



Annual report and summary financial statements

1 April 2010 to 31 March 2011

University Hospitals of Leicester



NHS Trust

Caring at its best

Caring at its best

Our Values



We treat people how we would like to be treated

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



We do what we say we are going to do

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



We focus on what matters most

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



We are passionate and creative in our work

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



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

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

One team shared values

Contents

Welcome from the Chairman and the Chief Executive	5
About us	7
Our priorities and did we achieve them?	9
A year of change.....	10
Our preparation for foundation trust status	13
Quality and performance - how did we do?	18
Our new clinical divisions reflect on achievements in their first year.....	22
We're passionate and creative	31
<i>Includes information about research and development, releasing time to care, older peoples champions and our valuable volunteers</i>	
We do what we say we're going to do	35
<i>Includes information about the quality performance indicators which we are monitored on, complaints, our patient information and liaison service, our strategy, how we manage risk, health and safety, governance and risk and emergency planning</i>	
We treat people how we like to be treated	40
<i>Includes information about our nursing staff, listening, involving and engaging our patients and equality and diversity projects</i>	
We're one team and we're best when we work together	47
<i>Includes information about our staff, the national staff survey results, reducing staff absence, reward and recognition, learning and development and our membership</i>	
We focus on what matters most.....	53
<i>Includes information about preserving the privacy and dignity of our patients and same sex accommodation, preventing infections, safeguarding our vulnerable patients, chaplaincy and our estate developments and efficiency</i>	
Our priorities for 2011/12	61
Our Trust Board	62
Operating and financial review	64
Foreword to the accounts.....	72
Summary financial statements	73
Statement of internal control	83

Auditor's statement 91
Feedback form 92

Welcome from the Chairman and the Chief Executive

Welcome to the 2010-11 Annual Report,

It has been a challenging year for the NHS as a whole and hence for Leicester's Hospitals. The impact of the recession is now being felt in the NHS as the public sector contracts in terms of both size and available finance. All Trusts are required to do more with less.

The Government's white paper, 'Equity and Excellence: Liberating the NHS' was a tectonic shift in the established architecture of the NHS. At its heart is the principle that GPs should be responsible for the primary health needs of their population; the decisions to refer on to hospitals or other providers when necessary, and crucially the budget for all of this healthcare. Previously these responsibilities have been separate. To put it simply the GPs have made the decisions about referrals whilst the PCTs have been left to sort out the money. Under the new regime the conversations about referrals in terms of clinical decision making, about the best pathways for patients to follow and ultimately about how to make the healthcare affordable will be between hospitals and GPs, with clinicians taking the lead.

Ultimately this is the right approach. Doctors, nurses and other health professionals know what's best for their patients and armed with the right information about costs we are looking forward to some innovative and exciting conversations about how we can all make ends meet whilst improving the quality of our services.

In that sense we look to the future with a great deal of optimism. However, the journey betwixt the present and the future is likely to be a rocky one. The financial year which this report covers has seen the Trust save £31m from our operating costs. To do that without affecting clinical quality has involved a lot of hard work from our staff both in coming up with the savings schemes and in executing them. This year's financial challenge is even greater, we will need to find savings equal to £38m and to do that without materially affecting the quality of our services will necessarily mean making some difficult decisions.

For 2010-11: The operational performance of the Trust has, in the main, been good. We have hit the 18 week referral to treatment target for the year meaning that patients are consistently seen and treated now in Leicester more quickly than at any time in our past. We have continued to hit the cancer targets meaning that patients are seen, diagnosed and treated quickly without the long waits and worry which used to be the case in the NHS. We have seen further year on year reductions in numbers of MRSA and clostridium difficile infections; and we have introduced new processes for dealing with heart attack patients meaning that more people than ever now receive life and health saving treatment shortly after their heart attack.

As a university teaching hospital research and development is crucial to the overall success of the Trust; research brings with it both funding and clinical expertise which benefits local people. Last year we opened the new Biomedical Research Unit (BRU) at the Glenfield Hospital to investigate the genetic markers for heart disease. This year some of our leading clinical talents have been working on bids to bring two more BRUs to Leicester in areas which will strengthen

our position as a leading centre for research into hearts, respiratory illness and lifestyle. Success here will catapult Leicester's Hospitals into a strong position as one of the country's leading research hospitals, outside of London, Oxford and Cambridge.

But there have also been deficits in our performance. Most notably we have struggled to hit the target for people being seen treated and admitted or discharged in our Emergency Department. Overall as a health community (i.e. once the performance of minor injury units in other parts of the County are taken into account) we just hit the target, however, the hospital *alone* missed the target. Similarly our rates of readmissions to hospital following treatment are higher than we would like them to be and if this continues into the 2011-12 year then under the new payment policy we risk being penalised to the tune of £9m. Clearly A&E performance and readmissions will be a major part of our work this year both within the Trust and with our partners in primary care.

The rest of our Annual Report will provide readers with more detail on the things covered here and a lot more besides. We hope that you find it an informative and interesting read. We will, as we have done over the last few years, be producing an abridged version of the Annual Report and this will be available to our members and to the wider public at our Annual General Meeting in September.

Finally, we would like to thank our staff for the commitment they show to their patients and the Trust on a daily basis and we would also like to thank you the public and our stakeholders for your continued support and encouragement.



Martin Hindle
Chairman



Malcolm Lowe-Lauri
Chief Executive

About us

We are one of the biggest and busiest NHS trusts in the country, incorporating the Leicester General, Glenfield and Royal Infirmary hospitals. We have our very own Children's Hospital and run one of the country's leading heart centres.

Our team is made up of more than 10,000 staff providing a range of services primarily for the one million residents of Leicester, Leicestershire and Rutland. Our nationally and internationally-renowned specialist treatment and services in cardio-respiratory diseases, cancer and renal disorders reach a further two to three million patients from the rest of the country.

We work with partners at the University of Leicester and De Montfort University providing world-class teaching to nurture and develop the next generation of doctors, nurses and other healthcare professionals, many of whom go on to spend their working lives with us.

We pride ourselves on being at the forefront of many research programmes and new surgical procedures, in areas such as diabetes, genetics, cancer and cardio-respiratory diseases. In 2010 we earned £21.4m in research grants for the 825 clinical trials we led, bringing further benefits to thousands of our patients.

Our heart centre at the Glenfield hospital continues to lead the way in developing new and innovative research and techniques, such as surgery with a Robotic Arm, TAVI (Trans-Catheter Aortic Valve Insertion) and the use of the suture less valve in heart surgery. We also have one of the best vascular services nationally, with more patients surviving longer after following an aneurysm repair (to fix a life threatening bulge in a blood vessel).

We're proud to have some of the lowest rates of hospital-acquired infections, such as C.Difficile and MRSA, in the country; we have very good hospital standardised mortality rates, which is a good indicator of overall clinical quality; for the second year in a row the independent consumer group, Which? has rated our car parking in the top ten in the country; and our food has been rated as 'excellent' by an independent panel.

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

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

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

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 values

We have five values which help us deliver caring at its best

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 values and the NHS Constitution

When we created our values we made sure that they were in line with, and supported the NHS Constitution, which was put in place by the Government on 1 April 2010 following a public consultation.

The NHS Constitution was created to protect the NHS and make sure it will always do the things it was set up to do in 1948 - to provide high-quality healthcare that’s free and for everyone.

No Government will be able to change the Constitution without the full involvement of staff, patients and the public. The Constitution is a promise that the NHS will always be there for you.

For the first time in the history of the NHS, the constitution brings together in one place details of what staff, patients and the public can expect from the NHS. It also explains what you can do to help support the NHS, help it work effectively, and help ensure that its resources are used responsibly.

The Constitution sets out your rights as an NHS patient. These rights cover how patients access health services, the quality of care you’ll receive, the treatments and programmes available to you, confidentiality, information and your right to complain if things go wrong.

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

A full copy of the Constitution can be found at

www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Pages/Overview.aspx

Our priorities for 2010/11

We set the following priorities for 2010/11.

- Continued focus on reducing hospital acquired infections
- Improvement of emergency care through co-ordinated response to emergency support intensive care team
- Use of robust clinical indicators to compliment 'caring at its best'
- Ensure all national clinical quality targets are consistently met
- Continued development of the "releasing time to care" programme
- Reconfiguration of services to enable the most effective and efficient patient care across our three hospitals
- Implementation of enhanced recovery for patients
- Reconfiguration of stroke services
- Improve performance in trauma, and specifically fractured neck of femur outcomes
- Work to secure designation in paediatric cardiac services
- Manage the risks around the delivery of our maternity and neonates service
- Build PPCI (primary percutaneous cardiac intervention) capacity in line with our recent designation
- Maintain level 2 Clinical Negligence Scheme for Trusts (CNST) throughout the Trust and work towards level 3 where possible
- Continued engagement with patients and carers, for example through our patient advisors and Trust membership
- Publish a set of quality accounts which will include three areas of improvement, how progress will be monitored and measured, and how it will be reported
- Improved discharge planning across all specialties
- Improving care for people with dementia admitted to our hospitals
- Strive to ensure equality and diversity is threaded through everything we do in our organisation and that our senior team are more representative of our population.

Throughout this report we will share with you our progress on these priorities.

A year of change...

The changing NHS

Shortly after the election in May 2010 the new coalition government published their white paper 'Equity and excellence: Liberating the NHS'.

The paper described a new future for the NHS in post financial crash England. The basic principle of an NHS free at the point of need and not based on the ability to pay remained, but much of what the NHS had taken for granted over the previous decade in terms of structure and process was set to change.

Primary Care Trusts (PCTs), those commissioning organisations which hospitals like ours had been used to dealing with day to day would be abolished as would Strategic Health Authorities (SHAs). In their place general practitioners (GPs) would be encouraged to form 'commissioning consortia' to take on the role of buying health services from hospitals on behalf of their patients. For those services which were too big or too complex to commission locally, a National Commissioning Board would be established.

As we write this annual report the White Paper is subject to a 'pause'. Before the legislation resumes its journey through parliament, the voices and opinions of the many and various stakeholder groups in and around the NHS are listened to.

Whilst there will undoubtedly be some changes to the proposed legislation there will also most likely be lines in the sand which are here to stay. Principally that GPs will, in future, make commissioning decisions and in doing so will be both looking after their patients in terms of their healthcare and looking after the budget in terms of affordability.

With regards to affordability, the government has committed to real terms growth in NHS budgets for the lifetime of this parliament. Set against other public sector settlements this looks generous. However once inflation on pay and consumables and once the expected efficiency provisions are paid back then most, if not all trusts, will be budgeting for a significant reduction in income this year and for the foreseeable future.

Given that for the last 10 years the NHS has experienced very significant growth in spending i.e. from £35 billion in 1997 to over £100 billion now, then the virtual turning off of the tap is a major consideration for all Trusts.

The role of GPs in planning and buying healthcare

The fact that GPs will soon be responsible for the purchasing of health services on behalf of their patients is very significant. Previously GPs would refer patients into hospital or to other health providers and the bill would be picked up by the PCTs. Now, both the decision to refer and the cost of the referral are within the jurisdiction of GPs.

Whilst there has been much made of this point in the national media, citing potential conflicts of interest, here in Leicester we are upbeat about the prospects of working more closely with local GPs. Our simple philosophy is that services planned with input and intelligence from

both hospital and primary care doctors and nurses are more likely to get it right for the patient first time. If that is the case those same services are also likely to be more cost effective.

To build and strengthen our relationships with GP colleagues locally we have developed an account management structure in the Trust. Our most senior clinicians and managers are responsible for nurturing relationships with GPs in the three local commissioning consortia. Though it is early days we expect these relationships to develop and lead to more creative, more patient centered and ultimately more cost effective health care.

Restructure

At the same time as the external NHS landscape has been shifting, our own internal map has undergone some major alteration. For a long time the Trust was structured in a very traditional way with 13 clinical directorates led by 13 clinical directors and 13 managers. As a result, decision making was often painfully slow and the 'clinical voice' was sometimes lost from key conversations.

To address this, we began a complete restructure of the Trust last year with the aim of simplifying our structure and making sure the voice of our clinical teams were heard at the heart of the organisation. A year on, clinical divisions have replaced the 13 directorates, each led by a senior doctor, supported by an experienced manager and a senior nurse. The change was fundamental and unsettling for many of our staff, but over the last year the structure and the people have settled down and we are seeing greater clinical accountability and engagement.

The creation of our Strategy

One of the first jobs for the new clinical divisions was to help craft our strategy. We call it from 'Good to Great'. It is a journey from where we are now; a generally good hospital trust with good services and good clinical outcomes in most of those services, to where we want to be; a great trust with consistently great services.

Much of the work of the Board for the early part of 2010 was taken up with discussions about the overall strategic direction of the trust, whilst much of the thinking within the clinical divisions was taken up with strategy at service level.

The process of integrating the service and the trust wide strategy is still underway but the key themes are captured in the diagram, which we now call 'the bull's eye.'



Centre of an emergency network: we are open all day and night every day of the year for emergencies. Sometimes we see people in our accident and emergency department who do not really need to be treated as an emergency but they come to us for any number of reasons...because they know we're open; they don't know where else to go; there is nowhere else to go or they can't get an appointment elsewhere. The thing is that there are many ways of dealing with patients who are ill but not all need to be treated as an emergency. So, working with our colleagues in GP surgeries and in Social Services we are keen to completely reinvent the way that people use emergency care services. The aim is to create new ways of accessing health care so that local people are not as reliant as they are now on the A&E department.

The regional hospital of choice for planned care: 'Planned care' is anything which is not an emergency. For example, if a patient needs a hip replacement they are usually referred to us a few weeks in advance of the operation and they and we have time to plan their operation. Many people choose to have their operation in Leicester's hospitals because they have previously been given good treatment by us for other illnesses or because their relatives or friends have recommended us. However some people only choose to come to one of our hospitals because we are the nearest... in that sense they have no choice. We would like to change that. That means we will need to change the way we work to take some of the hassle out of coming to our hospitals. It also means that as well as providing good clinical care we will need to make sure that we make patients feel genuinely looked after. In short, we would like to feel that all patients come to Leicester not out of necessity, but out of choice.

Nationally recognised for teaching and clinical services: Some of Leicester's services are amongst the best in the country. Though it's not often talked about, our clinical outcomes are good and mortality is really low when compared to other hospitals, (to be blunt, that means that compared to other average hospitals, patients are less likely to die in Leicester because of the quality of our services). We want to make sure that patients, the public and trainee doctors and nurses know that. This will mean that people outside of Leicestershire and Rutland will want to be treated by us which in turn will mean that we receive more funding which can then be invested in our hospitals.

Internationally recognised for specialist services and research and development: Leicester's hospitals are home to some world leading services. Often these cutting edge treatments are underpinned by teams of clinicians engaged in advanced research. Research is important to us. Not only does it mean that local people often have access to new treatments which people from other areas might not be offered, but it also means that we

attract top clinical talent and cash to further our research. This means that we are constantly looking for tomorrow's new ideas and treatments, today.

Underpinning the Good to Great strategy are six principles (see below). The first four (patients, process, people, partnerships) lead to the final two. In other words, by doing the right things by the right people in the right way, we ultimately transform Leicester's hospitals into a profitable trust, able invest more into services for local people.

Patients	All that we do is defined by what patients want and need
Process	Quality lies at the heart of our work, leading to efficient and effective services
People	Staff feel rewarded, supported and trained to do their job
Partnerships	We focus on what we are good at, partnering with others for their expertise
Performance	Leicester's Hospitals is the centre of a quality health system, patient friendly, with excellent access and communications
Profitability	We generate profit through clinical quality and process excellent which is then invested to create new, better services for our patients

The journey to take us from good hospitals to great hospitals will take time, but we are convinced that by achieving the four objectives in the bull's eye we will ultimately deliver our core purpose... which is to give our patients, 'Caring at its Best'.

Our preparation for foundation trust status

We started our journey towards foundation trust (FT) last year (2009/10). As part of this journey we consulted with the public and our key stakeholders on our reasons for becoming an FT and to seek their support. The full consultation document was made available to the patients and service users across all three hospital sites through a number of traditional as well as more innovative channels. We were really pleased to have received an overwhelmingly positive response to our proposals.

Becoming an FT will give us a number of generic freedoms that support our journey from 'good to great':

- the freedom to set our own goals and make our own decisions based on what local people want and need from Leicester's hospitals;
- the freedom to keep any extra money that we make after running our services. We can then invest these in developing new services for local people;

- the freedom to create new governance arrangements which will make us more accountable to local people and our staff, instead of national government.

During the last year we have taken part in numerous conversations with staff and stakeholders about our FT proposals. The discussions have ranged from explaining the benefits of becoming a NHS FT to detailed planning at division and Clinical Business Unit (CBU) level for our future as an NHS FT.

Foundation Trusts are governed differently to normal hospital Trusts. Governors are elected from staff and public members and they take their place around the council of governors table alongside representatives from our partner organisations, called partner governors. Once formed, the council of governors is then involved in discussions with the board of directors of the trust over matters like the priorities, objectives and future strategy of the hospitals. We think that will be a powerful partnership.

Becoming an FT will also help us achieve our specific strategic objectives:

- it will support our objective to become the centre of a local acute emergency network through the greater involvement and engagement of our local stakeholders in the acute network as part of our council of governors;
- it will support our objective to become the regional hospital of choice by protecting, improving and growing the NHS and our own brand. It will also enable us to grow our market;
- it will support our objective to become a nationally recognised provider of teaching, clinical and support services by enabling us to be more innovative in our business models and pursue joint ventures and partnerships more freely;
- it will support our objective to become an internationally recognised provider of specialist services supported by research and development by helping us to attract partners and funding;
- it will support our workforce plan by enabling us to recruit and retain new and existing staff who are committed to working for a high quality organisation;
- it will support staff engagement by formally allowing our staff, who are automatically members of our trust, to vote for or stand for election on the council of governors;
- the most important benefit of becoming an FT is that it unites doctors, nurses, managers and local people together in a powerful partnership.

Becoming an FT is not an entitlement. The freedoms have to be earned and as such during the next financial year we have a lot of work to do to prove to the Department of Health and the FT regulator, Monitor that we have the wherewithal to take this next step in the development of Leicester's hospitals. If all goes to plan we would expect to be authorised as an FT in Spring 2012.

Cost Improvement Programme

As discussed previously, the outlook for NHS finances is real terms growth in overall government funding. However, this translates into reduced revenues for trusts once inflation, wages and other factors are taken into account. This means that trusts like ours will have to make less money go further.

Last year we set ourselves the task of reducing our costs by £31m without affecting the quality of our care. This was a challenge and as the finance commentary later in this report states, we achieved what we set out to do.

For future years the challenge is likely to increase. The cost improvement target for 2011/12 currently stands at £38.2m which is about 5.5 per cent of our predicted turnover, and by far the highest target we have ever set.

In the private sector year on year efficiency or productivity improvements are taken for granted by most businesses. In contrast, in the NHS as a whole, efficiency and productivity has not improved over the last decade. This means our challenge is to relentlessly drive down those costs which add little or no value to the patient in order to create sufficient surpluses for us to be able to reinvest in patient facing services.

The local emergency care network

A significant component of our ability to reduce costs is wrapped up in the relative effectiveness of the local emergency and urgent care system. Over the last year we have struggled to hit the national target of patients being seen, treated and discharged or admitted within four hours. The vast majority of our patients are seen within 4 hours but there are a significant minority who are not.

There is no single reason for this and therefore there is no single solution. The local health service is over reliant on our emergency department for out of hours care. The department itself is too small for the numbers of patients attending. We have struggled to recruit doctors to work in the department and at times the numbers of people being admitted to hospital has far exceeded the numbers of people being discharged back to their homes or into social care. All of this has meant that the emergency department has been blocked up with patients waiting for beds.

In October 2010 we talked to colleagues in the PCTs, the ambulance service and in social care about the creation of a 'Health Summit' at which the leaders of each of the organisations involved in the delivery of emergency care would gather to address this issue. As a result of the summit there has been a greater shared understanding of the issues and which agency is best placed to tackle them. We are clear about our role in the creation of an emergency care system which works at all times of the day and night. In January 2010 our trust board agreed in principle to a business case which involved the redesign of the emergency department at the Royal Infirmary and a further investment in staff. Sorting out

an effective, quality and efficient system for dealing with emergency and urgent care remains our top clinical priority.

The national review of children's cardiac services

Our next most important clinical priority is to secure the future of children's heart services for Leicester and the wider East Midlands.

In 2010 a group of experts nationally recommended that the number of hospitals carrying out complex heart operations on children and infants should reduce from the current eleven to six or seven. This was as a response to an enquiry which took place in the 1990's into the care of children with heart conditions at the Bristol Royal Infirmary.

The premise for the recommendation to reduce the number of centres was that children's heart surgery is so specialist that only those centres that could do a certain number of operations a year should continue.....the theory being that the more you do the more skilled you are.

Our Glenfield Hospital is home to the East Midlands Congenital Heart Centre, which specialises in children's heart conditions and is therefore affected by the review.

In February 2011 the national review team published their report into children's heart services which they called, 'Safe and Sustainable'. Their report concluded that there were four possible options of the future disposition of children's heart services nationally. 'Option A' was the only option with the Glenfield hospital in; it was also the 'preferred option'. The publication of the expert report also signalled the start of a period of consultation with patients, parents, stakeholders and staff and at the time of writing this annual report that consultation process is ongoing.

There are clearly consequences to Leicester and the wider East Midlands of losing this service.

Apart from the most important and the most obvious fact that patients and parents would have to travel much further (to Birmingham) for their surgery and ongoing treatment. The loss of surgery would have other damaging effects. First, we would lose many doctors and nurses who have spent their lives training to provide this service; Second we would lose a significant amount of funding for Leicester's hospitals and finally and crucially this would mean that the children's ECMO service would be lost from Leicester and that would then make the adult ECMO service unviable.

ECMO, 'Extra Corporeal Membrane Oxygenation', is 'total life support' for the sickest of the sick. Currently, we use ECMO to buy valuable time and stabilise children and adults with lung and heart problems giving them the chance to have their surgery and to help them heal after. It's for this reason that Leicester treats children other centres cannot. Leicester is the national home of ECMO and the largest centre in the UK. In fact we train people from other centres and in other parts of the world. If Leicester loses children's heart surgery it is likely

that we will lose both children's and adult ECMO as a consequence because we will not see enough patients to make the centre viable.

During last winter's H1N1 pandemic, the leaders of the NHS nationally said that the "*nation owed Leicester a debt of gratitude*"... this is because as the largest children's and adult ECMO centre we were treating many patients whose lungs and respiratory systems had given up under the impact of the H1N1 virus. Services like ECMO are so important they have to be planned nationally and cannot be closed in one centre, or moved to another, without the direct approval of the Secretary of State for Health. This is why the expert panel concluded that 'the optimum is to maintain nationally commissioned services (like ECMO) in their current locations.'

Clearly cost is not the main issue. However, in these extremely difficult financial times it would benefit the NHS and the taxpayer if the best option was also the best value option. The review team found that to be the case with the Leicester option. The set up costs of Option A are the cheapest of the four options at £11.785m....the set up costs for Option B, the most expensive option, is double that at £22.967m. This is why the review team concluded that Option A was the best option based on an assessment of 'legacy costs'

The team of doctor's, nurse and managers, aided and often led by our many parent supporters, have devoted enormous amounts of time and energy campaigning to keep this service in the East Midlands. We believe that the Leicester centre has got the right quality, with great outcomes, is in the right place, with the right number of patients, and it has the lowest cost....this combined with the fact that we think it would be madness to destabilise something as nationally important as ECMO, means we will keep on campaigning.

Care of older people

Over 70 per cent of our patients are over 70 years old. And the overwhelming majority of our older patients rate the care they receive in our hospitals as good, very good or excellent. However our own data and the stories we occasionally hear from patients and relatives show that this is not always the case.

Last year we there were two stories which caused us particular concern and which prompted the local newspaper, the Leicester Mercury to launch a campaign to lobby for improved care for older people in hospital.

Listening to the relatives of people who had been under our care and who had received poor care in our hospitals at trust board meetings was enlightening and distressing. Reading about similar stories in the media was distressing.

In response to the criticism and the feedback we received from some of our patients and their relatives we launched a new regime aimed at dramatically improving the experience of everyone treated in our hospitals but most of all our older patients. Some of the key components of this are...

- Hourly ward rounds to solve issues before they happen

- 'Nurse in charge badges' so patients and relatives are clear who they should talk to
- 'Caring at its Best' training for every nurse and healthcare assistant
- 'Meet the Matron' sessions on every ward.

It is too early to say with absolute certainty whether these new initiatives are working. We have involved and asked for advice from other local experts like Age Concern Leicester and we are very grateful to them for their constructive and inventive support. For now, we will keep a close eye on the implementation, and if these interventions produce results we will work harder at them....and if they do not we will try something else, until we can say that all our patients receive the kind of care that they are entitled to.

Quality and performance – how did we do?

Although the Care Quality Commission (CQC) did not publish annual health ratings last year we are still monitored centrally against a range of targets and thresholds as published in the Operating Framework by both the CQC and Monitor, (the FT regulator). This section relates to a mixture of national and local quality and performance measures which are priorities for the trust. We provide our trust board with a monthly quality and performance report summarising quality, operational, finance and human resources performance. This report can be found in the trust board papers on our website www.uhl-tr.nhs.uk.

These are some of the things we are monitored on and our performance against them:

Further reduce health care associated infections: In 2010/11 our aim was to have no more than nine MRSA bacteraemia cases and no more than 212 UHL attributed CDiff cases. Whilst we did not achieve the challenging MRSA target we did reduce the number of cases to 12, an 8 per cent reduction on the previous year. We did achieve the CDifficile target with 200 cases reported in 2010/11, a reduction of 15 per cent on the previous year.

Success has been celebrated by receiving the Healthcare Associated Technology award from the Department of Health for our success in reducing MRSA and CDifficile infections.

We are now screening all eligible elective patients for MRSA before they are admitted. In January 2011 we started screening non-elective patients for MRSA and in February 98.6 per cent of that group of patients were screened.

Reduce venous thromboembolism (VTE): Nationally, more people die as a result of a VTE in hospital than as a result of infections and road traffic accidents combined. Which is why last year we said we wanted to increase the percentage of adult inpatients that had a VTE risk assessment when they were admitted to our hospitals, from 50 per cent to 90 per cent.

We are one of the 18 VTE exemplar sites in the UK, with streamlined pathways of care for patients presenting with acute thrombosis. We have consistently increased the number of adult patients who are assessed for their risk of VTE. In March that stood at 79 per cent.

Improve performance in trauma - fractured neck of femur outcomes: We have responded to the improvement target to get patients to theatre within 36 hours of their admission/diagnosis of fractured neck of femur (broken hip). This target was 50 per cent in April 2010 and by November 2010 had increased to 90 per cent.

We have made significant progress on this target and reached 75 per cent for our overall performance for the year. We review the reasons for any patient not getting to theatre for their operation within 36 hours so we can improve our performance. We have also seen an improvement in our mortality rates for these patients, i.e. more are surviving.

Same Sex Accommodation: 100 per cent of our patients on wards stay in same-sex accommodation. We have redesigned our services to create separate male and female facilities, in our intensivist areas such as endoscopy at the Royal to help us achieve full compliance.

A&E performance: The emergency department (ED), eye casualty and urgent care centre (based at the Royal Infirmary site) has seen its busiest year ever. We have worked with the local PCTs this year on a programme to divert patients at the entrance to the emergency department to the urgent care centre if appropriate. This has meant we've seen a decline in activity from 2009/10, but the urgent care centre has seen an increase in activity as a result. With 159,100 patients attending ED and eye casualty achieving the 95 per cent standard has remained a challenge. Our performance for the year (ED and eye casualty) is 93.8 per cent and if we include minor injury units and the urgent care centre, we achieved 96.1 per cent for the full year.

The emergency care system across Leicester, Leicestershire and Rutland remains fragmented and a considerable amount of work is being done to improve patient pathways, as mentioned earlier in the report. Focussed areas of work looking at redesigning the footprint of the department to make sure that clinical quality and patient safety is optimised and by redesigning our workforce we can make best use of resources and to minimise the time patients wait for assessment and treatment.

Readmissions to hospital: Our 30 day emergency readmission rates continue to be higher than the reported national average and also against those of our peers.

In March 2010 our readmission rates stood at 8.8 per cent. This has reduced slightly in 2010/11 to 8.4 per cent. Work is being done at speciality level to review patient pathways and to emphasise the importance of communication around discharge.

We have also introduced urgent outpatient appointments for those surgical and some medical patients where it's clinically appropriate.

Cancer waits: During this year we have continued to deliver all existing national standards for cancer waits, including 14 day from referral to first appointment, 31 day from decision to treat to treatment and 62 day from referral to treatment

In addition to this, two new cancer standards have been introduced which we have successfully achieved. These are 14 days for symptomatic breast patients from 1 January 2010 and 31 days subsequent radiotherapy from 1 January 2011

Referral to treatment – 18 weeks: The 18-week target of 90 per cent for admitted patients (patients requiring inpatient or day case treatment) and 95 per cent for non admitted patients (patients treated in outpatient setting) has been achieved throughout the year. Although it has proven a little more challenging in a small number of specialties.

Primary Percutaneous Coronary Intervention (PPCI): PPCI is the preferred treatment for patients who have had an acute myocardial infarction, a heart attack. By changing our processes we have managed to improve our performance and 87.1 per cent of eligible patients received a PPCI within 150 minutes of calling for medical help against a target of 75 per cent.

Improve theatre utilisation to 86 per cent: We have made significant progress in the way we use our theatres. During February 82.9 per cent of theatres for inpatient procedures and 90.4 per cent of theatres for day case procedures were occupied, against a threshold of 86%.

Cancelled operations: The number of operations cancelled at short notice for non clinical reasons increased in 2010/11 to 1.3 per cent for all of our elective (planned) activity.

The causes of this include the increased demand for emergency care and in particular the outbreak of Swine Flu during the winter. We remain committed to improving this position, and we will continue work with partners to reduce demand for emergency care as well as improving our internal processes and productivity.

Here is a look at the work of our hospitals expressed by the numbers of patients we treated last year.

Patients treated:

Activity Type	2006/07	2007/08	2008/09	2009/10	2010/11	Increase compared with 2009/10	
Day Cases	72,700	74,100	76,500	78,500	77,600	-900	-1.1%
Elective Inpatient	27,300	27,300	25,600	24,900	23,300	-1,600	-6.4%
Emergency Admission	80,200	81,500	87,600	91,100	90,400	-700	-0.8%
Births	10,200	10,700	10,800	10,600	11,000	400	3.8%
New Outpatients	209,700	206,700	218,900	235,500	240,800	5,300	2.3%
Follow Up Outpatients	485,400	482,000	501,900	499,600	507,400	7,800	1.6%
Accident & Emergency (including Eye Casualty)	155,500	153,800	156,100	160,400	159,100	-1,300	-0.8%

Visits by the Care Quality Commission

The CQC regulates providers of health and social care. We are required to demonstrate that we comply with 16 essential standards of quality and safety which are laid down in

regulations. Monitoring of compliance with these outcomes is carried out on an ongoing basis.

As part of their regulation the CQC have powers to visit us at any time to see how well we are complying with the 16 outcomes. They can do this by carrying out a planned (as part of their scheduled activity) or responsive (in response to information/ intelligence) review of our hospitals.

During the year the CQC carried out planned reviews of the Royal Infirmary, Glenfield and General hospitals. The review process involved the following three stage approach:

- submission of information to the CQC
- a site visit
- publication of a report.

The CQC found that we were compliant with the outcomes at all three sites. Copies of the CQC reports can be obtained from <http://www.uhl-tr.nhs.uk/aboutus/performance/care-quality-commission>

Our new clinical divisions reflect on achievements in their first year

As we have already shown, we embarked on a complete restructure of the trust last year as we moved away from clinical directorates into the new divisions and clinical business units (CBUs).

The drive for the structure change was to increase clinical engagement and to promote quicker, local decision making.

It was a very busy and challenging year for all of the divisions and CBU's, but they soon found their feet and here we reflect on some of the accomplishments in their first year.

Acute Care Division

As the biggest division covering some of our most challenging clinical areas not least, our emergency department, the acute division certainly have had their work cut out.

Despite that, the divisional restructure and the development of CBU's has provided staff with the opportunity to appreciate and engage in the challenges and celebrate the achievements of other services.

Reflecting on what went well; we moved from taking patients on three sites to just two – the Royal and the Glenfield – closing the Emergency Medical Unit at the General to improve the process for patients and subsequently we have doubled the number of patients we've seen since it opened in 2004. There's been some work trialled within our acute medicine service triaging bed bureau patients on our acute medical unit to avoid patients being unnecessarily admitted. Although it is early days, the project is already showing some positive results.

Improvement of emergency care: We are in the process of developing and implementing professional standards for all of our clinical areas. This includes all patients having an estimated date of discharge. Improved patient flow; including timeliness of diagnostic and discharge. Work is still on-going in these areas. Lean process design in the emergency department to improve flow within the department is also underway.

Respiratory services: The Thoracic Surgery team has the highest resection rate (when a doctor can completely remove a tumour by surgery without leaving any of the tumour tissue, or without causing death to the patient by removing or damaging an essential structure) for the treatment of 'Lung Cancer' in the country. They also treat the highest number of patients with Mesothelioma. The Leicester Thoracic Oncology team, led by the CBU, were highly commended in the Excellence in Oncology Team Awards 2010. They have also consistently sought and had excellent patient feed back.

They have successfully piloted a new service to diagnose and treat pulmonary embolis in the community rather than hospital via a Regional Innovation Award and more recently have started a similar community service for the treatment of Pneumothorax. They continue to explore innovative ways of reducing hospital admissions and the patient's length of stay.

Our respiratory specialties, clinical immunology and allergy CBU has had a busy year with many successes, such its successful merger into a single service with the unit delivering a comprehensive allergy portfolio consistent with the House of Lords Allergy report. The service has increased its immunoglobulin replacement therapy service for patients with antibody deficiencies and offers several innovative therapies for a variety of conditions.

They have continued their respiratory research with several successful grant applications, ongoing clinical and bench research projects and multiple publications in high impact journals. Members of the CBU have a national and international profile and lead several national committees, edit national specialist journals further enhancing the profile of the unit.

Caring for our older patients: With support from the other health and social care organisations in our local health economy, we have developed a frail older peoples' strategy which sets out ways to improve and better coordinate the care of frail, older patients. This has helped us develop an emergency frailty unit run by a dedicated geriatric team. They provide early assessment, care planning and discharge for frail older people attending our emergency department. The unit is now seeing between 10-16 patients a day many of whom would have previously been seen in the Acute Medical Unit at the Royal.

We now have a frail older peoples' advice and liaison service, which is a multi-disciplinary team supporting the AMU at the Royal. This team sees between five and eight frail older patients a day and is able to help about one in five older people return home who would otherwise have been admitted to hospital, with very low readmission rates.

We have established clinics across the city and county to support patients discharged from hospital and to help primary care colleagues in the management of patients in the community.

We are beginning to introduce support from our geriatricians to the 300+ community hospital beds, which will help use reduce a patients length of stay by one to two days which will mean more beds available in the community (average length of stay in a community hospital is currently 25 days).

We are also running a clinical trial providing geriatricians in an outreach programme for patients at high risk of readmission from the AMU.

There are falls prevention services across the city and county which we continue to support that are designed to medically assess patients, help determine the risk factors for the individual falling again and try to put in place preventative actions to reduce the likelihood of the individuals having a repeat fall.

Cardiac, renal and critical care service: Our cardiac surgery and cardiology services have had a challenging year coping with the impact of swine flu which used many of our intensive care beds, and an increased need for our ECMO service. All of this has meant that there was an impact on some of our elective surgery as we found ways to make sure that our patients didn't experience delays in their treatment. Our experiences through this busy period will help us with our planning for the coming winter so we are more prepared.

We successfully transferred our cardio-vascular assessment unit from the Royal to the Glenfield. This was done to ensure our patients would not be delayed and the majority of the expertise in this area was already based at the Glenfield, which means we could improve the service for those patients using it.

The cardiology and cardiac surgery services continued to develop new and innovative techniques to improve patient care, including developments like the Robotic Arm and TAVI (Trans-Catheter Aortic Valve Insertion) in cardiology and the use of the suture less valve in cardiac surgery.

Dermatology: Our service is in demand more now than ever. In fact we've seen an ongoing annual increase of more than 15 per cent in two-week wait referrals, so we have sought ways to improve our service and put in more flexible arrangements to provide clinics to fit the variable demand.

We have been working with our commissioners through the East Midlands Specialised Commissioning Group to set up a Mohs service during 2011/12. Mohs micrographic surgery is a procedure which involves the removal of certain skin tumours in cosmetically important areas, such as on the face. Sometimes described as "slow Mohs" (because of the method used to process the tissue specimen takes 24 hours) this treatment enables us to completely remove the tumour making it less likely that some tumour is left behind. It also means that we only need to remove the smallest amount of surrounding normal skin, providing better quality of care to patients with skin cancer at no extra cost. From April 2011 we will bring under our umbrella the City Community Dermatology service which means that this service will start to be consultant-led, a greater benefit for patients.

Rheumatology: We have continued to provide a high quality service to our patients in terms of out-patient, day-case and in-patient activity.

We have successfully integrated our service into the Medicine CBU, and developed a robust forecasting model for high cost drugs, leading to changes in ways of working to help control costs in this high spend area.

We are improving various aspects of our service in line with the vision of the CBU. We continue to provide support to reduce length of stay for patients and offer prompt consultation for any rheumatology referrals from the medical wards including the AMU at the Royal Infirmary.

We are currently in the process of developing early arthritis clinics in line with NICE recommendations, and exploring opportunities to provide certain aspects of care in the community, closer to people's homes.

Infectious disease: We have been successful in securing £45,000 in regional innovation funding to help support setting up and developing a nurse-led community based Hepatitis C treatment service. The service, started during the year, will allow patients with chronic Hepatitis C to be treated outside the hospital environment, thereby improving patient uptake and compliance with treatment.

In the early part of 2011 the service developed plans to provide home delivery of drug treatment for some stable HIV patients; this will be a more convenient for patients and will also result in reduced drug costs for the service.

We have also started to develop plans to provide a virtual Hepatitis B/C clinic - which will be more convenient for patients and increase efficiency of the service. We have an outpatient antibiotic service which we hope will reduce length of stay and be more convenient for a group of patients and setting up a TB (tuberculosis) multi-disciplinary team clinic to strengthen clinic management processes and facilitate clinch networks in the region. We will develop these services further during the coming year.

Diabetes services: In April we started to see patients in our new Integrated Community Diabetes Service in Leicester City, just three months after being awarded a five year contract. We have had over 700 referrals during 2010/11.

Earlier in the year we started a pilot study in Lutterworth and Blaby which involves consultants and district nurses seeing patients with GPs and practice nurses. There is a strong emphasis on education of primary care clinical staff. We're currently assessing the success of this pilot and the benefits to those involved.

The diabetes programme, DESMOND has had a productive year with over 600 patients being trained, 30 per cent more than 2009/10. In April 2011 we will take the County Diabetes Specialist Nurses as part of the transfer of services from the PCT.

The service successfully secured £50,000 of regional innovation funding to help support 'Think Glucose' training across 30 of our wards over the next 12 months. This initiative raises awareness of the specific clinical needs of diabetes inpatients to healthcare professionals providing care at ward level through the use of patient and staff audit and diabetes specialist nurse led education. This will result in improved patient satisfaction, reduced diabetes related prescribing and less errors and reduced inpatient length of stay for patients with diabetes. The appointment of a new Diabetic Specialist Nurse will help oversee all of this work.

Neurology and Neuro-Physiology: We have relocated the acute neurology service and created a neurosciences ward at the Royal. By redesigning the service we have been able to provide specialist neurological input into patient care sooner in the patient journey and to a greater number of patients.

Division of Women's and Children's Services

Our new division has brought together these two important family based services and our first year has been both busy and exciting with a number of key achievements helping to improve the quality of care to women, children and their families.

Neonatology: A new £9m facility for babies needing special high dependency and intensive care on a purpose built neonatal unit opened in September last year. We'd like to thank the

people of Leicestershire who helped enhance the environment of the unit by generously fund raising. The new facility has improved the clinical facilities for babies and their parents.

Maternity: Following extensive collaboration and engagement with our commissioners and the general public, a significant investment has been agreed for local maternity services. This investment will increase the capacity for maternity services at both the Royal and the General hospitals to respond to the increasing birth rate. It will allow us to increase the number of midwives and essential support staff we employ to improve the journey of pregnant women from their time of booking through birth and on to post natal care.

It is still part of our plans to work towards gaining a level 3 CNST for our maternity services (the highest level), and we are expecting an assessment in October 2011.

Clinical genetics: The service has achieved designation status as a recognised centre for the diagnosis of genetic disorders. As a growing medical specialty it has moved to new centralised outpatients facilities designed around the needs of their patients. It continues to develop a strong research portfolio and a new consultant appointment has also increased the services commitment to post graduate education.

Gynaecology: The service has delivered a strong performance against all its targets including national cancer 30 and 62 day targets, further reduced its new to follow up rates and reduced the length of stay in hospital for patients through its involvement in a major redesign programme. In 2011 the service is working very closely with maternity services to reconfigure all its services to allow maternity to expand its capacity to cope with an increasing birth rate and improve gynaecology services.

Sexual health: In the early part of 2011 the service introduced home delivery of drug treatment for its HIV patients. Our aim is that over 70 per cent of patients using this service which will be a more convenient for patients and will reduce drug costs for the service. The community HIV nursing service has joined our team and expanded to improve the support offered to this group of patients out of hospital.

Children's hospital brand: Our Children's hospital has designed a new logo with the help of the staff and children who helped to choose the final design. Thanks to everyone involved in not only creating a new logo but also a new brand for our Children's Hospital. We will use this new brand to raise awareness of our Children's Hospital over the coming year.



Children's Admissions Unit: In December 2010 we opened a newly refurbished Children's Admissions Unit at the Royal, which moved to its new home on ward 9 in the Balmoral building from ward 28, in Windsor so that it is closer to the children's Emergency Department. This has the benefit of reducing transit times for children and improving safety when transferring children from one department to the other. This purpose built, child friendly, environment provides an improved hospital experience at a traumatic time for children and their families.

Patient and public involvement: The Children's hospital has been working with local schools to help them ensure they are providing child focussed services through, for example, the development of a patient survey and information leaflets, food tasting and surveys and providing age appropriate art work for the clinical areas.

We are also piloting a week long scheme for raising aspiration and opportunities for the young people of Leicester, in collaboration with Leicester University and Leicester Education in Partnership. It offers students the opportunity to come in and talk to staff from all disciplines to understand the many diverse roles in the NHS and employment opportunities for young people in the future.

Children's diabetes service: The diabetes service has launched its insulin pump service and since September 2010 has successfully placed 19 children into the programme. This will make a significant difference for children with type 1 diabetes who previously have had to have multiple injections through out the day. Having a pump reduces this significantly. There will also be long term benefits for patients, who should develop fewer complications when they are older due to better control of their condition. The plan is to increase the number of children on these new pumps over the coming year.

Cystic fibrosis for children: We have established a parents group to look at the needs of families and children with cystic fibrosis, looking at improving communication, advice and support to families. We have developed menus specifically for these children which cater for their specific needs offering more choice while they are in hospital. We are also developing our home therapy service to reduce the number of times children need to come into hospital.

Children's cancer service: The Children's East Midlands Cancer Service was launched on the 1 April 2010 with children being looked after across Nottingham and Leicester by both hospital trusts working closely together on a shared service. The model that is being used in the East Midlands is unique and provides care closest to home wherever possible. Some parts of the service have been centralised into one of the two centres to maximise expertise and improve clinical outcomes. The service has developed collaborative working between the two centres and support to other peripheral hospitals to ensure care is delivered closer to the child's home.

Teenage and young adult cancer unit: We have launched a charitable appeal to raise £1.4m to refurbish our children's cancer ward to provide upgraded facilities for children. It will also provide a dedicated space for teenagers and young adults up to the age of 24 years. The funding raising will be a joint venture with the Teenage Cancer Trust.

Children's ward up grades: Wards 28 and 12 have both been upgraded giving the areas a more child friendly environment for our patients and their families; incorporating the new space rocket logo.

Children's out-patients: We have introduced partial booking for all follow up appointments, which means families can book appointments that are convenient for them and fit in with

family life. This has significantly reduced hospital and patient cancellations along with DNA (do not attend) rates.

Children's pharmacy: In January 2011 the Children's Hospital satellite dispensary became fully staffed with the appointment of a Medicines Management Assistant. This has helped the team process around 350 packages of medicine to take out at discharge per month. The waiting time for these medicines has been successfully reduced by over three hours down to less than 30 minutes.

As well as discharge, the dispensary continues to provide 500 inpatient items per month. As a result of the effective implementation of the satellite pharmacy service the children's pharmacy the team was awarded UHL Team of the Year 2010. Congratulations to all of the team.

Planned Care Division

The new division of Planned Care brought together the four clinical business units – Gastro intestinal surgery/ medicine/ urology, specialist surgery, cancer/ haematology/ oncology and musculo-skeletal from 1 April 2010.

The first year has been challenging as we established new teams whilst managing a very full agenda. We have made some significant achievements to improve the quality of care to patients.

Musculoskeletal: In December 2010 this CBU opened four new theatres at the General hospital. These have given the service the ability to treat more patients and reduce waiting times as well as helping the trust to make other moves across the sites.

Plastic surgery: In May 2010 the speciality opened the newly refurbished Burns, Plastics and Dressings Clinic. This new area gives patients greater privacy and dignity, and means that local anaesthetic procedures can be done in the clinic instead of sending patients to theatre.

Breast - 23 hour mastectomy project: In January 2011 the breast team launched a project to reduce the length of stay for patients undergoing a mastectomy. Patients are now discharged within 23 hours of their procedure with a drain insitu and brought back to an outpatient appointment to remove the drain. This improves the patient experience by allowing them to return to their home environment.

Ear, nose and throat: This specialty has been able to see more patients on a day case basis by changing clinical practice moving traditional inpatient stays to day case.

Maxillofacial surgery: This team has worked with our local PCT to reduce number of referrals and offer greater choice for patients requiring local anaesthetic wisdom teeth extractions. This has significantly reduced the waiting time for patients and allowed care closer to home for appropriate cases. The more complex cases are still performed at the hospital as we have the skills and expertise to deal with them.

Vascular surgery: The team have been part of the East Midlands Vascular Review (EVAR) which started this year. The specialty is in a very strong place with clinical outcomes amongst the best nationally. Our five and ten year mortality rates for aneurysm repair are extremely low, largely due to the zero mortality rates associated with EVAR over the last six years (to our knowledge, no other vascular unit in the UK has achieved this level of quality).

GI surgery: Successfully implemented an emergency avoidance clinic which means that less patients have had to be admitted in an emergency.

Our general surgeons have worked together to create a fully flexible rota which means that we have been able to improve how and when we use our theatres, putting us in the top 25 centile performing trusts in the country.

Cancer and haematology: The team in our cancer services has reduced emergency length of stay which means that we can allow those of our patients on the outskirts of the county to return to their local hospital. This means that we can improve the quality and access to specialist care.

Division of Clinical Support Services

Our services are highly diverse and are essential to support the rest of the trust. We provide all of these services:

- Pathology
- Imaging
- Operating theatres
- Anaesthesia, pain and sleep
- Central outpatients
- Pharmacy
- Medical physics
- Therapies
- Sterile services
- Medical records
- Nutrition and dietetics
- Specialist discharge team

Although we only set up the new top team in May 2010, we quickly built a revised management structure and agreed our service plans and priorities for the year. We have met our key financial performance targets and we have delivered step change improvement in key workforce performance targets such as staff appraisals and attendance management.

Operating theatres: In our operating theatres we have been able to set up a series of service improvement projects which help our theatre staff to get the most out of the efficient use of highly skilled labour resources and time.

This has meant that we have improve the way we use our theatres, moving from 72 per cent in April 2010 to 83 per cent by March 2011.

Partnership working: We began working in partnership with Nottingham University Hospitals NHS Trust to develop a joint venture for Pathology Services to create one of the largest pathology departments in the country.

With commercial partners we developed our existing arrangements for medical imaging equipment to make sure we continued to secure the best value for money and the latest equipment for the benefit of our patients and staff.

We successfully transferred our in-house sterile services and decontamination service to Synergy Health plc. This will bring about big changes for the administrative processes for medicine prescribing which will improve patient safety, reduce paperwork for busy clinical staff and help the Trust manage medicine dispensing more effectively.

Service developments: We revised our earlier plans to develop electronic prescribing in our ward areas and we're now in a position to roll-out a major programme of work for our pharmacy services in 2011.

We finished planning work to expand and improve on our aseptic unit service, which will enable us to provide a better level of support for our oncology research and services.

We brought on stream breast imaging digitalisation for the Glenfield. For our patients this means we have excellent and enhanced image quality at the press of a button which will minimise call-back appointments purely for imaging. These improved images help our clinical teams to compare and contrast with later images should there be a need for subsequent visits.

We have been consulting with our anaesthetists and theatre staff about what refurbishment is needed to improve their working environment and provide the space they need to make changes in their working practices across our surgical specialties.

Research and development

Our research and development programme has had a very successful year. This is important to our patients because a vibrant research culture enables us to attract and retain first-class staff, obtain extra funding, improve quality of care and outcomes, and promote an evidence-based approach to everything we do.

Our research is funded from many prestigious sources, including the National Institute for Health Research (NIHR), Medical Research Council, Cancer Research UK, British Heart Foundation and the Wellcome Foundation. During the year, our external income for research and development increased to £21.5m with the NIHR providing £17.1m. We were responsible for 825 research studies and are pleased that we were able to recruit significantly more patients to our clinical trials this year compared to last year.

In November the Secretary of State for Health, Andrew Lansley opened our new Leicester Cardiovascular Biomedical Research (CBRU) Unit at the Glenfield hospital as part of a multi-million pound scheme to prevent, diagnose and treat ill-health. The unit is funded by the NIHR and includes a research facility in the heart of the hospital providing a state of the art environment for patients who are involved in clinical trials. We expect thousands of people in the region to benefit from this new unit as the team uses ground-breaking research developed at the University of Leicester to provide life-saving treatments at the Glenfield hospital. The Right Hon Andrew Lansley said: "Research is fundamental to our future health, it underpins the advances in diagnosis, prevention and treatment of disease that are essential for a 21st century NHS. We simply cannot expect health outcomes to improve without investing in research and the brilliance of our doctors and scientists."

We have established the Leicester Centre for Diabetes Excellence at the General hospital which opens in summer 2011. Our diabetes research team is one of the best in the country and leads the world in areas such as diabetes prevention and early detection. The centre will provide a national focus for this work and a wonderful facility for our diabetic patients. Our respiratory team are leading a national initiative that brings together the pharmaceutical industry and NHS in order to improve the discovery and development of new treatments (Respiratory Therapeutic Capability Cluster). The group have also become a major partner in a Medical Research Council funded project on pulmonary rehabilitation and have obtained major European Union funding for their work into the causes of respiratory disease.

We host three NIHR research networks – the South East Midlands Diabetes Network, the Trent Stroke Research Network and the Leicestershire, Northamptonshire and Rutland Comprehensive Local Research Network. These are some of the best performing networks in the country, recruiting an increasing number of patients into quality clinical trials.

We continue to host a NIHR Collaboration in Leadership for Applied Health Research and Care (CLAHRC). This involves every NHS trust in Leicestershire, Northamptonshire and Rutland and is beginning to make a real difference in understanding how best to manage long term conditions underpinned by evidence-based providers and commissioners.

Releasing time to care

In June 2009 we introduced a programme called Releasing Time to Care – the Productive Ward (RT2C). The overarching aim of this programme has been to empower ward teams to identify areas for improvement by giving staff the information, skills and time they need to improve the way they work and the care they provide to patients. This also improves morale and enhances the working lives of nurses and other ward based staff.

The programme is currently one of the most well known improvement programmes within the NHS and 58 of our wards have so far taken part in the programme, reaping many benefits for staff and patients.

All areas on the programme are adopting lean principles in order to improve processes around each of the RT2C modules. This has resulted in incorporating value added time to the patients, deleting waste and streamlining existing processes.

Older people's champions

An older people's champion is a member of staff who has completed additional training to highlight the specific needs of older people. We have around 1400 staff and volunteers working across our hospitals as older people's champions to improve the experiences of our older patients.

These champions are clearly identifiable with an older people's champion badge. Information regarding the role of the champions is publicised locally in the bedside information booklet supplied to all patients who are admitted to hospital.

Improving care for people with dementia admitted to hospital is a priority both nationally and locally. The newly formed trust-wide Dementia Care Action Group has a clear vision to improve the quality of care for people with dementia when they are admitted to one of our hospitals. The group has identified several priorities for this year following the national audit of dementia care in hospital and will be working together to make those improvements and recommendations.

The Lord Mayor's Forget-Me-Not Appeal funds will be used to help support and improve the quality of care for people with dementia, including the development of a sensory garden at the General hospital designed to be calming and easily navigated by dementia patients. It will also help transform patient day rooms into



forget-me-not appeal

reminiscence/ retreat rooms, enhanced specialist dementia training for staff and volunteers and introduce meaningful activities for people with dementia.

Volunteering

We now have over 1,130 volunteers actively working around our hospitals. The volunteer services team also interview around 30 prospective volunteers every month, provide an induction training programme and monthly training sessions for around 25 new volunteers every month.

Our team of volunteers is representative of the communities we serve and between them they speak over 30 different languages and have ages ranging from 16 to 89.

We have seen a steady increase in the number of younger volunteers many who are hoping to pursue a career in medicine, nursing or health and social care and part of their motivation is to gain experience relevant to this.

This year we have developed the volunteer mealtime assistants project and now have 180 volunteers trained to assist patients at mealtimes. They support our adult patients who may have difficulties opening packages, cutting up food or they might just sit with a patient and help them to eat and drink. This project has been so successful that we've needed to secure a post to better manage the volunteers who provide this valuable resource. The post will work between clinical staff and volunteers to ensure that those areas with a high concentration of patients get the additional support they need.

The successful buggy project now runs on two of our hospital sites five days a week and carries on average 2,100 passengers on 1,220 journeys each month. This service is now relied on by patients, visitors and staff and is provided entirely by volunteer drivers.

Volunteers continue to respond to requests to help with patient surveys on wards and in outpatients departments, to assist with events and activities and to meet the specific needs of individual patients.

The patient ward library at the Royal is about to increase the service to cover our children's wards and there are plans to expand at both of the other sites.

Our Time for a Treat Service broke all of its previous records this year delivering a total of 190 treatments in the Breast Care Unit, 500 treatments at the General and over 1,000 treatments for patients in Oncology and Haematology – a real success story for our 35 volunteers.

As always, a huge 'thank you' goes out to all of our volunteers for the dedication and kindness that they continue to show.

Leicester Hospitals Charity – making an impact

Leicester Hospitals Charity has had a very busy year, supporting a variety of good causes. Here are examples of the work we have funded.

Dementia care given a boost by Lord Mayors of Leicester’s Forget-me-not Appeal:

Leicester Hospitals Charity was chosen as the Lord Mayor of Leicester’s charity appeal in 2010/11. The Forget-me-not appeal aimed to raise funds to improve the support for patients with dementia in hospital, providing a specially designed ward, a secure and pleasant sensory garden, information for families and carers supporting people with dementia and enhanced training for staff in the issues around dementia care

Emma Spencer, service development manager, said “One in every three older people will experience some form of dementia. Older people with dementia are also highly vulnerable to illness, accidents and falls, all of which can lead to hospital admission. The support from the Forget-me-not Appeal has been tremendous, enabling us to improve support for this vulnerable group of patients.”

Tim Diggle, head of fundraising, added: “We are very grateful for the support we have received from the people of Leicester and in particular significant donations from WRVS and the Glenfield Support Shop. This helped us exceed our target and raise over £150,000 to support this really important work. We are also indebted to all of the staff who took part in **UHL’s Got Talent**, either as performers or volunteers on the night, raising a fantastic £12,000 in support of this appeal.”

2010 Skin Cancer Appeal: A group of dermatology clinicians and staff from Leicester Hospitals Charity, joined forces with Brown Dog Cancer Charity on a sponsored challenge. They climbed eight fells in the Lake District in fourteen hours last summer to raise funds for a Molemax 111 machine, used in the diagnosis of skin cancer.

Debbie Adlerstein, community and events fundraising manager for Leicester Hospitals Charity, took part in the 24 mile trek through the Lake District. She said: “It was a tough challenge, but worth it. Together with the other activities associated with the Skin Cancer Appeal we raised an amazing £60,000”. She added “Brown Dog deserve huge credit for the work they do in supporting Leicester’s Hospitals and other NHS trusts. Without them we could not have bought the Molemax111”. In fact the appeal was so successful that enough funds were raised to provide another piece of equipment - the MOHS micrographic system used in the treatment of skin cancer.

Sven becomes Leicester Hospitals Charity Ambassador: Following the opening of the new neonatal unit, Sven Goran-Eriksson, manager of Leicester City FC agreed to become an Ambassador for Leicester Hospitals Charity, helping raise the profile of Leicester’s Hospitals and the charity.

We do what we say we're going to do

Patient information and liaison service (PILS)

The PILS continues to provide an invaluable service to patients, their relatives and carers when they wish to raise a concern, request specific information or indeed make a formal complaint to the trust.

The team endeavour to achieve a resolution as quickly as possible by talking with the appropriate specialities and providing a response within 24 working hours. Sometimes this is not possible and, because of the seriousness and complexity of issues, a more detailed investigation is required. A time frame for response is then allocated as either 10, 25 or in very difficult cases, 60 working days.

Contacting PILS is easy and can be done in any of the following ways:

- Calling the freephone number 08081 788337
- E-mail (pils.complaints.compiments@uhl-tr.nhs.uk)
- Website (www.uhl-tr.nhs.uk/patients/support-and-advice/pils)
- In writing to:

Patient Information and Liaison Service,
Gwendolen House, Gwendolen Road,
Leicester, LE5 4QF

or
The Chief Executive,
Trust Headquarters,
Level 3, Balmoral Building,
Leicester Royal Infirmary,
Leicester, LE1 5WW

Complaints

During the year we received a total of 1,531 formal complaints, 1,289 verbal concerns and 356 requests for information.

We endeavour to meet our commitment to provide a response to formal complaints within the agreed 10, 25 or 60 working days. The table overleaf identifies by division and clinical business unit how well we did.

Business Unit grouped by Division	60 day complaints			
	Number received	No. replied within 60 days	No. replied over 60 days	% replied within 60 days
ACUTE				
ED	2	2	0	100
Medicine	17	16	1	94
Cardiac, Critical Care and Renal	10	7	3	70
Respiratory and Thoracic	6	6	0	100
Divisional average	35	31	4	89%
PLANNED				
Specialist Surgery	3	3	0	100
GI Medicine/Surgery/Urology	11	10	1	91

Business Unit grouped by Division	60 day complaints			
	Number received	No. replied within 60 days	No. replied over 60 days	% replied within 60 days
Cancer/Haematology/Oncology	5	5	0	100
Musculoskeletal	10	10	0	100
Divisional average	29	28	1	97%
CLINICAL SUPPORT				
Anaesthesia, Theatres, Pain Management	1	1	0	100
Pathology, Pharmacy, Dietetics				
Outpatients, Therapy, Phlebotomy				
Imaging	1	1	0	100
Divisional average	2	2	0	100%
WOMEN'S & CHILDREN'S				
Women's, Perinatal & Sexual Health	10	10	0	100
Children's	8	8	0	100
Divisional average	18	18	0	100%
Totals:	84	79	5	94%

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

During the year we received 264 freedom of information requests, 14 more than 2009/10.

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

Managing risk

Our move to a divisional structure during the year meant decision making was devolved away from central control. This has made it more important to ensure that risk management processes are effective and enable risks to be controlled locally and escalated throughout the organisation 'from ward to board' if they are rated as high or extreme.

A revised risk management strategy, including a more effective risk reporting framework, has been developed to establish this with regular reporting of high and extreme risks to our Quality and Performance Management Group and the Governance and Risk Management Committee.

An integrated Strategic Risk Register and Board Assurance Framework (SRR/BAF) has been developed and implemented to provide assurance to our Trust Board that strategic risks are being managed appropriately and that we are providing high quality care in a safe environment for patients by staff who have received the appropriate training that it is complying with legal and regulatory requirements; and that it is meeting its strategic objectives.

To help ensure that patient care and the quality agenda is at the heart of our work, the impact of delivering a £32m cost improvement programme during the year was risk assessed before starting and during the implementation of the cost improvement programme to ensure that any significant risks were mitigated.

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 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:

Serious Untoward Incidents 2010-2011		
Level 3 SUIs (reported directly to the SHA/PCT/Information Commissioner)	2009-2010	2010-2011
	1	0
Summary of other personal data related incidents		

Category	Nature of the Incident	2009-2010	2010-2011
1	Loss of inadequately protected electronic equipment, devices or paper documents from secured NHS premises	0	1
2	Loss of inadequately protected electronic equipment, devices or paper documents from outside secured NHS premises	1	1
3	Insecure disposal of inadequately protected electronic equipment, devices or paper documents	1	1
4	Unauthorised disclosure	6	3
5	Other	0	0

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

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 maintained the reduction in the number of reportable accidents to staff following last year's success.

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 (HSE) we have increased our monitoring of work related skin problems. We produce our own in house bulletin "Safety Matters" which is circulated to all wards and departments to promote safety awareness and learning.

We have been running stress awareness workshops for our busy frontline staff and offered them advice and support when they need it. We have also carried out stress audits and risk assessments based on the guidance from the HSE. We continue to risk assess, report, audit and analyse data and to improve our safety performance.

Emergency planning

Following a re-structure this year, our main priority in emergency planning has been to consolidate and review our current plans to deal with a major incident.

As well as reviewing our major incident plan there has been extensive work on updating our response to an incident that requires the decontamination of members of the public following exposure to a hazardous material or CBRN (chemical, biological, radiological or nuclear) incident. This work followed on from Exercise Earthquake, a multi-agency CBRN exercise held at Leicester Racecourse. During the exercise we set our silver command to link in with the multi-agency tactical co-ordinating group working at Police Headquarters.

We also participated in Exercise Casper, a Strategic Health Authority led communications exercise.

In October the English Defence League organised a demonstration in Leicester with a counter demonstration led by the Unite against Fascists group. We worked alongside a number of organisations across Leicester to prepare ourselves and make sure we had systems in place to respond should there have needed to provide one. It was crucial that we maintained our services during this demonstration and that we ensured the safety of our staff and visitors to the Royal Infirmary.

We also responded to two unrelated unexpected electrical power shutdowns during the year. In both instances the teams involved responded well, ensuring the safety of patients and staff, with no adverse affects. These incidents highlighted the importance of relevant and up-to-date business continuity plans.

During December we saw a large increase in influenza related admissions. A number of the patients that were admitted needed intensive medical support requiring the use of ventilators. This put our intensive care units under an increased amount of pressure which unfortunately resulted in the cancellation of some planned surgery. Leicestershire had high numbers of people with flu like symptoms, so it was crucial that we worked closely with our partners in the local health community to manage these high numbers of patients and as such we managed this challenge efficiently and effectively.

We treat people how we like to be treated

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. Patient experience has very much been our focus during the year.

'Caring at its best'

We are developing an infrastructure that enables nurses to care in the way that our patients expect. A quality based approach to nursing care affirms the value of nurses who are crucial to ensuring the delivery of safe, fair, personalised and effective care.

We focus on key areas essential to care delivery, the aim being to raise standards and achieve best practice

Clinical care indicators or nursing metrics, cover those areas which are our highest priority and support Caring at its Best.

Metrics measure our standards of record keeping for the core activities that we carry out when caring for our patients. These clinical care indicators demonstrate our professionalism and give an accurate and contemporaneous record of our patients care. The implementation of these clinical care indicators demonstrates a systematic approach to quality improvement.

Listening to our patients

Since July 2010 we have been doing a monthly patient experience survey with our patients, families and carers within in-patient areas who can comment on any aspect of their experience. The Patient Experience Team is currently working on plans that will involve all of our clinical areas in the monthly survey during 2011.

Since it started we've been gathering the feedback of around 850 of our in-patients, which is then analysed and made available via our intranet, INSite, for all of our staff to view. All comments are collected and fed back directly to the specific clinical areas, which allows them to act locally on specific improvements based on their own patient feedback.

A link is now available on the front page of the public website to allow patients, families and carers to provide us with feedback regarding their experience in Leicester's hospitals (<http://www.uhl-tr.nhs.uk/patients/your-experience>).

Throughout this process we regularly share with teams the thoughts of their patients to ensure that changes are made and excellence is celebrated.

Listening to patient stories is a powerful way to illustrate how it feels to be cared for at Leicester's hospitals. These stories can be used to inform staff of the need for change and provide illustrations of how services should be developed in line with patient need.

Our trust board receives quarterly patient stories, giving each division the opportunity to present. Over the next year the divisions will be asked to use patient stories to illustrate key themes identified by patients.

The Patient Experience Team will devise a template, allowing patient stories to be linked with service improvements and the on-going review of those services.

Carers' survey: Nationally and locally there are clear requirements for trusts to address the issue of recognition and support for carers, particularly around the time of discharge.

We will continue to look for opportunities to gather the views of carers on the services we provide. This includes listening to carers' by attending local carers groups, gathering feedback from the carers surveys completed on our public website and touch screens and from this years CLASP Carers Centre Survey.

Any information we gather will be regularly fed back to teams to ensure that changes are made and excellence is celebrated.

Engaging and involving our patients and the public

Patient and public involvement (PPI) encompasses a wide range of activity that sees patients and the public engaging in decisions about their health services. Involvement may be at a strategic level, it may be managed through large organised events, through small focus groups or by surveys and questionnaires. Whatever methods used, we believe that involving our patients and the wider public is the only way to ensure that we are adequately responding to their needs and providing the most appropriate services for our local communities.

Patient and public involvement structure: Good patient and public involvement depends upon the ownership our staff take of this agenda. As such, each CBU has nominated a senior member of staff to lead PPI activity in their area. Supported by the trust's PPI manager, these leads take responsibility for coordinating and monitoring patient involvement, acting as a local PPI resource. Recent activity includes a programme of involvement for families of children with Cystic Fibrosis run by staff in our Children's Hospital, involvement through user groups led by our lead cancer nurse and a patient experience day organised by nurses in our thoracic surgery team.

We recently took a decision to combine our regular PPI and patient experience meetings to ensure that activity which aims to improve the patient experience is developed with good patient involvement. We see this as an important step towards building a culture of involvement across the organisation.

Working with Local Involvement Networks (LINKs): Over the year we have continued to develop good working relationships with our LINKs in Leicester, Leicestershire and Rutland. LINK representatives regularly meet with our chief executive and senior managers to discuss any issues and concerns. Our staff also attend LINK board meetings and a recently formed Leicester's Hospitals LINK sub group. We are keen to develop our partnership with LINKs and recently joined with both city and county LINK representatives to produce a joint consultation response for the Office of National Statistics. We also worked closely with both LINK organisations to engage black and minority ethnic (BME) service users in a programme of events which aimed to explore their experience of hospital services (see below). Most recently we have been working with both city and county LINKs to raise awareness of a consultation regarding the provision of heart surgery for children.

Equality and diversity

In May 2010 our trust board revised and agreed our Single Equality Scheme. Our equality objectives are to:

- mainstream equality into all that we do through strengthening our leadership and governance processes;
- improve data collection, monitoring and use to better understand where the gaps in services are;
- ensure that our workforce increasingly represents the communities we serve;
- enhance our engagement strategy with groups/communities that have the potential to be disadvantaged;
- improve access to services.

We've made a lot of progress in all of the areas listed above since our last annual report. We have mainstreamed equality into many of our processes and now have good governance arrangements in place with the redesign and re-launch of the Equality Board, the production of bi-annual equality (service) reports to our Governance and Risk Management Committee and workforce reports to the Workforce and Organisational Development Committee, as well as an inclusive Equality Impact Assessment process and the delivery of an Equality Seminar to the trust board in September 2010.

As well as this we successfully delivered six equality projects as part of the Department of Health's national Pacesetter programme which has since ceased. Several of the projects were nationally commended and five of the six projects have continued beyond the life of the programme and are now integrated into the equality work programme.

One of our highlights this year includes the production and distribution of the "Pregnancy and You" DVD which is a translated guide to understanding pregnancy filmed using ladies from the Bengali community. The DVD details the journey from conception to care after the babies birth and we've shared this DVD not only locally, but nationally too.

Comments received from Bangladeshi women who have viewed the DVD, have been positive:

“The DVD is spot on”

“Hats off to them, they’ve done a great job”

“It’s very visual, very practical”

“If I was pregnant, I would watch it”

“That’s good [hospital scenes], I didn’t have that, it’s good to see it as reading about it wasn’t as good and I panicked when it happened to me”

Interpreting and translation service: This year we reviewed and changed our interpreting and translation service to improve the timeliness and responsiveness of the service.

To do this we worked in partnership with other NHS trusts across our region to identify a provider that can meet the increasing demands for this resource, because with 85 different languages spoken locally it poses a real challenge to health services.

During its first month the company has provided 366 face-to-face interpreting appointments for the trust and on nine occasions and has even managed to provide an emergency interpreter onsite within one hour of the request. We are confident that this new service will improve the quality of service that we can provide to patients and their families.

Learning disability acute liaison nurses: After the success of our “Make My Stay” project, which was featured in last year’s annual report, we have been able to secure funding from our commissioners to appoint three acute liaison nurses. Their role is to improve the experience of patients with a learning disability when they come to our hospitals for treatment.



Since the service was launched in October 2010 they have seen 100 service users, and the majority of those service users have been from the white British population.

The majority have been visits have been to the service users once they have been admitted to hospital. However, six have included pre-admission/ community care liaison to aid planned admissions and treatment. In addition to this, the team have provided telephone advice, some education and training to ward staff and are in the process of developing some clinical care pathways for this patient group in partnership with local colleagues.

The anti bullying and harassment adviser service...one year on: As the pilot of the anti bullying and harassment adviser service proved so successful, it has been extended to continue to support staff throughout the trust. We have six volunteer staff members that this year have provided a confidential signposting and advice service for 61 people. This is in

addition to the formal services available from Human Resources. To support the team we have also developed an anti bullying and harassment e-learning programme for staff which was launched in December 2010.

Project search: Last year we became a Project Search Site. This is a great initiative which is about providing work trials and potential employment for students aged 18-25 with learning disabilities. As only 7 per cent of people who have a learning disability are in paid employment, this type of project is a great way of improving the range of employment opportunities for young people with learning disabilities. The project is managed in partnership with Leicester College, who provide the students and tutors alongside the supported employment provider Remploy, who provide an on site job coach to ease the students into their roles. Early evaluation suggests that the project is proving to be a huge success for both the students and for our staff working alongside them.



Workforce: For any organisation to implement the Equality and Diversity agenda successfully, it has to be a completely “embedded” way of thinking about the business and functions of the organisation in relation to the needs of our diverse communities who are both patients and/or staff. Every decision made in the organisation should consider the equality and diversity impacts.

A workforce report is produced and presented to our trust board twice a year. Following a submission earlier in the year it was agreed that there were two issues that we needed to focus on. They are representation (BME and women) at senior levels and the recruitment process.

Representation at senior levels: During the year there have only been a minimal number of “managerial” posts recruited to and therefore only a limited number of opportunities were provided through external recruitment to change the make up of the senior strata of the organisation.

However to ensure that we’re providing support to BME and female staff who wish to progress in a management position, we have started several initiatives. One of these was the support and opportunity that was offered to three members of staff on the “Towards Strategies for Success” initiative which is part of the national “Breaking Through” programme run by the NHS Institute. The “Towards Strategies for Success” programme is a leadership programme specifically aimed at staff from BME backgrounds in Band 7 or above (or medical equivalent). Three of our staff applied in late 2009 and all three were accepted onto the programme and all have since said it was very valuable.

Black and minority ethnic candidates through the recruitment process: We have analysed the statistics for our Band 5 recruitment, which showed that a proportionate number of people short-listed were appointed from both white and BME backgrounds. However there was a slight bias in favour of white candidates at short listing stage. Further work will be done to look at Band 6 nurses applying for Band 7 ward manager roles as we are aware that the proportion of BME staff in senior posts declines above Band 6.

NHS Employers partner status: We were granted NHS Employers Equality and Diversity Partner status for the year, from April 2010 to April 2011. This followed a thorough assessment process, evidencing activities that were taking place across the trust. Partner sites are considered to be exemplar sites and duties include, contributing to the development of good practice and contribute to relevant consultation processes initiated by NHS Employers in response to national equality issues

The Equality Delivery System (EDS) and community engagement: The EDS is a new monitoring framework developed by the National Leadership Council led by the Chief Executive at the Department of Health. Full implementation of the framework isn't due until 2012; however we have opted to be an early adopter of the new equality standards.

An essential element of the new framework is the local engagement of individuals and groups affected by potential inequality to determine what our equality objectives need to be. We recently invited people from a range of communities and organisations to a health symposium where we identified the priorities of BME communities. We wanted to know about their priorities when it came to their experience of our services so we could include them in the equality work programme for 2011 and to establish a programme of community involvement for 2011 and beyond. We invited participants were invited to;

- identify issues relating to their experience of, and access to our services,
- agree as a group their top two priorities, and
- discuss these priorities and suggest possible solutions.

The symposium proved to be a lively and well attended event which included participants from a diverse range of backgrounds and communities including south Asian, gypsy traveller, Zimbabwean, Polish and Somali. They raised many issues during the evening; however two themes emerged as clear priorities. These were communication and the need to improve our organisation's "cultural competence". During the evening we made a commitment to make progress on these priorities through the our equality work programme. We also pledged to continue meeting with these groups to understand these priorities in more detail and involve them in finding solutions.

Since the initial meeting, we've had three follow up events in December, January and March. A feedback event is planned for June 7 2011 where participants will be invited back to hear

about the progress we have made. Following the success of these events, we're planning in April to start meeting with other groups/communities including disabled people, faith and lesbian, gay, bisexual and transgender groups.

Our staff

We have a total of 10,171 substantive staff in post (as at 31 March 2011). They are broken down into the following groups:

	2010/11	2009/10
Medical and Dental	1,477	1,496
Administration and Estates	2,054	2,104
Healthcare Assistants and other support staff	2,117	2,284
Registered Nursing and Midwifery	3,301	3,261
Scientific, Therapeutic and Technical	1,222	1,278

NHS staff survey

The eighth national annual staff attitude and opinion survey was carried out between October and December 2010. The survey is conducted on behalf of the CQC and the results form a key part of the Commission's assessment of us in respect of its regulatory activities such as registration, the monitoring of ongoing compliance and reviews.

The purpose of the survey is to collect staff views about their experiences of working in their local NHS trust. It provides trusts with information about the views and experiences of employees to help improve the working lives of staff and the quality of care for patients.

The survey is done through a self completed questionnaire by a random sample of staff selected from across the whole trust. We randomly selected 1,500 staff to receive the survey and 865 completed responses were returned, giving us a response rate of 58 per cent.

Each trust is required to appoint a contractor to administer the survey and for the third year we used Quality Health for our survey management and local analysis and reporting.

The overall response rate for the 171 NHS organisations that used Quality Health was 55 per cent and for staff selected to participate in acute Trusts, the response rate was 51 per cent, so our response rate was average, but still a reduction of 8 per cent on the previous year.

The results of the 2010 staff survey generally indicate a plateau of responses following last year's very positive improvement in a number of key areas. This year we have not seen a significant increase in many areas and have seen a slight deterioration in some areas for 2010.

The 2010 survey provides 38 key findings about working in the NHS derived from the responses to 140 questions.

In comparison with other acute trusts nationally, the summary of our 38 key findings were:

- 5 – top (highest 20 per cent)

- 22 – average (better than average)
- 9 – below average
- 2 – bottom (lowest 20 per cent)

The key areas that need addressing are:

- Communication
- Appraisal (although we were in the top 20 per cent of trusts nationally in terms of staff having received an appraisal , we want to focus on the quality of the appraisal undertaken)
- Values/ behaviours/ staff attitudes
- Relationships/communications between senior managers and staff; access to senior managers
- Recognition and acknowledgement (through our Reward and Recognition Strategy)
- Trust commitment to work/life balance and health and well being
- Opportunity to develop; potential at work; access to training and development; developing talent
- Equality and diversity training

Over the coming months we will be focusing this feedback to managers and staff with a list of initiatives and actions for them to work towards. We hope this targeted work will help us see some improvements in our results for the 2011 staff survey.

Reducing staff absence

This year we had an average of 444 staff off work sick at any one time, giving us an average sickness absence rate of 3.73 per cent. This meant that we had the lowest sickness rates of all acute Trusts in the East Midlands and the average nationally for NHS trusts was 4.4 per cent (Managing Sickness Absence in the NHS – Audit Commission 2011). Given this success and our desire to continually drive down our sickness absence rate, our target is now 3 per cent which represents around 356 staff off at any time.

There are many positives benefits from improving employee health and well being; these include increased staff productivity, better morale and improved communication between teams. This in turn leads to better quality services, improved patient satisfaction and a decrease in staff turnover.

A comprehensive programme of actions is in place to support improved attendance at work through our in-house occupational health service, staff counselling service, fast track physiotherapy and health awareness sessions for staff.

The At Work for Patients project (@w4p) continues work to support staff attending work regularly. This is closely supported by the staff lottery funded health and well-being programme which has recently been reviewed following a survey of staff and includes: exercise classes, reduced fees for gym membership; team tournaments; healthy eating initiatives and walking challenges.

Consulting staff/ staff engagement

Staff engagement is an absolute prerequisite for our success. Effective staff engagement creates a culture where staff feel valued, developed and supported. In 2009, we carried out work in identifying our five values which enable us to define how we want to behave. Our values and behaviours are central to enabling staff to work together in achieving our vision to deliver 'Caring at its Best'.

It is important to recognise that staff engagement is multi-faceted, to ensure that we are addressing what matters most to our staff, patients and the trust as a whole. During the year, a great deal of work has been done in this area.

We incorporated our values and behaviours into our appraisal process for those of our staff on Agenda for Change. Work is currently being carried out in implementing values assessment within the medical staff appraisal system.

The assessment of values and expected behaviours are being effectively incorporated into our recruitment and selection processes and practice changes are currently being reflected in the relevant training programme(s) and within key branding, recruitment and selection documentation.

Following some really useful feedback from our new starters we reviewed and improved our corporate and local induction programme, aligning it to our values. The new programme has been very well received, improving the impression new staff have about our organisation.

Engaging with our medical staff has also been a key priority and to help with this we have taken part in some medical engagement research with Warwick University and the National Institute for Innovation and Improvement. A new way forward developing a dynamic model of engagement interventions for these staff has been agreed, which includes a quarterly forum where our executive team and consultant colleagues can meet and share ideas and approaches.

In January 2011 we started local quarterly staff polling for the first time ever. This will help us to gather more frequent data to share thinking around what matters most to our staff. To coincide with employee survey best practice we will survey all of our staff during the course of a year. We are currently in the process of collating and analysing data from our first survey and over the coming months we will report key findings back to our staff and celebrate and share areas of best practices as well as act appropriately with interventions to continuously improve the staff experience across the trust.

Leadership development

Our Leadership Academy provides a range of services to improve staff engagement and performance, share best practice as well as offering bespoke interventions to meet the changing requirements of the trust. The academy is our centre of excellence for leadership and contributes significantly in developing the workforce.

Our leaders have a crucial role to play in transforming the services we currently provide to ensure the delivery of the best quality healthcare to the population we serve. During the year, we have started a set of crucial actions to support our leaders, which include the development of a set of leadership competencies and behaviours that coincide with the delivery of the trust's vision and values. Over 300 of our senior leaders have taken part in a 'Leadership Excellence' development programme, which included 360 feedbacks and coaching. We recently launched a similar programme for our level 4 leaders, called the Clinical Leadership Development Programme.

We're really pleased that our new 'Performance Excellence' development initiative has been designed in such a way, to provoke debate and share thinking around embedding values and behaviours.

Learning and development

We have an enviable reputation locally and nationally for our commitment to staff development as well as the quality and range of education, training and development we offer and deliver. This is evidenced by our continuing ability to meet and exceed standards required for accreditation at national and local level.

Our training service provides a range of vocational qualifications in various subject areas including health, health and social care, customer service, business administration, leadership and management and training and assessment. Vocational and work-related qualifications, such as the NVQs (National Vocational Qualifications), have changed to become more responsive to the demands of employers and learners based on a new framework for vocational qualification known as the Qualifications and Credit Framework (QCF). During the year, we have successfully updated our internal vocational qualification programmes to meet the revised national occupational standards, based on the new framework. The updated qualifications will be more accessible to a wider range of staff and more relevant to staff and the needs of our organisation.

Appraisal is integral to staff development and our national 2010 staff attitude and opinion survey findings demonstrate a continued improvement in the number of staff reporting that they had an appraisal. In 2009 87 per cent of our staff received an appraisal and that rose to 91 per cent in 2010. Our score of 91 per cent was in the highest (best) 20 per cent when compared with trusts of a similar type and only 1 per cent below the best 2010 score (92 per cent) for acute trusts.

We are the first NHS based approved training provider nationally to offer apprenticeship frameworks in Health, Health and Social Care and Customer Service. An apprenticeship framework comprises of an NVQ, technical certificate and key/ functional skills. Skills for Health have mapped 80 apprenticeship frameworks to over 200 NHS jobs and we are working closely with other local training providers on the delivery of a range of frameworks.

During the year we saw first-hand how apprenticeships enabled young people to develop new skills and realise their potential. They are a fantastic way of creating a skilled, motivated and loyal workforce. We have recruited young apprentices into a range of areas including accident and emergency, occupational therapy, neonatal and midwifery, facilities, human resources, health and safety, ophthalmology and other ward areas. The managers that have employed the apprentices are finding that training them is more cost effective than hiring skilled support staff, leading to lower overall training and recruitment costs.

Work experience is a vitally important experience for young learners and is a great way for us to raise our profile and provide opportunities for future recruitment. During the year we implemented a Health Ambassadors Project and recruited and prepared over 40 health workers from across Leicester, Leicestershire and Rutland to act as ambassadors for NHS careers in schools and colleges. During the year, we achieved accreditation to deliver the City and Guilds 7300 'Introduction to Trainer Skills' award and offered this training to all ambassadors, for development purposes.

In July 2010 we received an award from the Leicestershire Education Business Company at their annual celebration event, for our commitment to developing careers and work experience in schools and colleges.

Reward and recognition (including staff awards)

We recognise that our staff are our most valuable resource and are key to the delivery of high quality services for the benefit of the population of Leicestershire, Leicester and Rutland.

The vast majority of our staff are on national NHS pay, terms and conditions which include a comprehensive set of employment policies and procedures. However, it is also important that we recognise our staffs successes, innovations, quality and exceptional work for patients.

In 2010 we held the very successful annual awards ceremony for staff. As it has done in previous years, staff nominated colleagues in seven categories, identifying best practice, innovative developments, exceptional work to improve and advance the way we do things, or just for when they go the extra mile.

The categories of 'Teach, invent, inspire'; 'leadership', 'trust achievement'; 'Caring at its best'; 'unsung hero' and 'team' award were joined by a new category - Hospital Hero – where members of the public could nominate staff.

The awards this year went to individuals such as the CLIC Sergeant support and activity co-ordinator for her exceptional work with children and young people with cancer and the domestic training team for their work in training domestic staff to high cleaning standards set by the British Institute of Cleaning Science (BICS). The event held at the Tiger's to present the winners with their awards was a huge success.

We have developed a reward and recognition strategy which is a result of a thorough assessment and prioritisation process that supports our strategic plan in the move towards FT status. We need to consider how the broader reward elements can be used in delivering services in accordance with our vision and values by recognising and rewarding the achievement of our talented, dedicated and professional staff.

The strategy sets out what reward should look like in our organisation and what this will include in the future. In short, it shows how our staff will be rewarded for the delivery of high quality services, working together for better patient care. This is not just about basic pay, we need to look at variable payments; benefits; employee recognition; development of skills and career opportunities.

We must consider the link between reward and performance within the context of the financial climate which we are now operating in, and be imaginative in how recognition can be incorporated and managed as part of a total reward package. As part of the strategy we will:

- explore the development of flexible pay options for staff within their current remuneration
- review variable payments such as overtime to ensure that we are using employed staff efficiently and effectively
- review the provision of NHS benefits schemes and ensure that these are communicated effectively to all staff
- through staff focus groups, ensure that recognition and opportunities for staff are attuned to their views, and
- further develop options for recognising contribution, innovation and quality through a range of events and processes.

Members

We are a membership organisation with over 12,000 public members. In addition to their involvement in our annual public meeting, members are also offered opportunities to get more involved in the work of the trust. For example, members attended dedicated events during our FT consultation exercise, and have recently participated in surveys relating to our discharge processes, stroke awareness and the development of our new web site. Our monthly “Medicine for Members” events have also been used to involve members in the development of patient information, and to keep them informed of our other initiatives. We have also kept our members up to date with a quarterly magazine, which provides information on new developments and opportunities to get more involved.

We focus on what matters most

Preserving the privacy and dignity of our patients

During the year all our clinical teams have worked hard to ensure that our patients are treated with privacy and dignity as part of this important patient experience agenda.

During the year we have improved the access and quality of the environments we provide for staff, patients, relatives and carers. As part of this we have created a dignity retreat room

near the reception in our Windsor Building at the Royal Infirmary, with the support of Leicester Hospitals Charity. Patients, families and staff have seen some real benefits from upgrading and developing rooms like these. For example these rooms provide an extremely private, calm and relaxed area, free from distraction, for families to



hear to information about end of life care for their relatives. This is crucial in preserving privacy and dignity and improving the patient experience. The area can also be used by health care staff for consultations.

A second dignity retreat room is being developed on ward 38 at the Royal Infirmary and a plan is underway for us to develop more retreat rooms across our hospitals.

Providing same sex accommodation

We are pleased that we are compliant with the Government's requirement to eliminate mixed-sex accommodation, except when it is in the patient's overall best interest, or reflects their personal choice.

We have the necessary facilities, resources and culture to ensure that patients who are admitted to our hospitals will only share the room where they sleep with members of the same sex, and same-sex toilets and bathrooms will be close to their bed area. Sharing with members of the opposite sex will only happen when clinically necessary (for example where patients need specialist care, equipment or facilities such as in intensive care or high dependency units, or when patients actively choose to share, such as haemodialysis units).

If our care should fall short of the required standard, we will report it. We also have an audit mechanism to make sure that we do not misclassify any of our reports. We will publish our reports on Unify.

Patient safety and saving lives will always be our priority however the provision of same-sex accommodation is now fully available across the trust.

Infection control

We have continued to work hard to maintain our success at reducing healthcare acquired infections (HCAI). Our targets set for the year were that we had no more than nine cases of MRSA bacteraemia (we had 12) and no more than 212 patients newly identified with *Clostridium difficile* (CDiff) (we had 200).

For comparison, in the previous year 2009/10, our targets were no more than 41 cases of MRSA bacteraemia and 340 patients newly identified with CDiff. Our actual achievement in 2009/10 was much lower than these targets with only 19 patients with MRSA and 236 patients with CDiff.

In 2011/12 we've been set a targets of no more than nine patients with MRSA bacteraemia and no more than 165 patients with CDiff.

These figures, prescribed by the Department of Health, will be very challenging for us to meet. Every year hospitals have been required to demonstrate reductions in these figures, but we have no way of knowing when the lowest numbers achievable will have been reached as not all patient infections can be prevented. However, we have been able to demonstrate a continued reduction in these infections in our hospitals up to now.

Results showed that 95 per cent of our staff consistently followed our hand hygiene policy. That means that all staff who have clinical contact with patients followed the 'bare below the elbow' policy for and all of our healthcare staff should follow our hand hygiene policy.

We complete thorough investigations of any cases of MRSA and CDiff which are recorded on their death certificate to make sure that we learn lessons and that they're fed back to ward teams for them to translate into actions.

We have appointed a CDiff liaison nurse who visits newly identified patients daily across our three hospitals and supports the clinical teams in managing these patients. Each patient's treatment is reviewed weekly by a multi-disciplinary team to ensure that there is specialist input into their care. Ward teams are subsequently supported by the Infection Prevention Team as well. This is in line with the Department of Health recommendations found in '*Clostridium difficile* infection - How to deal with the problem' (Jan 2009)

We have introduced MRSA screening for both elective (planned) and non-elective (emergency) patients in accordance with the Department of Health guidance. This has been done in collaboration with our local commissioners and infection prevention specialists from the Health Protection Agency (HPA) and local PCTs.

By the end of March 2011 all of our clinical staff will have been trained in the aseptic non-touch technique (ANTT). This is a technique that aims to prevent the contamination of wounds and other susceptible sites, by ensuring that only uncontaminated equipment, referred to as 'key parts' or sterile fluids come into contact with susceptible or sterile body sites during clinical procedures. Assessments relating to performance will form an element of on-going monitoring throughout the coming year (2011/12).

We have two antimicrobial pharmacists who provide expert guidance to our clinicians and we monitor antibiotic prescribing against our local antibiotic policies. From discussions our microbiologists and anti-microbial pharmacists hold with other NHS trusts, we believe we have one of the most robust prescribing policies currently in place in England.

The cleanliness of our environment is very important to us. We monitor our environmental cleanliness against compliance cleaning standards and aim to complete a deep/ steam cleaning programme across our hospitals. This programme takes up to two years to complete in a trust of our size. We have introduced minimum cleaning frequencies across our hospitals in line with national guidance. Patient Environment Action Team (PEAT) inspections are carried out on a quarterly basis, and we have excellent results cleanliness in our three hospitals.

Making sure we have clean equipment and instruments is of course a priority and we closely monitor the process through an audit programme that links to the national decontamination guidelines. During 2011 we will be opening a new decontamination facility based at the Meridian Business Park. We will be able to send our instruments to a 'state of the art' facility for re-processing, ensuring all our hospitals are able to demonstrate compliance with 'best practise' guidance from the Department of Health.

Our infection prevention team continues to work with clinical colleagues to embed good infection prevention practise at ward level. Our nursing teams record our compliance by our and elements of these are included in our infection prevention surveillance programme.

In 2009 the Commissioning for Quality and Innovation scheme at the Department of Health introduced a surveillance programme. Our infection prevention team continues this work and we are already seeing quality outcomes for our patients as a result of this work, which will of course continue into 2011/12. We have been advised that our programme is one of the most developed in England by the Matching Michigan project team. This is an initiative that has been rolled out to trusts in England, and seeks to support clinicians in reducing central venous catheter associated blood stream infections that can occur in patients.

Finally, our infection prevention team were pleased to receive a Healthcare Associated Technology award from the Department of Health for our success in reducing MRSA and CDiff infections. The award funding has helped us install new electronic patient management system, which will provide the infection prevention team with an invaluable resource to help us to continue to keep patients safe in our hospitals.

Safeguarding adults and children

We work hard to provide the highest possible standards of care for all patients in a safe, secure and nurturing environment, this is particularly important for our most vulnerable of patients. Over the past year a lot of work has been done to build on our existing child and adult safeguarding practices. The focus has expanded from protection to a much wider remit of developing services to provide early intervention and support to people at risk from

abuse. We work closely with partner agencies including NHS partners, social care, police and voluntary organisations to develop initiatives.

Over the past year all of our staff received training in safeguarding adults and children, and we have made sure that our new staff receive safeguarding training during their induction period.

We've had positive external reviews from NHS East Midlands and the Care Quality Commission and we have continued full registration with the Care Quality Commission which included evidencing the work done in safeguarding.

Our district has been recognised as an exemplar for best practice with partners in relation to deprivation of liberty safeguard referrals and we have a named nurse for safeguarding adults who has raised the profile of adult safeguarding practice by providing access to local expertise in all of our hospitals.

We have integrated child and adult safeguarding services through the creation of a head of safeguarding post and the development of infrastructure to support this. This structure has meant that we have been able to strengthen our systems for sharing information between hospital and community services through a review of liaison services in community midwifery and hospital services.

We publicly declared our compliance to provide assurance on our systems, process, policies, training, governance and resource arrangements for child safeguarding practice and have continued to be part of a range of multi-agency safeguarding across Leicester, Leicestershire and Rutland boards.

We have reviewed the reporting mechanisms used within the organisation to record safeguarding incidents and integrated information received from complaints and incidents to ensure that any incidents about safeguarding raised are investigated and that we learn lessons through the process.

We recognise the importance of seeking to continually improve the services we provide to safeguard children and adults and over the next year we plan to complete a number of initiatives to support this. These include:

- using markers of best practice quality indicators for adult and child safeguarding practice;
- doing peer review audits with a partner NHS hospital trust to share and build upon best practice in safeguarding, and
- raising public awareness about safeguarding practice through the introduction of public awareness events.

The chaplaincy

The chaplaincy at Leicester's Hospitals is an integral part of the care that is 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 chaplaincy team consists of three full-time chaplains and ten 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 chaplaincy team has made bedside visits to over 14,000 patients, in some cases supporting an individual many times during their hospital admission. They have offered religious support to many of these, perhaps in a simple prayer or a religious ceremony.

Chaplaincy is a valuable part of our commitment to deliver "care 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, death, meaning and purpose - questions that can be acutely highlighted by illness and suffering.

We provide an emergency out-of-hours service which is there to particularly support patients who are approaching death and are called to support relatives after a death has taken place, sometimes in very traumatic circumstances. We provide a simple funeral service for those who have lost a baby.

Patients and relatives have access to multi-faith chapels and prayer facilities on each of our hospitals sites, and one to one pastoral support for staff also takes a prominent place.

Our chaplaincy will continue to work hard to deliver a 24 hour service providing high quality emotional, spiritual and religious support to patients and staff, of all faiths and none.

"A big Thank you" for the lovely service today at Gilroes for our baby. It was the most kindest few words anyone has said to our daughter since the horrible nightmare happened. This is all we needed - some understanding as to how we are all feeling.

The words of a mother following a funeral led by a chaplain

Sustainability

We have a large and complex site configuration, with our oldest building dating back to 1771. The fact that this building is still being used demonstrates the approach we take to sustainability where practical, albeit with modernisation to ensure suitable accommodation is provided.

Sustainability has been one of our objectives for a long period, and has involved all aspects of our site planning and service provision. We endeavour to establish a culture of environmental and social responsibility for our actions, and service efficiency, which combined create a sustainable provision of healthcare for the population we serve.

We report on three major elements linked with a sustainable healthcare provision, they are

1. estates developments – indicating how we are changing the estate for clinical care to continuously offer sustainable expertise in our treatment areas.
2. energy and carbon management – continuous improvement is vital to ensure that our CO₂ emissions are controlled and minimised, with financial benefits from this being redeployed into further improvements and patient care.
3. Waste minimisation and management – by ensuring we manage our waste generation and disposal streams and minimise the use of natural resources.

Estate developments

Some large and significant investments have taken place, with the completion of our hospital sites this year. The £9.3m state of the art neonatal unit at the Royal Infirmary was completed in September 2010, the four innovative £6.2m orthopaedic theatres at the General in November 2010, the installation of a new £2.3m research MRI scanner at Glenfield, the £1m refurbishment of two linear accelerator rooms at the Royal Infirmary and the opening of the biomedical research unit at Glenfield in September 2010. This international class cardio respiratory research was a collaboration between ourselves and the Medical School at the University of Leicester.

In another collaboration with the University of Leicester we are constructing an ambitious £12.6m extension to the Clinical Sciences Wing at the Glenfield. The cardio vascular research centre will be completed in 2012 and will house the Leicester Biobank, the cardiovascular research unit, the clinical research informatics unit and the data to knowledge unit.

As well as these exciting developments many smaller projects have been completed ranging from floor replacements to electrical infrastructure replacements, with a combined cost of £5.7m, all centred on ensuring the hospitals can support the clinical care required for our patients.

Energy and carbon management

Having three very busy hospitals that are open 24 hours a day 365 days a year means we are a very large user of energy. We therefore take the need to reduce the amount of energy we use seriously, from both an economic perspective and to reduce the carbon emissions we generate.

We have implemented some substantial capital projects this year and with all of them we have made sure that energy saving initiatives are incorporated into them. We have an on going program of replacing old lighting fittings and tubes with high efficiency units, along with motion detection where appropriate.

In advance of the start of the Carbon Reduction Commitment (CRC) in April 2012, we have installed remote meter reading which feeds into a data collection system. This allows us to

monitor key energy usage on a half hourly basis and make informed decisions on future investments.

Unfortunately during the year we had failures with three of our six combined heat and power units (CHP). We are currently doing studies on to decide the optimum replacement strategy. We generate our own electricity at the Royal Infirmary and Glenfield hospital sites by running these CHP units, which burn gas in modified diesel engines. These power alternators produce electricity and we use the heat generated from these engines for heating and hot water.

This loss, along with the increased patient activity and the new equipment installed requiring environmental temperature control has affected our energy performance this year.

Description	2009-2010	2010-2011	Changes	
Gas Usage (KWh)	93,697,272	96,694,476	2,997,204	3.20%
Electrical Usage (KWh)	36,426,819	39,489,130	3,062,311	8.41%
Totals (KWH)	130,124,091	136,183,606	6,059,515	4.66%
Costs (£)	5,136,734	5,282,765	146,031	2.84%
CO2 Emissions (tonnes)	36,910	39,236	2,326	6.30%

Within our capital plan we are allocating a separate funding stream for carbon emission reduction schemes. Initially the first two years are targeted on replacements for the CHP units we have currently have with new ones being optimally sized and located to ensure maximum advantage is gained from them. In conjunction with this we are continuing to systematically replace lighting units and controls and will be changing pump and fan motors and controllers.

By focused investments we aim to reduce our direct CO2 emissions by at least 3 per cent every year over the next five years. As well as doing this we are also working with the supply chain to reduce the carbon emissions from our purchases, which the NHS Sustainability Unit calculates to be approx 60 per cent of the emissions attributable for an NHS organisation.

Waste minimisation and management

We have successfully introduced various initiatives to reduce the waste we generate and to optimise the ability to recycle the waste we dispose of.

We use the services of a local contractor for our general waste who sort through the collections within their facilities and is able to recycle 85 per cent of the 388 tonnes of waste we produced this year. This method avoids the need for us to segregate our waste on our hospital sites where we do not have the space available to do it.

Where we do have space on our site for segregating waste we carry out “primary recycling”. During the year we collected 102 tonnes of paper, glass, metals, cardboard and electrical equipment. This was directly disposed of by recycling organisations.

Waste arising from our clinical activities has strict disposal routes for us to comply with set by the Environmental Agency's (EA). There are two routes that we use, incineration for the classification directed by the EA and "alternative treatment" which allows the resulting sterile process output to be used in some manufacturing processes. 75 per cent of the 1,850 tonnes of clinical waste generated during the year was disposed of through the alternative treatment route.

Our priorities for 2011/12

Whilst 2011/12 will be a challenging year, we have a strong track record of delivery. This coupled with the ambition and commitment of our staff puts us in a strong position to deliver our annual plan in 2011/12. these are our priorities:

- Improving the experience patients have of our hospitals so that we are rated in the top 20 per cent of trusts for patient experience
- Making some fundamental changes to our emergency department in order to improve our response to the demands placed upon this department
- Achieving designation for the provision of Paediatric Congenital Cardiac Services
- Investing in our neonatal, paediatric and maternity services
- Making the best use of our staff and resources through the redesign of patient pathways and transforming our workforce
- Investing in our centres of excellence for research and development
- Progressing the Pathology joint venture, promoting partnership working with Nottingham University Hospitals NHS Trust and the commercial sector
- Successful delivery of a £38m cost improvement programme that does not impact on the quality of care our patients receive
- Delivery of £1.3m surplus against an operating income of £695m and an expenditure plan of £693m
- Increasing our cash balance to £25m
- Delivering a capital investment programme of £44m to improve services and facilities
- Becoming authorised as an NHS Foundation Trust by April 2012.

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
Mrs K Jenkins (from 1 July 2010)	Non-Executive Director	Employed by Citi Group
Mr R Kilner	Non-Executive Director	Member of the Patient Group for Countesthorpe Health Centre Director of Deltex Consulting Ltd
Mr P Panchal (from 1 July 2010)	Non-Executive Director	Board member of the Akwaaba Ayeh Mental Health Project; Company Secretary of the Leicestershire Ethnic Minority Partnership Ltd (charity)
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	Non-Executive Director	Board Chair, Leicestershire and Rutland Probation Trust
Professor D Wynford-Thomas	Non-Executive Director	Trustee, Hope Foundation; Dean of the University of Leicester Medical School
Mr M Lowe-Lauri	Chief Executive	Trustee, Thomas Cook's Children's Charity; Members, NIHR Advisory Board; Director, NIHR RISC Programme (honorarium paid to UHL); member, Life Science Innovation Delivery Board; member, HEFCE Health Education Advisory Committee; Chair, East Midlands Collaboration in Management Sciences; Chair, Scientific Advisory Board, NIHR Safety and Service Quality Research Centre, Kings College Hospital
Ms K Bradley	Director of Human Resources	None to declare
Dr K Harris (Acting Medical Director prior to May 2010)	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 A Tierney	Director of Strategy	None to declare
Mr A Seddon	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 2009-10 annual report and accounts. The first joint event was with NHS Leicestershire County and Rutland at Loughborough Town Hall on Tuesday 31 August 2010. The second joint event was with NHS Leicester City at the Walkers Stadium in Leicester on Thursday 30 September 2010. 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

This year was another challenging year both financially and clinically. I am pleased to report that, for the eleventh year in succession we have met our financial duties and delivered a breakeven position.

We provide hospital and community based healthcare services to patients across Leicester, Leicestershire and Rutland and specialist services to patients throughout the UK. As such, our main sources of income are derived from PCTs, the National Specialised Commissioning Group and education and training levies. We are actively engaged with key stakeholders to implement NHS policy to improve health services in the local area through a range of formal and informal partnerships. 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 31 March 2011

We met its financial and performance duties for 2010-11:

- **Balancing the books** - delivery of an income and expenditure surplus of £1m prior to a technical impairment charge of £3.6m due to the valuation of the Trust's new buildings which have come into use.
- **Managing cash** - undershot the external financing limit by £3.3m which is permissible.
- **Investment in buildings, equipment and technology** - invested £28.2m in capital developments.
- **Invoice payment performance** - 95% of our invoices in value terms were paid within 30 days.

Performance against our financial plan

We delivered a surplus of £1m as planned, with total revenue of £696.3m (£4m over plan) and total expenditure of £695.3m (£4m over plan). Further details of our income and expenditure are shown in the table overleaf.

Summary Statement of Comprehensive Income for the year ended 31 March 2011

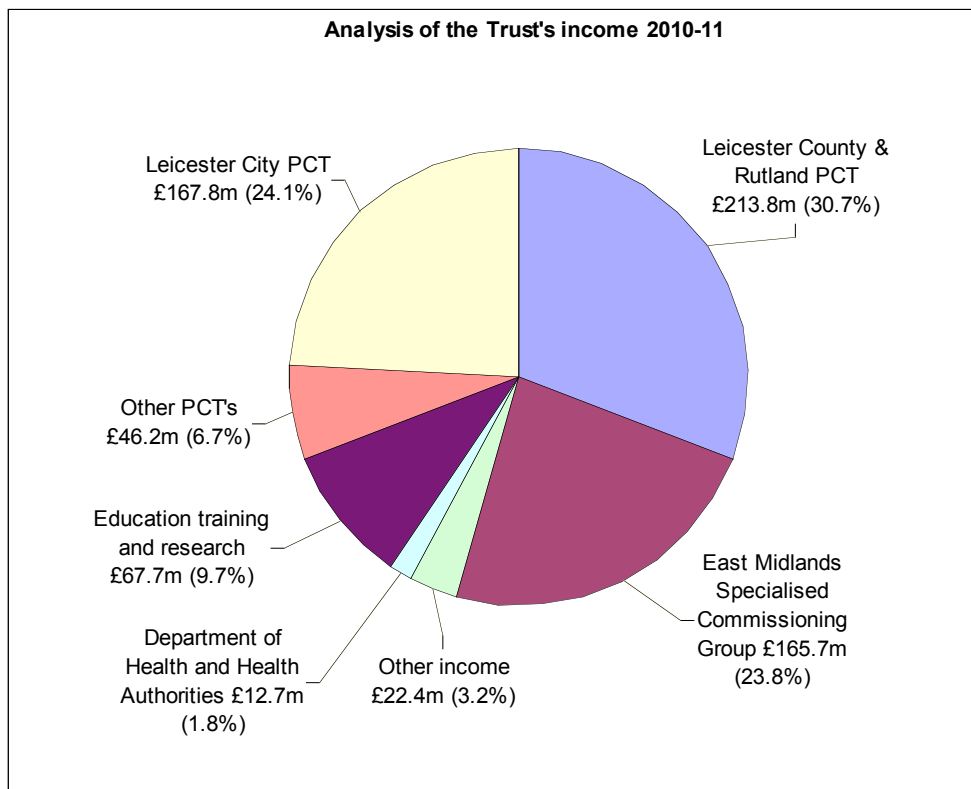
	2010-11 £m	2009-10 £m
Total revenue	696.3	697.7
Operating expenses	(685.1)	(687.8)
Operating surplus	11.2	9.9
Total finance costs	(0.4)	(0.5)
Surplus for the financial year	10.8	9.4
Public dividend capital dividends payable	(13.3)	(13.3)
Retained surplus/(deficit) for the year	(2.5)	(3.9)
Impairments	3.5	4.0
Reported NHS financial performance position	1.0	0.1

Key financial indicators

Our income 2010-11

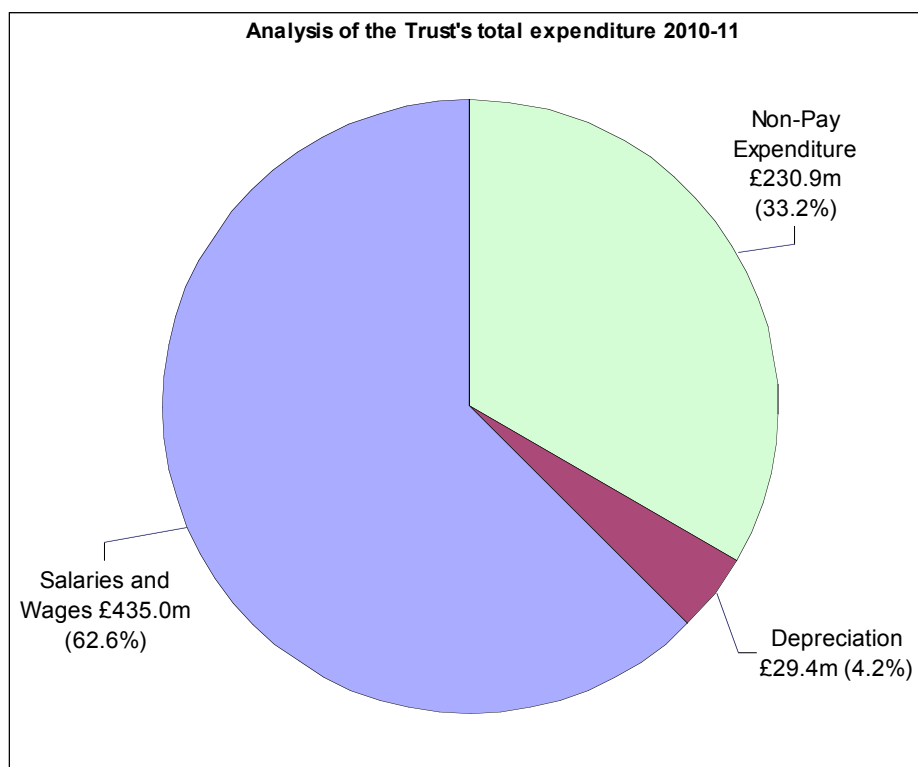
The chart overleaf details the £696.3m of income we received. This is a £1.4m decrease from the £697.7m received in 2009-10, reflecting:

- increased PCT income of £13.8m
- reduced income of £2m from SHAs, as a consequence of a substantial increase of £4.6m in 2009/10 due to increased ECMO activity, a direct consequence of the Swine Flu (H1N1) outbreak;
- reduced education, training and research income of £1.2m due to decreased training numbers and a reduction in flexibility and sustainability funding for research and development;
- decreased other revenue of £13.2m primarily due to the £10.75m received from the Department of Health in 2009-10 in relation to compensation in relation to the PFI scheme; and
- other reductions of £1.25m.



Our expenditure 2010-11

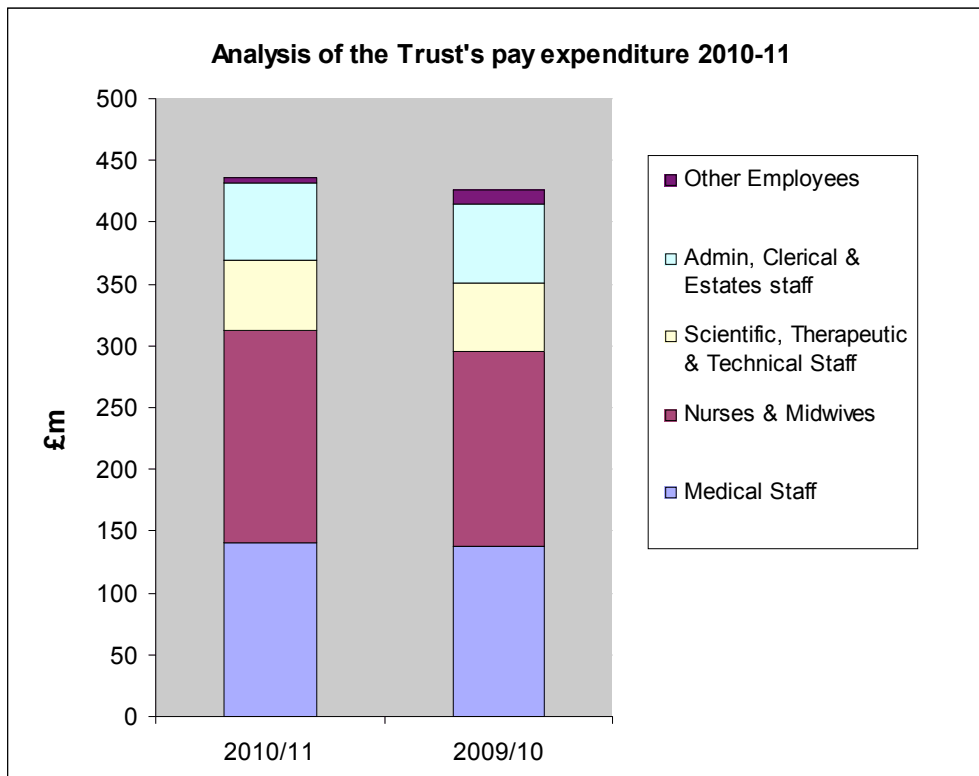
Our total expenditure (excluding impairment) decreased by £2.3m (0.3 per cent) to £695.3m. The chart below details the breakdown of our total expenditure.



Pay expenditure by staff group

The chart below shows what we spent on pay during the year. It increased by £8.6m (2 per cent) to £435.0m over the 2009-10 total of £426.4m. This increase is due to a number of factors including:

- national pay awards;
- incremental drift and impact of Agenda for Change;
- clinical excellence awards, both national and local;
- consultant scale progression;
- delivery of cost improvement programmes;
- costs of putting on additional capacity in order to meet activity targets; and
- increased use of non-NHS salaries, especially agency staff to support increased patient activity particularly over the winter months.

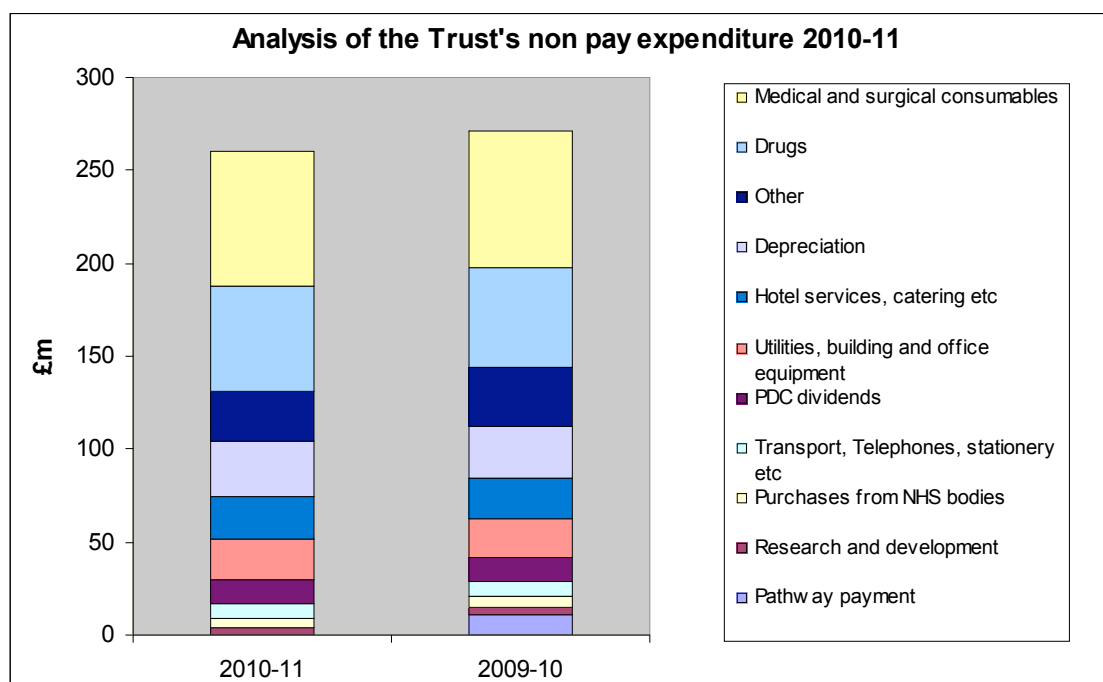


Non-pay expenditure

The chart below shows our non-pay expenditure for 2010-11 which was £260.3m, a £11.1m (2.8 per cent) decrease over the 2009-10 total of £271.4. This overall decrease is due to a number of factors including:

- an increase of £8.6m (3.3 per cent) due to inflation and increases in activity volume as the Trust treated 9,000 more patients in 2010-11 than in 2009-10, a 0.8 per cent increase;

- a decrease of £10.7m (4.1 per cent) due to cost improvement efforts through better materials management, the introduction of category management and increased clinical engagement in procurement;
- a significant decrease in other expenditure as a result of the £10.8m (4.1 per cent) compensation payment in 2009-10 in relation to the PFI scheme; and
- other increases of £1.8m including a £2.0m increase in depreciation offset by a £0.2m decrease in finance costs.



We revalued buildings in 2010-11 resulting in a £3.5m technical impairment which has been charged to expenditure.

Working capital balances

We planned to reduce our cash holdings by £2.3m by the end of March 2011, which we have achieved with an actual cash balance of £10.3m at the year end.

Our debtors position decreased by £14.5m in 2010-11, primarily due to the inclusion in 2009-10 of the £10.75m PFI settlement funding receivable from the Department of Health. 2010-11 has also seen improvement in our performance on debt recovery.

Our creditor position has decreased by £14.3m in 2010-11. The underlying creditor position has been maintained with us continuing to achieve the Better Payment Practice Code performance of 95 per cent of invoices paid within 30 days. The decrease in creditors is primarily due to the inclusion in 2009-10 of £10.75m in relation to the Pathway PFI project.

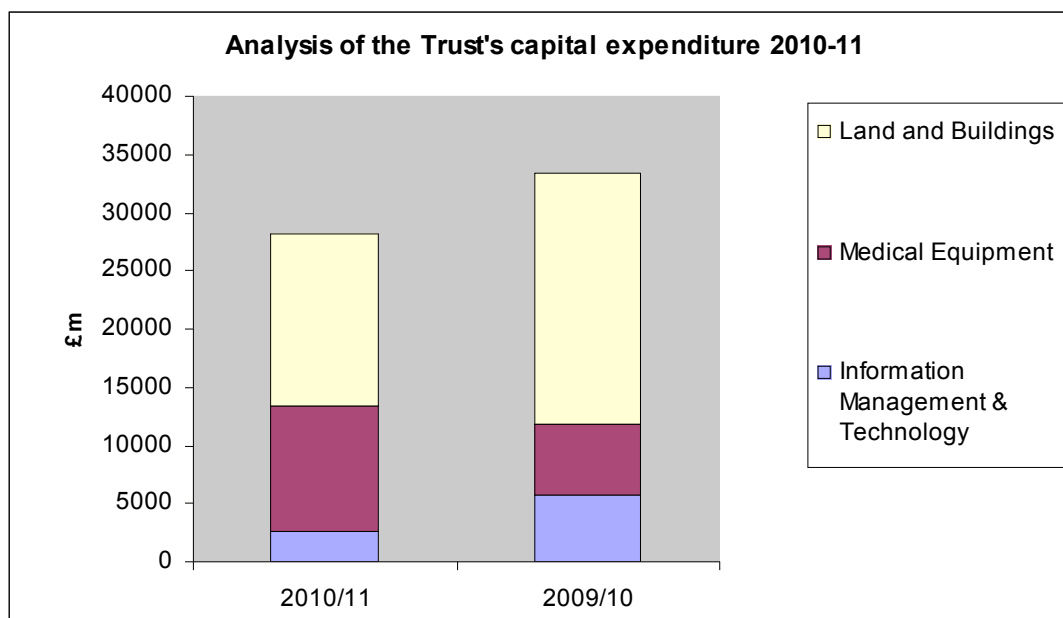
A further analysis of our assets and liabilities is given in the table overleaf.

Summary Statement of Financial Position as at 31 March 2011

	31 March 2011 £m	31 March 2010 £m
Total non-current assets	424.1	426.4
Total current assets	45.0	62.0
Total assets	469.0	488.4
Total current liabilities	(18.9)	(14.2)
Total assets less current liabilities	405.1	412.2
Total non-current liabilities	(5.4)	(9.2)
Total assets employed	399.7	403.0
Financed by: Total taxpayers' equity	399.7	403.0

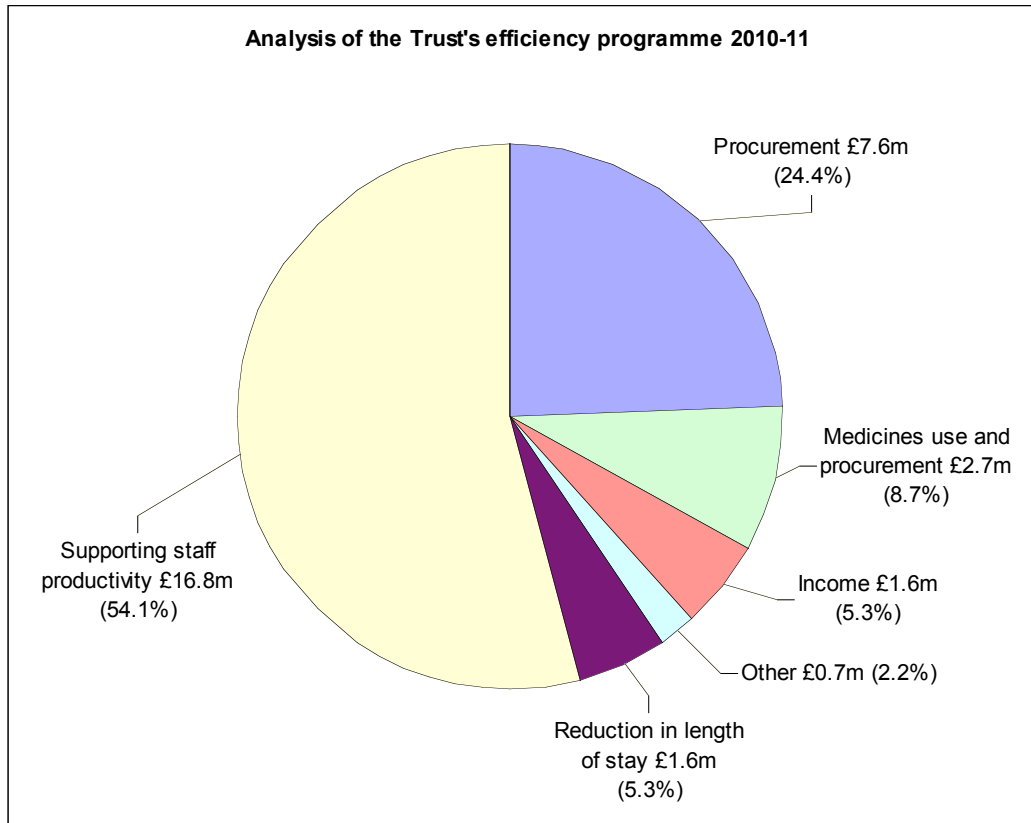
Capital expenditure

We spent £28.2m against a capital plan of £29.0m, detailed in the chart below.



Our efficiency programme 2010-11

We delivered a £31m cost improvement programme during the year. The major components of the delivery of the programme are outlined in the chart overleaf. All schemes were clinically derived and risk assessed prior to implementation, and were delivered as part of our focus on productivity whilst maintaining high quality patient services.



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.

As in 2010-11, 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 that there will be even greater focus on efficiency and effectiveness over the months and years ahead. We have already identified that delivering greater efficiency while continuing to provide excellent clinical services is one of our top priorities. In 2011-12, we have set a challenging efficiency target of £38.2m (representing 5.5 per cent of turnover) which includes schemes in the following key areas:

- buying goods and services
- length of stay reduction
- administration and "back office" efficiency.

We are making a significant investment in new assets and infrastructure in 2011-12 with a £24.5m capital programme. Key planned developments include:

- £1.5m to improve the Emergency Department;
- £2.0m to refurbish theatres at the General hospital, including the centralisation of elective orthopaedics
- £0.8m to expand the Glenfield hospital paediatric heart surgery unit ready to become a regional heart surgery centre; and
- £1m to improve carbon management.

In addition, we will be spending £19.2m on other essential building and equipment expenditure.

There will also be continued focus in 2011-12 on our FT application.

Foreword to the accounts

University Hospitals of Leicester NHS Trust

These accounts for the year ended 31 March 2011 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 2010-11 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 2011

	2010-11 £000	2009-10 £000
Revenue		
Revenue from patient care activities	606,135	593,769
Other operating revenue	90,122	103,923
Operating expenses	<u>(685,085)</u>	<u>(687,829)</u>
Operating surplus	11,172	9,863
Finance costs:		
Investment revenue	70	82
Finance costs	<u>(459)</u>	<u>(616)</u>
Surplus for the financial year	10,783	9,329
Public dividend capital dividends payable	<u>(13,325)</u>	<u>(13,321)</u>
Retained surplus/(deficit) for the year	(2,542)	(3,992)
Other comprehensive income		
Impairments and reversals	(194)	(13,886)
Gains on revaluations	0	12,309
Receipt of donated/government granted assets	486	175
- Transfers from donated and government grant reserves	(781)	(816)
- Release of other reserves	<u>(272)</u>	<u>0</u>
Total comprehensive income for the year	(3,303)	(6,210)

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2011

	31 March 2011	31 March 2010
	£000	£000
Non-current assets		
Property, plant and equipment	417,069	420,157
Intangible assets	5,119	4,481
Other financial assets	0	0
Trade and other receivables	1,878	1,774
Total non-current assets	424,066	426,412
Current assets		
Inventories	11,923	12,213
Trade and other receivables	22,722	37,263
Other financial assets	0	0
Cash and cash equivalents	10,306	12,495
Total current assets	44,951	62,971
Total assets	469,017	488,383
Current liabilities		
Trade and other payables	(59,556)	(73,851)
Borrowings	(3,649)	(1,203)
Provisions	(667)	(1,146)
Net current assets liabilities	(18,921)	(14,229)
Total assets less current liabilities	405,145	412,183
Non-current liabilities		
Borrowings	(3,237)	(6,442)
Provisions	(2,232)	(2,762)
Total assets employed	399,676	402,979
Financed by taxpayers' equity:		
Public dividend capital	273,903	273,903
Retained earnings	8,204	11,301
Revaluation reserve	108,683	108,128
Donated asset reserve	7,938	8,389
Government grant reserve	948	986
Other reserves	0	272
Total Taxpayers' Equity	399,676	402,979

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2011

	2010-11 £000	2009-10 £000
Cash flows from operating activities		
Operating surplus	11,172	9,863
Depreciation and amortisation	29,383	27,373
Impairments and reversals	3,555	4,043
Transfer from donated asset reserve	(743)	(778)
Transfer from government grant reserve	(38)	(38)
Interest paid	(385)	(599)
Dividends paid	(13,325)	(13,321)
(Increase) / decrease in inventories	290	(1,699)
(Increase) / decrease in trade and other receivables	14,369	(13,659)
Increase / (decrease) in trade and other payables	(12,666)	19,777
(Decrease) in provisions	(1,080)	(2,715)
Net cash inflow from operating activities	30,532	28,247
Cash flows from investing activities		
Interest received	67	85
Payments for property, plant and equipment	(27,982)	(33,836)
Payments for intangible assets	(1,357)	(1,510)
Net cash (outflow) from investing activities	(29,272)	(35,261)
Net cash inflow / (outflow) before financing	1,260	(7,014)
Cash flows from financing activities		
Public dividend capital received	0	6,023
Other capital receipts	0	175
Capital element of finance leases and PFI	(3,449)	(1,917)
Net cash inflow / (outflow) from financing	(3,449)	4,281
Net (decrease) in cash and cash equivalents	(2,189)	(2,733)
Cash and cash equivalents at the beginning of the financial year	12,495	15,228
Cash and cash equivalents at the end of the financial year	10,306	12,495

Management costs

	<u>2010-11</u>	<u>2009-10</u>
Management costs	24,148	23,421
Income	696,257	697,692
Percentage of income	3.5%	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. The Trust's compliance with this policy is shown below:

Non-NHS Payables	<u>£000s</u>	<u>Number</u>
Total non-NHS trade invoices paid in the year	420,823	125,435
Total non-NHS trade invoices paid within target	399,899	117,230
Percentage of non-NHS trade invoices paid within target	95%	93%

NHS Payables

Total NHS trade invoices paid in the year	64,821	5,034
Total NHS trade invoices paid within target	60,684	4,465
Percentage of NHS trade invoices paid within target	94%	89%

Audit Fees

Our external auditor for statutory audit and services during 2010-11 was KPMG LLP. The Audit Commission appointed KPMG LLP as our external auditors in 2000. We spent a total of £340,000 on audit services in 2010-11, including total payments to KPMG LLP of £288,000 for statutory audit services.

Pension liabilities

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 the Trust's 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.

Charging for information

We comply with the Treasury's guidance on setting charges for information in line with the HMRC's 'Managing Public Money'.

Salary and pension entitlements of senior managers

Name and Title	2010-11			2009-10		
	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	210-215	0	0	210-215	0	0
S Hinchliffe, Chief Operating Officer	160-165	0	0	155-160	0	0
K Bradley, Director of Human Resources	120-125	0	0	120-125	0	0
Professor D Rowbotham, Director of Research & Development	20-25	200-205	0	20-25	195-200	0
S Ward, Director of Corporate & Legal Affairs	100-105	0	0	100-105	0	0
M Wightman, Director of Communications	95-100	0	0	100-105	0	0
Kevin Harris, Acting Medical Director (from 19.01.10)	35-40	170-175	0	5-10	40-45	0
A Seddon, Director of Finance and Procurement (from 01.02.10)	140-145	0	0	20-25	0	0
A Tierney, Director of Strategy (from 06.07.09)	135-140	0	0	95-100	0	0
D Wynford-Thomas, Non Executive Director	5-10	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
R Kilner, Non Executive Director (from 01.12.09)	5-10	0	0	0-5	0	0
J E Wilson, Non Executive Director (from 01.12.09)	5-10	0	0	0-5	0	0
P Panchal, Non Executive Director (from 01.07.10)	0-5	0	0	0	0	0
K Jenkins, Non Executive Director (from 01.07.10)	0-5	0	0	0	0	0
R Pinsent, Director of Facilities (until 31.03.10)	0	0	0	100-105	0	0
H Seth , Acting Director of Strategy (until 05.07.09)	0	0	0	25-30	0	0

Name and Title	2010-11			2009-10		
	Salary	Other remuneration	Benefits in kind	Salary	Other remuneration	Benefits in kind
	(bands of £5000) £000	(bands of £5000) £000	rounded to the nearest £100	(bands of £5000) £000	(bands of £5000) £000	rounded to the nearest £100
J Aird, Director of Information Management & Technology (until 31.03.10)	0	0	0	115-120	0	0
Dr R Graham-Brown, Director of Services For Older People (until 02.09.09)	0	0	0	40-45	70-75	0
A Cole, Medical Director (until 18.01.10)	0	0	0	90-95	60-65	0
A Maitland, Director of Operations (until 31.05.09)	0	0	0	20-25	0	0
J Shuter, Acting Director of Finance and Procurement (until 31.01.10)	0	0	0	95-100	0	0
J Matharu, Non Executive Director (until 30.11.09)	0	0	0	0-5	0	0
C Emmett, Non Executive Director (until 31.01.10)	0	0	0	5-10	0	0
A Kapur, Non Executive Director (until 30.11.09)	0	0	0	0-5	0	0
J S Worthington, Non Executive Director (until 30.11.09)	0	0	0	0-5	0	0

R Graham-Brown, K Harris and D Rowbotham's salaries have been split according to the time allocated for managerial activities.

R Pinsent (Director of Facilities) is no longer included in the above note as following the Trust's restructure this post now reports to the Director of Strategy who is a non-voting member of the Trust Board. Values for 2009-10 are still disclosed in the note.

Salary and pension entitlements of senior managers

Pension Benefits

Name and title	Real increase in pension at age 60 (bands of £2500) £000	Real increases in lump sum at age 60 at 31 March 2011 (bands of £2500) £000	Total accrued pension at age 60 at 31 March 2011 (bands of £5000) £000	Lump sum at age 60 related to accrued pension at 31 March 2011 (bands of £5000) £000	Cash Equivalent Transfer Value at 31 March 2011 £000	Cash Equivalent Transfer Value at 31 March 2010 £000	Real Increase in Cash Equivalent Transfer Value £000	Employers Contribution to Stakeholder Pension To nearest £100
M Lowe-Lauri, Chief Executive	(0.0-2.5)	(2.5-5.0)	85-90	255-260	1,618	1,725	(192)	0
A Seddon, Director of Finance and Procurement	0.0-2.5	5.0-7.5	10-15	40-45	244	215	18	0
S Hinchliffe, Chief Operating Officer	0.0-2.5	0.0-2.5	55-60	165-170	941	989	(98)	0
K Harris, Medical Director	0	0	0	0	0	0	0	0
K Bradley, Director of Human Resources	(2.5-5.0)	(2.5-5.0)	30-35	90-95	490	555	(92)	0
A Tierney, Director of Strategy	12.5-15.0	0	15-20	0	97	13	83	0
Professor D Rowbotham, Director of Research & Development	0	0	0	0	0	0	0	0
M Wightman, Director of Communications	0-2.5	0.0-2.5	15-20	50-55	221	246	(37)	0
S Ward, Director of Corporate & Legal Affairs	(0.0-2.5)	(0.0-2.5)	30-40	105-110	579	627	(79)	0

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

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

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

Exit Packages

NHS Body	University Hospitals of Leicester NHS Trust			
Exit package cost band (including any special payment element)	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band (total cost)	Number of departures included in (b) and (c) where special payments have been made (special payment element totalled)
<£20,001	38	0	38 (223)	0
£20,001 - £40,000	3	0	3 (68)	0
£40,001 - 100,000	0	0	0	0
£100,001 - £150,000	0	0	0	0
£150,001 - £200,000	0	0	0	0
>£200,000	0	0	0	0
Total number of exit packages by type (total cost)	41 (291)	0		
			Total number (and cost) of exit packages	Total number of special payments (and total cost of special payment element)
			41 (291)	0

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 the East Midlands Strategic Health Authority (NHS East Midlands), 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 joint Chief Executive of the two local PCTs and Leicestershire Partnership NHS Trust. The Trust's participation in delivering the Leicester, Leicestershire and Rutland urgent and emergency care system improvement programme 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 2011 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. The Trust Board has approved a 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 and extravagance 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 (Deputy Chief Executive) 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 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 coordinates the process for ensuring that the Trust achieves compliance with the requirements 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 and advises the Trust Board on governance matters;
- the Director of Facilities – 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 has managerial responsibility for the Information Management and Technology and Facilities Directorates, respectively.

From 1 April 2010, new management arrangements took effect, with the creation of four new Divisions, each led by a Divisional Director. From that date, Divisional Directors, supported by Divisional Managers and Heads of Nursing have exercised responsibility for the management of risks at individual Divisional level.

I meet with all the Executive and other Directors of the Trust on a regular basis to discuss and review performance. The Executive Team, which includes all of the aforementioned Directors, assists me in my role. I chair this group, which meets weekly, and it regularly considers significant risks, issues and exceptions and the proposed corrective action.

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 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.

4. The risk and control framework

The Trust's revised risk management strategy 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 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 have included 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 2010/11.

During 2011/12, the Trust Board will continue to review regularly the Trust's control environment to enable it to manage these and the other significant business risks identified in the organisation's 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 2010/11, the Director of Strategy 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 2010/11.

The Trust took further actions during 2010/11 to secure improvements in its information governance arrangements. An Information Governance Steering Group monitors and oversees 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. This contains 45 standards of good practice. This year, the Department of Health has structured the standards to be significantly more prescriptive and the bar to achieving a 'satisfactory' rating has been raised. 'Satisfactory' will only be achieved when all 45 standards achieve level 2 out of a possible score of 3. The Trust has scored level 1 on 5 standards (out of 45). The Trust's overall percentage score is 75 per cent compared to 77 per cent in 2009/10.

Within the 45 standards, 22 are considered key assurance standards which comprise the 'Statement of Compliance'. The Trust has scored level 1 on five of these standards. Plans are in place to ensure that the Trust achieves level 2 scores in 2011/12.

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, Governance and Risk Management Committee, Research and Development Committee and Workforce and Organisational Development 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 on Fraud. 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 Quality and Performance Management Group (acting on behalf of the Executive Team) 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 Audit Opinion for 2010/11, the Head of Internal Audit has noted the Trust's processes for in-year monitoring and scrutiny of the assurance framework which is updated with relevant risks and controls on an ongoing basis. The Head of Internal Audit has stated that the Trust's assurance framework processes are well embedded within the organisation and that in-year monitoring and scrutiny of the assurance framework, and the established reporting arrangements, are working effectively.

The assurance framework 2010/11 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 2010/11, 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 CQC essential standards of quality and safety.

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.

The Trust is fully compliant with the CQC essential standards of quality and safety.

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 2010/11, 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 a climate change risk assessment and developed an Adaptation Plan, to support its emergency preparedness and civil contingency requirements, as based on the UK Climate Projections 2009 (UKCP09), to ensure that this organisation's obligations under the Climate Change Act are met.

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 Audit Opinion for 2010/11, 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 Trust's objectives, and that controls are generally being applied consistently.

During 2010/11, Internal Audit issued 20 reports arising from their work. In all but three instances, significant assurance was provided that there was generally a sound system of internal control, designed to meet the Trust's objectives, and that controls were being applied consistently. None of the three instances identified any high risk issues; and the Trust has since acted, and continues to act, to address Internal Audit's findings and recommendations to strengthen controls in the areas in question (clinical audit; information governance; and appraisals training and development).


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 2010/11, 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 2010/11, 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, Executive Team, Finance and Performance Committee, Governance and Risk Management Committee, Workforce and Organisational Development Committee and Audit Committee. During 2010/11, 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.

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 2010/11. In particular, further work will be undertaken in 2011/12 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 2011/12.

I am of the opinion that the implementation of the actions described above will strengthen the Trust's system of internal control in 2011/12 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: 
Chief Executive
(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 statements for the year ended 31 March 2011.

This report is made solely to the Board of Directors of University Hospitals of Leicester NHS Trust, as a body, in accordance with Part II of the Audit Commission Act 1998. Our audit work has been undertaken so that we might state to the Board of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board of the Trust, as a body, for our audit work, for this report 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 University Hospitals of Leicester NHS Trust for the year ended 31 March 2011. We have not considered the effects of any events between the date on which we signed our report on the statutory financial statements 9 June 2011 and the date of this statement.



Andrew Bostock

For and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants
One Snowhill
Snow Hill Queensway
Birmingham
B4 6GH

15 September 2011

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 2011.

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

1 The information we give:

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

.....

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

.....

2 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	
A year of change, including how we perform against targets	
Our new clinical divisions reflect on achievements in their first year	
We're passionate and creative, including research and development, releasing time to care, older people, volunteers and our charity	
We do what we say we're going to do, including PILS, complaints, FOI, risks, information governance, health and safety and emergency planning	
We treat people how we like to be treated, including nursing, listening, engaging and involving patients and equality and diversity	
We are one team and we're best when we work together, including staff, national survey results, reward and recognition and members	
We focus on what matters most, including privacy and dignity, same sex accommodation, infection control,	

	Please list your priorities Start with 1 for your most useful and 12 for least useful (1 as top priority)
safeguarding, chaplaincy and sustainability	
Our priorities for 2011/12	
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 2012/13 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

BACK PAGE

Published by the University Hospitals of Leicester NHS Trust

June 2010

(TO BE TRANSLATED)

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

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

If you would like this information translated
please contact our Service Equality
Manager on 0116 258 8295

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 लीफ़्लेट का लिखती या टेप पर अनुवाद चाहिए तो कृपया
डैव बेकर, सर्विस ईक्वालिटी मैनेजर से 0116 258 8295 पर सम्पर्क कीजिए।

જો તમને આ પત્રિકાનું લેખિત અથવા ટેપ ઉપર ભાષાંતર જોઈવું હોય તો મહેરબાની
કરી ડેવ બેકર, સર્વિસ ઇક્વાલિટી મેનેજરનો 0116 258 8295 ઉપર સંપર્ક કરો.

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

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

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

Published by University Hospitals of Leicester
NHS Trust June 2011

University Hospitals of Leicester



NHS Trust

Caring at its best