relevant Regulations, but had made a recommendation in relation to the Venous Thromboembolism (VTE) indicator as, via testing, it had been established that the Trust had reported an outcome that reflected a lower performance than actually achieved during the reporting period. Management had accepted the recommendation for improvement and it was noted that the Trust was in the process of implementing electronic VTE risk assessments in 2019/20. In the interim, the Trust would undertake periodic sample checking of cases to ensure that Patient Centre accurately reflected the VTE risk assessments recorded in patients' notes.

  The Committee endorsed the Quality Account 2018/19 (appended to this summary) and recommended it for adoption by the Trust Board: upon adoption, it was noted that the Quality Account 2018/19 would be placed on NHS Choices by 30th June 2019, as required.

- **Mortality Report** – the Committee received paper E, the latest quarterly mortality report including, at appendix 1, the UHL mortality rates slide deck and, at appendix 2, details of learning from the deaths of patients in the Trust's care during 2018/19. The Committee noted:

  - UHL's crude mortality rate for the 2018/19 financial year was 1.1%, slightly lower than in 2017/18; whilst the usual seasonal increases in mortality in December and January had been experienced, both months were below the previous year's figures;
  - UHL's latest published Standardised Hospital Mortality Index (SHMI) was 99, covering the period January to December 2018 – within the expected range;
  - those diagnosis groups with a SHMI above 100 which were most contributing to the Trust-level SHMI, as identified in paper E,
  - UHL's SHMI by hospital site: NHS Digital was now publishing 'hospital-site SHMIs'. It was noted that there would often be differences between sites for various reasons, and NHS Digital had stated, *"the range of SHMI values is considerably greater at site level than at Trust level. There are several factors which contribute to this. These include some sites having particular specialisms and service models (for example dialysis, maternity and end of life care) and also some inconsistencies in how Trusts have defined their 'site'";*
  - the Medical Director's commentary on the learning from deaths work undertaken via:
    - the Medical Examiner Process, in collaboration with Bereavement Services,
    - Specialty Mortality and Morbidity meetings, and the Structured Judgement Review Process,
    - The Bereavement Support Service,
    - the serious incident reporting and investigation process;

- that, in 2018/19, three adult deaths and one neonatal death had been considered by the Specialty Mortality and Morbidity meeting process to be more likely than not due to problems in care: each death had been reviewed by the Patient Safety Team, and three had been investigated as a serious incident. Details of the learning and actions arising from the investigations were included in paper E, and it was noted that monitoring of agreed actions would be undertaken by the Adverse Events Committee;
- the work of two task and finish groups, established since the last quarterly report, examining (1) inter-site hospital transfers and (2) the Acute Abdomen Pathway, respectively;
- work undertaken to review all perinatal deaths, as set out in paragraph 4.4 of the report;
- that a presentation on end of life care would be made at a future Trust Board Thinking Day, building on the information presented at a recent 'Dying Matters' conference.

QOC commended the latest quarterly mortality report, appended to this summary, to the Trust Board for adoption.

RESOLVED ITEMS

- **Outpatient Transformation – Progress Report** – the Outpatient Transformation Manager presented paper D, updating QOC on the Outpatient Transformation Programme, noting the significant progress achieved over the past six months and highlighting, in particular:

  - delivery of the two way text reminder service across 92% of eligible outpatient clinics;
  - reduction in non-attendance (DNA) rates from 8.05% to 6.74%;
  - delivery of cost improvements of £963,000, against a target of £990,000 in 2018/19;
  - work undertaken to establish a formal customer care training programme: formal launch would take place as part of implementing the Quality Strategy, and having regard to the results of the Leadership Behaviours survey;
  - launch of the 'Referral Support System' (RSS) in Leicester, Leicestershire and Rutland for musculo-skeletal conditions, and dermatology;
  - the roll-out (above target) of the 'Advice and Guidance' process, which would continue.

  QOC welcomed the progress being made, taking particular assurance from the significant extension of the work programme beyond the initial specialties.

  QOC noted the updated 2019/20 outpatient transformation programme, as set out in paper D, while urging the Outpatient Transformation Manager to continue to give consideration to the possibility of UHL adopting a fundamentally different outpatient model, appropriately informed by external advice, in order to maximise patient experience.

  The Committee Chair welcomed the development of a single performance dashboard for 2019/20 to support performance improvement and requested that (a) waiting times in clinic, and (b) hospital cancellations feature prominently in the dashboard to ensure that there was a focus on improving performance in respect of these two indicators which had significant implications for patients' experience.

- **Oral and Maxillofacial Surgery Services – Update on patient contact process** – the Medical Director presented paper F, updating the Committee on the Trust's receipt of a further external review report and the results of that external review. Further patient contact was now in hand, and an update report would be submitted to the public meeting of the Trust Board in July 2019.

- **Freedom to Speak Up – Update: Quarter 4 2018/19** – the Freedom to Speak Up Guardian introduced paper H, the latest quarterly update on concerns raised by staff via the various reporting routes. QOC noted that the Freedom to Speak Up Guardian was due to meet with the Chief Executive during week commencing 3rd June 2019 to discuss how best to ensure that feedback was provided to staff on concerns raised, learning and actions implemented in response to staff speaking up, and QOC agreed that the outcome of those discussions should be incorporated into the Guardian's 2018/19 Annual Report to be presented at the July 2019 Trust Board meeting. QOC noted that the Freedom to Speak Up Guardian was in discussions with the Director of People and Organisational Development on the possibility of revising the Trust's Grievance Policy to become a 'Resolution Policy' (replicating practice from another Trust) and agreed that the outcome of the discussions be reported to a future meeting of the People, Process and Performance Committee.

- **Leicester Maternity Service – Safer Maternity Care: Update** – the Head of Midwifery introduced paper I, briefing the Committee on the actions taken, and planned, by the Trust's Maternity Service in response to a variety of national initiatives which, in total, aimed to improve the safety of maternity care. QOC noted that a report examining maternity care provided at Shrewsbury and Telford NHS Trust would be published shortly, and noted that it would be appropriate for the Trust to review the findings of that report, undertake a gap analysis and

develop an overarching Maternity Improvement Plan. The Chief Nurse confirmed that, going forward, there would be quarterly reports submitted to both the Executive Quality and Performance Board and QOC on Maternity Services, and this was welcomed by the Committee.

QOC noted that the Trust's application to NHS Resolution in relation to year 2 of the 'Maternity Incentive Scheme' would be the subject of report to both the Executive Quality and Performance Board and QOC in July 2019, ahead of review by the Trust Board at its August 2019 meeting, in time for submission of the application by the deadline of 15th August 2019.

QOC welcomed the report and drew assurance from the fact that the Trust's Maternity Service was engaged fully with the national maternity safety strategy, committed to improving safety and had made good progress in implementing transformational change.

- **Monthly Highlight Report from the Director of Safety and Risk – May 2019** – the Director of Safety and Risk presented paper G, highlighting (a) the new primary care concerns process; the proposed safety key performance indicators for the 2019/20 quality and performance dashboard; and gaps in some basic elements of care which had been identified following a recent analysis of incidents and complaints, followed up by specific safety walkabouts.

  QOC noted the new primary care concerns process; endorsed the proposed safety key performance indicators for 2019/20; and noted that, at the Executive Quality Board on 7th May 2019, Clinical Management Groups had been requested to address the issues identified concerning basic elements of care at their next Quality and Safety Board meetings.

- **Nursing and Midwifery Safer Staffing Report – March 2019** – presented in the new format, the report provided triangulated information relating to nursing and midwifery quality of care and safe staffing, and highlighted those wards triggering a level 3, 2 or 1 concern in the judgement of the Chief Nurse and Corporate Nursing Team. In March 2019, one ward had triggered a level 3 concern (two fewer than February). Seven wards had triggered a level 2 concern (one more than February), with 15 wards triggering a level 1 concern (eight fewer than February). The vacancy position had slightly improved, but UHL was running below the national average for Registered Nurse/Midwifery care hours (care hours per patient day – CHPPD), partly because of the additional ward capacity which remained open.

- **Care Quality Commission – Update** – the Chief Nurse reported orally and briefed QOC on a range of activities in hand to ensure that the Trust was prepared for the next CQC inspection. QOC welcomed the support of NHS Improvement who were working with the Trust in reviewing Clinical Management Group governance, systems and processes; and in developmental work more generally, including conducting a focus group with the Chairman and Non-Executive Directors on 4th July 2019.

- **Items for Noting** – QOC received and noted the following reports:

  - Learning from Claims and Inquests – quarterly report,
  - Quality Commitment 2018/19 – quarter 4 performance,
  - Getting It Right First Time reports: Hospital Dentistry, Orthopaedics and Renal Medicines,
  - New Interventional Procedures Authorising Group – Annual Report 2018/19,
  - Clinical Audit quarterly report – quarter 4 2018/19,
  - Executive Quality Board – actions from 7th May 2019,
  - Executive Performance Board – action notes from 23rd April 2019.

Matters requiring public Trust Board consideration and/or approval:

Recommendations for approval: -

1. Quality Account 2018/19
2. Mortality Report

Items highlighted to the public Trust Board for information:

1. None

Matters referred to other Committees:

1. Potential revision of the Trust's Grievance Policy to become a 'Resolution Policy' referred for report by the Director of People and Organisational Development to a future meeting of the People, Process and Performance Committee.

Date of next meeting:	27 June 2019

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Quality Account 2018/2019

University Hospitals of Leicester NHS Trust

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1. Introduction from the Chief Executive

I am delighted to introduce to you our Quality Account and Quality Report for the University Hospitals of Leicester NHS Trust (Leicester's Hospitals) for 2018/19. Within an exceptionally challenging financial environment, we remain committed to focusing our resources and actions to providing safe services and the very highest of care for our patients and this report is an outline of our achievements and successes against our quality priorities over the past 12 months.

In our Annual Report I summarise the key features of the year so I will focus here on our core efforts to improve the quality of the care we offer to our patients. This has very much been based around our well-established Quality Commitment approach, which has helped us to achieve marked improvements in outcomes, safety and patient experience since its inception some six years ago. I am very pleased, not to say excited, that we will now be taking this to the next level with our comprehensive Quality Strategy, "Becoming the Best", which is described in Section 3 of this report.

Winter: Overall, our winter plan worked better than in recent years, with good attention to detail and more capacity. This was despite very significant increases in demand e.g. a 10.6 per cent increase in emergency attendances in February 2019 compared to February 2018. Our performance on ambulance handovers was also much improved but not always where we would want it to be.

Part of our winter plan was to open some additional capacity to help with bed pressures. We opened two wards at the Royal infirmary and a ward at the Glenfield and while we plan to decrease the additional bed capacity over the summer months we will be keeping one ward open for medicine at the Royal Infirmary throughout the year and then flexing up additional capacity for winter again.

Cancer care: We clearly have more to do to improve the care for cancer patients, and we know the services where we see the most challenge and are working with them to decrease the number of steps in patients pathways to ensure that patients are diagnosed and treated as quickly as possible. We have also seen great progress in the Living with and beyond Cancer team who play such an essential role to our patients and their families in providing support and education. We remain proud of our increased focus and achievements in cancer care and are committed to doing more in 2019/20.

Electives – We have made positive strides throughout the year for patients waiting for planned treatment. The central target was to meet national planning guidance and have a waiting list size at the end of March 2019 that was less than March 2018. Following final validation, we have managed to achieve this with over 200 fewer patients on the waiting list for planned care.

Key to achieving this were positive changes to the cancellations policy, including a more robust escalation process and protecting planned operations for long waiting patients. Over the course of the year, 117 fewer patients were cancelled on the day for non-clinical reasons and 1,371 fewer patients cancelled prior to the day of their operation. This allowed us to reduce the number of patients waiting more than 18 weeks for planned treatment by 542 in 12 months - working with the independent sector this year has helped with that progress. As demand rises, the challenge for us remains to have the available capacity to treat these patients.

Over the winter of 2018/19 we maintained more elective care than in 2017/18. As a result we were able to avoid any patients waiting over 52 weeks since July 2018. This remains a key quality standard nationally, and will remain priority for us throughout 2019/20.

Never Events: NHS Improvement defines Never Events as serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented, although a recent CQC report suggests that system issues and human factors are the principle reasons for their occurrence. In 2018/19, we reported eight incidents (the same number as in 2017/18) which met the definition of a Never Event.

We thoroughly investigate each event to understand exactly what happened and we review national Healthcare Safety Investigation Branch reports to understand the wider system issues. Every Never Event is discussed at our monthly Chief Executive's Briefings and we provide an action plan and learning bulletin for each event. Patients and / or their families were informed of the subsequent investigations and involved throughout the process and learning is shared with staff. We share the learning from these incidents locally, regionally and nationally and have also heard the patient's story of such an event at the public Trust Board meeting.

We continue to see a good track record of staff reporting incidents and pleasingly the trend of serious incidents is down.

SHMI: In March the latest published SHMI mortality data (from October 2017 to September 2018) was published. 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.

Our SHMI is currently at 99, which is within the expected threshold. We have continued to review pathways of care for any patient or diagnostic groups with a SHMI above 100 in order to identify any areas for learning or improvement as part of our Quality Commitment programme. We have also made excellent progress with implementing our Learning from Deaths programme and specifically our Medical Examiner process which will become a national requirement from 1st April 2019.

Success for patients with a broken hip: A clear success this year, and a marked improvement for our patients, is the work around improving the speed in which we treat patients with a broken hip - Fractured Neck of Femur, also called #NOF.

In June 2018 our #NOF service was labelled as failing due to inconsistency in the way we treated that group of patients and our inability to get more than 72% of these patients operated on within the first 36 hours. There is national evidence that the sooner a patient is treated the better the outcome and the greater the delay, the greater the mortality and morbidity. The target is 72% as a proportion of patients will not be fit for surgery in that timeframe.

We knew we needed a different approach so brought together key clinical leads from all of the specialties involved in the care of these patients and between them they developed a new approach to care. Fundamental to this was the message that these patients should be treated as emergencies moving concentration away from the '36 hour target'. The team reorganised existing resources and developed capacity.

The outcome is that in the eight months from August 2018 to March 2019 we have consistently been above 72% - with a year to date average of 74.6% (target 72%). Thus group of patients are being operated on in a more timely way which means they can mobilise more quickly and go home sooner.

Research and Innovation: We are offering more patients opportunities to be the first to try new treatments and care pathways, with over 14,000 participants taking part in research in 2018/19, an increase of 22 per cent on the previous year. Our research programmes continue to impact local, national and international guidelines for evidence-based practice. This year we led a global consensus on how to best manage hyperglycaemia in type 2 diabetes, and have demonstrated

that mass screening of women for abdominal aortic aneurysms is not a cost-effective measure to identify those at risk.

Medical Education: This year has seen significant improvements in our medical education and training. Our recent bi-annual survey revealed that 88.6 per cent of junior doctors would recommend their current post to a colleague. In response to a survey of junior doctor morale, a Listening into Action programme to improve junior doctors working lives has delivered improvements in post-shift rest facilities, information on raising concerns and 100 additional parking passes. We have appointed lead junior doctors who work less than full time and those returning to work after a prolonged will improve induction, support networks and training opportunities over the next 12 months.
Student approval ratings have risen too following the successful implementation of the new undergraduate curriculum and more medical students are now choosing to stay and work locally for their Foundation training.

This year we introduced our Educators Awards to recognise the excellent standard of teaching within our organisation by senior and junior medical staff and a successful cross-specialty Grand Round Meeting. In November we recruited a Communications Officer for Medical Education to improve recruitment and retention of junior doctors and we are now effectively communicating topical information about our medical training through our website and social media channels. For 2019/20 we have developed a new Medical Education Strategy to sustain and build upon the improvements we have already made.

Moving into 2019/20: We start the new financial year with building work already underway at the Glenfield and the Royal. From a quality perspective, this is part of key changes that are designed to ensure the future sustainability, and thus quality, of our clinical services. At the Glenfield the expansion to our Intensive Care Unit has started which will create an additional 11 beds so we can better treat those patients who need life-saving care. We are also building three new surgical wards for Hepato-biliary and Transplant services and creating a new Interventional Radiology department. At the Royal we have started the refurbishment of three of our existing wards, creating a new ambulatory and emergency General Surgery Unit and colorectal ward. Later on this year work will begin to redevelop part of the Kensington Building to move the East Midlands Congenital Heart Centre from the Glenfield. These improvements will improve the environment and experience, not just for our patients and visitors, but also our staff.

I hope this Quality Account provides you with a clear picture of how important quality improvement and patient safety are to us at Leicester's Hospitals.

To the best of my knowledge and belief the Trust has properly discharged its responsibilities for the quality and safety of care, and that the information presented in this Quality Account is accurate.

John Adler, Chief Executive

2. Review of quality performance in 2018/19

2.1 Our aims for 2018/19

Last year we set the following priorities for 2018/19:

- To improve patient outcomes by greater use of key clinical systems and care pathways
- To reduce harm by embedding a 'Safety Culture'
- To use patient feedback to drive improvements to services and care

2.2 Review of last year's Quality Commitment priorities

We said we would:

Improve patient outcomes by greater use of key clinical systems and care pathways

In 2018/19 we:

- Continued to embed the use of our electronic clinical information system Nervecentre for clinical handovers, in board rounds and ward rounds and in the escalation of clinical care
- Ensured that senior clinician led daily rounds (board rounds and ward rounds) take place daily in all clinical areas
- Embedded our Red2Green processes (Red2Green is a process for minimising both internal and external delays for patients)
- Ensured that our frail patients have a Clinical Frailty Score (a score which can identify whether a person in likely to be fit or living with mild, moderate or severe frailty)

Results: (as at quarter 3)

- Clinical Management Groups (CMGs) report that:
  - Red2Green processes are followed in 90% of applicable clinical areas across Leicester's Hospitals
  - Senior clinician led daily rounds take place in 80% of clinical areas across Leicester's Hospitals
- We have embedded the use of a Clinical Frailty Score in our Emergency Department

Further improvements we need to make are:

- Rolling out the use of the Clinical Frailty Score throughout the rest of Leicester's Hospitals
- Continuing to embed senior clinical daily rounds across Leicester's Hospitals

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We said we would:

Reduce harm by embedding a 'Safety Culture'

In 2018/19 we:

- Developed our electronic patient information systems to enable clinical staff to view and act on patient diagnostic results in a timely way
- Provided training and education to empower our staff to 'Stop the Line' in clinical areas (an approach that allows staff to "Stop the Line" if they see something unsafe)
- Improved the management of diabetic patients who are being treated with insulin, through better staff education and training, systems and process and information management technology

Results:

- 8 Never Events (compared to 8 Never Events in 2017/18)
- 2,684 staff have been trained in 'Stop the Line'
- 80% of nursing and midwifery staff and 62% of medical staff have undertaken insulin safety training
- Achieved a 50% reduction in the number of patient who experience an insulin error (prescribing or management) 27.2% by Q4 of 2018/19

Further improvements we need to make are:

- Rolling out the mobile version of ICE (an electronic requesting and ordering communications system) across Leicester's Hospitals
- Continuing to reduce the number of Never Events (serious incidents that are largely preventable)
- Ensuring that 95% of both our nursing and midwifery staff and our medical staff have undertaken insulin safety training
- Continuing to reduce the number of patients experiencing an insulin error (prescribing or management)
- Continuing with 'Stop the Line' training and develop 'Stop the Line' videos
- Continuing to adapt and implement safer surgery checklists across our clinical specialities

We said we would:

Use patient feedback to drive improvements to services and care

In 2018/19 we:

- Improved patient experience in our outpatient service and transformed outpatient models of care in ENT & Cardiology
- Actively involved end of life care patients and their families in decision making about their care

Results:

- Consistently achieved 95% positive Friends and Family test results in outpatients
- Although Leicester's Hospitals saw an overall increase of 1.7% in outpatient follow-up attendances in 2018/19, 29 specialities achieved a 20% reduction in follow-ups or a reduction of 100 or more attendances
- Reduced the number of hospital cancellations in ENT outpatients clinics by 25%
- The number of end of life care patients who have moved wards three or more times during their last hospital stay remained static between 2017/18 and 2018/19
- Developed a GREAT discharge podcast and lanyards for junior doctors

Further improvements we need to make are:

- Continuing to reduce the number of end of life patients who move wards three or more times during their last inpatient spell prior to death
- Continuing to implement GREAT discharges (improving end of life care discharge communication between Leicester's Hospitals and GPs)
- Continue to make improvements to patient experience in our outpatients services

2.3 Patient Safety Improvement Plan

'Sign up to Safety' campaign

In September 2014 Leicester's Hospitals signed up to the national 'Sign Up to Safety' campaign. The aim of the campaign was to strengthen patient safety in the NHS and make it the safest healthcare system in the world.

Although this campaign comes to an end in March 2019, we have pledged to continue this work by including our patient safety improvement plan within our quality improvement plans for 2019/20.

As part of this continued improvement, we will:

- 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 2017/18 our 'Sign up to Safety' safety improvement priorities were aimed at improving the recognition, escalation and on-going management of the deteriorating patient. In 2018/19, as part of the continuation of the 'Sign up to Safety' campaign we:

- Embedded a team with the emergency department, dedicated to the recognition and management of sepsis. This team continues to provide training and support to both the emergency department and across all three sites
- Used the "The Little Voice Inside" obstetric training package (TED) to share best practice and improve patient safety.
- Continued to develop our patient safety portal, responding to feedback and the learning needs of our stakeholders

- Continued to monitor and disseminate the human factors and ergonomics e-learning modules. These provide a more in-depth understanding of human factors and the part this plays in adverse events

- Embedded the roll-out of electronic observations across all specialities, whilst also implementing new clinical pathways and observation tools

Duty of Candour

On 1st April 2015 the statutory Duty of Candour (Regulation 20 Health and Social Care Act 2008) regulated by the Care Quality Commission, came into force for all health care providers.

The intention of the regulation is to ensure that providers are open and transparent in relation to care and treatment provided. It also sets out specific requirements to ensure patients and their families are told about 'notifiable patient safety' incidents that affect them. Patients and their families receive an explanation and an apology person to person. This is then followed up in writing and documented in the patient's records. Patients and / or their carers are kept informed of any further investigations / actions if and as appropriate.

To help staff understand the duty of candour requirements we have:

- Added a short training video and letter guidance to our hospital intranet

- Further updated and improved our duty of candour (being open) policy

- Included duty of candour training in all of our patient safety training

- Improved our level of compliance, by adding a mandatory duty of candour prompt on our incident management system so that when incidents are reported staff are encouraged to record the relevant information and take the appropriate action

- Increased our compliance with copies of letters uploaded centrally as evidence of compliance

2.4 National Patient Safety Alert compliance

Patient safety alerts are issued via the Central Alerting System, a web-based cascading system for issuing patient safety risks, alerts, important public health messages and other safety critical information and guidance to the NHS and other organisations.

NHS trusts who fail to comply with the actions contained within patient safety alerts are reported in monthly data produced by NHS Improvement and published on the NHS Improvement website. Compliance rates are monitored by Clinical Commissioning Groups and the Care Quality Commission. Failure to comply with the actions in a patient safety alert results in a red status report on the NHS Choices website.

The publication of this data is designed to provide patients and their carers with greater confidence that the NHS is able to react quickly to nationally identified risks.

Within Leicester's Hospitals there is a robust accountability structure to manage patient safety alerts. Heads of Nursing take an active role in the way our Clinical Management Group manage alerts and our Executive Quality Board and Quality and Outcomes Committee provide oversight of this process. Internal assurance meetings also scrutinise Clinical Management Group performance. Any alert that fails to close within the specified deadline is reported to the Executive Quality Board and Quality and Outcomes Committee with an explanation as to why the deadline was missed and a revised timescale for completion.

We have formed a patient safety alert panel to monitor performance and to audit how the recommended actions from these alerts are applied, working closely with clinicians and managers to ensure actions are implemented within prescribed timescales wherever possible.

During 2018/19 we received nine patient safety alerts. None breached their due date.

Table 1: National patient safety alerts received during 2018/19

Title	Due date	Current Status
NHS/PSA/W/2018/002 – Warning alert Risk of death or severe harm from inadvertent intravenous administration of solid organ perfusion fluids	31/05/2018	Closed
NHS/PSA/RE/2018/003 – Resources alert Resource to support safe adoption of the revised National Early Warning Score (NEWS2)	21/06/2018	Closed
NHS/PSA/RE/2018/004 - Resources alert Resources to support safer modification of food and drink	01/04/2019	Closed
NHS/PSA/RE/2018/005 - Resources alert Resources to support safer bowel care for patients at risk of autonomic dysreflexia	25/01/2019	Closed
NHS/PSA/RE/2018/006 - Resources alert Resources to support safe and timely management of hyperkalaemia (high level of potassium in the blood)	08/05/2019	Open
NHS/PSA/2018/RE/007 – Resources alert Management of life threatening bleeds from arteriovenous fistulae and grafts	13/05/2019	Open
NHS/PSA/RE/2018/008 – Resources alert Safer temporary identification criteria for unknown or unidentified patients	05/06/2019	Open
NHS/PSA/W/2018/009 – Warning alert Risk of harm from inappropriate placement of pulse oximeter probes	18/06/2019	Open
PSA-D-2019-001 – Directive alert Wrong selection of orthopaedic fracture fixation plates	10/05/2019	Open

2.5 Never Events 2018/19

Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

In 2018/19, eight incidents occurred which met the definition of a Never Event. Thorough root cause analysis is undertaken for Never Events and robust action plans are developed to prevent a similar occurrence.

The following table gives a description of the eight Never Events, their primary root cause, the key recommendations to prevent reoccurrence and the level of patient harm. Patients and / or their families were informed of the subsequent investigations and involved throughout the process.

Table 2: Summary of Never Events during 2018/19

Never Event type	Description of incident and level of harm	Primary root cause	Recommendations
Unintentional connection of a patient requiring oxygen to an air flow meter **(April 2018)**	An adult patient in an ED emergency room (ER) was supposed to given oxygen as part of their treatment. On admission to the ER, the ambulance crew had attached the patient to the air flowmeter. **Minor Patient Harm**	Failure to fully mitigate risk of inadvertent connection by not removing air flow meters from immediate access within all areas of the Trust Human error	Remove all air flow meters from immediate access areas within all areas of the trust.
Wrong site surgery – wrong patient **(May 2018)**	Patient B attended the endoscopy unit at Hinckley Hospital, where he underwent a cystoscopy procedure. During the procedure it became apparent that Patient B was not the patient for whom a cystoscopy referral had been made. **Minor Patient Harm**	Failure to follow the correct policies and procedures for searching for a patient on HISS (one of our electronic patient information systems). There were several missed opportunities for the incident to be avoided which were the result of a combination of human and system failures.	Follow policy and procedure when searching on HISS for a patient using the NHS number and a 3 point identity check. Follow all aspects of the checking process in endoscopy when admitting a patient for cystoscopy.

Never Event type	Description of incident and level of harm	Primary root cause	Recommendations
Wrong site surgery **(June 2018)**	Patient was listed and consented for a left leg Angioplasty. It was identified that the route of the entry should be the left femoral artery in advance of the planned procedure. It became apparent from the angiogram images being viewed it became apparent that the right femoral artery had been punctured in error rather than the intended left. **No Patient Harm**	System issues predisposing to human error	Review the Interventional Radiology consent and site marking process. Patient pathway to be reviewed revised and condensed. New patient pathway documentation to be embedded into practice. Interventional Radiology team to receive Stop the Line training. Safer surgery checklist to be reviewed and revised based on Stop the Line including a multipoint check at the stop moment. New Standard Operation Procedure to be embedded.
Wrong site surgery **(June 2018)**	Patient was referred for a right leg Angioplasty but was consented for a left leg Angioplasty. In this patients case it was identified that the route of entry should be the right femoral artery in advance of the procedure. The left leg angioplasty commenced as per consent form. From the duplex scan being viewed it became apparent that the left femoral artery had been punctured in error rather than the right. **No Patient Harm**	System issues predisposing to human error	Review the Interventional Radiology consent and site marking process. Patient pathway to be reviewed revised and condensed. New patient pathway documentation to be embedded into practice. Interventional Radiology team to receive Stop the Line training. Safer surgery checklist to be reviewed and revised based on Stop the Line including a multipoint check at the stop moment. New Standard Operation Procedure to be embedded.
Wrong site surgery – wrong patient **(Sept 2018)**	Patient attended day case surgery at LGH site for a flexible cystoscopy and botox to his bladder. A full circumcision was performed on the patient instead of the intended procedure.	Human error as a result of: • Failure to act as a team in applying the principles of the Safer Surgery Checklist in the theatre	Empower staff to use 'Stop the Line' to escalate safety concerns using a common language. To further explore human factors with the theatre teams. Encourage the use of professional language and positive confirmation when giving and receiving

Never Event type	Description of incident and level of harm	Primary root cause	Recommendations
	Major Patient Harm	environment due to a lack of leadership on the day of the incident. • Failure to engage the patient in the confirmation of their identity and planned procedure as part of the safer surgery checking process. • System error as a result of the printer not being functional or networked resulting in the inability to print out a revised theatre list.	instructions. Embed the 'traffic light' reprinting process when list order changes. Modify the current check list for local anaesthetic lists to reduce repetition when it is not required. Team based training to develop the non-technical skills of team working, leadership, communication, situation awareness, task management and decision making, as well as to set standards for safe practice.
Wrong implant / prosthesis **(Nov 2018)**	Patient admitted with a fractured left neck femur, right ankle dislocation with a possible underlying fracture. Right ankle was successfully fixed and fixation was carried out on the left femur. It was identified during the procedure that a right side nail had been inserted into the left femur causing a cortical perforation. **Moderate Patient Harm**	The checking process failed due to deviation from standardised checking procedures in theatres prior to implantation.	Review the process for the returning of unused medical equipment back to stock store room. Review layout of prosthesis store taking human factors into account in any redesign. Review team input into stock management. Provide refresher "stop and pause moment" training for checking and confirming surgical items prior to prosthesis being implanted. Audit that the "stop and pause moment" process is truly imbedded within theatres. The supplier should use the correct safety alert processes in line with national requirements. All surgeons and theatre staff are alerted with regard to the shortage of supply of prostheses sizes. Alert surgeons and equipment

Never Event type	Description of incident and level of harm	Primary root cause	Recommendations
			supplier regarding “cold welding” issue experienced and request further investigation into this by the supplier. Nurses and doctors involved in the incident reflect on the case for their learning and to prevent a similar occurrence.
Wrong site surgery **(March 2019)**	Patient with longstanding spinal stenosis and leg pain was admitted for a left side root nerve block at L4/5 procedure. It was identified during the procedure that the incorrect (right) side had been injected. **No Patient Harm**	Root Cause Analysis investigation still in progress	Root Cause Analysis investigation still in progress
Wrong site surgery **(March 2019)**	Patient was admitted for a right canthopexy and a biopsy of a small lesion to the side of her right eye and biopsy of a small lesion to the side of her right eye. After successful procedures to the right eye, it was identified that the surgeon had proceeded to start a canthopexy procedure on the left eye, which was incorrect. **Moderate Patient Harm**	Root Cause Analysis investigation still in progress	Root Cause Analysis investigation still in progress

2.6 NHS Outcome Framework Indicators

Table 3: NHS Outcome Framework Indicators

NHS Outcomes Framework domain	Indicator	2017/18	2018/19	National Average	Highest Score Achieved	Lowest Score Achieved
Preventing people from dying prematurely	SHMI value and banding	95 Apr17-Mar18 Band 2	99 Oct17-Sep18 Band 2	100 Oct17-Sep18 Band 2	127 Oct17-Sep18 Band 1	69 Oct17-Sep18 Band 3
	% of admitted patients whose deaths were included in the SHMI and whose treatment included palliative care (contextual indicator)	25.3% Apr17-Mar18	27.5% Oct17-Sep18	33.8% Oct17-Sep18	59.5% Oct17-Sep18	14.3% Oct17-Sep18
Helping people to recover from episodes of ill health or following injury	Patient reported outcome scores for groin hernia surgery	NHS Digital ceased collection of data from October 2017	NHS Digital ceased collection of data from October 2017	NHS Digital ceased collection of data from October 2017	NHS Digital ceased collection of data from October 2017	NHS Digital ceased collection of data from October 2017
	Patient reported outcome scores for hip replacement surgery (Hip replacement Primary)	0.425 (341 records) EQ5D Index Apr17 – Mar18	NHS digital data not available	0.469 EQ5D Index Apr17 – Mar18	0.566 (99 records) EQ5D Index Apr17 – Mar18	0.376 (32 records) EQ5D Index Apr17 – Mar18
	Patient reported outcome scores for knee replacement surgery (Knee replacement Primary)	0.306 (487 records) EQ5D Index Apr17 – Mar18	NHS digital data not available	0.339 EQ5D Index Apr17 – Mar18	0.417 (59 records) EQ5D Index Apr17 – Mar18	0.233 (127 records) EQ5D Index Apr17 – Mar18
	Patient reported outcome scores for varicose vein surgery	NHS Digital ceased collection of data from October 2017	NHS Digital ceased collection of data from October 2017	NHS Digital ceased collection of data from October 2017	NHS Digital ceased collection of data from October 2017	NHS Digital ceased collection of data from October 2017
	% of patients <16 years old readmitted to hospital within 28 days of discharge	NHS digital data not available see alternative indicator below	NHS digital data not available see alternative indicator below	NHS digital data not available see alternative indicator below	NHS digital data not available see alternative indicator below	NHS digital data not available see alternative indicator below
	% of patients <16 years old readmitted to hospital within 30 days of discharge*	11.9% Apr17-Mar18 Source: CHKS	9.4% Apr18-Feb19 Source: CHKS	NHS digital data not available	NHS digital data not available	NHS digital data not available
	% of patients 16+ years old readmitted to hospital within 28 days of discharge	NHS digital data not available see alternative indicator below	NHS digital data not available see alternative indicator below	NHS digital data not available see alternative indicator below	NHS digital data not available see alternative indicator below	NHS digital data not available see alternative indicator below
	% of patients 16+ years old readmitted to hospital within 30 days of discharge*	9.0% Apr17-Mar18 Source: CHKS	8.7% Apr18-Feb19 Source: CHKS	NHS digital data not available	NHS digital data not available	NHS digital data not available
Ensuring that people have a positive experience of care	Responsiveness to inpatients' personal needs (Patient experience of hospital care)	67.5 Hospital stay: 01/07/2017 to 31/07/2017; Survey collected 01/08/2017 to 31/01/2018 Aug 2018 Publication	Results due Aug 2019	Results due Aug 2019	Results due Aug 2019	Results due Aug 2019
Treating and caring for people in a safe	% of staff who would recommend the provider to friends or family needing care	65% Source: National NHS Staff Survey 2017	65% Source: National NHS Staff Survey 2018	71% Source: National NHS Staff Survey 2018	87% Source: National NHS Staff Survey 2018	40% Source: National NHS Staff Survey 2018

NHS Outcomes Framework domain	Indicator	2017/18	2018/19	National Average	Highest Score Achieved	Lowest Score Achieved
environment and protecting them from avoidable harm	% of admitted patients risk-assessed for Venous Thromboembolism	94.2% Q4 2017-18 (Jan18 - Mar18) Source: NHS England	95.8% Apr18 - Mar19 Source: UHL	95.6% 2018-19 (Apr18 – Mar19) Source: NHS England	100% Q4 2017-18 (Jan18 - Mar18) Source: NHS England	67.0% Q4 2017-18 (Jan18 - Mar18) Source: NHS England
	Rate of C. difficile per 100,000 bed days	13.2 Apr17 - Mar18 Source: NHS Digital	9.9 Apr18 – Mar19 Source: UHL data	13.7 Apr17 - Mar18 Source: NHS Digital	91.0 Apr17 - Mar18 Source: NHS Digital	0.0 Apr17 - Mar18 Source: NHS Digital
	Rate of patient safety incidents per 1000 admissions (IP, OP and A&E)	46.6 Oct17 – Mar18 Source: NHS Digital	41.9 Apr18 – Mar19 Source: UHL data	21.4 Oct17 - Mar18 Source: NHS Digital	124 Oct17 - Mar18 Source: NHS Digital	0.0 Oct17 - Mar18 Source: NHS Digital
	% of patient safety incidents reported that resulted in severe harm	0.1% Apr17 – Sep17 Source: NHS Digital	0.1% Oct17 - Mar18 Source: NHS Digital	0.4% Oct17 - Mar18 Source: NHS Digital	1.5% Oct17 - Mar18 Source: NHS Digital	0.0% Oct17 - Mar18 Source: NHS Digital

*NHS Digital data out of date so alternative national indicator used (30 days readmissions).

Where NHS Digital data is unavailable, alternative data sources (specified) have been used.

Preventing people from dying prematurely

Summary Hospital Level Mortality Indicator (SHMI)

The Summary Hospital Level Mortality Indicator (SHMI) is a measure of mortality developed by the Department of Health. It compares our actual number of deaths with our predicted number of deaths.

For the period October 2017 to September 2018, Leicester's Hospitals SHMI was 99. This is in line with the national average.

The University Hospitals of Leicester NHS Trust considers that this data is as described for the following reason:

Our patient deaths data is submitted to the Secondary Uses Service and is linked to data from the Office for National Statistics death registrations in order to capture deaths which occur outside of hospital.

The University Hospitals of Leicester NHS Trust intends to taken the following action to reduce mortality and so improve the quality of its services, by:

- Implementation of our Quality Strategy priorities
- Sustained use of e-Obs and sepsis clinical rules in Nervecentre (our clinical information system) to support earlier recognition of sepsis
- Implementation of the Acute Kidney Injury Alert and Care Bundle and Fluid Balance Assessment and Care Bundle in Nervecentre
- Development of a Cardiology Decision tool and care bundle within Nervecentre
- Embedding the use of the customised centile GROW charts and a fetal growth guideline both of which support detection of fetal growth restriction.
- Further development to improve the pathway for patients admitted for cardiac surgery
- Development and implementation of an 'acute abdomen pathway'
- Improving our processes for transferring patients between our hospitals

As part of our mortality monitoring and investigations, we continue to make use of our Medical Examiners. At the end of April 2019 our Medical Examiners had screened over 3,000 adult patient records (over 96% of all adult deaths between April 18 and March 19). 10% of these records were referred for a Structured Judgement Review as part of the Specialty Mortality and Morbidity process and 12% were referred for clinical review by the patient's clinical team for learning and actions.

Helping people to recover from episodes of ill health or following injury

Patient reported outcome scores

Patient reported outcome measure (PROM) is a series of questions that patients are asked in order to gauge their views on their own health. NHS England undertook a consultation on the national PROMs programme in 2016. As a result

of the findings of that consultation, NHS England took the decision to discontinue the mandatory varicose vein surgery and groin-hernia surgery national PROM collections.

NHS England are continuing with hip and knee surgery PROM collections and are working with NHS Digital to make the national data on them easier to use and to provide a range of automated outputs that are tailored to the needs of trusts, CCGs and other users.

In the examples of knee replacement and hip replacement surgery, patients are asked to score their health before and after surgery. We are then able to understand whether patients see a 'health gain' following surgery. Participation rates and outcome data is published by NHS Digital.

The University Hospitals of Leicester NHS Trust considers that this data is as described for the following reasons:

The latest released PROM's report 'Provisional April 2017 – March 2018' showed a slight increase in patients reporting a worsened pain score post-surgery: '0.2% increase in knee replacement and 0.6% increase in hip replacement'. Within both pre and post op surveys UHL is reporting within a 1% margin from the English average score.

The slight rise within the post-operative pain score has been reviewed by the relevant clinical teams, who are happy that nothing clinically has changed which would contribute to the slight variation. In 2017/18 NHSE initiated elective pause during the winter pressures of 2017/18. This was to support the national emergency pressures felt across the NHS where unprecedented levels of emergency demand were being felt. The resulting elective pause resulted in non-urgent non-cancer planned elective surgery being cancelled which impacted on the number of hip and knee procedures being performed. Due to the smaller number of patients being operated on through, each individual negative result would cause a greater impact on the overall percentage.

The Trust's participation rate for pre-operative questionnaire was 91.0% compared with the national average of 84.2%.

The response rate for post-operative questionnaires was 71.2% compared with the national average of 66.4%.

The University Hospitals of Leicester NHS trust intends to take the following actions to improve the quality of its services:

Leicester's Hospitals will continue to collect PROMs data to help inform future service provision.

The percentage of patients readmitted to hospital within 28 days of discharge

Data for the percentage of patients readmitted to hospital within 28 days of discharge is not available on NHS Digital. Leicester's Hospitals monitors its readmissions within 30 days of discharge.

The data describing the percentage of patients readmitted to hospital within 30 days of discharge is split into two categories: percentage of patients under 16 years old and percentage of patients 16 years and older. This data is collected so that Leicester's Hospitals can understand how many patients that are discharged from hospital, return within one month. This can highlight areas where discharge planning needs to be improved and where Leicester's Hospitals need to work more closely with community providers to ensure patients do not need to return to hospital.

The University Hospitals of Leicester NHS Trust considers that this data is as described for the following reasons:

Data shows that the overall Trust level readmission rate has reduced despite an increase in emergency activity across the Trust.

The University Hospitals of Leicester NHS trust intends to take the following actions to improve the quality of its services:

- Improving communications with GP practices so that they can do more effective patient follow up work
- Working more closely with care homes, including a pharmacist review of any patient discharged with more than eight medicines
- Targeting key areas, including respiratory, to ensure patients with multiple readmissions are flagged for community review by specialist teams
- Readmission/discharge lead identified to work on pilot on Clinical Decisions Unit to prevent multiple admissions/readmissions by frequent attenders
- Making better use of Nervecentre, our electronic clinical information system, to record patients reasons for readmission

- Actively using the developed Standard Operating Procedure for managing patients at high risk of readmission within 30 days (using the PARR30 model)

Ensuring people have a positive experience of care

Responsiveness to inpatients personal needs

Based on the Care Quality Commission national inpatient survey, this indicator provides a measure of quality. A 'composite' score is based on five questions:

- Were you involved as much as you wanted to be in decisions about your care and treatment?
- Did you find someone on the hospital staff to talk to about your worries and fears?
- Were you given enough privacy when discussing your condition or treatment?
- Did a member of staff tell you about medication side effects to watch for when you went home?
- Did hospital staff tell you who to contact if you were worried about your condition after you left hospital?

The University Hospitals of Leicester NHS Trust considers that this data is as described for the following reasons:

The results for the national inpatient survey published in June 2018 show a slight increase of 0.1, from 6.7 to 6.8 in the composite score for these five questions.

The question "were you involved as much as you wanted to be in decisions about your care and treatment" has improved from 6.8 to 7.2, an increase of 0.4.

The University Hospitals of Leicester NHS trust intends to take the following actions to improve the quality of its services:

- The elements of care that matter most to patients will continue to be our focus

- Leicester's Hospitals will continue to actively seek feedback from patients, carers and family members detailing their experience of care while in Leicester's Hospitals

- Clinical teams will be encouraged and supported in reviewing and responding to feedback received, to improve the experience of patients and families in their care

- "Patient Feedback Driving Excellence" boards will be displayed in clinical areas, detailing any improvements that have been made in response to feedback received

- A monthly bulletin will continue to be produced, showcasing excellent work that has taken place on the inpatient wards and outpatient clinics in response to feedback. The bulletin is circulated throughout the Trust, to share the work as a tool to drive improvements in other areas

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

Percentage of staff who would recommend the provider to friends or family needing care

The NHS staff survey is one of the largest workforce surveys in the world and has been conducted every year since 2003. It asks NHS staff in England about their experiences of working for their respective NHS organisations.

The University Hospitals of Leicester NHS Trust considers that this data is as described for the following reasons:

- The NHS staff survey asks respondents whether they strongly agree, agree, disagree or strongly disagree with the following statement: "If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation"

- The results for this element of the NHS staff survey (65% or respondents said they would be happy with the standard of care) remains unchanged from the previous (2017) NHS staff survey

The University Hospitals of Leicester NHS Trust intends to take the following actions to improve this and so the quality of its services:

- To make more progress Leicester's Hospitals need to do something different. One of the most important aspects of this is having the right culture which is powered by the right leadership behaviours. This will be at the heart of our quality strategy

Venous thromboembolism (VTE)

Assessing inpatients to identify those at increased risk of venous thromboembolism (VTE) is important to help to reduce hospital associated VTE. We work hard to ensure that not only are our patients risk assessed promptly but that any indicated thromboprophylaxis is given reliably.

The University Hospitals of Leicester considers that this data is as described for the following reasons:

- Matrons and lead nurses undertake a monthly review of VTE occurrence as part of the safety thermometer

- VTE risk assessment rates are reviewed by Leicester's Hospitals Thrombosis Prevention Committee and in our Quality and Performance Report presented to the Quality and Outcomes Committee.

The University Hospitals of Leicester has taken the following actions to improve this and so the quality of its services:

- Provided VTE risk assessment rate data to clinical areas and presented to the Thrombosis Prevention Committee and Clinical Quality Review Group to highlight where changes to clinical practice where required

- Provided pharmacological and / or mechanical thromboprophylaxis to eligible patients

- Carried out root cause analysis from case notes and electronic patient information systems for all inpatients who experience a potentially hospital associated VTE during their admission or up to 90 days following discharge

- Developed VTE risk assessment modules within existing electronic clinical information systems. This will enable closer scrutiny of our performance against NICE guidance and allow real time audit of compliance with this patient safety indicator

Clostridium Difficile (CDiff)

CDiff is a bacterial infection which can be identified in patients who are staying in hospital.

The University Hospitals of Leicester NHS Trust considers that this data is as described for the following reasons:

- Clostridium difficile numbers are collected as part of alert organism surveillance. Numbers are reported to and collated by Public Health England on behalf of the NHS

- A weekly data set of alert organism surveillance is produced by the infection prevention team within Leicester's Hospital and disseminated widely throughout the organisation

The University Hospitals of Leicester has taken the following actions to improve this and so the quality of its services:

- The weekly data set is used to inform clinical governance and assurance meetings that take place. Clinical teams are then able to direct the focus of actions and interventions to continue to ensure that infection numbers are as low as possible

Patient safety incidents

A patient safety incident is an unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care.

The University Hospitals of Leicester NHS Trust considers that this data is as described for the following reasons:

- Patient safety incidents are captured on Leicester's Hospitals patient safety incident reporting system, Datix and are also reported to through the National Reporting and Learning System (NRLS)

- Moderate, major and death harm incidents are validated by the corporate patient safety team and this process is subject to external audit

- Themes and trends are reported monthly and quarterly to provide a local and national picture of patient safety incidents

- Our top three reported incidents are pressure sores, slips / trips / falls and incidents relating to the monitoring of patients

The University Hospitals of Leicester NHS Trust has taken the following action to improve the percentage of harm incidents by:

- Having a clear focus on the issues that have caused the most harm to patients as a key priority within the safety element of our quality commitment
- Actively encourage a culture of open reporting and widespread sharing of learning from incidents to improve patient safety
- Being open and transparent about our safety work, our incidents and our actions for improvement
- Undertaking a structured programme of work to ensure that we learn and improve and we will continue to work with NHS Improvement, the Healthcare Safety Investigation Branch and other groups to maximise our efforts
- Focusing on culture and leadership as well as supporting national, system-wide barriers to reducing harm events

2.7 Learning from deaths

During 2018/19, 3,340 patients were part of the Learning from Deaths process within Leicester's Hospitals, as follows:

Table 4: Number of deaths reviewed in the Learning from Deaths process in 2018/19

Time period	Number of deaths
April 2018 to end March 2019	3,340
Q1	826
Q2	762
Q3	833
Q4	919

By the end of April 2019, 296 case record reviews and 10 investigations were carried out in relation to the 3,340 deaths. In seven cases, a death was subject to both a case record review and an investigation.

Table 5: Number of case record reviews during 2018/19

Time period of death	Deaths Reviewed or Investigated
April 2018 to end March 2019	299
Q1	117
Q2	80
Q3	73
Q4	29

4 (0.12% of 3,340) deaths reviewed or investigated (as at the end of April 2019) were judged 'to be more likely than not to have been due to problems in care provided to the patient'. All were investigated and 3 confirmed to be a serious incident.

This consisted of:

Table 6: Number of deaths reviewed or investigated during 2018/19 and judged to be more likely than not to have been due to problems in the care provided to the patient

Time Period	Deaths reviewed or investigated and judged to be more likely than not to have been due to problems in the care provided to the patient (% of all deaths in that period)
Q1	0
Q2	2 (0.26%) (Data not yet complete)
Q3	1 (0.12%) (Data not yet complete)
Q4	1 (0.11%) Data not yet available

31 (0.93% of 3,340) deaths were found to have problems in care but these were considered unlikely to have contributed to the death.

These numbers have been calculated by undertaking a case record review using the national Structured Judgement Review template and the University Hospitals of Leicester NHS Trust death classification criteria or an investigation using the Serious Incident Framework.

Learning identified through our case record reviews, has included:

- Recognising the importance of the handover of patients' clinical history and management plans, particularly at weekends and for patients being transferred between our hospitals
- The need for clearer pathways of care for patients presenting with an 'acute abdomen'
- An awareness of the need for increased steroids for unwell patients on long term therapy
- The importance of fluid balance monitoring, particularly for patients with cardiac problems and acute kidney injury
- The need for the earlier recognition of patients approaching end of life and the importance of good communication with both patients and relatives about prognosis and management plans

In most of the cases reviewed, actions were around raising awareness and disseminating the lessons learnt to clinical teams. The other key action has been to further develop clinical assessments and care bundles in our electronic clinical information system, Nervecentre.

Our Mortality Review Committee reviews the themes from our case record reviews and ensures that we have the appropriate work streams in place to take forward lessons learned. The Mortality Review Committee will assess the impact of actions taken to in response to lessons learnt from case record reviews.

492 deaths were subject to case record reviews as part of specialty mortality and morbidity review in 2017/18.

99 case record reviews and investigations were completed after 2017/18 which related to deaths which took place before the start of the reporting period.

Following the completion of these additional 99 case record reviews, there were in total, seven out of 3,360 deaths in 2017/18 (0.21%) which were considered to be more likely than not, to have been due to problems in care. All of these seven cases were investigated by the patient safety team.

2.8 Seven day hospital services

The seven day service national survey covers the management of patients admitted as an emergency, measured against the four priority standards.

Priority Clinical Standards	
	• Standard 2: Time to Consultant Review • Standard 5: Diagnostics • Standard 6: Consultant directed interventions • Standard 8: On-going daily consultant-directed review

Standard 2	Standard 5	Standard 6	Standard 8
All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital	Hospital inpatients must have scheduled seven-day access to consultant-directed diagnostic tests and completed reporting will be available seven days a week: • Within 1 hour for critical patients • Within 12 hours for urgent patients	Hospital inpatients must have timely 24 hour access, seven days a week, to consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear protocols	All patient with high-dependency needs should be reviewed twice daily by a consultant and all other inpatients should be reviewed by a consultant once daily seven days a week, unless it has been determined that this would not affect the patient's care pathway

Progress towards standards is measured twice a year through a 7 Day Service Self-Assessment tool. All acute NHS provider trusts undertake and submit a sample of case notes reviews for standards 2 and 8 across a seven day period and complete a self-assessment for standards 5 and 6.

Leicester's Hospitals have improved across many areas and will continue to complete submissions of monitoring performance through a new Board Assurance Framework.

We continue to face challenges in achieving these standards, however benchmarking across the East Midlands and across the country show that we are well within national and regional parameters.

2.9 Performance against national standards

Indicators

ED 4 hour wait and ambulance handovers

Table 7: Performance against the ED targets

Performance Indicator	Target	2018/19	2017/18
ED 4 Hour Waits UHL	95%	**77.0%**	**77.6%**
ED 4 Hour Waits UHL + LLR UCC (Type 3)	95%	**83.2%**	**80.6%**

Key: **Green = Target Achieved** **Red = Target Failed**

There have been significant challenges all year with providing timely care at the Leicester Hospital's emergency department (ED). Leicester's Hospitals have not met the target to treat and discharge a minimum of 95% of patients within four hours. ED Type 1 attendances for 2018/19 have increased by 9.8% in comparison to 2017/18, which has put considerable pressure on the system.

Despite the high number of patients in the department at any one time we have strived to meet the urgent care standards but the increased demand for emergency care has inevitably put additional pressure on the ability to deliver a consistently high standard of care for patients.

Phase 2 of the new Emergency Floor opened in June 2018 and provided an improved environment to enhance patient and staff experience. We have also introduced a frailty emergency multi-professional team who provide a seven day service to ED and the emergency floor. This along with other initiatives has helped improve the ambulance handover times; however it is recognised these still remain too long and are a very serious concern for both Leicester's Hospitals and the East Midlands Ambulance Service NHS Trust.

The improvements we have made in ambulance handover have been challenged by the increase in ambulance attendances compared to 2017/18.

We continue to work with partners across Leicester, Leicestershire and Rutland to improve our emergency performance and the quality of care provided on the emergency care pathway.

Our chief executive is the chair of the A&E delivery board which oversees the plan for improvement and includes all of our health system partners including the Leicestershire Partnership NHS Trust and the local councils.

Referral to treatment (RTT)

Table 8: Performance against the referral to treatment

Performance Indicator	Target	2018/19	2017/18
RTT - incomplete 92% in 18 weeks	92%	**84.7%**	**85.2%**
RTT - waiting list size	Less than March 18	**64,506**	**64,751**

Key: **Green = Target Achieved** **Red = Target Failed**

The RTT incompletes standard measures the percentage of patients actively waiting for treatment. The RTT target was not achieved in 2018/19.

Planning guidance for 2019/20 sets out the expectation that providers will achieve a smaller waiting list size at the end of March 2019 than March 2018. Leicester's Hospitals have achieved this.

Over the winter of 2018/19 we maintained more elective care than in 2017/18. As a result we were able to avoid any patients waiting over 52 weeks since July 2018. This remains a key quality standard nationally and will remain priority for us throughout 2019/20.

The factors that have impacted on our ability to deliver the 92% standard are:

- The after effects of the elective pause and winter pressures in 2017/18 resulting in an increase of 4,666 patients waiting over 18 weeks by the end of March 2018

- A 15.5% increase in two week wait referrals resulting in capacity being moved from routine RTT patients at longer waits to potential cancer patients at shorter waits

Although the number of patients waiting over 18 weeks has reduced year on year, it remains higher than the level required to achieve the 92% RTT performance standard. Our focus remains treating the most clinically urgent and longest waiting patients.

We continue to have capacity constraints within some key services, notably adult and paediatric ENT, General Surgery, Urology, Orthopaedics and Gynaecology. This is being addressed by reviewing and improving efficiency within these services and working closely with commissioners to reduce demand.

Winter care

In the Winter of 2018/19, in common with many other acute trusts, Leicester's Hospitals experienced compromised emergency department performance, increased numbers of patients in hospital for over seven days and high levels of occupancy (the number of beds filled). We ensured that over the winter months our patients were safe and received treatment as quickly as possible.

Winter planning for 2019/20 has already started and we will:

- Ensure that our plan addresses both the physical and mental health needs of our patients
- Ensure that we understand the shortfall in beds against the predicted admissions and have robust efficiency plans in place to reduce the shortfall as much as possible.
- Develop a system wide plan for winter which includes social care, primary care and community care
- Ensure robust staffing over holiday periods
- Ensure realistic phasing of elective activity throughout the year to decrease the risk of cancellations
- Ensure that our most urgent and cancer patients are not cancelled due to non-clinical reasons.

- Ensure that **Red**2**Green** (a process for minimising both internal and external delays for patients) is as effective as possible, reducing occupancy prior to winter

- Ensure that super stranded (patients in hospital for more than 21 days) are kept to a minimum throughout the year and especially over winter

Cancelled operations and patients rebooked within 28 days

Table 9: Performance against the cancelled operations targets

Performance Indicator	Target	2018/19	2017/18
Cancelled operations	1.0%	**1.1%**	**1.2%**
Patients cancelled and not offered another date within 28 days	0	**242**	**336**

Key: **Green = Target Achieved** **Red = Target Failed**

Although overall cancellation rates for the year have been above the target, Leicester's Hospitals have made significant inroads into processes which have previously contributed to high short notice cancellations.

Leicester's Hospitals has seen year on year improvements in the cancellation performance for every month from August 2018 onwards.

We also saw a reduction in the number of patients not offered a date within 28 days of a cancellation, as improvements in the cancelled operation performance has resulted in fewer patients requiring a date within 28 days. Increased competing pressures on available theatre capacity with clinically urgent patients, patients on a cancer pathway and long waiters means Leicester's Hospitals will continue to struggle to meet this target of zero.

Our theatre programme board has a work plan to reduce short notice cancellations for patients. This will also have a positive impact on our 28 day performance indicator.

Diagnostics

Table 10: Performance against the diagnostic waiting times target

Performance Indicator	Target	2018/19	2017/18
Diagnostic Test Waiting Times	1.0%	0.9%	1.9%

Key: Green = Target Achieved Red = Target Failed

Leicester's Hospitals have worked hard to sustain a steady performance against the routine six week to scan target, despite ever-increasing demand.

Waiting times for MRI scans have stabilised. This is in part due to increased investment and the transformation of patient pathways for key tests. Pressure remains within cardiac CT, which led to breaches of the 99% within 6 week target over the summer of 2018. This remains a key challenge for 2019. Measures have been put in place to try to manage demand, including a business case for further investment and strengthening of referral pathways.

Cancer targets

Table 11: Performance against the cancer targets

Performance Indicator	Target	2018/19	2017/18
Cancer: 2 week wait from referral to date first seen - all cancers	93%	92.3%	94.7%
Cancer: 2 week wait from referral to date first seen, for symptomatic breast patients	93%	79.3%	91.9%
All Cancers: 31-day wait from diagnosis to first treatment	96%	95.2%	95.1%
All cancers: 31-day for second or subsequent treatment - anti cancer drug treatments	98%	99.6%	99.1%
All Cancers: 31-day wait for second or subsequent treatment - surgery	94%	86.1%	85.3%

Performance Indicator	Target	2018/19	2017/18
All Cancers: 31-day wait for second or subsequent cancer treatment - radiotherapy treatments	94%	97.9%	95.4%
All Cancers:- 62-day wait for first treatment from urgent GP referral	85%	75.2%	78.2%
All Cancers:- 62-day wait for first treatment from consultant screening service referral	90%	82.3%	85.2%

Key: Green = Target Achieved Red = Target Failed

We have seen an increase in referrals to cancer this year across all the tumour sites. There are national challenges in Urology capacity and regionally in robotic provision and we are working to manage this. Despite the growth in referrals, we have made improvements against the 62 day cancer standard this year. This standard remains one of the key priorities for Leicester's Hospitals.

Alongside improvements in our 'Next Steps' programme (which ensures all patients who are on a suspected cancer pathway know what their next step is and receive the date for that within an agreed timeframe) we have introduced a shorter wait for first appointments.

This year we have received significant funding for transformation projects in lung, and prostate and work is underway to deliver changes which will shorten patient pathways. We will see the benefit of this work in 2019.

For those cancer standards that are not being met, Leicester's Hospitals has agreed a cancer recovery plan with commissioners. This has resulted in some clear signs of improvement that will continue into 2019/20.

MRSA

Table 12: Performance against the MRSA targets

Performance Indicator	Target	2018/19	2017/18
MRSA (All)	0	3	4

Key: Green = Target Achieved Red = Target Failed

In 2018/19 there were 3 Meticillin Resistant Staphylococcus aureus (MRSA) blood stream infections reported, against a trajectory of zero avoidable cases. All 3 cases were deemed un-avoidable.

For all cases a Post- Infection Review (PIR) on all patients who have a Trust or non-Trust apportioned MRSA identified was undertaken. This is in accordance with the standard national process and involves a multiagency review of the patients care to determine if there have been any lapses of care which would have contributed to the infection and where lessons maybe learned to prevent further occurrence.

Pressure ulcers

Table 13: Performance against the pressure ulcer targets

Performance Indicator	Target	2018/19	2017/18
Avoidable Pressure Ulcers – Grade 4	0	0	1
Avoidable Pressure Ulcers – Grade 3	27	7	8
Avoidable Pressure Ulcers – Grade 2	84	62	53

Key: Green = Target Achieved Red = Target Failed

Leicester's Hospitals are committed to reducing year on year the number of pressure ulcers that occur in our hospitals. This year we saw a decrease in the number of Grade 3 and 4 pressure ulcers.

The care of any patient who has acquired a pressure ulcer whilst in Leicester's Hospitals is reviewed at a monthly validation meeting, where there is scrutiny of the circumstances relating to the injury.

Through this scrutiny and challenge process Leicester's Hospitals have seen a year on year reduction in the number of avoidable pressure ulcers. This year we introduced a number of initiatives to improve care, including:

- The introduction of an electronic system to record "bestshot" assessments which helps staff to be prompted to undertake skin assessments
- The celebration of national pressure ulcer day to raise awareness of strategies to prevent pressure ulcers, using a twitter campaign and local ward events
- Issuing certificates of achievement for clinical areas that have achieved their target for the number of pressure ulcer free days

Currently Leicester's Hospitals is reviewing its total bed management contract, with the aim of ensuring patients are cared for using the best equipment that helps increase patient comfort and minimise harm.

2.10 Mental Health

We are seeing an increasing number of patients attending our hospitals with either a primary or secondary mental health problem. We have a responsibility for ensuring that all patients seen at Leicester's Hospitals have access to the right treatment at the right time with the right healthcare professionals.

During their unannounced inspection in November 2017, CQC inspectors were impressed with the physical environment for mental health patients in the emergency department.

The process for referring for a mental health assessment is well established in the emergency department. The number of referrals for a mental health assessment in the emergency department has continued to increase.

Leicester's Hospitals has jointly committed with the Leicestershire Partnership NHS Trust, to reduce the number of patients who repeatedly attend the emergency department as a direct consequence of an underlying mental health condition. There has been good progress with this over the last twelve months.

A new service model has been jointly developed with Leicester Partnership Trust and we are submitting a bid for new National Health Service Executive (NHSE) investment to meet the increased demand from our patients.

2.11 Equality & diversity

A new interpretation and translation service provider was appointed in January 2018, offering 24/7 cover for all of our interpreting and translation needs. As of January 2019, our average fill rate for interpreting requests was 98%.

We have reviewed and updated our interpretation and translation policy to ensure that friends and family are not used as interpreters.

We run a successful anti-bullying and harassment helpline which assisted 32 individuals during 2017 and 41 individuals in 2018. Leicester's Hospitals wants to address issues of bullying and harassment where they occur and to further promote and publicise the service and help available through resources such as anti-bullying badges and promotional banners.

Leicester's Hospitals are signed up to the British Sign Language Charter and we are developing plans to improve services to deaf and hard of hearing people. Improved British sign language interpreting arrangements have been put in place across our hospitals and a replacement programme for induction loops in all reception areas has been carried out. A two way texting service is now available for all patients, but which will particularly benefit deaf patients who cannot use conventional methods to contact our services.

Race equality will be a key priority for Leicester's Hospitals in 2018/19, with the under representation of Black, Asian and Minority Ethnic (BAME) employees at leadership level an area of particular focus. Whilst our total workforce is representative of the Leicestershire BAME community (33%), BAME leadership (at 15.6%) is not.

Leicester's Hospitals have been successful in improving its WRES indicators one to four, which includes improvements in BAME candidates being successful when applying for jobs, access to non-mandatory training (equitable across all ethnic groups) and no disproportionate impact on those entering the formal disciplinary process.

Leicester's Hospitals recognise that there is still much to do in terms of the equality, diversity and inclusion agenda. Examples of equality and diversity initiatives at Leicester's Hospitals in 2018/19 are:

- Reverse mentoring (with 21 BAME mentors trained and 14 mentees undergoing training across Leicester, Leicestershire and Rutland)
- A local stepping up programme aimed at BAME staff, to be launched in partnership with the East Midlands Leadership Academy during 2019
- Unconscious bias and professional behaviour master classes
- Targeting of graduate trainees from BAME backgrounds
- The Royal College of Nursing cultural ambassadors programme, with those trained advising on disciplinary issues
- A BAME network conference in March 2019
- A differently able voice (disabled staff) network
- Piloting of "dignity gowns" for patients who feel uncomfortable wearing traditional patient gowns whether this be for cultural or other reasons

2.12 Patient and public perspective

Information for public and patients

We produce a quarterly magazine called 'Together' for staff, members and the public. In this, we share news, research, innovations, information and opportunities to get involved, from across our hospitals.

Our communications team manages several social media accounts such as Twitter, Facebook, Vimeo, Instagram and YouTube, which we use to share information, images and advice. We respond to issues / concerns raised by members of the public through these forums as well as responding to comments posted on NHS Choices and Patient Opinion about our services.

Our public website (www.leicestershospitals.nhs.uk) provides patients and visitors with information about our hospitals and services. We regularly issue press releases about good news and interesting developments within our

hospitals, along with `news alerts` for those who have signed up to receive notifications.

Patient and public involvement strategy

Our patient and public involvement strategy sets out the ways in which Leicester's Hospitals:

- Communicates and engages with stakeholders
- Involves patients and the wider community in service development
- Is working to achieve high quality stakeholder, patient and public involvement

Our patient and public involvement strategy is regularly refreshed and in the spring of 2019 underwent a review to ensure that it aligns closely with our quality strategy.

Our patient and public involvement strategy describes how we work with our Patient Partners to ensure that the patient voice remains at the centre of what we do. It also sets out our programme of community engagement and relationship building with other stakeholders.

Patient Partners

Patient Partners – Comments by Martin Caple, Chair, Patient Partner Group

"Within Leicester's Hospitals the patient voice is mainly represented through Patient Partners who are members of the public selected to provide an independent lay perspective on the work within the hospitals. We are involved and consulted at all stages of the patient journey in UHL and interact with all levels of staff. As individuals we provide feedback and work with staff to address patient matters whilst at the same time sharing our collective thoughts and concerns with senior managers at our regular bi-monthly meetings. There are now 18 people fulfilling this role from a diverse range of backgrounds and experiences.

Established in 2002 and originally called Patient Advisors, the role has grown and developed over the years. During 2018/19 we have been involved in a wide range of issues from speaking to patients on wards and in out-patient departments to advising on new developments, involvement in recruiting staff and

undertaking patient surveys on specific topics. We are also members on a number of UHL committees relating to issues including finance, education, performance, nutrition, end of life care, complaints, quality, research and safeguarding.

Currently we are attached to Clinical Management Groups, with two or three Patient Partners being allocated to one of the seven Groups. However, in addition, a lot of our work is now undertaken across the Trust on issues affecting all areas, such as reconfiguration projects, serious incident investigations, a review of complaints and stakeholder recruiting sessions for senior posts.

There have been numerous initiatives undertaken by Patient Partners in the past 12 months notably:-

- Three Patient Partners, (one of whom who has a background in customer care in the licensing trade), with UHL staff, have spoken and given advice to outpatient staff about their interactions with patients and the public. This has culminated in the production of a e-learning customer service staff training module being produced across these areas

- All Patient Partners have been involved in a nutrition and hydration survey across wards in all three hospitals. The survey forms are now being assessed by the Nutrition and Hydration Committee for improvement actions to be considered

- A Patient Partner has interviewed patients in the Emergency Department who have mental health issues and identified some areas for improvement. She has presented her findings with suggested areas for improvement to senior staff and some changes are being implemented

- Patient Partners have facilitated patient user events with former Intensive Care Unit patients and their relatives where they share their experiences with doctors and nurses; with action plans being produced on any areas for improvement

- A Patient Partner utilising her own family experience has advised on improving end of life care

- A Patient Partner is a dementia champion supporting patients with that condition

- Patient Partners were involved in stakeholder recruiting groups when three new director appointments were made in 2018

As a group our main concerns and priorities which we have brought to the attention of the Board this year are:

- Patient communication
- Cancelled operations
- Capturing patient data effectively
- Never Events and serious incidents
- Patient food and nutrition
- Nursing staffing levels

At our bi-monthly group meetings we are feeding back our views and concerns on these and other key matters to relevant directors and suggesting areas for improvement. With regard to the Never Events and other serious incidents we are pleased to be involved in the individual investigations.

Following an evaluation and review of the Patient Partner role some changes will be made in the near future. At the time of writing this report (in March, 2019) consideration is being given by the UHL Board to a revised model for the role so it is linked to the new Quality Strategy (Becoming the Best). This will feature involvement with staff in addressing the 12 key priorities identified in the Strategy.

To ensure we can contribute effectively in this new initiative we have emphasised that our role needs to be clearly identified so everyone is aware of it and to emphasize that Patient Partners are just one source of patient involvement and engagement, and other patient groups and the wider public also need to be involved.

The new model is still under discussion with Patient Partners being consulted by the Chief Executive and it is hope to be finalised by April. Consideration is being given as to whether we will still all be allocated to Clinical Management Groups and to our membership of certain strategic committees.

There have been some significant improvements across UHL in the past year notably planning work which has led to £30 million being approved for enhanced Intensive Care Unit and ancillary facilities at Glenfield Hospital. It is pleasing to see significant improvements in end of life care and performance figures in several key areas showing an upturn.

Despite the many increasing pressures on staff within UHL as Patient Partners we continue to see a hard-working and committed workforce, ably led, who are dedicated to providing high quality patient care. The Board is supportive of patient and public involvement and Patient Partners and we look forward to being involved in the changes to our role".

Community engagement

As part of a programme of community engagement, Leicester's Hospitals run quarterly "Community Conversations" events. The aim of these events is to enable Trust Board members to be more visible in the local community, to listen to a diverse range of views on our services and promote and publicise the work of our Hospitals. These events are held in a variety of different community venues across Leicester, Leicestershire and Rutland. Over the last year our events have included engagement with people with disabilities, people from the African Caribbean community and South Asian women living in Leicester.

Patient feedback

Feedback from patients, family members and carers is actively sought by Leicester's hospital and we respond to both positive and negative feedback.

Our "You Said We Did" boards displayed in ward areas highlight some of the actions that we have taken in response to the feedback that we have received. These boards have been reviewed and our responses to patient feedback will be displayed on new "Patient Feedback Driving Excellence" boards, showing the actions that have been taken in the area in response to the feedback received, whether this is areas for improvement or positive feedback.

We collect feedback in numerous ways, including:

- Patient Experience feedback forms, both paper and electronic
- Family, Carers and Friends feedback forms, both paper and electronic

- SMS/texts sent to patients who attend outpatient appointments
- Recorded patient stories
- Community conversations, conducted by the hospital Engagement team
- Volunteer surveys
- Message to Matron Cards
- NHS Choices / Patient Opinion
- Compliments and complaints provided to the Patient Information and Liaison Service (PILS)
- The hospital website

Friends and Family Test

The Friends and Family Test is a national set question offered to patients, carers and family on discharge from all NHS Hospitals and asks 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 and don't 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.

NHS England is currently conducting a review of this question and the guidance related to the collection of the feedback.

Leicester's Hospitals achieved its target of a 97% positive response for inpatient and daycase in the Friends and Family Test in all twelve months in 2018/19.

The target for inpatients Friends and Family Test (97%) was met in two months out of twelve and the target for daycases (97%) was met in all twelve months.

Friends and Family feedback is collected by various methods. Inpatient and day case areas have paper forms, which are also available in an easy read format for patients who have language difficulties, literacy problems, visual impairment or learning difficulties. Paper forms are also available in the top three locally spoke languages; Gujarat, Punjabi and Polish, to allow patients whose first language is not English the opportunity to give their feedback.

There are rocket feedback forms for the children, which give them the opportunity to give feedback using illustrations of faces ranging from very happy to very sad. On the paper forms there is a space for the children to draw a picture on the back.

Leicester's Hospitals are keen to gather feedback from family members, carers and friends who attend the hospital with a loved one. There is a designated form for them to complete and give their views of their experience.

There are electronic feedback devices in some clinical areas and outpatients, which also provide the easy read and alternative language options.

An SMS / texting service is available for some patients who attend outpatients, which allows the patients to give their feedback after they have left the hospital; this is presented in an easy read format, to ensure inclusivity.

The hospital website provides a further opportunity for feedback to be given when the patient has left the hospital.

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. The Patient Information and Liaison Service is an integral part of the corporate patient safety team. The PILS service acts as a single point of contact for members of the public who wish to raise complaints, concerns, compliments or have a request for information.

The service is responsible for coordinating 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.

Table 14: PILS activity (formal complaints, verbal complaints, requests for information and concerns) by financial year - April 2015 to March 2019

	2015/16	2016/17	2017/18	2018/19
Formal complaints	1,553	1,445	1,876	2,257
Verbal complaints	1,445	1,152	856	493
Requests for information	433	325	142	114
Concern (excludes CCG & GP)	703	1,284	1,146	1,168
Total	4,134	4,206	4,020	4,032
% change of total against previous year	9% increase	2% increase	4% decrease	0.3% increase

Learning from complaints

Leicester's Hospitals Patient Information and Liaison Service (PILS) administer all formal complaints and concerns. Between April 2018 and March 2019 we received 2,257 formal complaints and 1,168 concerns.

Leicester's Hospitals achieved 91%, 91% and 80% for the 10, 25 and 45 day formal complaints performance respectively.

The most frequent primary complaints themes are Medical care, Waiting times and Appointment issues.

Complaints are a vital source of information about the views of our patients, families and carers about the quality of our services and standards of our care. We are keen to listen, learn and improve using feedback from the public, HealthWatch, feedback from our local GPs and also from national reports published by the Local Government and Parliamentary Health Service Ombudsman.

We have continued to work jointly with commissioners and primary care on improving the process for responding to GP concerns. This year we have seen a 115% increase in GP concerns as the new process has become embedded. The most frequent GP concern themes are related to inaccurate discharge summaries and requests for GPs to undertake tasks that are not appropriate. Working with the transferring care safely group we now need to focus our improvement work on the themes identified.

Learning from complaints takes place at a number of levels. The service, department or specialty identifies any immediate learning and actions that can be taken locally.

A quarterly report identifies themes, trends and suggestions for improvement based on a variety of feedback (complaints, friends and family test, social media, Patient Choices etc). This report is discussed at our Patient Involvement and Patient Experience Assurance Committee, Executive Quality Board and Quality Outcomes Committee.

Complaint data is triangulated with other information such as incidents, serious incidents, freedom to speak up data, inquest conclusions and claims information to ensure a full picture of emerging and persistent issues is recognised and described. This is undertaken in part at the Adverse Event Committee. Learning from complaints is shared with staff at a variety of meetings and is built into our safety and complaint training.

Many of the actions identified from complaints form part of wider programmes of work such as our Quality Commitment for example the outpatient transformation programme (reducing waiting times and cancellations) and the work this year to actively involve patients and their families in decision making about their care.

An annual complaints report is produced each summer and is available on Leicester's Hospitals website.

Reopened complaints

Table 15: Number of formal complaints received and number reopened by quarter April 2017 to March 2019

	Formal complaints received	Formal complaints reopened	% resolved at first response
2017/18 Q1	391	46	88%
2017/18 Q2	481	51	89%
2017/18 Q3	488	32	93%
2017/18 Q4	516	68	87%
2018/19 Q1	532	42	92%
2018/19 Q2	584	45	92%
2018/19 Q3	549	57	90%
2018/19 Q4	592	47	92%
Total	4,133	388	91%

Improving complaint handling

Throughout 2018/19, Leicester's Hospitals continued to participate in the Independent Complaints Review Panel process.

This panel reviews a sample of complaints and reports back on what was handled well and what could have been done better. This feedback which is used for reflection and learning included:

- Improved PILS 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

- Better and more timely local management and resolution of complaints. Staff training and education has been included in the Patient Safety training programme packages

- The need to reduce the amount of medical jargon used. The PILS team are encouraged to mirror the language and terminology used by the complainant to provide the most appropriately worded responses

This year to improve our complaints process and handling of cases we have:

- Changed from a paper to an electronic triage process
- Updated our PILS patient information leaflet
- Ensured consent within the complaints process is in line with best practice and national guidance

In 2019/20, we will:

- Develop an electronic complaint satisfaction survey
- Launch our Complaints Intermediate training programme
- Assist the Parliamentary Health Service Ombudsman with their development of a good practice framework with regard to complaints

Parliamentary Health Service Ombudsman

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

Table 16: Parliamentary Health Service Ombudsman complaints - April 2016 to March 2019

	2016/17	2017/18	2018/19	Total
Enquiry only - no investigation	4	1	6	**11**
Investigated - not upheld	12	7	3	**22**
Investigated - fully upheld	1			**1**
Investigated - partially upheld	3	3	2	**8**
Complaint withdrawn	1			**1**
No decision made yet			4	**4**
Total	**21**	**11**	**15**	**47**

2.13 Staff perspective

Staff survey results

Each year Leicester's Hospitals participate in the National Staff Survey. The results of this survey are used to develop human resource, workforce and organisational development strategies aimed at improving staff experience of working at Leicester's Hospitals.

In 2018 25.7% of Leicester's Hospitals staff reported that they had experienced harassment, bullying or abuse from staff in the last 12 months (compared to 28.4% nationally). This compares with a score of 26.1% in 2017.

In 2018 81% of staff reported that they believed that Leicester's Hospitals provides equal opportunities for career progression or promotion (compared to 83.9% nationally). This compares with a score of 82.9% in 2017.

Freedom to Speak Up Guardian

Taking every opportunity to listen to staff views and concerns is extremely important to Leicester's Hospitals, as we know that this improves patient safety and staff engagement. We appointed our freedom to speak up guardian in February 2017 and since then have built on mechanisms whereby staff can speak up.

For many years we have run a dedicated staff concerns reporting line' which enables any member of staff to report a safety concern 24/7. They may do this anonymously if they wish and every concern reported via this route (more than 30 in 2018/19) is followed up by the director on call for that day. This ensures an immediate, senior and impartial response to serious safety concerns. Staff may also speak up or raise concerns via the chief executive 'breakfast with the boss' sessions, during director ward and department safety walkabouts, through the junior doctor gripe tool, as well as directly with the freedom to speak up guardian.

In 2018/19 (April 2018 - March 2019) the freedom to speak up guardian followed up on 139 staff concerns, 101 of those concerns were reported directly to the guardian, 39 through the staff reporting tool. 114 staff concerns were reported through the junior doctor gripes tool which the Freedom to Speak up Guardian currently manages.

The freedom to speak up guardian role continues to be visible across the trust and we actively promote this role and encourage staff to let us know any safety concerns they may have through:

- Trust Induction and other mandatory training programmes
- Posters promoting the role visible across Leicester's Hospitals
- A social media account on Twitter
- Staff surveys on raising concerns / speaking up
- Clinical Management Group Quality and Safety Board meetings
- Key questions added to exit interview documentation

The freedom to speak up guardian has undertaken monthly "here for you" events across all sites in partnership with the Leicestershire Partnership Trust guardian and head of chaplaincy and has held drop-in sessions in several departments to provide an opportunity for our staff to raise concerns. In addition, the guardian has undertaken a number of shadowing shifts with a variety of staff to see first-hand the challenges they face.

To promote a 'gold standard' approach when responding to staff concerns, we have designed a short animation called the: '5 steps to responding to staff concerns' https://www.youtube.com/watch?v=Ne1npID0AeY which encourages all staff to have a positive experience when raising concerns. Every member of staff who raises a concern (who leaves their name) receives personal feedback and on-going information and support should they require it.

The Executive Quality Board and Quality and Outcomes Committee receives a quarterly report covering the themes and trends of concerns raised, together with actions taken or proposals for the Board. In this last year we have completed our Freedom to Speak Up vision, strategy and plan which are available on the safety portal for all staff to see.

The freedom to speak up guardian periodically attends our Trust Board and other meetings to present data, outcomes of actions and staff stories and we will continue to support and promote this role in 2019/20.

Doctors rotas

In line with the requirements of Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016, an annual guardian report is submitted to the Trust Board. This report includes annual vacancies at Leicester's Hospitals. The next annual report will be submitted in April 2019.

The number of junior medical staff vacancies at Leicester's Hospitals fluctuates, with the highest being 12% in June 2017 and the lowest being 6% in February 2019.

Vacancies are pro-actively managed with a rolling programme of Trust Grade recruitment to fill junior medical staff vacancies, by filling substantive posts where possible to avoid locum backfill and premium pay.

3. Our Plans for the Future

3.1 Quality improvement at Leicester's Hospitals

UHL's new Quality Strategy, "Becoming the Best", seeks to learn from trusts which have shown significant and sustained improvement. Its goal is to enable us to deliver Caring at its Best to every patient, every time and thus be judged to be an outstanding organisation. Building on our strengths whilst also addressing what we need to do better, or differently, our Quality Strategy is designed to be a comprehensive, evidence-based approach, capable of transforming our organisation.

The development of our Quality Strategy has involved a wide range of people within the trust, particularly those with quality improvement and organisational development expertise. It has also had extensive input through Trust Board Thinking Days and through our Leadership and Consultant conferences.

Our Quality Strategy sets out our improvement methodology and our priorities for improvement; a "unified programme" approach will mean a single programme incorporating all the key things that we need to do using the overall approach set out in this strategy. It reframes our approach into one of constant learning and improvement and ensures that quality improvement is our organising principle.

The success of our Quality Strategy will depend on a complete commitment from the top level of the organisation to the approach set out in our Quality Strategy. This includes visible championing of the approach and changing the way in which we do things. It also depends on creating the head space for everyone to talk about how best to pursue this ambition.

In order to measure and evidence the impact of our investment in quality improvement, we will carry out a systematic review of our reporting structures and processes to ensure that they are fit for purpose. We will introduce processes to ensure the basic quality and functioning of all our clinical services, combining both quality control and quality assurance.

3.2 Quality plans for 2019/20

Our quality priorities for 2019 – 2021/2022 are:

- Embedding safe and effective care in every ward by introducing a Trust wide assessment and accreditation framework

- Consistently implementing the safest practice for invasive procedures, with a focus on consent, NatSSIPS and the Five Steps to Safer Surgery; and we will improve our learning when things go wrong

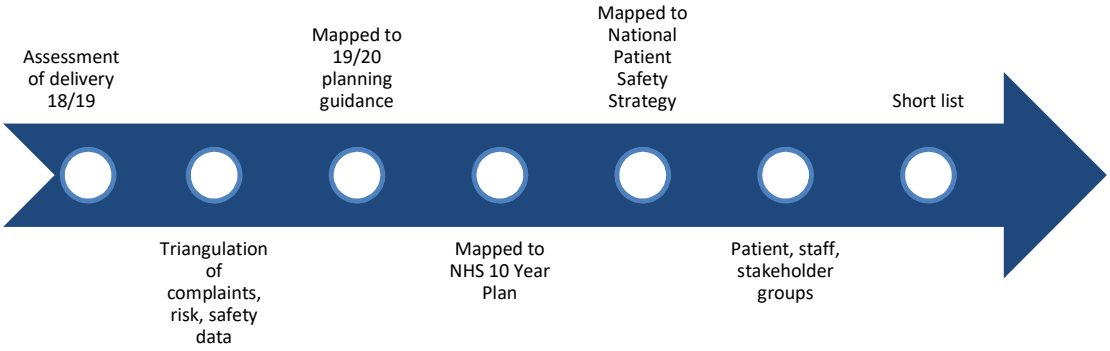
- Implementing safe and timely discharge for all patients in our care, 7 days a week, by embedding safer discharge processes and eliminating avoidable delays

- Providing high quality and timely diagnosis & treatment for patients on cancer pathways by redesigning those pathways in conjunction with our partners

- Working as a system to create safe, efficient and timely urgent and emergency care, with a focus on embedding acute frailty and Same Day Emergency Care

- Providing high quality, efficient integrated care by redesigning pathways in key clinical services to manage demand, improve use of resources and deliver financial improvement

Our quality improvement plan takes account of both local and national priorities, incorporating patient experience, clinical effectiveness and safety. Further, we have triangulated harms and clinical outcomes data, patient complaints and GP concerns to identify the most pressing issues for improvement.



Key performance indicators are developed for each priority. Progress is reported against each priority to our Executive Boards.

4. Statements of Assurance from the Board

4.1 Review of services

Leicester's Hospitals comprises of three acute hospitals; the Leicester Royal Infirmary, the Leicester General and Glenfield hospital and the midwifery led birthing unit, St Mary's.

The Royal Infirmary has the only Emergency Department which covers the area of Leicester, Leicestershire and Rutland. The General provides medical services which include a centre for renal and urology patients, and Glenfield provides a range of services which include medical care services for lung cancer, cardiology, cardiac surgery and breast care.

During 2018/19 Leicester's Hospitals and the Alliance provided and / or sub-contracted in excess of 120 NHS services. These include:

- Inpatient - 64 services (specialties)
- Day Case - 61 services (specialties)
- Emergency - 68 services (specialties)
- Outpatient - 86 services (specialties)
- Emergency Department and Eye Casualty
- Diagnostic Services - including Hearing Services, Imaging, Endoscopy, Sleep Studies and Urodynamics
- Direct access - including Imaging, Pathology, Physiotherapy and Occupational Therapy
- Critical Care Services in Intensive Therapy Unit (ITU), High Dependency Unit (HDU), Post Anaesthesia Care Unit (PACU), Coronary Care Unit (CCU), Paediatric Intensive Care Unit (PICU), Obstetrics HDU, Neonatal Intensive Care Unit (NICU), Extra Corporeal Membrane Oxygenation (ECMO), Special Care Baby Unit (SCBU) and also Paediatric and Neonatal Transport Services

- A number of national screening programmes including Retinal Screening (Diabetes), Breast Screening including age extension (Cancer), Bowel Screening (Cancer) and Abdominal Aortic Aneurism (AAA), Cervical screening, foetal anomalies, infectious diseases of the newborn, newborn infants physical examination, newborn blood spot and sickle cell thalassemia

Services are also provided at:

- Dialysis units in Leicester, Loughborough, Grantham, Corby, Kettering, Northampton and Peterborough

- The Alliance partnership at Ashby & District Hospital, Coalville Hospital, Fielding Palmer Hospital, Hinckley & District Hospital, Loughborough Hospital, Melton Mowbray Hospital, Rutland Memorial Hospital and St Luke's Hospital

- The national Centre for Sports ad Exercise Medicine at Loughborough University

The University Hospitals of Leicester NHS Trust has reviewed all the data available, on the quality of care in these NHS services. The income generated by the NHS services reviewed in 2018/19 represents 100% of the total income generated from the provision of NHS services by Leicester's Hospitals for 2018/19.

Examples of how we reviewed our services in 2018/19

A variety of performance and quality information is considered when reviewing our services. A few examples include:

- A Quality and Performance report (available at http://www.leicestershospitals.nhs.uk/) is presented at the Executive Quality Board, Executive Performance board and in a joint session between the Quality and Outcomes Committee and the People, Processes and Performance Committee

- Monthly Clinical Management Group Assurance and Performance Review Meetings chaired by the chief operating officer

- Service level dashboards (e.g. women's services, children's services, fractured neck of femur and the Emergency Department)

- Ward performance data at the Nursing and Midwifery Board and Executive Quality Board
- Results from peer reviews and other external accreditations
- Outcome data including mortality is reviewed at the Mortality Review Committee
- Participation in clinical audit programmes
- Outcomes from Commissioner quality visits
- Complaints, safety and patient experience data
- Review of risk registers
- Annual reports from services including the screening programmes

4.2 Participation in clinical audits

Leicester's Hospitals are committed to undertaking effective clinical audit across all clinical services and recognises that this is a key element for developing and maintaining high quality patient-centred services.

National clinical audits are largely funded by the Department of Health and commissioned by the Healthcare Quality Improvement Partnership (HQIP), which manages the National Clinical Audit and Patients Outcome Programme (NCAPOP).

Most other national audits are funded from subscriptions paid by NHS provider organisations. Priorities for the NCAPOP are set by the Department of Health.

During the 2018/19 period Leicester's Hospitals participated in 92% (55 out of 59) of the national clinical audits. Of the ten national confidential enquiries, Leicester's Hospitals has participated in 100% of the studies which have commenced and which it is eligible to participate in.

The national clinical audits and national confidential enquiries that Leicester's Hospitals participated in and for which data collection was completed during the

2018/19 period are listed in appendices 1.1 and 1.2 alongside the number of cases submitted to each audit or enquiry where possible.

Leicester's Hospitals have reviewed the reports of 44 national clinical audits and 350 local clinical audits in 2018/19.

University Hospitals of Leicester NHS Trust intends to take the following action to improve the quality of healthcare provided:

- An audit summary form is completed for all audits and includes details of compliance levels with the audit standards and actions required for improvement including the names of the clinical leads responsible for implementing these actions. These summary forms are available to all staff on our intranet

- There are various examples within this Quality Account of the different types of clinical audits both national and local being undertaken within our hospitals and the improvements to patient care achieved

- Each year we hold a clinical audit improvement competition for projects that have improved patient care and a summary of the winner and runner-up this year are provided below:

Emergency Department Prescribing Audit

A collaborative approach between the medical and nursing teams and the adult and paediatric areas of the Emergency Department has resulted in a change to practice (the re-designed prescribing documentation) which has shown a measurable, sustained improvement to patient care and safety.

Grab-Bag Emergency Equipment Checklist

Complications in remote airway site management are potentially life threatening. Those caused by the lack of equipment or drugs are completely avoidable. Ensuring the grab bag is checked and appropriately stocked guarantees the correct equipment and drugs are available for the team managing the remote airway.

4.3 Participation in clinical research

The number of patients receiving NHS services provided by or subcontracted by the University Hospitals of Leicester in 2018/19 that were recruited during that period to participate in research approved by a research ethics committee was 14,990.

The University Hospitals of Leicester were involved in conducting 1035 clinical research studies. Of these 823 80% were adopted onto the National Institute for Health Research portfolio, and 239 (23%) of the total were commercially sponsored studies. Leicester's Hospitals used national systems to manage the studies in proportion to risk. 67% of the studies given approval were established and managed under national model agreements.

In the calendar year 2018 there were over 200 full papers published in peer reviewed journals.

A research team led by Professor Chris Brightling (consultant respiratory physician) has shown that the asthma drug Fevipiprant reduces smooth muscle in the airway lining, which could help reduce asthma attacks. Phase III trials are coming to an end and, if successful, the pill could be available in severe asthma clinics across the country within a year.

Professor Melanie Davies CBE (consultant endocrinologist) chaired a panel on behalf of the European Association for the Study of Diabetes and the American Diabetes Association that has published consensus guidelines on managing hyperglycaemia in type 2 diabetes.

An international team co-led by Dr David Adlam (interventional cardiologist) has identified the first common genetic risk factor for spontaneous coronary artery dissection (SCAD) – a type of heart attack that almost exclusively affects young to middle-aged women. The next steps are to identify further genetic risk factors and understand the biological consequences of these, so that ultimately the condition is better understood, managed and treated.

Routine screening for abdominal aortic aneurysm in women was shown not to be cost-effective, concludes study co-authored by Professor Matt Bown (consultant vascular surgeon).

The Society of Radiographers has named the post-mortem imaging team as UK Team of the Year 2018 for 15 years of pioneering research that led to the first

non-invasive autopsy service that is used as standard practice by HM Senior Coroner for Leicester City and South Leicestershire.

4.4 Use of the CQUIN Payment Framework

A proportion of Leicester's Hospitals income in 2018/19 was conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework (CQUINS). The CQUIN schemes, ran for two years (2017-19) with the aim to improve quality of outcomes for patients.

In 2018/19 Leicester's Hospitals had:

- Five mandated National CQUINS, each with a minimum weighting of £1,110,865
- Ten NHS England Specialised CQUINS with a total value of £5,651,842 and
- Four locally agreed CQUINS, to support the development of Sustainability and Transformation Partnerships, each with weighting of £1,376,082

The combined 2018/19 CQUIN schemes were worth 2.5% of Leicester's Hospitals contract value which equated to £16,660,494.

Further details of the agreed goals for 2018/19 are available electronically at: https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-17-19/

Leicester's Hospitals did not fully meet the targets set for three of the National CQUINs:

- Improving staff health & wellbeing
- Reducing the impact of serious infection and
- Preventing ill health through risky behaviours

One of the NHS England Specialised CQUINS was partially met:

- Hepatitis C Network

One of the local Sustainability and Transformation Partnerships CQUINS relating to 'Implementing the use of the Clinical Frailty Scale in ED' was also only partially met.

The end of year variance for all the CQUIN schemes has yet to be confirmed but is expected to be approx. £1,700,000.

4.5 Data quality

University Hospitals of Leicester NHS Trust will be taking the following actions to improve data quality:

- Our Data Quality Forum has oversight of our data quality processes. It seeks assurance of the quality of data reported to the Trust Board and to external agencies to ensure that it is of suitably high quality, is timely and accurate. This process uses a locally agreed Data Quality Framework to provide scrutiny and challenge on the quality of data presented. Where such assessments identify shortfalls in data quality, risks are identified together with recommendations for improvements to ensure that the quality is raised to the required standards

- There are quarterly reports on the quality of commissioning data and Clinical Coding presented to the Executive Quality Board and/or Quality Outcomes Committee. These review the hospital's position compared to peer organisations within the Data Quality Maturity Index (produced by NHS Digital) and benchmarking of Coding completeness

- There is a Secondary Uses Service Assurance Group to establish and agree the priorities for improving the quality of data used for commissioning and other secondary uses. This includes developing action plans and implementing changes mandated for national data and commissioning standards; acting on external data quality advice and using external benchmarking to improve the quality of commissioning data; ensuring that data is analysed over time, trends are monitored and unexpected variation is investigated. We work closely with the local Commissioning Support Unit to ensure that they receive additional local data flows to support the commissioning process.

- Our weekly corporate data quality meeting challenges inaccurate and incomplete data collection. Our data quality team action reports on a daily

basis to maximise coverage of NHS Number, accurate GP registration and ensures singularity of patient records

4.6 NHS Number and General Medical Practice Code Validity

The University Hospitals of Leicester NHS Trust submitted records during 2018/19 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data:

- which included the patient's valid NHS number was:
  - 99.8% for admitted patient care
  - 99.9% for outpatient care
  - 98.7% for emergency department care
- which included the patient's valid General Medical Practice Code was:
  - 100% for admitted patient care
  - 100% for outpatient care
  - 100% for emergency department care

4.7 Clinical coding error rate

Clinical coding translates the medical terminology written by clinicians to describe a patient's diagnosis and treatment into standard, recognised codes. The accuracy of this coding is a fundamental indicator of the accuracy of the patient records.

The University Hospitals of Leicester NHS Trust was not subject to a Payment by Results clinical coding audit during 2018/19.

4.8 Data Security and Protection Toolkit Score

University Hospitals of Leicester NHS Trust's Data Security and Protection Toolkit score for 2018/19 was 100%.

We recognise the importance of robust information governance. During 2018/19, the chief technical officer retained the role of senior information risk owner and the medical director continued as our caldicott guardian.

All NHS Trusts are required annually to carry out an information governance self-assessment using the NHS Data Security & Protection Toolkit.

This contains 10 standards of good practice, spread across the domains of:

1. Robust Patient Confidential Data processes
2. Staff training around Patient Confidential Data
3. Staff training for General Data Protection Regulation (GDPR)
4. PCD is accessed by appropriate personnel
5. Policy and Process Review Strategy in place
6. Cyber Attack Prevention
7. Continuity Plan in place for Data
8. Unsupported Software Strategy
9. Cyber Attack Strategy
10. Contract Management

As this is the first year of the toolkit, Leicester's Hospitals are not required to meet a specified target to be considered a Trusted Organisation. It is expected that we will be complaint with all mandatory assertions by the 31/3/2019. Any non-mandatory assertions will require an action plan to achieve within a specific time frame set by Leicester's Hospitals.

Our information governance improvement plan for 2018/19 was overseen by our information governance steering group, chaired by the data protection officer.

4.9 Care Quality Commission (CQC) ratings

University Hospitals of Leicester NHS Trust is required to register with the CQC and its current registration status is 'Requires Improvement'.

In November and December 2017, the Care Quality Commission (CQC) carried out unannounced inspections of our services. This was followed by an announced well-led review in January 2018. The aim of these inspections was to check whether the services that we are providing are safe, caring, effective, responsive to people's needs and well-led.

This inspection covered five of the nine core and additional services:

- Urgent and emergency services (A&E)
- Medical care (including older people's care)
- Maternity
- Outpatients
- Diagnostics services (such as x-rays and scans)

Where services were not inspected by the CQC in 2017/18, they retain their rating from the previous comprehensive inspection in 2016.

The reports from this inspection have been published are available on the CQC's website along with their ratings of the care provided, a summary of which is:

Key to tables

Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding

Overall trust ratings

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement

Royal Infirmary

	Safe	Effective	Caring	Responsive	Well-led	**Overall**
Urgent & emergency services	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Medical Care (including older people's care)	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Surgery	Requires improvement	Good	Good	Good	Good	Good
Critical Care	Good	Good	Good	Good	Good	Good
Maternity	Requires improvement	Good	Good	Good	Good	Good
Services for children & Young People	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
End of Life Care	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Outpatients	Requires improvement	N/A	Good	Requires improvement	Requires improvement	Requires improvement
Diagnostic imaging	Requires improvement	N/A	Good	Good	Requires improvement	Requires improvement
Overall	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement

General Hospital

	Safe	Effective	Caring	Responsive	Well-led	**Overall**
Medical Care (including older people's care)	Requires improvement	Good	Good	Good	Good	Good
Surgery	Requires improvement	Requires improvement	Good	Requires improvement	Good	Requires improvement
Critical Care	Requires improvement	Good	Good	Good	Good	Good
Maternity	Requires improvement	Good	Good	Good	Good	Good
End of Life Care	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Outpatients	Requires improvement	N/A	Good	Requires improvement	Requires improvement	Requires improvement
Diagnostic imaging	Requires improvement	N/A	Good	Good	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Glenfield

	Safe	Effective	Caring	Responsive	Well-led	**Overall**
Medical Care (including older people's care)	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Surgery	Requires improvement	Good	Good	Good	Good	Good
Critical Care	Good	Good	Good	Good	Good	Good
Services for children & Young People	Good	Outstanding	Good	Good	Good	Good
End of life care	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Good	N/A	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement

St Mary's Birth centre

	Safe	Effective	Caring	Responsive	Well-led	**Overall**
Maternity	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Of the 115 ratings in total (for each domain of each main service grouping):

- 1 is 'outstanding' (for the effectiveness of our East Midlands Congenital Heart service at Glenfield)
- 71 are 'good'
- 38 are 'requires improvement'
- None are 'inadequate'
- Five are unrated for technical reasons

Through their inspections, the CQC found a strong link between the quality of overall management of Leicester's Hospitals and the quality of its services. Ratings for both maternity services and the 'effectiveness' of services overall are now rated as 'good' and no services are now rated as inadequate. CQC inspectors also noted the significant improvements in our urgent and emergency services.

University Hospitals of Leicester NHS Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

The CQC has taken enforcement action against University Hospitals of Leicester NHS Trust during 2018/19 as follows:

In December 2017 the CQC issued a Section 29A Warning Notice in relation to insulin safety. This Warning Notice remained in place until June 2018.

Since the Warning Notice was issued we have accelerated our work to improve insulin safety. We have focused on face to face education and training for our doctors and nurses, improved decision making tools and enhanced support from the diabetic specialist team.

In November 2018 the CQC carried out a review of the effectiveness of health services for looked after children and the effectiveness of safeguarding arrangements within health for all children within Leicestershire.

The focus was on the experiences of looked after children and children and their families who receive safeguarding services.

The CQC looked at:

- the role of healthcare providers and commissioners
- the role of healthcare organisations in understanding risk factors, identifying needs, communicating effectively with children and families, liaising with other agencies, assessing needs and responding to those needs and contributing to multi-agency assessments and reviews
- the contribution of health services in promoting and improving the health and wellbeing of looked after children including carrying out health assessments and providing appropriate services

Fifty one recommendations are set out in the report from this review and an action plan to address these has been co-ordinated by the West Leicestershire Clinical Commissioning Group.

5. Other Statements

5.1 Statements from our stakeholders

Statement from Healthwatch Leicester and Leicestershire

We welcome this opportunity to comment on the UHL Quality Account for 2018/19. We continue to value the positive and open relationship between Healthwatch and UHL.

Our Healthwatch Chair sits on the Trust Board meetings and we have supported the re-established the quarterly meetings between Healthwatch across the LLR region and key UHL board representatives to discuss issues that have emerged from our ongoing engagement with local groups and communities.

Patients report mixed experiences at UHL. Through the year we have heard from patients sharing their stories of wonderful and supportive care received in different services within our local hospitals, we have also heard from patients who felt their care fell well below what they had expected to receive. Through our relationship with UHL we have ensure these patient stories have been highlighted to share the public experience. It has also been concerning that UHL have logged the number of Never-Events that they have. Staffing issues has an understandable impact on the ability to deliver effective patient care and we know UHL are working hard to mitigate this.

A study conducted by Healthwatch of the discharge lounges at the Glenfield Hospital and the Leicester Royal Infirmary highlighted some possible inconsistencies in patient experience and we are working closely with senior UHL staff to better understand what the full impact on patient care this may represent.

As Healthwatch, we believe that the Trust is open to patient involvement and patient views are welcome. The Trusts' new PPI strategy is an excellent example and we are pleased to see that the revised strategy distinguishes between the role of UHL's Patient Partners and the wider patient and public involvement.

UHL has come under criticism this year for the transfer of ICU beds from the General site and how this has been handled historically. Healthwatch Leicester and Healthwatch Leicestershire did not feel that all of the criticism was warranted but

did agree that key lessons need to be learned about keeping an open dialogue with the public during this period of significant change.

Overall this year has continued to be a challenging year for UHL, and we would like to commend them for their work on reducing the number of cancelled elective operations, which was in conjunction with their key NHS partners.

Harsha Kotecha – HAB Chair

Statement from the Leicestershire County Council Health Overview Scrutiny Committee

LEICESTERSHIRE COUNTY COUNCIL HEALTH OVERVIEW AND SCRUTINY COMMITTEE

COMMENTS ON THE UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST QUALITY ACCOUNT FOR 2018/19

April 2019

The Leicestershire Health Overview and Scrutiny Committee is of the view that the Quality Account presented by UHL offers a balanced picture of the trust's performance and is not aware of any major omissions.

It is disappointing that Leicester's Hospitals have not met the target to treat and discharge a minimum of 95% of patients within 4 hours. The Committee has long had concerns that the new Emergency Department would not have the positive impact on delays that UHL hoped for and is pleased that UHL have now recognised that further work needs to be carried out to improve the flow of patients through the hospital and the discharge process. The Committee has raised concerns that some of the discharge delays are due to patients waiting for medication to be provided by the hospital pharmacy and ask UHL to give consideration to how this can be improved. The Committee welcomes the fact that implementing safe and timely discharge is a quality priority for 2019/20.

It is right that the Quality Account addresses the challenges UHL faced during the winter due to the increase in demand over that period. The Committee is concerned that performance may not improve in future winters taking into account that the population of LLR is continuing to increase. Nevertheless, it is reassuring that winter planning for 2019/20 has already started and work is being undertaken to address the gap between capacity and demand. The Committee is of the view that further work needs to be carried out to ensure the public are aware when they should attend the Emergency Department and when an Urgent Care Centre would be a better option.

It is pleasing that the Quality Account recognises capacity constraints within some key services and that UHL acknowledges that action needs to be taken with regards to Outpatient services. During the year the Committee raised

concerns regarding waiting times for Outpatient appointments (particularly ophthalmology and ENT).The Committee is aware that consideration is being given to how the process for follow up appointments could be more efficient and hopes that the backlog is not going to be passed onto GP Practices. It is noted that improvements have been made in cancellation performance, though cancellation rates are above the 0.8% target. With regard to the amount of patients that fail to attend appointments the Committee notes that appointments are often cancelled and rearranged which causes confusion. Members were pleased to receive reassurance that going forward greater use will be made of technology such as two way text reminders and 'way finding' mobile phone apps. The Committee looks forward to the development of this system though hopes that UHL take into account that not all patients are able to use these types of technology.

The Committee has been monitoring the performance for Cancer referrals and questions whether the system has the capacity to meet demand. It is noted from the Quality account that many of the standards are not being met, though the performance for the 62 day cancer standard has improved. The Committee welcomes the fact that improving the performance for the 62 day standard is a key priority for Leicester's Hospitals.

Statement from the Leicester City Council Health and Wellbeing Scrutiny Commission

Due to the timing of local elections and the transition to a new chair, the Leicester City Council Health and Wellbeing Scrutiny Commission has been unable to provide commentary on Leicester's Hospitals' Quality Account for 2018/19.

The Commission have however provided scrutiny of Leicester's Hospitals throughout the year and where possible, this has been reflected in the Quality Account.

Statement from the Clinical Commissioning Groups

UHL Quality Account 18/19

The Leicester, Leicestershire and Rutland Clinical Commissioning Groups (CCGs) have reviewed the information provided by University Hospitals of Leicester Trust (UHL) in this report. There is recognition of the continued commitment from hospital staff to address national and local challenges in order to provide safe, effective care to patients.

In particular, the CCGs acknowledge the improvements UHL have made in relation to the number of patients with a fractured neck of femur who have accessed theatres for a surgical repair within 36 hours. The contract Performance Notice, originally issued in June 2016 in relation to this quality standard, has recently been closed as a result of the sustained evidence of improvement.

The CCGs acknowledge the increasing demands on UHL services against a backdrop of workforce challenges and financial pressures and is pleased to note that, despite this, the number of patients who had operations cancelled has reduced from the previous year.

The CCGs remain concerned around the number of Never Events that have occurred in 2018 relating to surgery. A Contract Performance Notice was originally issued in May 2017 in relation to Never Events generally; however, actions taken so far have not led to a reduction or cessation in similar errors occurring. The CCGs welcome the focus on Safer Surgery as one of UHL's three quality priorities and look forward to the implementation of the newly developed Quality Strategy as a vehicle to achieving the Trust's quality ambitions.

Chris West

Director of Nursing and Quality (Leicester City CCG) on behalf of Leicester City CCG, West Leicestershire CCG and East Leicestershire and Rutland CCG

20/04/2019

NHS
University Hospitals of Leicester
NHS Trust
Caring at its best

5.2 Statement from our External Auditors

Independent Practitioner's Limited Assurance Report to the Board of Directors of University Hospitals of Leicester NHS Trust on the Quality Account

We have been engaged by the Board of Directors of University Hospitals of Leicester NHS Trust to perform an independent assurance engagement in respect of University Hospitals of Leicester NHS Trust's Quality Account for the year ended 31 March 2019 ("the Quality Account") and certain performance indicators contained therein as part of our work. NHS Trusts are required by section 8 of the Health Act 2009 to publish a Quality Account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010 and as subsequently amended in 2011, 2012, 2017 and 2018 ("the Regulations").

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to the limited assurance engagement consist of the following indicators:

- percentage of patients risk-assessed for venous thromboembolism (VTE); and
- percentage of patient safety incidents resulting in severe harm or death.

We refer to these two indicators collectively as "the indicators".

Respective responsibilities of the directors and Practitioner

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health and NHS Improvement has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the Regulations).

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

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

The Directors are required to confirm compliance with these requirements in a statement of directors' responsibilities within the Quality Account.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2014-15 issued by the Department of Health in March 2015 ("the Guidance"); and

- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

We read the Quality Account and conclude whether it is consistent with the requirements of the Regulations and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Account and consider whether it is materially inconsistent with:

- Board minutes for the period 1 April 2018 to 24 May 2019;
- papers relating to quality reported to the Board over the period 1 April 2018 to 24 May 2019;
- feedback from Leicester City Clinical Commissioning Group, West Leicestershire Clinical Commissioning Group and East Leicestershire and Rutland Clinical Commissioning Group dated 20 April 2019;
- feedback from Healthwatch Leicester and Healthwatch Leicestershire dated 16 May 2019;
- feedback from Leicestershire County Council Overview and Scrutiny Committee dated 1 May 2019;
- feedback from Leicester City Council Overview and Scrutiny Committee dated 9 May 2019;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and National Health Service Complaints (England) Regulations 2009, dated 2 April 2019;
- the national patient survey dated 22 November 2018;
- the national staff survey dated 26 February 2019;
- the Head of Internal Audit's annual opinion over the Trust's control environment dated 24 May 2019;
- the annual governance statement dated 24 May 2019; and
- the Care Quality Commission's inspection report dated 14 March 2018.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these documents (collectively the "documents"). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Board of Directors of University Hospitals of Leicester NHS Trust. We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and University Hospitals of Leicester NHS Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement under the terms of the Guidance. Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- limited testing, on a selective basis, of the data used to calculate the indicators tested against supporting documentation;
- comparing the content of the Quality Account to the requirements of the Regulations; and

- reading the documents.

A limited assurance engagement is narrower in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques that can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

The nature, form and content required of Quality Accounts are determined by the Department of Health and NHS Improvement. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.

In addition, the scope of our limited assurance work has not included governance over quality or non-mandated indicators which have been determined locally by University Hospitals of Leicester NHS Trust.

Our audit work on the financial statements of University Hospitals of Leicester NHS Trust is carried out in accordance with our statutory obligations and is subject to separate terms and conditions. This engagement will not be treated as having any effect on our separate duties and responsibilities as University Hospitals of Leicester NHS Trust's external auditors. Our audit reports on the financial statements are made solely to University Hospitals of Leicester NHS Trust's directors, as a body, in accordance with the Local Audit and Accountability Act 2014. Our audit work is undertaken so that we might state to University Hospitals of Leicester NHS Trust's directors those matters we are required to state to them in an auditor's report and for no other purpose. Our audits of University Hospitals of Leicester NHS Trust's financial statements are not planned or conducted to address or reflect matters in which anyone other than such directors as a body may be interested for such purpose. In these circumstances, to the fullest extent permitted by law, we do not accept or assume any responsibility to anyone other than University Hospitals of Leicester NHS Trust and University Hospitals of Leicester NHS Trust's directors as a body, for our audit work, for our audit reports, or for the opinions we have formed in respect of those audits.

Basis for qualified conclusion

The indicator reporting the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism (VTE) during the reporting period did not meet the six dimensions of data quality in the following respects:

- Accuracy and validity: in our testing of 25 cases we identified 2 records recorded as 'not being VTE risk-assessed within 24 hours' which had a completed VTE form in the patient record which had been completed within 24 hours of the admission time. The errors resulted in both cases being incorrectly recorded in line with the applicable guidance.

Qualified conclusion

Based on the results of our procedures, with the exception of the matter reported in the basis for qualified conclusion paragraph above, as described in this report, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and

- the indicators in the Quality Account identified as having been subject to limited assurance have not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

Grant Thornton UK LLP
Chartered Accountants
Birmingham

24 May 2019

5.3 Statement of Directors' responsibilities in respect to the Quality Account

The directors at Leicester's Hospitals are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amendment Regulations 2011). In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

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

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

By order of the Board

Karamjit Singh, Chairman John Adler, Chief Executive

6. Appendices

6.1 Appendix 1.1 The national clinical audits that Leicester's Hospitals were eligible to participate in during 2018/19

Name of Audit	Did Leicester's Hospitals participate?	Stage / % of cases submitted
Adult Cardiac Surgery	Yes	Continuous data collection
Adult Community Acquired Pneumonia	Yes	Continuous data collection
BAUS Urology Audit - Cystectomy	Yes	Continuous data collection
BAUS Urology Audit – Female Stress Urinary Incontinence (SUI)	Yes	Continuous data collection
BAUS Urology Audit - Nephrectomy	Yes	Continuous data collection
BAUS Urology Audit - Percutaneous Nephrolithotomy (PCNL)	Yes	Continuous data collection
BAUS Urology Audit – Radical Prostatectomy	Yes	Continuous data collection
Cardiac Rhythm Management (CRM)	Yes	Continuous data collection
Case Mix Programme (CMP)	Yes	Continuous data collection
Fracture Liaison Service Database (FFFAP)	NA	Leicester's Hospitals do not provide this service
National Audit Inpatient Falls (FFFAP)	Yes	Continuous data collection
National Hip Fracture Database (FFFAP)	Yes	Continuous data collection
Feverish Children (care in emergency departments)	Yes	100% data submitted
Inflammatory Bowel Disease programme / IBD Registry	No	Registered but no data submitted as at Jan-19
Major Trauma Audit	Yes	Continuous data collection
Myocardial Ischaemia National Audit Project (MINAP)	Yes	Continuous data collection
National Asthma and COPD Audit Programme	Yes	Continuous data collection
National Audit of Anxiety and Depression	NA	Leicester's Hospitals do not provide this service

Name of Audit	Did Leicester's Hospitals participate?	Stage / % of cases submitted
National Audit of Breast Cancer in Older People	Yes	Data submitted
National Audit of Cardiac Rehabilitation	Yes	Continuous data collection
National Audit of Care at the End of Life (NACEL)	Yes	Data submitted
National Audit of Dementia	Yes	Data submitted
National Audit of Intermediate Care	NA	Leicester's Hospitals do not provide this service
National Audit of Percutaneous Coronary Interventions (PCI)	Yes	Continuous data collection
National Audit of Pulmonary Hypertension	NA	Leicester's Hospitals do not provide this service
National Audit of Seizures and Epilepsies in Children and Young People	Yes	Continuous data collection
National Bariatric Surgery Registry (NBSR)	Yes	Continuous data collection
National Bowel Cancer Audit (NBOCA)	Yes	Continuous data collection
National Cardiac Arrest Audit (NCAA)	Yes	Continuous data collection
National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis (NCAREIA)	Yes	Continuous data collection
National Clinical Audit of Psychosis	NA	Leicester's Hospitals do not provide this service
National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)	NA	Leicester's Hospitals do not provide this service
National Comparative Audit of Blood Transfusion programme	Yes	Data submitted
National Congenital Heart Disease (CHD)	Yes	Continuous data collection
National Diabetes Foot Care Audit (NDA)	Yes	Data submitted
National Diabetes Inpatient Audit (NaDIA) - reporting data on services in England and Wales (NDA)	Yes	Data submitted
NaDIA-Harms - reporting on diabetic inpatient harms in England (NDA)	Yes	Data submitted

Name of Audit	Did Leicester's Hospitals participate?	Stage / % of cases submitted
National Core Diabetes Audit (NDA)	Yes	Continuous data collection
National Pregnancy in Diabetes Audit (NDA)	Yes	Data submitted
National Emergency Laparotomy Audit (NELA)	Yes	Continuous data collection
National Heart Failure Audit	Yes	Continuous data collection
National Joint Registry (NJR)	Yes	Continuous data collection
National Lung Cancer Audit (NLCA)	Yes	Continuous data collection
National Maternity and Perinatal Audit (NMPA)	Yes	Continuous data collection
National Neonatal Audit Programme (NNAP)	Yes	Continuous data collection
National Oesophago-gastric Cancer (NAOGC)	Yes	Continuous data collection
National Ophthalmology Audit	No	No data submitted yet
National Paediatric Diabetes Audit (NPDA)	Yes	Data submitted
National Prostate Cancer Audit	Yes	Continuous data collection
National Vascular Registry	Yes	Continuous data collection
Neurosurgical National Audit Programme	NA	Leicester's Hospitals do not provide this service
Non-Invasive Ventilation – Adults	Yes	Data collection ongoing
Paediatric Intensive Care (PICANet)	Yes	Continuous data collection
Prescribing Observatory for Mental Health (POMH-UK)	NA	Leicester's Hospitals do not provide this service
Sentinel Stroke National Audit programme (SSNAP)	Yes	Continuous data collection
Seven Day Hospital Services	Yes	Data submitted
UK Cystic Fibrosis Registry	Yes	Continuous data collection
Vital Signs in Adults (care in emergency departments)	No	Non participation agreed
VTE risk in lower limb immobilisation (care in emergency departments)	Yes	100% data submitted
Elective Surgery (National PROMs Programme)	Yes	Continuous data collection

Name of Audit	Did Leicester's Hospitals participate?	Stage / % of cases submitted
Learning Disability Mortality Review Programme (LeDeR)	Yes	Continuous data collection
Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection	Yes	Continuous data collection
National Mortality Case Record Review Programme	NA	Not invited to submit data yet
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)	Yes	Continuous data collection
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance	Yes	Continuous data collection
Surgical Site Infection Surveillance Service	Yes	Continuous data collection
Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection	Yes	Continuous data collection

6.2 Appendix 1.2 The national confidential enquires that Leicester's Hospitals were eligible to participate in during 2018/19

Name of Enquiry	Did Leicester's Hospitals participate?	Stage / % of cases submitted
Child Health Clinical Outcome Review Programme	To be confirmed	
Maternal, Newborn and Infant Clinical Outcome Review Programme	Yes	Submitted all data possible
Dysphagia in Parkinson's Disease	Study not started	
Acute Heart Failure	Yes	Submitted all data possible
Cancer in Children, Teens and Young Adults	Yes	Submitted all data possible
Perioperative diabetes	Yes	Submitted all data possible
Pulmonary embolism	Yes	Submitted all data possible
Acute Bowel Obstruction	Yes – Active study	Data collection stage
In-hospital management of out-of-hospital cardiac arrest	Study not started	
Mental Health Clinical Outcome Review Programme	N/A	N/A

6.3 Feedback form

We hope you have found this Quality Account useful. In order to make improvements to our Quality Account we would be grateful if you would take the time to complete this feedback form and return it to:

CQC Project Manager
Leicester's Hospitals
The Leicester Royal Infirmary
Infirmary Square
Leicester
LE1 5WW

Email: Helen.harrison@uhl-tr.nhs.uk

1. How useful did you find this report?
   Very useful □
   Quite useful □
   Not very useful □
   Not useful at all □

2. Did you find the contents?
   Too simplistic □
   About right □
   Too complicated □

1. Is the presentation of data clearly labelled?
   Yes, completely □
   Yes, to some extent □
   No □

2. Is there anything in this report you found particularly useful?

3. Is there anything you would like to see in next year's Quality Account?

NHS
University Hospitals of Leicester
NHS Trust
Caring at its best

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

إذا كنت ترغب في الحصول على هذه المعلومات في شكل أو لغة أخرى ، يرجى الاتصال مع مدير الخدمة للمساواة في 0116 250 2959.

আপনি যদি এই লিফলেটের অনুবাদ - লিখিত বা অডিও টেপ'এ চান, তাহলে অনুগ্রহ করে সার্ভিস্ ইকুয়ালিটি ম্যানেজার ডেভ বেকার'এর সাথে 0116 250 2959 নাম্বারে যোগাযোগ করুন।

如果您想用另一种语言或格式来显示本资讯，请致电 0116 250 2959 联系"服务平等化经理" (Service Equality Manager)。

જો તમને આ પત્રઇકાનું લેખિત અથવા ટેઈપ ઉપર ભાષાંતર જોઈતુ હોય તો મહેરબાની કરી સર્વિસ ઈક્વાલિટી મેનેજરનો 0116 250 2959 ઉપર સંપર્ક કરો.

यदि आप को इस लीफलिट का लिखती या टेप पर अनुवाद चाहिए तो कृपया डेब बेकर, सर्विस ईक्वालिटी मेनेजर से 0116 250 2959 पर सम्पर्क कीजिए।

Jeżeli chcieliby Państwo otrzymać niniejsze informacje w tłumaczeniu na inny język lub w innym formacie, prosimy skontaktować się z Menedżerem ds. równości w dostępie do usług (Service Equality Manager) pod numerem telefonu 0116 250 2959.

ਜੇਕਰ ਤੁਹਾਨੂੰ ਇਸ ਲੀਫਲਿਟ ਦਾ ਲਿਖਤੀ ਜਾਂ ਟੇਪ ਕੀਤਾ ਅਨੁਵਾਦ ਚਾਹੀਦਾ ਹੋਵੇ ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਡੈਬ ਬੇਕਰ, ਸਰਵਿਸ ਇਕੁਆਲਿਟੀ ਮੈਨੇਜਰ ਨਾਲ 0116 250 2959 'ਤੇ ਸੰਪਰਕ ਕਰੋ।

Ak by ste chceli dostat túto informáciu v inom jazyku, alebo formáte, kontaktujte prosím manažéra rovnosti sluzieb na tel. čísle 0116 250 2959.

Haddaad rabto warqadan oo turjuman oo ku duuban cajalad ama qoraal ah fadlan la xiriir, Maamulaha Adeegga Sinaanta 0116 250 2959.

Appendix 1

UHL Mortality Rates Slide-deck

May 2019 for QOC

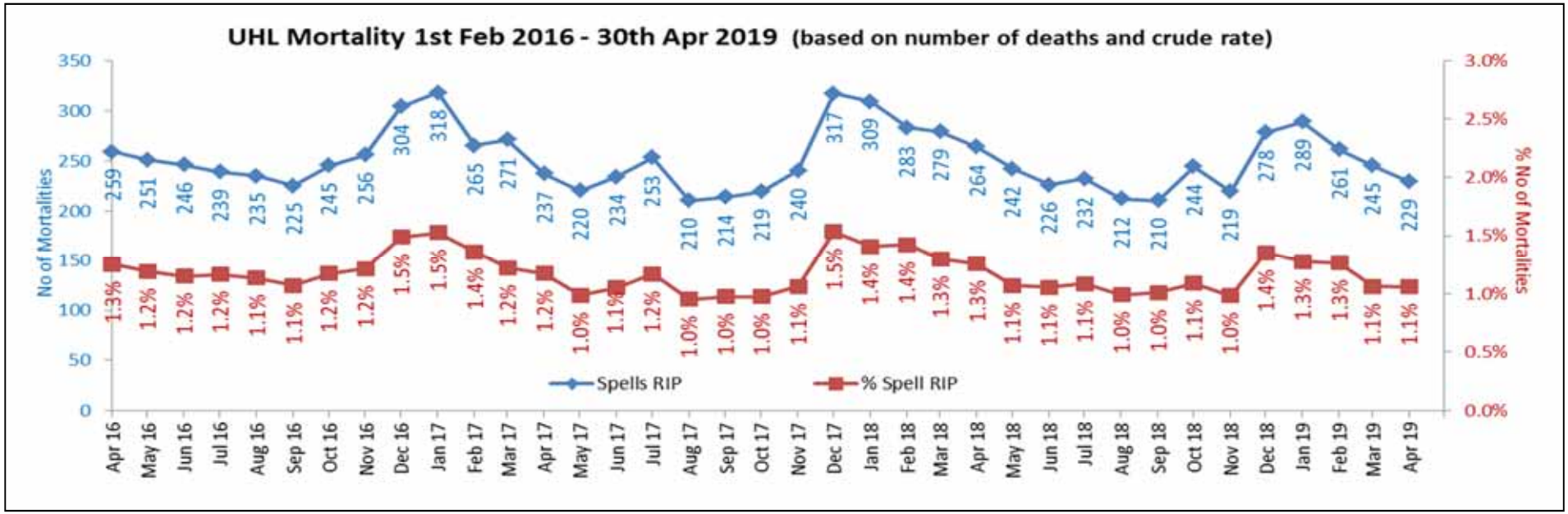
Sponsor: Medical Director

M&M Information & Project Manager
Head of Outcomes & Effectiveness
Deputy Medical Director

What are UHL's current overall crude and risk adjusted mortality rates?

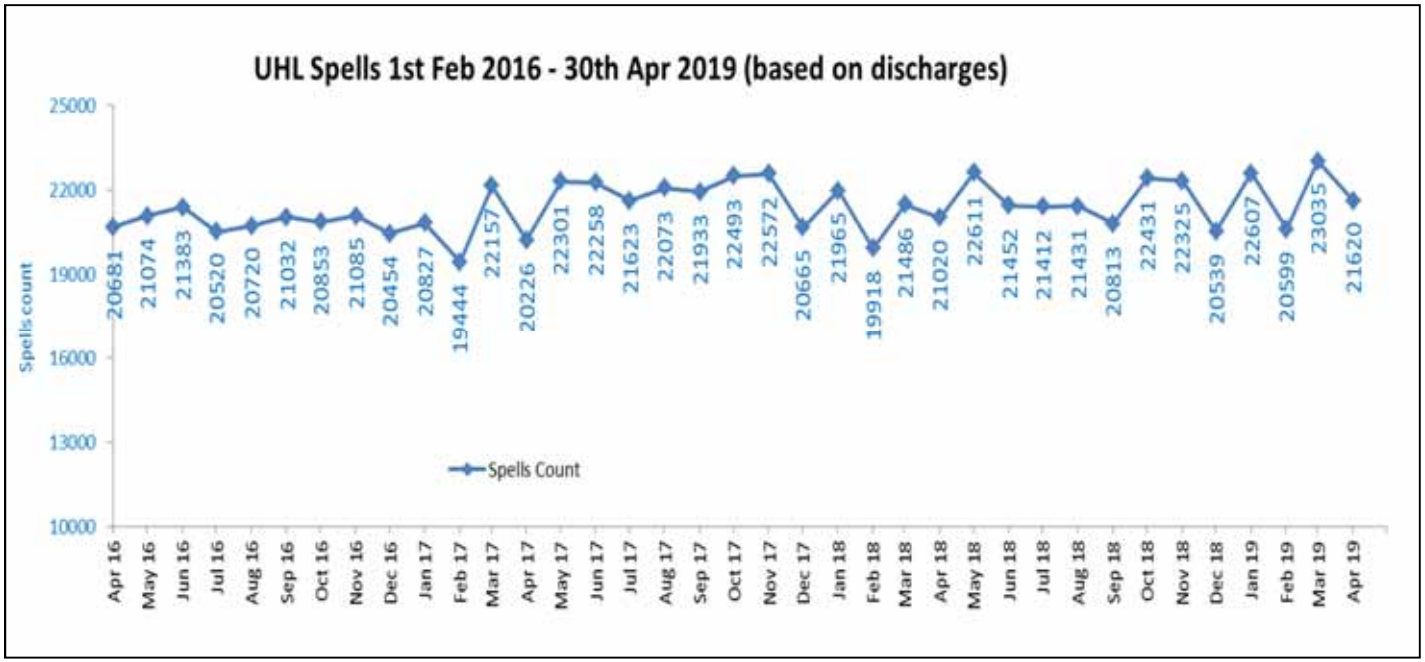
Crude mortality:
i.e. number deaths and proportion of discharges where death is the outcome

How many people died in the Trust between Feb 2016 and 30th Apr 2019 and what is the Trust's crude mortality rate? (excluding ED data)

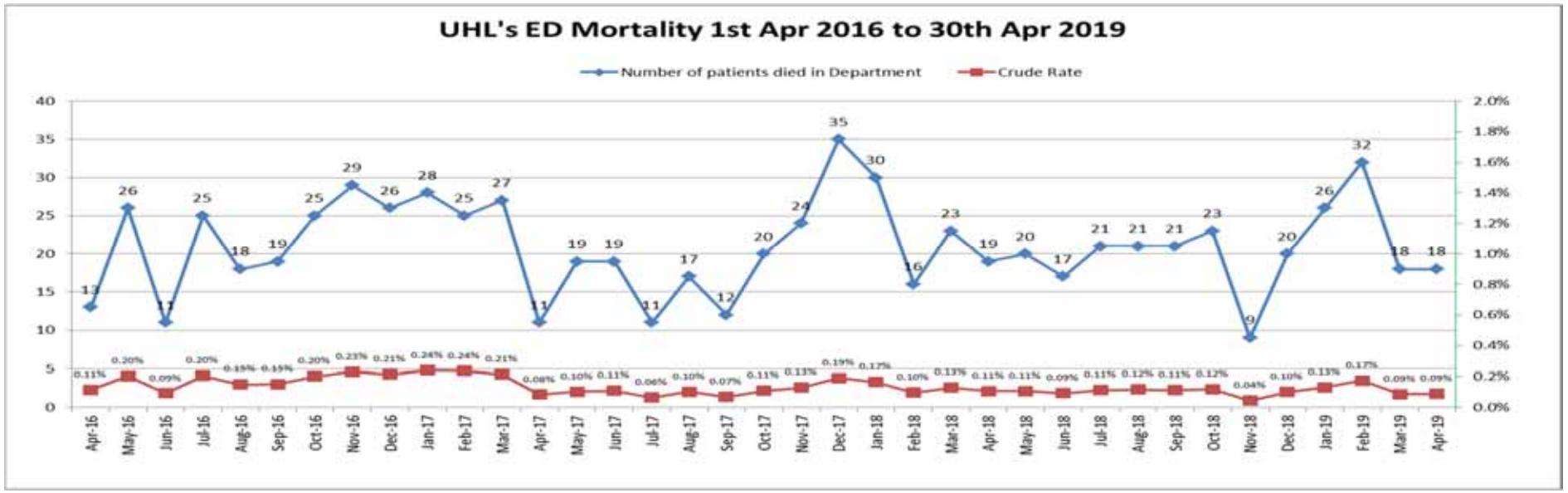


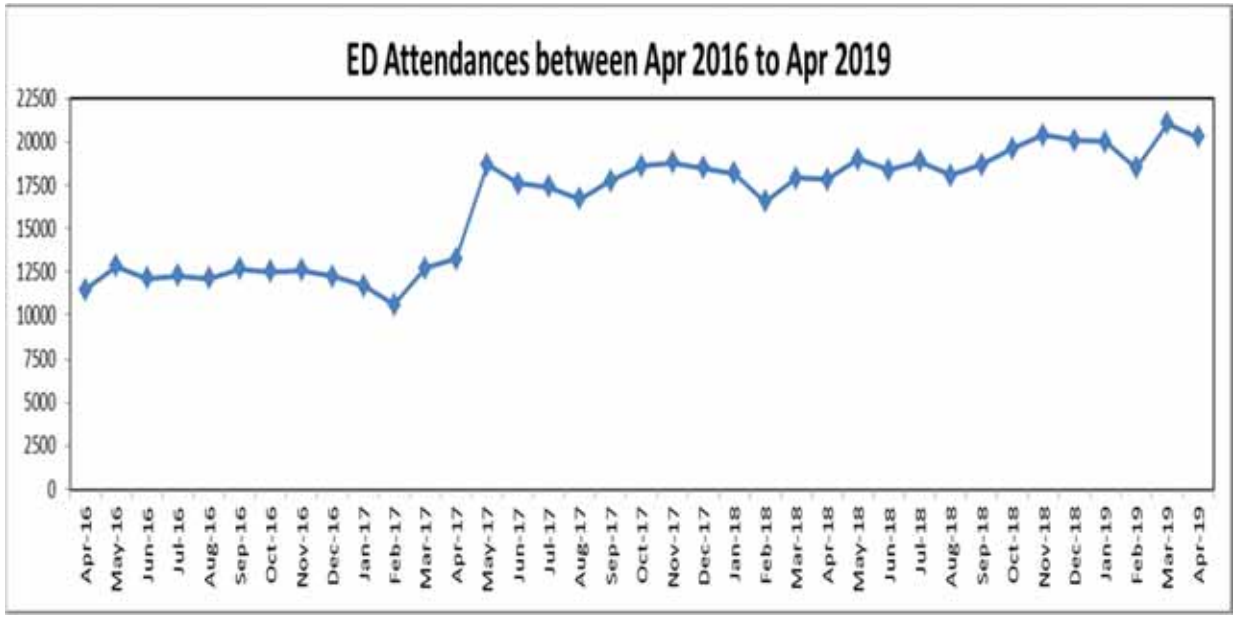
What is the data telling us?

- There has been a month on month reduction in the number of deaths since the winter peak in January and as reported last month both the number of deaths and crude rate for 18/19 over all were lower than for 17/18.
- Whilst we would anticipate our risk adjusted HSMR & SHMI to reflect this lower number/rate, this will depend upon whether other trusts have seen a similar reduction.



Deaths in the Emergency Department (ED) between April 2016 and April 2019





	18/19	17/18	16/17
ED Attendances	**230,449**	209,857	145,706
Deaths	**247**	237	272
Mortality Rate	**0.11%**	0.11%	0.19%

What is the data telling us?

- Deaths in the ED do not include those admitted to the EDU
- There were 10 more deaths in 18/19 than in 17/18 and 400 more attendances so our crude rate remains the same.

UHL's Elective vs Emergency Mortality data

Discharged During…	Emergency Discharges Deaths % Rate	Elective IPs Discharges Deaths % Rate	Daycase Discharges Deaths % Rate	Total Discharges Deaths % Rate
FY 2019/20 YTD (Apr)	11,326 220 1.9%	1,680 9 0.5%	8,614 0 0.0%	21,620 229 1.1%
FY 2018/19	135,509 2847 2.1%	20,867 74 0.4%	103,899 1 0.0%	260,275 2922 1.1%
FY 2017/18	136,684 2948 2.2%	20,290 67 0.3%	102,565 1 0%	259,539 3016 1.2%
FY 2016/17	129,047 3043 2.4%	21,340 71 0.3%	99,846 0 0%	250,233 3114 1.2%
FY 2015/16	128,524 2913 2.3%	21,622 77 0.4%	94,630 3 0%	244,776 2993 1.2%
FY 2014/15	122,456 2932 2.4%	22,252 65 0.3%	91,181 0 0%	234,889 2997 1.3%

What is the data telling us?

- The overall increase in activity for 2018/19 is due to increase in day case and elective activity but, emergency has decreased.
- UHL's overall crude mortality rate for 18/19 has slightly improved on previous years' performance and whilst there has been an increase in activity, there have been fewer deaths.

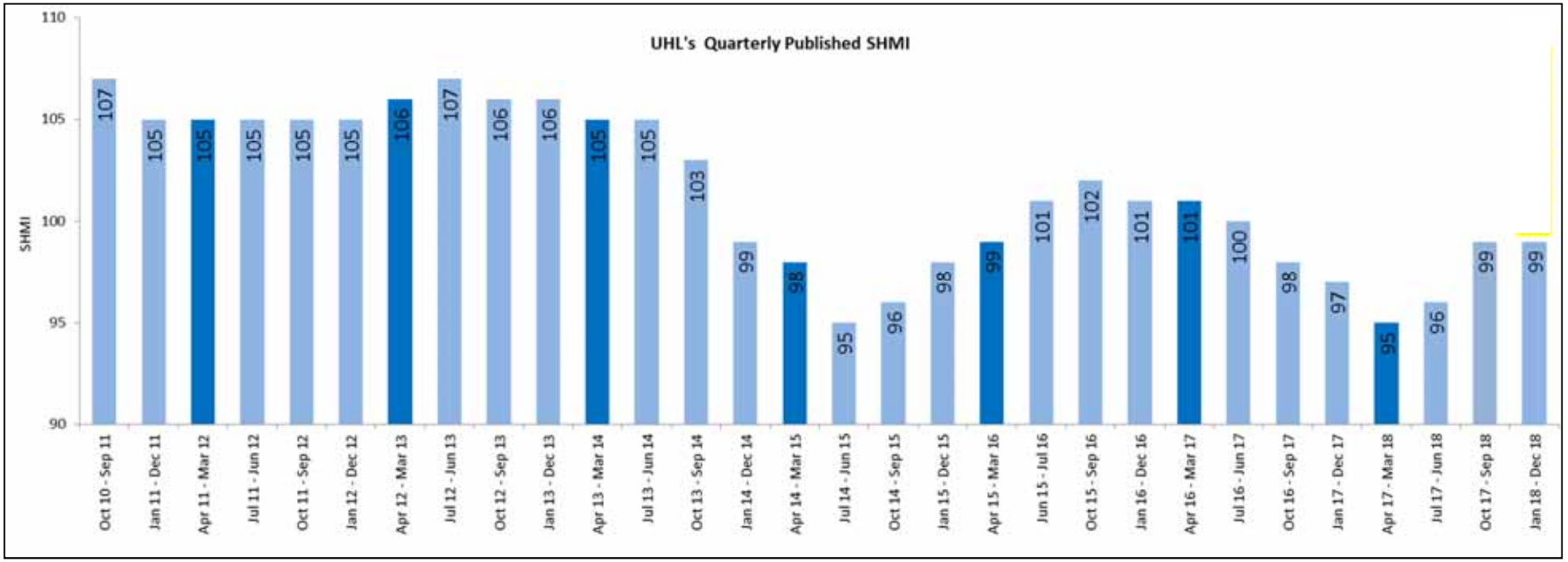
SHMI:
Summary Hospital Mortality Index
ie risk adjusted mortality where patients die either in UHL or within 30 days of discharge
(incl those transferred to a community trust)

NHS Digital have advised that they will be releasing the SHMI data on a monthly basis and that from the May 19 publication onwards, a breakdown of data by hospital site will be available (see Slide 9)

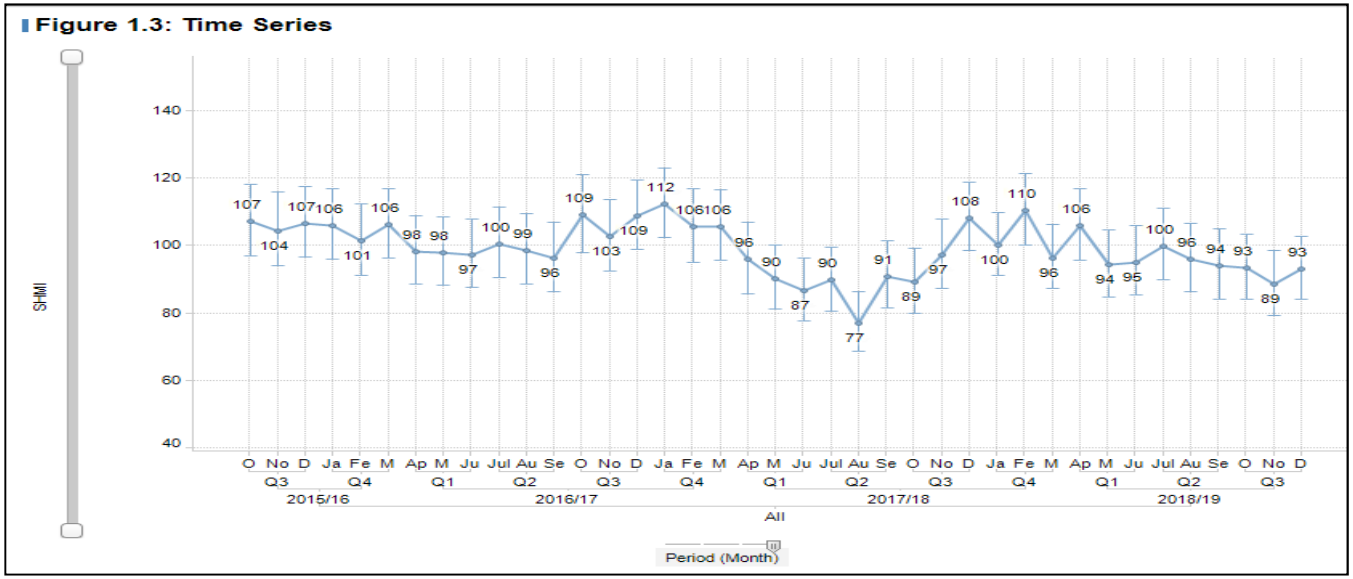
UHL currently subscribes to the University Hospitals of Birmingham's "Hospital Evaluation Dataset" Clinical Benchmarking tool (HED) which uses HSCIC methodology to replicate SHMI. This has allowed us to review our SHMI pre publication and benchmark with other Trusts.

NOTE:
Although HED rebase their SHMI database following uploading of new data, the unpublished SHMI value is usually 1 or 2 below the final NHS Digital published SHMI

What is the Trust's current Summary Hospital Mortality Index (SHMI)?



UHL's monthly SHMI (as reported by HED) Apr 15 – Dec 18



What is the data telling us?

- UHL's latest SHMI published by NHS digital is **99** (as expected) and covers the 2018 Calendar year
- Our 18/19 SHMI should be available in September

Crude rate, HSMR & SHMI breakdown by sites *(data from HED)*

	LRI	GGH	LGH	Total
Crude Mortality Rate*				
2015/16	4.19%	2.20%	1.25%	3.13%
2016/17	4.44%	2.20%	1.13%	3.24%
2017/18	4.01%	2.16%	1.00%	2.95%
2018/19 Apr – Dec	3.60%	2.21%	1.10%	2.75%
HSMR				
2015/16	107	70	91	97
2016/17	114	73	89	102
2017/18	105	72	68	93
2018/19 Apr – Dec	111	79	83	99
SHMI				
2015/16	115	85	85	105
2016/17	113	79	78	103
2017/18	105	74	68	94
2018/19 Apr - Dec	104	79	79	96
Jan 18 – Dec 18 by NHS Digital	***109***	***81***	***80***	***99***

What is the data telling us?

* The data in this table Includes in hospital and out of hospital deaths - where in the community (includes non acute hospitals – For example Loughborough, Melton, St Luke's)

- UHL's overall crude mortality rate (as reported in the SHMI) has improved since 2015/16 which has been reflected in our SHMI figure being below 100.
- The LRI has always had a greater number of deaths and higher SHMI than the other 2 sites but up until recently had seen a year on year reduction in both.

UHL's SHMI for 0 days LOS and 1+ days LOS (Jan 18 to Dec 18 from HED)

NHS Digital have been reviewing the SHMI methodology. It is unclear what changes will be made, or when, but there is a suggestion they may remove '0 LoS' patients from the dataset.
We have therefore undertaken some analysis using the HED tool

UHL Length of Stay	SHMI	SHMI95% CI Lower	SHMI95% CI Upper	Expected number of deaths	Number of patients discharged who died in hospital or within 30 days	Number of mortalities occurring in the hospital	Number of provider spells	Percentage of admissions with palliative care coding	Average comorbidity score per spell	Crude mortality rate	Obs.- Exp.
1 + Days	100.3	97.3	103.4	4137	4149	2678	103866	2.2%	4.9	3.99%	12

UHL Peers' average SHMI for 1+ days LOS = 103.8
National average SHMI for 1+ days LOS = 104.5

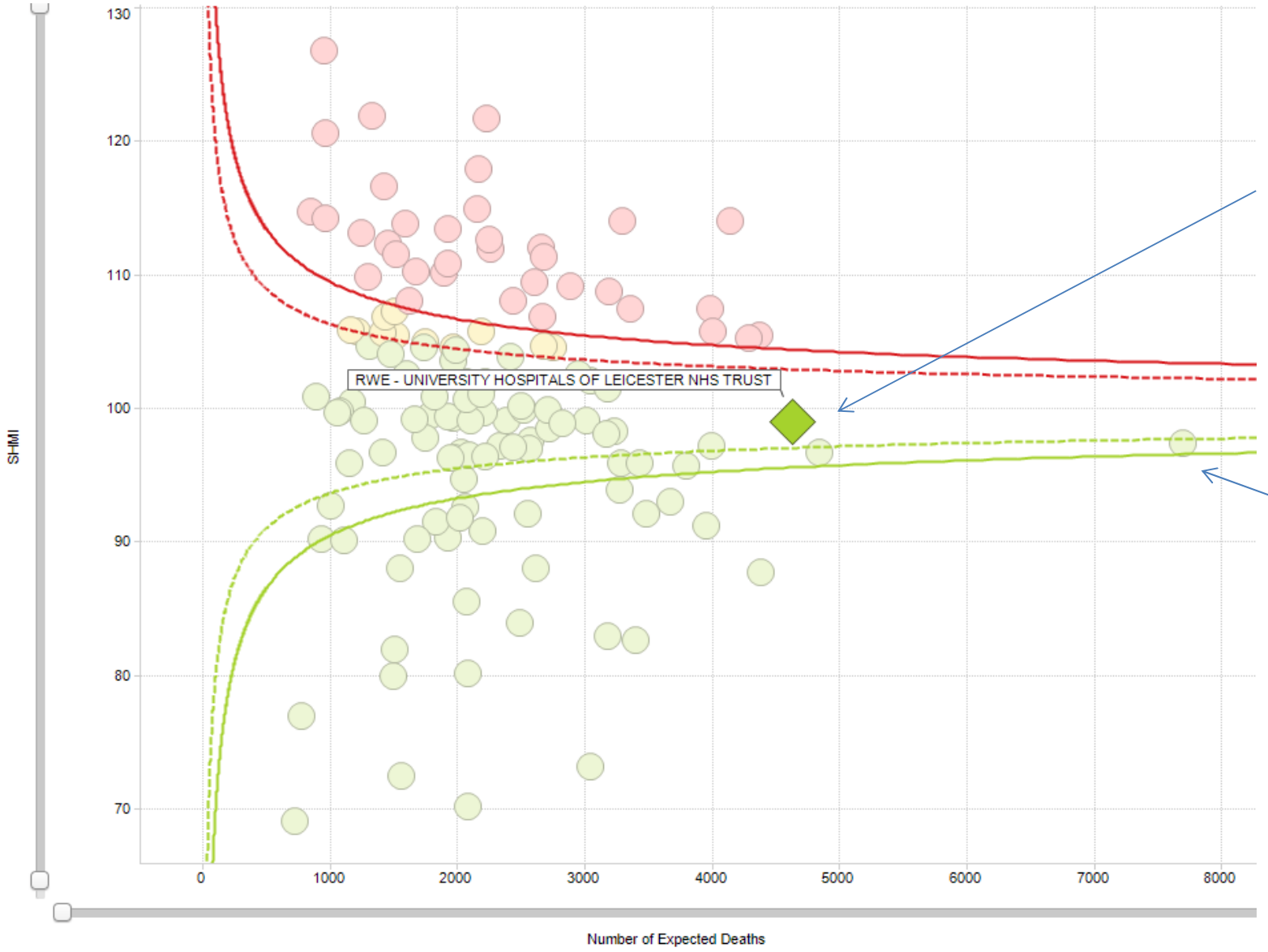
UHL LOS	SHMI	SHMI95% CI Lower	SHMI95% CI Upper	Expected number of deaths	Number of patients discharged who died in hospital or within 30 days	Number of mortalities occurring in the hospital	Number of provider spells	Percentage of admissions with palliative care coding	Average comorbidity score per spell	Crude mortality rate	Obs.- Exp.
0 day	70	62.91	78.43	462	325	256	49756	0.1%	1.6	0.7%	-137
1 day	87	79.05	95.32	517	449	317	35779	0.2%	2.6	1.3%	-68
2 days	77	69.14	86.47	408	316	219	16980	0.7%	3.4	1.9%	-92
3+ days	105	101.83	108.96	3212	3384	2142	51107	4.2%	7.1	6.6%	172
All Patients	97*	94.46	100.18	4599	4474	2934	153622	1.5%	3.9	2.9%	-125

Note

- 0 days LOS according to HES data is any admission and discharge that happens on the same day before midnight.
- For example: - If a patient arrives at 23:10 hours and leaves at 00:20 hours, it will classify in the data as 1 day LOS
- Using the HED tool, the '0 day LOS' SHMI for our 'Peers' is 51.0 and Nationally is 51.4

* The HED SHMI is usually 1-2 points lower than the nationally published SHMI

How does UHL's SHMI – as reported by HED - compare against all Trusts (Jan 18 to Dec 18)



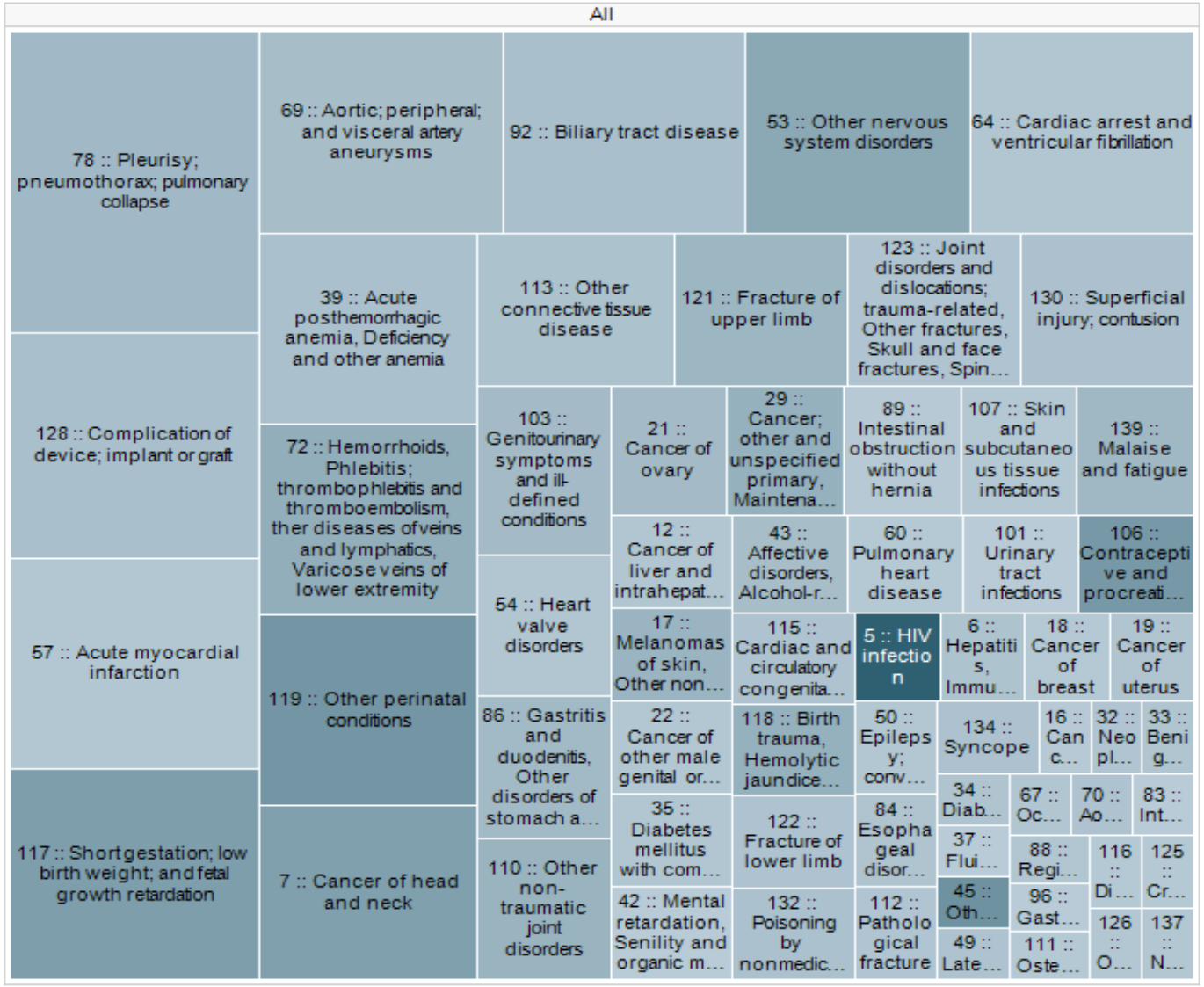
What is the data telling us?

UHL's published SHMI for the period January to December 2018 remains at 99 and is in line with other similar sized trusts.

2 large trusts have recently merged, one of which had previously been a merger of 3 hospitals. The newly merged trust therefore has a much higher number of admissions (over 270,000) and a higher number of 'expected deaths' than other trusts.

Which are the diagnosis groups most contributing to our SHMI?

Diagnosis groups with a SHMI above 100 (Jan 18 to Dec 18)



What is the data telling us?

The box plot chart presents those diagnosis groups with a SHMI above 100. the size of the box indicates the number of excess deaths and the colour indicates the SHMI. i.e., The larger the box, the greater the number of deaths above expected and the darker the colour, the higher the SHMI value.

The top 3 diagnostic groups with excess deaths are :

a) 78 :: Pleurisy; pneumothorax; pulmonary collapse = **16**
b) 128 :: Complication of device; implant or graft = **15**
c) 57 :: Acute myocardial infarction = **14**

The top 3 diagnostic groups with highest SHMIs are:

a) 5:: HIV Infection = **455**
b) 45:: Other mental conditions, Personal history of mental disorder; mental and behavioural problems; observation and screening for mental condition, Pre-adult disorders, Schizophrenia and related disorders = **289**
c) 119:: Other perinatal conditions = **277**

Top 3 diagnosis groups with highest SHMI have not changed compared to previous report, 128 :: complication of device; implant or graft diagnosis group have 15 deaths above expected which for the first time has come up in the top 3.
All these groups have already or are currently being reviewed.

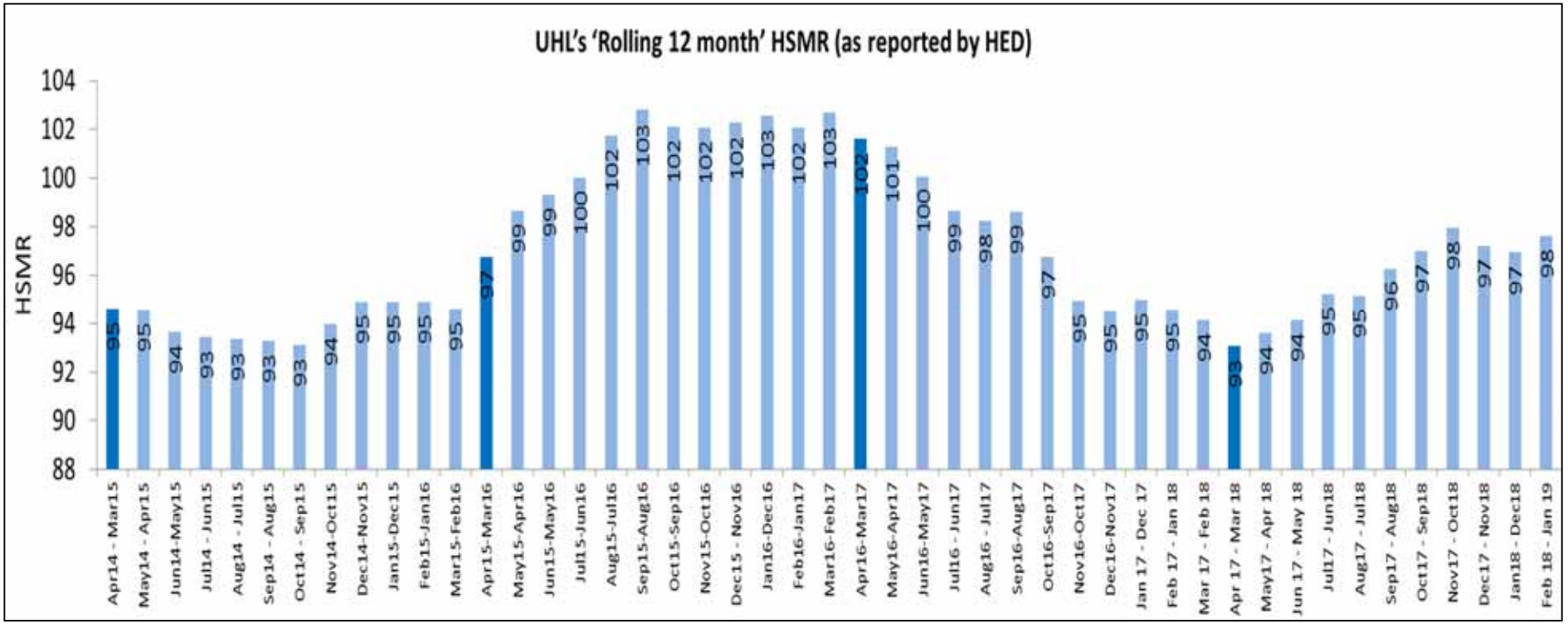
HSMR:
Hospital Standardised Mortality Ratio

HSMR is risk adjusted mortality where patients die in hospital (either in UHL or if transferred directly to another NHS hospital trust) **over a 12 month period within 56 diagnostic groups** (which contribute to 80% of in-hospital deaths).

The HSMR methodology was developed by the Dr Foster Unit at Imperial College (DFI) and is used as by the CQC as part of their assessment process, however the 'rolling 12 month' data presented in the next chart is taken from the Hospital Evaluation Dataset (HED) as their HSMR has been more recently rebased against all other trusts.

NOTE: Following upload of new national data, both HED and DFI 'rebase' their HSMR dataset and therefore Trusts may see a change in their previously reported HSMR.

What is the Trust's current Hospital Standardised Mortality Ratio (HSMR)?



What is the data telling us?

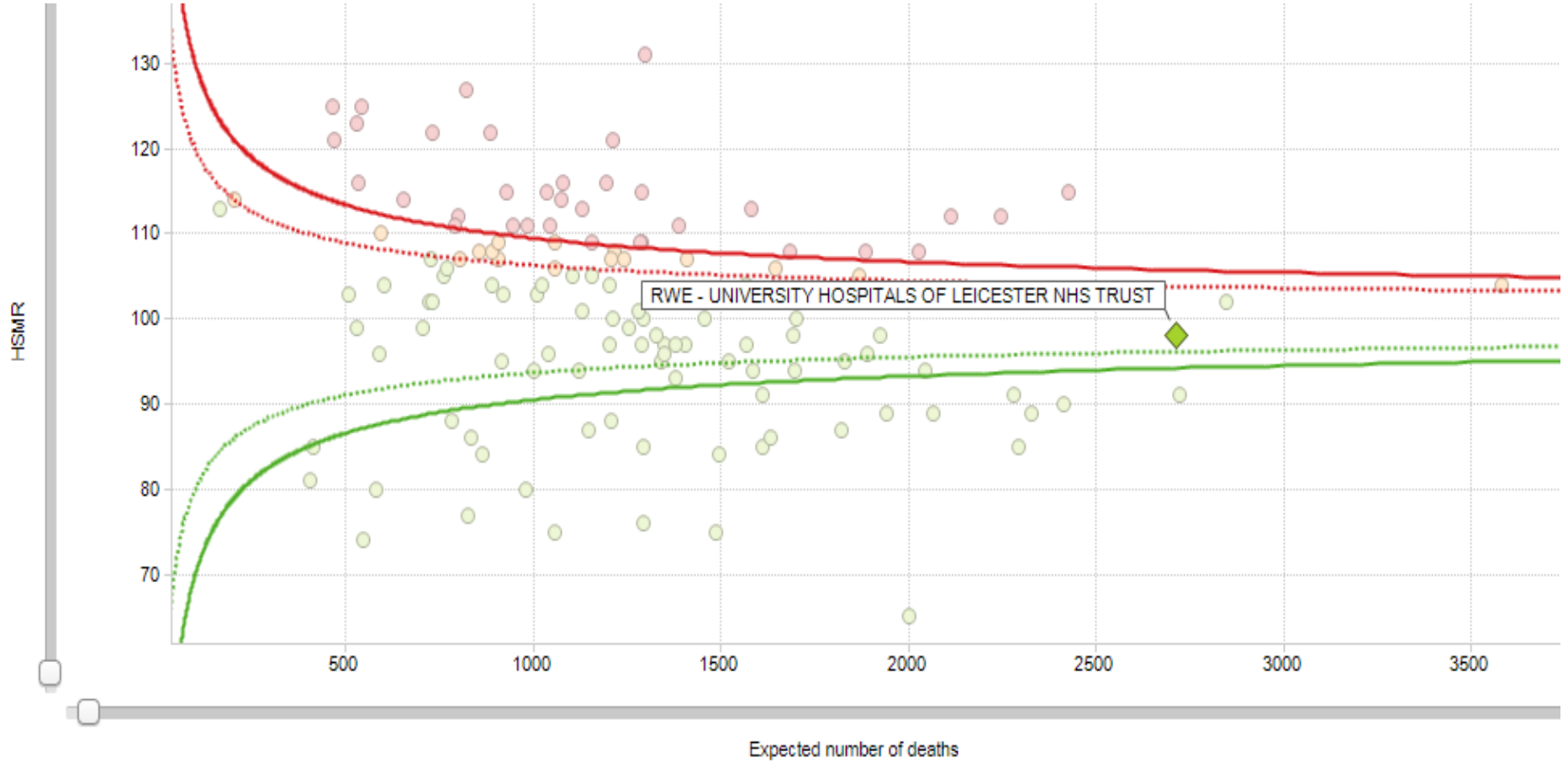
The latest 'rolling 12 month' HSMR in the HED tool covers the period **February 18 to January 19 and UHL's HSMR in the HED tool is 97.6** (ie as **expected) Our HSMR in the Dr Fosters Intelligence tool** for the same period is **94.**

UHL's HSMR was 93 for the financial year 2017/18 (as reported by HED) and 92 (as reported by DFI). DFI have changed their rebasing approach and so it is expected that future data will correlate more closely with that provided by HED.

Our 18/19 FYE HSMR will be available for the next Quarterly report.

Financial Year	HSMR (HED)	HSMR (DFI)
2014/15	95	95
2015/16	97	95
2016/17	102	102
2017/18	93	92

How does UHL's HSMR* compare with our Peer trusts? (Feb 18 – Jan 19)
*Data taken from HED



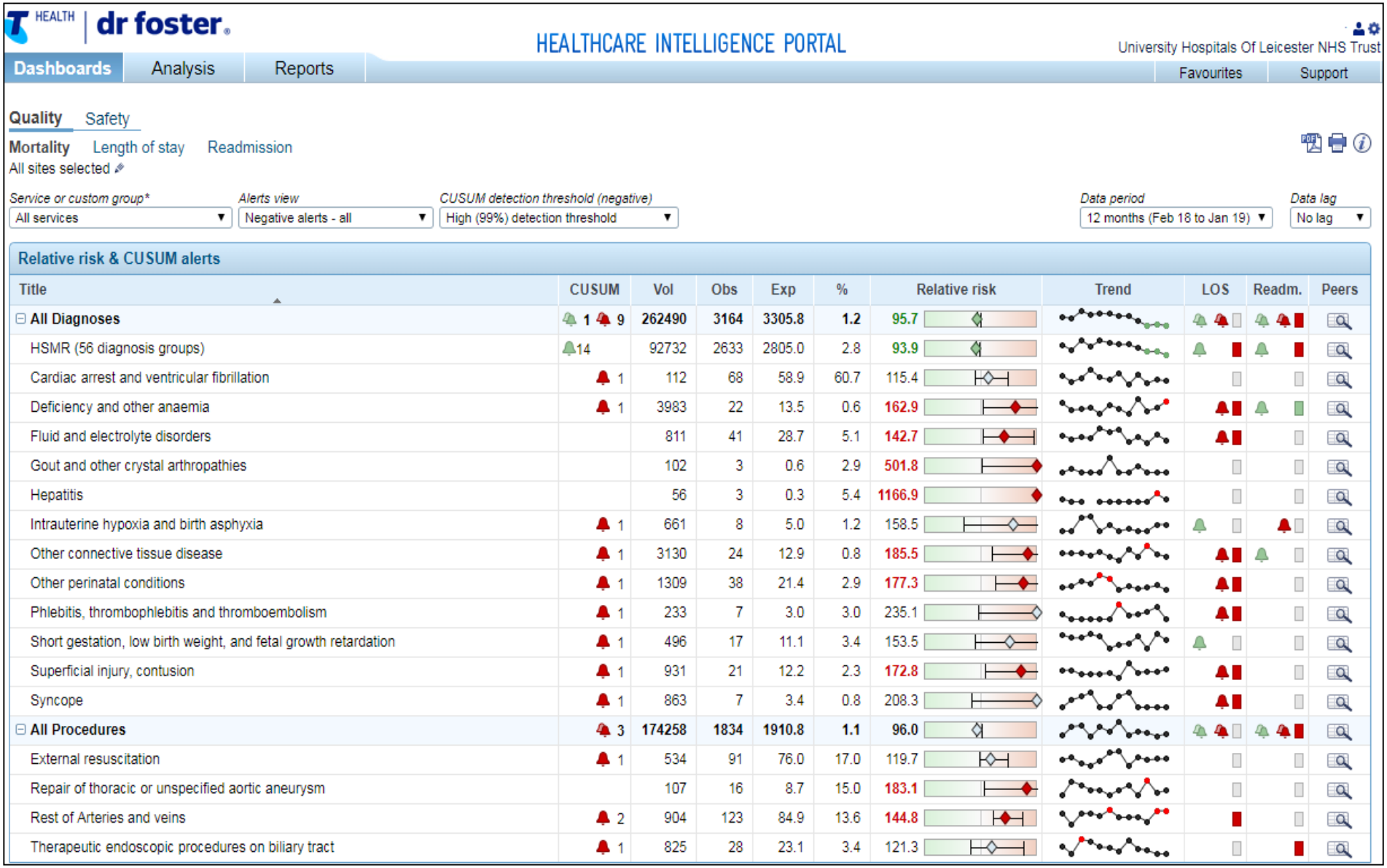
What is the data telling us?

- UHL's HSMR at 98 (97.6) s well within the funnel plot when compared to our peer trusts ▼ and nationally ○.
- Whilst our 'FYE HSMR' may change following inclusion of Feb and Mar data and national rebasing, we expect to stay below 100 as we have improved our crude rate.

HSMR:
Hospital Standardised Mortality Ratio

Dr Fosters' Healthcare Intelligence Portal
Diagnosis and Procedure Group HSMR

Dr Foster's Healthcare Intelligence Portal Dashboard for UHL – (as of 30.04.19)



HEALTH | dr foster.

HEALTHCARE INTELLIGENCE PORTAL

University Hospitals Of Leicester NHS Trust

Dashboards | Analysis | Reports | Favourites | Support

Quality | Safety

Mortality | Length of stay | Readmission

All sites selected

Service or custom group*: All services | Alerts view: Negative alerts - all | CUSUM detection threshold (negative): High (99%) detection threshold | Data period: 12 months (Feb 18 to Jan 19) | Data lag: No lag

Relative risk & CUSUM alerts

Title	CUSUM	Vol	Obs	Exp	%	Relative risk	Trend	LOS	Readm.	Peers
All Diagnoses	1 9	262490	3164	3305.8	1.2	95.7				
HSMR (56 diagnosis groups)	14	92732	2633	2805.0	2.8	93.9				
Cardiac arrest and ventricular fibrillation	1	112	68	58.9	60.7	115.4				
Deficiency and other anaemia	1	3983	22	13.5	0.6	162.9				
Fluid and electrolyte disorders		811	41	28.7	5.1	142.7				
Gout and other crystal arthropathies		102	3	0.6	2.9	501.8				
Hepatitis		56	3	0.3	5.4	1166.9				
Intrauterine hypoxia and birth asphyxia	1	661	8	5.0	1.2	158.5				
Other connective tissue disease	1	3130	24	12.9	0.8	185.5				
Other perinatal conditions	1	1309	38	21.4	2.9	177.3				
Phlebitis, thrombophlebitis and thromboembolism	1	233	7	3.0	3.0	235.1				
Short gestation, low birth weight, and fetal growth retardation	1	496	17	11.1	3.4	153.5				
Superficial injury, contusion	1	931	21	12.2	2.3	172.8				
Syncope	1	863	7	3.4	0.8	208.3				
All Procedures	3	174258	1834	1910.8	1.1	96.0				
External resuscitation	1	534	91	76.0	17.0	119.7				
Repair of thoracic or unspecified aortic aneurysm		107	16	8.7	15.0	183.1				
Rest of Arteries and veins	2	904	123	84.9	13.6	144.8				
Therapeutic endoscopic procedures on biliary tract	1	825	28	23.1	3.4	121.3				

What is the data telling us?

- Dr Fosters dashboard highlights the highest relative risk diagnosis groups and the ones which have a CUSUM alert. These diagnosis groups are further reviewed by either the Corporate M&M team and/or the respective specialty to understand why it is higher than expected

Update and plans regarding Apr 19 DFI Alerts

1. **Cardiac arrest and ventricular fibrillation –** Cardiac HoS and HOE in process of auditing this diagnosis group along with Acute Myocardial Infarction and are due to report in Jun 19 MRC

2. **Deficiency and other anaemia –** previously reviewed in summer 2018 with cause of death and ICD on Discharge - no concerns. Clinical coding team to re-look at the deceased patients case notes to check appropriateness of coded diagnosis (reason for alert when reviewed last year)

3. **Fluid and electrolyte disorders –** Review in process to identify if any link to the perception of increased number of admissions due to dehydration during the Summer. The alert appears to primarily relate to the number of deaths in July and August 18. Correlation with Mortality Screening, Specialty Reviews and Laboratory data currently being undertaken. To report in Jun 19 MRC

4. **Gout and other crystal arthropathies and Hepatitis –** Clinical Coding Auditor reviewing the 3 deaths in each diagnosis group and to report in Jun 19 MRC

5. **Intrauterine hypoxia & birth asphyxia, Other Perinatal conditions and Short gestation, low birth weight and fetal growth retardation diagnosis groups –** Dr Foster's consultant and Perinatal Mortality Lead reviewing these diagnosis groups and will be reporting an update to the Perinatal Mortality Oversight Group in May prior to reporting to MRC in July 19

6. **Phlebitis, thrombophlebitis and thromboembolism –** Deceased patients reviewed by VTE Nurse specialist. Review findings to be presented to the May 19 MRC.

7. **Superficial injury, contusion –** This previously alerted alert in Feb 18 and 4 deaths in Sep 18 has increased the Relative Risk. Clinical coding previously amended 10 out of 21 primary diagnosis in either 1st or 2nd consultant episodes due to a more significant diagnosis being the primary reason for admission. However, a 'cluster' of 8 cases between Oct 18 to Jan 19 may be the reason this diagnosis group in the alert dashboard. Clinical Coding auditor will be reviewing the more recent cases.

8. **Syncope –** on the dashboard due to the previous CUSUM alert in mid April 18 which was reviewed and not found to have any clinical concerns. No new deaths in the last 4 months.

Appendix 2

Learning From the Deaths of Patients in our Care 18/19 Q1-4

May 2019
Medical Examiner Screening
Specialty Structured Judgement Reviews
Bereavement Support Follow Up

UHL's "Learning from Deaths" Framework

- **Medical Examiners (MEs)** – (Currently 14 MEs working 1 PA a week). ME process includes all ED and Inpatient adult cases – MEs support the Death Certification process and undertake Mortality Screening – to include speaking to the bereaved relatives/carers and screening the deceased's clinical records. Where Screening identifies potential areas for learning by the clinical team(s), the case will be sent to the relevant Specialty for further review.

- **Specialty Mortality & Morbidity Programme (M&M)** – involves full Mortality Reviews (SJRs) where meet National criteria (see previous slide) or are referred by the ME or members of the Clinical Team. M&M meetings confirm Death Classification, Lessons to be Learnt and taking forward agreed Actions

- **Clinical Teams** – involves reviewing care of patients where families have raised concerns about the end of life care or other patient experience issues

- **Bereavement Support Nurse (BSN**)– 'follow up contact' for bereaved families of adult patients, liaises with both the MEs and Clinical Teams where families have unanswered questions. Also sign posts bereaved relatives to appropriate support agencies where unmet bereavement needs identified.

- **Patient Safety Team (PST)** – where death considered to be due to problems in care, will review against the Serious Incident reporting framework and take forward as an investigation where applicable.

- **Mortality Review Committee (MRC)** – oversee the above and support cross specialty/trust-wide learning and action

Deaths covered by UHL's "Learning from the Death" process

Quarters 1 – 4 (April 18 to March 19)

	Q1	Q2	Q3	Q4	All Deaths
Adult	**781**	**737**	**810**	**894**	**3222**
Inpatient	690	634	716	777	2817
ED	56	60	53	78	247
Community*	35	43	41	39	158
Child	**9**	**12**	**8**	**7**	**36**
Inpatient	7	8	6	3	24
ED	1	4	1	1	7
Community**	1		1	3	5
Neonate	**36**	**13**	**15**	**18**	**82**
Inpatient	36	13	15	18	82
All Deaths	**826**	**762**	**833**	**919**	**3340**

What is the data telling us?

* Will usually be where death certification is facilitated by UHL's Bereavement Services, requested by the Coroner's Office. Not all will involve the Medical Examiner Screening and therefore will not be included in "performance data"

** Includes Deaths where child died post discharge/transfer from UHL and the Children's Hospital Specialty have reviewed as part of their M&M process .

Adult Deaths – ED or In-Patients*
Number and % Screened by a Medical Examiner in 2018/19

	Adult Deaths	Screened	Not Yet	No*	% Screened
Q1	746	735	0	11	98.5%
Q2	694	693	0	1	99.9%
Q3	768	751	17		97.68%
Q4	849	782	66	1	92.1
18/19	**3057**	**2961**	**83**	**13**	**96.9%**

What is the data telling us?

UHL target is 95% of all Adult Inpatient or ED Deaths to be 'screened'

Over 3,000 adult deaths were processed by the Bereavement Services Office during Q1-Q4
The table above includes In-Patient and ED deaths only.

In addition there were 158 'community death' where the deceased's body was brought to the UHL Mortuary for Death Certification purposes

133 (84%) of these community cases were also screened by the Medical Examiner

During Q1-4, there were 3,057 deaths in either ED (247) or In-Patient (2,817).

Of these 2,961 (96.9%) have been screened by the Medical Examiner to date. Most cases not screened were deaths referred to the Coroner (68) or deaths at the LGH/GH (12) and so Medical Records not yet retrieved. Retrospective screening will be carried out until the end of May.

What happens where Medical Examiners (ME) think further review required?

- **MEs refer cases for:**
  - Structured Judgement Review through Specialty M&M**)**
  - Clinical Review by Consultant responsible for patient care or Matron/Ward Sister
  - Follow up by Bereavement Support Nurse
  - Feeding back to Non UHL organisations
- **Structured Judgement Reviews are requested where the Medical Examiner thinks there is potential for learning in respect of:**
  - Clinical management
  - Delays or omissions in care
  - Meets the national criteria for SJR (death post elective surgery, patient had a Learning Disability, Severe Mental Illness)
- **Clinical Reviews are requested where concerns are raised by the bereaved about:**
  - Pain management; end of life care, DNACPR
  - Nursing care, such as help with feeding; responding to buzzers
  - Communication with patient/relatives about patient's prognosis, deterioration
  - Previous discharge arrangements
- **Bereavement Support Nurse follow up will be requested where**
  - The relatives appear to be particularly distressed - to signpost to 'bereavement counselling services'
  - Say they have questions or concerns about the care provided but do not feel ready to talk about them
- **Feeding back to Non UHL Organisations**
  - Process established with the EMAS, LPT and CCG Quality & Safety Leads for feeding back where relatives raise concerns about care provided outside UHL, or MEs think there may be learning for other organisations,

Number of Adult Deaths and Further Review in 2018/19

Further Review details	Q1	Q2	Q3	Q4	All
No further review	542	508	552	565	2,166
Structured Judgement Review*	86	78	84	76	324
Clinical Review	96	97	93	98	384
Feedback	43	40	49	61	193
Theme Review	2	2	4	4	12
Follow up by Bereavement Support	9	8	9	15	41
Patient Safety Team / SI Investigation**	3	4	3	5	15
ALL (includes Community Deaths where screened)	**781**	**737**	**792**	**823**	**3,135**

What is the data telling us?

***Some deaths may be referred directly for SJR without ME screening if meets National Criteria**
*** 3 Deaths were subject to a Serious Incident investigation**

69% of 18/19 deaths screened by the Medical Examiner to date were not considered to need further review.

10% of deaths have been referred for Structured Judgement Review by the Specialty M&M – this includes deaths meeting the national criteria

12% of deaths were referred for Clinical Review by the clinical team looking after the patient

6% of deaths have been referred for Feedback only – mostly relates to staff attitude, communication issues

Progress Update on ALL 18/19 Deaths Referred for Structured Judgement Review, SI Investigation or Clinical Review

	Completed	In progress	%	ALL
Clinical Reviews				
Q1	56	40	58%	96
Q2	39	59	40%	98
Q3	29	64	31%	93
Q4	34	64	35%	98
All (to date)	**157**	**227**	**41%**	**384**
SJR/SIs*				
Q1	117	14	89%	131
Q2	80	26	75%	106
Q3	73	35	68%	108
Q4	29	72	29%	101
All (to date)	**299**	**147**	**67%**	**446**

* Where a death is subject to a Serious Incident Investigation, an SJR may not be undertaken as the SI investigation findings will be used to inform the Learning from Deaths programme.

NOTE: Further cases may be referred for SJR or Clinical Review once ME Screening completed

SJR Completion Performance

Following discussion with the Specialty M&M Leads, an internally set target for completion of SJRs was agreed as: 75% within 4 months of death and 100% within 6 months.

At end of April 2019 all of Q1 and all of Q2 deaths should have had an SJR completed, where applicable.

- 89 % of Q1 and 75% of Q2 SJRs have been completed to date

75% of Q3 deaths should have had an SJR completed, where applicable.

- 65% of SJRs for Q3 have been completed

Whilst we have not achieved our internally set threshold for either timeframe, performance has improved since previously reported.

The above figures do not include SJRs that have been completed but need further review by another Specialty M&M to confirm the Death Classification.

More SJRs may have been undertaken but not yet collated by the Corporate Team.

Progress updates have been sought on all outstanding SJRs.

Adult Specialties with most SJRs requested in 18/19 to date were:

Geriatrics – 42
Gen Surg (LRI) -26
Acute Medicine – 23
Gen Surg & HPB (LGH) -21
Cardiac Surgery – 15
Cardiology 26

Whilst Cardiac Surgery is still working through their backlog of SJRs, all other Specialties have made good progress.

Death Classifications for All Deaths where SJR or SI Completed

DEATH CLASSIFICATION	REASON FOR REQUESTING SJRS FOR ADULT DEATHS IN 2018/19 (to date)									% of all InPatient Activity
	ME	Rels	Child	Neonate	El Proc	LD	SMI	Specialty	Total	
1	1	2		1					4	0.12%
2	19	3	2	2	1	1	1	1	31	0.93%
3	45	12	4	16	2	3	1	3	86	2.57%
4	30	8	4	28	20	6	7	5	108	3.23%
5	11	4	15	17	8	5	5	5	70	2.10%
All	106	29	25	64	31	15	14	14	299	

What is the data telling us?

One Neonatal death has been investigated jointly with the Ambulance Service and problems in care found to have contributed to the death (see Slide 15).

For the adult deaths given a Death Classification of 1:

Cardiology and Cardiac Surgery – problems in care related to delays with referral from a another hospital and also once arriving at UHL . The death has been investigated by the Patient Safety Team.

- Need for a TAVI Co-ordinator identified as the key action.

Nephrology and Renal Transplant – CMV negative patient received CMV positive kidney without appropriate prophylaxis – this death has been investigated and reported externally as a Serious Incident and was a Coroner's Inquest

- Actions related to review and changes being made to the Transplant work up and pre op pathway

Trauma and Orthopaedics – problem in care related to patient not receiving thromboprophylaxis when immobile due to injury who then had a cardiac arrest due to pulmonary embolism. Investigated and reported as a Serious Incident and reported to the Coroner.

- Lower Limb Immobility Pathway and Thromboprophylaxis implemented in ED and Fracture Clinic

Learning and Actions where Death Classification = 2 (Adult Deaths)

31 cases have given a Death Classification of 2 by the Specialty M&M.

- Key Learning points were:

• **Delay in transfer to CCU**	• **Review of Hb in dialysis patients receiving EPO**
• **Staff need to be very careful with relevant blood results. Serum Calcium blood tests on admission**	• **Recognising and treating Type 2 Respiratory failure and familiarity with NIV at the LRI**
• **Xray reviews – should be reviewed on admission and when reaching base wards**	• **Interpretation of abnormal findings on CXR and positioning of NG tube**
• **Sub-optimal management of PD meds**	• **Access to gastroenterology advice out of hours**
• **Knowledge and communication / treatment of Atrial Fibrillation**	• **Patient on surgical ward at LGH - should have had Medical review**
• **Regular blood tests in relation to fluid management/obstructing type problems**	• **Fluid management of hypernatraemia Recognition of delirium**

In addition to feeding back to clinical teams and awareness raising, improvement actions identified include:

- Addisons Crisis Guidelines development and ePMA prompt about steroid safety
- Review of Postpartum Haemorrhage Guideline
- Development of Acute Abdomen Pathway
- Review of Cross Site Transfers Pathway
- Training about using hoists in bariatric patients

Theming of Learning and Review of Actions will be undertaken by MRC once all SJRs and Clinical Reviews are completed.

Child Deaths – Quarters 1 to 4

"Child Deaths" include babies under one year, where the baby died outside Maternity / Neonatal Unit.

There were 36 Child Deaths included in the UHL Learning from Deaths Process in 18/19

All child deaths are also reviewed by the LLR Child Death Overview Panel (CDOP).

5 Child Deaths were reviewed as part of the Specialty M&M process but the child died following discharge or transfer from UHL .

All 31 in-hospital deaths have been or are being reviewed as part of the relevant Specialty M&M process.

13 babies (<1 yr) were either born in UHL and transferred to Cardiac surgery or were transfers into UHL from other hospitals or were admitted via ED to the Children's Intensive Care Unit from Home

1 baby died following elective cardiac surgery – this death has been subject to a Multidisciplinary Mortality Review and then discussed at the Specialty M&M where it was confirmed that there were no problems in care.

9 children were admitted via ED or as an Emergency Transfer and died in Intensive Care

1 child died on the oncology ward

6 babies (<1 yr) and 1 child (1-5 yrs) died in the Emergency Department

A summary of all M&M reviews will be presented to the June MRC

Further discussions have been held about how to best implement the Medical Examiner process for Child Deaths and to better co-ordinate UHL's M&M process with that of the LLR Child Death Overview Panel (CDOP). Details of the proposed changes to process will also be discussed at the June MRC meeting.

Neonatal Deaths – Quarters 1 to 4

"Neonatal Deaths" include babies who either die on the Maternity Unit or in the Neonatal Unit.

50 babies were still born or died in the Delivery Suite during 2018/19

31 babies died in the Neonatal Unit - 25 born in UHL and 6 were babies transferred in from other Maternity Units.

1 baby was delivered stillborn whilst the mother was receiving ECMO at Glenfield Intensive Care Unit.

All deaths are reviewed and discussed at the Perinatal Mortality Review Group which reports to the Perinatal Mortality Oversight Group. Deaths of babies born from 23 weeks of gestation are also reviewed by CDOP

UHL reports on its perinatal mortality nationally to Mothers and Babies: Reducing Risk through Audits Confidential Enquiries across the UK (MBRRACE). From December 18 we have been using the Perinatal Mortality Review Tool (PMRT) in line with the NHS Resolution Maternity Incentive Scheme Safety Action 1 (see next slides)

64 Reviews have been completed for Q1-4 deaths

There were 2 deaths where there were problems in care but unlikely these contributed to death
- 1 related to Growth Scan
- CTG monitoring

both have been subject to further investigation as a Moderate Patient Safety Incident

1 death was considered to be due to problems in care and has been investigated as a Serious Incident in collaboration with the Ambulance Service. This death has also been reviewed using the PMRT. Details of learning and actions are on Slide 15.

Actions have been agreed for all 3 cases which are on track or have been completed.

Details of all cases and UHL's Perinatal Mortality rates (as reported in the SHMI and HSMR) will be reviewed at the July meeting of the Mortality Review Committee and included in the next Quarterly Mortality Report.

NHS Resolution Maternity incentive scheme – year two

- NHS Resolution is operating a second year of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care.
- The maternity incentive scheme applies to all acute trusts that deliver maternity services and are members of the CNST. As in year one, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund.
- The scheme incentivises ten maternity safety actions. Trusts that can demonstrate they have achieved all of the ten safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds.

Requirements for Safety action 1:

Are you using the National Perinatal Mortality Review Tool to review perinatal deaths* to the required standard?

a) A review of 95% of all deaths of babies suitable for review using the Perinatal Mortality Review Tool (PMRT) occurring from Wednesday 12 December 2018 have been started within four months of each death.

b) At least 50% of all deaths of babies who were born and died in your trust (including any home births where the baby died) from Wednesday 12 December 2018 will have been reviewed, by a multidisciplinary review team, with each review completed to the point that a draft report has been generated, within four months of each death.

c) In 95% of all deaths of babies who were born and died in your trust (including any home births where the baby died) from Wednesday 12 December 2018, the parents were told that a review of their baby's death will take place and that their perspective and any concerns about their care and that of their baby have been sought.

d) Quarterly reports have been submitted to the trust Board that include details of all deaths reviewed and consequent action plans.

* Includes babies born from 23 weeks gestation onwards and excludes deaths arising from Termination of Pregnancy

NHS Resolution Maternity Incentive Scheme

Perinatal Mortality Review Tool (PMRT) Dashboard – Performance as at end May 2019

				SAFETY ACTION 1		
Month	**Eligible Stillbirth**	**Eligible Neonatal Death**	**Eligible Late Fetal Death**	**a) % PMRT started by 4 months**	**b) % draft report within 4 months**	**c)Parents Informed & consulted before the review**
Dec 18	2	0	0	100%	100%	50%
Jan 19	1	1	0	100%	50% to date	100%
Feb 19	3	4	0	100%	15% to date	100%
Mar 19	3	2	0	100%		100%
Apr 19						
May 19						
Jun 19						
Aug 19						

Safety Action 1d) Learning and Actions of PMRT Cases - where completed

M&M Ref	Mth of Death	Mth of Review	Learning	Action	Action Update	Action Status
2302	Dec 18	March 19	Late booking. Mother aware of need to book early for care in next pregnancy. No issues in care identified.	None	N/A	N/A
2510	Dec 18	May 19	No issues in care identified. Mother's progress in labour was monitored on a partogram but the partogram was only partially completed	Midwives to be reminded that the partogram should be completed as fully as possible to record progress in labour and maternal condition in the case of an Intra-uterine fetal death.	To be included in a Newsletter	In Progress
2576	Jan 19	May 19	Every effort should be made to initiate transfer of women in advance labour to hospital, if they are not intended to be having a home birth and/or are high risk	Maternity Assessment Unit Review to include -working practices and guidelines on abdominal pain guideline and pre-term labour Generate UHL guidance regarding unplanned home birth and births before arrival	MAU Review Task and Finish Group established and work programme agreed. Guidance re unplanned home births agreed and in place and shared with Ambulance Service	In Progress
2919	Feb 19	May 19	The parents have raised questions around the communication from the senior medical team about the outcome for the baby and how this was addressed	Feedback to be given to the clinical team.	Meeting being arranged to feedback response to the parents questions	In Progress

How is UHL engaging with bereaved families and carers (adult deaths)

Bereavement Support Service

- The Bereavement Support Service (Adult) offers bereaved families/carers the opportunity to talk about what matters to them regarding their bereavement and offers information and support and signposting to bereavement counselling and other support organisations as required
- **Follow up contact by the Bereavement Support Service is offered to the bereaved relative/carer for all UHL adult deaths**.
- Contact is offered either by the Ward staff or Bereavement Services. Where death referred to the Coroner, the BSN contacts the family directly
- Contact is made by the Bereavement Support Nurse (BSN) 6-8 weeks after the death

- **2,248 families of deceased patients in 18/19 requested** a follow up phone call by the Bereavement Support Nurse
- To date, BSN have to date managed to speak to **1,600 (71%)** of bereaved relatives who requested telephone follow up
- Relatives of patients who died in March will be contacted during May
- Where telephone follow up requested but the Bereavement Support Nurses are unable to speak to the family on the phone, a voice mail message, letter or email is sent with their contact details for future reference

Feedback from Bereaved Relatives

BSS signposted 381 families for bereavement support

Signposting to bereavement services included CRUSE, LOROS, Sharma Women's Centre, Child Bereavement UK

1,316 (80%) of bereaved families provided feedback on EoL care.

1054 (64%) of families rated care as Good or Very Good

115 (8%) of families said their experience of care was either Poor or Very Poor

Main concerns related to:
Communication (medical and nursing) End of Life Care; Delays and Clinical Management

Next steps facilitated by the BSS Nurses included:

- Follow up with the clinical team by Meeting (15)
- Review by the Clinical Team and Feedback (39**)**
- Going through the Complaints Process (26) – a further 10 had already made a complaint

2 families did not want to speak to the BSS Nurses as they were very upset with the care provided by UHL – both deaths had been referred to the Coroner.

Full theming of feedback received from the bereaved and learning and actions will be included in the next Quarterly report