

Annual report & accounts 2009/2010



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Welcome from the Chairman

This is my third year as Chairman here at Leicester's Hospitals, and I've now realised, you may say belatedly, that there is no such thing as a 'normal year' in the NHS!

As we were preparing the annual report last year the full impact of the banking crisis on government debt was becoming apparent..... this year the full impact on the NHS is clearer. We've dealt with the swine flu pandemic, the coldest winter in years, our busiest ever 24 hours in terms of emergency admissions; we've restructured the Trust, appointed five new members of the Board and launched our Foundation Trust consultation, not to mention that we've seen and treated more patients than ever before.

As I write this, just a few weeks after the general election, policy makers in the Department of Health and their new political masters are busy setting the agenda for the new Con Lib coalition.

Speculation is rife about which of the existing structures, targets and priorities will remain and which will be consigned to history. By the time this annual report is published much will have become clearer.

It would be easy to be sidetracked by all this uncertainty. However, my job, and that of my board colleagues is to make sure we remain focused on the things which really matter..... our patients, our staff, our stakeholders, the financial viability of our hospitals and the wider health economy. Our view is simple; get those things right and we will be doing a good job whatever the future has in store.

As a board we were reminded of this point when we digested the lessons from Robert Francis QC's enquiry into the events at Mid Staffordshire Hospitals. We have spent a lot of time this year as a Trust, and as a board, reflecting on what happened there and thinking about what more we could do to make sure that care in Leicester's Hospitals remains safe.

The public should be reassured there are many, many ways that we monitor the quality and safety of the care we provide, as you will see throughout this report.

However, perhaps the biggest lesson from what happened in Mid Staffordshire is that a hospital's board of directors cannot afford to become insulated from what is happening out on the wards. I do not think that is the case in Leicester. But to make absolutely sure, earlier this year we increased the number and frequency of our executive team walkabouts to ensure that even the non-clinical directors were receiving first-hand accounts from patients and staff about the quality of the care we provide. Hospitals are about people and no matter how well written the board report, there is no substitute for getting out and about.

In a similar vein, and for similar reasons, this year we started to invite patients and relatives to provide 'video testimony' or join us at our board meetings to talk about those occasions when we have not provided the kind of care which people want and deserve. Again, we could just continue to read about complaints in report form, but inevitably reports have less impact because they rarely tell the stories of the real people behind the facts. I won't pretend that this

has always made for comfortable board meetings, but it's important and we will continue to do it.

In times of uncertainty and great change we all need reminding of what the important things are. There are so many things one could worry about when running a hospital and the danger is that if we worry about everything we will fail to focus on the essentials.

With this in mind last year we held a series of events for staff called 'The Big Conversation'. The aim was to create a set of values for our hospitals which every member of staff would recognise and support. Traditionally, the way organisations set about doing this is to send a small group of directors off into a huddle to make up some values and then try and 'sell' those values to everyone else who works for them. It doesn't work.

Instead, we invited staff to come along and talk about the things which inspired, motivated, annoyed or angered them about their jobs and the Trust. More than 2,000 staff took part and over a period of six weeks we were able to build with our colleagues a set of values and corresponding behaviours which we think will define Leicester's Hospitals in the eyes of the people we serve. These are our shared values...

We treat people how we would like to be treated

We do what we say we're going to do

We focus on what matters most

We are one team and at our best when we work together...

We are passionate and creative in our work

.....there's more on pages 19-21.

Of course, building the values together was important but really the work starts now. If we prove to our patients, their families, the public, our stakeholders and to one another, that we honour these values by behaving in a way which makes them real, then I'm sure Leicester's Hospitals can achieve marvellous things on behalf of the communities we serve.

I want to end by saying thank you to all those people who devote so much of their time and energy to our hospitals: our volunteers, our partners in other organisations, local GPs, our local charities and fundraisers and most of all, to our fantastic staff.



Martin Hindle

Chairman

Introduction from the Chief Executive

The nature of annual reports inevitably means we talk about what has happened in the previous year..... with your permission I'm going to break with tradition this year and start by looking to the future. Why? Well, put simply there's a lot going on and we don't have the luxury of time to dwell on the past for too long!

Between 1 April, 2009 and 31 March, 2010 we treated 1,100,600 patients. That's 23,000 more than 2008 and 65,000 more than 2007. That's more than 3,000 patients a day, or if you prefer 125 every hour, or two patients every minute, of every hour, of every day, for a whole year. And, unsurprisingly, it cost a lot of money to treat those patients, £684m to be exact.

Simple maths would suggest that every one of the almost one million people living Leicester, Leicestershire and Rutland was a patient in our hospitals at least once over the last year. We should, of course, be wary of 'simple maths' because the fact is that most people are perfectly well most of the time. However, there are some people who can be unwell much more often. It is these people the NHS rightly spends most of its time and money on. But there's a problem. In fact, there are a few problems with this...

1. We have an ageing population with increasing health needs in later life - three out of four patients in Leicester are over 70 years old;
2. More people have serious long-term health conditions like diabetes and cardiovascular disease, and this is on the increase (on average six out of ten hospital beds are occupied by people with a long term condition); and
3. The financial crisis which began in 2008 means the NHS cannot rely on the kinds of funding increases which it has grown accustomed to over the last 10 years.

Funding of the NHS has tripled from £35 billion in 1997/98 to £102 billion now. One pound in every six spent by the government is spent on the NHS. It is highly unlikely this will continue.

Whilst nine out of ten patients come into contact with the NHS outside hospital (for example with their GP) 60 per cent of the money is spent in hospital.

Where am I going with this?

Well, I'm trying to make two fundamental points. Firstly, the NHS is too reliant on hospitals as the 'solution' for looking after people who are ill. And secondly, that while this continues to be the case it is neither good for the patient nor for the taxpayer. Why? Well, let's face it nobody wants to be in hospital if they can possibly help it and it is an expensive way to treat people, but importantly, it is also not always the best place to treat people.

I have likened our over-reliance on hospitals as the equivalent of sending every item of your clothing to the dry cleaners rather than washing the simple stuff at home and just having the posh dress or suit done by the specialists. Your clothes would be no cleaner and it would

certainly be less convenient and more expensive, which is exactly the issue facing the NHS over the split between care delivered in hospital and care that could and should be delivered elsewhere.

So, this is the challenge for the NHS here, and everywhere else across the country. How do we rebalance the service so patients are looked after and supported in their own homes or in their communities more and in doing so, become less reliant on expensive and often inappropriate hospital care? (A recent study by the consultancy group McKinsey found that four in ten patients in hospital were in beds unnecessarily and could be treated elsewhere). There is a simple answer, but simple does not mean it is easy to accomplish. The simple answer is that working with our partners in primary care, we need to design services which help keep people well in the first place (prevention); we need services which offer patients creative alternatives to our big city hospitals (innovation); we need to make sure all our services whether in hospital or in the community are efficient and not wasteful (productive)..... and most of all we need to make sure all our services, wherever they are provided, are of the standards that patients and the public expect (quality).

I would hope that most people would think that is common sense, but sometimes common sense can be forgotten when people are faced with change..... and if there's one thing we know about the future, it is that there is going to be a lot of change!

I'll give you an example: over the last 20 years the NHS nationally has reduced the number of beds it has in all its hospitals by a third (from 270,000 to about 160,000). In Leicester the pattern has been the same.

We are planning to reduce our bed base by about 200 beds this year. This equates to around seven fewer wards. We will be able to do this not because we are seeing fewer patients, but because those patients we do see need to spend less time in hospital as the quality of our care improves. With similar numbers of patients staying for less time, we can manage with fewer beds and hence fewer wards..... this saves money, which when added together means we can save about £7m over the course of a year, **without** the need to cut services. Sadly, when we announced this we were met with howls of protest. If you think about it another way, the fact we need fewer beds is because *we are getting people better more quickly* and that should be cause for celebration. The reality is that change of any kind to a much loved institution causes people anxiety.

I share this story with you because I think it highlights the challenge facing us as the people who manage the NHS and you, the people who give us our jobs, the public.

Our challenge is whether together we can reach agreement on what is best for the local NHS given these austere times. We will undoubtedly be called upon to make difficult decisions about priorities. This will mean some people may feel they will lose out in order for others to gain. An example which is close to my heart and I know is something which concerns local people, is car parking. This year we have created nearly 300 extra spaces at

the General and the Glenfield, but we know the Royal is still a problem. Let's be honest, we could do something about it. It would involve millions of pounds in investment but this year we have invested in our neonatal service with a £9m refit to provide better care for the most poorly babies. We can't do both. And we are going to have to have more of these difficult conversations and make difficult decisions in future.

Given all that I've said so far, you may think it strange to hear that despite the tough times ahead we are pretty upbeat about the future of our hospitals. Why would that be?

Well, because regardless of the economic and post-election uncertainty, there is evidence that the programme we kicked off last year, called 'Getting into Shape' is working.

Last year we said we wanted to make our hospitals better for patients and despite seeing record numbers we have dramatically reduced infections and waiting times. Meanwhile, the National Patient Survey has shown that in 75 per cent of the questions asked our patients tell us that we have improved year on year.

We said we wanted to improve the well-being of our staff and the National Staff Survey has shown that we are the most improved Trust in the region.

We said we wanted to strengthen our research portfolio and we have attracted £5.5m to fund a Cardiovascular Biomedical Research Unit at the Glenfield Hospital.

We said we wanted to improve our efficiency and effectiveness. To enable this we have restructured the Trust putting doctors and nurses at the heart of decision making about how our services should be run.

We said we wanted to be ready to tackle national emergencies like a flu pandemic and we have been told, just recently, that the 'nation owes us a debt of gratitude' for the brilliant work our staff did running the Glenfield's specialist ECMO service, which saved many lives (more about all of these later on in the report).

And we said we wanted to prepare for Foundation Trust status and we have kicked off our public consultation and engaged with more than a thousand people.

So, if last year was about 'Getting into Shape' and much progress has been made, then this year is now about moving from 'good to great'. We want our hospitals to be 'great', not out of arrogance but because we believe that 'great' is what our patients deserve. We recognise there is still a lot to be done and I look forward to reporting back our progress next year.

Finally, I'd like to add my own thanks to those of the Chairman, and especially to our staff.

They do a brilliant job in sometimes the most difficult of circumstances and it is a daily privilege to work with them.



Malcolm Lowe-Lauri

Chief Executive

About us

Our hospitals include the Glenfield, Leicester General and the Royal Infirmary. Formed in 2000, we are now one of the largest and busiest teaching Trusts in England, employing over 10,000 staff. We provide services for a diverse population of nearly one million people across Leicester, Leicestershire and Rutland. However, the nature of our business means our specialist services reach a further two to three million people from neighbouring counties.

Our national and international reputation has been gained through our high quality specialist care particularly in cancer, renal and cardiac services. We are at the forefront of many research programmes and new surgical procedures, such as keyhole heart valve surgery and our research into diabetes, genetics and cardiovascular and respiratory diseases. As a teaching Trust we play a vital role in the education and training of doctors, nurses and other healthcare professionals, working closely with local universities.

The Care Quality Commission rated Leicester's Hospitals 'good' for quality of services and 'good' for use of resources in their 2008/09 ratings.

Our quality of services rating was lowered from 'excellent' in the previous year due to our decision to downgrade ourselves based on our handling of staff appraisals. We thought our performance on staff appraisals was poor...not in comparison to other hospitals, but against our own standards.

Our rating for 'use of resources' improved from the previous year, in no small part due to the amount of work we have put into strengthening our governance and reporting arrangements from the board to our wards.

Last summer we introduced our improvement plan, '*Getting into Shape*' and since then have made real progress. We have changed the way we are governed, we have strengthened accountability and performance management from the board to the ward; developed a 'Leadership Academy' and fixed some of the 'irritants' which got in the way of our ability to do a good job. We still have a way to go and this report will show some of the improvements we have made and our plans for 2010-2011 to bring us closer to becoming an excellent Trust.

Our purpose

To deliver "Caring at its best" for all the people who visit Leicester's Hospitals, either as patients, the public or as staff.

Our vision

To be the number one major provider of emergency and specialist services in England; recognised for the quality of our care and the strength of our business. We want to be in the premier league of research organisations.

Our values

Our values are new, and were created this year through a large piece of work with our staff, called the Big Conversation. There is more about this later on in the report.

We treat people how we would like to be treated

We do what we say we are going to do

We focus on what matters most

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

We are passionate and creative in our work

Our priorities and did we achieve them?

We set clear priorities for 2009/10 to guide the way we developed our services and standards. These were:

1. **Improve the patient experience and quality of care.**

This included: ***Working with patients, relatives and carers to ensure that their health care respects their diverse needs, preferences and choices and that we work with other organisations to reduce health inequalities***

So how did we do? We have two external groups made up of members potentially affected by inequality. Both of these groups provide advice to us on the issues pertinent to them. The learning disability service user group also has carer representation and they have been invaluable in helping us to deliver the 'Make my stay' project, which delivered a range of initiatives to improve our services for patients who have a learning disability. We work very closely with local health and social care organisations to share good practice, we work to achieve the same goals and are responsive to the diverse needs of our patients.

Improving advocacy for patients and prove we are listening to their feedback

So how did we do? Real-time patient feedback is gathered through the use of touch screen and handheld devices. These devices have been used continuously over the last year and more surveys are planned. They allow patients to make their views known to frontline staff and staff can see the results and act quickly to make changes. Surveys are conducted on local issues and allow changes to be made at a local level. There are more examples later in the report.

We also have 1,500 older people's champions who act as advocates, ensuring the concerns of our older patients are addressed and that services are improved to benefit everyone. We have also set up our new PILS (patient information and liaison service), whose staff listen to and resolve patient concerns.

Continue to exceed national targets and create a 'no wait' culture

So how did we do? We have worked hard during the year to make sure our patients wait no longer than they need to. Over 97 per cent of those who visited our emergency department waited less than four hours. We have also met all of our 14 day, 31 day and 62 day cancer targets, 100 per cent of patients were offered an appointment at our genito-urinary medicine (GUM) clinic, we met inpatient and outpatient waiting times, we also hit our 18-week targets, waits for diagnostic tests and the two-week wait for chest pain.

Improve patient safety and reduce risk

So how did we do? During last year we continued to implement systems to improve the safety and reliability of the care we provide. This is something that we're keen to expand upon in 2010/11 so patients consistently receive safer, higher quality care where mistakes and harm are eliminated. We signed up to the Patient Safety First campaign and have made good progress in implementing all five of the interventions (leadership for safety, identification and response to the deteriorating patient, reducing central line and ventilator acquired infections, reducing harm during operations and reducing harm from high-risk medicines). In the last twelve months, we have brought the voice of the patient to the heart of our board by using patient safety stories at Trust Board meetings. We have improved medication safety, fully implemented VTE (venous thromboembolism) risk assessments and reduced central line infections. We have also implemented the WHO (World Health Organization) safer surgery checklist, the 'think glucose' initiative and signed up to the 'Matching Michigan' project. Safety walkabouts have increased significantly, early warning scores are now completed and used in all in-patient areas and we have improved our Central Alerting System performance to be one of the best Trusts in the country.

Ensure we have strong and tested plans to maintain services in an emergency/ major incident

We regularly review our major incident plan – which sets out our pre-planned responses to internal and external major incidents. One of our most important specialist response capabilities is our CBRN (chemical, biological, radiological and nuclear) response plan; which provides us with the ability to appropriately decontaminate casualties of this nature. We have also developed a range of business continuity plans to ensure our key services and capabilities can still continue during a major incident. These business continuity plans cover how each department will respond to risks as diverse as electrical power supply loss, extreme winter weather and very high levels of staff illness.

For a large part of the year we dealt with the swine flu pandemic, more about that later in the report.

Transform our outpatient and elective care processes, for example use 'virtual' clinics where possible in the community

This year we were able to agree with our commissioners (those who buy our services) that we could use new ways to engage with patients. We have been able to develop clinics and appointments where the patient sees the most appropriate person, and in some instances does not need to meet face-to-face. A number of the new clinical business units will be taking these initiatives further during the coming year.

This has been a huge success in areas such as our sleep and pain services where our patients have given very positive feedback following a follow-up telephone consultation or 'virtual clinic' experience. Patients do not have to make the journey into the hospital and in some cases patients have chosen to be called at work. This method of consultation follows strict protocols and is audited to ensure patients are happy with the care they receive. Not every patient is suitable for this type of consultation and this is all part of our desire to match care to what our patients need.

2. Prove we value our staff and improve satisfaction and motivation.

This included:

- Become a model employer
- Support staff to become the best they can be and to deliver the best care
- Ensure our leaders are supported in the relevant leadership development and talent management programmes

So how did we do? 2009 was an exciting, demanding and rewarding year for us all as we continued our work to show we value our staff and sought to improve staff satisfaction and motivation. Our aspiration to become a model employer has been supported through:

- Our work in developing our values based on the involvement of staff
- Focused work to improve our appraisal rate
- Maintaining and expanding our well-being at work programme.

In supporting staff to become the best they can be we focused on increasing the opportunities staff have to access a range of training and development opportunities and ensuring everyone had personal development plans identified at their appraisal. We invested significant resources in delivering an innovative and intensive leadership development programme for our most senior leaders, whilst maintaining and supporting internal and external leadership development programmes and opportunities for our other leaders. First line managers and supervisors benefited from completing the nationally accredited Institute of Leadership and Management programme (ILM) and staff were also able to access the East Midlands SHA leadership programmes.

Our national staff attitude survey results for the year can be used as a measure of our success with these priorities. These are detailed later in the report but we were particularly delighted to note that the staff motivation measure is better than average for Leicester's Hospitals and this gives us an excellent springboard to improve again in the coming year.

3. Integrate Research and Education with 'the day job'.

This included:

- Develop the concept of an East Midlands Academic Health Science Cluster (AHSC) with partners in Leicester, Nottingham and Loughborough and a Health Innovation and Education Cluster (HIECs) in partnership with Leicester University
- In partnership with the Deanery (the body responsible for training medical staff), develop an advanced clinical skills simulation centre.

So how did we do?

During the year we met regularly with partners in Leicester, Nottingham and Loughborough to establish collaborations which will form the basis of an AHSC in our area.

We were successful in our application (led by Leicester University) in partnership with several NHS organisations in our region for the establishment of a HIEC. We have also opened a state-of-the-art clinical research centre at the Glenfield Hospital to support the work of our Biomedical Research Unit in cardiovascular disease.

The Deanery appointed an external company to conduct a survey looking at the current provision of simulation facilities across the East Midlands, the current models of simulation training delivery and the future requirements for skills training using simulation techniques.

The survey and report were completed at the end of March 2010 and have been submitted to the Strategic Health Authority for further discussion. The findings will support the creation of the East Midlands simulation strategy, which will determine how simulation is used to support the continuing development of our practitioners across the region.

Through collaboration and setting up training networks we will be able to maximise resources and expertise and continue to develop models of training to improve the quality of the learning experience.

During 2010/2011, we will create our simulation strategy, based on the regional model.

4. Develop the long-term plan and prepare for Foundation Trust status.

This included:

- In preparation for Foundation Trust status prepare a detailed five year integrated business plan with detailed service development plans which include activity, workforce and estate requirements, areas where we can make efficiencies and identifying funding streams for the capital investment we need.
- Work with our local primary care trusts to design and deliver seamless services for local people based on their needs, wants and expectations
- Develop a programme of engagement, pre-consultation and consultation with all appropriate stakeholders
- Develop, agree and implement our estates strategy to ensure care is provided in environments which promote patient and staff well-being and respect for patients' needs and preferences.

So how did we do?

Over the past year we have engaged with our stakeholders to start to develop our five year integrated business plan. Through rigorous external benchmarking we have identified key themes and priorities for service development, which are aimed at improving patient experience and increasing our productivity. Year one of the five year plan was approved by the Trust Board on 26 March 2010, and takes into account future activity and demand, workforce requirements and estate priorities. There is still significant work to do and we are now shifting our focus onto finalising the details for year's two to five of our business plan. We also launched our Foundation Trust application, and have consulted with over 1,000 patients, public, staff and stakeholders. The overwhelming majority of responses support our Foundation Trust ambitions.

5. Step change in efficiency and effectiveness.

This included:

Identifying opportunities for improving quality whilst simultaneously making cost savings reducing length of stay for patients and allowing patients choice in the service they access

So how did we do? We have continued to reduce the average length of stay for emergency admissions for four consecutive years. The result is a reduction in an average length of stay of more than one day for every patient we see. We've achieved this by improving our assessment and discharge procedures and reducing delays in discharging medically fit patients to community hospitals and nursing homes. We have been working with colleagues in the primary care trusts and community services to increase the availability and quality of services available outside hospital.

These services, often known collectively as intermediate care, provide a level of care which fits between primary or GP led care and acute hospital care. Further development of these services will reduce hospital admissions and length of stay for those patients who still need hospital care. Not only does this ensure hospital beds are available for those who really need them, it also keeps patient care as close to home as possible. Developments of this type are being pursued in our care of the elderly and in stroke rehabilitation. In the near future we will also be addressing rehabilitation for post- cardiac and respiratory illness.

We are also working on a scheme to speed up recovery after an operation and reduce length of stay after elective surgery. This involves the adoption of a more progressive recovery regime where rehabilitation begins sooner and recovery goals are more ambitious. Swifter recovery reduces scope for hospital acquired infections and ensures a faster return to normal daily living.

Optimise the use of information technology to improve access for our clinicians and primary care to ensure the right care can be provided, in the right place, at the right time.

So how did we do? We have integrated PACS (picture archiving computer system) and RIS (Radiology Information System), ensuring our clinicians have access to patient images and results from anywhere across Leicester, Leicestershire and Rutland and have the ability to share these images with colleagues in Nottingham, Northampton and Kettering to support emergency care.

Staff are now able to use i.CM (clinical manager) to make orders, requests for radiology – and viewing results, therapy services, smoking cessation, social services support for patient care and speeding up diagnostic services for in-patients.

We've also worked to improve our clinical correspondence with all discharge summaries going to GPs. Clinicians are now able to link patient details and write the letters in real time and send them to GPs within 24 hours of patients leaving hospital so they can continue to support their patients at home.

We have enabled the secure transfer of emails between primary and secondary care, so clinicians can share confidential patient information quickly, safely and securely.

We have introduced the "Map of Medicine" which is a new tool that uses locally agreed protocols for pathways of care from primary through to secondary care. Clinicians can be confident of the correct course of treatment in the right location and patients know what to expect.

Patient identity wristbands are now being electronically printed. The bands include a bar code and can help improve patient safety. They will also support applications such as "blood track" and electronic prescribing of medicines.

Finally, we have been promoting the use of the single NHS number by making sure the data is available on all patient based systems and clinical documentation. By ensuring we have these electronic links we can provide a fully comprehensive single record for patients across the health community from primary through to secondary care.

I want to put on record the intelligent and thoughtful treatment given to me, a lady of very senior years, when I became a patient in Leicester's Hospitals Emergency Department, which I consider could be the best hospital in the country.

I was just a helpless bloodstained old lady, and very impressed by the kind and efficient behaviour of the medical staff.

How thoughtful and charming they were to me and all the people who were in their care.

My gratitude to everyone remains. I shall remember them always, their thoughtfulness, skill, thoroughness, and I remember all the staff, doctors, nurses and ward maids.

Ms M, Leicester

Valuing People

Our staff

We have a total of 10,423 substantive staff in post (as at 31 March 2010). They are broken down into the following groups:

Medical and Dental	1,496
Administration and Estates	2,104
Healthcare Assistants and other support staff	2,284
Registered Nursing and Midwifery	3,261
Scientific, Therapeutic and Technical	1,278

NHS staff survey

The 2009 staff survey results have shown that we are the most improved NHS Trust within the East Midlands. This is testament to the hard work and planning from everyone across the Trust in response to the findings of the 2008 survey and in working towards ensuring that the experience of our staff is what we would all want it to be.

We are in the top 20 per cent of acute Trusts nationally for our results in the following key findings:

- The number of staff agreeing they have an interesting job
- The number of staff using flexible working options
- The number of staff that received an appraisal in last 12 months, the number who said their appraisal was well structured and the number of staff who had personal development plans in place
- The low number of staff who experienced harassment, bullying or abuse from patients and/ or relatives in the last 12 months
- The increase in staff perceptions of the effective action we take towards violence and harassment.

Our four lowest ranking scores were:

- Our commitment to work-life balance
- The number of staff who felt pressure in last three months to attend work when feeling unwell
- The number of staff experiencing harassment, bullying or abuse from other staff in the last 12 months, and
- The number of staff witnessing potentially harmful errors, near misses or incidents in the last month

These will form the focus of our improvement work in the coming year.

There was only one area where our results deteriorated and this was the number of staff saying hand washing materials are always available. This will of course be addressed as a priority in our improvement work.

Our action plan will address the above issues raised in the survey, prioritised so we can see an improvement in future surveys. We also recognise the need to maintain the good work from last year to prevent deterioration. For example, we have significantly increased the number of appraisals that have taken place and staff are benefiting from time spent discussing their development and performance with their manager. The survey also shows an increase in staff training and development which we will continue to support and monitor throughout the coming year. Our focus for the coming year includes:

1. Team working and communication

There will be a focus on team-working, including the structure of team meetings and relationships within teams and how they can be improved. We will look at feedback and praise, communication and how ideas and suggestions can be encouraged to make changes which benefit everyone.

2. Healthy workplace

We will investigate the causes of stress in the workplace and create solutions to enhance the Health and Well-Being Programme. We will also look at near misses and errors and how we can identify and implement measures to prevent them.

3. Appraisal

We will continue to develop our appraisal process, incorporating our new values and behaviours, to ensure our staff receive a good quality appraisal from their manager. There will also be some work to review job design and roles.

4. Employer of choice

We will continue our work to become an employer of choice, promoting opportunities for flexible working arrangements, building on training and development opportunities and access to career development. We will also launch our People Strategy, Learning and Development Strategy and Bridging the Gap, which is a policy to address equal opportunities and social inclusion.

Reducing Staff Absence

We had a sickness absence rate for 2009 of 3.85 per cent, which means an average of around 450 staff are off work at any one time. Our target was 3.5 per cent which represents around 350 staff off at any time – this year it will be 3 per cent. However, during 2009 we had the lowest sickness rate of all acute Trusts within the East Midlands.

Lower absence means less overworked teams, more satisfied staff, more productive teams, better quality care, better patient experiences and it makes us a more attractive employer.

To help support a reduction in absence we have produced a detailed programme of actions following the Boorman NHS Health and Well Being Report. It incorporates initiatives relating to occupational health, staff counselling, musculoskeletal absence and stress reduction. Our 'At Work for Patients' project also continues to work to reduce short-term and long-term

sickness absence amongst our staff. This has been supported by well-being initiatives across the Trust, including 14 different exercise classes each week, walking routes around our sites and a subsidised cycle to work scheme. We are also rolling out an in-house 'Sickness Monitoring and Reporting Tool' (SMART). The electronic system provides timely and detailed information to managers to assist them in supporting staff to return to work. We also support our managers with training and offer additional support to those areas where absence is higher.

Consulting staff/ staff engagement

Our newly developed Staff Engagement Strategy identifies key areas to effectively engage our staff. These are:

- Developing shared values
- Promoting a clear strategic vision
- Leadership and effective management
- Two way communication
- Career development and training
- Involvement in change
- Model employer.

Effective staff engagement creates a culture where staff feel valued, developed and supported. This is crucial to promoting well-being at work. Our priority areas for action were identified in 2009 as:

- Developing shared values and promoting a clear strategic vision
- Two way communication
- Appraisal and production of personal development plans as the basis for career development and training.

As mentioned earlier in the report, our values were co-created through the involvement of a quarter of our workforce in focus groups, surveys, and "Big Conversation events". These events were also key in developing the dialogue between staff and senior managers, identifying areas where we do things well as an organisation, and where we could improve. Following the events we collated all of the feedback. This was a mammoth task which involved analysing 4,777 separate suggestions and 34,000 words!

The results were really interesting. Firstly, the four draft values which we started out with were very popular. But during the course of the eight weeks it took to start and finish the Big Conversation we noticed that a lot of people were talking about their 'creativity' and 'passion' for their jobs. We thought this was missing from the original four values and so we added a fifth value.

Once the values were agreed we looked at what staff had to say about how we should all behave if we wanted to make the values 'real'.

This is where it got complicated! A member of our staff, Carl Walker, wrote a special computer programme which enabled him to analyse every word used to describe a style of behaviour.

In all, Carl ran 34,000 words through the computer, looking for the ones which appeared most often. It was a painfully slow process at times but we were keen that we captured every 'voice.'

So for example for the value "We treat people how we would like to be treated" one of the themes which appeared most was 'listen / listening'. Staff were telling us that it was everyone's responsibility to be better listeners to patients and their relatives and to our work colleagues.

After many hours looking at which words appeared most often in relation to each of the values we arrived at a list of supporting behaviours for each value.

Below is what we have created as a team. Our new values and behaviours are:

'We treat people how we would like to be treated'

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

'We do what we say we are going to do'

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

'We focus on what matters most'

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

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

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

'We are passionate and creative in our work'

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

We have set up a staff engagement steering group, led by the Director of Human Resources, which is responsible for ensuring the strategy is implemented. There is a rich depth of work which is being focused on thorough action plans to embed our new values in eight work streams;

- Induction
- Appraisal
- Staff recognition and reward
- Recruitment
- Branding and literature (communication)
- Decision making and governance
- Patient experience
- Living our values

We recognise and value the working partnership we have with our “*staff side*” (*this is the collective name for our trade union representatives*) colleagues. They play a vital role in assisting us to focus on what matters most to our staff. To support the engagement of staff we have a recognition agreement with more than ten trade unions. A number of projects are developed in partnership with staff side organisations and there is a regular joint staff consultation and negotiation committee, chaired rotationally by the Chief Executive and Staff Side Chair.

Creating tomorrow's leaders, today

Leadership and effective management is also a priority area identified through our Leadership and Talent Management Strategy. Development of our leaders and managers is critical in creating and promoting a culture which values staff. During the year we launched our Leadership Academy. The programme's aims were not only to develop the skills of our leaders, but also to make a cultural shift within our Trust. Feedback from those who took part has been very positive and they say they have benefited from the experience both personally and professionally by learning new skills, knowledge and tools they will apply at work. The development of relationships across professional and specialty boundaries has been mentioned many times in the feedback. There is a stronger network and community as a result of these relationships. We will continue to focus on:

- Support for the newly formed divisional teams. These four new divisions (planned care, acute care, women's and children's and clinical support services) are led by clinicians and will have clinical business units beneath them;
- Helping leaders to share learning, practice skills, use appropriate tools, and develop a coaching style and philosophy for leadership;

- Promoting ownership and accountability for leadership development of others within teams and individual managers.

The Leadership Academy will support all future leadership activity across our organisation. The working group supporting it will concentrate on a wide variety of subjects designed to meet leadership requirements at all levels in the organisation.

Learning and development

In a constantly changing environment with increasing pressure on resources, learning and development are key to ensuring we continue to be accredited as a teaching hospital and to help us achieve our vision and strategic goals. We want to ensure all staff have the right knowledge, skills and behaviours to deliver safe, effective care and give our patients an excellent experience.

Our training service provides national vocational qualifications (NVQs), a wide range of externally accredited and in-house staff development, management and leadership development programmes, as well as organisational development consultancy, coaching and team development.

The training service was visited by OFSTED (Office for Standards in Education, Children's Services and Skills) during 2009 and was rated "outstanding". OFSTED awarded us the highest grades possible for overall effectiveness, quality of the service we provide, achievement and standards. This result ranks our training service amongst the best training providers in the country, putting us in the top six per cent.

Our service is the first NHS based training provider nationally to offer apprenticeships in health, customer service, support services in health care and health and social care. We have recruited apprentices in a range of areas including pharmacy, finance, ward areas, the plaster clinic, corporate nursing and human resources.

During the year we signed up to a national initiative called "Test the NHS", which is aimed at improving access to training and development in literacy, numeracy and the English language. This initiative supports our commitment to the national Skills Pledge and continues to build on existing good practice of engaging staff in training. All our staff were given the opportunity to access further learning and development to work towards national qualifications in literacy, numeracy and English language up to a level two GCSE standard. Our training service also won the prestigious Learndirect East Midlands Achievement Award. The service was praised for offering "a true learning culture across the organisation, fully embracing the benefits of learning."

Recognising our amazing staff

It's important we celebrate success. Every year we identify best practice and ensure our staff are rewarded for innovative developments, exceptional work to improve and advance the way we do things, or just for when they go the extra mile.

This year was no different and staff nominated colleagues and teams in seven categories: patient involvement; education and training; leadership, Trust achievement; Caring at its best; unsung hero and the overall team award. The awards this year went to individuals such as the deputy sister in the renal unit for her exceptional work involving patients in service design and the housekeeping team on ward 32 at the Royal for huge improvements in cleanliness. The event held to present the winners with their awards was a huge success and we look forward to celebrating even more staff achievements in 2010.

Engaging and involving our patients and the public

This was a significant year for patient and public involvement. From April 2009 NHS organisations have been required by law to involve local people in their plans to develop services. This "duty to Involve" requires us to involve or consult with patients whenever we are:

- Planning services
- Developing or changing the way services are provided
- Making decisions which might affect the operation of our services

Naturally, it is only by listening to, and understanding the experience of people who use our services that we can make them better for everyone. This new legal requirement helped to ensure we were involving people in each area of our organisation and developing services which have a positive patient experience at their heart. Everyone in the organisation has a responsibility to listen to, and respond to our patients. However, in order to coordinate activity, we have identified a number of senior staff to act as a patient and public involvement (PPI) leads. These individuals worked closely with our patient advisors to develop plans to engage for the year.

We have engaged with patients and members of the public in a variety of different ways. Sometimes we have focused on giving people information, raising awareness of issues and promoting specific initiatives. On other occasions we have actively sought views and opinions to make sure we understand what matters most to patients. We have also directly involved patient advisors in some of our key decision making forums.

Below are some of the opportunities that we have taken to engage patients and the public over the last year:

- A medical physics open day, which raised awareness of career opportunities for scientists and technicians. More than 60 people learnt more about the role of the department, and were given a guided tour to show them the various services the department provides

- Patients and representatives from the “Breast of Friends” patient group have been involved in the design of new hospital gowns. These gowns, which have now been introduced in our Breast Care centre, are specially designed to disguise body asymmetry and are made in a wrap around style which provides a greater degree of privacy than conventional gowns
- Patients have been asked to come in to the hospital to take part in training sessions for our staff. This has been an effective way of ensuring that we understand the experience of service users, particularly in relation to care at the end of life
- Patients using our cancer and haematology service were surveyed to help us develop a new “grazing menu” which has been designed to better suit the needs of these patients
- Two successful focus day events were held by one of our matrons working in cardiac services. Patients were invited to speak about their journey through the NHS and identify areas for improvement. These ideas were then put into an action plan and shared with staff and those who took part. One of the days specifically focused on the experience of patients from South Asian backgrounds
- An initiative to provide follow-up support for patients who have had bowel surgery has been developed using the results of a patient satisfaction survey.

Overall, we have done a wide range of public involvement activity. However, we recognise there is still some distance to travel before we can confidently say we regularly and routinely involve patients and the public in what we do.

We will continue to raise the profile of engagement and involvement and spread a clear message among our staff that it is everyone’s business and it can help them to make the right decisions.

Preserving the privacy and dignity of our patients

During the year we were lucky to receive £735,000 from the government’s privacy and dignity fund to help us to make a number of improvements to our accommodation so patients can have their care delivered in a same-sex environment.

The funding has helped us put more frosting and screening in wards, increase the number of single-sex toilet and bathroom facilities so men and women do not have to share or pass members of the opposite sex to go to the toilet. We have also fitted new bigger, signage to make facilities easier to find for people with visual or language difficulties and those with dementia.

We are determined to make sure our patients have the best possible care in an environment they feel comfortable in. We know from patient research that being in mixed-sex accommodation can heighten concerns and compromise privacy and dignity at a time when

patients are already feeling vulnerable, which is why providing same-sex accommodation is so important to us.

However, there are occasions when patients need to be treated in an area with the opposite sex, particularly in an emergency. This is because we need to treat patients as quickly as possible and their safety and saving their life is our first priority. This might happen in our high dependency areas such as coronary care units, high dependency units or acute care bay.

In every case we make every effort to move patients into a same sex area as soon as possible to continue their care.

The final part of our plan will see the few remaining areas of our hospitals make the necessary changes needed to eliminate mixed-sex accommodation in 2010.

Research and development

We host many research teams with national and international reputations. This strong research culture helps us provide the very best service for our patients, delivered by first-class staff who are aware of the most modern and effective treatments.

We continue to make major advances and discoveries in many medical specialties, including cardiovascular, renal and respiratory diseases, cancer, infection and diabetes. Much of our research is in collaboration with Leicester University and other regional universities including Loughborough and Nottingham. We also work closely with many NHS Trusts in our region (especially primary care trusts) and an increasing number of academic partners worldwide. Funding for research comes from the Department of Health (via the National Institute for Health Research) and major research organisations, for example the Medical Research Council, Cancer Research UK, British Heart Foundation and the Wellcome Foundation. The pharmaceutical industry is also an important partner and these clinical trials give our patients early access to new treatments supported by highly trained staff.

During the year we were awarded £15.7m by the National Institute for Health Research.

There are currently over 800 clinical trials taking place in Leicester's Hospitals and our investigators continue to publish more than 600 peer-reviewed papers annually.

This year, supported by government funding, we have established a Biomedical Research Unit in cardiovascular disease. This extra investment was awarded in recognition of our expertise in the treatment and prevention of heart disease and raised blood pressure. The new facility has been built at the Glenfield Hospital which will enable patients involved in research to be managed in a dedicated unit with access to state-of-the-art equipment, including a new MRI scanner.

We continue to host three National Institute for Health Research networks – the South East Midlands Diabetes Network, the Trent Stroke Research Network and the Leicestershire, Northamptonshire and Rutland Comprehensive Local Research Network. These have been very successful. They have significantly increased the number of patients taking part in

research within our region, which means we will get more funding this year. We also host a National Institute for Health Research funded initiative entitled the Leicestershire, Northamptonshire and Rutland Collaboration in Leadership for Applied Health Research and Care. The research partnership between every NHS Trust in these counties is investigating the effectiveness of treatments for long-term conditions and how to ensure that those affected by these conditions receive the very best care.

Our nursing staff

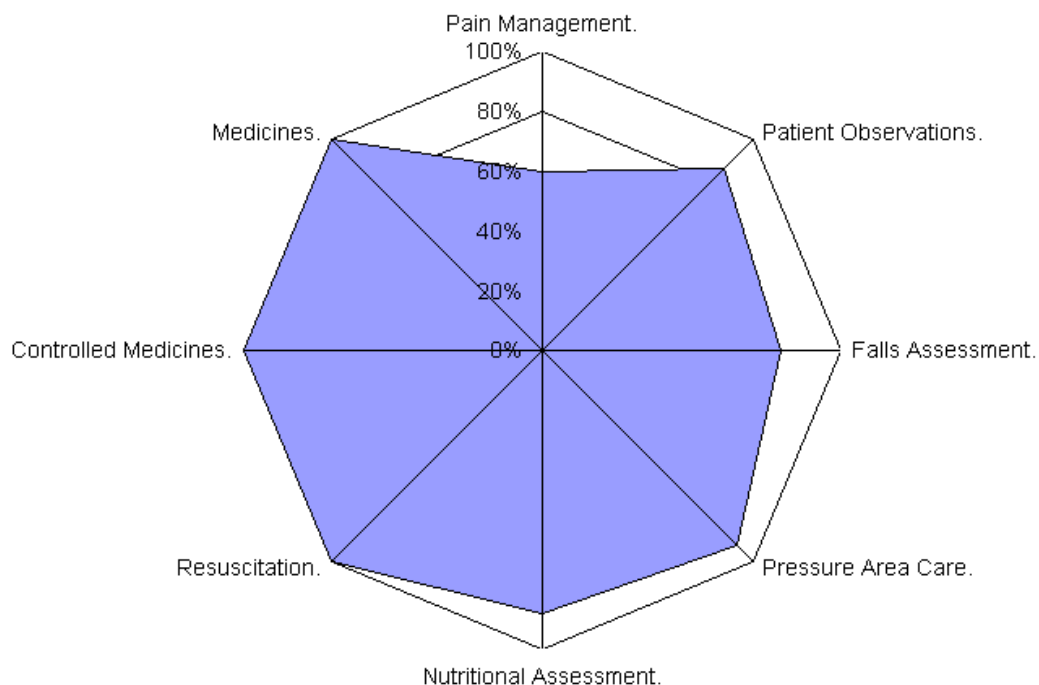
Nurses and midwives deliver 'Caring at its best' reflecting their unique contribution to patient safety, compassion, caring and high-quality care. Over 3,000 nurses and midwives in our hospitals are at the centre of the patient experience and delivering the care which reflects the values and beliefs of the profession and the Trust, while respecting and promoting a positive patient experience, putting the patient at the heart of care.

Quality metrics

Led by our Chief Nurse Suzanne Hinchliffe, and supported by our senior nursing team, our nurses have introduced a new audit tool which measures the quality of our nursing. It allows ward staff to receive feedback and then improve areas such as managing pain, falls and nutrition. It was originally adopted in small pockets of the organisation and has now been rolled out across all of our inpatient areas. Ward staff receive feedback pictorially, using spider graphs, and there is great enthusiasm to improve the results each month. Already this initiative has created changes to patient risk assessments and care planning.

The chart below shows how we measure the eight areas of nursing care:

UHL Indicators



Infection control

The safety of our patients, visitors and staff is central to the work of our infection prevention and control team. During the year we continued to make considerable progress in developing and strengthening our infection prevention and control performance and in making our hospitals even safer.

We continue to be rated amongst the top 25 per cent of Trusts in England for our reduction of MRSA bacteraemia and clostridium difficile infections. We have worked with our colleagues from the East Midlands Strategic Health Authority to provide information to patients, the public and our staff on cleanliness, MRSA, clostridium difficile, antibiotics, MRSA screening and what we can all do to maintain a safe environment.

The Department of Health requires all NHS Trusts to screen every elective patient for MRSA. During the year we worked hard to ensure we were compliant with this programme and we will now continue this work to ensure all patients admitted in an emergency also receive screening.

We have set up an infection surveillance programme. The baseline information we gather will allow us to make the best use of our resources and effectively target areas, if it shows we need to make improvements.

We have worked closely with our facilities colleagues to make sure our hospitals continue to be regularly monitored for cleanliness and also to ensure any work to upgrade or build new areas is done in line with the current national guidance.

We would like to thank our staff, patients and visitors for their efforts, hard work and continued commitment to patient safety.

Based on our success this year, the Department of Health has set us even more

challenging targets for the coming year. Whilst celebrating our success we are committed to achieving these targets. We cannot do this alone and it requires everyone who visits, stays and works at our hospitals, to make sure that preventing infections is at the forefront of what we do.

"My father spent the last three weeks of his life on Ward 4 at the General, and we have nothing but praise for the staff and the care he received.

Thanks to these dedicated people my father was able to end his life with dignity and we will be forever grateful for that.

In the midst of adverse publicity, I think it is important to pay tribute to the hard work and dedication that we experiences."

Mrs P, Worcester

Electronic Rostering

Our nurses now use a computer software package called electronic rostering (ER) to produce and maintain duty rotas. There are many benefits to the ER system; it saves time on producing rotas, it can help identify hours lost, it can produce reports such as sickness, absence, it means we can utilise staff more effectively, use less temporary staff and it has improved staff satisfaction.

Temporary staffing

Our 'staff bank' offers a flexible staffing solution to support teams with any short-term staffing issues. As well as providing valuable support it offers value for money when compared with alternatives, such as commercial recruitment agencies.

Our bank currently has 3,723 nursing and administrative and clerical (A&C) staff on its books. Some of them have substantive posts in the Trust and choose the bank as a flexible option to work more hours and others choose to work exclusively through the bank service because they like the flexibility it offers them. In 2009 the staff bank recruited the following staff.

Nurses	213
Health care assistants	164
A&C staff	107

Between 1 April, 2009 and 31, March 2010 the service received requests for 775,926.13 hours worth of support (this is equivalent to about 400 full time staff).

Releasing Time to Care - The Productive Ward

The NHS Institute has found that ward nurses in acute settings spend on average 40 per cent of their time on direct patient care. The productive ward series is an innovative and practical programme of work which aims to help turn around this situation by releasing time to care. More than that, it is a systematic and inclusive approach to improving the reliability, safety and efficiency of the care that is delivered.

The programmes apply best known practice techniques from industry and works on six principles:

- Sort – get rid of what's not needed
- Set - organise what belongs where
- Shine – clean, see and solve problems
- Standardise – who does what to keep it up
- Safety – see and fix unsafe conditions
- Sustain – be disciplined.

"I was admitted to the admissions unit ward 15 at the Royal Infirmary.

The care and attention I received from doctors and nurses was exceptional. The consultants and nurses gave me reassurance and I was cared for by the nurses with dignity.

I wanted to share my positive experience of a dedicated and hard working team".

NB, Leicester

We have received funding to cover programme costs up until 2011 to implement the Releasing Time to Care - Productive Ward Programme.

By creating a really strong focus on the processes of care within wards, Releasing Time to Care significantly increases the proportion of time spent providing direct care to patients, improves the experience of both staff and patients and organises the ward so it works for the ward team rather than against them, saving staff time and effort.

Throughout the programme patient experience is gathered on a monthly basis. It is displayed openly, along with infection rates and complaints, for everyone on the ward to see - staff, patients and relatives.

Alongside this, staff surveys are done every three months to measure whether there has been improvement in staff morale in the wards during the programme.

This initiative started in June 2009 and now there are 24 wards involved across the organisation. The plan is that 75 wards will have started this programme by May 2011

Equality and diversity

We have a clear commitment to prevent discrimination and promote and value equality and diversity, as both an employer and as a provider of healthcare services. We don't do it just to satisfy legal requirements but in the belief that it makes sure everyone is treated with dignity and respect and receives fair services.

Like all hospitals we have a single equality scheme with a three year plan that tells people how we:

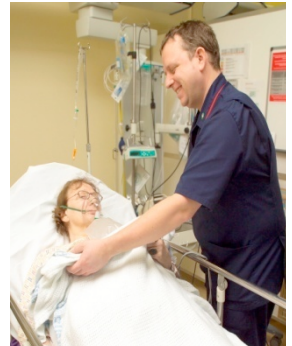
- Ensure that we do not discriminate against any individual or groups of people
- Identify areas for change, and
- Make sure that equality is core to all that we do.

We have a range of services which demonstrate our ongoing commitment to supporting the more vulnerable groups of service users and our staff. Below are several examples from our equality work programme which aim to positively impact upon people's health by improving access to hospital services.

'Make my Stay' project Make my Stay' aims to improve the experience of patients with a learning disability when they come into hospital. We appointed a specialist nurse trained in learning disability who provides support to patients and advises staff. The project has been very successful so far with more than 25 people receiving advice and support.



Frail elderly people in emergency care This project aims to improve the experience for older people and increase staff awareness of the specialist needs of older patients attending our emergency department. This again has been successful so far with staff saying they are much more aware of the needs of older people.



'Parents to be' We have produced a translated DVD on pregnancy for 'parents to be' from the Bengali community. There are higher incidents of infant death in the Bengali community than in any other community and the project aims to reduce this. The idea for a DVD came from feedback that parents didn't fully understand some of the maternity information we were giving them. The DVD was launched in April 2010.

Bullying and harassment adviser service We have been trialling a bullying and harassment adviser service which provides help and advice to our staff. Whilst we are disappointed that incidences of bullying are still being reported, we are committed to doing something about it. The service will continue beyond the trial period as a result of the positive feedback we have received.

Staff diversity e-forum We have a commitment to promoting equality in the workplace. In the past various staff forums had been set up including a Black and Minority Ethnic (BME) forum, to enable staff to raise concerns and explore ways in which our organisation might address them. Low attendances at these forums highlighted the need to do something different, so the e-forum was launched. The forum serves as both a staff support network and a vehicle for meaningful discussion and consultation between staff and senior members of the Trust. Although it is early days the site has had lots of visits and people seem to use and like it.

Workplace adjustments project We have developed a resource toolkit for managers and staff which is available on our internal website. It provides useful information, advice, support and funding streams to help managers and staff in managing long-term health conditions and disabilities. We also have a database to log information about adjustments at work and any specialist equipment that may be re-used for any of our other staff.

Safeguarding adults and children

We have strengthened our adult and child safeguarding services during the year as part of our ongoing commitment to maintain high standard services.

In December 2009 we confirmed that all of our staff had received up-to-date training on safeguarding, appropriate to their roles and responsibilities. This was a significant achievement and it has meant we have been able to raise awareness of people at risk of harm at an earlier stage and to put in place interventions to provide support and help.

We were inspected by the East Midlands Strategic Health Authority as part of the annual children's safeguarding review and we also submitted evidence to the Care Quality Commission as part of their safeguarding review. Both exercises confirmed there was sufficient assurance in the arrangements that we have in place for safeguarding. This resulted in us being able to make a public safeguarding declaration in January 2010.

In February 2009, we appointed our very first named nurse for safeguarding adults, Sarah Meadows. She has created a safeguarding adults resource folder which is being shared with all clinical areas across the Trust to support our frontline staff with any safeguarding adult concerns. We've also displayed information leaflets and made posters available for members of the public across our hospitals.

The chaplaincy



The chaplaincy at Leicester's Hospitals is an integral part of the care provided for patients and their families. Our chaplains and volunteers do a very demanding job, in difficult circumstances, and they are highly valued by patients, their relatives and our staff.

The team consists of three full-time chaplains and thirteen part-time chaplains

from the Christian, Hindu, Muslim and Sikh faiths.

We also benefit from the services of over 100 volunteers of various beliefs, including Baha'i, Buddhist, Christian, Hindu, Jewish, Humanist, Muslim and Sikh. In the past year the team have made bedside visits to more than 14,000 patients, in some cases supporting an individual many times during their hospital stay.

The chaplaincy is part of our commitment to deliver "Caring at its Best" to patients and their relatives right up to the end of life.

Chaplains support those who face emotional distress arising from questions concerning life,

*Feedback from a patient's grandmother:
"My daughter could not have coped over the three agonising months of day and night care she bestowed lovingly on her very sick son without the care and support of the chaplains."*

death, meaning and purpose - questions that can be acutely highlighted by illness and suffering. Our service extends to an emergency out-of-hours service, particularly to support patients who are approaching death.

One-to-one pastoral support of staff has also taken an increasingly prominent role in the past year.

As we look ahead, the chaplaincy will continue to work hard to deliver high quality emotional, spiritual and religious support to patients and staff, of all faiths and none.

Volunteering

We now have over 1,120 volunteers actively involved in helping across our hospitals. We have been pleased and overwhelmed by the interest of local people to help their hospitals, with an average of around 20 to 30 new enquiries every week. We interview over 35 new volunteers and train around 25 new volunteers every month. Such is the popularity of volunteering we've had to create a waiting list for those interested in voluntary work with people having a short wait before they can begin to donate their time to helping us.

However, those who have completed the process and become volunteers have already shown true determination and commitment before they even start as volunteers.

Our volunteer workforce is aged between 16 and 89 and between them they speak 45 different languages. More than 100 of them are older peoples' champions and 28 are dignity volunteers, and we have plans to increase these numbers over the coming year.

During the year we developed our volunteer mealtime assistants project and there are over 100 volunteers trained to help patients eat their meals, helping to improve their nutrition and hydration during their stay in hospital. Other Trusts have shown an interest in our work and are looking to set up similar programmes in their hospitals.

Volunteers now also help as hand holders in ophthalmic theatres, reassuring patients and staying with them throughout their surgery and recovery to help them remain calm and relaxed during the process.

Our patient buggy project operates at the Royal and the Glenfield hospitals five days a week and we will be introducing it at the General hospital on a trial basis later this year. Patients, visitors and staff rely on and value this service which is entirely provided by volunteer drivers.

"Time for a treat" is a volunteer-led service providing beauty treatments such as hand massages, facials, manicures and pedicures which was started for patients in cancer and haematology. During the year, the service expanded and now offers treatments to patients in our medical and stroke wards, dialysis unit and the young disabled unit as well as our patients in cancer services.

Older people's champions

An older people's champion is someone who has completed additional training to understand the specific needs of older people; they work across our hospitals to improve the experiences of our older patients. The older people's champion network is supported from board to ward and now has more than 1,400 champions. We publicise our champions and information leaflets are sent to any person over the age of 65 who is coming to one of our hospitals for treatment.

Members

As an aspiring NHS Foundation Trust we have grown our membership to almost 24,000 members - 13,938 public members and over 10,000 staff members, including contractors. These people are representative of our local population and have expressed an interest in the work of Leicester's Hospitals. We actively look for opportunities to talk and listen to them on a number of topics that are important to them and us. Listening to these members helps us to learn about people's priorities for improving our services.

Our thousands of members give us an invaluable insight into what people want to see in their local health service and events often stimulate lively discussion about experiences and priorities. We keep in touch with members through regular newsletters and events, like the popular medicine for members' which consist of presentations from staff about some of our services.

Our members are also involved with their feedback via online questionnaires on the dedicated members' area on our website or by email inviting them to share their thoughts and views on specific topics. This year these topics included our single equality scheme and our proposals to become an NHS Foundation Trust.

Anyone can become a member and it gives people a real stake in the future of their local hospitals. Members can influence the way that their local hospitals are run because they have the power to elect their fellow members to a 'Council of Governors'. The council will work alongside our board of directors and get involved in shaping and challenging decisions that are made.

If you would like to become a member please visit www.uhl-tr.nhs.uk/members/becoming-a-member/apply-to-be-a-member, or call the membership office on 0116 258 8685.

Patient advisors

Patient advisors are ordinary members of the public who work with us regularly and last year saw several changes to the role of patient advisors in Leicester's Hospitals. Their primary role of providing an independent lay person's viewpoint on hospital services and policies at the grass roots level (being a "critical friend") remains, but over the past year this has been extended. Five advisors were invited to sit on the following key Trust committees:

- Governance and risk management

- Finance and performance
- Charitable funds
- Research and development
- Patient safety

This is a significant change and means patient advisors now have an input into important policy making and monitoring areas.

In April the number of advisors increased from nine to fifteen. This has meant that during the year every directorate has benefited from the support a patient advisor can give. The larger directorates, such as surgery and medicine, now have two advisors.

Every directorate uses their patient advisors in a slightly different way, depending on the type of services they offer and the skills and background of the advisors themselves. There are some common issues where most advisors can become involved, notably observational audits, (where a specific ward or outpatient department is observed noting good and bad practice), giving a lay person's view on infection control measures and being consulted on draft patient information leaflets prior to final publication.

Martin Caple, a patient advisor since 2002, said:

"The changes in the role in 2009 and those planned for the coming year mean that not only is our role more meaningful, but it has also raised the profile of advisors and the voice of the public

is now heard by senior management far more than in the past. We welcome the changes and developments and are pleased to be involved in the work of the Trust."

"I have been a regular visitor to the Glenfield's paediatric intensive care unit over the last six weeks, and I cannot praise the staff in the unit highly enough. They show extraordinary levels of dedication, commitment and professionalism in a highly stressed job, and yet still find the time to show great kindness to patients and visitors. We are so lucky to have this unit here in Leicester".
Ms C, Leicester

*"As a nurse at the Royal I know that staff are bound by a duty of care to their patients, but I personally feel that the care I received went above and beyond that expected of staff.
On New Year's Day I gave birth to a baby girl at the Royal, but suffered severe complications which led to two trips to theatre.
Looking back I now understand that without the fast response and caring nature of those involved, it is almost certain that I would not be enjoying the life I live with my little girl and partner today.
No words I say in this letter will ever tell them how I feel about what they did for me. Not only me, but all of my family, would like to thank the staff involved."
Ms L, Leicester*

*"My husband recently attended the A&E department at the Royal following a fall. The treatment received during the visit was quite outstanding; not only was the proficiency of Mr Shahid excellent, his manner was extremely pleasant, and the duty nurse Rachel, was pre-eminent.
We were privileged to witness our NHS at its very best during this visit, very many thanks.
Ms H, Leicester*

*"I would like to express my thanks for the way my wife was cared for recently on Wards 15 and 33. The wards were spotless, and the care given was without fault.
Everyone was so kind, thoughtful and helpful. Thank you."
Mr B, Glenfield*

Sustainability

Estates developments

We've made considerable investments in improving our infrastructure and developing our services during the year. The most significant amongst these have been the £9.3m neonatal unit replacement project at the Royal Infirmary, which is due to be completed in the autumn of 2010; the £6.2m project for four new orthopedic theatres at Leicester General Hospital due to be completed in November 2010; the new, larger clinical decisions unit; and the new biomedical research facilities, both at the Glenfield which total around £2m.

As well as this we have been installing new lifts on all three sites as part of a phased replacement plan which started three years ago. We've also been replacing flooring, refurbishing toilets and providing 300 extra car parking spaces at the Glenfield and Leicester General.

In total we've invested £17m this year in estate developments for the benefit of our patients, staff and visitors.

Carbon management

We take the challenge of providing modern healthcare from sustainable facilities very seriously. We have a carbon implementation plan, which was produced in conjunction with the Carbon Trust, as part of a national programme and we are investing in capital projects which will reduce our energy consumption and carbon emissions.

The drivers for these initiatives are the desire to be a low carbon organisation, to become a leading example of sustainable activity within healthcare, and to reach full compliance with the government's green agenda.

During 2008/09 we invested around £200,000 in projects to reduce our carbon emissions, followed with an investment of a further £400,000 this year. These investments have been aimed at a multitude of small scale improvements, which fall into the categories of "good housekeeping", but which are now contributing to both energy savings and a reduction in our carbon emissions.

The table below shows how during the year we reduced our energy consumption and greenhouse gases as a result of investments and good practices being introduced; all done in line with the requirements of the Department of Health's targets.

The table compares our usage in 2009/10 with 2008/09.

Description	2008-2009	2009-2010	Changes
Gas Usage (KWh)	99,227,195	97,727,656	1,499,539
Electrical Usage (KWh)	36,387,829	36,465,889	(78,060)
Totals (KWH)	135,615,023	134,193,545	1,421,479
Costs (£)	£6,859,903	£5,231,587	£1,628,317
CO2 Emissions (tonnes)	37,904	37,671	233

Our use of mains electricity increased during the year. This was mainly due to the unavailability of two combined heat and power (CHP) units at the Royal Infirmary. We generate our own electricity at the Royal Infirmary and Glenfield hospital sites by running CHP units which burn gas in modified diesel engines. These power alternators produce electricity and we use the heat generated from the engines for heating and hot water. The loss of the two units meant we needed to use more mains electricity. We are currently undertaking a survey and feasibility study to examine how best to address this.

There has been a reduction in the amount of gas we have used over the past year.

Tariffs for energy supplies have been extremely volatile over recent years and a significant saving was made last year with the reductions in tariffs, along with using less energy.

Investments over the year will include improving the lighting on all three sites, upgrading our building management systems and the thermal insulation at the General and Glenfield and putting in a new steam condense system at the Royal.

Projects we are planning over the next five years include:

- Installing new boilers at Glenfield hospital
- Integrated smart metering at all sites
- Developing a carbon reduction commitment program to make sure we're compliant and to reduce any potential ongoing costs to a minimum
- Revised energy/ carbon awareness campaigns to further reduce our energy consumption to comply with carbon reduction commitment
- Review air conditioning reports and take the necessary actions as recommended across the three sites
- Continue with the CIMP (carbon implementation management plan) and NHS carbon plan
- Continue to implement the new NHS Carbon Reduction Strategy
- Continue to install smart and sub metering on all new projects and additional areas of large consumption
- Ensure compliance with European Union-Emissions Trading Scheme, climate of change levy
- Apply for Carbon Trust standard to assist with our CRC liability costs
- Replace the Royal Infirmary boiler house equipment as new energy centre

- Replace the General hospital boiler house equipment.

Waste minimisation and management

We are constantly looking to reduce our waste by reducing the amount produced and disposed of through landfill and incineration.

Waste arising from our clinical activities has strict disposal routes so that we comply with the Environmental Agency's legal requirements, which in the past has required incineration. However, recent changes in classification have enabled some low-risk categories of clinical waste to undergo alternative treatment which turns it into a sterile flock, which can be used as fuel for a variety of manufacturing processes.

We have introduced waste segregation between the high risk waste for incineration, and lower risk waste for alternative treatment over the past year. As a result 75 per cent of the 2,075 tonnes of clinical waste generated during the year was disposed of through the alternative treatment route.

General domestic waste is disposed of through a local company who sort through the waste as it arrives at their premises. They segregate the waste into its component parts, e.g. glass, plastic, wood and metal for recycling. This meant we recycled 85 per cent of the 1,425 tonnes of waste we produced.

As well as all of this we do primary recycling on each site where space permits and during the year we collected 250 tonnes of paper, glass, metals, cardboard and WEEE (electrical) equipment last year. This was directly disposed of by recycling organisations on top of the clinical and domestic waste systems we already use.

Our performance against national targets

The Care Quality Commission (CQC), the independent watchdog for the NHS, is responsible for publishing annual performance ratings for the 391 NHS Trust's in England. These ratings measure quality and effectiveness standards through a rating system ranging from 'excellent' to 'weak' for the quality of their services and for the effectiveness of their financial management.

Our ratings for **2008/09** were:

Use of resources: GOOD

Quality of services: GOOD

The quality of services score is made up of the following assessments:

Meeting core standards: ALMOST MET

Existing commitments: FULLY MET

National priorities: GOOD

As well as providing an overall rating, the CQC assessments look at how well healthcare organisations perform in a number of different areas of interest to patients and the public. The scores below show how many of the assessments we met.

It is important to note that some of the CQC assessments count more than others in the overall quality score.

Safety and cleanliness

This includes reducing the risk of infection, safeguarding children, handling medicines and equipment properly and disposing of waste safely.

13/14 assessments met

We didn't meet the standard relating to providing care in surroundings that supported the privacy and confidentiality of patients. This relates specifically to a lapse in same-sex accommodation compliance between 1 April and 31 November, 2008 in our renal and urology directorate. However, we declared compliance from 1 December, 2008 and have remained compliant since.

Waiting to be seen

This includes whether we saw patients within set timeframes and made our services equally available to everyone.

12/13 assessments met

We didn't meet the standard that deals with the proportion of patients whose operations were either cancelled for non-medical reasons or who were not offered a new date within 28 days.

As an organisation we have become better at recording data and this has highlighted areas for improvement. We're working on a number of projects looking at tackling the reasons for cancelled operations and hope to see improvements in the coming year.

Standard of care

This includes the supervision and training for staff, whether we work with other organisations to meet patients' individual needs and whether we follow national guidelines.

8/8 assessments met

Dignity and respect

This includes whether we treat people as individuals, observe confidentiality and have a transparent process that patients can access easily if they have a complaint.

9/9 assessments met

Keeping the public healthy

This includes whether we help to improve the health of the local community, understand local people's health needs and promote public health.

5/5 assessments met

Good management

This includes whether we treat staff fairly, store information properly and carry out all of the necessary checks before recruiting staff.

16/18 assessments met

During 2008/09 we declared a lapse in the standard of having systems in place to support all staff in their own development; this means not enough of our staff received an annual appraisal. We achieved compliance of this standard in 09/10.

The maternity data quality indicator is scored as 'data not returned' due to a validation check introduced by CQC measuring birth to delivery ratio. Unfortunately, we incorrectly labelled some births and we were identified as being outside the range permitted and failed the validation check. A significant amount of work has been done on maternity data since then to make sure that data flows reflect the high quality of data we collect.

2009/10 Key Performance Indicators	TARGET	Performance
A&E waiting times	98%	98.2% *
Access to genito-urinary medicine clinics - offer of appointment within 48hrs of contacting service	98%	100%
Hospital cancelled operations on or after the date of procedure	<0.8%	1.1%
Hospital cancelled operations not treated in 28 days	<5%	8.0%
Delayed transfers of care	3.5%	1.4%
Inpatients waiting longer than the 26 week standard	99.97%	100%
Outpatients waiting longer than the 13 week standard	99.97%	100%
Rapid access chest pain waiting times	98%	99.3%
Thrombolysis within 60 minutes of calling for help - Apr to Dec	68%	63.3%
18 week referral to treatment waiting times - non-admitted	95%	> 95% each month
18 week referral to treatment waiting times - admitted	90%	> 90% each month
Cancer - 14 day - urgent referral to first outpatient appointment for all suspected cancers	93%	93.7%
Cancer - 14 day - urgent referral to first outpatient appointment for breast symptoms - quarter 4	93%	95.7%
Cancer - 31 day - diagnosis to treatment wait for all cancers	96%	97.8%
Cancer - 31 day - subsequent treatment: anti cancer drug treatments	98%	99.9%
Cancer - 31 day - subsequent treatment: surgery	94%	94.1%
Cancer - 62 day - referral to treatment for all cancers	85%	86.1%
Cancer - 62 day - referral to treatment from screening service referral	90%	93.6%
Cancer - 62 day - from consultant upgrade	100%	100.0%

2009/10 Key Performance Indicators	TARGET	Performance
Clostridium difficile infections	340	236
MRSA bacteraemias	41	19

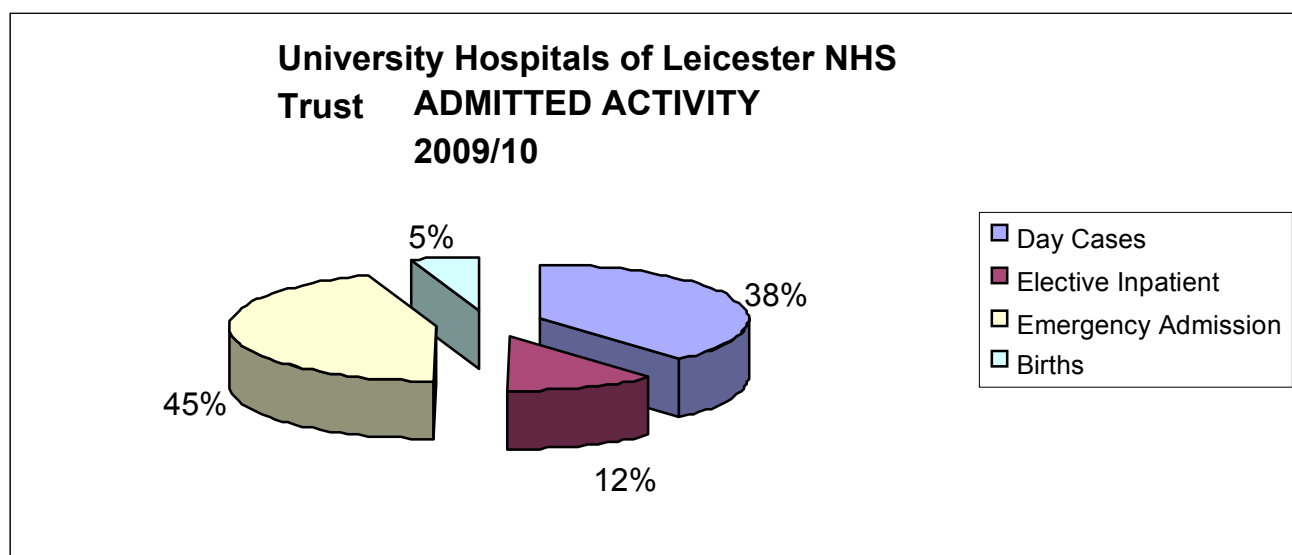
* This figure includes our emergency department as well as walk-in centres and minor injury units around the city and county.

Patients treated

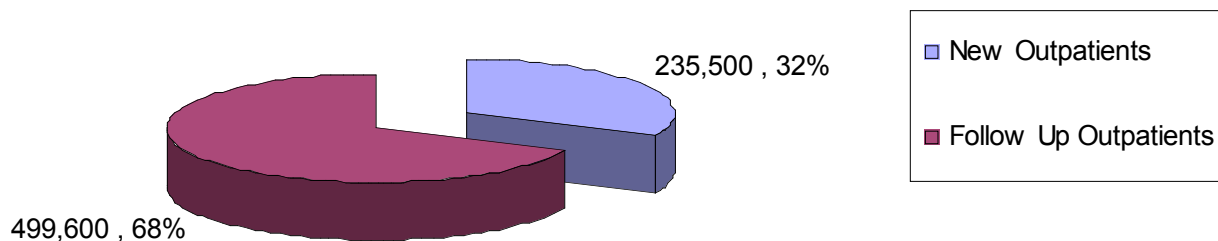
Activity Type	2007/08	2008/09	2009/10	Increase compared with 2008/09	
Day cases	74,100	76,500	78,500	2,000	2.7%
Elective inpatient	27,300	25,600	24,900	-700	-2.6%
Emergency admission	81,500	87,600	91,100	3,500	4.3%
Births	10,700	10,800	10,600	-200	-1.9%
New outpatients	206,700	218,900	235,500	16,600	8.0%
Follow up outpatients	482,000	501,900	499,600	-2,300	-0.5%
Accident & Emergency (inc. eye casualty)	153,800	156,100	160,400	4,300	2.8%

Notes

- Admitted activity is in spells (discharges)
- Emergency excludes maternity
- Births include home births and those at St Mary's Birth Centre(Melton)



University Hospitals of Leicester NHS Trust OUTPATIENT ATTENDANCES 2009/10



Being accountable

Patient information and liaison service (PILS)

We changed our service this year. It followed changes in the NHS Complaints Policy and Regulations published on 01 April 2009, and feedback from our patients, their relatives and carers. We decided to merge our complaints and PALS (patient advice and liaison service) functions to create PILS.

The new PILS (patient information and liaison service), set up in April 2009 has been a great success. We have seen a reduction in formal complaints but a significant increase in verbal concerns, queries and requests for information. This could be linked to the publicity we did around the new service to raise awareness of what we can do to help. All of the issues raised have been dealt with promptly and effectively providing a resolution to issues within 24 to 48 hours. We have provided a new free telephone number (**08081 788 337**), email address (pils.complaints.compliments@uhl-tr.nhs.uk) and website (www.uhl-tr.nhs.uk/patients/support-and-advice/pils) which has made it easier for people to access our service. The team listen and then direct the issues to the most appropriate individual or service within our hospitals. However, we sometimes have to put concerns into our formal complaints process so they can be thoroughly investigated and responded to.

We are constantly looking at ways to improve our service and value feedback from our users.

Our patient safety managers, who all have clinical backgrounds, review all of our complaints when we receive them. They assess the complaints and identify a response timeframe of 10, 25 or 60 working days, depending on the complexity or seriousness of the concerns that have been raised.

"I spent 10 days in ward 27 at the Glenfield and cannot thank everyone enough.

The love, care and attention was unbelievable and the food was first class – nothing was too much trouble.

Mrs C, Shepshed

The table below breaks down by directorate the number of formal complaints, concerns and requests for information and how quickly they were responded to.

10 day and 25 day formal complaints – 1 April 2009 to 31 March 2010

Directorate	10 day				25 day			
	Number received	No. replied within 10 days	No. replied over 10 days	% replied within 10 days	Number received	No. replied within 25 days	No. replied over 25 days	% replied within 25 days
Anaesthetics, Critical Care & Pain Management	11	11	0	100	20	20	0	100
Cancer & Haematology Services	13	13	0	100	43	43	0	100
Cardiology Respiratory Services	11	10	1	91	69	64	5	93
Children's Services	10	10	0	100	54	45	9	83
Clinical Services Directorate	34	33	1	97	26	26	0	100
Trust Medical Director					1	1	0	100
Facilities Directorate	25	21	4	84	28	27	1	96
Finance & Procurement	1	1	0	100				
Imaging Directorate	19	19	0	100	17	16	1	94
Information Management & Technology	2	2	0	100				
Medicine & Emergency Department	44	43	1	98	256	234	22	91
Musculo Skeletal Services	35	35	0	100	95	95	0	100
Nursing Directorate	3	3	0	100	2	2	0	100
Operations	1	1	0	100	1	1	0	100
Pathology Services	2	2	0	100	1	1	0	100
Renal Services & Urology	13	11	2	85	43	32	11	74
Strategy Directorate					1	1	0	100
Surgical Services	70	65	5	93	198	176	22	89
Women's, Perinatal & Sexual Health	12	12	0	100	143	136	7	95
Totals:	306	292	14	95%	998	920	78	92%

60 Day formal complaints – 1 April 2009 to 31 March 2010

Directorate	60 day			
	Number received	No. replied within 60 days	No. replied over 60 days	% replied within 60 days
Anaesthetics, Critical Care & Pain Management	3	3	0	100
Cancer & Haematology Services	2	2	0	100
Cardiology Respiratory Services	18	17	1	94
Children's Services	7	7	0	100
Clinical Services Directorate	2	2	0	100
Facilities	1	1	0	100
Medicine & Emergency Department	19	17	2	89
Musculoskeletal Services	11	11	0	100
Renal Services & Urology	1	0	1	0
Surgical Services	14	12	2	86
Women's, Perinatal & Sexual Health	14	14	0	100
Totals:	92	86	6	93%

I recently went to the Royal Infirmary to have operations on my eyes. I found each eye department, eye casualty and Ward 37 to be very busy and absolutely spotless.

I would like to say a big thank you to everyone, especially Mrs Burns' team of eye surgeons and theatre staff. Well done, you were marvellous.

Ms E, Leicester

Freedom of information

The Freedom of Information Act was passed on 30 November 2000, and the full act came into force on 1 January 2005. The act applies to all public authorities including us.

The purpose of the act is to allow anyone, no matter who they are, to find out whether information on a particular subject is held by us and to ask to see that information. The act sets out exemptions from that right, covering any information that may not have to be released.

In 2009/10 we received 250 freedom of information requests.

Health and safety

Protecting the health, safety and welfare of our employees, patients and visitors, is very important to us. Health and safety is a fundamental part of our business and forms an essential part of our risk management strategy, which is led by our Trust Board. We have reduced the number of reportable accidents to staff by 40 per cent over the last year.

This year we continued to ensure our staff, from every level within the organisation, received health and safety training appropriate to their individual role. Following advice from the Health and Safety Executive we have invested a significant sum of money to improve safety within the pathology laboratories at the Leicester Royal Infirmary. We have also introduced a safety cannula needle that cannot stab members of staff when it is contaminated with a patient's blood. We produce our own in-house bulletin "Safety Matters" which is circulated to all wards and departments to promote safety awareness and learning.

Information governance

Information governance sits alongside these other governance initiatives, it is to do with the way organisations process or handle information. It covers personal information, such as that relating to patients/service users and employees, and corporate information, e.g. financial and accounting records.

Information governance provides a framework to bring together all of the requirements, standards and best practice that apply to the handling of information, allowing:

- Implementation of central advice and guidance;
- Compliance with the law;
- Year on year improvement plans.

At its heart, information governance is about setting information handling standards and giving organisations the tools to achieve the standards.

The ultimate goal is to help organisations and individuals to be consistent in the way they handle personal and corporate information and avoid duplication of effort, leading to improvements in:

- Information handling activities;
- Patient and service user confidence in care providers;
- Employee training and development.

We are obliged to report information governance incidents during the year. The tables below detail that:

Summary of Serious Untoward Incidents involving personal data as reported to the Information Commissioner's Office in 2009-2010				
Date of incident	Nature of incident	Nature of data involved	Number of people potentially affected	Notification steps
April	We have a collection and delivery service within Leicestershire for pathology samples. Samples were stolen from the van when it was parked outside a GP surgery	Request forms attached to the samples containing NHS Number, surname, forename, date of birth, sex, address, clinical information, and GP Details.	90	GPs contacted the patients.
Further action on information risk		Drivers to manually check the locking of the van.		

Summary of other personal data related incidents in 2008/09		
Category	Nature of the incident	Total
I	Loss of inadequately protected electronic equipment, devices or paper documents from secured NHS premises	0
II	Loss of inadequately protected electronic equipment, devices or paper documents from outside secured NHS premises	1
III	Insecure disposal of inadequately protected electronic equipment, devices or paper documents	1
IV	Unauthorised disclosure	6
V	Other	0

More detail is covered in our statement of internal control later in the report.

Emergency planning

The overriding activity this year for emergency planning and resilience has been the development and co-ordination of our response to the H1N1 (swine flu) pandemic.

Although Trusts throughout the NHS have been actively preparing for a pandemic flu outbreak for several years, the pandemic we eventually faced was very different from the one we expected.

H1N1 proved to be at its most dangerous when combined with other underlying illness, with the most significant impact in young adults, children and pregnant women. This meant that the relatively long standing plan to manage pandemic flu cases all on one site (at the Glenfield) through the respiratory service was soon considered inappropriate. This meant our flu response plan had to be completely re-written.

The use of anti-viral drugs and a vaccine meant that the two or three wave pandemic pattern failed to materialise; with only one very clear peak of activity last August. Staff absence peaked at around 120 absences per day, and the number of cases in the hospital on any one day peaked at around 45 patients.

An important dimension to our response to H1N1 was the rapid expansion of our ECMO service. This very specialised form of intensive care was found to be effective in caring for the most serious cases, and we agreed with the Department of Health to rapidly double our capacity at the Glenfield – making us the biggest unit in the world. This required a great deal of effort on the part of the ECMO team and other staff with ECMO experience who were redeployed from across the Trust.

Once a vaccine became available our occupational health team were very active in vaccinating 41 per cent of our front line clinical and support staff, putting us in the top five of all Trusts nationally for the total volume of staff vaccinated.

We have been able to learn through this process and strengthen our planning to ensure we are more prepared for future events.

This was a real team effort and thanks go out to everyone for getting involved and for often going above and beyond to make sure staff understood changes in practice to protect themselves and our patients.

What is ECMO?

ECMO, which stands for extra corporeal membrane oxygenation, is most commonly used to treat a variety of conditions that affect the respiratory system.

The ECMO machine is made up of several parts: a pump, an artificial lung, a blood warmer and an arterial filter. The machine takes the blue blood (without oxygen) out of the right side of the heart and pumps it through the artificial lung (oxygenator). The blood is now red blood (with oxygen). This blood is warmed and filtered before being returned to the body.

Treatment involves inserting one or two large tubes into the major blood vessels of the heart allowing blood to pass into the ECMO machine which can, for up to several weeks, act as an artificial heart and lung. This allows the patient's organs time to recuperate.

"I have been attending the cardiology clinic at the Glenfield for some six years, and I wanted to say a big thank you to all of the staff on ward 34, some of their names I don't know, but I do remember the doctor. Dr Woo is kindness itself."

Mr M, Leicester

"I recently had surgery at the Glenfield and I feel absolutely compelled to write and both congratulate you and thank you and your magnificent staff for the way in which I was received and treated, as well as for the cleanliness, quality and friendliness which seemed to exude from your exceptional hospital wherever I went.

I really cannot find a single word of criticism; cleanliness (I witnessed a lovely girl who said she loved cleaning, move everything moveable in my ward), the catering was wonderful, and the quality of your staff in every department was something I shall remember for the remainder of my days – especially those super lasses in Ward 31."

Mr T, Grantham

"I would like to formally thank, on behalf of myself and my family, the staff in your ITU department for the dignified care of my father in his final 48 hours. Particularly Dr Flint and staff nurse Marvin who cared directly for him.

My father had also been an outpatient and occasional in-patient in haematology/oncology, so I would like to extend my thanks to the staff there who cared for him."

Ms T, Derbyshire

Our priorities for 2010/11

Despite the current financial challenges we're facing, we will not let it have a negative impact on the quality of our care.

There is significant evidence to support the view that organisations who successfully gain control of their environment, benefit from improved quality, cost and risk management.

Bearing that in mind, and the recommendations from the Mid Staffordshire enquiry, we are making sure we have robust clinical governance processes in place to constantly monitor our performance, planning and managing continuous improvement. We also work hard to identify performance which may be below standard or out of line, investigate it and take urgent action to make sure we have the best possible patient safety.

The following are the priorities that are embedded within our services plans for this year and will ensure that we continue to provide excellent patient care.

- Driving clinical quality
- Improving patient experience
- Focussing on patient safety
- Increasing productivity and effectiveness
- Managing demand and activity
- Enhancing research and development activity and profile
- An effective organisation
- Investing in people
- A risk aware organisation
- Leveraging resources
- Upgrading financial management
- Exploiting information technology
- Partnerships

Our Trust Board

NAME	POSITION	INTEREST(S) DECLARED
Mr M Hindle	Trust Chairman	Board member, Leicestershire and Rutland Probation Trust; Board member, Health Protection Agency; Chair of the Health Protection Agency Finance Committee
Mrs C Emmett (up to 31 January 2010)	Non-Executive Director	Partner, Bee Consulting; Involved in conducting Gateway Reviews in the Department of Health and NHS; Chairman, Rutland and Melton Mowbray Conservative Women's Organisation; Spouse is a PCT Non-Executive Director
Mr A M Kapur (up to 30 November 2009)	Non-Executive Director	Director and 50% shareholder, Signum Corporate Communications Ltd; Director and 50% shareholder, Signum Communications Ltd; Director and 33.3% shareholder, Sempervox Ltd; Director (nil shareholder), Leicestershire Business Voice; Governor, De Montfort University
Mr R Kilner (as of 1 December 2009)	Non-Executive Director	Member of the Patient Group for Countesthorpe Health Centre
Mr J Matharu (up to 30 November 2009)	Non-Executive Director	Lay Associate, General Medical Council (Fitness to Practise Panels); Lay Partner, Health Professions Council (Fitness to Practise Panels); Lay Partner, Postgraduate Medical Education and Training Board; Lay Adjudicator, Nursing and Midwifery Council (Chair, Fitness to Practise Panels); Lay Reviewer, Royal College of Surgeons of England
Mr I Reid	Non-Executive Director	Poppy Day Collector for the Royal British Legion; Trustee of Bitteswell United Charities
Mr D Tracy	Non-Executive Director	None to declare
Ms J Wilson (as of 1 December 2009)	Non-Executive Director	Board Chair, Leicestershire and Rutland Probation Trust
Mrs J Worthington (up to 30 November 2009)	Non-Executive Director	Chair, General Medical Council Fitness to Practise Panels; Deputy Chair, Investigating Committee, Royal Pharmaceutical Society of Great Britain; Member, General Chiropractic Council; Chair of the General Chiropractic Council Audit Committee; Board Member, Appointments Board, Nursing and Midwifery Council; Chair, University of Leicester Medical School Fitness to Practise Committee; Chair, General Osteopathic Council Professional Conduct Panels
Professor D Wynford-Thomas	Non-Executive Director	Trustee, Hope Foundation; Dean of the University of Leicester Medical School
Mr M Lowe-Lauri	Chief Executive	Director, Picker Institute Europe
Ms K Bradley	Director of Human Resources	None to declare
Dr A G H Cole (up to 7 January 2010)	Medical Director	Chairman of Health Action Leicester-Ethiopia (HALE)

NAME	POSITION	INTEREST(S) DECLARED
Dr K Harris (as of 7 January 2010)	Acting Medical Director	Clinical Vice-President of the Renal Association; Senior Medical Advisor to Kidney Research UK
Mrs S Hinchliffe	Chief Operating Officer/ Chief Nurse	None to declare
Mrs H Seth (up to 30 June 2009)	Acting Director of Strategy (post acts as advisor to the Board as of August 2008)	Relative works for the Trust's Managed Equipment Service provider
Mrs A Tierney (as of 1 July 2009)	Director of Strategy	None to declare
Mr J Shuter (up to 31 January 2010)	Acting Director of Finance and Procurement	School Governor, Greystokes Primary School, Narborough, Leicester
Mr A Seddon (as of 1 February 2010)	Director of Finance and Procurement	Spouse is an Equity Partner in Morgan Cole Solicitors
Mr S Ward	Director of Corporate and Legal Affairs (post acts as adviser to the Board as of January 2007)	None to declare
Mr M Wightman	Director of Communications and External Relations (post acts as adviser to the Board as of January 2007)	None to declare

Trust Board meetings

Trust Board meetings are held in public and details of dates are on our website. They are usually held at one of our hospital sites. Staff and members of the public are welcome to attend.

During the year we held joint annual public meetings with both NHS Leicester City and NHS Leicestershire County & Rutland presenting our 2008/09 annual report and accounts. The first joint event was with NHS Leicestershire County and Rutland at Loughborough Town Hall on Tuesday 15 September. The second joint event was with NHS Leicester City at the Walkers Stadium in Leicester on Tuesday 29 September. Both events began in the afternoon with well-being markets which were well attended, giving members of the public the opportunity to mingle with staff and learn more about our services. The public meetings held in the evening were an opportunity for people to raise questions to the boards of all three organisations on issues that interested or concerned them.

Openness and accountability

We have adopted the NHS Executive's code of conduct and accountability and incorporated them into our corporate governance policies, comprising of the Trust's Standing Orders, Standing Financial Instructions and Scheme of Delegation.

Operating and Financial Review

2009/10 was challenging both financially and clinically. Nevertheless, we consolidated our position to provide “Caring at its Best” for our patients through continuous improvement in operational efficiency, patient focus and financial stability. I am pleased to report that, for the tenth successive year, we have met our financial duties and delivered a break even position. As the main provider of hospital and community-based healthcare services to patients across Leicester, Leicestershire and Rutland, and specialist services to patients throughout the UK, our main sources of income come from primary care trusts, the national specialised commissioning group and education and training levies. We are actively engaged with our key stakeholders to implement NHS policy to improve local health services through a range of formal and informal partnerships. These include the primary care interface group, networks with other providers, academic partners and with patients, members and public groups.

Financial review for the year ended 31st March 2010

We met our financial and performance duties for 2009/10 by:

- **Balancing the books** - delivering an income and expenditure surplus of £51,000 prior to a technical impairment charge of £4m due to the revaluation of our land and buildings
- **Managing cash** – we underspent against our external financing limit by £2.1m which is permissible
- **Investment in buildings, equipment and technology** – we invested £33.4m in capital developments, an underspend of £2m against the capital resource limit of £35.1m
- **Invoice payment performance** – we paid 96 per cent of our invoices within 30 days, a 10 per cent improvement on 2008/09

Performance against our financial plan

We delivered our forecast break even result, which included a planned income of £662m, with a matching £662m expenditure plan (excluding impairment). The final year end position showed the following:

- Income - £698m actual, £36m over plan
- Expenditure - £698m actual, also £36m over plan

These income and expenditure variances predominately related to:

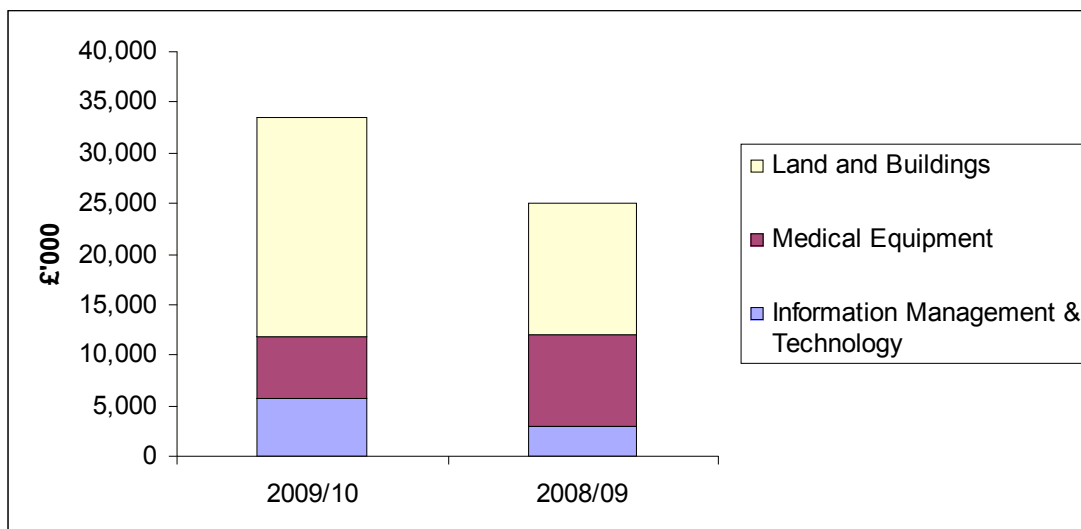
- Seeing more patients than we had planned to, resulting in additional income of £16.5m for this over performance, including income related to the swine flu pandemic

- £11.5 million in additional money for research, development, training and education, reflecting our continuing strategy of developing our research portfolio. The growth in research funds was mostly for the development of our new Biomedical Research Unit, Collaboration for Leadership in Applied Health Research and Care (CLAHRC) funding and Comprehensive Local Research Network (CLRN) funding and
- A £10.75m contribution from the Department of Health for the settlement of claims relating to the Pathway Private Finance Initiative (PFI) project, cancelled by the Trust in 2007

The swine flu pandemic impacted on our activities, notably on Extracorporeal Membrane Oxygenation Services (ECMO), resulting in extra income of £7.6m funded by the national specialised commissioning group.

Capital expenditure

We spent £33.4m against a capital plan of £35.1m, detailed in the chart below. Slippage on building schemes enabled resources to be freed up within the year for additional medical equipment and IM&T (information management and technology) initiatives.



International Financial Reporting Standards (IFRS)

In line with all NHS bodies, we adopted International Financial Reporting Standards (IFRS) from 1 April, 2009. The restatement of our 2008/09 accounts were approved by our external auditors in line with Department of Health timetables earlier in the year. The key change for us from the adoption of IFRS is the recognition on our balance sheet of the assets and related financing liabilities of our managed equipment service schemes. Prior year comparatives have been restated onto the new accounting basis.

Balance sheet

In accordance with IFRS, our land and buildings were revalued in 2009/10 resulting in a reduction in their value by £5.6m and a £4m technical impairment charge to expenditure. We planned to reduce our cash holdings by £3m by the end of March 2010, which we have achieved with an actual cash balance of £12.5m at the year end.

Our creditor position has increased by £20m in 2009/10. The underlying creditor position has continued to improve during the year by achieving the Better Payment Practice Code performance with 96 per cent of invoices paid within 30 days. The increase in creditors reflects two issues:

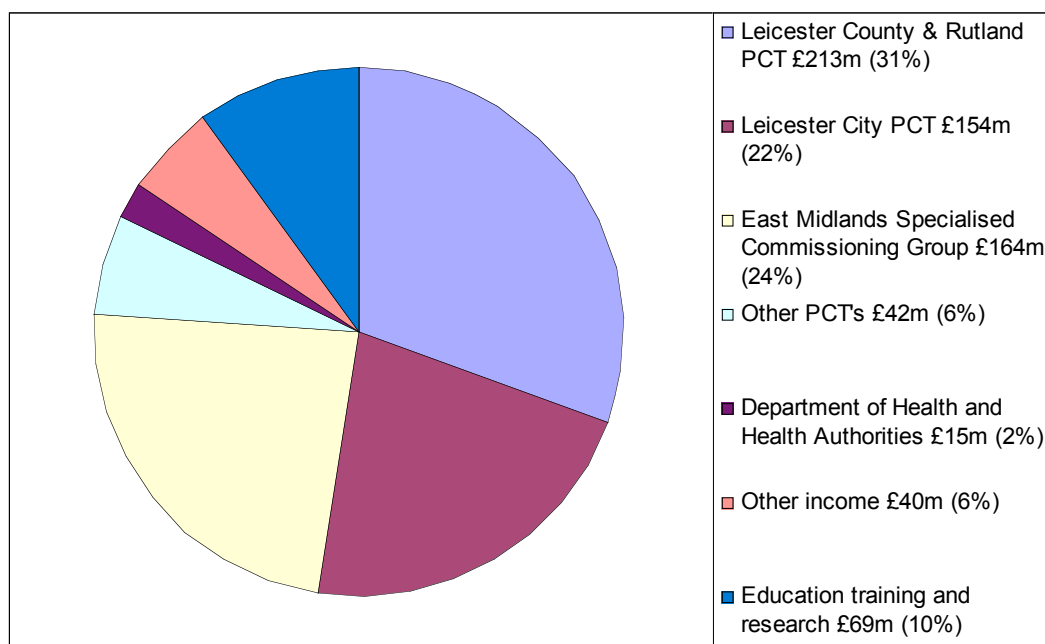
- A payment after the 2009/10 year end of £10.75m in relation to the Pathway PFI project; and
- In March 2009 we paid pension and tax creditors of £8.6m in advance of payment terms and did not repeat this in March 2010

Debtors increased by £12m in 2009/10, reflecting the inclusion of the £10.75m PFI settlement funding received from the Department of Health.

Key Financial Indicators

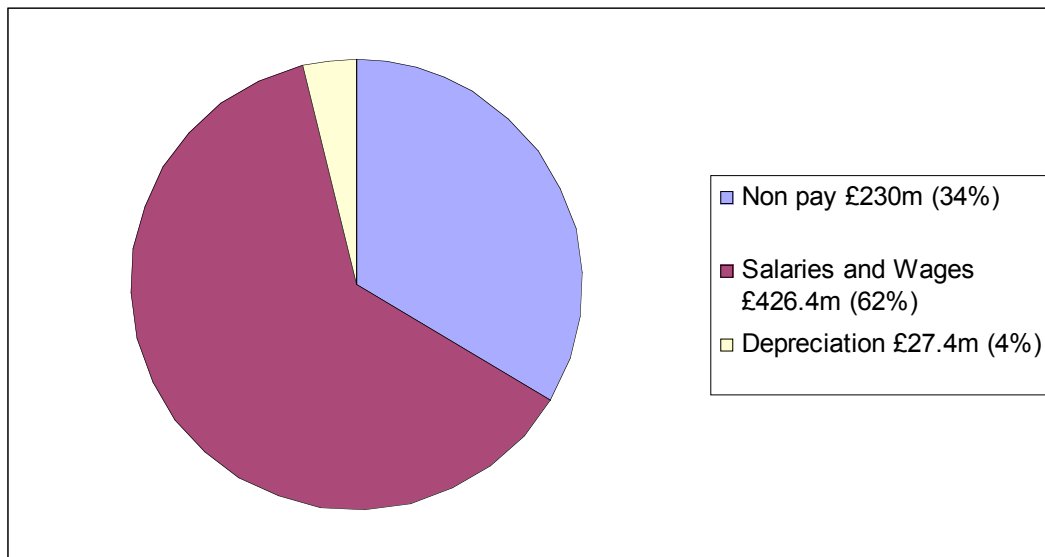
Trust income 2009/10

The chart below details the £698m income we received. This is a seven per cent increase from the £652m received in 2008/09, reflecting planned funding increases from our commissioners, the in year patient care activity over performance and increased research and development undertaken detailed previously.

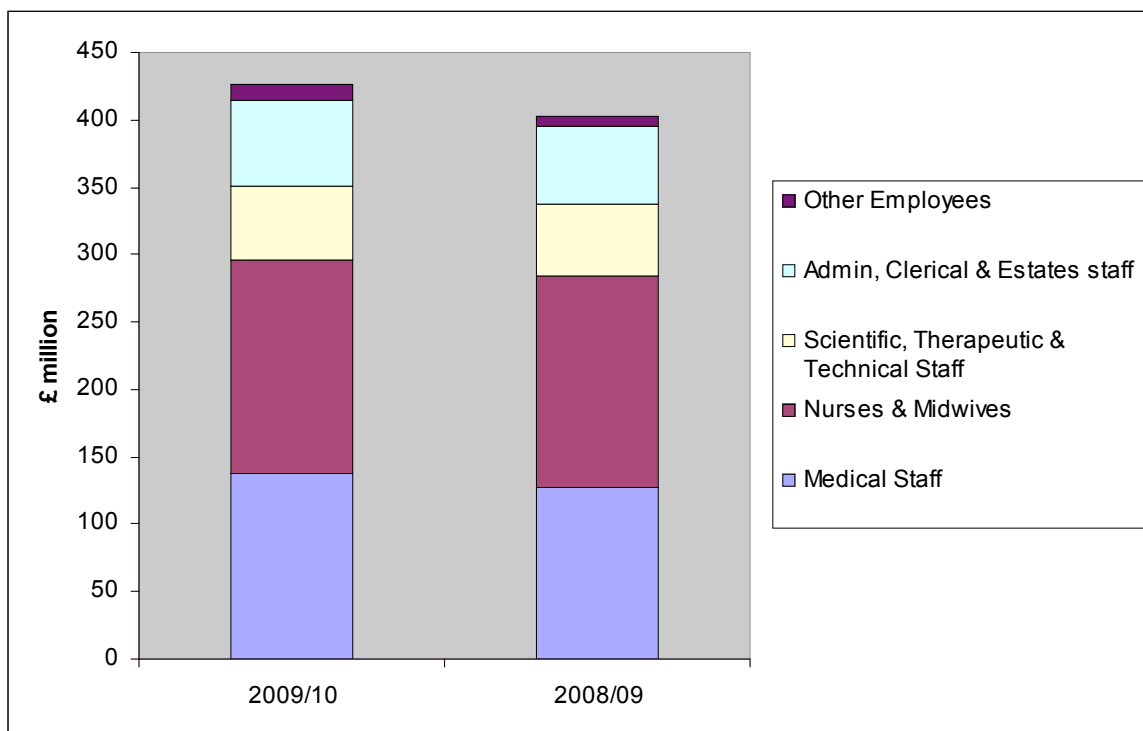


Trust expenditure 2009/10

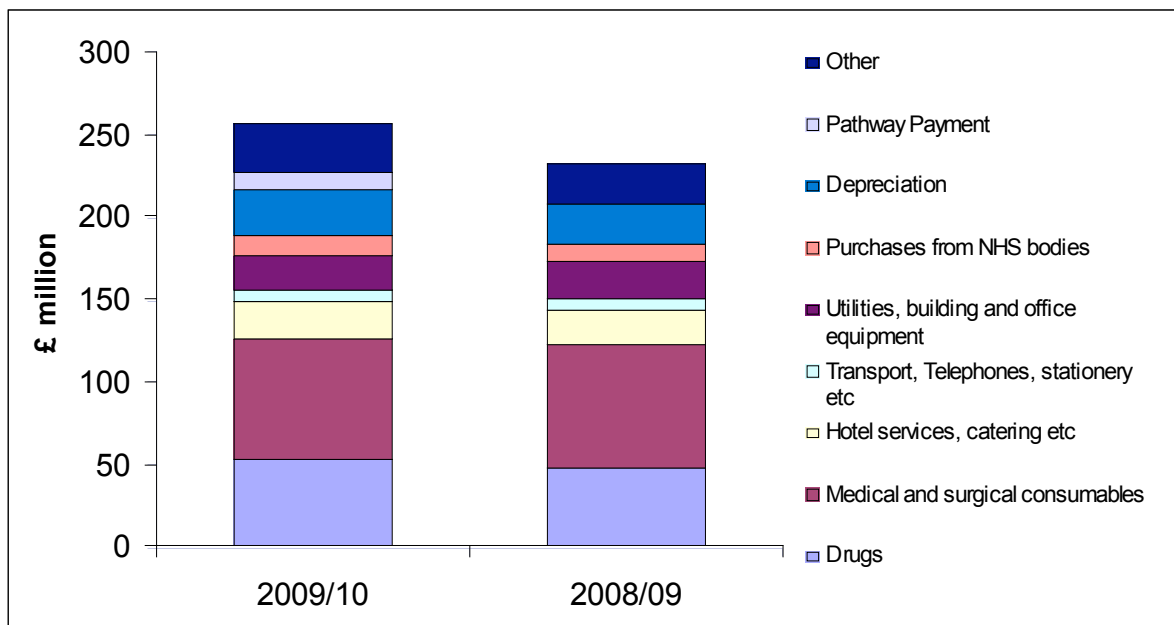
Operating expenditure (excluding impairment) increased by £48.6m (7.6 per cent) to £684m. A key contributor to this increase was inflation and development costs of £12.2m identified in the financial plan. The additional increase of £36.4m related to the anticipated PFI settlement, costs incurred through delivering the increased patient care activity and additional research and development activities. Total operating expenditure is shown in the chart below:



Pay expenditure by staff group

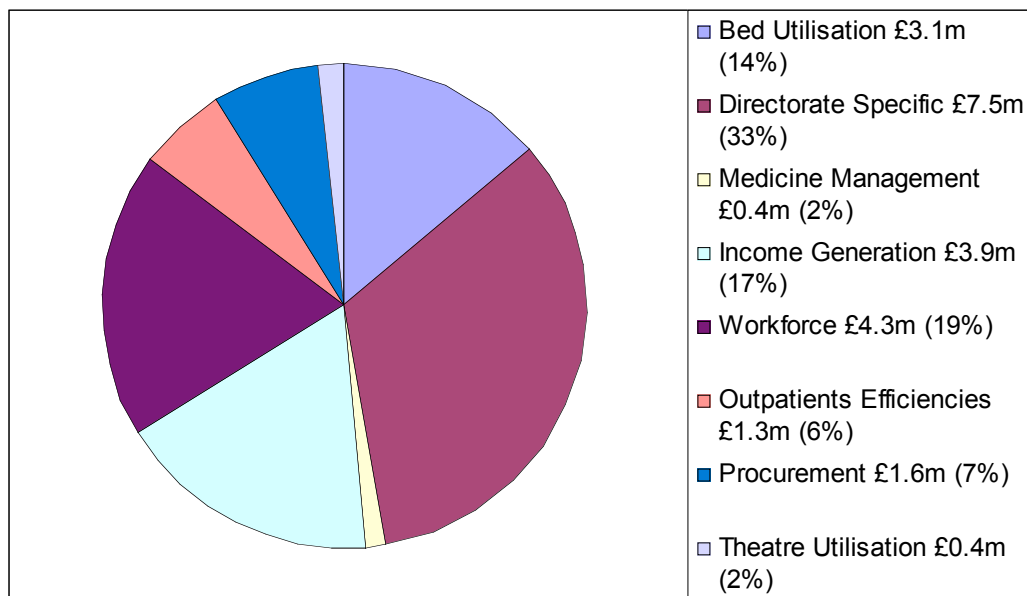


Non pay expenditure



Our efficiency programme 2009/10

We delivered a £22.6m cost improvement programme in 2009/10; the major components of this are outlined in the chart below. These components were delivered as part of our focus on productivity whilst maintaining high quality patient services.



Improved Information and Reporting

We introduced patient level information and costing during the year to help us get greater accuracy and understanding of the cost of providing services to individual patients. This will enable better decision making on how we use resources to continue to improve patient care.

Managing Risk

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

We will continue to manage key risks linked to management and control of infection, the patient experience, delivery of national waiting time targets and delivery of financial balance.

Future Challenges

The challenging financial climate means there will be even greater focus on efficiency and effectiveness over the months and years ahead. We have already identified that delivering greater efficiency whilst continuing to provide excellent clinical services is one of our top priorities. In 2010/11, we have set a challenging efficiency target of £32.8m - representing 4.8 per cent of our turnover. The focus of this programme will be in the following areas:

- Administration and "back office" efficiency
- Theatre productivity
- Length of stay reduction
- Buying goods and services
- Discretionary staff pay (overtime, waiting list payments, bank and agency staff)
- managing staff turnover

We are making a significant investment in new assets and infrastructure in 2010/11 with a £29.2m capital programme. Key planned developments include:

- £4.8m for new orthopaedic theatres
- £4.7m to complete the new neo-natal facility
- £3.6m for new linear accelerators for cancer treatment
- £2.2m for a new MRI research scanner
- £1.7m for new theatre instruments.

As well as this, we will be spending £12.2m on other essential buildings and equipment as well as continuing to focus on our application to become a Foundation Trust.

Salary and pension entitlements of senior managers

Name and Title	2009-2010			2008-2009		
	Salary (bands of £5000) £000	Other remuneration (bands of £5000) £000	Benefits in kind rounded to the nearest £100	Salary (bands of £5000) £000	Other Remuneration (bands of £5000) £000	Benefits in kind rounded to the nearest £100
M Hindle, Chairman	20-25	0	0	20-25	0	0
M Lowe-Lauri, Chief Executive (from 06.05.08)	210-215	0	0	185-190	0	0
A Cole, Medical Director (until 07.01.10)	90-95	60-65	0	115-120	75-80	0
Kevin Harris, Acting Medical Director (from 07.01.10)	5-10	40-45	0	-	-	-
A Maitland, Director of Operations (until 31.05.09)	20-25	0	0	120-125	0	0
P Tagg, Director of Nursing (until 31.07.08)	-	-	-	45-50	0	0
C Ribbins, Director of Nursing (from 01.07.08 to 31.12.08)	-	-	-	40-45	0	0
S Hinchliffe, Director of Nursing (from 01.01.09)	155-160	0	0	30-35	0	0
C Walker, Director of Finance & Procurement (until 22.06.08)	0	0	0	25-30	0	0
J Shuter, Acting Director of Finance & Procurement (from 23.06.08 until 31.01.10)	95-100	0	0	85-90	0	0
A Seddon, Director of Finance and Procurement (from 01.02.10)	20-25	0	0	-	-	-
J Aird, Director of Information Management & Technology	115-120	0	0	110-115	0	0
Dr R Graham-Brown, Director of Services For Older People (until 02.09.09)	40-45	70-75	0	100-105	135-140	0
R Pinsent, Director of Facilities	100-105		0	100-105	0	0
K J Renacre, Acting Director of Human Resources (until 25.08.08)	-	-	-	40-45	0	0
K Bradley, Director of Human Resources (from 26.08.08)	120-125	0	0	70-75	0	0
Professor D Rowbotham, Director of Research & Development	20-25	195-200	0	15-20	190-195	0
S Ward, Director of Corporate & Legal Affairs	100-105	0	0	100-105	0	0
M Wightman, Director of Communications	100-105	0	0	90-95	0	0
H Seth , Acting Director of Strategy (from 01.07.08 until 30.06.09)	25-30	0	0	75-80	0	0
A Tierney, Director of Strategy (from 01.07.09)	95-100	0	0	-	-	-
C Emmett, Non Executive Director (until 31.01.10)	5-10	0	0	5-10	0	0
A Kapur, Non Executive Director (until 30.11.09)	0-5	0	0	5-10	0	0
I Lauder, Non Executive Director (until 31.07.08)	-	-	-	0-5	0	0

Name and Title	2009-2010			2008-2009		
	Salary (bands of £5000) £000	Other remuneration (bands of £5000) £000	Benefits in kind rounded to the nearest £100	Salary (bands of £5000) £000	Other Remuneration (bands of £5000) £000	Benefits in kind rounded to the nearest £100
D Wynford-Thomas, Non Executive Director (from 01.08.08)	5-10	0	0	0-5	0	0
R Kilner, Non Executive Director (from 01.12.09)	0-5	0	0	-	-	-
J E Wilson, Non Executive Director (from 01.12.09)	0-5	0	0	-	-	-
J Matharu, Non Executive Director (until 30.11.09)	0-5	0	0	5-10	0	0
I Reid Non Executive Director	5-10	0	0	5-10	0	0
D Tracy, Non Executive Director	5-10	0	0	5-10	0	0
JS Worthington, Non Executive Director (until 30.11.09)	0-5	0	0	5-10	0	0

Salaries for A Cole, R Graham-Brown, K Harris and D Rowbotham have been split according to the time allocated for managerial activities.

Salary and pension entitlements of senior managers

Pension Benefits

Name and title	Real increase/decrease in pension at age 60 (bands of £2500) £000	Real increases/decreases in lump sum at age 60 at 31 March 2010 (bands of £2500) £000	Total accrued pension at age 60 at 31 March 2010 (bands of £5000) £000	Lump sum at age 60 related to accrued pension at 31 March 2010 (bands of £5000) £000	Cash equivalent transfer value at 31 March 2010 £000	Cash equivalent transfer value at 31 March 2009 £000	Real increase/decrease in cash equivalent transfer value £000	Employers contribution to stakeholder pension To nearest £100
M Lowe-Lauri, Chief Executive (from 06.05.08)	0.0-2.5	0.0-2.5	80-85	245-250	1,725	1,571	76	0
J Shuter, Acting Director of Finance & Procurement (from 23.06.08 to 30.01.10)	0.0-2.5	2.5-5.0	20-25	65-70	332	278	34	0
A Seddon, Director of Finance & Procurement (from 01.02.10)	0.0-2.5	0.0-2.5	10-15	30-35	215	165	7	0
A Maitland, Director of Operations (until 31.05.09)	(0.0-2.5)	(0.0-2.5)	20-25	60-65	372	375	(4)	0
S Hinchliffe, Chief Operating Officer (from 01.01.09)	15.0-17.5	50.0-52.5	50-55	155-160	989	598	362	0
A Cole, Medical Director (until 07.01.10)	(0.0-2.5)	(5.0-7.5)	85-90	255-260	0	0	0	0
Kevin Harris, Acting Medical Director (from 07.01.10)	0	0	0	0	0	0	0	0
K Bradley, Director of Human Resources (from 26.08.08)	2.5-5.0	7.5-10.0	30-35	95-100	555	420	114	0
J Aird, Director of Information Management & Technology	0.0-2.5	2.5-5.0	30-35	100-105	844	750	57	0
Dr R Graham-Brown, Director of Services for Older People (until 02.09.09)	0.0-2.5	5.0-7.5	80-85	240-245	0	2,057	(1,988)	0
H Seth , Acting Director of Strategy (from	(0.0-2.5)	(0.0-2.5)	25-30	80-85	446	410	4	0

Name and title	Real increase/decrease in pension at age 60	Real increases/decreases in lump sum at age 60 at 31 March 2010	Total accrued pension at age 60 at 31 March 2010	Lump sum at age 60 related to accrued pension at 31 March 2010	Cash equivalent transfer value at 31 March 2010	Cash equivalent transfer value at 31 March 2009	Real increase/decrease in cash equivalent transfer value	Employers contribution to stakeholder pension
	(bands of £2500) £000	(bands of £2500) £000	(bands of £5000) £000	(bands of £5000) £000	£000	£000	£000	To nearest £100
01.07.08 until 30.06.09)								
A Tierney, Director of Strategy (from 01.07.09)	0.0-2.5	0	0-5	0	13	0	10	0
R Pinsent, Director of Facilities	0.0-2.5	0.0-2.5	35-40	105-110	890	804	46	0
Professor D Rowbotham, Director of Research & Development	0	0	0	0	0	0	0	0
M Wightman, Director of Communications	0.0-2.5	2.5-5.0	15-20	50-55	246	203	32	0
S Ward, Director of Corporate & Legal Affairs	0.0-2.5	0.0-2.5	30-35	100-105	627	564	35	0

Non-executive members do not receive pensionable remuneration, so there will be no entries in respect of pensions for non-executive members.

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and from 2004-05 the other pension details, include the value of

any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Professor Rowbotham and K Harris are members of the Leicester University pension scheme.

Dr R Graham Brown CETV = £0.00 because he has reached retirement age

Foreword to the accounts

University Hospitals of Leicester NHS Trust

These accounts for the year ended 31 March, 2010, have been prepared by the University Hospitals of Leicester NHS Trust under section 98 (2) of the National Health Service Act 1977 (as amended by section 24 (2), schedule 2 of the National Health Service and Community Care Act 1990) in the form which the Secretary of State has, with the approval of the Treasury, directed.

The University Hospitals of Leicester NHS Trust was formed on 1st April, 2000, following the merger of Leicester Royal Infirmary, Leicester General Hospital and Glenfield Hospital.

The accounts for 2009/10 have been prepared under International Financial Reporting Standards (IFRS), which have been effective for the NHS from 1st April 2009.

Under IFRS, the income and expenditure account is renamed the Statement of Comprehensive Income and the balance sheet is renamed the Statement of Financial Position.

These accounts comprise a summarised version of the Trust's annual accounts. A copy of the full financial statements for the Trust and its charitable funds can be obtained on request from:

Assistant Director of Finance (Financial Accounting)
University Hospitals of Leicester NHS Trust
Gwendolen House
Gwendolen Road
Leicester, LE5 4QF
Telephone: 0116 258 8643

Summary financial statements

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2010		
	2009/10 £000	2008/09 £000
Revenue		
Revenue from patient care activities	593,769	564,796
Other operating revenue	103,923	87,363
Operating expenses	(687,829)	(633,630)
Operating surplus	9,863	18,529
Finance costs:		
Investment revenue	82	1,655
Other gains and (losses)	0	(8)
Finance costs	(616)	(594)
Surplus for the financial year	9,329	19,582
Public dividend capital dividends payable	(13,321)	(15,523)
Retained surplus/(deficit) for the year	(3,992)	4,059
Other comprehensive income		
Impairments and reversals	(13,886)	(23,146)
Gains on revaluations	12,309	150
Receipt of donated/government granted assets	175	492
- Transfers from donated and government grant reserves	(816)	(850)
Total comprehensive income for the year	(6,210)	(19,295)

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2010		
	31 March 2010 £000	31 March 2009 £000
Non-current assets		
Property, plant and equipment	417,049	415,784
Intangible assets	4,481	3,519
Other financial assets	2,910	3,039
Trade and other receivables	1,774	326
Total non-current assets	426,214	422,668
Current assets		
Inventories	12,213	10,514
Trade and other receivables	37,263	24,985
Other financial assets	198	198
Cash and cash equivalents	12,495	15,228
Total current assets	62,169	50,925
Total assets	488,383	473,593

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2010		
	31 March 2010	31 March 2009
	£000	£000
Current liabilities		
Trade and other payables	(73,851)	(54,058)
Borrowings	(1,203)	(1,108)
Provisions	(1,146)	(3,579)
Net current assets/(liabilities)	(14,031)	(7,820)
Total assets less current liabilities	412,183	414,848
Non-current liabilities		
Borrowings	(6,442)	(7,742)
Trade and other payables	0	(959)
Provisions	(2,762)	(2,981)
Total assets employed	402,979	403,166
Financed by taxpayers' equity:		
Public dividend capital	273,903	267,880
Retained earnings	11,301	15,428
Revaluation reserve	108,128	109,571
Donated asset reserve	8,389	8,384
Government grant reserve	986	1,631
Other reserves	272	272
Total Taxpayers' Equity	402,979	403,166

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2010

	2009/10 £000	2008/09 £000
Cash flows from operating activities		
Operating surplus	9,863	18,529
Depreciation and amortisation	27,373	25,550
Impairments and reversals	4,043	0
Transfer from donated asset reserve	(778)	(794)
Transfer from government grant reserve	(38)	(56)
Interest paid	(599)	(535)
Dividends paid	(13,321)	(15,523)
(Increase) in inventories	(1,699)	(1,060)
(Increase) in trade and other receivables	(13,659)	(1,682)
Increase/(decrease) in trade and other payables	19,777	(6,774)
(Decrease) in provisions	(2,715)	(1,237)
Net cash inflow/(outflow) from operating activities	28,247	16,418
Cash flows from investing activities		
Interest received	85	1,845
Payments for property, plant and equipment	(33,836)	(27,136)
Payments for intangible assets	(1,510)	(1,390)
Net cash inflow/(outflow) from investing activities	(35,261)	(26,681)
Net cash inflow/(outflow) before financing	(7,014)	(10,263)
Cash flows from financing activities		
Public dividend capital received	6,023	361
Other capital receipts	175	492
Capital element of finance leases and PFI	(1,917)	(2,688)
Net cash inflow/(outflow) from financing	4,281	(1,835)
Net (decrease) in cash and cash equivalents	(2,733)	(12,098)
Cash and cash equivalents at the beginning of the financial year	15,228	27,326
Cash and cash equivalents at the end of the financial year	12,495	15,228

Management costs

	2009/10	2008/09
Management costs	23,421	22,057
Income	697,692	652,159
Percentage of income	3.4%	3.4%

Better Payment Practice Code - Measure of Compliance

The CBI prompt payment code requires trade creditors to be paid within 30 days of the receipt of goods or a valid invoice. Our compliance with this policy is shown below:

	Number	£000s
Non-NHS Payables		
Total non-NHS trade invoices paid in the year	125,321	384,596
Total non-NHS trade invoices paid within target	118,522	370,221
Percentage of non-NHS trade invoices paid within target	95%	96%
NHS Payables		
Total NHS trade invoices paid in the year	4,947	53,882
Total NHS trade invoices paid within target	4,305	51,463
Percentage of NHS trade invoices paid within target	87%	96%

Audit Fees

Our external auditor for statutory audit and services during 2009/10 was KPMG LLP. The Audit Commission appointed KPMG as our external auditors in 2000. The total value of payments to KPMG for statutory audit services in 2009/10 was £258,000.

Pension liabilities

The University Hospitals of Leicester NHS Trust is a member of the NHS Pensions Scheme. Information regarding how we account for our pension liabilities is reported at note 10 of our annual accounts.

Statement of directors

Each director has stated through their response to our representation letter, that, as far as they are aware, there is no relevant audit information of which the NHS body's auditors are unaware and that they have taken all the steps that they ought to take as a director in order to make themselves aware of any relevant audit information and to establish that the NHS body's auditors are aware of that information.

Statement of Internal Control

1. Scope of responsibility

The Trust Board is accountable for internal control. As Accountable Officer, and Chief Executive of this Board, I have responsibility for maintaining a sound system of internal control that supports the achievement of the Trust's policies, aims and objectives. I also have responsibility for safeguarding the public funds and the Trust's assets for which I am personally responsible as set out in the Accountable Officer Memorandum.

As Accountable Officer, and Chief Executive of this Board, I, too, am subject to internal control. As Chief Executive, I am accountable to the Trust Board for ensuring that the Board's plans and objectives are implemented and that progress towards implementation is regularly reported to the Board using accurate systems of measurement and data management. The Trust's corporate governance policies and other advice on expected standards of behaviour of staff apply equally to me as Chief Executive as to any other member of staff. I subscribe to the Code of Conduct for NHS Managers.

The Trust has a range of mechanisms in place to facilitate effective working with key partners, in particular with the East Midlands Strategic Health Authority, NHS Leicester City, NHS Leicestershire County and Rutland, Leicestershire Partnership NHS Trust and East Midlands Ambulance Service NHS Trust, respectively. I meet regularly with the Chief Executives of each of these organisations, individually, jointly and collectively. Within Leicester, Leicestershire and Rutland (LLR), I meet at least monthly with the Chief Executives of the two local PCTs and Leicestershire Partnership NHS Trust. The Trust's participation in delivering in Leicester, Leicestershire and Rutland 'Excellence for All' programme (the health community's response to the NHS Next Stage Review) is further evidence of the organisation's commitment to partnership working.

2. The purpose of the system of internal control

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

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

The system of internal control has been in place in University Hospitals of Leicester NHS Trust for the year ended 31 March 2010 and up to the date of approval of the annual report and accounts.

3. Capacity to handle risk

Amongst other duties, the Trust Board has collective responsibility for providing leadership to the organisation within a framework of prudent and effective controls. As outlined in 'The Healthy NHS Board : Principles for Good Governance' (NHS National Leadership Council 2010), the Trust Board is responsible for ensuring that the organisation has appropriate management processes in place to deliver the annual plan and comply with the regulatory requirements of the Care Quality Commission (CQC), the quality regulator. This includes systematically assessing and managing its risks. These include financial, corporate and clinical risks.

The Trust Board itself ensures that leadership is given to the risk management process. During 2009/10, it approved an updated risk management strategy which sets out the Trust's attitude to risk and, amongst other matters, describes the way in which risks are identified, evaluated and controlled.

Working within the framework of the risk management strategy, and acting through and on behalf of the Trust Board, an appropriate infrastructure has been established to carry through the risk management agenda. In terms of individual Executive Director responsibilities for managing risks:-

- I am the Accountable Officer, with responsibility for ensuring that the organisation has in place effective management systems which safeguard public funds; for achieving value for money from the resources available to the Trust; for avoiding waste, excess and unnecessary costs in the organisation's activities; and for ensuring that expenditure by the Trust complies with Parliamentary requirements;
- the Director of Finance and Procurement leads on financial risk management, with a specific responsibility to support me in my role as Accountable Officer to see that appropriate advice is tendered to the Trust Board on all matters of financial probity and regularity, and more broadly on all considerations of prudent and economical administration, efficiency and effectiveness;
- the Chief Operating Officer/Chief Nurse leads on operational performance, emergency preparedness and business continuity risk management; as Director of Infection Prevention and Control, the Chief Operating Officer/Chief Nurse leads on infection prevention and control; and, with the support of the Director of Nursing, also leads on child and adult safeguarding matters;
- the Medical Director has co-ordinated the process for ensuring that the Trust achieves compliance with the core Standards for Better Health; and also leads on the

Trust's fulfilment of its clinical governance and clinical risk management responsibilities, ensuring that the organisation has in place systems and processes to support individual, team and corporate accountability for the delivery of patient-centred, safe, high quality care, within a reporting and learning culture. Supported by the Director of Clinical Quality, the Medical Director co-ordinates the process for ensuring that the Trust achieves compliance with the requirement of the CQC. Supported by the Director of Safety and Risk (the Trust's designated Patient Safety Lead), the Medical Director also has operational responsibility for the maintenance and development of the Trust's strategic risk register and assurance framework, complaints management, health and safety management, and the Trust's safety alert broadcasting system, respectively;

- the Director of Human Resources leads on workforce issues, organisational development and is managerially responsible for the Trust's occupational health service.

The Executive Directors are supported in discharging their risk management responsibilities by the following Directors:-

- the Director of Communications and External Relations – leads on reputational risk management;
- the Director of Corporate and Legal Affairs – is Secretary to the Trust Board and leads on corporate governance;
- the Director of Facilities (who reports to the Director of Strategy) – leads operationally on fire safety and estates risk management;
- the Director of Research and Development - leads on research governance and research risk management, respectively;
- the Director of Strategy - leads on the process of developing the Trust's integrated business plan and application for NHS Foundation Trust status and assumed managerial responsibility in 2009/10 for the Information Management and Technology and Facilities Directorates, respectively.

During 2009/10, Clinical Directors, supported by General Managers and Heads of Nursing, have exercised responsibility for the management of risks at individual Clinical Directorate level. From 1 April 2010, new management arrangements have taken effect, with the creation of four new Divisions, each led by a Divisional Director.

I meet with all the Executive and other Directors of the Trust on a regular basis to discuss and review performance. The Trust Executive, which included all of the aforementioned Directors, assisted me in my role during 2009/10. I chaired this group, which met monthly, and it regularly considered significant risks, issues and exceptions and the proposed corrective action. From 1 April 2010, the newly formed Executive Team will undertake this role, meeting weekly for the purpose.

Trust staff are equipped and trained to manage risks in a variety of ways. The Trust's Staff Handbook, made available to all new staff joining the organisation, includes information on managing risk. The Trust's induction programme, attended by all new staff, includes a risk awareness module.

The Trust has adopted a policy for statutory and mandatory training, defining mandatory training programmes including those relating to the management of identified risks.

The Trust declared compliance with core healthcare standard C11b for 2009/10. This standard required healthcare organisations to ensure that staff concerned with all aspects of the provision of healthcare participated in mandatory training programmes.

The Trust additionally provides risk management training for staff across a wide range of subjects, the principal aim of which is to equip staff to better manage risk in a way appropriate to their authority and duties. Subjects covered include:

- risk assessment;
- root cause analysis;
- display screen equipment;
- stress management;
- control of substances hazardous to health;
- working safely;
- the role of the departmental safety co-ordinator;
- moving and handling;
- patient safety;
- personal safety awareness;
- fire safety;
- food hygiene;
- latex allergy;
- first aid at work;
- child protection and protecting vulnerable adults;
- infection prevention and control, including effective hand hygiene;
- clinical skills and resuscitation training;
- radiation protection;
- safe use of diagnostic and therapeutic equipment;
- violence and aggression.

The Trust seeks to learn from good practice in handling risks. The Trust is a member of the Patient Safety First campaign, sponsored by the National Patient Safety Agency, NHS Institute for Innovation and Improvement and The Health Foundation. This campaign aims to improve patient safety and reduce avoidable harm and, in February 2010, the Trust was one of just 25 organisations to be presented with a certificate of recognition by the campaign, recognising the Trust's achievements since joining in June 2008.

4. The risk and control framework

The revised risk management strategy approved by the Trust Board in 2009/10 sets out how, as part of its risk management process, the Trust:

- identifies corporate and operational risks;
- assesses the risks for likelihood and impact;
- identifies mitigating controls;
- allocates responsibility for the mitigating controls;
- undertakes a risk assessment for strategic policy decisions and in project initiation documents.

The Trust maintains, and the Trust Board regularly reviews, a register of strategic risks linking them to strategic business objectives and assigns ownership of each risk to an appropriate, named individual. This process is designed to ensure that key risks are being effectively managed and mitigated and that key risks, and actions to mitigate them, help drive and shape the Trust Board agenda. The Trust's assurance framework is combined with the strategic risk register, enabling the Trust Board to satisfy itself and demonstrate that the assurance framework is fully embedded in the Trust's business processes.

The organisation's major in-year risks include the risk of patient safety being significantly compromised; of poor outcomes of clinical care; and failure to deliver a high quality patient experience. Future risks identified by the Trust Board include the risk of inadequate organisational development, threatening the fitness for purpose of the Trust. Each of these risks, and the controls in place to mitigate them, has been examined in depth by the Trust Board during 2009/10.

During 2010/11, the Trust Board shall continue to review monthly the Trust's control environment to enable it to manage these and the other significant business risks identified in the organisation's strategic risk register. The reviews will continue to take place in the public section of Trust Board meetings, underlining the Trust's commitment to transparency and public accountability.

The Trust recognises the importance of robust information governance. During 2009/10, the Director of Information Management and Technology led on information governance issues as the Trust's Senior Information Risk Owner, supported by an Information Governance Manager. The Medical Director was the Trust's Caldicott Guardian during 2009/10.

The Trust took further actions during 2009/10 to secure improvements in its information governance arrangements. An Information Governance Steering Group was established to monitor and oversee compliance with information governance requirements. The Trust fully supported NHS East Midlands' information governance awareness campaign to promote secure handling of personal data ('NHS Confidential').

All NHS Trusts are required annually to undertake an information governance self-assessment using the NHS Information Governance toolkit. For 2009/10, the Trust scored 77% overall, a modest improvement of 1% on the 2008/09 overall score. Twenty five of the sixty two information governance toolkit standards form the 'Information Governance Statement of Compliance' – the minimum standards expected of organisations connected to the NHS network. The Trust attained the Statement of Compliance standard and improved its information security score from 69% to 83%.

The Trust remains committed to strengthening its information governance arrangements to achieve the minimum requirements across all of the sixty two toolkit standards in 2010/11.

The arrangements in place at the Trust which provide further evidence of the organisation's commitment to robust internal control include the following:

- the establishment and operation of an Audit Committee, Finance and Performance Committee and Governance and Risk Management Committee respectively, reporting to the Trust Board;
- documenting of key internal control policies and procedures;
- ensuring that Internal Audit services have sufficient status, independence and resources;
- publishing Standing Orders, Standing Financial Instructions, a Scheme of Delegation to Officers, a Code of Business Conduct for Trust staff and a Policy for Countering Fraud and Corruption. The Trust Board has also adopted formally the NHS Code of Conduct and Code of Accountability, respectively, together with the 'Nolan Principles' ("The Seven Principles of Public Life");
- establishing sound human resources policies;
- establishing a system of personal appraisal and development review which seeks to ensure that individual objectives flow from the organisation's objectives.

A key element of the Trust's risk management strategy is to help to create a culture which encourages staff to identify and control risks which may adversely affect the Trust's operational ability. A traditional risk assessment matrix is used to ensure that a consistent approach is taken to assessing and responding to risks and incidents. The Trust's Risk Assessment Policy sets out details of the methodology that is used and this forms an appendix to the Trust's risk management strategy. The risk management strategy identifies options for the treatment and control of risks to the Trust. Very low and low risks to the Trust will normally be managed through action by line managers, while more serious categories of risk will fall to be addressed by a more senior manager supported, if required, by a member of the Corporate Risk Team.

The Trust Executive has regularly reviewed 'corporate risks' featured on the Trust's risk register; the Trust Board's Governance and Risk Management Committee does likewise at its meetings.

The Trust's assurance framework has helped the Audit Committee and Trust Board to identify the principal risks to the organisation meeting its principal objectives and to map out both the key controls in place to manage them and also how it has gained sufficient assurance about their effectiveness.

In his interim Audit Opinion for 2009/10, the Head of Internal Audit has noted that the Trust has continued to develop the processes by which the Board Assurance Framework is informed and embedded within the organisation.

The assurance framework 2009/10 was designed and operated to meet the Department of Health's requirements and provide reasonable assurance that there is an effective system of internal control to manage the principal risks identified by the Trust.

During the course of 2009/10, the Audit Committee and Trust Board accepted that there were specific – though not significant – gaps in certain areas of control and assurance as identified within the assurance framework itself. These concerned, for example, the ongoing work to provide sufficient assurance of compliance with the core Standards for Better Health. The Trust Board was informed of, and endorsed, the actions that were taken to address each of these matters. Progress was, and will continue to be, measured and reported regularly to the Executive Team, Audit Committee and Trust Board (as appropriate) through the Trust's well established performance reporting and monitoring processes. In turn, this will enable the Trust to strengthen its assurance framework, thereby helping to embed improved risk management, control and review processes appropriate to the Trust's circumstances across all of its core business activities.

At each of its monthly meetings, the Trust Board receives information about operational performance, focussed on the most important measures of performance, with exceptions highlighted. Through the use of 'traffic light' indicators, the Trust Board's attention is directed to significant risks, issues and exceptions; to the controls in place to mitigate the identified significant risks; and to the proposed corrective action. The Trust Board is assisted in this task by both the Finance and Performance Committee and Governance and Risk Management Committee, which it has established to improve the overall governance arrangements of the Trust.

During the course of 2009/10, the Trust has co-operated with other NHS bodies, local authorities and other relevant organisations with an interest in the local health economy to ensure that patients' individual needs are properly managed and met.

In particular, senior representatives of the Trust have met regularly with the Trust's Patient Advisers and the Joint Health Overview and Scrutiny Committee for Leicester, Leicestershire

and Rutland, respectively, and, in this way, the Trust has engaged with, and involved, public stakeholders in managing risks which impact on them.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. Where appropriate, the Trust undertakes and acts upon the findings of equality impact assessments.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme's rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

The Trust is committed to sustainability and sustainable development. The Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UK CIP 2009 weather projections, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

5. Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the assurance framework and on the controls reviewed as part of the internal audit work.

I have noted that, in his interim Audit Opinion for 2009/10, the Head of Internal Audit has stated that significant assurance can be provided that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently.

A significant majority of the assignments completed by Internal Audit during 2009/10 have provided positive assurances.

Executive Directors, other Directors and senior managers within the organisation who have responsibility for the development and maintenance of the system of internal control also provide me with assurance. The assurance framework itself provides me with evidence that the effectiveness of controls that manage the risks to the Trust achieving its principal objectives have been reviewed. My review is also informed by the findings identified and conclusions reached by the Internal and External Auditors and other bodies in their reports in 2009/10, including the Care Quality Commission, Clinical Pathology Accreditation Ltd, the Environment Agency, Health and Safety Executive, Health Overview and Scrutiny Committees of local authorities, Human Tissue Authority, Information Commissioner, Health Service Ombudsman, Medicines and Healthcare Products Regulatory Agency, National

Patient Safety Agency and the NHS Litigation Authority. I also note that, in 2009/10, the Trust remained accredited at Level 2 by the NHS Litigation Authority in relation to its general and maternity clinical risk management standards, respectively.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by Internal Audit, External Audit, the East Midlands Strategic Health Authority, Trust Board, Trust Executive, Finance and Performance Committee, Governance and Risk Management Committee, and Audit Committee. During 2009/10, each of these bodies has been involved in a series of processes that, individually and collectively, has contributed to the review of the effectiveness of the system of internal control.

The Trust was required in 2009/10 to assess once again its compliance with the core Standards for Better Health. The Standards, published by the Department of Health in 2004, do not of themselves set out new expectations of the NHS, but are based on a number of standards and requirements that already exist. They describe a level of service which is acceptable and which must be universal. The Trust is expected to comply with the core Standards. The Trust's Healthcare Standards and Improvement Steering Group, which I chaired, oversaw the monitoring of the Trust's compliance with the core Standards in-year. The core Standards include a requirement that healthcare organisations undertake systematic risk assessment and risk management. Having reviewed the available evidence, the Trust assessed itself as compliant with this requirement.

The Trust declared full compliance with all of the core standards for 2009/10.

During 2009/10, the Trust experienced one serious untoward incident involving personal data. Patients affected were contacted via their General Practitioners and appropriate action has subsequently been taken by the Trust to seek to prevent recurrence.

In April 2010, a former Trust employee was sentenced to five years imprisonment for committing offences of theft, fraud and obtaining property by deception while employed in Bereavement Services. During 2009/10, the Trust acted on the recommendations of Internal Audit and Local Counter Fraud Specialists to strengthen the Trust's controls in this area.

A plan to address weaknesses and ensure continuous improvement of the system of internal control is in place. This plan includes work to improve the Trust's control environment for the recording, monitoring and reporting of waiting times within the Emergency Department, a subject on which the Trust's Internal Auditors reported in 2009/10. In particular, further work will be undertaken in 2010/11 to review and strengthen the Trust's governance, risk management and internal control systems, policies and procedures. This work will contribute to the Trust's aim of submitting its application for authorisation as an NHS Foundation Trust in 2010/11.

I am of the opinion that the implementation of the actions described above will strengthen the Trust's system of internal control in 2010/11 and beyond.

My review confirms that the University Hospitals of Leicester NHS Trust has a generally sound system of internal control that supports the achievement of its policies, aims and objectives.

Signed: *Made Sam Lowe-hamri*

Chief Executive

Date 10 June 2010

(on behalf of the Trust Board)



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

We have examined the summary financial statement for the year ended 31 March 2010 set out on pages 56 to 82.

This report is made solely to the Board of the Trust, as a body, in accordance with Section 2 of the Audit Commission Act 1998. Our audit work has been undertaken so that we might state to the Board of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board of the Trust, as a body, for our audit work, for this report or for the opinions we have formed.

Respective responsibilities of directors and auditor

The directors are responsible for preparing the Annual Report.

Our responsibility is to report to you our opinion on the consistency of the summary financial statement within the Annual Report with the statutory financial statements.

We also read the other information contained in the Annual Report and consider the implications for our report if we become aware of any misstatements or material inconsistencies with the summary financial statement.

We conducted our work in accordance with Bulletin 2008/03 "The auditor's statement on the summary financial statement in the United Kingdom" issued by the Auditing Practices Board. Our report on the statutory financial statements describes the basis of our opinion on those financial statements.

Opinion

In our opinion the summary financial statement is consistent with the statutory financial statements of the University Hospitals of Leicester NHS Trust for the year ended 31 March 2010. We have not considered the effects of any events between the date on which we signed our report on the statutory financial statements of 10 June 2010 and the date of this statement.

Andrew Bostock

Senior Statutory Auditor
for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants
One Snowhill
Birmingham

14 July 2010

Please help us to improve the way we give people information

We would like your views on the presentation of our annual report and accounts.

We would be very grateful if you could answer the questions below and send your response to us by 31 December 2010.

The answers you give will help us to ensure we present, not only the annual report, but other information in a way people find useful.

1 The information we give:

a) Have we missed anything out? Please tell us any area you would like to see covered.

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b) Is there any category you think we should leave out?

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2 Please tell us which area of the annual report you found most useful

	Please list your priorities Start with 1 for your most useful and 12 for least useful (1 as top priority)
Welcome from the Chairman	
Introduction from the Chief Executive	
About us	
Our priorities and did we achieve them?	
Valuing people	
Sustainability	
Our performance against national targets	
Being accountable	
Our aims for 2010/11	
Our Trust Board	
Operating and financial review	
Foreword to the accounts	
Summary financial statements	
Statement of internal control	
Auditor's statement	
Feedback form	

What do you expect to achieve from reading this annual report? *Please tick*

	Gain a broad understanding	Gain a detailed understanding
The Trust and its achievements		
The Trust's performance against targets		
The Trust's plans for the future		
The Trust's financial position		

Do you have another comments or suggestions about the Trust’s annual report or its other publications?

.....
.....
.....

If you would like to be notified when the 2011/12 annual report is available, please give your email address

.....

Completed questionnaires can be sent to:

Communications Team, University Hospitals of Leicester NHS Trust, Gwendolen House,
Gwendolen Road, Leicester, LE5 4QF

This is the annual report 2009/10 for the University Hospitals of Leicester NHS Trust

Published by the University Hospitals of Leicester NHS Trust

If you would like this information translated please contact our Service Equality Manager on 0116 258 4382

আপনি যদি এই লিফলেটের অনুবাদ - লিখিত বা অডিও টেপ'এ চান, তাহলে অনুগ্রহ করে সার্ভিস ইকুয়ালিটি ম্যানেজার ডেভ বেকার'এর সাথে 0116 258 8295 নাম্বারে যোগাযোগ করুন।

यदि आप को इस लीफ़लेट का लिखती या टेप पर अनुवाद चाहिए तो कृपया डेव बेकर, सर्विस ईक़ुअलिटी मैनेजर से 0116 258 8295 पर सम्पर्क कीजिए।

ਜੇ ਤੁਸੀਂ ਆ ਪਰਿਚਿਤ ਨੂੰ ਲਿਖਤ ਅਥਵਾ ਟੇਪ ਉੱਪਰ ਆਪਣੇ ਜੇਠਨੂੰ ਡੇਖੋ ਤੇ ਮਦਦ ਆਨੀ ਡੀ ਡੇਵ ਬੇਕਰ, ਸਰਵਿਸ ਈਕੁਅਲਿਟੀ ਮੈਨੇਜਰ ਨਾਲ 0116 258 8295 ਉੱਪਰ ਸੰਪਰਕ ਕਰੋ।

Haddaad rabto warqadan oo turjuman oo ku duuban cajalad ama qoraal ah fadlan la xiriiir Maamulaha Adeegga Sinaanta 0116 258 8295.

ਜੇਕਰ ਤੁਹਾਨੂੰ ਇਸ ਲੀਫਲਿਟ ਦਾ ਲਿਖਤੀ ਜਾਂ ਟੇਪ ਕੀਤਾ ਅਨੁਵਾਦ ਚਾਹੀਦਾ ਹੋਵੇ ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਡੇਵ ਬੇਕਰ, ਸਰਵਿਸ ਇਕੁਅਲਿਟੀ ਮੈਨੇਜਰ ਨਾਲ 0116, 258 8295 ਤੇ ਸੰਪਰਕ ਕਰੋ।

Eğer bu broşürün (kitapçığının) yazılı veya kasetli açıklamasını isterseniz lütfen servis müdürüne 0116 258 8295 telefonundan ulaşabilirsiniz.